How to Play by the (Final) Rules: An Overview of Meaningful Use Stage 2 and the Standards and Certification Criteria Final Rules

8/30/2012

- Travis Broome – Office of eHealth Standards and Services, CMS
- Steve Posnack, MHS, MS, CISSP – Director of the Federal Policy Division, ONC
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Kate Berry
Hello, everyone, and welcome. Thank you for joining us today for our program on the Meaningful Use Stage 2 and Standards and Certification Criteria Final Rules. This is Kate Berry, CEO of National eHealth Collaborative. NeHC is a public/private partnership with a mission to advance nationwide health information exchange, to improve health and health care. Today, we are pleased to welcome Travis Broome from CMS and Steve Posnack from ONC. In just a few moments, I'll introduce them, as they are our foremost experts on these rules. Next slide, please.

Recently, NeHC launched a membership program, and the benefits are highlighted on this slide. They include visibility and recognition for being a part of an influential health Internet organization; preferential participation in leading strategic workgroups; unique networking opportunities; discounts on our programs; and weekly summaries of health IT media stories and syntheses of critical information. For more information, please do visit our website. Next slide, please.

This slide just shows the logos of our members, and we're really pleased to have diverse and leading organizations joining NeHC. We have health systems, health information exchanges, technology companies, state agencies, patient-focused and quality organizations, health IT startups, and much more. Next slide, please.

I would also like to just bring your attention to a conference that NeHC will be hosting with InfoComm in D.C. on November 27 and 28. This is the Technology Crossroads Conference, which will explore the intersections between audiovisual technologies and health IT, as well as health information exchange. We have some outstanding speakers lined up, and there will be some thought-provoking discussions on how AB technologies are being used in health care in innovative ways, such as telemedicine, remote monitoring, and patient engagement innovations.

As part of this conference, there will be a special track dedicated to health information exchange, including presentations of the initial outcomes of NeHC's health information exchange Learning Network, on topics such as HIE

sustainability, health information exchange functions that support new payment and delivery models, and more. You can find more information about this conference on our website. Next slide, please.

I wanted to also just highlight a couple of upcoming NeHC University programs. Next week, on September 5th at 2:30, we'll have Gwenn Darlinger to present our Health IT Orientation program, which will provide an overview of the health care industry landscape and key trends, including both major government and private-sector initiatives.

Then on September 11th at 1 o'clock Eastern time, we will be kicking off a new series on health IT in rural and underserved communities, with the Rural Health IT Landscape. On September 12th, we will have a special program with Joy Pritts and colleagues from the Privacy Office at ONC, and that will be about an online game on privacy. Next slide, please.

On September 13th, we'll have David Muntz and Doug Fridsma as well as some other speakers joining us for a program to update everyone on the progress and accomplishments of the Standards and Interoperability Framework. On September 14th, we are very pleased to have Dr. Mostashari, Dr. Clancy and Patrick Conway joining us for a special program about how ONC, AARP and CMS are collaborating to leverage health IT to improve quality.

And on September 19th at 1 o'clock Eastern, we'll have several speakers: Paul Tuten, from ONC; Bill Braithwaite with Anakam; Michael Nelson with Equifax; and Drew McNichol of HEALTHeLINK to discuss increased medical records security for both physician and patient access. This webinar is being sponsored by Equifax. Next slide, please. [Moderator gives housekeeping instructions.]

We do have recordings of our previous programs on this topic available, and will also post the recording from this program as well, so lots of material available to you on the website. Next slide, please. [Moderator gives question instructions.]

Now I'd like to introduce today's speakers. We have Travis Broome, who is a policy analyst in the office of eHealth Standards and Services at the Centers for Medicare and Medicaid Services. Travis develops and writes CMS policies for Medicare and Medicaid EHR incentive programs. He's been mostly focused on developing the Meaningful Use criteria.

We also have Steve Posnack with us once again. He's the director of the Federal Policy Division within ONC's Office of Policy and Planning. Steve is responsible for ONC's legislative and regulatory affairs, including leading ONC's review of legislation and regulations, briefing ONC leadership on legislative and regulatory issues, and developing regulations on behalf of ONC.

Travis is going to lead us off with his presentation. We'll turn the controls over to Travis; and then Steve will present on the certification rule. And at that point we will [unintelligible 6:23] for Q&A. So, Travis, we'd like to turn the program over to you at this time.

Travis Broome
Great. Make sure I can do this. Great. Thanks again to NeHC for inviting us and hosting this—we're really appreciative, on short notice, and over and over—hosted these webinars for us. It's very important to us to get all this information out there, so we certainly thank them for that.

So, what is in the rule? It is slightly more than Stage 2, and we are going to cover pretty much all of the things you see here on the screen today, some in more detail than others. But the rule contains some changes to Stage 1, obviously Stage 2, our new clinical quality measures; and what we'll really focus on today more is the new clinical quality measures reporting mechanism. It does contain all the details about the payment adjustment and the hardship exemptions that are available.

There are some slight Medicare Advantage program changes; we won't be going over those today because they're so very specific to a small audience. And then finally we'll briefly go over some Medicaid program changes in regards to trying to get more people into the Medicaid side of the program.

So, what does Stage 2 mean to you? The first thing is that it starts in 2014 for providers who have met Stage 1 for years two and—for two or three years. You'll need to meet those Stage 2 criteria. The important thing to read there is for providers who have met Stage 1, so this is personal to you, your timeline is personal to you, though not everyone will start Stage 2 in 2014.

Stage 2 really focuses on three areas and really makes two giant leaps, if you will, in the last two areas. But most of the things in Stage 2, I would hope, if you're familiar with the Meaningful Use concept, won't be much of a surprise for you. Thresholds went up. Stage 1 menu measures moves to core. Most of it I hope you see as a very logical and natural progression from Stage 1.

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The two areas where we really took a big step forward if you will from Stage 1 are in care coordination and patient engagement, so I'll talk more about those as the presentation goes on. Better care coordination, better clinical decision support, and better patient engagement will really further us to those outcomes. You'll see the arrow slide in a second, given the ideas to get to those outcomes of saving money, time and want.

So Stage 2 eligibility, not a lot of information here because Congress didn't give us a lot of latitude so that we could really change many things. It is determined by the HITECH Act. There are no changes to the HITECH Act; therefore the only eligibility changes we could make have to do with the hospital base and the Medicaid ones I mentioned earlier.

We'll go ahead and talk about that hospital base change right now. Currently, hospital base was based solely on place of service. We've revised that in the Stage 2 change. In Stage 2, using that rule—phrase loosely, it'll be effective for everyone, regardless of stage. And it basically allows for EPs that demonstrate that they fund the acquisition, implementation and maintenance of CEHRT, including supporting hardware and interfaces needed for Meaningful Use without reimbursement from the hospital; and they use that instead of the hospital's CEHRT.

So if you waded through all that and you find yourself in that situation, yet based on the site of service you were hospital-based, you can apply to CMS and we will review your application and potentially make you non-hospital-based, even though you performed more than 90% of your services in the inpatient or emergency department. Again, this is going to be a very small group of people, obviously, primarily those who built out EHRs long before hospitals had them. But if you do find yourself in this situation, you can apply to CMS, and that makes you eligible for the incentives, but also for the payment adjustments as well.

Now we're going to dive into Stage 2. This is certainly where we'll spend the bulk of the presentation. You're foreshadowed the arrow slide, so we are in Stage 2 now, the advanced clinical process. Hopefully we'll obviously talk more details about that. The stages of Meaningful Use remain the same, the philosophy is the same, so build that foundation in Stage 1, develop processes that utilize that foundation; and then Stage 3, do they lead to improved outcomes.

So this is for Medicare EPs. This gives you an idea of your personal timeline. If you start by 2014, as you can see, you always start in Stage 1. You always get Stage 1 for a minimum of two years, regardless of when you start. For hospitals, same timeline. We try and put their—incentive is based on a complicated formula, so we didn't try to get it on the slide. But the stage timeline is exactly the same. Two years of Stage 1, starting whenever you start your first year of Meaningful Use. And this is continuous, so if I demonstrate Meaningful Use, say, for the first time in 2013, but for some reason I can't in 2014, I'm still looking at Stage 2 in 2015.

Changes from Stage 1 to Stage 2 on a broad overview slide. Basically you're looking at the same number of total objectives, but a distinctive shift from emphasis on, from the menu to the core. So as you can see, the totals remain the same, but the number of core went up, while the number you have to select from the menu went down.

Some overall polices that changed to Meaningful Use. The biggest change from an overall policy perspective on Meaningful Use as opposed to objective by objective is how the menu objective exclusions are dealt with. While you certainly can claim exclusions, they will no longer, starting in 2014 for both stages, count towards meeting the number of menu objectives, so to back up here real fast, the way that works is currently, if you're at Stage 1 and you need an exclusion for one of those five of ten menu objectives, that exclusion counts as one of the five.

Starting in 2014, it will no longer count as one of the five, and you'll essentially have to meet five of nine that are remaining to you. If you do find yourself in this situation—this is only possible for EPs because hospitals don't have enough exclusions—where you have more than five if you're in Stage 1 or more than three if you're in Stage 2 exclusions, then you would just attest to all of those exclusions plus the remaining criteria. So, say you're in Stage 1, you meet six exclusions in the menu, you report those six exclusions and then there remain four menu objectives.

Things that did change: The eligibility criteria for how many of your patients have the benefit from certified EHR technology to be eligible for the incentive. So, 50% of your outpatient encounters. Again, this is an eligibility question. So you ask yourself can you pass this bar before you even worry about Meaningful Use.

