

## **Understanding Eligibility, Registration & Attestation Processes for the Medicaid EHR Incentive Program**

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### **Panelists:**

- **John Allison-Centers for Medicare and Medicaid Services**
- **Suma Nair-Health Resources and Services Administration**
- **Michelle Mills-Centers for Medicare and Medicaid Services**
- **Melanie Lawrence-Oklahoma Health Care Authority**
- **Jim Crawford-Oklahoma Primary Care Association**

**This transcript is as close to exact transcription as possible. Though some differences may exist, the written and audio content are sufficiently identical, with no significant content differences.**

**Operator:** Good afternoon. I would like to welcome you to the webcast titled “Introduction to Registration for the Medicare and Medicaid Electronic Health Records Incentive Program.” If you have questions, you may type a question to the question and answer box located at the bottom of the interface below the slides. Click the submit button to send your question to the speaker. Questions will be collected and answered at the end of the presentation. Please note this conference is being recorded. If you have objections you may disconnect. It is my pleasure to turn the conference over to John Allison from CMS.

**John Allison:** Thanks and hello everyone and welcome. This is John Allison at the Center for Medicare and Medicaid Services in the Center for Medicaid, CHIP, and Survey and Certification. Thank you for joining CMS as well as the Health Resources and Services Administration, the Oklahoma Health Care Authority, and the Oklahoma Primary Care Association for today’s webinar focusing on the electronic health records incentive registration.

As you have heard we are excited about the first 11 states that launched their Medicaid EHR incentive programs on January 3. We are also glad by the fact that since then four states have made incentive payments to eligible professionals and we are looking toward other states launching in the coming months. Now that we have live Medicaid EHR incentive programs it's important to make sure that Medicaid eligible professionals can complete the registration process. As you are going to hear, Medicaid EPs have to initiate the registration process through the CMS EHR registration portal and the process has to be completed through a state website. We would like you to walk through the registration process from beginning to end, starting at CMS and ending at the state Medicaid program, which in this case, is the Oklahoma Health Care Authority. Let's also remind that the webinar is being recorded and both a recording and a transcript will be made available on the CMS EHR incentives website in the future. Also participating today are regional extension centers in listen only mode.

We have three presenters. The first is Michelle Mills. Michelle is a technical director at CMS in the Center for Medicaid, CHIP, and Survey and Certification. She works on policy and technical coordination between quality of care initiatives and health IT programs and serves as one of the

agency leads in the planning and implementation of the Medicaid EHR incentive program. And she will be walking us through the registration process for the Medicaid EHR incentive program.

**Michelle Mills:** Hello everyone. The thing I'm going to cover today is a brief overview of program eligibility and I'm hoping the folks on this call know most of the details on how to be eligible for this program. I also encourage you to check out our website if you need more information but I will give a high level overview. I'm focusing the presentation on eligible professionals and not on eligible hospitals since our audience is primarily folks involved with federally qualified health centers. After that I will cover registration with CMS. Our registration site is available through a link on our website and I'm going to go through what that would look like with different screenshots. After I give my presentation, Melanie Lawrence from the state of Oklahoma's Medicaid program will go through what looks like after you finish registering with CMS and continuing your eligibility and verification process with the state.

The next slide shows eligible professionals for both the Medicare and Medicaid programs. It's important to note there are some eligible professionals that could be eligible for both programs regardless of care settings. Even providers and FQHCs, if they are doctor of medicine, doctor of osteopathy, etc. they could be eligible for either Medicare or Medicaid. The Medicaid only professionals include, in addition to the ones just mentioned, nurse practitioners, certified nurse midwives, and physicians assistants are only eligible when they are working at an FQHC or an R. H. C. "so led" by a physician's assistant. In our final rule we clarified what we meant by "so led"—there was a couple of different scenarios applying to that. Moving to the next slide.

As we talked about on the previous slide, you must be one of the five types of eligible professionals to participate in the program and hopefully folks have been through this before, but there are two ways you can participate in the program. The first is if you have Medicaid patient volume equal to or greater than 30 percent, and that would be equal to or greater to 20 percent for pediatricians, there's an exception for pediatricians. Or if you practice predominately in a FQHC or RHC and have 30 percent patient from needy individuals, which is defined in the final rule, and those include folks that are receiving Medicaid or CHIP or free or sliding scale services. Additionally you must be licensed in credentials appropriately in order to participate. We've had folks what does it mean to be a pediatrician. This table will define what it means to be a pediatrician, but you must be licensed and credentialed as a pediatrician in order to participate in the state's program. The states will also be checking to make sure we don't have non-eligible professionals registering as an eligible professional. Let's say a registered nurse saying they are a nurse practitioner. The state will verify this and make sure that they are a nurse practitioner. We also want to make sure you don't have any OID exclusions which means she would be prohibited from receiving money and you would be on the Office of the Surgeon General's exclusion list. We're going to check to make sure you are a live and, finally, eligible professionals for this program can't be hospital-based which means more than 90 percent of the clinical services were provided either in an inpatient or emergency department setting and those are defined as place of service codes, 21 and 23 on the CMS 1500 form. Moving to the next slide, both Medicaid EPs and hospitals must have an ENPES web user account. ENPES is the system of enumeration that we use for the national provider identifiers. In order to register for our program you have to have a web user account which means you do not fill out a paper application but complete an

application online. You will use that user ID and password from ENPES to log into the registration system and I will get to that later.

