Centers for Medicare & Medicaid Services
Medicare and Medicaid EHR Incentive Programs:
Understanding Meaningful Use Conference Call
Moderator: Diane Maupai
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1:30 p.m. ET

Operator: Welcome to the Medicare and Medicaid EHR Incentive Programs: Understanding Meaningful Use Conference Call. All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed.

If anyone has any objections, you may disconnect at this time. Thank you for participating in today's call. I will now turn the conference call over to Diane Maupai.

Ma'am, you may begin.

Introduction

Diane Maupai: Oh, thank you. Good afternoon, everyone. This is Diane Maupai. I'm in the Provider Communications Group in CMS in Baltimore.

So, thank you for joining us today. If you haven't already pulled down the slides for today's presentation, they're on the CMS EHR website. That's an important one, so I'm going to spell it out for you, www.cms.gov/EHRIncentivePrograms.

It's on the Spotlight and Upcoming Events page. It's the first link under Presentations towards the bottom. And as always, I like to give an update about where we are in the program and participation. As of July 30th, almost $400 million has been paid in Medicare and Medicaid EHR incentive payments.

There are over 77,000 active registrations of eligible professionals and eligible hospitals for the Medicare and Medicaid Incentive Programs. On the Medicaid side, 23 States have launched their Medicaid EHR Incentive Programs. The last two on August 1st were New Mexico and Wisconsin.

And as of July 30th, 16 States have paid more than $248 million in incentives. Today's call is going to be focused on meaningful use requirements for the incentive program. I know, looking at the questions you submitted, you have a lot of questions on a lot of topics.

So, I would like you to mark your calendars. On Friday, September 9th, at the same time, 1:30 Eastern, we'll be having a call for eligible professionals on registration and attestation. So, hopefully, we'll be answering a lot of those questions at that time.

And, also, again, on our website, we have a lot of materials. We have tip sheets, frequently asked questions, user guides, write-ups. You know, there is a wealth of information there.

I'm happy to introduce our speaker for today. He's Travis Broome. He's a Special Assistant in the Consortium for Quality Improvement and Survey and Certification Operation. He is based in our Dallas office, but we're happy he has joined us in Baltimore here today. And after Travis makes his presentations, we'll open the lines for questions.

Presentation Part 1

Travis Broome: Thanks, Diane. And, I'll apologize in advance. That probably won't be my last sneeze. As Diane mentioned, I'm from Texas where all the allergens have burned away long ago with our heat things, and now I came somewhere where you still have them. Sorry about that. All right, so, we will jump right in to the first slide with text on it, the meaningful use slide.

And like Diane mentioned, we really focus on meaningful use. But we will discuss a lot of as aspects about timeline and things like that that cover some of your questions you've submitted as well as we roll through it. So, the number one question we get about meaningful use is basically: what is it?

Well, Congress first adopted the phrase meaningful use, so it came straight out of the law. And back when they did that, our first instinct was basically just to reach for the dictionary, Webster's or Oxford. However, that didn't quite work out. Basically, the way Congress intended and the way we use meaningful use is how we describe why we care if providers use EHRs over pen and paper, or stone tablets, or anything else. So, meaningful use is basically, you know, why do we care about EHRs?

So, meaningful use in that context became the key to three different things. One is to improve care- quality, safety, and efficiency, and reducing health care disparities- what we all think of initially. But also we believe it can engage patients and their families in their health care.

It can be used to improve care coordination and population and public health and not just personal health through quality and safety. And then, we all know we have to maintain privacy and security while we do those things because if we can't maintain the privacy and security of EHRs, we won't be able to use them in a way that goes after these other four. So, that's really – that's kind of what it is from a philosophical standpoint.

There are two very practical uses of meaningful use. One is that it's the gateway to billions of dollars in incentives that the American people provided through Congress because they believe the EHRs can do the things we just talked about. Overall, the program between CMS and ONC, and a little bit of HRSA and CDC in there, it's about $30 billion or estimated to be $30 billion.

So, to put that number in perspective, everybody listening, everybody you met today is kicking in about 100 bucks towards this effort. Finally, we use meaningful use as kind of a framework to get from where we are today with EHRs, to where we want to be in order to actually improve care and population health. With that, we'll roll on to slide three.

Congress didn't just say meaningful use. They did provide us three quick examples of what they anticipated. The first one is pretty circular, use of a certified EHR technology in a meaningful manner. And then, they called out specifically, electronic exchange of health information and clinical quality measurement.

So, slide four is basically our conceptual approach to meaningful use. So, this is the framework we were talking about. This is the structure that gets us from where we are, to where we want to be.

We divided meaningful use into three stages. We're in Stage 1 right now. The first stage really involves collecting health information in a structured way and taking the first steps towards using that data. Structured data is critical to meaningful use. You can't really do anything else without it.

And what we mean by structured data- and we use that phrase all throughout the objectives so it's important to understand structured data- is that the system recognizes the data for what it is and knows how the data interacts with other data available in the system.

For instance, even Microsoft Word knows that aspirin is a seven-letter word. It even knows how it should be spelled. But it doesn't know that it's a drug and it doesn't know that it's one that should be given to a patient showing signs of a heart attack and not given to a patient who is also taking another anticoagulant. So, that's what we mean by structured data. It's not just that you know it's a word, know how to spell it, but that you know what's behind that word in a health care context.

The second stage involves designing and implementing processes that are going to use all these data in a way that we think will actually improve outcomes. Our advisory committee, the HIT policy committee, Health Information Technology committee, has already issued recommendations for Stage 2. Those are available not on our websites, but on the ONC's website which is healthIT.gov. It's pretty easy to remember.

And we will be issuing Stage 2 proposed regulations in January '12. So, Stage 2 is right around the corner. And then, third stage – I call it the third stage- finding out if we were right and finding out the effects of the meaningful use on outcomes.

All right. But as I've said, we're in Stage 1 right now. So, we're going to spend the rest of the time getting into a little bit of nitty-gritty on Stage 1 covering hopefully many of your questions you submitted ahead of time. And then, also, some of the things we've heard from others as well.

So, the first thing about meaningful use is you have to demonstrate it over a reporting period. For your first year, the reporting period is 90 days.

We get lots of questions about the 90 days. And there are only two things you need to know about the 90 days. It has to be continuous. So, once you start, you can't stop until you've hit 90 days. And it has to be fully contained within a year. And that's a Calendar Year for eligible professionals and a Fiscal Year for hospitals.

It does not have to be lined up by a month. It doesn't have to be lined up by another program or anything like that. It could be March 13th through whatever 90 days after March 13th is- well, for this year it can't anymore, but for next year it could be. Or it could be August 18th through whatever 90 days is now from the 18th.

The reporting of meaningful use is done through attestation. We're not going to spend too much time on that. As Diane said, there's going to be a call about attestation. You're going to go to a computer screen just like you might be looking at one now. And you're going to type in the data for meaningful use and you're going to hit submit. So, that's what we mean by attestation. It takes about 15 minutes I understand if you have the data sitting next to you. Though, it's going to take a little longer to collect the data, I will admit.

The reporting is basically divided into two types. You either say yes if you want to pass, or no if you don't meet an objective or we do have numerator and denominator information.

And we'll talk about what makes up numerators and denominators here in a few minutes.

All right, let's go on to the next slide. So, you've already heard me say the word objectives and measuring. Meaningful use is basically made up of objectives. Every one of which has a measure. There are 15 core objectives for professionals, 14 for hospitals. You have to do the core or meet an exclusion. We'll talk about that in a second. And then, there is a menu set.

And you only have to do five out of the ten for the menu set, same for hospitals and docs. We don't care which five you pick with the exception of public health.

We want you to pick at least one of the three if you're hospital or one of the two if you're a doc or other eligible professional- from public health. But other than that, you could pick whichever ones you want -we don't even ask you why. And then, also, you have to submit Clinical Quality Measures, which we'll go over separately.