Measure compliance does equal objective compliance in every case. And then we do continue the policy—we proposed to change it, but in the final rule,

[unintelligible 14:47] policy where denominators are based on outpatient location equipped with CEHRT, and so depending on the measure, that might be all such encounters at those locations, or it might be just those encounters for patients whose records are maintained using the certified EHR technology.

Changes in 2014: The EHRs must meet the ONC standards, regardless of what stage you're in. I'll certainly let Steve talk more about that. In an effort to spread out the rollout of that 2014 edition, we have allowed any provider in either stage, Stage 1 or Stage 2, to have a three-month reporting period in 2014. The reason we went with three months as opposed to using 90 days again is we're really pushing hard toward alignment with other quality programs, and that [unintelligible] 90-days thing just pretty much destroys any hope of alignment with other quality programs, which none of them use that, so that's why we went with the three months.

The other innovation that will start no later than 2014 for providers in either stage is the ability to batch report. This is still individual EP attestations, and their individual information. However, a practice, a group, a hospital, with a provider practice, whatever, can put all of that information on one file and upload it to CMS, as opposed to working through the Web-based attestation system for each individual EP. Like I said, that will be available, both stages, no later than the 2014 reporting year. If we can get it up sooner, I'm sure we will. But no later than 2014.

All right, so now we're going to dive into the core objectives. My focus on these is going to be, talk about what's changed, if it was a Stage 1 objective; and to talk about essentially the things that aren't there on the slide. It will take me long enough to go through each one of these slides that you'll be able to read everything on here, so I won't read them to you.

So, CPOE, you can see the 60 and the 30 and the lab and the radiology added. What you can't see, what isn't on the slide, are three other changes. We changed the denominator for CPOE from patients with at least one medication of this order type, or one order type of X type, to the natural denominator of number of orders, number of laboratory orders ordered by the EP or an authorized provider at the hospital.

There were some concerns, especially in Stage 1, that that denominator wasn't knowable. Those concerns have pretty much been waylaid, both by public comment and to the rule itself, and then interactions with the industry and providers in between the rules; so we're going to go with that natural denominator.

This is one of those ones that's limited to patients with their records in CEHRT, though.

Now, two other changes that have to do with CPOE. The first is we're expanding the, who can order it. So, anybody who can—it used to be licensed health care professionals only. Now we're expanding it from licensed health care professionals to certified medical assistants. The primary reason for this is our EPs, many EPs function without a licensed health care professional in the office [unintelligible 18:28], but they do have certified MAs, so wanted to expand that to give them that option to not have to do it themselves if they so choose.

And then we did, as part of requested comments, provide detailed descriptions of what a laboratory order is and a radiology order is. So I'd read those to you, but they're available in the reg.

For e-prescribing, and there's the obvious, it went from 40 to 50%. Two other things we changed is we will allow you, if you want, to count both permissible prescriptions, which is the non-narcotics that are controlled by the DEA. You can keep those out of your denominator as you did before; or if you want to, if you have a compliant e-prescribing system that you're using, you can include them in your denominator at your, basically, provider choice.

The other thing we did was we added an exclusion for those EPs and hospitals who might not have any pharmacy within ten miles of their location. That excepts e-prescribing. This is very, very few places in the country, but they do exist in some of the, you know, Alaska, North Dakota, that type of place. And so if that does apply to you, then you can meet that exclusion then.

No real changes in demographics, vital signs and smoking status, except the one you see there on the slide, 50 to 80%. Interventions for clinical decision support, the number went up. We ask that you try and link them to your CQMs that you're using. If that's not possible, then, to relate them to high-priority conditions for your scope of practice. Labs, again, nothing real new there. More than 55%, percentage went up. Patient list, literally nothing new there. Again, just the idea is to demonstrate the capability to do that. We leave it to the EPs and the hospitals to best utilize that capability for their own patients and to improve their own care.

Patient reminders or preventative reminders, we did add—change the denominator here slightly, with the addition of two or more office visits in the last two years. In Stage 1, EHRs were new to most people and there's kind of a natural history of

limitation of how long you've had your EHR. As time goes on, that natural limitation keeps getting longer and longer and longer, so we imposed this limitation on it, starting in Stage 2, of two or more office visits in the last two years, to maintain the relevancy of the denominator to patients who need reminders.

Patient access: We have slides that talk in more detail about this one, so I won't spend a lot of time on it here, but obviously the big thing is the movement to core, 50% available, 5% actually accessing it. Office visit summaries, pretty much the same deals that you would be used to from before, 50%. Education resources, again, not many changes there.

Use the EHR to identify the resources and provide them; that does not mean the resources have to be native to the EHR. EHR, what it will do is identify patients who are good recipients or potentially good targets for specific types of education and categories of education. It doesn't mean you have to exactly use the one demonstrated by your EHR.

Secure messaging is our new one for EPs, and again, this is a patient engagement push, as I mentioned at the beginning. It's more than 5% of patients send messages to their EP. The measure isn't the other way around, because we want it to be a two-way street, and this is one way to ensure that happens.

Med rec, the only real change there is went from menu to core. Summary of care, again, this is one of the ones I'll spend some time on in an individual slide talking about. The 50%, just like med rec went from menu to core, and then we added two more measures, the 10% sent electronically using CEHRT, and then at least one case of breaking down any vendor barrier that might exist.

Immunization, and this is true essentially of all the public health objectives, essentially what they did was, with one exception, they moved to core. If they were menu, if they were new, they're in the menu; and we're going with successful ongoing transmission, as opposed to the test environment we had before. All the same exclusions are still out there, you know, my public health agency doesn't want immunizations from me because they don't want adult immunizations and only see adults; they're not ready to accept HL7 2.5; all those—the exclusions that were there before are still here for Stage 2, hopefully explained a little better, but essentially the same.

But the measure, if you don't meet an exclusion, is now to actually make that happen, and we define successful ongoing transmission as one of two things: one being the obvious, of I am actively transmitting. So when I get an immunization, that report goes off to the public health agency. The other thing, which isn't as intuitive, is if you are actively engaged in an ongoing process with the public health agency, and there's specific criteria; in the rule, it kind of spells out what that means [unintelligible 24:00] reference.

Security analysis, we did call out that [unintelligible], but the actual requirements stay the same. It's incorporated into your risk management process. Meaningful Use does not create new privacy and security requirements; it's simply saying, we're incentivizing you to introduce EHR into your world. We know that that has privacy and security implementation, so have you updated your risk management process that is compliant with HIPAA, to account for HRs? Yes, sir.

All right, so that brings us to the menu for the EPs. Imaging results, 10% of imaging results accessible through the certified EHR technology. Keywords here are "accessible through." It doesn't mean you have to store every image in your EHR; it means that you have direct access to image from your EHR. So it could be if I come see you and you're a physician, I'm patient Travis, I—and when you pull up my record and I had a scan, you can click on a link that would take you to maybe a PAC system or something that would have that image. But you would be able to directly get from your EHR to my image, even that doesn't require native storage of that image.

Family health history, more than 20%. This is one of the ones that was pretty popular both in proposed and popular with commenters as well. One entry for one first-degree relative of structured data.

Syndromic, cancer, specialized—these are all public health. One old, two new. Again, successful ongoing transmission. The important thing to remember for cancer and specialized registry is that these are tinted to essentially give credit where credit is due. So if you do this and you treat cancer, or you work with a specialized registry, the idea is to give you Meaningful Use credit for doing that electronically.

There are exclusions for both of these that are written in such a way that … so, don't read these as, oh, my gosh, I have to go find a cancer registry even though I don't diagnose cancer. And you will meet the exclusion if you don't treat cancer, of a cancer registry. Similarly, for specialized registry. The universe of registries is

limited to those that are sponsored by PHAs or national medical societies. So if you're not already know of one and linked up with one, it's highly likely that you meet the exclusion here as well.

The menu objectives, progress notes. Enter a progress note for more than 30%. Some of you might know CMS resisted progress notes as, we don't need to incentivize it, it's already happening for a long time. But the public comment this time around was pretty much unanimous that there were some cases where it wasn't happening the way it needed to be happening for their [unintelligible 26:58] use. So in response to that public input, there it is.

So obviously I'm not going to go over every one in the same detail for hospitals. I'll just highlight the differences for hospitals. And to find differences on the first page, we gotta go all the way to the bottom of this slide—eMAR. eMAR is implemented with an assistive technology and used for more than 10% of medication orders.

We've had some questions come in of what does the assistive technology mean. This is where it becomes very important to read both rules. Assistive technology is very well defined in the ONC rule; everybody who comes to me with that question, I point them to the ONC rule, and they basically come back saying, oh, yep, that makes perfect sense; thanks for pointing me in the right direction. Again, these rules are very linked together.

Again on this page, not too much different at all from EPs. We'll certainly talk more about summary of care and patient access in a second. Hospitals have three core public health measures: immunizations, labs, and syndromic surveillance.

The menu for the hospital is different. You'll see some familiar things, progress notes, imaging, family history. The other three are different. So we are introducing e-prescribing for discharge medications. We had proposed it be for new and changed, and we had asked for comments on whether it should include basically a continued medicine, that the patient was on when they were admitted. We didn't change from while they were in the hospital [unintelligible]. Public comment basically said that we should, so if we do new, unchanged and changed medications that you issue scripts for at discharge.

Advanced directives does remain in the menu as the same measure from Stage 1, and remains in the menu for the same reason it was in the menu for Stage 1. There's still uncertainty in some states about whether an advanced directive in an

EHR is something that can be acted upon, and if it can't be acted upon, then it raises the question of whether it's even wise to have it in the EHR. So we continue to leave that decision to the individual hospitals, by keeping this in the menu objective or in the menu set.