Additionally you have to have adopted and implemented and upgraded or meaningful used certified EHR technology and we will get to certified EHR technology later in the presentation. Next you must get the EHR certification number from the CHAPEL which is a site run by ONC which will determine which products are certified and you will get a number based on a product or combination of products that are certified to meet meaningful use.

Finally you must attest to meeting all program requirements and you do that with the states and Melanie is going to go through that shortly. Those would include things like patient volume and -- at a certain point states will accept that you attest to meeting these requirements and request additional figures to support that attestation and states will be running pre- payments and audit determination so they will be checking your data to make sure what you are providing appears to be matching up.

We got through all the basics of the program and now that folks are ready to register, what is next? You will go to the CMS website. We tried to make the process as easy as we could but we are giving out a lot of money for this program; we need to make sure there were a lot of checks and balances in place so when we hand over this cash we are assured you are the right person receiving the right amount of money. With that said, we did try to cut through the red tape for this program and make it easy as possible.

There are three steps for the program. Register for the program, attest to meeting the program requirements and eligibility requirements for the state and then get paid by the state. The first thing you are going to do is go to the CMS EHR incentive website and click on the registration tab. We have a big button that talks about how to register. After you have completed the CMS part, you go to your state website and complete the application. States will pay you no later than five months after you register. Most are paying much sooner. We have Oklahoma with us today and they are paying immediately as soon as they get through the registration process. They had some folks register on day one and were able to pay them a couple of days later. Kentucky, Iowa and Louisiana were the first four states to pay. Other states like CMS are a little bit slower to bring their systems online in order to pay you. They are processing your information but we've given them a maximum of five months to make the payments.

This slide shows you what our registration site looks like. Before you log in, you will see some general information that explains about the site. It links you to the CMS website for more information or if you have questions, you will see that same link throughout this process.

This next slide shows you what the login page looks like and this is where you use your ENPES or NPI web user account and password.

The next slide shows you the tabs at the top. You've got your home page which gives you general information and then the registration page. The attestation page for Medicaid eligible professionals is not relevant. You won't be to click on that page and if you do it says you will need to complete that process with your state, there is no information there. The status tab will

give you your status in the process at any time. If you register today, it will say you have registered and you are waiting state validation. That means your file was sent to the state for them to do the validation checks. Finally the account management tab is your administration stuff to change name and whatnot. It's important to note that if you change any information it does not go back and change the system of record. For example, we are going to pull in a lot of information from other systems to make it easier on the provider. The main system for Medicaid is ENPES. You will see your name, address and other information is pre-populated. If you change that it will change it for purposes of the CMS EHR incentive program only and not update ENPES and there are notices throughout the site that remind you of this.

This slide shows you the registration instructions including how you would register and modify your registration, cancel a registration, and then reactivate or resubmit a registration after you have canceled. There aren't many reasons we can think of that folks would need to cancel a registration, but you could. Modifying a registration is important in this program. If you, for example, registered with the Medicaid program in Oklahoma and decided that you would rather do the Medicare program and you haven't been paid yet, you can switch with no penalty. You could even change your mind again. After you have received a payment, you can only switch between the Medicare in Medicaid programs one time before 2015. You can switch your states annually but we only allow for a switch after you have had a payment. Prior to payment you can switch as many times as you need to up to the point that you have attested to either CMS or the state.

This slide is another example of some registration topics. It shows you the things you have to complete in order to register. You could start the registration and then come back later and it will show you what you need to do. This is under the registration tab.

This slide shows you what it looks like when you're selecting between Medicare and Medicaid. You would use the buttons and select either Medicare or Medicaid and hit apply and then you would select your provider type as well. I have to slides that are very similar to show you as well. There is the EHR certification number box at the bottom. If you select yes, that box appears and you would need to type in your EHR certification number. Since you can register for this program before you have certified EHR technology, you don't have to complete that box at the time of registration but you do have to complete it in order to get paid.

On the next slide, we will show you what that looks like. If you select no, the box isn't there. That means that the state will not have received a CMS EHR certification number from you and you will need to provide that to the state so they can verify you were using certified software for this program in order to get your incentive payments. Someone could register for this program without having that and then provide that information later to the states. On the same page after you select Medicaid, you would select a state in which you want to participate. For Medicaid EPs, only states with programs that have launched will be in the drop down menu. For example, Maryland has not launched their program yet. If you register today, Maryland would not be an option. We have 11 states with launched programs in the drop down menu. As each state meets all the requirements to launch their programs, and they've tested interfaces with us and can exchange files and completed their state Medicaid IT plan and requested funding, then we will let them launch their program and it will appear in the drop-down menu. If you have questions

about why your state is not on that list, you can click on the link to the right and it will take you to a page that explains that states can launch at any time or not at all. It also lists all of the expected launch dates. Some states are very specific and others are more vague. We plan to update that list of monthly so you can check back for changes on our website as well.

On the next slide, for Medicare providers, we are going to be deriving information from the payment system used for Medicare and there will be information pre-populated here that tells where a Medicare EP wants the payment to go. For Medicaid, there will be a text field and you can say I want my payment to go to my employer or my managed care organization. You can reassign it to a number of entities in accordance with our rules and you can also assign it to yourselves. But that combination between your national provider identifier and the tax ID number you are selecting, needs to make sense to the state. In other words, if you have your NPI entered and you select a tax ID number for your cousins Subway restaurant down the street, the state of Oklahoma would reject that because they would not recognize that as a match. It needs to be an organization that you received money from before through the Medicaid program.