All right, the next slide has to do with the earlier mentioned exclusions. And this has to do with not all of the meaningful objectives are going to be applicable to everyone. I give some examples there on the slide. You know, dentists don't give immunizations, which is one of the menu exceptions. Chiropractors would probably go to jail if they prescribe medication. So, e-Prescribing is kind out for them. So, the exclusion is really focused on these ideas where you have a null denominator because the specialist doesn't do any of these things.

The important thing to remember about exclusions is they are unique to every objective. So, if you think an objective doesn't apply to you, and there is an exclusion for it, you look at that criteria. You evaluate that criteria in the same way you would evaluate criteria if you were trying to meet the 80 percent thresholds or whatever it might be.

Despite these exclusions, we do still get a lot of questions from specialists about their ability to meet meaningful use. We got lots of them submitted for this call. We get lots of them over e-mail on all other days at all times.

Most of the objectives of meaningful use do not require patient interaction. You know, we'll talk about three of them, you know, problem list, med list, med allergy list.

That information could come from another doctor. It could come from the patients themselves in some circumstances. But it doesn't have to be gathered directly by the physician into the system. It just has to be in the system.

So, with the only two exceptions, which are computerized provider order entry and e–prescribing, you really are looking at anybody can get that information into the system. What we're looking at for meaningful use is does the EP have access to it, not so much did they create it. So, it is possible for nearly every specialty to meet meaningful use if they are getting that information from others.

The other big question we get about specialties is in regards to payment adjustment. So, it's all well and good for us to say that for incentives when we say well, you can always just say I won't pursue the incentive if I disagree with you. But we get lots of concerns because you don't get the option to say that on the payment adjustments, which go into effect in 2015.

All I can say about that is we will be including all the regulations about payment adjustments in the rule that I mentioned that is coming out in January of 2012. So, look to there to find out more information on the payment adjustment side.

OK, so, go to the next slide. I won't spend a lot of time on this one, but basically it divides the denominator of meaningful use. This is really a hospital issue more than an eligible provider issue, because eligible professionals tend to keep all of their records in EHRs.

So, if you do have a situation where you have some records in EHRs and some records in other ways- whenever we make the denominator complicated for you, we say patients of a certain age or count all your orders or, you know, patients who have X- we allow you to limit that population to just those that are in your EHRs. And we're confident doing that because there are two – three, sorry, measures that have an 80 percent threshold where it's all patients in the denominator.

All right. The next couple of slides are just for your reference. And so, we'll skip all the way through to slide 11, which is the Stage 1 Core Set Objectives. It looks like a table.

All right. And these tables, basically, I'm going to use them. We're not going to read them all. I'm not going to read them off to you. You can see them there. They're all over our website if you need more information. But I'm going to give them to answer some of the questions that were submitted ahead of time.

So, recently, we received a lot of questions about what it means to be seen by an EP. That is a very common denominator for us-in the meaningful use functional objectives "seen by the EP." And we have an FAQ out there on that one. It's I.D. number 10664 or you could just search the phrase "seen by the EP" in the FAQs on our website. So, basically, it means every actual physical encounter where the EP renders a service to the patient should be included in "seen by the EP."

However, in cases where the EP and the patient don't actually have a physical encounter or a telemedicine encounter, but the EP does render some service to the patient- you know, consultative, reading EKG, or what not- we provide the EP basically discretion on what type of those nonphysical or telemedicine interactions to include in "seen by the EP."

The only thing we say about it is that it has to be consistent across the whole reporting period. You can't, you know, cherry pick on this day I'll count my EKGs and on this day, I won't. And it can't be zero. So, if you are an eligible professional who never has an actual physical interaction with a patient, you do need to count some of these consultative things that you do as "seen by you".

You can't have a zero for "seen by the EP" because basically that means that meaningful use has become meaningless to you because you'd have zeros for well over half of meaningful use.

All right. The next objective that's really gotten a lot of interest on this phase is the objective of computerized provider order entry. And I'm going to spend a little bit of time on this one because it gives us the opportunity to talk about – a little bit -about how to think about meaningful use. So, the question of,

you know, getting way back to the beginning of the presentation, why does anybody care about meaningful use? The answer is that we care because we think it will improve health care, you know, short version.

So, what does CPOE do to improve health care? It basically provides the opportunity for an EHR to provide clinical decisions support at the time an order is being made or at least in the timely manner and it reduces the likelihood of mistakes made in communications of those orders. So, with these goals in mind, we came up with an FAQ that basically says we want CPOE to be done by a licensed health care professional.

So, that means when- if that clinical decision support comes up, it's coming up in front of somebody who can evaluate. They might not be able to change the order, you know, if it's a nurse or something. But they can at least evaluate it and they've been licensed to evaluate health care information in some capacity and can take action that's needed. The action might just be alerting the ordering provider, but they can take some kind of action.

The other thing was to reduce medical communication errors. So, we said CPOE needs to be done- that needs to be how the order becomes part of the patient's medical record. So, those were two kinds of our clarifying parts about CPOE and that concept can be applied essentially through all of meaningful use. Where if you ask the question, OK, so why is this particular option going to be useful? To improve care coordination, to improve health care.

And when you answer those questions and look through our guidance, we hope you'll see that, you know, our guidance is focused on moving us in those ways. And if you've kind of aimed for the stars on that question, you're almost always going to be good when it comes to meeting meaningful use.

Just a couple of check-the-box answers here to some of the questions we have. E-Prescribing, we get – frequently get asked, does it have to be the doctor who does the actual prescription? The answer is no. It can be anyone who is authorized to send prescriptions on behalf of EP can also do e-prescribing.

The last one on this slide I want to talk about is problem list. Problem list is another good illustration for us, in the sense of it is meaningful use of certified EHR technology. We get a lot of questions about that "of", you know, what does it mean to be certified or what does it mean when I have to have certified EHR technology? Does that mean we have to do it exactly however my vendor says or what if I think my vendor is wrong? The problem list gives an excellent example of use of the "it's meaningful use of certified EHR technology. Well, certification provided the capability to maintain a problem list unique to a patient of structured data and it provided a standard, in this case, ICD-9 or SNOMED CT.

It doesn't limit EHRs to just doing those few things. So, an EHR could use a common language problem list that is cross walked to a problem list in ICD-9 or SNOMED CT. It doesn't – there's nothing in there about who has to enter the problem list. It could be office staff. It could be the provider themselves. It could be clinical staff. It could be any number of individuals that way. All this says is that when you go in to see if you've met meaningful use, you want to see a structured data problem list for that patient. You want to be able to find it in ICD-9 or SNOMED CT. And that's it. You've checked the boxes.

And the reason we leave a lot of flexibility like that is really hoping that by leaving those flexibility, you know, to do crosswalks and to do things like that, it leaves open the door to innovation by the developer of these systems in both usability of the products themselves and how they're used to improved health care.

Presentation Part 2

All right, so, move on to the next slide where we talk about some examples here. And, again, these are just going to kind of be answering some questions we received ahead of time.

Vital signs, we get a lot of questions about the exclusion for vital signs. Providers want to know if they record height or weight but don't record blood

pressure, if they record blood pressure but not record height and weight, do they meet the exclusion?

And the exclusion right now is you need to collect all three or none of the three. So, if you collect any of the three, you need to collect all three to meet the measure. If you want to meet the exclusion, you can't collect any of them.

The other question we get sometimes is smoking status. Again, this gets back to certification and standard. There are six standard fields that your EHR was certified to and the question becomes do I have to use those fields or what happens if my EHR has other fields? When your EHR was certified, if it does have additional fields, those should be mapped back to those original six. So, you can use whatever fields are in your certified system because they're mapped back to the certified six as well.