And finally the new one, another new one in addition to progress notes that we discussed but we didn't propose, is to provide structured electronic lab results to EPs or other ordering ambulatory providers for 20%, and here's the important part, of electronic orders received. So the denominator is those orders that were received by the outpatient lab of the hospital or the lab at the hospital electronically. So that kind of, by putting that limitation in the denominator, we've already guaranteed at least some electronic link between the EP and the lab. And then this measure basically seeks to make sure that link is two ways, and that it uses structured results for averages.

So I promised a deeper look at patient engagement, so here we are. As I mentioned already, this is one of the two big pushes of Stage 2. There are two things. We already talked about secure messaging; the other one is more than 5% of patients must access their health information online. We originally proposed 10%, we took it down to 5, primarily because we were concerned that in some areas of the country, that all you're going to have to do to meet 5%, 10, 20%, is just make this available to patients.

You know, I have a 19-month-old son, his pediatrician, yeah, he probably makes this available to his clientele, he probably gets 30% without a sweat. Other places, other patient populations, 10% might have been a significant challenge. So therefore we moved it down to 5%, which is basically as low as we could go while maintaining the principle. But we did finalize the principle and stand behind the principle that providers need to be pushing patients to be engaged, and that if they do have influence in this area, it is possible for them to influence their patients in this area, and that's reflected in these two measures.

There is an exclusion for both of these measures that have to do with broadband availability in the provider's county; 50%, three megs. You can check it out on your county on the SCC website. All right.

Electronic exchange care coordination, our other big push. The first measure will seem very familiar to everyone. Stage 2 requires providers send a summary of care for more than 50%, and transition of care and referrals is to be done anyway. I'll use my own example again: I got referred to an ENT. The pediatrician literally

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printed it off, handed it to me and said, "Provide this to your ENT when you go see them." That meets the 50%.

The next limitation, the handoff would not meet. And this is that a provider electronically transmits a summary of care for more than 10%, so knocked 40% off the threshold for transitions of care and referrals, using certified EHR technology. Could be either a push or a pull, so I send it to them, or I know that the person I'm transitioning to or referring them to pulled it down from me, using the standards that are laid out in the certification that Steve will talk about.

And then the third measure adds yet more limitations in our efforts to push this forward and incentivize the care coordination we all want. And that is, at least one of those documents that was sent as part of the 10%, was sent to a recipient or pulled by recipient with a different EHR vendor. Absent that, we expect almost all providers are going to find themselves in that situation. But if you happen to know any facility or provider that you regularly refer to electronically, using the different systems, any one of those is, boom, you're done, move on.

For those who that isn't easy for, and it's not that simple for, we have this alternative, which is to test your system with a CMS-designated test EHR that ONC, CMS and this will collaborate on, and therefore it will obviously be different than your EHR vendor, and that would satisfy this third measure as well.

Okay, so we're going to move on from Stage 2 and talk about changes to Stage 1 CPOE. Basically the denominator change I already mentioned is now, is available as an option starting in 2013 for those who want to use it. It is optional going forward.

Vital signs, I didn't mention this in the Stage 2, but we are making changes to the age limits and the exclusions for vital signs. They will be optional in 2013, required in 2014, and were required from day one for Stage 2. So we're getting rid of the age limitation, height/weight. Makes a lot of sense because it's almost the most important when you're age—you're two. And then we're upping the blood pressure to three, based on the updated clinical recommendations that are out there.

Exclusion side, we're allowing providers to separate blood pressure. So I can say, I only care about height/weight. I don't do blood pressure for my scope of practice; therefore, I'm going to report a numerator and denominator of height/weight. I can now do that, starting in 2013, or I could do the opposite: I care about blood

pressure, I don't care about height/weight. Seems less likely, but if it is the case, you can do that as well.

Testing of HIE effective for EHR reporting periods in 2013, it goes away. Much more to say about that. E-Copy and the provide timely access in Stage 1, that's already mentioned. 2014, everybody regardless of stage is going to do 2014 edition certified EHR technology, starting in the week of '14, so to update this objective to that new capability, we do adopt the measure 50%, but not the measure of the 5% actually accessing that information. So there is no requirement in Stage 1 of 5% actually accessing.

Public health is just the clarity thing; it doesn't change the requirements at all. It's designed to clarify when I need to report on public health objectives, when I'm in a situation where my public health agency will take them; but it doesn't require that I send them. The requirement has always been for Meaningful Use, you send them; if they'll take them, you send them. And this is just added language to try and make that clearer to folks.

All right, so now I'm going to move on to CQM. I am not the expert of CQM the way I am on the Meaningful Use objectives, so I'm going to focus primarily on what you need to do and how you need to do it, as opposed to the clinical nature of CQMs and their selection.

So, this is a lot of information on this slide, but the important part is the first line. CQM reporting will remain the same in through 2013. So you still have the attestation for the pilot participation options that you have today, you have in 2013. Nothing changes in 2013 in regards to the CQMs.

The electronic specifications are not updated, but there is flexibility in implementing the certified 2014 edition, so I get a vendor, they get on the ball, they get it certified. I'm looking to upgrade and I upgrade in the middle of 2013. What do I do about reporting in 2013 with my new technology? Well, you report the same ways, but you can use the results obviously out if your 2014 certified EHR. There are some CQMs that go away, so you wouldn't report on those for EPs, but hospitals includes all 15, so [unintelligible 37:57].

So we got rid of this core objective. This is one of those things that it sounded good in a regulatory, but when we actually built it out, it didn't make much sense to people to attest to an objective in the system and then turn around and actually

provide data separately. So now when you provide the data, that counts as your attestation. You don't have to separately attest as a core objective.

All the providers have to select CQMs from at least three of the six of our strategy domains. Again this is part of the [unintelligible] into too much, but those are the domains as part of the national quality strategy. And then your CQMs should focus on at least three of these. We don't make you decide which ones go with which; there will be and is a mapping in the rule, and what we—more educational stuff on our website about which ones go with which.

I already mentioned alignment earlier when I was talking about the three-month period. We are very interested in alignment and moving towards alignment, and starting in 2014, these are the programs we're looking to align, and I'll talk about how that actually happens in a second.

So, this is how it essentially happens for EPs. You can submit once and get credit for CQMs in two programs individual; you could use the PQRS EHR reporting option and get basically credit for PQRS and EHR incentive programs. If you do a group practice ops, then you could use the PQRS GPRO, and to get the credit for PQRS and EHR incentives; or you can use Medicare's Shared Savings Program or the pioneer ACOs and get credit for those and the EHR incentive programs. The crux is, you have to use certified EHR technology in your reporting of any of these options, because that's a statutory requirement for EHR incentive programs.

Eligible hospitals are kicking off a reporting pilot for IQR; however, that's in such early stages that … there aren't as many concrete details on that. But as that becomes available, then you'll be able to do the same one for IQR and EHR.

So starting in 2014, everyone who is beyond—not in their first year, or [unintelligible 40:27] folks, they're going to stick with attestation. Everybody else must electronically report. The CQMs they're going to report will come up on our website, and they're also in the rule. There is not a core set for EPs in the sense that it's required, but we do have a recommended core of nine for adults and nine for pediatric [unintelligible].

Basically this walks through a little bit about how we decided on what the core would be. Again, as I said, this isn't my particular area of expertise; I won't spend a lot of time here. But you can see the bullet points there on the slide. They're available for your review later. Just more criteria on how we decided on what's recommended in the core.

All right, so this is the what you're going to report, as opposed to the how that I said I would focus on. And for EPs, you're going to report nine out of 64 possible ones, covering at least three. Eligible hospitals, you're going to do 16 out of 29, again, covering at least three domains. So that's the new requirement for Stage 1 folks and Stage 2 folks, starting in 2014.

And how do you send in the what? This is a great chart that tells you the various options for how. How to recommend flagging this one in slide 47, printing it out or saving it to your desktop or whatever. The best way for you to keep it in front of you. For EPs in their first year, as I said, they're going to stick with attestation because they've got that 90—ending 90-day thing going. EPs beyond, there's the option one, and essentially we'll call that EHR incentive program only option. And that is aggregate all payer information submitted electronically so you're looking at [unintelligible 42:23].

Option two, that is to satisfy the requirements of the EHR reporting option using CEHRT. This is patient level, Medicare, electronic, using QRDA [unintelligible]. And then there's the two group reporting options, so this is the Pioneer and the PQRS GPRO option I already discussed, and those are patient and Medicare as well. Eligible hospitals, the same thing, year one, attestation. After you move past year one and you get into 2014, again, you have either the aggregate all-payer option, or you have the patient-level all-payer. Notice the sample option through the IQR reporting pilot that we're launching.

Timing: This is basically, gives you an idea of the various time frames. There really isn't a change from Stage 1 to Stage 2. But there's a nice reference table for you that you can bookmark. It's always two months following the end of the EHR reporting period for electronic submission, of the submission period for after your first year. Obviously your first year of MU, it's whenever you attest.

For 2014, within three months, the submission period stays the same, but the period you're reporting on becomes more flexible, as demonstrated there on the chart. But it's important to know that the submission period does stay the same.

Okay. That brings me to payment adjustments and hardship exemption. I'm going to go through this section relatively quickly, because there are, essentially the only thing we care about for payment adjustments and exceptions, five questions you gotta ask yourself to know about this. Number one: Who they affect. Number two: How much are they? Number three: When do they go into effect? Number four:

What do I need to do to avoid them, and when? And number five, are there any exceptions?

The reason this is going to go quickly is because CMS doesn't have any control over the first three questions. Those answers were in statute, so we only have to worry about the last two. We do have reference slides for the first three, but so … there's not much we can do on them.