This slide, after you get through the registration screens, there are a bunch of legalese about how we will tar and feather you and prosecute to the full extent of the law if you provide false information. At the bottom of the page, you will hit a degree in order to continue with the program. If you don't agree your registration will be stopped at that point.

This shows you what looks like if you have a failed submission. If you provided information to the registration module and then there was an automatic match that you are on the Social Security masterfile which is a list of individuals nationally that are considered dead, you would get a failed submission page and you wouldn't be allowed to continue until you reconciled that issue with the Social Security administration. If you were on the OIG exclusions list, that would be another reason you have a failed submission.

This slide is for hospitals and I forgot to pull this out from a different presentation. Hospitals have a different process so I will skip this slide.

This is what it looks like when you have a successful submission. It reminds you that if you are a Medicaid provider, the process is not done yet. We give you a link that shows you where you would need to continue with your state's process. If you click on this link in the middle it says you can find your state here and it will take you to a list that shows you the registration URLs or the web addresses for your state so you can continue the process. It takes 24 hours between when you get the successful submission notification until the state receives the file from CMS. We are batching these files nightly so you would be need to wait until the next day to go to your state so they have the information that you are registered. Additionally, it gives you a registration ID. At this point you are registered for the program. You may not be eligible to receive a payment because the state may determine you have not met the patient volume requirements or any other number of requirements at the state but at this point you are considered registered.

I should mention on this slide, at this point in our process you will not receive a confirmation e-mail; you need to either print this or take an electronic screen shot or save it. We are collecting e-mail addresses on a voluntary basis right now in order to pass that to the state so they can

communicate with you and tell you we have received your file and finish the process. At this point we haven't asked for authority to collect e-mail addresses from providers to communicate other things. It's something we expect later to do in the program. In order to get started on time, there were a number of things we had to hold off on and this was one of that. Print that screen or take a screenshot of it and save it electronically.

This is the certified health IT products list run by the Office of the National Coordinator. The testing bodies that go out and say that this is a certified product that meets the requirements, they will enter those products into this website and then there will be comments provided to you about the products. I may have one certified system, let's say my product is some basic EHR software from Centricity, I select that and I'm fine and I have one EHR. If I have another product that needs a combination of other certified products, like a e-prescribing module or a CPOE module or something added on to make it certified to make meaningful use, then I would need get a approval of all products and modules and then get a number on the website. That's the number you'd use on the CMS website and that's the number generated by the chapel, not by the number you were getting from Drummond or the other certified testing bodies.

With that, this is the final page with additional tools and the CMS website. Folks are welcome to contact me with any questions. We are getting lots of questions right now and I will get back to you as soon as I am able to do so—any questions with relation to registering with CMS. We also have on our website a new help desk. The phone number is on the website and you can send them an e-mail through the website or you can call them for help too. We are getting at least 500 questions a day there, so they are up and running. With that, I would turn it back to John.

**John Allison:** Thank you, Michelle. In my rush through my comments I completely cut out our partner in webinar event, HRSA. I would like to allow Suma Nair make some remarks.

**Suma Nair:** Thank you John. We just wanted to welcome everyone to today's session and thank our partners: the Oklahoma Primary Care Association, the Oklahoma Health Care Authority, and CMS for joining with us to present this information. One of the focus areas is improving quality of healthcare outcomes. We are focused on supporting health centers' adoption and meaningful use of health care technologies. We believe this is an important means to improving the health of our communities. We are pleased to be co-hosting with CMS to share the information. We hope all the eligible providers will take advantage of this to support their adoption of meaningful use efforts. Today's presentation is targeted to FQHCs and the Medicaid incentive program. We will leave time at the end for questions, but if there's anything we are not able to address, contact us at the mailbox listed at the bottom. It is [bphc/hit@hrsa.gov](mailto:bphc/hit@hrsa.gov). Please do follow up with us if you have any questions. Thank you again for your participation.

**John Allison:** Thank you. Before we introduce our second speaker I wanted to address a question several people have e-mailed in and that is the availability of the slides. Yes, we will make these slides available after the webinar. Perhaps we can even push them out through the registration lists we have accumulated during the course of the webinar. Now we are going to move onto our second presenter who is Melanie Lawrence. She is a senior health IT analyst for the Oklahoma Health Care Authority, the Oklahoma Medicaid agency. She is the lead information services analyst with the Oklahoma EHR incentive program. Her background

includes four years with Oklahoma health care Authority and 19 years with the Contra Costa health services department which operates 10 FQHCs in the San Francisco Bay area. She will walk us through the Oklahoma incentive program, attestation and payment process.

**Melanie Lawrence:** Thank you. It's an honor to be presenting with such fine people today and we welcome all other Oklahoma providers who may be on the line. Today what we're going to talk about is the way Oklahoma processes attestations for the EHR incentive program and there is an old adage "once you have seen one state's Medicaid system you've seen one state's Medicaid system" and every state will be implementing this differently. The way Oklahoma has done it is to incorporate as much as possible into our existing claims processing system which we call the Medicaid information management system..