All right. And move on to the next slide. We're going to move out of improving, health care quality directly and more into engage patients and their families, care coordination, and some of the things that are very important for health overall but maybe not an individual office visit.

Clinical summaries after office visits, by far, very popular ones we got a lot of questions on this call. We got a lot of questions afterwards. And, basically, it's how do I go about meeting this measure? And just to run you through a quick example of meeting clinical measures, you have an office visit with the patient. That patient is leaving and you provide that visit summary electronically, normally by default.

So, when that patient leaves and you tell them, you know, your summary will be online. You basically can have three possible reactions by patients X, Y, and Z. Well, say, patient X, he politely nods, says thanks, that's great. Never accesses the portal, never looks at it. But since you made that clinical summary available to him within the three business days, the eligible professional would count that as a success of providing summary.

Patient Y – patient Y is our golden patient here. So, he asks for the Internet address as he's leaving. He accesses the summary, pulls it down. You know, that's ideal and, of course, that counts.

Patient Z- not too big into this electronic stuff. So, he asks for a paper copy. And a patient can ask for that paper copy. And if asked for that paper copy, it needs to be provided by the EP in order to count that patient in the numerator within three business days.

So, those are pretty much the three scenarios and you can – if you default to paper, you can just kind of reverse those. You know, patient X would be the one who says, no, I don't want the paper, wads it up and throws in the trash on the way out. Patient Y would be the one who takes it and says, great, and reads it thoroughly and calls you back about it.

And patient Z would be the one who said, no, I lose paper. Can you provide it to me electronically? And then, you can provide it to them electronically in any way you want to. So, it could be portal, it could be e-mail - secure e-mail, it could be physical electronic media like a USB stick.

We get a lot of questions about the next one, which is care coordination and testing the exchange of health information. I'm not going to spend a lot of time on the call going over this one because it takes a long time to go over.

But we have two FAQs on this one. And the gist of those FAQs are essentially certification of your EHR did not require – does not require a specific transport method. So, you could do that testing using any over-the-wire transport method you want. It could be a health information exchange in your State. It could be a secure e-mail to another provider. It could be FTP to another provider. It could be uploading information to a patient portal. Basically, any over-the-wire transfer of this information would count. Mailing physical electronic media like a CD-ROM or USB stick does not count.

The next question that we always get is well, what needs to be tested? That is in certification. Your system will certify to send a problem list, a med list, a

med allergy list, and diagnostic lab results. So, you need to test your ability to send at least those four things.

The last on this slide, privacy and security. We didn't create any new requirements about privacy and security. It's still the existing HIPAA requirements. But we know that by bringing certified EHR technology into your world, you will need to re-evaluate your compliance with HIPAA and conduct an analysis. That analysis can happen during your reporting period or it can happen before your reporting period. It just has to happen after you implement certified EHR technology for the obvious reasons of it wouldn't be very useful before your EHR technology is available.

All right, so, the next table, which – on slide 16 is going to bring us into the menu set. We won't spend nearly as much time on these because if you find one that's overly complicated, you can always just pick another one.

But feel free to ask questions about this at the end as well. The only one I want to mention on this first slide is incorporate lab results.

And- so, lab results, we'd love for this to be HIE. We always get the question of whether this means that you have to have an interface with the lab.

We'd love for that to happen, but we don't require it for Stage 1. So, you know, you're going to order a lab. You're going to get- the only limit to those labs is that you're going to give a numeric result like say, cholesterol or an affirmative yes/no result. You're going to get that information into the patient's records somehow. We want you to get in there as structured data. It does not have to come as HIE to meet this requirement.

All right, so, the next table on slide 17, that gets us into more patient engagement, more care coordination. So, it's just a little bit on the care coordination.

Again, we love for it to happen using electronic health information. But it's not required that that these things happen with electronic health information exchange. So, you can transmit it electronically through an HIE all the way

down to printing out a summary of care, handing it to the patient, and telling them to give it to whatever cardiologists, just for example, you're referring them to or whatever cardiologist they choose, which if you don't know it ahead of time might be a good reason as opposed to a lazy reason to not use electronic exchange for that.

We get a lot of questions about what is medication reconciliation? Really that's for the eligible professionals decide. It's basically- at its most basic medication reconciliation- it's just about the reconciliation of what the patient knows about their medications with what you know about their medications.

So, the next slide brings us to our population and public health improvement one. And if you remember from when I was talking about the menu before, this is the only limitation we've put on the menu set. You do need to pick one of these or you need to be able to exclude to all of them.

So, we get tons of questions about these, but it's really a three-step process to meet these objectives. And this applies to all three. The first one is you're going to go out there and you're going to try and find a public health immunization registry who you, due to your patient population, would have a need or at least a want to send information to. You don't need to check with a public health agency who has absolutely no interest in the data on your population. So, if you're in Texas as an eligible professional, you don't need to check with the public health agency in Maryland. You can check with the ones in Texas who are interested in your patient population.

So, if you go through all those, and you find somebody who takes the HL7 messages and could do the electronic testing, you go with that person. If you fail to find anyone who both wants your information and can test with you, then you meet the exclusion. So- you're kind of done at that point, so we'll stick with our person who found one.

If that person found someone and then they want to actually conduct the test with that public health agency, if the test fails, you're done again and you attest yes and you move on. If that test is successful, then you would move up

to follow-up submission with just that entity. If you're in a situation where maybe the Texas Department of Public Health and I'm just making this up says, yes, we can test with you but we can't on board you for actual submission until after your reporting period, that's fine. You still attest yes to meeting that objective.

So - three-step process that you follow through. If the process falls apart for reasons beyond your control at any of the levels, then you can still meet this objective, you just exclude it as opposed to hitting yes. If you fall out without finding anybody to test to, you exclude. If you have someone to test with and you conduct the test, then you hit yes whether the test was successful or not.

All right, so, the next slide has to do with something that never – that hasn't happened. And that's the ability of a State to get flexibility in meaningful use -no State has requested that ability as of today. So, I won't spend any time on that.

The next slide is really our last slide about the functional side of meaningful use, and that happens to focus on eligible professionals. And this is in cases where an EP practices at multiple locations but might not have EHR in multiple locations. It's not impossible, it happens all the time. You know, if you're a surgeon – you have EHR in your office and the outpatient department of the hospital but not your ambulatory surgical center, those two things can happen.

So, what we did here is we basically created a minimum standard of use. If 50 percent or more of your encounters happen at a location where certified EHR technology is available, then meaningful use only focuses on those encounters where certified EHR technology is available and you can ignore the other ones. If you don't meet the 50 percent threshold, then you're not eligible for the incentive payment.

We get a lot of questions about what encounter is. Encounter is basically any interaction with a patient. It's not defined by billing. So, if you do have a situation where you globally bill, like say for surgery, six visits, all of those

visits count as an encounter. It's not one. And, you know, that can be crucial for the ability of some providers to make it, because typically the global bill would have a place of service, say at the ASC, where they didn't have it whereas the follow up would be in the office where they did. If it was globally – it was only the global bill and you could run into problems real fast, even though the patient spends 80 percent of the time in the office where you have it.

All right, the slide is kind of self-explanatory. Meaningful use does apply to hospitals. They are eligible for both the Medicare and the Medicaid payment, so, they only have to do meaningful use once and that's to CMS.

All right, and that brings us into Clinical Quality Measurement. I readily confess I am not an expert on the details of any individual clinical quality measure. We do have someone in the room who is if you have questions on that. But I'm going to focus on how you attest to them as opposed to how you arrive at them.

The biggest thing about Clinical Quality Measures is for Stage 1, we're focusing on automating the process of calculating the Clinical Quality Measures. We're not focused yet on perfect data. So, if you have certified EHR technology, the first step to being a meaningful user, then you would use whatever output is generated by that system. And you just take that output, you'll go to the attestation system, punch it in with the keyboard, hit submit. It's OK if that data isn't perfect.

