

## FAQ – Meaningful Use Town Hall Meeting, March 1, 2013

**1. There was a mention of templates for communication and meeting certain requirements so they can document Meaningful Use (MU). Are these going to be distributed?**

1.1. Yes, we will be distributing these documents. We are currently working closely with the Stage 2 Meaningful Use Public Health Task Force to develop these documents.

**2. When you are talking about physicians and providers reporting through this mechanism, does this apply to ambulatory centers and radiation facilities as well? Would they be reporting data in the same format or would it be different?**

2.1. Ambulatory centers and radiation facilities themselves are not Eligible Professionals (EPs), but the individual providers within those facilities could qualify as an EP. An individual provider qualifies as an EP if they diagnosis and/or treat cancer patients. The Centers for Medicare & Medicaid Services (CMS) is a good resource to refer to as it provides a more detailed overview (<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/>). All Eligible Professionals will use the HL7 CDA format specified in the Implementation Guide for reporting under Meaningful Use.

**3. How might states tap into resources for funding MU implementation activities (referring to State Medicaid Implementation Advanced Planning Document (IAPD))?**

3.1. Some state cancer registries have been successful in securing a percentage of a person that would help work on MU activities for cancer registry reporting. States need to contact their Medicaid office and work with them to identify possible collaborations and ways to support implementation of cancer reporting within your state. The availability of funds to support cancer reporting really depends on your individual state Medicaid office, and measures, such as the percentage of your registry cancer cases that are on Medicaid.

3.2. CMS has a cost sharing and match requirement; this is different than the type of funding that we are accustomed to. The most they will pay is 90% of the Medicaid-only portion of your cancer activities, requiring at least a 10% match in state funds. The cost share is determined by “cost allocation,” and cost allocation methods vary across states. They are usually tied to the percentage of Medicaid eligible professionals or Medicaid population in your state, and consider the % of your cases that are Medicaid patients.

3.3. There are other ways you can get support through the IAPD and your Medicaid agency, such as their including cancer registry information in their education and web information.

## FAQ – Meaningful Use Town Hall Meeting, March 1, 2013

### 4. What does ELR stand for?

4.1. Electronic Laboratory Reporting (ELR) [Note: ELR was mentioned in the context of other public health objectives in MU. It refers to communicable disease laboratory reporting and is separate from ePath reporting.]

### 5. When the different phases were reviewed you said “the registry will” indicating the registry is going to do all of these steps. It is my understanding that this is just a guidance document, correct?

5.1. Correct this is a guidance document, however most steps listed in phase 2 and 3 will need to be completed because they are required as part of Stage 2 MU.

### 6. It is our understanding that only physicians that participated in Stage 1 MU are eligible to participate in Stage 2 MU. Is there a way to get a list of physicians in our state that participated in Stage 1 MU, so that we can target our correspondence?

6.1. You are correct that they must complete Stage 1 MU before moving forward to Stage 2 MU. CMS provides an outline of these activities on their website at;

[http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage\\_2.htm](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.htm)

6.2. Ask your State MU Coordinator, Immunization Program or Health Information Technology (HIT) Coordinator because they would have had some sort of formal registration process for Stage 1 MU, which is the only way we know of at this time.

6.3. In the “Identification of Critical External Partnerships Physician Reporting Planning Document”, there is a link to a list of the State HIT Directors we suggest contacting them to obtain a list. You also may be able to get a list from your state Medicaid program of all physicians that have already attested for Stage 1 MU. At the present time, CMS is not releasing a list of physicians, to the states, of who has attested for Medicare. The “How to Count Physicians Document”, that will be distributed soon, will also provide more guidance on this.

### 7. Aren't there some core activities in Stage 1 MU that would have them interfacing with Medicaid directly for patient care?

7.1. Yes, that is why going to your state Medicaid program is your best route for obtaining a list of providers that have already attested for MU.

### 8. How do we prioritize which providers we work with first?

## **FAQ – Meaningful Use Town Hall Meeting, March 1, 2013**

8.1. CDC provided some general guidance in a blast email, CDC-NPCR Program Standards, Guidance Documents, and Progress Template that went out to program directors on January 31, 2013. The Physician Reporting Guidance Document that was attached recommended certain specialties (dermatology, urology, gastroenterology, hematology, medical oncology, radiation oncology, and independent surgery) to focus on first based on known issues with underreporting of certain types of cancers. You may also want to consider the volume of cases a specific facility would be reporting.

### **9. There was a comment made at the beginning of the call that there would be some support from CDC and I think funding was mentioned, do you know if there is any potential funding coming down the line for MU?**

9.1. There is some funding that we [CDC-NPRR] hope to receive that will provide resources to support states as a whole, such as developing and providing additional tools to states as needed. As far as funds going out to states specifically, we are not aware of any additional funding at this time. The reference to funding to support Stage 2 MU activities was referring to funding for CDC to provide resources and support to states.

### **10. I'm interested in hearing from some participating states who are already involved in this, the amount of staff and time it has taken to get this process off the ground and to ensure that providers are providing what is needed and so on?**

10.1. For cancer we have two pilot states (Kentucky and Missouri), who through the Comparative Effectiveness Research (CER) money have been working on implementing physician reporting to their registries., You could also contact your state's other public health programs (immunization, Syndromic surveillance, and ELR) who were involved in MU Stage 1 for information.