The first process, as Michelle described, is we have received -- states receive daily batch files from CMS. Those are the registrations that come from the process she described. Oklahoma picks up those files every day in an electronic mailbox and we file them in our MMIS system. Once the registrations are there, at that point the provider is able to successfully attest for the EHR incentive program. Until that registration number is in our system, there's not a lot they can do.

Before we ask providers to attest, it's important to distinguish between a registration versus an attestation. Registration essentially says you're interested in the program. Attestations says I'm ready for my payment and I meet all of the eligible requirements. For Oklahoma, registration is done through the CMS process. There's no specific registration at the state level. In some states there is a registration at the state level, so again, every state is different. Before the eligible professional is ready to attest we give them a little checklist to make sure they are ready to go. First you need your CMS registration number or the ID that was completed on the acknowledgment page at the CMS system. You need your EHR certification number from the website, at ONC. For our state, you need a contract with the state Medicaid agency for at least 90 days. You will need for our site, for Oklahoma, they need a login and password for our secure site because our attestation is online, they have to login to do it. For ARRA reporting to the federal government, we have to, as a state, report the number of jobs created at a particular site. The jobs created as a result of the stimulus money. This is not from last year's health reform, this is from the 2009 ARRA act. We have to report back. We also, at the state level, need some kind of legal or financial document showing a link between the provider in the clinic and the certified version of the EHR software. This is proving to be a challenge for some providers and they are ending up going to their vendors to get a letter stating that. We are also requiring patient volume numbers for a 90 day period in the preceding calendar year.

Once the provider has the things they need and they are ready to attest, they log into our secure site which is the site they can submit claims and look up member eligibility and do all the things that are routine operational processes for Medicaid. As part of Oklahoma's secure site, we have automated our provider contracting processes. It is called electronic provider enrollment system. Providers can renew the contracts, update their phone numbers, add providers to their groups, and so forth. For providers who are of the type of the five types that Michelle outlined earlier, a link displays in there when they log in on their main menu and it says they can amend their

provider agreement to receive EHR incentives. This is considered an amendment to their contract.

As one last check, we ask providers if they are ready to attest now and it's another place that says "here are the things you need to continue." At the bottom of the screen it requests providers enter a CMS registration number, which is the one they got from the CMS site and again they have to wait at least 24 hours before they get to this point. Once they enter their CMS registration ID, there's some intelligence behind that process. Our system will check the individual providers NPI in the registration against this particular login and verify they have the same MPI. It will also check their tax ID number and NPI to verify those IDs are associated with the individual's NPI. That is they are a valid group according to our system. If the provider is try to decide their payment other than a group they are registered under for Oklahoma Medicaid, it will not let it go through. If everything is fine, the system displays where the payment has been indicated to go. If the provider is good with that then they are good to go, but if not they must wait another 24 hours for the state to get the update.

At that point, the next screen asks for the EHR certification number for the certified technology, the product name, and the version number. This allows us to make sure we are searching for the right software. The next piece of information they need is the number of jobs created. When it comes to groups or clinics, we ask that only one provider have all of the jobs reported under his or her attestation and everyone else recorded as zero to avoid duplication.

On the next screen, there is more legalese, there's a provider contract that indicates all of the enrollment criteria and the provider is attesting that they meet all the enrollment criteria. On the next slide I have listed everything that is in that amendment just in case you're interested, I'm not going to read it to you. After they have read through that, they check a box that says everything is accurate and complete and that we accept an electronic signature either from the provider themselves or from a member of the provider's staff or an agent of the provider. At that point, they can click submit. They are essentially done with the electronic portion of the attestation.

On the next page they get an acknowledgement. It tells them who has attested, their Medicaid provider ID, their MPI number, where the payment has been designated to go, and the type and year of attestation. In the first year of 2011 we are only allowing eligible professionals to attest to adopt, implement, and upgrade; Oklahoma is not ready to accept meaningful use information. It's there by default for this year.

What happens next is the provider will need to print a personal fax cover sheet. It has the tracking number that is associated with this particular attestation and it lists the documents they need to submit. They print that fax cover sheet and they also have to print a patient volume worksheet which I will show you in a minute. For any pediatrician attesting to between 20 and 29 percent patient volume, we ask for proof of board certification. We also ask for proof of adopting and implementing and updating a certified system. They have to print these forms and then they are ready to fax the document.

This is the header of our patient volume form. The provider must enter their individual NPI at the top. They have to list the 90 day period for the preceding calendar year for their patient volumes,

their name, and tell us what kind of provider they are reporting as. Since this audience is primarily for FQHCs and RHCs, I've included the definition of a needy patient encounter. We are asking all the Medicaid and everything related to needy patients be included in the number given to us. Part of our form includes a place to use the group totals or the clinic totals for the individual provider as their patient volume. We have another portion of this form used for individual providers who are not part of the clinic but it makes more sense for FQHCs and RHCs with such a huge percent of needy patient volume adjusted user group totals so we ask for the service location NPI of the group or the clinic and under the needy patient are, we ask for the total number of encounters for the state of Oklahoma and any other states and the total patient encounters of the clinic for that 90 day period. Internally, we have a process to calculate the percent to make sure it is at least 30 percent and document that we have verified this piece of eligibility.