It's also OK if that data gives you a zero denominator for some of your CQMs. You know, this is one of those things that obviously – you know, I wouldn't count on lasting forever. But, certainly, for Stage 1, that's how we're doing attestation of clinical quality measures.

So, on the next slide, on 22 is- basically this next slide is going to be charts of the measures. For eligible professionals, they have a core set of measures and an additional set of measures. We want them to report on that core set.

If you do have a zero in any of the denominators of these three, for every zero you have, we want you to replace that with the next slide, which is the alternate core set. And after you – if you do run into a situation where you can't get three out of these six, then you can report zeros as determined by certified EHR technology. So, if I had four measures where I have zeros, I'd report numbers on two and zeros on the other four.

And then there is the additional set. And this is a long list of 38 measures, of which you would pick three. And then, you're picking three that your certified HR technology supports.

Certified EHR technologies are not required to support all 38. We highly encourage you when you – if you're in the evaluation stage, that should definitely be a criteria of your evaluation of a specific EHR. Does it support the clinical quality measures that are relevant to me? There's no point in having an EHR that ignores the Clinical Quality Measurements that matter to your practice. It doesn't work out for you. I certainly won't read all 38. Hospitals- much easier. They have 15. They have to report on all 15. And all – and all EHRs are certified for all 15.

All right, so, we spent all this time talking about meaningful use, but we do want to mention that there is a way to get incentive money without meaningful use. So, if you want to ignore the last 40 minutes, you're more than – and you qualify for the Medicaid program, in your first year only, you can get an incentive for basically adopt, implement, and upgrade. There is no EHR reporting for this. It's just kind of happens at a moment in time. But that is only available to our Medicaid providers and it's only available for the first year. After the first year, they will have to meet meaningful use as well.

So, this kind of gives you the milestone timeline- on the last slide here that I'm going to talk about.

And that slide is- kind of gives you a framework of the overall program. Again, you know, for you all, it's pretty much concerned about where you EHR reporting period falls, I will say if you want to maximize your Medicare

incentive and you're an EP, you need to get going this year or in 2012. If you want to maximize your Medicare incentive and you're an eligible hospital, you'll have either already started in 2011- there aren't 90 days left in the Fiscal Year- or you need to get started in 2012 or 2013.

Next slide – next couple of slides are really just reference slides. So, we got notable differences between the programs, brought up many of those as we've come though. The only one I'd like to call to your attention on slide 30 is that in addition to the A/I/U, the Medicaid program lasts a lot longer. You have to start the Medicare program by 2014, and there are payment adjustments starting in 2015. Medicaid, there are no payment adjustment and you can wait as long as until 2016 to get going. All right, and like I said, the rest of these slides are just reference for you.

You got links to the websites that we've mentioned and things like that. And with that, I'll turn it back over to Diane for the questions.

Diane Maupai: Well, thank you, Travis. You can see that he is clearly very knowledgeable on this topic. And we're lucky to have him today.

And now, Melissa, if you could open the line for questions.

Question and Answer Session

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question. So, anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Andrea Stinson. Your line is now open.

Andrea Stinson: Hi, we wanted to know how this affects us as far as having to choose of the three insurance companies that won the bid for Medicaid. So, how is this all going- if we're doing everything through the – one of those three insurance companies or all three? Then, how does this come into play?

I don't even know how to ask the question intelligently.

Travis Broome: Well, unfortunately, we're not – we're not quite sure as to what you're referring to. You just want to give her the national...

Diane Maupai: Why don't I give you the number for our help desk and they can route your question to the right person? That number is 1-888-734-6433.

Andrea Stinson: OK, Thank you. I have one more question. In regards to- a majority of what you all were talking about, I have – I wonder how it affects our dental office.

Like the dentist in the office.

Travis Broome: OK. So, dentists are eligible under both the Medicaid and the Medicare program. They do have to have certified EHR technology, which I understand is coming online a little slower on the dental side than it is on the – on the physician side.

But the- in theory it would be the same thing. The dentist is probably going to meet a lot of exclusions. You know, obviously, – you know, immunizations was one of the examples we used in the presentation.

But it is the same definition of meaningful use for them and the same definition of certified EHR technology. We have – we have had a lot of dentists starting to get – acquire certified EHR technology and get their A/I/U payment. I can't say for sure if we have any that are testing for meaningful use or not. I don't know that level of detail on our attestation.

But, so, for the dentist, you know, same definition of both things. But I would say a dentist would be looking real hard at these solutions that are available for various objectives.

Andrea Stinson: OK. And one last question. Are there any conferences coming up that we could maybe attend?

We're in Cady, Texas. So, I know you're from Dallas, Travis, right?

Travis Broome: Yes. Well, let's see. I don't know of any that are coming up for October.

But if you want to e-mail in your – the Regional Office- and do you know Monica for the Regional Office's e-mail?

Diane Maupai: I don't.

Travis Broome: You know, I think it's on our website. If you go to our cms.gov/ehrincentiveprograms website

Andrea Stinson: Yes.

Travis Broome: Incentive programs, there is a list – every region has a HITECH contact. And I'd encourage you – and the one in Dallas is Kathy Maris.

Diane Maupai: Here is where you go. You'll go to the Frequently Asked Questions page. And scroll down the page to the Downloads.

And there is a link there to EHR Resources, inquiries. And that will give you the RO e-mail.

Travis Broome: Yes.

Patrice Holtz: Address.

Travis Broome: And that will get in touch with Kathy and she will know every last event that is happening in – down in Texas.

Andrea Stinson: OK, great. Thank you.

Operator: Your next question comes from the line of Susan Oliver. Your line is now open.

Susan Oliver: Hi, I was just wondering if we're physically ready in the office for meaningful use. How do I know or are there forms to fill out for the reimbursement?

Travis Broome: Oh, yes. So, there's couple of different ways you would know. There is a calculator on our website that allows you to put in your meaningful use data and see how you do before you have to attest to anything.

And then, if you go through that and you're ready for meaningful use and you've met, you know, the measures, then you would go on to the actual attestation system. The first thing to do is to register. That's pretty quick.

But we encourage you to do it as soon as you can, because registration doesn't mean you have to attest. And if you do have any problems, let's say your NPI or something like that, the sooner you know that the sooner you can get it worked out.

But assuming everything goes swimmingly in registration, you can roll right into the attestation module. And like I say, you can just punch in the data straight ahead. All the certified systems are – as far as their certification for their individual part, they should be able to generate the information on numerators and denominators for the objectives.

Now, you know, you need to be- you're responsible, except for clinical volume measures like I mentioned, for the accuracy of that information. So, you want to make sure that, if you're using the EHR denominator, you want to be sure all your patients are under EHR. But, yes, you run through those objectives. Use the calculator, double check. You can play with different time periods if you want and then register and attest. And it's all done online.

Susan Oliver: So, is it best to do it quarterly?

Travis Broome: Oh, you only have to do it once per year, sorry. Yes.

Susan Oliver: OK.

Travis Broome: You only do it once per year. So, once you do it for one 90 days in 2012 or 2012 or whatever your first year is, you're done for that year. And then after that, it's a full year.

So, you would, start on January 1 if you're a doc and after December 31st, you know, in January or February, you would come in and attest again.

Susan Oliver: OK. Thank you.

Operator: Your next question comes from the line of Carmen Head. Your line is now open.

Carmen Head: Yes. Hi, hello. I have a question regarding- I registered one- we are a large group. I have registered one of the physicians and I received a e-mail from CMS stating that this physician will not be able to participate with us because it's registered also with an additional Medicare Advantage Organization, which she no longer is part of.

Travis Broome: Yes.

