COCA Call: **Medicare and Medicaid Electronic Health Records Incentive Program: Promoting the Adoption of Electronic Health Information Technology**
Date/Time: **January 25, 2011 (1:00 PM- 2:00 PM ET)**
Presenter: **Jessica Kahn and Travis Broome, Centers for Medicare and Medicaid Services**

Coordinator: All lines are in listen only mode until the question and answer session of today's call. At that time, to ask a question, please press star 1. I would now like to turn - oh excuse me.

Today's call is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the call over to Miss Loretta Jackson-Brown. Thank you. You may begin.

Loretta Jackson-Brown: Thank you (Cheryl). Good afternoon. I'm Loretta Jackson-Brown and I'm representing the Clinician Outreach and Communication Activity, COCA, with the Emergency Communication System at the Centers for Disease Control and Prevention.

I am delighted to welcome you to today's COCA conference call, Medicare and Medicaid Electronic Health Records Incentive Program: Promoting the Adoption of Electronic Health Information Technology.

We are pleased to have with us today Jessica Kahn and Travis Broome from the Centers for Medicare and Medicaid Services (CMS) here to provide information on the Federal incentive payments available to clinicians and hospitals when they adopt electronic health records.

During today's call you will hear the presenters referring to slides in their PowerPoint presentation. The PowerPoint slide set is available from our COCA Web site at emergency.cdc.gov/coca. Click on COCA calls, the slides that can be found under the call in number and call passcode.

The objectives for today's call are that participants will be able to understand the basis of the Medicare and Medicaid Electronic Health Records Incentive Program, understand the path to payment for the Medicare and Medicaid Electronic Health Records Incentive Program and identify national, regional and local resources available to clinicians related to electronic health record selection, implementation and meaningful use.

Following the presentation you will have an opportunity to ask our presenters questions. Dialing star 1 will put you into the queue for questions.

In compliance with continuing education requirements, all presenters must disclose any financial or other association with the manufactures of commercial products, suppliers of commercial services or commercial supporters as well as any use of an unlabeled product or products under investigational use. CDC, our planners and the presenters for this presentation do not have financial or other associations with the manufactures of commercial products, suppliers of commercial services or commercial supporters. This presentation does not involve the unlabeled use of a product or products under investigational use. There is no commercial support for this activity.

Our first presenter is Travis Broome, a Health Insurance Specialist and Special Assistant to the Consortium Administrator for Quality Improvement

and Survey and Certification, CMS. He leads the development of the criteria for meaningful use for the Medicare and Medicaid Electronic Health Records Incentive Program for the Office of E-Health Standards and Services. During the development of the regulations for Electronic Health Records Incentive Programs he was the writer for the meaningful use and other sections as well as a project manager for the regulation. Prior to his work on the Electronic Health Records Incentive Program, Mr. Broome was a presidential management fellow in CMS and participated in programmatic and administrative activities across every CMS regional division. He received his Masters of Public Health and Masters of Business Administration from the University of Alabama at Birmingham.

Our second presenter is Jessica Kahn. She's Technical Director for Health Information Technology in the Centers for Medicaid, Children's Health Insurance Program, Survey and Certification at CMS. In this role she contributes to health information technology, electronic policy development, drafting regulations and guidance, federal health information technology coordination, and over side of state's implementation of the Medicaid Electronic Health Records Incentive Program. She also serves as a Project Officer for the Health Information Technology Focus Medicaid Transformation Grants and is CMS lead for the Children's Health Insurance Program Reauthorization Act funded projects to develop a model pediatric electronic health records format in partnership with the Agency for Healthcare Research and Quality.

If you're following along on the slides, you should be on slide 6. Again the PowerPoint slide set is available from our COCA Web site at emergency.cdc.gov/coca.

At this time, please welcome our first presenter, Mr. Broome.

Travis Broome: Thank you Loretta. We'll - for inviting us here today to talk about this exciting program. These are fun times for Jess and I and all of our folks at CMS because registration is now actually open for the site so there's actually a call to action for us on the CMS side which always makes our presentations a little more interesting at the end.

So we'll go ahead and move onto past the title slide to Slide 7, give a little session overview. Really there's two goals to this main session that we want you to take home.

One is we want to talk about how EHRs can really improve patient workflow, clinical service, administrative processes, how they can engage patients and families, and the things that we believe EHRs can assist with and therefore be used to improve which is why we really care about this topic at all.

The second bullet we're really going to talk about is because we believe EHRs can do all these things and because Congress believes so they appropriated a lot of money to incentive payments to clinicians and hospitals for adopting meaningful use in certified EHR technology.