So the who is any Medicare EPs, subsection (d) or eligible hospital. So if you are eligible for the Medicare program, for the incentives, then you potentially have the payment adjustments applied to you as well, unless you meet a hardship exemption or you become a Meaningful HR user. If you're not eligible for the incentive, then you are not eligible for the payment adjustments. It either is both, or none. There is no situation where you wouldn't be eligible for the incentive, but you would get hit by the payment adjustment.

All right, so that gives then the what you need to do, is to successfully attest to Meaningful Use, which is not adopt/implement/upgrade; it has to be Meaningful Use by statute. So for EPs, this slide shows you, answers the question of how much. And that is somewhat varied for EPs. It's more complicated for EPs than for hospitals, which you'll see in a second. But the slide lays it out pretty well.

Two things to call your attention to is in 2015, if you were subject to the payment adjustment in 2014 for e-Rx, then it's 98%. In 2015, if you were not subject to it, then it's 99. And the way that works is essentially all claims that hit the Part B physician fee schedule, so if I'm an EP, I submit a claim, a $100 claim, to the Part B physician fee schedule in 2015 and it's paid out at $100 normally, but I'm subject to the payment adjustment and I was subject to the e-Rx payment adjustment in 2014, instead of a hundred bucks, I get 98.

And as you can see, it goes down a percentage until we get to 2018, and then there's a decision point in 2018 where these two tables converge. According to the statute, if less than 75% of EPs are Meaningful Users again in 2018, then it goes to 96%. And then if it's still true in 2019, it goes to 95%. Never gets lower than 95%. If more than 75% of EPs are meaningful users in 2018, it stays at 97 going forward.

So now we get to the, what we need to do to avoid the payment adjustment. The number one thing to remember is, about the what, is the same definition of Meaningful Use, same timeline with the stages. It all stays the same, whether

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you're talking about the incentives or the payment adjustments. There is no variation in the definition of Meaningful Use or what stage you're in because you switch over to the payment adjustment. Same definition, same stage progression.

So that basically just leaves us with the question of, when do I need to do it by. And it basically depends on when you start. So for EPs who have demonstrated Meaningful Use in 2011 or 2012, they need to do a full EHR reporting period in 2013. That will avoid the 2015. 2014-2016, 2015-2017, 2016-'18, '17, '19, '18, '20, etc., etc., etc. You must do it each year, else the stages doesn't mean much, to demonstrate Meaningful Use.

The other thing I'll point out at this junction is, a lot of people have asked and many of you might be thinking in your head now, why 2013 instead of into 2015; why not just do 2015 and 2015. The answer is summed up in two words: reprocessing claims. To make the determination after claims started to be paid in 2015, by statute, that first claim that has to hit January 1st, 2015, must have the payment adjustment applied to it. So if it turns out to be as a 2015 determination period, and it turns out that it went the other way from how we paid the first claim on January 1st, then that claim would have to be reprocessed, which is not only expensive for CMS and its contractors; it's also expensive for the providers that have to deal with zeroing out the claim in their accounting system, re-putting it in. So that's why we do the prospective determination.

The next slide just talks about our folks who start in 2013. Same deal for them, except obviously 2013 is their first year, so they get the 90-day EHR reporting period.

And the next slide is our drop—now, drop-dead date for, how do I avoid the 2015 adjustment. You have until October 1st to attest in 2014 to avoid the 2015 adjustment, which means you need to start your 90 days no later than July 1st. When you do that in 2014, that will get you for 2015 and 2016, and then you get on the same two-year timeline as everyone else.

Of course we recommend that absolutely no one wait until October 1st, because if something goes wrong, then you could find yourself out of luck, or some circumstances might not be—might be beyond your control. So certainly give yourself at least a month or two leeway at least, and preferably more. But that official last day is October 1st. If you are eligible for both programs, you must demonstrate Meaningful Use, but you can do it to either the Medicare or the Medicaid programs, based on the timelines I just outlined.

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All right, so hospitals—the rest of this can go real fast; it's very similar for hospitals and EPs. The hospitals, this is the how much. It's basically a lowering of the increase they would otherwise receive. You can see the math there on the slide as well as I could read it to you. The timeline is exactly the same, just on the fiscal year.

Again, the drop-dead date for hospitals, exactly the same. Same reasons, claim reprocessing. Just again on the fiscal year, moves our dates up to July 1st and April 1st for starting your period. Critical access hospitals, this is the reasonable cost as opposed to claims that CAHs find themselves in, and normally reimbursed 101%; the 1% eventually goes away. If they are subject to the payment adjustment.

This is where it's different for the CAHs. The CAHs, as I mentioned, don't really do claims. They have reasonable cost reimbursement, so they have an initial payment and a final payment. The difference between those payments is usually far more than the 1% that I just said was the payment adjustment, so we can use that process to account for that 1%. So therefore, they can do EHR reporting period in the payment adjustment year, as opposed to a prospective determination.

All right, so that brings us to question No. 5, our hardship exemptions, and wrapping up here. Turn it over to Steve pretty soon after this. The first three are pretty—call them the obvious ones, right? So if I don't have Internet, I can't use an EHR. At least I can't use it [unintelligible 52:29] Meaningful Use. If I don't—if I'm a new EP, I obviously haven't had the chance to demonstrate Meaningful Use.

And then there's the natural disaster, unforeseen circumstances, so if I got flooded out by Isaac, if my vendor goes out of business, if my hospitals goes bankrupt, all those types of extreme circumstances beyond our control. All those are application processes.

And then we get to the EP ones, the 4 and the 5. EPs must demonstrate that they lack the following criteria: Lack of face-to-face or telemedicine interaction; lack of follow-up needs of patient. Meaningful Use has tons of exclusions built into the measures themselves, so it is entirely possible for a provider, an EP, who doesn't have face-to-face and doesn't have follow-up needs to meet Meaningful Use. Many of them have.

But we did feel it rose to the level of a significant hardship, compared to those who do have face-to-face and follow-up needs, because EPs without face-to-face and

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follow-up needs are dependent upon other EPs to give them information that is necessary to meet Meaningful Use.

So there's two ways to go about this. We put in a criteria for anesthesiologists, pathologists and radiologists, to have that as their primary specialty in PECOS on January 1st, 2014. Would not have to apply, they would be granted this exception on an annual basis. And then if you don't meet that category, then you can apply, just like you would for the first three as well. You do not have to be in anesthesiology, radiologist or a pathologist to apply. Any EP can apply for this one if they feel they meet the criteria.

And No. 5 is EPs who practice in multiple locations must demonstrate that they lack control over the availability of more than 50%. If you control for more than 50%, if you remember way back when we started, then we already had a Meaningful Use solution for you. But if you don't have control over CEHRT, have locations that total up more than 50% of your outpatient encounters, then we have this hardship exemption for you. Now, this is only for those who practice in multiple locations. The classic example is being a surgeon, who spends all of his time in an AST. A geriatrician who spends all his time in a nursing home. Pathologist, ESRT, etc.

I already mentioned this. This is the slide about the specialty exemptions. Hospitals and CAHs, they basically get the first three, same manner as EPs. They obviously see patients face to face and have needs for follow-up, and obviously can control their certified EHR technology, so they don't get 4 and 5.

Just a slide for your reference on how to apply.

All right, Medicaid-specific changes. I'm not going to go into great detail about these, mainly because again it's not really my area of expertise; and then also it's a small group. But to sum it up, the—under current rules, it required that Medicaid have patient—have financial liability for an encounter for it to count. Now, they're going to add counts to basically provide—if you have an encounter with a patient who is covered by Medicaid, even if Medicaid doesn't have liability for that encounter, it still counts for your patient volume, basically what that is. There's claim—there's a couple slides that basically go through what I just said.

The next thing to change, CHIP encounters do include in this patient volume count, but only those who are under—was only under Title 19 in Stage 1, now it's

Title 19 and Title 2. If you know what that means, then you know as much as I do about this one; but basically it allows you to count your standalone CHIP programs in your—or, not your standalones, but allows you to count your non-standalone CHIP programs in your Medicaid patient volume.

We also granted more flexibility on the 90 days you pick to look at your encounter, your patient volume. Used to be only 12 months prior; now you can look back up to two years.

Finally, there were some children's hospitals that were not enrolled in the Medicare program, so therefore they didn't have a CMS certification number, so therefore they couldn't participate. We're changing that and we basically need to give them fake numbers, so that they can participate.

Okay, and that will do it. This is just a reference slide that you'll have in your deck, and I guess with that, I will turn it back over to Kate and Steve.

Kate Berry
All right, thank you so much, Travis. An incredible amount of information, very efficiently. We do have a lot of questions coming in already. So, Steve, do you want to walk us through, and hopefully we'll have a good amount of time left for some Q&A. And I think we turned control back to Ernest, so you can just let us know when you want to move forward.

Steve Posnack
I will do that, thanks a lot. Thanks, everyone, for joining us again. It has been a pleasure to give these presentations. We hope you're getting a lot out of them, if it's more than your first visit to the webinar.

I first want to thank everybody that commented on our rules, as well as on behalf of Travis, too. We saw an evolution in the comments between Stage 1 and Stage 2 and our rule in terms of our 2011 edition and 2014 edition certification criteria, with much more specific, much more poignant, much more detailed comments that really gave us some very helpful feedback in making policy determinations. So, hats off to you all that commented. For those of you that didn't, please do so the next time around, because we can very much use all the input that we can get. Next slide.

There are a few major themes in our Standards and Certification Criteria 2014 edition final rule. Enhancing standards-based exchange, we see a lot of areas in the

certification criteria that we've adopted, either new or revised, that we've included additional references to standards across the board, whether they be specific vocabulary standards, content exchange standards—otherwise known as "the envelope," so to speak—and transport standards for certain certification criteria as well.