Carmen Head: Go ahead, I'm sorry.

Lawrence Clark: Yes, under the Act, those EPs that practice more than 80 percent of their practice in an MAO can be claimed by the MAO. We started to get the list – the first list from the MAO last month. What you need to do is contact the MAO and clarify whether you are in fact part of that MAO or not.

And they will make that correction on the list. I would also recommend as Diane said earlier, calling the help desk. You

Diane Maupai: I'll give you the number.

Lawrence Clark: Know that number?

Diane Maupai: Yes, 1-888-734-6433. And you can also e-mail them and the information about the information center is on our website at the bottom of the registration page.

Lawrence Clark: Yes, and then what – when you call in to the help desk, they will route that information to the appropriate component here at CMS, so we can monitor that.

Carmen Head: OK, yes. So, I did call, but maybe at that time they had not received any information. I did contact the MAO and submitted the letter of termination.

Lawrence Clark: Yes.

Carmen Head: Because the physician has been with us for about a year and a half now or two.

Lawrence Clark: We update the list every 30 days.

Carmen Head: Where would I – how can I follow up with this, so that I can register this physician?

Lawrence Clark: Did you say you already called the help desk?

Carmen Head: Yes.

Lawrence Clark: Right.

Diane Maupai: Now, I tell you what. Can you repeat?

Lawrence Clark: You'll have to take the number.

Diane Maupai: Can you repeat your name again and we'll get back to you?

Carmen Head: Yes. First name is Carmen, C-A-R-M-E-N.

Diane Maupai: Yes.

Carmen Head: Last name is H as in Henry, E as in Edward, A as in apple, D as in David.

Diane Maupai: OK.

Lawrence Clark: All right. We'll follow up internally here and get back to you.

Carmen Head: Great. Thank you.

Operator: Your next question comes from the line of Thelma Alcott. Your line is now open.

Thelma Alcott: Hi, I'm looking at the quality measures where it says on slide 26 that you must complete three of the 38. And the question that I have is most of these 38 measures are not things that we regularly follow. Our practice is physical medicine and rehabilitation.

So, we don't do cancer screenings. We don't follow up with asthma or diabetes. In fact, the only thing that we would actively follow would be number 36, the low back pain.

I'm wondering, do we – if we select three of these items, are we then required to follow up with the patient for these three items?

Patrice Holtz: No. Tto meet this requirement, you do have to submit the three additional measures. So, select three and the information is going to be reported from your certified EHR.

And what you would expect then, since you don't see this population of patients, is that you will get zeros for the denominator and zeros for the numerator and zeros for the exclusions. That's what you will attest to. We're not looking at specific performance rates.

Right now, we're just looking that you are reporting clinical quality information from your certified EHR.

Thelma Alcott: So, when the patient – when the physician sees the patient and they are doing their exam, they are then required to – of those three items that we select, they're required to just put that information in there?

Patrice Holtz: Well, no. In Clinical Quality Measure, we're looking at data that's already happened. So, these encounters and the information that your EHR is reporting on, is information that has already been recorded in the EHR.

If the EHR does not contain those actions that were supposed to be performed by the provider, then it's going to report a zero. Either you don't have patients that are diabetic and it reported zero or you have patients who may be diabetics but you haven't performed the clinical action required by the numerator. And that will be zero or both will be zero.

If that's the information that's reported from EHR, that's what you attest to in the attestation screen. So, you're not following anybody. You're reporting on patients that have already been seen during a 90-day reporting period.

Thelma Alcott: So, the physicians don't have to actively keep these three parameters in mind, then?

Patrice Holtz: No.

Thelma Alcott: OK.

Patrice Holtz: What you have to do is report the information that comes out of the certified EHR on those Clinical Quality Measures that you select of the 38.

Thelma Alcott: OK. I'll have to figure out how we're going to work this then. One other question.

One of the gentlemen mentioned a calculator that was on the website. And I have been searching for this. And we've already done the registration for our three physicians.

I have not done the attestation yet. But if there is a calculator, then I would like to find that before I do the attestation.

Travis Broome: Sure. So, if you go to cms.gov/Ehrincentiveprograms, there are several options on the left hand side, one of the tabs is called Attestations.

And then, when you click on that tab, it will open up in the main window of the website a lot of information. The calculator is available by hyperlink.

It's about – probably about in the middle of that information. It's below the real-time attestation. I think you will have to scroll on the main window a little bit to get there.

But it's on the attestation tab. Depending on how big your monitor is- at the bottom of the screen or a little bit below the bottom of the screen on – in the main – after you click on the attestation tab.

Thelma Alcott: OK, All right. I will check on that page. Thank you very much.

Operator: Your next question comes from the line of Glenn Val. Your line is now open.

Glenn Val: Hi, I have two questions. My first question is, you guys said that for Stage 2, it's going to be issued in January 2012. Are there going to be significant guideline changes?

Travis Broome: Well, we can't comment on proposed regulations too much. We always intended for Stage 2 to be different and an evolution of Stage 1. But by far the most concrete of the information available would be the recommendation by the Advisory Committee, the Health IT Policy Committee, if you want to kind of get more concrete examples of what that evolution might look like.

We also kind of discussed it in our original rule of Stage 1. You know, what we said in Stage 1was more generic things like the other menu going to core, focusing more on care coordination, things like HIE, things like that. But the only specific information out there is just a recommendation at this point, is from the HIT Policy Committee.

And you would get to that by going to the ONC's website, which is healthit.gov.

Glenn Val: OK, I see. Another question I have is how does CMS keep track or know that the attested information is true? Is it by like an auditing process or…?

Lawrence Clark: That's within the repository system here at CMS, we calculate each of the objectives and associated measures when you submit your attestation, and

they're calculated almost instantly, and if they meet the threshold, then you'll get a report back that you successfully attested.

Glenn Val: But I want to know – now, my question is how do you know that information that's being inputted is actually true?

Travis Broome: Yes. So, right now, I mean, it is attestations, so we're essentially at this point taking your word for it.

There will be an audit process for meaningful use. All we can really say about that right now is that there will be one and as far as what to keep for that is,– whenever you do these numbers, you know, you've found out the numbers somehow, some way. You know, and you just keep the record as how you found that number and how you came about that number and that'd kind of be the documentation to keep.

Travis Broome: But there isn't like an active- we don't go flying into your EHR or anything like that.

Glenn Val: Oh, OK, All right. Back to the Stage 2 question. When you guys say that it's going to be issued in 2012, does that mean if – you know, we don't want – we've decided not to attest this year and we've decided to attest within 90 days in 2012, we'll be attesting to the new guidelines?

Travis Broome: No, you will not. Because system changes and things like that are necessary for each stage, the rules come out long before the stage would be in place.

So, for 2011 and 2012, it will be Stage 1 for sure. In our proposed rule for Stage 1, we had indicated that, you know, providers attesting in 2011 would switch over in 2013. That made a very short window to create that timeline; the HIT policy committee has recommended that we push that out to 2014.

So, you would actually do Stage 1 in 2011, 2012, and 2013. And the leadership of both CMS and ONC has, I think, the phrase is "agreed with the logic" that that timeframe is too short. And, you know, so therefore, putting tentative support behind that movement of a year.

So, for sure, 100 percent, you're looking at Stage 1 2011 and 2012. It's likely that you're also looking at Stage 1 for our 2013 providers. I would encourage you to go to the ONC website where they have all that, you know, parsed language out there.

And I don't know if CMS issued a press release or not. But it's certainly on the ONC website. And then 2014, that's when you're really looking at Stage 2.

Glenn Val: OK. Thank you.

Operator: Your next question comes from the line of Jennie Brittle. Your line is now open.

Jennie Brittle: Hi. Yes. My question has two parts to it. We're an optometric practice with five owners and two employee doctors.

Now, am I understanding this correctly that all seven can be registered?