So basically we're going to talk about why EHRs are useful and then what we're doing to incentivize that use.

So going onto Slide 8, it's a little bit of background. As I mentioned, Congress passed legislation as part of the Recovery Act. This particular section was the

HITECH or the Health Information Technology for Economic and Clinical Health Act back in February of '09 which doesn't seem that long ago to me but apparently is quite long ago.

The Office of the National Coordinator for Health Information Technologies, CMS and other agencies really have been laying the groundwork for the programs. You know, there's the incentive program and then the big program out of the Office of the National Coordinator is the idea of certified EHR technologies. Those are kind of the rule making programs.

However, both CMS, ONC and AHRQ and many other HHS agencies including CDC are doing a lot of behind the scenes work in education and outreach and laying infrastructure that really supports meaningful use and certification and make it possible and to actually bring it about.

Go ahead and move onto Slide 9. And so now we're going to really talk about what meaningful use is. Back in February of 2009 when the law was passed, everybody was kind of reaching for their dictionaries assuming this would be pretty straight forward thing to figure out and it hasn't turned out that way for those of you familiar with the program.

You know, over almost two years later, meaningful use has really become essentially three different things when we use it in this term. The first thing and the most important thing we say meaningful use is that the description of the use in certified EHR technology that we believe will improve quality and safety and efficiency and reduce health disparity.

We think it'll increase engagement of patients and families in their healthcare. We believe it'll improve care coordination, improve population and public health all the while safeguarding privacy and security.

Because of - the belief that certified EHR technology can do those things is really why we're all here. It's why Congress appropriated over $30 billion, or another way to think about that that usually nods head - gets heads to come up and everybody's eyes to open when I say it and I can see the people is it really amounts to $100 per person in the United States toward the adoption of EHRs and the meaningful use of them.

So everybody you meet today, including yourself, is essentially kicking $100 based on the belief that meaningful using certified EHR technology can do those things I just talked about.

The second thing it is, and this is the thing that's represented on the slide is it's a framework for getting from where most providers are using EHRs today or maybe even not using EHRs yet, that's still about half of providers, to where we believe the use needs to get in order to actually accomplish the things I talked about.

It's - one of the phrases used is it's not a paper saving exercise. Just having an EHR system in your practice or in your hospital isn't going to accomplish the five goals that I outlined previously. So we really need to focus on getting the systems in place and then progressing the use from where we are today to the type of use that has been shown to actually improve the things we talked about.

There's a recent study that just came out that talked about a basic system on I believe it was a Stanford study. It was 19 out of 20 measures that they looked at having EHR. Just having an EHR didn't make a difference. But for those systems where clinical decision support was part of the EHR, they made a statistically significant and greater difference in those measures over those who just had an EHR.

So that's the type of thing we talk about when meaningful use needs to move us forward. And I'll describe that arrow in just a second.

The third is meaningful use is the doorway for most of the incentives. It is the key phrase that Congress used in the HITECH Act to kind of be the decision point or the gateway from receiving the incentives or not receiving the incentives and Jess and I will explain how to go about passing through that gateway as the presentation goes on.

So the slide in front of you with the arrow with the three dots there, that really, like I said, is the framework for meaningful use that we outlined in our rules and are moving forward with. It was really the brain child of both internal CMS and HHS components and then as well from the HIT policy committee which is our Federal Advisory Board of how to get from where we are to where we want to be.

The first step, and each bubble there represents stages, so you hear me say Stage 1, Stage 2, Stage 3. Stage 1 circled there in red really data capture and sharing, so the Stage 1 really focuses on the idea of if the information isn't available in a way that the system can recognize, i.e. that aspirin is aspirin and not a seven letter word, that's the first step. Until you do that you can't have

clinical decision support. You can't share information. You can’t do any of the things that will actually lead to improve the outcomes.

So Stage 1 is really to require getting all that information into certified systems in a structured way that's recognizable by those certified systems. And then we want to go ahead and start testing the ability to use that information in clinical decision support and health information exchange and reporting to public health agencies and engaging patients and their families.

But the real core - you'll hear me - well there's an actual core that we'll talk about in a few minutes, is to get that information in the system.

Stage 2, the next step is all right well now that we have the information we have to design processes that we believe will use that information to improve quality, to improve care coordination, to improve population and public health. So that's really Stage 2 is having those processes, putting them in place and using them.

And then Stage 3 I call it the figuring out if we were right stage, and that's to actually see if we're generating improved outcomes based on the information we captured and the processes we designed to use it.