Besides the patient volume form we are also asking providers to provide proof to adopt, implement or upgrade which translates to some sort of documentation that links the individual provider or, at least the clinic, to the certified version of the EHR software and that is proving to be a little challenging because a lot of those contracts and invoices don't specify the version of the software in use or leased or purchased. We are at this point suggesting to a lot of providers to contact their vendors to get a letter to that effect so we can get some kind of proof of the certified version being either purchased, installed, or leased.

After the documents are sent in, we have some verification at the state. As Michelle mentioned, we are turning things around as fast as we can, although we only have gotten one or two attestations on the very first day or two, but we now have 184 registrations sent to us to date. Things are starting to back up a little bit. We're going to check the patient volume data for reasonableness against our paid visit and encounter claims data. We also verify the supporting documentation for an upgrade. We are contacting providers directly if there is something missing or if we need any clarification on anything. This means sometimes they are having to fax additional documentation. Once everything is in order to provider contracting unit, the healthcare authority approves the attestation and we can approve for payment. After we've approved the attestation, the healthcare authority sends a transaction to CMS showing the provider is eligible for the EHR incentive program and we send another one to check to see whether the provider has been previously paid or not by either Medicare or another state. If it all looks good, then CMS sends the transaction to Oklahoma giving us permission to pay. When Oklahoma received the transaction indicating the provider has not received payment, we add an inactivated expenditure to our system and our finance group reviews the inactivated expenditures weekly. We add information for reporting and payment purposes and to make sure the amount is appropriate and then activate the expenditure. In our system activated expenditures are included in the estimated payment portion of our weekly claims payment cycle and every week, Oklahoma draws down the money in preparation for the next week's payment. It takes a couple of weeks to get through this process. Providers receive payment approximately 1-2 weeks after the attestation has been approved. After the payment is made the transaction is sent to CMS and we tell CMS who has received the payment, whether for adopting, implementing, or meaningful use, the date and the amount and a few more pieces of information. The incentive payments are also listed on the provider's weekly remittance advice for the payee provider. If the provider

assigned their EHR incentive payment to their group, it would show up on the group's remittance.

Next year, providers do not have to go back to the CMS registration system unless something has changed. What happens next year in Oklahoma, providers will be able to come back to our electronic provider enrollment process and attest again. Next year, meaningful use will be included as part of that attestation. With that, I will turn it back over to John.

**John Allison:** Thank you, Melanie. We have one more presenter who will begin in a moment here, but first we had a few things we wanted to clarify. I'm going to ask Michelle Mills to go ahead and speak up.

**Michelle Mills:** Thank you. Melanie just talked about two things I talked about earlier and I wanted to provide clarification. One is you use the CMS registration ID for the Oklahoma login. That's what we talked about on this slide where it talks about, under registration tracking information, you have a registration ID, that was the number she was referring to that you would enter when you get to the Oklahoma website. A number of states are using the same passkey as entrance to the state eligibility verification process. Other states are using their current provider login portal as an alternative to using this as a passkey. The other thing I wanted to clarify was Melanie also talked about how the state would collect the certified EHR software number. I want to point out there could be more than one number here. You could have a vendor number, which is what would be entered here at the CHAPEL, the certified health IT products list run by ONC. The number is generated by the CHAPEL and given to you that is what you would need to enter on the CMS website when you register or when you go to the state website to continue the process. Again, you don't have to have this when you register for the program. You can enter it at the time of registration by saying yes you do have the certified EHR software and here is the number, or if you say no, you can enter it at this stage. Both CMS and the state will verify that through the chapel. The other thing I wanted to point out is that Melanie laid out a number of processes for the state. For example, you have to do certain things through filling out forms and faxing them in. That is how Oklahoma is handling the process right now. They were one of the first states to launch and we were proud of them that they were. Other states are developing online processes where you enter the same information online and automated, there will be no faxing. I think while the program is still pretty nascent, you can expect to see different processes like that. As the program matures, you will expect states to be looking more similar. With that, I will turn it back over to John.

**John Allison:** Thank you, Michelle. Before we move on, there's one other clarification we wanted to make and this was regarding the HRSA Bureau of Primary Healthcare IT mailbox. The correct e-mail address is [bphc\\_hit@hrsa.gov](mailto:bphc_hit@hrsa.gov). I believe the underscore was announced as a slash.

Our third presenter is Jim Crawford from the Oklahoma Primary Care Association. He is currently the health IT strategist for the OKPCA. Jim consults with community health center management on a wide range of technology issues touching healthcare and legislative aspects of the organization. He has worked in IT for over 25 years. During his HIMSS membership he has

served as the Oklahoma chapter program chair, the president elect and the president, and he now serves as the chapter past president.

**Jim Crawford:** Thank you, John. I echo Melanie's sentiments, it's very nice to be in this group of presenters and speak on this topic today. Thank you for attending and for listening.