Also, included revisions to promote EHR technology safety and security. Those two enable greater patient engagement and support some of those new objectives that Travis had mentioned earlier in his presentation. In some instances we have included as part of the certification program some other regulatory changes that we made to the permanent certification program's rules, was to include greater transparency as part of the certification process.

And overall, we took a wholesale look at how we could introduce some new flexibilities as part of our regulatory framework, as well as reduce regulatory burden in some cases. And in those instances, because our rule is more technically focused, many of those regulatory burden reductions, really the EHR technology developers are the beneficiaries of those. So going forward, I hope you'll see across the board that we've done a lot in this rule-making, and I think you'll see a lot of good changes and positive progress towards both interoperability and exchange. Next slide.

The one heads-up, fair warning, is that, as Travis mentioned, our rules are very complementary and very intertwined, and braided in most cases, for lack of a better word, in terms of how to describe them. But they do have different scopes and they do have different audiences with respect to how our regulatory text needs to be interpreted. And so for ONC's rule, the Standards and Certification Criteria rule, it is technically focused, and its scope specifies the capability that EHR technology must include, and how that EHR technology needs to be able to perform in order to be certified.

It doesn't specify how EHR technology needs to be used. That's really where everything that Travis just went through comes in, and the scope of Meaningful Use, and changing provider behavior and meaningfully using certified EHR technology in order to receive incentives. So the one thing that I would make sure that people try to keep in mind as you read ONC's rule is to not interpret it as a proxy for use, and so look at it for how EHR technology should be used, because in most cases, it could result in an incorrect interpretation of how providers need to demonstrate Meaningful Use and certified EHR technology under CMS's rules.

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Just as a quick example, for view, download and transmit to a third party, our certification criterion requires specific transport standards: the primary direct project specification, applicability statement [unintelligible 62:07] transport. And that's required for EHR technology to be certified; however, under CMS's rules,, they actually don't limit transport to that specific standard in demonstrating Meaningful Use of certified EHR technology for that transmit capability. So there are other options available to providers.

But from a minimal standpoint, and what needs to be part of their EHR technology that's been certified from a default standpoint, it needs to be certified for that transport standard in this case; so CMS has granted some additional flexibility. So if you were to interpret ONC's rule through the lens of use, you would come to the conclusion that that would be the only transport standard that could be used, and that would be an incorrect interpretation. So, I hope that's hope that's helpful for folks as you go through reading both rules. You really need to read them together, and I think we've done a pretty good job of indicating where some of these differences are. Next slide.

Many of the remainder of my slides—and some of them are in here for your reference, just like as Travis mentioned—so I'll do an overview of some; I'll dive a little bit deeper in others. To those that have caught the presentation that I gave back in March when the NPRMs came out, I've updated many of my slides that were NPRM-specific to shift over the NPRM part and put in our final rule as a little bit of a compare and contrast.

So here, I just want to give folks a real bird's-eye view that in large part, we pretty much stuck with the framework that we proposed. We had a little bit of a re-jiggering for the certification criteria in some of the categories that we had proposed, but in large part, we generally stuck at a high level with what we had proposed. In many cases, though, we've offered a lot of additional clarity and other changes and tweaks to the exact wording of certification criteria to make them, A, clear; B, testable; C, to deal with other types of concerns and burden issues that [unintelligible 64:10]. Next slide.

These tables are going to be to your reference, in order to expedite my presentation a little bit. We have three categories of certification criteria in our final rule: Quote, unquote, "new," which are generally those that we've adopted to support Meaningful Use Stage 2 objectives and measures. We have added in some others that are more specific to the certification process, but largely, all of these—and the table here notes the ones that we've struck out of the rule as well as the ones that

we've added in in terms of formal regulatory text for certain things that we had proposed. Next slide.

I should almost do this backwards, because the other two categories that we have are revised certification criterion unchanged, or patient criteria. The unchanged certification criteria, which are on the slide that follows, some of them, in response to public comments we determined that they need to be placed back into their revised category. So this is actually an expanded table of the certification criteria from which we proposed our revised category, so to speak. We can go to the next slide.

So in the next slide here, the five that are the orange strikeout, those are the ones that have been moved into the revised certification criteria table on the prior slide. Other two that we struck for reasons that we discussed in the final rule. The important thing with respect to the unchanged certification criteria is that as part of the permanent certification program final rule, these certification criteria and the test results associated with them are what's called eligible for gap certification.

And so as an efficiency point, part of the ONC HIT certification program going forward, EHR technology developers that got certified to the 2011 certification criteria and have those test results, can use them towards the certification criteria that essentially remain unchanged from a functional, technological perspective, and for what we specified for certification. So hopefully that will enable some more efficient certification for EHR technology developers. And then as we go forward, I think we'll see this list start to grow a little bit more and there will be less re— more of a full—less of a full-scale revision as we saw a little bit more this time around in our rule-making. Next slide.

Okay, so one of the main points that I'll focus on in the remainder of my presentation really has to do with the definition for certified EHR technology; as Travis likes to say, CEHRT. And the certified EHR technology definition was— created a bit of tension I think when our first rule came out. It took folks a while to understand the policy that we were expressing, and we received a significant amount of feedback, as I acknowledged during the proposed rule period.

And in response to that feedback and the potential burden that that comment has raised and stakeholders raised, we proposed a new definition, a new structure for the definition for certified EHR technology. And so in comparing the two, under our prior final rules, we had a static definition for certified EHR technology that was driven by the certification criteria, the—and you'll hear me refer to the

quantity. And so the quantity of certification criteria that we adopted in our final rule.

So in order to, under the final rule from 2010, in order to have EHR technology that met the definition for CEHRT, you needed to have EHR technology certified to the entire quantity, all of the certification criteria for the applicable setting. And that created an instance where, or an environment where the regulatory framework actually required providers, especially on the EP side, who had a different scope of practice and could qualify or meet Meaningful Use exclusions, as well as those menu objectives that they were choosing to defer, ultimately to have more technology than they absolutely needed to, to demonstrate Meaningful Use.

And in response to that feedback, in our proposed rule and now in this final rule, we've adopted a dynamic definition for certified EHR technology going forward that will be driven by Meaningful Use and driven by the stage of Meaningful Use that a provider seeks to meet. And I'm going to go into a little bit more detail about how this new dynamic definition fits in. So let me make sure I've got … all right. Next slide.

I used this slide during our NPRM, and it's really more for your reference. The center circle, which is the base EHR definition—we're going to cover it in a little bit more detail later—but generally speaking, this references certain fundamental capabilities that all eligible providers across the board—and we have this rooted in statute—that they need to have in order to subsequently or consequently meet the certified EHR technology definition.

So everyone starts, or would need to start in terms of their analysis for, do they have certified EHR technology going forward, would be to make sure that they have capabilities that have been certified for the base EHR definition. Where things start to become different for different providers, in terms of the quantity, or the EHR technology certified to certain sort of patient criteria for 2014, is where we get into the MU core and MU menu relative to the state of Meaningful Use the provider seeks to meet. And so if there are certain exclusions in the MU core that a provider seeks to meet, then they wouldn't necessarily need to have those capabilities as far as their EHR technology, and they could still meet the certified EHR technology definition.

Now, the one point I would raise here as that point I think sinks in for folks, is that there's a—the definition for certified EHR technology really speaks to two audiences. For the provider community, it informs the, I'll say again, quantity of

EHR technology certified to the 2014 edition that they'll need to have at a minimum to meet Meaningful Use, and the stage of Meaningful Use that they seek to meet. And that quantity will vary based on the stage, again, that a provider would need to meet, because obviously if you're trying to meet Stage 1, you need less capabilities than if you're going to meet Stage 2, because the MU objectives and measures that are in the core are larger, and subsume most of the core menus in Stage 1.

On the other side, the flipside, the other perspective that the definition speaks to, is—or the EHR technology developer stakeholder group and their understanding and their awareness of the capabilities, based on where their customers may be and the certifications that they may need to seek in terms of how they would be able to meet the certified EHR technology definition. Now that's a little bit more dynamic, and more flexible for the marketplace, to accommodate different types of software certifications for various different levels of use. So I'll move to the next slide.

The one point I wanted to emphasize here again with respect to the revised certified EHR technology definition is this concept of quantity, quantity, quantity, as I've got on the slide. And it's really about the quantity of EHR technology, certified to the 2014 edition EHR certification criteria for the Meaningful Use stage that a provider seeks to meet. And in the case of EHR technology developers, as I was just mentioning earlier, the new regulatory framework that we've proposed really offers EHR technology developers a fresh opportunity to rethink the EHR software packages that they can get certified, in order to offer what I've been trying to call and like to call right-size certifications for their customers.

And as I kind of played out a little bit, and I will again, you could see an instance where an EHR technology developer could get an EHR module certified for a certain quantity of certification criteria that would cover many of its customers' needs to meet Meaningful Use Stage 1, and wouldn't require those customers to adopt additional capabilities that they don't intend to use, to demonstrate Stage 1; whereas they could also get a different type of certification, another scope of certification, for a larger EHR module, so certified to a larger quantity of certification criteria that could support providers that are going to seek to achieve Meaningful Use Stage 2.

In both cases, as Travis alluded to as well in his presentation, we made a policy determination that the best policy to express here would be that all EHR technology needs to be certified to common, consistent capabilities and standards, and in this case, the variability again fits in with respect to the quantity that

providers may ultimately need to have. But we wanted to make sure, from both an interoperability perspective, capabilities that would be necessary to demonstrate Meaningful Use; that everyone has the same tools.