So that's really the framework for meaningful use. We'll talk mostly about Stage 1 and Stage 1 is focused on 2011, 2012. Hopefully we'll be having Stage 2 proposed rule making up this year, probably toward the very end of this year in time for it to be ready in 2013.

So we'll move onto the next slide which is Slide 10 and we'll get in to some of the details about Stage [1] meaningful use. Meaningful use - this really talks about kind of how we demonstrate. So how do you - how we know. How does CMS know that you're a meaningful user?

In the first year there's going to be a reporting period over which we'll essentially measure, or you all will measure and report to us your progress or status on 25 if you're an EP or 24 if you're a hospital objectives which include clinical quality measures.

You won't have to report on all of those and we'll talk about that in just a second. But that's the outline.

For the first year there's a 90 day reporting period. After that it's a year. This - the reason for that's very simple. It's just when you're first year you might not be ready to go live on say January 1, 2011 since that's passed. I'm sure that's true of many.

So the 90 days is to give you as much time to go live in a given year and still get an incentive for that year while still having a meaningful measurement period. Once you go live and you're up, then we think we can do the year successfully.

Now the first year does not mean 2011. It's whatever your first year is. So if your first year's 2012, then you would get the 90 days in 2012.

For Stage 1 we're talking about attestation which basically means exactly what it sounds like. You'll tell us your performance on a measure and just report it

to us. And if it meets the threshold, the self-reporting will be sufficient to get the incentive.

There's two types of objectives. Well there's really three types of objectives when you count clinical quality measures. But clinical quality measures use numerator and denominator. So some of the objectives you'll say, I throw out an example, I had 1000 patients during my EHR reporting period, 900 of them have structured data in their problem list. So 900 would be my numerator, 1000 be my denominator. Other objectives are, you know, did I test my capability for health information exchange, yes or no, and you just tell us yes or no.

Four certain objectives and measures like the one I just mentioned, problem list, you'll need at least 80% of your patients would have to have their records in certified EHR technology. So that means 20% could be out and it would still technically be possible to meet the measure. And we'll talk a little bit more about the numerator and denominator as we move on.

So go to Slide 11. Slide 11, and the next - actually the next four slides are kind of lumped together. There are really four major problems that were highlighted by the public during our rule making process.

The first was this idea of an all or nothing approach. You know, we had 25 objectives for an EP, 24 if you're a hospital. The way it was originally proposed, if you missed on one, you weren't eligible for the incentives.

Given the complexity of the EHR implementations, the - basically it was shown said to be too difficult or too high of a standard.

The next thing that's coming - we'll talk about on later slides is there's the burden of actually reporting meaningful use. You know, we want the focus to be on the actual meaningful use because that's what gets us the outcomes we want. So we're trying to minimize the burden of meaningful use - of reporting meaningful use.

The uncertainty created by allowing state flexibilities in meaningful use, there's a lot of concern by vendors and providers alike that if states has a large amount of flexibility and there were 50 different definitions of meaningful use, it essentially wouldn't be possible to create certified EHR technology. So we addressed that issue.

And finally the application of meaningful use to all specialties and various professionals that are eligible to receive the incentives. Not all objectives might be possible for all providers. For instance, I'll use an easy one, Chiropractors are an eligible professional under Medicare, but in every state they can't write prescriptions so e-prescribing becomes kind of irrelevant for them.

So we address those four areas and that's what I'm going to go over next. The first one we're going to talk about is what we did about the all or nothing approach. And what we did here is we took the idea of a core and a menu set.

So we put 15 objectives in the core if you're an eligible professional, 14 if you're a hospital. And the core objectives focus really on four things. One, there were some statutory requirements, namely e-prescribing, electronic

health information exchange and clinical quality reporting that were required to be a part of meaningful use. So those are in the core.

Then we really focused on those things that really focused on the data capture elements that I was talking about earlier, one of the foundational elements that you have to do if you actually want to do things like health information exchange or report clinical quality measures or do clinical decision support.

The third thing we focused on was engaging patients and their families. Under existing laws many of the requirements under meaningful use already exist in kind of a paper world so meaningful use moves them into the electronic world and then also provides a couple of best practice type objectives for engaging patients and their families.

And finally, if we don't protect privacy and security, nobody will have faith in this system at the provider level, the patient level, the public health agency level. So that had to be part of our core and it permeates throughout all of this.

So that's really how we decided on what went into the core. How we decided what went on the menu was essentially everything else. It does focus, like I said, more on the aspirational objectives of reporting to public health agencies some of the new engagement of patients and families, clinical decision support, things like that.