Travis Broome: Yes.

Jennie Brittle: OK. Now, second part to that question is we normally bill Medicare through a group NPI number.

Jennie Brittle: Will we now have to go back to billing Medicare with each individual doctor's NPI number?

Travis Broome: Well, I'm not a billing expert. But it's my understanding that every claim even though it might be reimbursed to the group NPI, identifies the doctor providing the service. So, you don't have – you're already putting essentially both on a claim.

Jennie Brittle: Yes.

Travis Broome: And then, the way it works on the incentive side is we'll run all the – all the claim data by individual NPI. But when your providers register, they can

assign their incentive payments to the group just like they assign their current claims.

Jennie Brittle: OK. So, it can go too either the individual doctor or it can go to the group. Is that – is that what I'm understanding?

Travis Broome: Yes. It all depends on what they specify at registration.

Jennie Brittle: OK. What's specified… OK.

OK, thank you.

Operator: Your next question comes from the line of Anna Ferguson. Your line is now open.

Anna Ferguson: Hi, I have two questions for you. The first question is, can you backdate your 90 days like can you give…

Diane Maupai: Excuse me. You're breaking up and we can't hear you.

Anna Ferguson: I'm sorry. Can you hear me now?

Travis Broome: There you go.

Question and Answer Session continued

Diane Maupai: Yes.

Anna Ferguson: OK. I'm sorry about that. My question is can you backdate your 90-day period.

Can you go like two weeks before or is it when you go in to attest you have to go from the date that you're attesting?

Travis Broome: No. When you go into attest, you specify both the start and the end date of your reporting period.

Anna Ferguson: Yes.

Travis Broome: It can be any 90 days in the year. And you have two months after the end of the year to actually go about and report it.

Anna Ferguson: OK.

Travis Broome: So, it certainly can be backdated.

Anna Ferguson: OK. And then, my second question is, there are three core menu – three core choices, three menu choices, totaling six, not nine, correct?

Travis Broome: Correct- for Clinical Quality Measures. The only way you would be reporting on, you know, say you're reporting on six…

Anna Ferguson: Yes.

Travis Broome: And ideally, it'd be from the core set and the additional set, but if you do have a situation in the core set where you have some zeros in those first three, you need to switch them out for ones in the additional set. And if you look at those sets- it basically focuses, the core set basically focuses on adults and the additional core set that focuses on pediatrics.

Anna Ferguson: OK. Thank you.

Travis Broome: OK.

Operator: Your next question comes from the line of Linda Webber. Your line is now open.

Linda Webber: Hi, there. I was wanting clarification with medical records. Let me see.

If we do a CD-ROM, does that qualify as an electronic medical record if the patient requests for medical records?

Travis Broome: Yes. So, the objective you're referring to is when the patient makes a request for an electronic copy of a medical record. And if you download, you know,

out of your EHR and onto a CD and provide that CD to the patient, that does count as an electronic copy.

Linda Webber: OK. Second question, under clinical summary, did – I just need clarification. We just need to meet four criterias out of the clinical summary when a patient comes and right now, we are not – we don't have the portal yet.

So, if we give – my understanding is that you need to give it to 50 percent of your patients?

Travis Broome: Right. Yes.

Linda Webber: Is this is we – if they asked for it or not?

Travis Broome: Yes.

Linda Webber: To meet.

Travis Broome: Right. So, for this one, this is the – you know, for 50 percent of office visits you basically provide a clinical summary in office – a summary of the office visit to the patient. And the certified systems were certified at a minimum to provide problem list, med list, med allergy list, and diagnostic lab test results.

So, if that's all your certified systems supports, that's all you have to include. If it supports more information, you know, immunizations given, instructions, things like that, if they can put on the summary that's certainly helpful to the patient. We encourage you to include those as well. As far as, do you have to provide?

It is for that when you're talking about is the denominator is all office visits. So, the idea would be – would be given to every patient after every office visit, either on paper or electronically. You know, if you remember from my examples from the speech, you can end up in a situation where the patient says, you know, you try and provide it to them and they just don't want it.

They throw it away or they refuse to take it. You know, you can still count that in the numerator as you provided it to them. But you do have to actively provide it.

You don't wait for them to request it.

Linda Webber: OK. How about if there is – how does the clinic summary? Again, here, let me ask a question.

You can select – could we have at least four items to meet the requirement?

Travis Broome: Right. You would have, you know, problem list at least in your summary. You would have any updates of the problem list, medication list, the medication allergy list, and any lab results that occur.

You know, so, some of the elements might be blank. You know, so, if the patient's not on any meds and that might be blank or they didn't want – they didn't have a new problem diagnosed so the problem list might be blank, and the lab that might be blank. But all four of those things should be on there.

You know and these are – you know, if there were things that should be on there, if they weren't, they wouldn't be. So, those four should be on every summary. And then if you put additional information, that's just better for you and the patient, but those four need to be on the summary.

Linda Webber: I get it. Thank you very much.

Travis Broome: All right.

Operator: Again, if you would like to ask a question, press star, then the number one on your telephone keypad. Your next question comes from the line of David Kaplan. Your line is now open.

David Kaplan: Yes, I had a question on the quality measures that I think was answered. Basically if you can't find anything, just find three that you can exclude yourself from and put zeros down for the denominator and that works for meaningful use?

Travis Broome: Yes. That essentially works. You know, well, basically, you know, our focus like Patrice said earlier is, you know, we want you to be recording the data you're recording, and then use your systems to automatically generate the three. You know, if you can generate more than three and some of them get data and other ones don't, I would encourage you to give us the data ones. But if your system, you know, was only generating three and it's coming up all zeros, then zeros is it is.

David Kaplan: Well, there is one that probably would fit which is the diabetic foot exam.

Travis Broome: Yes.

David Kaplan: Is there a specific ICD-9 code they would like to see for that?

Patrice Holtz: Yes, the measure specifications themselves all have coding vocabulary sets for each data element required in the Clinical Quality Measure. Depending on the measure and depending on the specific data element, it could be an ICD-9, or it could be a SNOMED code, it could be a CPT. So, it's just going to matter as far as what the specification says.

David Kaplan: OK. Where would I find those specifications on the website?

Patrice Holtz: OK. They're on our website. If you go to the main CMS EHR Incentive Program website.

David Kaplan: All right.

Patrice Holtz: There is a link on the left hand side for Clinical Quality Measures. And if you- or...

Travis Broome: It might be meaningful use.

Patrice Holtz: Meaningful use.

Travis Broome: Yes.

Patrice Holtz: Objectives. I'm sorry. Meaningful use objectives.

David Kaplan: And so..

Patrice Holtz: And if – and if you go there, one of the meaningful use objectives is Clinical Quality Measures.

Travis Broome: Yes.

Lawrence Clark: And you scroll all the way- after you click the meaningful use tab, just scroll all the way to the bottom of the main window and it'll have like, you know, related sites within CMS and one of them is th….

David Kaplan: And so the main EHR tab and so I navigate my way through the tabs?

Travis Broome: Right. So, you would go the main website, attestation, scroll to the bottom-

Patrice Holtz: No, meaningful use.

Travis Broome: Oh, yes. Sorry.

Patrice Holtz: Meaningful use.

Travis Broome: Main website, meaningful use. Scroll to the bottom. There should be a link to clinical quality.

David Kaplan: OK. So.

Patrice Holtz: Our help desk should also be able to guide you there if you have problems.

David Kaplan: So, who should be able to guide me there?

Patrice Holtz: I think that number, which we can give you right now should also be able to guide you to the website location.

David Kaplan: OK, that was the 1-888-734-6433 number earlier?

Diane Maupai: That's it.

David Kaplan: OK.

Patrice Holtz: If you have trouble finding it, just call them and they'll help guide you there.