We were asked to go out to the CMS website, give it a try, and give some initial feedback. We thought the best way to do that would be to elicit the help of some of our community health center eligible professionals and get their feedback since they would have some of his required information. We found the CMS website to be very intuitive and well organized and designed. We found the documentation to be very good. We would caution people to read those screens carefully. Particularly pay attention to click on the appropriate buttons at the appropriate time. I thought while the presentation was going on earlier, I thought about the apply button on the incentive program questionnaire once you have selected Medicare or Medicaid, be sure to click the apply button so the rest of the screen will follow along and you will be able to walk through the process much more easily. Carefully read the personal information and identifier screens. We found particular to where the incentive payments would be going, we found it might be easy for someone to overlook that and to get the incorrect information in those screens; this is a place you want to carefully look through. Be careful that you are looking for the registration and you are reviewing what you have on the screen and remember in your submission process there are multiple buttons you must press to begin your submission, and at the end, to submit. It's one of those things where it is well designed. We found John and his team to be very open to the feedback we gave and we found the documentation in the screens should be read carefully and not rushed through. Preparing to go to the site, be sure you have all the information Michelle pushed out earlier. Be sure you have all of this for each of your providers and have it available to them. Make sure they understand what each of those numbers are and where they go in the registration system.

When we went to work with Melanie and her team, we found a similar scenario. We found the website to be very well organized and are appreciative of the effort the Oklahoma Health Care Authority has gone through to make this process more seamless for us. We realize there was some faxing involved, as was outlined earlier, it is not a reregistration and that was something we were initially told. We found the documentation to be quite good. Take your time with it. There are points that are very easy to overlook and make sure you follow the screens carefully and make sure you have the patient volumes documented appropriately as it does cover a 90 day period in 2010. One note to community health centers and FQHCs, qualifications can be for the entire organization, it doesn't have to be for any individual providers. The need for the verification document from the EHR vendor, many of the organizations in Oklahoma, the documents they have will be initial documents when they license the software. They will be obtaining license rights and meaningful use certified versions of the product through participation in the EHR vendor's software updates program. We had made contact with the vendors and to make sure the letters are acceptable. Then realize your attestation at the Health Care Authority website is only for the first year of stage one meaningful use and I'm sure we will be getting additional information on what will be required for states in the near future, but realize the attestation and data will be required on an annual basis. Other than that in communicating with organizations we found their staff's to be helpful and open to our comments and questions

and I would encourage are you to use the resources at hand, such as the help desk. Other than that, I think we are at a point where we should be ready to go and we are quite excited for our organizations to have their providers ready to go and get them registered and attesting and moving this process forward. I think John it's time to turn it back to you.

**John Allison:** Thank you. It is now about 2:00 so we have some time left for the question and answer portion. One question that has recurred is “when are states launching the Medicaid incentive programs or is there a calendar when states launch the programs?” Right now there is a tool. You can find that on the CMS EHR incentive program website which is [www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms). If you go to the website you will see a series of tabs on the left-side of the screen and you can click on the Medicaid state information tab. In the center of the screen is a link labeled state EHR launch times and websites. There is a lot of fluctuation on when states will launch. As we said at the beginning of the webinar, eleven states launched in January and additional ones will be launching in the spring and summer, hopefully the majority by the end of the summer. If you would like to know when your state is going to launch, CMS has information at this tool that is updated periodically and you can also contact your state Medicaid agency but there is variation in when states will launch their incentive programs.

Other questions: Will Medicaid eligible professionals have to use PECOS? This may have been addressed in the presentations, but Michelle if you would like to put a point on that?

**Michelle Mills:** Sure, PECOS, the Provider Enrollment Chain and Ownership System is the Medicare system for making payments to hospitals and EPs. Medicaid eligible professionals are not required to be enrolled. Medicaid eligible professionals are not required to be enrolled in PECOS. All of the other provider types are, including Medicare EPs and Medicaid eligible hospitals.

**John Allison:** The next question, “I don't understand why I have to register for Medicaid or Medicare, why can't I register for both?”

**Michelle Mills:** That's a great question. [Audio Cutting In/Out]

**John Allison:** We seem to be having some technical difficulty there. Mike? Michelle, I don't know if you can answer that again but you seem to be breaking up.

**Michelle Mills:** Just to clarify, eligible professionals cannot participate in both the Medicare and Medicaid incentive programs. Eligible professionals need to select between the two programs and can receive an incentive from only one in each year. If you are eligible in more than one state and you selected the Medicaid program you have to pick one state as well. You can only select one incentive for each year. Hospitals may participate in both Medicare and Medicaid eligible hospitals program if they meet the requirements for both programs but not eligible professionals.

**John Allison:** Thank you, Michelle. For a first-year payment, do we have to track any of the core or menu metric data for any length of time or just attest to having a certified product?

**Michelle Mills:** For Medicaid, you can adopt, implement or upgrade in your first payment year. You don't have to meaningful use. Some states have also been prepared to accept meaningful use attestation in its first year. We think if you were prepared to demonstrate that you were a meaningful user you are also prepared to demonstrate you have adopted, implicated or updated certified technology and that requirement is much easier to meet and we encourage providers to look at that rather than demonstrating that they are a meaningful user in the first year to take advantage of the flexibility. If you want to meaningful use in your first year, you should consult with your state to make sure they are prepared to accept attestations for meaningful use.

**John Allison:** Thank you. I understand a provider cannot be registered in both the Medicare and Medicaid programs but within the clinic, can some providers be registered for Medicare and some be registered for Medicaid only or do all providers in one clinic have to be registered in the same incentive program?