So what we said, of the menu set you only have to do five out of ten both for hospitals and eligible professionals. There's no criteria - with the one exception when it comes to public health. You can defer any five for any

reason -- I don't like it. It didn’t work out for me. Whatever reason you want to use.

The only exception to that is in public health. There are three public health objectives if you're a hospital, two if you're an eligible professional. And since that's one of our goals, we didn't want to leave that goal completely behind.

So you either need to have exceptions to all of those which we'll talk about exceptions in a little bit or you need to report on one. Barring that caveat, you can defer any five you like.

One of the core objectives is clinical quality measure submission. For EPs they need to submit six total measures, three from a list of what we call core again or alternate core. So there's a list of three we want you to kind of first priority. If it doesn't work out for one of those there's another three. Just try and make it into the core.

And then there's a laundry list of 38 from the menu set, so you just report three more on those. If you're a hospital, there's just a list of 15 that you would report on.

And it's important to note on clinical quality measurement, there aren't exclusions for clinical quality in the sense that there are for the other meaningful use objectives. However, you can report if that’s correct for your situation. We call it zero denominator, you know, I had no patients that met that clinical measurement criteria and that is an acceptable submission.

So we'll move to the - what we did to address the next problem and that's the burden of reporting meaningful use. We actually did two things, only one of which is talked about on the slides.

One of the things we did is we just changed a lot of the ways that measurements are done. A good example is CPOE. Originally, the denominator for CPOE was all orders for a hospital, all orders for an EP. We limited that to medication orders and only one medication order for patients who have basically wrong medications, have a medication in their medication list.

So we changed a lot of the denominators and there certainly isn't time to go through each one here on the slide. But the more global thing we did is we looked at what was required by the denominator. What did you have to know?

And there was one denominator where it's all patients. You know, the idea there's no caveat. It's not patients aged five or over. It's not patients on a medication list. It's not patients, you know, with a certain disease. It’s if the denominator was all patients, seen or admitted, then we said well you can know that. That's a knowable number that you can determine even if some of those patients, their records aren't kept in certified EHR technology. They're still on paper because of Worker's Comp or you haven't done the complete rollout for whatever reason.

But those patients where we did ask for something more specific where we asked that, you know, it was - the number of labs ordered on behalf of patients or patients over 2 or patients over 65. Then we said that denominator is much more difficult to calculate without the assistance of certified EHR technology.

So any time we ask for a subset of the all patient denominator, we allow the EP or the hospital to base that only on patients whose records are kept using the certified EHR technology. That way certified EHR technology, if used correctly, will be able to provide you with the denominator as opposed to manual calculation.

The third thing I talked about was State flexibility. There is some State flexibility out there still. It's heavily limited. We focused on four public health related objectives. They're listed there on Slide 13, basically immunizations, lab reporting, Syndromic surveillance and then also generating a list of patients by specific conditions for QI, reduction disparage, research or outreach.

So those are the areas the State could modify. To date, no States have made a request to actually do that.

And that brings us to our last major concern that we addressed and/or changed and that's the idea of applicability and meaningful use, and this is on Slide 14.

So for some meaningful use objectives we just traded an exclusion. That information is available just like the information on the numerator, the denominator. I'll give you a little resource for that at the end of my section.

The important thing to note here is that there's two important things. Every exclusion is unique. So you can't say because I'm - so and so- because I'm a cardiologist, I don't have to X. Each EP or each hospital needs to read the

exclusion language and decide if they as an individual EP or they as an individual hospital meet the exclusion.

This is a different problem than the issue of the all or nothing approach therefore the exclusions are not lumped in with the core menu set. So in the case of an exclusion in the core, you just don't have to meet that one. In the case of an exclusion in the menu set, that will actually count if you exclude an objective. That does not take away from your ability to defer another five.

So for instance, if I don't do immunizations and I don't collect syndromic surveillance data, I have to exclude both of those under the public health caveat I said earlier. So in my case I would report data on three from the menu set. I would have my two public health exclusions and then I could defer the other five.

Moving on to Slide 15, a little information about clinical quality measurements. Basically the only thing I really want to say about this is we're attestation only. So it uses - it's the same as meaningful use. You just give us the number in the data and that's for 2011, 2012 you're going to go through and give us electronic support submission. This will be done through your certified EHR technology and it'll just be a little quicker.

The thing to remember here is that for Stage 1 we're focusing on the process of collecting clinical quality information, not making sure we get perfect numbers. For this reason we want you to use the capabilities of certified EHR's technology to determine the measures and then just report to us what the system generated.