David Kaplan: Thank you.

Operator: Your next question comes from the line of Judith Karadonick. You line is now open.

Judith Karadonick: Hi, I have a question. We have an EHR and we ran a test over a week just to see how we were doing. One of our physicians was out that week.

He was on vacation. However, on two of the days, he did pop in. On each of the days, he made two phone calls to a patient, and in addition he put in 12 clinical summaries of patients who are coming the next week.

He saw one patient for a visit and he documented he gave education for that. His level of education, the way our HR calculates it, is he scored one out of 17 for giving education to a patient.

And I've been arguing with them that this is – the denominator is unique number of patients seen by the provider, and putting a clinical summary in or adding a mammogram to a clinical summary while making a call on labs to a patient should not constitute seeing unique patients. I've put in three case reports on this and they refuse to change it. And I said that it's not their choice.

CMS has given the ruling, but we think we're going to get nonsense back.

Travis Broome: Yes. So, that – so, you know, if you remember our conversation earlier about "seen by an EP", we would certainly agree that, you know, just basically doing the paperwork does not constitute "seen by an EP". There should be some consultative thing going on be it reading the labs or actually seeing the patient.

So, I fundamentally agree with you. Now, actually, solving your specific problems, we need to contact you directly because we would need to know like…

Judith Karadonick: Please, I need you to contact the medical records company because this is a very big one. And we think they're going to attest to rubbish and we don't want to be attesting to rubbish.

Travis Broome: Right. And we need to reach out to you to get enough details to actually talk to them, including to find out who they are. We don't want you to say it on the call.

Judith Karadonick: No, I don't want to say it here either. But I've been battling for about a month with this. And I cannot get them to move.

Diane Maupai: If you could call our help desk... Do you need that number?

Judith Karadonick: Please.

Diane Maupai: And tell the problem and they can direct you the right way.

Judith Karadonick: OK.

Diane Maupai: It's 1-888-734-6433.

Judith Karadonick: 6433. Thanks very much.

Travis Broome: Yes.

Operator: Your next question comes from the line of Annette Cooper. Your line is now open.

Annette Cooper: Yes. We attest – I'm sorry, we registered for the incentive through Texas Medicaid and we received our incentive funds and we are upgrading to a certified EHR. And do we start the 30 – I'm sorry, the attestation this year or do we start that next year?

Travis Broome: Next year.

Annette Cooper: Next year.

Lawrence Clark: That was 90 days for you.

Annette Cooper: So, does that mean our 90 days has to be in 2012?

Lawrence Clark: Yes.

Travis Broome: Correct.

Annette Cooper: OK. That's what I needed to know. And 90 days, is that calendar days or is that working business days?

Travis Broome: Calendar.

Annette Cooper: Calendar.

Travis Broome: Yes.

Annette Cooper: OK. Wonderful. So, 90 calendar days and since we receive funding this year, we wait until 2012 to do our attestation and do our 90 days of meaningful use.

Travis Broome: You got it.

Annette Cooper: Great. OK, thank you so much.

Operator: Your next question comes from the line of Kate Hoefel. Your line is now open.

Kate Hoefel: Hi, thank you guys so much for this call. It's been really helpful. I had a follow-up for slide 20 where it says meaningful use for EPs working in multiple settings.

Travis Broome: Yes.

Kate Hoefel: I can't find any guidance relating to what would happen if an eligible professional moved locations. So, you know, set up a new – has the same NPI number but now wants to reassign, you know, the Tax Identification Number.

Is that professional able to use or attest to work that was done at a different site that assuming the different site had an EHR- certified EHR technology or

is their payment solely based on, you know, the time that they're at the place where there like a attesting?

Travis Broome: Right. So, all the payments are individually based. So, you know, as soon – you know, we'll go to the rearview scenario here.

So, I'm not a physician but if I were and I was working at practice A, they had certified EHR technology. In the middle of my reporting period, I went to practice B. You know, I, as the individual, assuming practice A is going to give me the information I need attest, I can attest to meaningful use just fine as an individual and then the incentive payment would be calculated on all claims no matter which practice they were, that hit the Part B Physician Fee Schedule associated with my individual NPI.

As far as how that works out with, you know, the agreements between practice A and practice B and that type of thing that's kind of between the physician and those practices.

Kate Hoefel: Right. Because that's assuming they will give the information to you. I mean, that's a huge assumption, right?

That they're going to be willing to share their data?

Travis Broome: It would be a huge assumption that they would do that. And, of course, you know, there is nothing to compel- , he can always just pick a new 90-day reporting period where he was solely at practice B and just ignore his participation at practice A.

That's an option as well.

Kate Hoefel: Oh, OK. And then, in that vein and sort of similar to, I think, what Carmen Head was alluding to, it does say that like there's going to be specifically like no duplicate payments made to EPs that are eligible for both the Fee-For-Service and the MA incentive payments.

But, interestingly, it said that if the EP did not receive the maximum possible incentive payment for the year, then the MAO receives the payment. So, I

could see a situation in which, you know, a physician moved from an organization like Carmen said, but the organization is still considering them as a part of the Medicare Advantage Organization where they have moved to another practice in Fee-For-Service. If they qualify, that one would be the first one that they'd go to.

But if they didn't – but if they didn't meet the maximum, then it just reverts back to their former employer.

Travis Broome: Right. So, they can still account for it. It hinges a little bit on registration, right?

So, to register, you need the provider's –the individual doc's- login for NPPES. So, you know, if he switches practices, it might be a good time to change that password or something. But the principle of the order of payment is correct.

So, if you have a doctor who leaves an MAO- well, but in our example this wouldn't even happen because the MAO would have to be.

Lawrence Clark: What would happen is the MAO basically has first preference over the EP from the list that we get each month from the MAOs. So, they identify each month to the NLR, all of EPs that are practicing within the MAO.

So, as you come in and register, you will automatically default to that list first because of the way our system is. But if you leave the MAO and you contact us and change your registration and we – then, you should drop off following month, from that MAO list. And then, you could proceed as a Fee-For-Service.

Travis Broome: Yes. So, it sounds like a provider in that situation in, you know, the order would be to get themselves off the MAO list, register with the new group number, and then attest on that.

Lawrence Clark: OK.

Kate Hoefel: So, after registration, pardon me, can you go in and re-register and, you know, make it…

Male: You would modify your registration.

Kate Hoefel: …make that selection separate.

Male: You would modify your registration.

Kate Hoefel: OK. And so, that – to that end, I mean, because the payments are going to be on a rolling basis, after CMS like I guess ascertains that they are eligible, how is CMS going to be able to ascertain if they are eligible based on the charges from two separate organizations? Assuming that, you know, they went from one organization where they were, you know, eligible because they were using a certified EHR technology, but then, their claim datas is from the second organization where they moved are still there?

Travis Broome: Right.

Kate Hoefel: All right.

Travis Broome: So, that – the way that works is like what I was saying before. We total up the Fee-For-Service stuff based on the individual NPI. So, you know, those could be claims when they were working in, an outpatient department of the hospital.

They could be claims from the ASC. They could be claims from practice A. They could be claims from practice B.

If they are on that individual NPI and they hit the Part B Physician Fee Schedule, they will be used in that provider's total regardless of anything – any group arrangement. The situation with the MAO charges is, you know, at the end of the year, like you alluded to, before we pay an MAO for them, by law, we have to make sure that they wouldn't max out under Fee-For-Service.

Assuming they don't max out under Fee-For-Service, then, you know, if they're still associated with the MAO and things, they would pay – they would go through the MAO.

Kate Hoefel: So, could you register as a provider and then not attest and reregister in the same reporting period for another- and assign another Tax Identification Number?

Travis Broome: Yes. Registration does not require you to attest in any way. So, you can – you register once, but you can modify that oh, as many times as you want to.