**Michelle Mills:** Providers in a clinic can go either way. They don't have to participate, but they can go either way.

**John Allison:** Next question. Are clinics permitted to register on behalf of their providers and do all the legwork?

**Michelle Mills:** This is a great question and we didn't talk about this because it's not a feature on the CMS website yet. In April and later, we expect to have a feature that allows professionals to do that. Essentially what you have to do at a high level is go into a different system and say that a clinic administrator is now eligible to register me for this program. We have to have some place where you have designated that. Otherwise you're clinic or group practice administrator could go in on your behalf and assign the payments to the clinic or group practice and maybe you had other plans for that incentive. For example, if you worked at two different locations you may have an idea about which location should receive the incentive. We do need the provider to give permission to the group practices as an eligible professional. That will only be for the CMS registration site. The states may have a different process for this. In most cases they won't right away because it is complex coding that needs to go onto their system and maybe something that develops later. We are looking for new ways to make the registration process more efficient for providers so that someone could do that on their behalf.

**John Allison:** How does this work for specialists? Do they have to work a minimum number of hours at a clinic in order to be a Medicaid EP? Specialists usually work at multiple locations.

**Michelle Mills:** There are no minimum number of hours. What you are looking at is your patient volume which is a ratio of either Medicaid or needy individuals that you have seen over all patients. It is a percentage. You could see one Medicaid patient and two non-Medicaid patients and that is 50 percent. You would qualify even though you have only seen three patients and maybe only worked two hours a week. The program applies to specialists the same way it applies to other practitioners.

**John Allison:** For Melanie, what information does the provider need regarding to jobs created?

**Melanie Lawrence:** In Oklahoma, we are just looking for the number of full-time equivalent jobs created by having this stimulus money. It could be the number of nurses or IT people. Even if it is half an IT person or someone who only comes in only one day a week. We are taking fractions at the state level. It is really more for reporting then for proof of anything. There's no supporting documentation relating to that we are asking for. It is due to the HIT implementation from the federal rule that this came from. I wanted to add to what Michele said about part-time providers because we are getting asked this a lot. We are cautioning people that some providers may work in multiple places especially a specialist and whoever attests on someone's behalf first has first dibs on the money. We are cautioning eligible professionals to make sure their wishes are known to all of their groups and clinics to make sure it is clear where they want their EHR incentive to go. It has been an education process to the clinics and the groups. The provider is only getting one incentive for one MPI. It is not one over here or over there, it is just the one. If the eligible professional wants to be paid directly and then divvy up the money among the different groups that is one thing, especially if they spend a minority of their time at one place, that maybe something us.

**Michelle Mills:** That is a really great point Melanie. I just want to add we have had a lot of clinics and group practices asked us about requiring the providers to turn over an incentive if for example they practice predominately or meet other requirements at that clinic. This program is intended to incentivize certain behavior at the provider level. We are trying to get eligible professionals to become meaningful users with certified EHR technology. In order to do that there is the certified EHR technology part. The provider needs to get these certified EHR information or number from the clinic administrator, but they also need to meaningful use it in the long run. We think this is a partnership between the clinic and the provider. Some clinics and group practices have told us they will tell the provider that we will get this information and if you are a meaningful user, you will get a bonus but since the practice in most cases shelled out the money initially to provide the EHR technology, they want to recoup that in order to offset some of those costs. The program is intended to incentivize the behavior at the provider level. We've encouraged clinics and group practices to look at their employment contracts and see what makes sense. There are a number of providers that work at many different locations. They may have demand similar to your clinic or group practice that is requesting they turn over the incentives as well. In the final rule we said each registration for each payment would be sent to one tax ID number. We are not requiring states to divvy that up among practices.

**John Allison:** A survey is going to pop up in a minute requesting some feedback on this webinar. If you could complete that, that would be great.

The next question, this could be for Melanie or Michelle, does Oklahoma require a minimum patient volume separate than the minimum patient requirements of Medicaid?

**Michelle Mills:** When we set up the final rule, we had a couple of different options for how we would measure patient volume. One includes the encounters, general encounters no matter who the payer is, e.g. managed care, fee for service, whatever, or as an encounter basis. States can also look at patient panels, this could be when individuals are assigned to a provider's patient panel and seen within that that last year -- for managed care practitioners, FQHCs and a number of settings. We know there is care management going on in between the encounters that were

paid for. There may be questions or prescriptions filled, we are trying to be a little more flexible in our definition. The difference is states have a lot of data supporting the encounters option and they don't in a lot of cases have a lot of data supporting the patient panel methodology. It would really slow down their ability to validate which providers met those requirements. In some states they do have that information and they are offering that. Other states are looking at how to incorporate that into the future, but again, since the program is so new they are not able to offer it off the bat. The percentage thresholds which were 30 percent Medicaid patient volume for all EPs except for pediatricians which have a 20 percent minimum threshold, those are statutory so the state has no additional flexibility to raise or reduce those percentage thresholds. Melanie, I don't know if you want to weigh in on that.

**Melanie Lawrence:** Different states are operating their Medicaid programs in different ways. In Oklahoma, we have a patient centered medical home but from a claims perspective, we are paying on a fee-for-service basis. For us, it made the most sense, logistically and operationally, to have providers tell us the number of visits or encounters in the 90 day period as opposed to their panel, that worked out well for us. That is the choice Oklahoma made as a state, but different states are choosing different approaches to get the patient volume.

**John Allison:** If the EP leaves a FQHC or transfers to another FQHC, what is the registration process then?

**Michelle Mills:** It sounds like someone is asking if somebody leaves the clinic, how would they register them for prior time where they may have worked with them. They wouldn't be able to do that. The EP needs to go in and register and if they are no longer with that clinic, they would not select that clinical side of practices.