All right. The Slide 16, this just gives you some information about where to find more information about meaningful use. The slide's unfortunately a little dated. The spec sheets are now available for e-prescribing and for hospitals. And the straight link to the meaningful use section, the Web site has changed but it's still easy to get to. You just go to www.cms.gov/ehrincentiveprograms - forget that last part [of web link www.cms.gov/EHRIncentivePrograms/99_Meaningful_Use.asp#TopOfPage]

In the left hand column there'll be a link called meaningful use and just click on that and it'll take you to all the spec sheets for all the meaningful use measures.

And with that I'm going to turn it over to Jess to talk about how to actually get the incentives and a little bit more about the Medicaid side of the program.

Jessica Kahn: Hello and thank you Travis. Okay. So as you mentioned, this program is actually two programs. There is a Medicare e-insurance in a program and a Medicaid e-insurance in a program. And Slide 17 outlines some of the high level differences between the two programs.

So if you are an individual professional, in some instances you might be eligible for both and would have to make a decision. So I'll walk through a little bit of that before getting into the up to date status of both programs.

So first of all for Medicare, CMS is implementing this program whereas for Medicaid it is state Medicaid agencies that are implementing the EHR Incentive Program. And it's voluntary. At this point all states are indicating

that they are implementing the program but it is voluntary for them and they set their own timeframe.

Under Medicare there will be payment reductions for eligible providers who do not demonstrate meaningful use beginning in 2015. There are no such Federal payment reductions under Medicaid.

Under Medicare, providers must demonstrate meaningful use as Travis described it in their first participation year, so that would be 2011 starting in 2011. Whereas for Medicaid they have this option called adopt, implement and upgrade where for their first participation year, and it could be any calendar year through 2016, they have to demonstrate that they have only adopted, implemented or upgraded. And I'll define those a little bit better. They don't have to demonstrate meaningful use until their second participation year.

The dollar amounts are different as are the timing. For Medicare it is a five year program. The maximum an eligible professional, which is what EP stands for, can receive is $44,000 though they can get a bonus for working in a health provider shortage area. Under Medicaid the total is $63,750 over six years.

We have one common definition of meaningful use for Medicare and Medicaid. We did allow in our final rule that states might be able to adopt some additional requirements for meaningful use subject to CMS prior approval. At this point we do not have any states exercising that flexibility.

The last year a provider can initiate the program for Medicare is 2015. They need to register by 2016. And as I mentioned before, the payment adjustments are given in 2015. For Medicaid it is a ten year program so it goes through 2021. The last year they can initiate or register the program though is 2016.

And then who's eligible varies between Medicare and Medicaid. So under Medicare, it's only physicians, sub-section (d) hospitals or otherwise known as acute care hospitals and critical access hospitals which is what C-A-H, CAH, stands for.

Under Medicaid it's a more expansive list. There are five types of eligible professionals. They are physicians, nurse practitioners, certified nurse midwives, dentists and some physician's assistants who are working in federally qualified health centers or rural health centers that are led by a physician assistant.

We also include acute care hospitals, children's hospitals and under our definition of acute care hospitals under Medicaid, critical access hospitals are eligible as well.

Moving on to Slide 18, as I promised, I would define adopt, implement and upgrade. And what that means for a provider who is eligible for Medicaid to get their first year incentive funding of $21,250.

So they have to demonstrate really, and that's why I have just adopted and upgraded highlighted because these are the two that really matter initially. There was no certified EHR technology prior to the fall of 2010. So they either already have something and they are upgrading it to the newly certified

version from an authorized testing or certification body from the Office of National Coordinator or they're adopting a new certified EHR technology or a combination of modules.

So to implement it we refer to as our poor middle child, it's neglected, because really it all hinges on adopting and upgrading at this point. And I want to emphasize that providers have to adopt or upgrade to certified EHR technology that's capable of meeting all of the meaningful use objectives.

And I say that because as you're probably well aware there's a variety of options on the marketplace. There are whole EHR systems which do everything, soup to nuts, and then there are some that only might fulfill one, two, three, four or smaller subset of meaningful use objectives and functions.

And so providers might be combining different certified EHR modules that once put together as a sum are capable of meeting all the meaningful use objectives.

So for the adopt, implement and upgrade, while you don't have to demonstrate meaningful use in your first year you do need to have the certified EHR technology that's capable of meeting meaningful use and all of the meaningful use objectives in order to get your first EHR incentive payment.

