Overview of Meaningful Use Stage 2 NPRM for Safety Net Providers

Webinar Questions

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Eligible Providers

Q: **Are there any plans to include PhD psychologists as eligible professionals?**

A: The definition of which specific types of professionals are eligible for the program was set in the HITECH statute and that is what the Centers for Medicare & Medicaid Services (CMS) has implemented. To CMS' knowledge there have been various bills introduced or discussed in Congress to add to that list, such as behavioral health or other mid-level providers. Were Congress to pass any such legislation, CMS would implement that, but right now that is not something we have regulatory authority to adjust.

Q: **How do clinics allow for turnover of providers and/or new providers that are hired? Will we need to provide any removal or addition of information as we provide our reports to CMS?**

A: The attestations are done individually by provider, and incentive payments are provided per individual provider, so usually it would be wherever the provider is currently working that would assist them in the attestation when that attestation comes online. If you do have a provider who you hired that was using an electronic health record (EHR) before and was a meaningful user before, it might be necessary to get data on their meaningful use performance from their previous employer and combine that with the data on performance at the new clinic, and vice versa. You may be asked to provide performance statistics for someone who leaves your clinic, similar to the situation you have already with providers who practice in multiple locations that are all equipped with certified EHR technologies. The incentive and the performance follow the individual providers, and it's up to those individual providers to work out how to get their necessary data when they have changes like that.

Incentive Payments

Q: **What happens to providers who work at two clinics that are both eligible for the Medicaid incentive program? How is that payment assigned?**

A: The provider chooses one place to send the payment. There aren't any other restrictions on them, for example, on subdividing their payments between the clinics. For CMS' part, when you register as a provider, you tell CMS where you want your payment to go.

Additionally, whoever receives the payment receives the tax liability associated with the payment—the payment is reviewed by the IRS as income like any other income. The model that CMS has seen is that the provider and their employer have negotiated where the provider will assign their incentive payment; and whoever or wherever the payment is assigned to assume the tax liability. Therefore, only providers who are self-employed receive the tax liability.

Population Eligibility

Q: **Understanding that eligible professionals need to have 30% Medicaid patients or needy individuals; would you please provide a brief description or definition of who that needy individual must be?**

A: Needy individuals would include any patient encounter that was Medicaid, Children's Health Insurance Program (CHIP), or sliding fee scale. CMS has not received much feedback from the federally qualified health center community about their eligible professionals struggling to meet that threshold given the preponderance of patients who are seen at federally qualified health centers.

CMS EHR Incentive Program FAQS: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html

Q: Are Ryan White Clinics considered covered by Meaningful Use?

A: The definition of a federally qualified health centers that CMS uses is the one that was already instituted in the Public Health Service Act. The EHR Incentive Program covers health centers described in Section 330 of the Public Health Service Ac, the 330 lookalikes, and the tribal and native clinics.

HRSA Health Center Definition: http://bphc.hrsa.gov/about/index.html
HRSA: What Ryan White Organizations Are Eligible for Meaningful Use Incentives?
http://www.hrsa.gov/healthit/toolbox/HIVAIDSCaretoolbox/Introduction/whtryanwhileorgs.html

Incentive Payments

Q: **Can critical access hospitals (CAHs) have both Medicare and Medicaid incentives?**

A: Yes, if a critical access hospital meets 10% patient volume for Medicaid, then they are eligible for an incentive from both.

Q: Once you receive an EHR incentive payment, what can the money be spent on? For example can it be sent on operations or patient equipment?

A: That's a great question. CMS does not put any requirements, or make anything required of the provider, about what the money is used for. This money is an incentive for EHR use --it is not a reimbursement for cost. Just as CMS doesn't tell providers what to do with the money they receive in payment for claims, CMS doesn't tell providers what to do with the incentive funds.

CMS has learned anecdotally about clinics and hospitals turning that money around back into their health information technology (HIT) investment, but that's absolutely their prerogative. The incentives may be spent however the receiving provider wishes.

Meaningful Use Fulfillment

Q: **For Stage 1, do providers have to get all of the data of the clinical quality measures in order to attest "yes" to CMS?**

A: The requirement for attesting for clinical quality measures for Stage 1 of Meaningful Use is that a provider would need to attest to the numerator and the denominator and the exclusions as reported from the electronic health record. CMS understands that in a lot of cases, providers are in a transition between paper and electronic records, and perhaps not all of the patient data is fully housed in the electronic health record. We understand that were CMS to come into your clinic and ask for the numerator and the denominator, inclusive of all of the information in your data systems, that might be a different answer than if that query was made based upon the data that is in your certified EHR technology because of that transition and the ongoing efforts around intra-operability between various systems. Therefore, the requirement to attestation for a meaningful use incentive is limited to the report that is generated from certified EHR technology and the data that is housed within certified EHR technology for the clinical quality measures.