And that was a really important point that we tried to emphasize in the final rule in response to comments that suggested that we should try to tie our definition to particular Meaningful Use stages, which would have created disparities and variability in the capabilities that providers had, just based on the stage of Meaningful Use that they were seeking to meet.

So the one last thing that I'll leave you with here in terms of both these bottom two points is that there really is an interdependence between what a provider would need in terms of the quantity of EHR technology and the certification criteria to which it would be certified, and the certification, the scope of the certification for EHR technology that an EHR technology vendor or developer would seek for its product, which is up to them. Because our certification process is voluntary, and they get to determine the capabilities for which they want to get certified in particular product offerings.

So there's a very tight interdependence here between what a provider needs and what a vendor gets certified, and that's why I think this new regulatory framework here that we've offered gives EHR technology developers and their customers a way to figure out some better pathways forward than what may have been created the first time around with our final rule. Next slide.

Okay. So what? Why should I be excited if I was sitting in your shoes? The biggest point here, as you probably were hearing me allude to, is that under this new definition, there is the potential, the possibility, very much expected, that there will be a single, quote unquote, EHR capital-M—which is our regulatory term of art, in terms of a certification that gets issued, Module—that could support in their entirety a provider's achievement of Meaningful Use Stage 1 or Stage 2.

And that's a significant difference and a significant flexibility added into our rules, where before, it was either, you needed to have a complete EHR, so all capabilities, including more than you would likely need to demonstrate Meaningful Use; or an equivalent combination of EHR modules that still covered those same capabilities.

And so now in this case, getting back to my prior point about right-size certifications, there is new room for innovation in the market and for software

packages to be put together, that will result I think in a lot less of the tension that we experienced the first time around with our last final rule. So, next slide.

I've got a lot of different images; still working on the best way to explain all these different concepts. And this is a new one that I've been experimenting with, so you have to bear with me. And I'm not going to touch on everything, but did want to give folks a sense of the scope, a sense of how the two types of certifications that get issued, the complete EHR certification and the EHR module certification compare to each other; and then how the quantity of certification criteria that an EHR module's scope would represent, associated with the stage of Meaningful Use that a provider would seek to meet.

First point being that to keep in mind, certification is really, for lack of a better word, a subset of all of the capabilities that EHR technology could include, and that EHR technology developers include in their products. And so they really—the certification criteria that we've adopted obviously tie directly to the correlated Meaningful Use objectives and measures, and in some cases, other capabilities that we've determined are necessary to push forward from the certification perspective. But in large part it isn't the entire universe of all capabilities, and so it's important to remember that the scope of a certification that gets issued is not representative of the entire suite of capabilities that may be included in EHR technology. It's only tied to the capabilities for its certification as required.

So, maybe I'll work my way in. At bubble No. 2, we've got EHR technology that would be in terms of size and quantity of certification criteria, certified and have met the complete EHR definition. So that probably means all the mandatory certification criteria that we have included in our rule, so we do have a few that we've designated optional.

And in this case, if you have a complete EHR, as the prior slide mentioned, it pretty much gives you in almost all cases, with the exception for those folks that are going to be cancer reporting, because that's one of the optional certification criteria that we designated, to support Meaningful Use Stage 1 or Meaningful Use Stage 2 achievement for any type of provider.

You could go to bubble 3, where we have an EHR module that's certified to a less amount of quantity of certification criteria to the 2014 edition, and this EHR module, though, has been certified to enough certification criteria that it would support Meaningful Use Stage 1 for certain providers. And certified to our 2014 edition, plus a quantity of capabilities and the certification criteria that the EHR

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module scope represents would allow them to meet the requisite core and menu that they seek to meet for Meaningful Use Stage 1.

Just going down further, I think hopefully it becomes a little bit more intuitive or apparent about the different scopes and the quantities of certification criteria that these different-size squares represent in terms of how certification will play out. Next slide.

Here's a little bit of a different look with respect to the image that I just had on the slide. This is kind of more of a bar chart-oriented style. Complete EHR certification on the left, and the quantity of certification criteria for what certification would be required and what those two complete EHR certification or EHR module certification scopes could look like. So on the left side, with bubbles 1 and 2, if you have an EHR technology developer or vendor that gets a complete EHR certification in Stage 2, it's going to support across the board the menu and the core, and have the base EHR definition requisite capabilities.

If you're attempting to meet Stage 1 and you adopt the 2014 edition complete EHR, then you've gone to the above and beyond, and you've got the additional capability that you may determine you wanted to use, but not necessarily to meet Meaningful Use. So you would have more flexibility in choosing the objectives and measures that you would seek to achieve for Stage 1.

On the right side of this dashed line are all the different types of capital-M EHR Module approaches, getting back to that right-size certification, that would fit in. And so two points that I just wanted to call out here: With this new dynamic, Meaningful Use driven definition for certified EHR technology, if you look at bubble 4, you could see it as a for-example, an instance where—and I'll call your attention to the MU-1 core box—this could be a dentist, this could be a chiropractor, this could be any type of other EP that has a specific scope of practice where there are as a matter of fact particular MU objectives and measures that they would be able to meet exclusions for.

And as that interdependence plays out with respect to our definition, you have an environment where the provider doesn't need those capabilities to demonstrate Meaningful Use; and thus under this new definition, EHR technology developers that service those customers, that have these types of EPs as customers, wouldn't have to seek certification for those capabilities either. And under the prior definition, that was one of the tensions that was raised from a burden perspective on the EHR technology developers, that they were having to go forward and get

capabilities certified just to get certified, in order for their customers to be able to have certified EHR technology. And so on both sides of the coin, so to speak, there is some flexibility and some burden reduction, both from the adoption side and from the certification side on the EHR technology developers' standpoint.

The other point that I would want to raise here, and I'll get to it in another slide coming up, is that for bubbles 3 and 6, tried to show that the base EHR concept is a concept, and is a definition, and it's more to be treated like a checklist, and not be meant to be interpreted as a specific type of EHR technology that is called a, quote unquote, base EHR. It's a quantity of EHR technology that's been certified to certification criteria, and if you have an EHR technology that's been certified to them, it will meet the base EHR definition, and then you'll have to make sure that you have those other capabilities to achieve the Meaningful Use stage that you seek to meet.

So, I wanted to show that there isn't an explicit requirement in our rules that a single EHR technology developer needs to get something that meets the base EHR definition certified. The little bit of a common misconception that we saw in the comments that we received, and I am still being, in some cases with some of the questions or blogs that I've been able to read, to see myself. So, just wanted to make sure that people are aware of that flexibility, and/or that the distinction that we're trying to make clear. Next slide.

So on to the base EHR definition. As I mentioned, it's meant to be treated like a checklist, and the first five rows of the table under the EHR technology, that column, come from the statute, come from the HITECH Act. And what we did was assign certification criteria at a minimum, like I mentioned at the beginning of my presentation, that are essential, universally applicable to providers across the board for Meaningful Use Stage 1 or Stage 2; and that they would need to have, in order to ultimately meet—have EHR technology that meets the definition for certified EHR technology.

And so they don't necessarily need to be supplied by a single EHR technology developer, as long—at the end of the day, as long as you have EHR technology that's been certified to the certification criteria listed in this table, you will have something that satisfies the base EHR definition. And then you just have to go through the analysis to make sure that you've got the correlated certification criteria for those objectives and measures that you seek to meet Meaningful Use Stage 1 or Stage 2, through the EHR module or complete EHR that you adopt. Next slide.

Okay. I haven't updated this slide, but I have a better way to describe it now, thanks to a few questions I've got. And I'll kind of work backwards. The Meaningful Use-driven definition for certified EHR technology, we originally proposed to be effective for the right side of this table, for the fiscal year/calendar year 2014 EHR reporting periods and forward. In response to comments, we decided to add in an additional flexibility, and this is the bullet 2 on the left side of the table. That allows people to jump straight ahead in 2013, when the 2014 edition EHR technology is available, to adopt that straightaway and to use that more flexible definition.

In the EHR reporting periods to the left here, fiscal year/calendar year 2011 to 2013, there are really three scenarios in which the certified EHR technology definition can be met. And I'll walk through these pretty quickly.

The first scenario is the statement before the underlined text in bullet 1, which is, an AP or an EH critical access hospital just uses their 2011 edition EHR technology all the way through their calendar year, fiscal year reporting period. And then at that point, because of the special quarter reporting period in 2014, they have that time to do a transition, and to transition to 2014 EHR technology.

The second scenario builds off from that underlined text in the table in bullet 1, where you'd have a scenario that a provider has, 2011 edition EHR technology, and received, as an example, an EHR module that's been certified to a certain number of 2014 edition certification criteria. And in that case, they'd have a mix of 2011 and equivalent 2014 edition certification capabilities. And that mix would be permitted to meet the definition for certified EHR technology.

In those two scenarios, it still needs to meet the old 100% of the applicable setting and certification criteria that we defined in our 2010 final rule. In the third scenario, if a provider jumps to adopting all solely 2014 edition EHR technology that's been certified to the 2014 certification criteria, they'd be able to pursue essentially the definition that's on the right side, and be able to use that EHR technology to meet the definition for certified EHR technology. So they would be able to get that benefit of being more flexible and dynamically driven by Meaningful Use definition for certified EHR technology.

So I wanted to be clear that there are really three options, and I'm probably going to re-describe this slide the next time I present, to lay out those three options a little bit more clearly between the 2011 and 2013 reporting period. Once we get into

2014, then it's strictly the new driven by Meaningful Use definition for certified EHR technology which would be able to support and accommodate either Stage 1 or Stage 2. Next slide.