And there's no EHR reporting period for this because obviously adopting and upgrading is something that you've signed a contract or a user agreement or a license agreement. You've acquired it in some way. That's not something that you need to do over a sustained period of time. It's something that you can frankly accomplish in a day. There's no EHR reporting period.

So moving on to Slide 19, let's talk about which states have launched their EHR Incentive Programs and what they need to do in order to do that. So CMS has administrative funding available to states to help them implement the program.

As I said, CMS is implementing the program for Medicare so the states need to set up a similar infrastructure to implement their programs. So how do they know - how do they allow providers to continue their enrollments? How do they determine who's an eligible provider? How do they make the payments? How do they capture the information and so on?

So they have to submit a plan to us which we call a State Medicaid HIT Plan which has to be approved. They also have to request funding through an Implementation of Advanced Planning document, an IAP and a few other steps in order for CMS to allow them to launch.

We now have 14 states that have both approved plans and approved funding. And as you can see there are a number of final plans and funding requests that are in the queue currently under review. So we have a lot of momentum and interest here.

Slide 20 is talking about which states have launched their programs this month. So hopefully you know this if you're a provider, but let's go through it just in case. Oklahoma, Louisiana, Kentucky, Mississippi, Alaska, North Carolina, South Carolina, Michigan, Iowa, Texas and Tennessee all launched their state Medicaid EHR Incentive Programs on January 3rd of 2011.

And of these, four of them have already issued EHR incentive payments. Another one will be making payments, Michigan, hopefully by the end of this month. And North and South Carolina will also issue payments before March.

So we are seeing large amounts of money already moving out to the providers which is of course is the intent. As Travis mentioned, this was part of the stimulus bill, so we have many goals with our program.

And so I just wanted to point this out because when we talk about or when we hear about what might be some of the challenges to participating in this program, there are a number of providers both eligible professionals and hospitals who have already successfully registered with CMS, transferred their information or we transferred their information, I'll go through that in a minute, over to the state.

They completed what they needed to do with the state and the state has cut a check and it's hit their bank account. As a matter of fact, in several of the states even though these are the days of electronic funds transfer, they actually printed large giant checks and had some press events where they were handing a large check to the providers like Ed McMahon - it was exciting.

And of course, CMS went out to videotape that and we'll be posting that on our YouTube site on our Web site.

So if you're not from one of these 11 states, you're thinking okay, what's the status of my state and when is my state going to launch their program because you're probably trying to decide whether you're eligible for Medicare or Medicaid. And part of your decision making might also be around the timing.

So on our CMS Web site there is a PDF file and also an interactive map where you can click on your state and it has not only the timeframe when the state thinks they're going to launch their EHR Incentive Program but also the Web address the state has given us for where information about their program resides on their State Medicaid agency Web site because we have their information, we update it monthly, but they have the most timely information.

So if you want to go to your own state's Web site and see what they say as well we recommend that. So again, on our CMS general Web site, cms@hhs.gov/cms - I'm sorry, slash EHR Incentive Programs and I'll show that on a slide in a minute, you can find this information. [www.cms.gov/ehrincentiveprograms]

So let's talk about registration. So what do you need to participate? And hopefully most of you are aware of this but let's go through it. And of course we're going to have questions at the end.

All providers must use certified EHR technology. Travis and I have both talked about that, whether it's to adopt, implement, upgrade or meaningful use it in their first year. All providers, whether you're choosing Medicare or Medicaid register via the CMS EHR Incentive Program Web site. So it's one front door for both programs.

You have to have a National Provider Identifier and have a National Plan and Provider Enumeration System Web user account. We're leveraging these existing identifiers and these existing systems to facilitate registration because

we can pre-populate and validate some of your information much easier that way.

So those same NPPES which is the acronym for that system, the NPPES user ID and password will be used to log into the EHR Incentive Program system.

Moving on to Slide 23, you have to be enrolled in Medicare Fee for Service, Medicare Advantage or Medicaid Fee for Service or managed care. Again this is an EHR Incentive Program for Medicare and Medicaid providers who I would think somewhat common sense would need to be a Medicare or Medicaid provider enrolled.

And I say this, but we have had providers who have registered at the states and have been rejected because they are not enrolled providers with the state Medicaid program. So let me just emphasize that again. You need to be enrolled in Medicare or Medicaid, both fee for service and managed care are available.

All Medicare providers and all Medicaid specified hospitals and eligible professionals and all Medicaid eligible hospitals must have an active enrollment record in the Provider Enrollment Chain and Ownership System, otherwise known as PECOS.