**John Allison:** If the FQHC as a group meets the patient volume but an individual provider does not, will this provider still qualify?

**Michelle Mills:** We really didn't talk about that today that in our final rule, we have additional details on this in the final rule at 495.306 H. We do allow some flexibility to use the group or clinics patient volume and apply that where the individual EP as a proxy volume. We know lots of FQHCs don't differentiate between patient volume for the individual practitioners, but look at the whole practice. There are several conditions upon how that would be used in order to make sure there is no double accounting. In addition to the final rule we also have an FAQ on our website that addresses this.

**John Allison:** Does the provider still need to attest they spent 15 percent of the estimated cost of the EHR?

**Michelle Mills:** Great question. The answer is no. We were able to get a technical fix into the Medicare and Medicaid extenders bill at the end of last year which did remove that requirement. It was an administrative requirement for states and providers and that is no longer a requirement. We have issued informal guidance to states and we are in the process of developing more formal guidance and we expect to modify that in the next iteration of our rulemaking process which will be later this year.

**John Allison:** If this is a voluntary program for the states, can they do it for two years and then stop participating?

**Michelle Mills:** Yes, there's nothing that requires them to continue other than the fact they are in for a penny, in for a pound once they start the program. There is a lot of demand that states do administer this program, I don't want people to think that states will yank the rug out from under them. We haven't had any states indicate they would start the program and then stop. Just to further underscore that, hospitals stand to get millions of dollars for their participation in this program and I think they are holding the state's feet to the fire on administering the program.

**John Allison:** Do states need to pay within the calendar year if the registration process is not ready until October?

**Michelle Mills:** I think they are asking would they need to pay within that calendar year. If they launch the program in October do they need to pay before December 31st and the answer is no. We have had to stated that states need to pay no longer than five months after launching their program.

**John Allison:** If an FQHC opts to measure needy individuals on a clinic-wide basis, do all providers need to practice "predominantly" to be eligible?

**Michelle Mills:** No, only the practitioners that wish to be eligible by that method. Providers can either practice predominately and meet the needy individual threshold or the Medicaid threshold -- at a clinic you have to use all practitioners. Not all eligible professionals but all practitioners at that clinic to roll up your patient volume. We talk about this in the final rule and the FAQ I mentioned, I encourage folks to take a look at that but, at that point, any eligible professionals make it the incentive but not all practitioners. The idea is to make sure administrative efficiency and if we start peeling back whose encounters can't count toward that rollup it makes it inefficient here it.

**John Allison:** Can you elaborate how to get providers to sign payment over to the FQHC when the EPs are employed by the FQHC?

**Michelle Mills:** This is something that CMS is staying out of but we think would be visited by your employment contracts. The eligible professionals need the CMS certification number we showed you that you get at the CHAPEL site and they wouldn't have the information without the clinic administration giving it to them. They wouldn't know what is certified and what isn't and what the number is. They need the information from you. Furthermore, if they don't register for the program and meet the other requirements like a testing to the requirements in the years of the program, no one gets the incentive money. We encourage the clinics in group practices to work with the eligible professionals and talk to them about their intentions for the program. If they have other clinical sides of the practice they may need to also divvy up the money on the backend with them. This should be discussed with your staff.

**John Allison:** Can you register before your EHR upgrade? We are currently running on an older version but plan to upgrade in the spring?

**Michelle Mills:** You can register as long as your state has launched. You can come back anytime in the year to finish the process in order to get the incentives. In this case, the screen that talked about if you have certified EHR technologies you would say no, and you would still continue the process but then the state would ask you for that information later. You wouldn't go back and complete the process for the state until you are ready to get paid.

**Melanie Lawrence:** This is Melanie, as long as the provider has some sort of document showing they have a commitment to install, we realize a lot of vendors are running behind because of the increased demand for installation. If we are looking at contracts and indications that the certified version of the technology has been purchased or leased and is scheduled to be installed.

**Michelle Mills:** I think the terminology CMS has used is there must be some sort of legal obligation that requires you to fulfill a contract or lease or purchase agreement of some sort. As long as one of those things is in place that we see you are legally obligated you can proceed.

**John Allison:** If my EP wants to verify meaningful use this year, what period of time would they count patient encounters across?

**Michelle Mill:** Let's ask that person who asked that to follow up with their state. Many states are not capable of that yet and you would be needing to demonstrate, implement or upgrade your first year and meaningful use in the follow years.

**John Allison:** It looks like the remaining questions are variances on ones we have already asked. Most of these questions seem to be --

**Michelle Mills:** It may be worth mentioning, I said earlier we have a FAQ on our website specific to the group practice methodology but there are a number of FAQs our website. You can type in FQHC if you want target FAQs. You can look through all of them.

**John Allison:** At this point I believe we will end the question and answer portion. Again, let me thank all the speakers as well as our sister agencies, HRSA and their contractor NORC, that helped us get this set up and handling logistics. We hope this was worth your time. We want to remind people this is being recorded and a recording and a transcript will be available on the CMS EHR incentives website in the near future. I will see if anyone from HRSA or anyone else would like to add a few closing comments.

Okay. We will go ahead and wrap this up. Again, we thank you for your time and look forward to talking to you in the future.