So we're going to get into a few of the things where I'm just going to jump forward pretty quickly. This is a resource available. We have these bull's-eye diagrams that have assigned certification criteria to each of those rings that I showed earlier in my slides. And there are four of them available, two for EPs, two for eligible hospitals, critical access hospitals, based on the stage of Meaningful Use that they seek to meet. Next slide.

This is an infographic-type decision flow diagram that we put together to help people really just see the logic and the steps that they would need to take to determine if they have certified EHR technology that meets the revised certified EHR technology definition for Meaningful Use. And we have again PowerPoint versions of these available on our website, linked at my slide at the end, that you can go and download and use.

The point here being that hopefully the numbers, little Post-It notes, images that we got right there, will help folks follow along. Step 1, if you've got a complete EHR 2014 edition for the ambulatory or patient setting, then you've got what you need, because the way we designed the EHR definition through a regulatory framework is that it includes the base EHR definition. It's obviously been certified to many— all of the mandatory certification criteria, and it would meet the certified EHR technology definition in large part.

The one exception would be the cancer case reporting, which is designated as optional, for reasons discussed in the final rule; and in that case, in meeting the overall definition for certified EHR technology, providers would need those—the certified capabilities and that meet that Meaningful Use objective and measure. In other cases, you'll see that if you don't adopt complete EHR, then you have to go through the three steps for making sure that your EHR technology has been certified to the certification criteria assigned to the base EHR definition. If you've got a yes to that, then you move on, depending if you're an EP or an EH.

We have specific requirements for the quantity of clinical quality measures at a minimum that the EHR technology needs to include and be able to support in order to meet the certified EHR technology definition. So, step 2A or 2B, I'll walk you through those minimum requirements. And then 3A, 4A, and 3B and 4B go across what we had described again in terms of the other quantity of certification criteria

that would need to be represented by the, in this case, an EHR module's scope to cover those other certification criteria. Next slide.

This one here is just an example of a stripped-down version for EPs. And we've got these as well on our website too for your reference. Next slide.

Okay, so just briefly, to leave some time for questions, we made some changes to the certification program rules that we had; specifically, the permanent certification program. One of those being, as we indicated in our proposed rule, that the temporary certification program would sunset upon the effective date of this final rule. So that, if I'm not mistaken, will be October 4th, at which point the permanent certification program processes will be up and running. And testing and certification will have to go through those processes as defined by the permanent certification program rule-making.

We did change the name in this rule-making as well, to just generally refer to the ONC HIT certification program, since we don't need to have this distinction between temporary and permanent. There are other revisions that we made to the EHR module certification requirement that had posed particular burdens to EHR technology developers, that we have since removed; and we've made some other tweaks to make certification more efficient from specific minimum standards for vocabularies [unintelligible 93:23]. Next slide.

There are a few other things, in terms of the—as part of the certification process that ONC ACBs, the ONC authorized certification bodies, will need to take into account as they are issuing certification to EHR technology as a complete EHR, or as an EHR module; and there are some of these new certification criteria we included and finalized: the safety-enhanced design certification criterion that we had proposed, which requires user centered design to have been applied to these eight medication-related certification criteria, as well as the certification criterion for an EHR technology developer to identify the quality management system that was used in developing those capabilities where certification was sought, or is being sought.

The other two points that we think, from a transparency perspective, that we solicited comment on and have finalized, both require ONC ACBs to take additional steps to—the first, from a price transparency to a cost transparency. The ONC ACBs are required to ensure that these are acknowledged developers, notify eligible providers about additional types of cost, of this being either a one-time cost for if you're figuring something; an ongoing cost, if that would be hosting a

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portal or maintaining an interface or something along those lines, that would affect a certified complete EHR, a certified EHR module's total cost of ownership for the purposes of achieving Meaningful Use.

And so this is explained in greater detail in the final rule, and the responsibilities that the ONC ACBs have, and the corresponding responsibilities that EHR technology developers have to be transparent about these types of costs. It doesn't require them to disclose the specific price, because a lot of feedback that we got was that that is an imprecise type of metric, and wouldn't be beneficial.

And so what we've done here is to make sure that there's really a smart disclosure, some upfront awareness for providers that they know, in adopting the certified products, that there could be additional cost related to the implementation and use of it going forward. The other has to do with test result transparency, and so under the permanent certification program processes that we have finalized, EHR technology developers first get tested.

They will get a—for a colloquial term, they'll get like a test report card. That test report card will be submitted to the certification body, to be used as a basis for the certification that gets issued; and the ONC ACB is required to submit a hyperlink to those test results, the test report card that was used as a basis for issuing that certification to the complete EHR or EHR module. Next side.

These are just for your reference, so we can—next slide—I'm not going to get into detail on the standards part here. Next slide. And the brief timeline of what's next, what to expect. Final rule has been issued. Final rule will be published I believe September 4th, to be effective October 4th. During this time period there is a very intensive effort in working with our colleagues at NIS, at CMS, to produce waves of test procedures in the coming next few months; and those will be available for a period of public comment. As I mentioned, this temporary certification program will sunset, and all these processes need to fall in place and get up and running, and we will just continue to march forward as fast as we possibly can. Next slide.

So please go to this URL for all the resources that we have. I believe we also cross-referenced some of CMS's resources. Make sure that you don't get confused by the end of the URL here. Make sure you've got the 2-0 at the end. We still have the old NPRM URL up as well, and that will take you just to the NPRM resources, and you may get yourself confused.

So, right up there now is a few other grids and tables that we pulled from our final rule as resources, and we've got these infographic flows and the bull's-eye diagrams that I mentioned. And then we'll have other grids and resources coming out available that will help people better understand how our certification criteria map to Meaningful Use Stage 1 or Stage 2 objectives and measures. And I believe that's it.

Kate Berry
All right, thank you Steve and Travis. This is Kate again, and we do have lots of questions. We have almost 20 minutes for Q&A, so I'm just going to jump right in. This one is for Travis, and it's sort of a two-part question. So first of all, will hospital-based radiation oncologists be penalized in 2015 because they are unable to demonstrate Part B Meaningful Use compliance, using a hospital Part A Meaningful Use certified system? In other words, are they included with the rest of hospital-based physicians, like radiologists, in being exempt? So that's part 1, and I'll let you answer that, and then give you the second part.

Travis Broome
Okay. Yeah, so radiation oncologists are not included in our radiologist definition, because they obviously have face-to-face care and follow-up. So there's two other parts to the question, though. One—and that's not—when I say they're not included in that, that doesn't mean they couldn't apply; it just means they're not included in the wrap-up or in the specialty designation. So to the extent that they don't, then that was wrong, and they don't have face-to-face and follow-up, they could do that.

If they were truly hospital-based, in the sense that they have 90% or more of their services in a hospital, then they're not subject to payment adjustments, just like they're not eligible for the incentive payment. And then the third aspect of the question had to do with the concern that I can't use my—so if they have any work in an outpatient department, provider-based outpatient department of a hospital, in a hospital, rolled out the inpatient certified EHR technology to that department, but not the outpatient.

ONC has already—and CMS—have already put out guidance that allows them to, for those objectives, where it's the same, that it doesn't matter if you use inpatient or ambulatory-certified EHR technology. Obviously to do complete EP Meaningful Use, you will need more capabilities, as a glaring example, being e-prescribing. Then you will—just imagine radius [sic] oncologists will be doing a fair amount of, would need to … have that capability as well, as like an add-on

module or whatever, to the inpatient piece. But to the—for those that it overlaps, you can use either inpatient or ambulatory, and I believe the ONC FAQ actually contains a list of those overlapping objectives. So, I think that was all the elements of the question.

Kate Berry
Great. And kind of the follow-up there was, can you direct us to any documentation or evidence as to how Meaningful Use Stage 2 will save doctors and hospitals time and money, as stated on one of your slides?

Travis Broome
Sure. So, yeah, there's the various different studies that have been done, some showing significant savings, some showing no savings, some—you know, so the literature—I know when David Blumenthal was at ONC, he did a big literature review that found that the majority showed either improvements of quality or savings, or both. So [unintelligible 101:34] that article would probably be the best one to go for; I believe it was published in *Health Affairs*, because it will have all those articles referenced in it.

And the—how much you save or how it works, a lot of it depends on lots of things that are beyond certification and Meaningful Use. How well did you redesign your workflow? How useful is your system? I know there's been a lot of talk recently about how useful the out-of-visit—office visit summaries are, and 90% of the time, their usefulness is 100—is predicated on how well they're designed, as opposed to anything to do with Meaningful Use or certification.

So there's certainly evidence out there that EHR use—and we certainly are pushing the areas that have been called out in some of the research as areas that will improve quality and eventually save money as well in our Meaningful Use things. But this is definitely a public and private partnership [unintelligible 102:37], and frankly, most of the details are going to be on the private side. We encourage you all to focus on those goals when I give the presentation as a more general vision thing, so I'm just saying, focus on the objectives and goals in your workflow and in your implementation, because that's where most of the bang for the buck is [unintelligible].

Kate Berry
Excellent. Travis, from another different specialty point of view: If recording blood pressure is not relevant to a specialty, such as dermatology, how can Meaningful

Use be achieved? And is there risk if the provider is recording blood pressure when it's not relevant? Does that increase liability for them?

Travis Broome
Sure. So, the first part is, understates today and yesterday, if you—there was an exclusion that basically the provider could intentionally attest to that height and weight and blood pressure were both not applicable to me, and therefore I meet that exclusion. Starting in 2013, those will be the options, to just do one or the other, so if they are a dermatologist who is interested in height and weight but not blood pressure, starting in 2013, they'll be able to exclude out just blood pressure.