This does not apply to Medicaid eligible professionals. But all Medicare providers and the Medicaid eligible hospitals have to have an active enrollment record in PECOS. They will not be able to (include) registration if they don't have PECOS enrollment. And on our slide here, we have a Web

link that you can go to to verify if you have an active PECOS enrollment record.

As I mentioned, this is one front door for this program on a modified 24. All eligible providers could register at this one site. So then what happens if you select Medicaid? So roll this back up. So let's see what just happens when - if you select Medicare.

So if I'm an eligible professional and I have to choose and I've selected Medicare, or if I'm an eligible hospital I'm eligible for both and I selected both, you can register as of January 3rd, but they can't come back to a test to meaning meaningful use of certified EHR technology until April of 2011.

So we will hold your registration information until then. You would need to come back at that point and complete your attestation in order to move on. You're past the payment.

For Medicaid, registration launched on January 3rd for those 11 states that I listed and the others are coming on board in the coming months. So we have, as I said, that document on our Web site that lists their timeframes.

So how do we hand off that registration to the states? So if I selected Medicaid or I'm a hospital that selected both, after I complete my registration on the CMS site, they are given a link to the state's Web site where they need to complete that information.

So if I selected Alaska, it gives me the Web site URL for Alaska's Medicaid EHR Incentive Program. And they would go on there, log in and complete the

submission of any required information for the state and also do their attestation for adopt, implement and upgrade.

Just to clarify terms, what do I mean by attestation? It's similar to online filing of taxes where you complete certain information through dropdown menus or entering data and then you have a digital electronic signature where you attest that that information that you have provided is true.

So they would complete that information at the state and the state will then verify it. And just to note, that this process has been completed successfully already in four states. And as of last week, as of January 18, 2011, over 13,650 providers had initiated registration for both Medicare and Medicaid.

So there's tremendous interest and we're excited to see the initial payments and all of the providers who are registering for both programs.

So how can CMS help? On our Web site there's a Registration User's Guide. We are doing Webinars and calls such as this one, some focusing just on registration, focusing on the program at large. We are going to be doing Webinars on attestation examples so for both Medicare and Medicaid so that the first time you see what an attestation for meaningful use or for adopt, implement and upgrade looks like shouldn't be when you're either on the CMS site ready to do it or when you're at the state site ready to push submit.

We'd like you to have the opportunity to walk through it and to see it beforehand so that you feel comfortable with it.

We also have published frequently asked questions on a variety of topics, many of the ones we mentioned today plus many others. Those are all on our Web site. There's a searchable dynamic list. There's also a PDF file with some specific Medicaid frequently asked questions.

We have an information center that is open and it receives approximately 300 to 350 calls a day, and they also can be contacted through email, and they will help providers with the registration process.

And under Medicaid we are creating Communities of Practice so that states who are launching their programs can help those who haven't launched yet to save time, to save resources. And while these Communities of Practice are not focused on providers, I think you would appreciate that the more help we can get to the states, the more efficient and timely their launching of their EHR Incentive Programs will be, and consistent.

Again, resources to get help and to learn more, all that I've mentioned, the frequently asked questions, the meaningful use certification sheets that Travis mentioned, the tip sheets and so forth are all on the Web site that you see here on Slide 27. It's www.cms.gov/ehrincentiveprograms with an S and that's where you can find a lot of information.

There's even an eligibility wizard where if you're not really sure which program you might qualify for, it can walk you through some Qs and As and help you make that decision.

And if you want more information about the process for certifying electronic health records and which electronic health records have already been certified

as well as the other Office of the National Coordinator programs designed to support providers as they make the transition from paper to electronic health records, the Web site is on the slide for our sister agency, the Office of National Coordinator and that's at healthit.hhs.gov, no www on that one.

So again there's a lot of information that's available to you both online and on the phone. And of course we are welcome to take questions afterwards and be here as a resource for providers and for our CDC colleagues. With that I'll stop and turn it back to Loretta.

Loretta Jackson-Brown: Thank you Miss Kahn and Mr. Broome for providing our COCA audience with such a wealth of information. Also of note is that the resources to get help and learn more links are available on our COCA Web page under the call in information. We will now open up the lines for the question and answer session.

Coordinator: Thank you. If you have a question or comment, please press star 1. You will be prompted to record your name in order to identify your line. To withdraw your question, press star 2. One moment while we wait for the first question.

Our first question comes from Betsy Dunford. Your line is open.

Betsy Dunford: Hi. This is Betsy Dunford with the American Academy of Pediatrics. Thanks so much for doing this today. I know you said that 13,000 people have registered. We were wondering if you have any breakdown on how many pediatricians have applied and how many have received funding.