Kate Hoefel: OK, great. All right.

Travis Broome: Yes.

Kate Hoefel: Thank you very much.

Question and Answer Session continued

Operator: Your next question comes from the line of Chartera Joiner. Your line is now open. Ms. Chartera Joiner, your line is open. Your next question comes from the line of Kelly Bradshaw.

Your line is now open.

Kelly Bradshaw: Hello. I'm with a group that is – a dental group that sees primarily Medicaid children and I have been to many, many meetings and so forth with REC and so far have not heard any certified dental systems, but you alluded to one. Can you give me the name of a system that's actually certified?

We're having a terrible time getting our system certified.

Travis Broome: I'm not going to be able to pull the precise name out of my hat. I do know that the only I have heard of is not certified as complete.

Kelly Bradshaw: OK.

Travis Broome: You know, they only certified to some of the objectives. So, a lot of the dentists who have been already getting their A/I/U payments or whatnot have essentially been combining, you know, non – you know, they're EHRs, just not EHRs that aren't marketed solely to dentists to cover the gaps.

Kelly Bradshaw: But they can attest with an incomplete system in this case?

Travis Broome: Well, they can't attest with an incomplete system. What they would do is check off boxes 1 through 15 with this system and then they would get another system to check off boxes, 15 through 20 and then one more for 20 through 25. If you go to the ONC website, the Health IT, there's something called the CHPL. And it's a silly acronym, but they have all the certified products in it.

And if you go in there and just basically search dental, I think a few products come up. And at that point you and the REC would know better than we would as far as the usability of those products to your practice.

Kelly Bradshaw: OK, thank you.

Operator: Your next question comes from the line of Gina Yost. Your line is now open.

Gina Yost: Hello. We have a couple of questions for you. Related to the objective to incorporate clinical lab results into the EHR, do LOINC codes have to be associated with those lab results to count or meet that objective?

Travis Broome: We would certainly love them to be. But no, they did not have to be.

Gina Yost: OK. Next question is, is if we register for Medicaid incentives, do we have to meet meaningful use in the next consecutive year or can we skip years?

Lawrence Clark: You can skip years. It's only successive in the Medicare program. You have up to ten years in the program after you come in with A/I/U.

Gina Yost: OK. And what?

Lawrence Clark: Adopt, Implement or Upgrade.

Gina Yost: OK. That's helpful. Thank you.

Last question, if we plan to attest for Stage 1 in 2013, will our method of attestation be dependent upon the current method at that time or will it just be attestation?

Travis Broome: Could you repeat that again?

Diane Maupai: Are you talking about whether you would be required to submit your data electronically?

Gina Yost: Correct. If we are doing Stage 1 attestation in 2013, will we still be attesting or will we have to do data…?

Lawrence Clark: So, the scenario is, you come into Medicaid now and then you want to do meaningful use in 2013?

Travis Broome: Right.

Lawrence Clark: OK. So, you skip 2012.

Gina Yost: Correct.

Lawrence Clark: OK. Yes.

Travis Broome: Yes, I mean.

Travis Broome: So, you know, 95 percent yes. We've hesitated to move to electronic reporting because of a lot of the issues of guaranteeing the accuracy of the reports, certifying the vendors, all that fun stuff. So, when we move that direction, unless it's fool proof and definitely easier than having to sit in front of the computer and type, it will probably be kind of an either or at your option thing.

But so, I can't say definitively because the rule comes out in January. But, it will be attestation or something you'll like better. At least we hope so. No guarantees for Patrice's Clinical Quality Measures.

Patrice Holtz: Hey, these are winners!

Travis Broome: But as far as the functional measures, we have nothing on the board right now except attestation.

Gina Yost: OK. Thank you.

Operator: Your next question comes from the line of Michelle Mason-Order. Your line is now open.

Michelle Mason-Order: Yes. I had a question about the terminology of structured labs.

Travis Broome: Yes?

Michelle Mason-Order: Hello?

Travis Broome: Yes?

Michelle Mason-Order: Yes. I was just wondering about what that means exactly when it talks about a structured lab.

Travis Broome: Yes. That actually doesn't refer to the lab as much as the data. So, if you go back to my aspirin example, if you ran structured results from, say, a cholesterol test- say we're doing total cholesterol, , say it's 157. Structured 157 would mean that the system knows that's a total cholesterol number and can relate that to whether it's good, bad and things like that as opposed to just knowing that it's just a one, a five, and a seven.

Michelle Mason-Order: All right. OK. Thank you.

Travis Broome: All right.

Operator: Your next question comes from the line of Dr. Goodman. Your line is now open.

Dr. Goodman: I have a question. Again, I think this is a same thing we covered on pages 23 and 24. If we don't have any of those three core measures, then we would just attest to zero?

Travis Broome: Right. So, we're in the Clinical Quality Measures for the core set and you have zero, zero, zero for the first three. The first thing you do, would go see if you have any from that additional core set- the other three.

Dr. Goodman: We don't.

Travis Broome: OK. So, yes, if you end up with six zeros – you end up with six zeros, and that's it.

Dr. Goodman: Because we're – I mean, we're ophthalmology, so we don't check…

Travis Broome: Well, there you go, yes.

Dr. Goodman: …you know, that stuff.

Travis Broome: So, yes.

Dr. Goodman: We have three on the other set.

Travis Broome: You can meet that measure with zero across the board if you're an ophthalmologist.

Dr. Goodman: Yes. We have plenty on the three out of 38.

Travis Broome: Yes.

Dr. Goodman: I just don't have the core set.

Travis Broome: Yes. So, for you, you'd do the three zeros and then the three from the 38.

Dr. Goodman: OK. And then, my second question is, for these – for the Medicare, it doesn't matter if it's for primary or secondary, correct? It just has to be on there for Medicare?

Do we get points for this for meaningful use if it's Medicare secondary?

Travis Broome: Oh, for meaningful use, it's all your patients.

Dr. Goodman: OK.

Travis Broome: Yes. For when we calculate your incentive, then we're only looking at the Medicare Part B Physician Fee Schedule. But for meaningful use, it's all patients regardless of payer.

Dr. Goodman: Right. But for the calculation part, it doesn't matter if it's primary or secondary Medicare or Medicaid?

Travis Broome: I don't think so. Yes, from – I mean, as long as – well, you know, as long as, you know, the secondary is covered under the Part B Physician Fee Schedule, it would be included as well.

Dr. Goodman: OK. And then, for the clinical summaries, we – how would you keep track that you gave that electronically like if you wanted to put it on – put it on a CDs versus – ours is going to be like three pages and we don't want to print that for every person.

Travis Broome: Right, right.

Dr. Goodman: So, how would we keep track of that if we put it on a CD for our patient or faxed it?

Travis Broome: Right. So.

Dr. Goodman: Because our EMR won't keep track if we fax it.

Travis Broome: So, yes. So, because your EM – and if your EMR can't track it for you, then, you'd have to come up with an alternative method of, I guess, tallying it up from a spreadsheet or something. There are a lot of people out there, that's what they do is they offer to help with stuff like that or you can come up with kind of a homegrown solution.

Dr. Goodman: So, as long as we can provide – to show that we did on these people and this is how we provided it to them if we ever got audited, that would work?

Travis Broome: Sure. Yes, yes. For purposes of audit, you know, and things you're not required to do everything the way your vendor wanted to. So, if you track it separately and you have that information available, use it for meaningful use and hang on to it and you're in good shape.

Dr. Goodman: OK. That was my question.

Diane Maupai: All right. Well, I'm afraid we're out of time for questions today. But thank you for joining us.

Thanks to our speaker, Travis, and to Larry and Patrice for helping out with the questions. I want to remind you again about the registration attestation call, which will be Friday, September the 9th, 1:30, Eastern time. So, thank you very much and have a great afternoon.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END