10.2. There has been work from the CDC side to manually analyze sample files. The validation tool we hope to develop will be a significant help in providing you with more support in this area.

10.3. Based on Kentucky's experience to date, there is a need for someone in your registry to help coordinate things with providers and vendors; there is also the technical aspect but CDC will be there to lend support. There will be a need for staff to be involved in scrutinizing records and reviewing the data that come in.

### **11. Have any of the states that have done this come up with some sample position descriptions or duty statements?**

11.1. Kentucky indicated that they could contribute to those descriptions.

## **FAQ – Meaningful Use Town Hall Meeting, March 1, 2013**

11.2. Maine shared that they have one person that performs about 2-3 hours per week on activities such as setting up, going to and rescheduling meetings, as well as participating on a cross-agency taskforce. Other activities include investigating options for funding.

### **12. I haven't heard anyone talk about the computing or software side of the work and whether or not you have to find your own solutions for programming or if they have been able to work with the health information technology agency?**

12.1. eMaRC Plus will receive the data from the physicians' EHRs in accordance with the implementation guide that was adopted by ONC for cancer reporting. Kentucky and Missouri are currently Alpha testing this and as soon as it is ready it will be made available to all states. The scheduled Beta release date is end of September 2013.

12.2. As far as validating the content, we are planning to provide not only written guidance on how you might validate but also a tool that you can use to assist in validation.

### **13. eMaRC Plus is the translator that we are all familiar with, the underlining question is if it is looking at a CDA message in a particular format, how sure are we that software vendors supplying software to physician practices know anything about our required NAACCR formatting?**

13.1. Vendors aren't required to know about our required formatting; eMaRC Plus will map the CDA record into the required NAACCR format.

13.2. Any Electronic Health Record (EHR), in order to be certified for MU, must adhere to the cancer implementation guide that was cited in the Office of the National Coordinator for Health Information Technology (ONC) final rule. The structure within the implementation guide is the Health Level 7 (HL7) Clinical Document Architecture (CDA) format that eMaRC Plus will read in and translate into the NAACCR format.

13.3. There is also a structural validation tool available that was developed by the National Institute for Standards and Technology (NIST) for EHR vendors to test the structure of their CDA file.

### **14. If the state is only getting these physician forms electronically, is that enough for them to meet requirements for reporting to CDC?**

14.1. Missouri indicated that so far they have only received test data from the EHR and have not received live data at this point. The hope is that after all the testing and tweaking that when the live data is sent that yes this will meet the requirement.

## **FAQ – Meaningful Use Town Hall Meeting, March 1, 2013**

**15. If we approach oncologists and they aren't already on board for MU Stage 1, can they start that process in this calendar year?**

15.1. Eligible Professionals will need to go according to calendar year; they would start Stage 1 MU on January 1, 2014 for two years before moving to Stage 2 MU.

**16. Is it possible that we may have providers out there that aren't doing MU at all, but because they have a vendor that has other clients that are doing MU, we could still capitalize on obtaining reports from these non-participating providers more easily with all the same parameters?**

16.1. Missouri indicated that this is possible; however the situation that they have run into is that there could be an additional cost for this to the provider.

**17. Can providers be exempt from going through this process if cases are going through a hospital or if their volume is below a certain threshold?**

17.1. The way the regulations are currently written there are two ways a provider can take an exemption, and it is the provider and not the public health agency that determines if they qualify for the exemption. One: the state doesn't have the capacity to receive the data, and two: they do not diagnose or treat patients for cancers that are deemed reportable to the cancer registry.

**18. If we have eMaRC Plus we will be able to accept the reports, but what if we have no ability to validate and confirm the messages are good?**

18.1. The way MU Stage 2 regulations are written, the provider has to be active in the onboarding process and the state/public health agency decides what that means. If desired, your state could ask the providers to start sending test messages and then wait until you have enough to verify. They would be on hold but still meeting requirements for onboarding. As a state public health agency, you can decide how fast you want to move.

18.2. From a regulatory standpoint there are a couple of things the provider has to do to meet the requirements for onboarding submission: register within 30 days of the start of the reporting period, this is something they keep track of, not the state; register their intent to report; and after registered they have 60 days to respond to any requests from the state public health agency.

18.2.1. Example: If a provider has registered and you cannot get back to them for 6 months that is fine because they will have met the requirement for onboarding.

18.2.2. Officially say you have the capacity and then work out a process, accept the registration and then let them know when to proceed. This is to avoid having providers think you do

## **FAQ – Meaningful Use Town Hall Meeting, March 1, 2013**

not have the capacity and end up not sending you data. Not having the capacity allows them to claim an exemption.

### **19. When a physician is 100% employed by a hospital and all the patients they see are in the hospital what requirements do they have as an individual physician when the hospital is doing all the reporting to the cancer registry?**

19.1. As far as the Medicaid / Medicare incentive payments go, the physician is either part of a hospital and the hospital is receiving those payments as an Eligible Hospital or the physician is an Eligible Professional and receiving those payments directly as an Eligible Professional. Cancer reporting in MU Stage 2 is only applicable to Eligible Professionals. If the physician is not receiving a payment themselves, then there really isn't any incentive for them to report independently of the hospital. It depends on how they are classified for the Medicaid / Medicare incentive payments as to whether they are an Eligible Professional or part of an Eligible Hospital.