And it isn't—don't think of it as a got-you situation. So if the hypothetical auditor were to show up and say—he's not going to say, oops, now there's three blood pressures, I see them right there—across their whole records, you know—it's related to your scope of practice. So as long as you're not systematically collecting blood pressure, if you're excluding it, or systematically collecting height and weight for a certain section of your patients, then you can attest to the exclusion. Three, five, a dozen blood pressures scattered randomly throughout your records certainly aren't going to make you in danger of not being an exclusion.

Kate Berry
The next one is related to Meaningful Use Stage 1 and 2 as it relates to patient involvement. If a patient walks into a freestanding lab, for example the Kentucky state public health lab, is the lab allowed or required under Meaningful Use 1 or 2 to give that patient, after verifying his or her identity, their lab results?

Travis Broome
Well, independent standalone labs aren't included in, aren't eligible professionals or facilities under the program, so they're not required to do anything under Meaningful Use.

Kate Berry
Next one—oh, I think we covered that. Let's see. What specific version of the HIT-B standards for the CQMs will be required for 2013?

Travis Broome
2013, we're not making any changes to the electronic specifications that are required. All the changes for CQMs will occur starting in 2014.

Kate Berry

If a radiologist doing outpatient imaging center work and tele-radiology work, for example, reading studies and rendering a report remotely, can all the tele-rad work be excluded from patient counts, and thereby qualify only on the imaging center patient volume?

Travis Broome
There's actually an FAQ out there about what it means to be seen by an EP. In the general guidance for—regarding that is it can't be zero, so you gotta have some denominator; and then you can't—and then you have to consistently apply your choices based on kind of a clinical situation across your area. So for example, the example you gave, and the questioner was giving in the question is probably a good one, where actually interacts with patients, I work with them at the imaging center. And then somebody sends me information over a PAC system and I look at it, and send it back [unintelligible 106:45] patient, that would probably be a good example of a clinical decision.

What you can't do is say, I like the EHR I use over at imaging center X, so I'm going to say that I only see patients over there, when I essentially do the same thing at imaging center Y as well, which also has an EHR. If I don't like that one, or they won't give me the data or whatever, that—you can't make the distinction based on that. But you can make it based on clinical lines.

A non-radiology example that comes up very, very frequently is cardiologists who read EKGs prior to patients going into surgery [unintelligible] and they're a good candidate for the surgery and then move on. Many cardiologists will not include those as seen by the patient EP.

Kate Berry
Regarding Medicare patient adjustments, how will those who are ineligible for both Medicaid and Medicare incentive programs report Meaningful Use to avoid point adjustments?

Travis Broome
They don't have to, because they're not subject to payment adjustments. Really, if you're not eligible for the incentives—and I can't say this enough—you are not subject to the payment adjustments, even if you bill the Part B physician fee schedule or something.

Kate Berry

Just reading a couple questions here. If first attesting work for MU for 2013, how long in 2013 must you use certified technology in a meaningful way?

Travis Broome
Any year that's your first year, be it 2017 or 2013 or 2012, it's any continuous 90-day period during the year that you pick.

Kate Berry
When you acknowledge starting in 2014, that really means starting October 1, 2013, for hospitals, as that is the start of fiscal year 2014. Correct?

Travis Broome
Well, it depends. So in 2014, nobody's going to have to do a full EHR reporting period. So the soonest you could start your three-month reporting period if you're in year two or beyond, or your 90 days if 2014 happens to be your first year, is October 1st, 2013. But you would have all the way till what, December, October—July 1st, 2014, to start your—the Stage 2 or Stage 1 in 2014. So, yeah, 2014's special in the sense that after your—even if it's your first year, the same as everything else, 90 days. If it's your second year or more, then it's the three months. For Medicare.

Kate Berry
I'm assuming this next one is for Medicaid. The question is, since states are able to determine if they are doing a 90-day continuous reporting period or a quarterly pegged reporting period, what is the deadline for states to make this decision? This is in reference to 2014.

Travis Broome
I actually don't know the deadline for them to make—the answer to that, if there's a specific deadline off their case. They would have to submit that to CMS as part of their IAP or their plan of action. But I'm not aware of a specific deadline that they have to turn that in by. But we can certainly get back to you on that case.

Kate Berry
If we could pop up page 17. The comment is, on that slide you commented that the eligible provider—if the eligible provider starts demonstrating Stage 1 in 2013 but is not successful in demonstrating in 2014, would then demonstrate Stage 2 in 2015? Is this what you said? Is this a change? Is this true for both Medicare and Medicaid?

Travis Broome
Right. It's not a change. Once you start your Meaningful Use clock, you start at—you're off and running. The difference—there is a difference between Medicare and Medicaid, though. In Medicaid, you have that first year for AIU. So you can take off time between AIU—adopt/influence/upgrade—and your first year of Meaningful Use. But once you start your Meaningful Use clock, you've started your Meaningful Use clock, as it were; but you can take as much—on the Medicaid side, you can take as much time as you want, subject to H7s running out on you. Between AIU and Meaningful Use.

Kate Berry
Do you have to be on 2014 edition of a CEHRT by fiscal year 2014, even if you are just attesting to Meaningful Use Stage 1?

Travis Broome
Yes.

Kate Berry
Next one: In my EHR, I have printed clinical summaries that do not have a problem documented on the problem list, and it is counting in my reports. Obviously it shouldn't. I haven't read 2014 certification standards yet, but will the certification process protect me from errors such as this?

Travis Broome
Finally, a Steve question.

Kate Berry
Yes, Steve. Sorry.

Steve Posnack
Sorry, I thought that one was a Meaningful Use one. Can you say—actually, before you say that one again, let me just add in on the prior question, when Travis just said yes. I would add, yes, when you demonstrate your—during your EHR reporting period for 2014, you need to be on 2014 edition EHR technology. It doesn't need to be at some arbitrary date before that. So as long as you're on it when you're completing your EHR reporting period, that's when you need to have 2014 edition certified EHR technology.

[TALKOVER]

Kate Berry

Okay, good, thanks for chiming in on that.

Steve Posnack

And so, say your question again?

Kate Berry

Yeah. The comment is, in my EHR I've printed clinical summaries that do not have a problem documented on the problem list, and it is counting in my reports. But obviously it shouldn't. I haven't read 2014 certification standards yet, but will the certification process protect me from errors such as this?

Steve Posnack

I don't know if I could diagnose the exact error, but I can say going forward we are looking at having more substandard requirements for both test data and the evaluation of the accuracy of the reporting capabilities associated with those certification criteria for which we require in our rules. But I think going forward, folks will see more substantive and rigorous testing for those capabilities.

Kate Berry

Great. So, regarding—oops, I missed that. With the optional measure for CPOE coming this October, what do we do if our vendor refuses to allow us to measure, using the new denominator?

Travis Broome

In 2013, there's not too much you can do besides exert what pressure you have over your vendors. It's one of the reasons why it's optional in 2013. Come 2014, that gets to what Steve was just talking about: to get their system upgraded to the 2014 edition, they'll need to be able to calculate the new measure. But in 2013, there isn't any regulatory mechanism to force the vendor, which is why we made it optional in the rule.

Kate Berry

Next one: My practice only sees residents in nursing homes, so I'm not sure how we will meet some of the measures for electronic access for patients. Could it be that their caretaker has electronic access, or will we be able to take exclusions?

Travis Broome

Yeah, so for slide usage and permitting, we never add this part, but in the regulations and stuff, you'll see it's patient or their authorized representative. So

it's their child or their caregiver or whoever, who—if they are the one accessing, that counts as well.

Kate Berry
When a Stage 1 change is described as optional for 2013, but required in 2014, is the intent that it is optional for eligible providers and hospitals, and then meaning a state incentive program has to offer the option? Not that the state has the option to implement the change in 2013?

Travis Broome
States would want to make both measures available to all the patients. Most of the optionals then required—for instance, the vital sign one—has to do with what we were talking about before. Even ones like, say, vital signs that we would like to update tomorrow, we can't guarantee providers that their calculation systems will update as well. That's why it's optional in 2013. 2014, when everybody has to pull in the 2014 edition, then we know that they are [unintelligible 116:30] measure.

Kate Berry
So, last question, and then we'll bring it to a close. Lab results come out of LAS systems, which are not certified yet, not out of the EHR. The hospital menu set for sending structured data to the physician, how can we do this, since EHRs are not the sending system? Do we need to push to get our LAS vendors to certify?

Travis Broome
Come on, Steve, you know I'm going to make you answer that one.

Steve Posnack
All right. I think we've expressed this in the rules. We have never viewed certified EHR technology to be limited to I think what folks may construe as a core EHR component. And so we've always viewed it as more of a general perspective that if there's EHR technology that would be performing a capability for which certification is required, then it can be certified.

We've, I believe, issued guidance that health information exchange and the technical capabilities that it could offer could be certified as an EHR module, or some other type of public health reporting, where an HL7 message could be formatted, would be able to get certified as an EHR module. So we don't make a distinction maybe at the level that the questioner is asking, about what specific systems either may previously have been considered not part of a, quote unquote,

EHR; but we have a broad perspective on what EHR technology means as it was given to us in the statute.

Kate Berry
All right. We'll let that be the last word, Steve, so we're going to bring the presentation to a close. Thank you both, Steve and Travis, for once again covering an incredible amount of information and taking as many questions as we could fit in. I know you're going to be doing these talks in multiple settings to come, and there's lots of additional information on the NeHC website as well as the CMS website and ONC's website. So, hopefully you all will find the information that you need.

So thanks, everyone, for joining us today. And as you exit the webinar, we are going to pop up a very short survey, so please complete that for us. Your feedback is really important to us. So thanks everyone, once again, and enjoy the holiday weekend.

[End of file]