Jessica Kahn: Hi. That's a great question and I appreciate why you'd be interested in it as well. So specialist information is not always available to us at the point of registration. If a provider is in PECOS, so they perhaps either serve both Medicare and Medicaid patients or they are just a Medicare provider, there is some provider specialization specialist information in there and we can capture that.

However, Medicaid only providers are not required to be in PECOS. And so that information isn't available to us at the Federal level. However, states are of course capturing that and will be generating reports for us on how many pediatricians have registered, how many have received payments and so forth.

And similarly with the children's hospitals which are only eligible for Medicare - for Medicaid, we can track that just because we know from their CCN how many will be registering and how many will be receiving payment and we'd be glad to share that information when we have more than say three weeks under our belt worth of data.

Betsy Dunford: Thank you very much.

Jessica Kahn: Um-hmm.

Coordinator: Our next question comes from Dr. Marguerite Erme, Summit County Health Department, Akron, Ohio - open.

Marguerite Erme: And good afternoon. Thank you so much for this program. I have a question because as a public health department we kind of fall in the middle between

hospitals and clinical practices, and wondering if there is specific guidance for health departments.

Jessica Kahn: Hi. That's a good question. So again those who are eligible for the program are the individual professionals or as you noted some hospitals. So in the case of public health departments or public health clinics it would be your eligible professionals themselves who are eligible, not the clinic as a whole.

And they're eligible insofar as they meet our criteria, which is likely to be Medicaid if they do any billing. If they don't do any billing for Medicaid or Medicare then they're obviously not included.

So we have had some discussions with some states where public health clinics have adopted certified EHR technology and they do bill Medicaid. And if those clinics have 30% Medicaid patient volume or their eligible providers have that patient volume individually, then they can receive the EHR incentive payment.

And we have another sort of aspect to this program where eligible professionals have the ability to reassign their payment to their employer if they so choose or their employer requires it. It's not something that CMS gets involved in because it's between the employer and the employee.

But we do know that a lot of clinics are adopting this technology at a clinic level for cost and then they are expecting - and they're providing the support and the training and the hardware and so forth. And then they're revising their employment agreements to ask their providers to reassign their EHR incentive

payments to them. So I would imagine the same options would be available for public health.

Marguerite Erme: Thank you.

Coordinator: Our next question comes from (January Linda Morris). Your line is open.

(January Linda Morris): Hi. Thank you for this session, this informative session. I was just wondering if the provider or hospital does not meet the threshold or the target measure for the objective or core measure, do - are providers or the hospital would get the money for it as because I know the first year is attestation.

Travis Broome: Right. So you still have to meet - even though it's attestation, you still have to meet the thresholds. If we're talking about a core measure that you don't exclude like say...

(January Linda Morris): Correct.

Travis Broome: ...problem list or CPOE, yes, you would need to have, you know, meet the percentage thresholds on your numbers. So if you reported a numerator and denominator that say for problem lists ended up at 75% and, you know, and that's in core, you wouldn't get the incentive.

One of the things to keep in mind, especially in your first year is you can do multiple EHR reporting periods because it's the 90 days. So, you know, you - just because you did your first 90 days say in, you know, whenever starting in January through March and you didn't meet some measures, there's no reason

why you couldn't rerun the numbers for February through April and see if you got better. But yes, you would need to meet the thresholds.

Coordinator: Just a reminder, if you have a question press star 1. You will be prompted to record your name to identify your line.

At this time I show no further questions.

Loretta Jackson-Brown: Thank you. On behalf of COCA, I would like to thank everyone for joining us today with a special thank you to our presenters, Jessica Kahn and Travis Broome. If you have additional questions for today's presenters, please email us at coca@cdc.gov. Put Jessica Kahn or Travis Broome in the subject line of your email and we will ensure that your email is forwarded to them for a response. Again, that email address is coca@cdc.gov.

The recording of this call and the transcript will be posted to the COCA Web site at emergency.cdc.gov/coca within the next few days.

Free continuing education credits are available for this call. Those who participated in today's COCA conference call and would like to receive continuing education credits should complete the online evaluation by February 28, 2011 using course code EC1648. That is E and as echo, C as in Charlie and the numbers 1648.

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CDC training and continuing education online system at www, the number 2, the letter A dot CDC dot gov forward slash TCE Online.

To receive information about upcoming COCA calls, please subscribe to COCA by sending an email to COCA at cdc.gov and write subscribe in the subject line. Thank you again for being a part of today's COCA conference call and have a great day.

Coordinator: This concludes today's conference. Please disconnect at this time.

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