Q: **How will the potential delay of the ICD-10s impact the Stage 2 meaningful use requirements? Or will there be?**

A: Stage 2 doesn't start until 2014, so at this point, CMS doesn't have any further information about what could or would be the impact of the delay of ICD-10.

An important item to note on ICD-9 is that it is the only incorporated and meaningful use standard currently under the Office of the National Coordinator (ONC) certification regulations. ONC is proposing to update the problem list to exclusively be SNOMED CT, which would kind of remove the link to ICD-9 or 10 in that problem list. So, things are in flux a little bit, but where that will really impact situations is more on the certification side than the meaningful use side.

SNOMED CT: http://www.nlm.nih.gov/research/umls/Snomed/snomed_main.html
ONC EHR Certification Regulations:
http://healthit.hhs.gov/portal/server.pt/community/standards_and_certification/1153/home/15755

Q: **What indication do you have that the vendor community is prepared to provide the necessary functionality in their EHRs to meet the Stage 2 requirements?**

A: CMS has not developed the Stage 2 requirements yet, because at the moment, it is just a proposed rule, but it is safe to say that the vendors in the provider community were very vocal with the Department of Health and Human Services about the need to have ample time to incorporate any changes into their product, push that product out effectively to their client base,

and get them to the point where they have incorporated the changes into their workflow. Therefore, Stage 1 has been extended for a third year.

ONC is also proposing changes to the way certification occurs and one of the proposed changes is that, for things that don't change, they wouldn't have to get recertified. There are really only a handful of truly new capabilities, completely new capabilities in Stage 2 meaningful use, and therefore, need Stage 2 certification. So, to the extent that things are completely new, obviously all products would have to be certified to for those new capabilities; but in instances where features don't change at all, there would be no new certification.

Q: **As a rural hospital with a majority of patients that are Medicaid and Medicare, there is concern with regards to how many patients will actually access their information electronically when it's available due to limited access or resources that they may have in some of the rural communities. Are there any thoughts or discussions around this challenge that is probably not unique to rural environments?**

A: Yes. CMS recognizes this challenge and had one proposal that had to do with broadband penetration at the county level—which pertains to rural broadband access. However, CMS would like the attendees to keep in mind that this is a proposed rule, and we really want to hear your thoughts and comments in response to that proposal so that we can consider your comment for the final rule.

Q: **What if the state can't meet the public health objectives in the functional menu measures? Would you need to select other measures?**

A: In Stage 1 when all the public health objectives are in the menu, if your state can do one, but not the other you need to select the one the State can do. If the State does not support either public health objective (or any of the three for hospitals), then you would attest to the exclusion of one public health objectives and select four more other objectives from the menu. For the Stage 2 proposal, since the immunizations is moving to the core anyway, it's no longer necessary. So in Stage 2 if you are an EP and you met the exclusion for immunizations, you would not have to pick syndromic surveillance from the menu, but rather could pick any 3 of the 5 in the Stage 2 menu set.

Q: **Could you please clarify whether CAHs have until September 2015 to complete the 90 day attestation, and they will not have any penalties until that time? Is this correct?**

A: That's correct. The way the penalty would work is you wouldn't be assessed a penalty until CMS goes to do the final cost report reconciliation for FY 2015. By then CMS would know if you were a meaningful user or not; and if you were not, then applying the penalty would be part of that reconciliation process. If you were a meaningful user, then obviously it would not be part of that process. Due to this lag, you get that full year.

Q: **Have you surveyed HRSA grantees on the status so far of meaningful use attestation and reporting among HRSA funded providers? If so, can you share any information about that?**

A: That's a great question, and CMS has just partnered with HRSA and the National Association of Community Health Clinics (NACHC) to try to get at some of that data. We do have some data, but it is difficult to run an analysis right now. When a provider registers, they provide to CMS their name, their business address, their NPI, and the tax ID number to where they want to have their EHR incentive payment sent. Given that many providers have multiple tax ID numbers or NPIs, because maybe they work in more than one location and so forth, CMS does not know necessarily, that this is a provider who works at a HRSA grantee clinic.

Once the provider goes to the Medicaid side, and needs to attest patient volume, by default, they would only be able to pick up the needy individual patient volume if they work at a federally qualified health center or rural health center which immediately flags that this is someone who meets that criteria of at least 50% or more of their encounters from the prior year. It wouldn't pick up anybody who is just say a part-timer in a very limited sense in one of those clinics, but it is good for the majority. With the HRSA and NACHC partnership, CMS is going to extract data from eight or nine states to see what the level of participation has been. Initially, it is just going to be for adopt, implement, and upgrade payments to date, because we have only a handful of states that have started taking meaningful use attestations. So, eventually CMS will have data, and will absolutely share it with HRSA and all of the grantees. The data will not be completely representative of all those attesting nationally, but it will be a good sample of states that have a mix of urban and rural, different kinds of provider types, and have been in the program for long periods of time or for shorter periods of time.

In moving forward, when states need to report to CMS on an annual basis about the EHR incentive program analytics, CMS is very interested in the participation among safety net providers.