Centers for Medicare & Medicaid Services
Medicare and Medicaid EHR Incentive Programs and Certified EHR Technology
National Provider Call
Moderator: Diane Maupai
June 27, 2013
2:30 p.m. ET

Contents

Announcements and Introduction

Operator: At this time, I would like to welcome everyone to today's National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Diane Maupai. Thank you. You may begin.

Diane Maupai: Hi, everyone. This is Diane Maupai from the Provider Communications Group here at CMS in Baltimore, and I will be serving as your moderator today. I'd like to welcome you to this National Provider Call on Certified EHR Technology for the Medicare and Medicaid EHR Incentive Program. National Provider Calls are part of the Medicare Learning Network.

Before we get started, I have a few announcements. You should have already received a link to the presentation for today. It was in the announcement in the e-news. And there was also a link to it in both the confirmation and reminder emails that you received about this call.

If for some reason you didn't get it, that link was emailed to all registrants again today at 1 o'clock, 12:58, and those materials can also be downloaded from the National Provider Calls web page at www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the June 27th call from the list.

I want to remind everybody that this call is being recorded and transcribed. An audio recording and written transcript will be posted soon to the National Provider Calls and Events section of the MLN Connects National Provider Calls web page.

This call is the second in a series of five EHR calls. We were actually going to have six, but we're going to combine the last two. So the calls we have are scheduled for Tuesday, July the 23rd, and that will be on clinical quality measures; Wednesday, July the 24th, which will be on Stage 2; and then our third call will be Thursday, August the 15th, and that will be about payment adjustments and hardship exceptions. And I'll repeat that again at the end of the call.

At this time, I'd like to introduce our speakers. From the Office of the National Coordinator for Health Information Technology, or ONC, we have Asara Johnson, Program Analyst in the Office of Certification. And from CMS, from the Office of eHealth Standards and Services, we have Travis Broome. Travis is the Team Lead for Policy and Oversight in the HIT Initiatives Group.

Travis will start off with an overview of the EHR Incentive Program. Asara will discuss ONC's Health Information Technology Certification Program and the 2014 edition testing and certification. Travis will come back and talk about how certification fits into registration and attestation for the incentive. And with that, I will turn it over to you, Travis.

Presentation

The EHR Incentive Program

Travis Broome: Great. Thanks, Diane. As Diane mentioned, we're going to go ahead and talk a little bit about Meaningful Use, specifically Stage 1. This is really kind of geared for those folks coming in new to the program. If you've already attested to Meaningful Use, you kind of would have needed to already know everything and have done everything in this presentation.

I'm going to focus, like I said, on Stage 1, on Meaningful Use, talk about the capabilities of your EHR that you'll need to use. And I'll turn it over to my colleagues from ONC to kind of discuss how they are going about ensuring that your EHR technology can do all the things I just discussed.

So what is Meaningful Use? For those following with the slide deck, that's slide 5. Meaningful Use is, you know, almost an acronym, a phrase that we've adopted from the legislation that created the Medicare and Medicaid EHR Incentive Programs. It's kind of a catchall term for using certified EHR technology in ways that we think will accomplish the goals you can see on slide 5, so: improving quality, safety, efficiency in reducing health disparities; engaging patients and families in their health care; improving care coordination; population and public health. And we have to maintain privacy and security while we do that. Otherwise, the whole thing kind of falls apart around us. People won't let you share their records if they don't believe you can do it securely. They're not going to give you access to the data you need to improve quality and reduce disparities if they don't think you'll keep it private. So that's the linchpin to the previous four improvements.

So the next slide talks about the basic overview of Stage 1 of Meaningful Use, again coming in to become what we call a Meaningful EHR user and, therefore, be eligible for the incentives that are available under Medicare and Medicaid. In start – in Stage 1 of Meaningful Use, you do a reporting period of any 90 days in your first year, and then after that, a full-year reporting period.

Reporting is currently done through attestation. And what that means is you will generate your reports all in your own systems, all in your own way, and then you just come in to a website and input the data directly into that website for your attestation. You're just attesting to – providing us the data and attesting to its accuracy.

There's two – really two parts to becoming a Meaningful EHR user. There's what we term Meaningful Use, and what that ends up being in reality, as I'll talk a little bit later, is a series of objectives that are coupled with measures.

Then there's the other part, which is the submission of clinical quality measures. So, these measures are less directly related to the use of EHRs and have a lot more to do with using EHRs to collect data and to analyze data on clinical quality—obviously, hence the name. So if you go back to kind of slide 5, you know, the clinical quality measures you can think of are the measures of quality, the measures of successful care coordination, the measures of safety, while the Meaningful Use objectives themselves are about using the EHRs in such a way to improve those clinical quality measures.

Those Meaningful Use objectives really speak – are two forms. Some of them are just yes/no. For example, we had to maintain privacy and security. That is a yes/no objective that we'll talk about in a little bit.

Others are numerator and denominators, and so this might be: "I issued a thousand medication orders in the 90 days, and I entered, using computerized provider order entry, 900 of them during that period." So that's an example of a numerator and denominator.

Most numerator – all numerator and denominator objectives, Meaningful Use objectives, come with thresholds. The highest threshold we have is 80 percent. So, to meet certain objectives and measures, those three at 80 percent. You need to have – at least have 80 percent of your patients in your certified EHR technology.

So, Stage 1 of Meaningful Use for eligible professionals: There are 13 core objectives in 2013, and you need to do 5 out of 10 menu objectives and then 6 clinical quality measures. We'll talk about the details of clinical quality on a later slide. Starting in 2014, there are still 13 core measures, but the menu objectives go down from 5 of 9, and I'll talk about the reason for that in – on the next slide.

So on slide 8 you can see the listing of the objectives—you know, so improving care, efficiency, and – objectives. These are lumped into this box. And these are really processes—so, actual processes and capabilities of technology that we think will improve care, efficiency, and safety. So, you have computerized provider order entry, you have electronic prescribing. You have clinical decision support interventions. You have drug—drug and drug–allergy interaction interventions.

And then you have what we call data you can use and share. So there's another host of objectives ensuring that the data that's in your certified EHR technology can be used to power things like clinical decision support and can be shared for care coordination purposes across settings.

And then the next section, engaging your patients: And you can see this is where we have a transition: "Provide patients with an electronic copy of their health information upon request." That transition's to just making their patient information available online in 2014, and that is what contributes to the change in the number of menu objectives, as you'll see in a second. And then "Provid[ing] clinical summaries for patients for each office visit"—so this is the office visit summary.

And then "Conduct[ing] a HIPAA-compliant risk assessment that includes your EHR." So, we didn't change any of the HIPAA rules; all of the HIPAA rules are still the same. The only thing we ask for Meaningful Use is we're incentivizing you to bring this thing into your world, called EH – certified EHR technology, that has privacy and security implications. So we are just asking that you update your security risk assessment after you bring that certified EHR technology into your work – world.

That brings us to the menu objectives on the eligible professional side. And you see lots of the same breakouts here: improving care, safety, and public health. So, drug formulary checking interventions, generating lists of patients by specific conditions, medication reconciliation, you know, improving care coordination, and summary of care records at each transition of care/ referrals.

And so, most of our data was in the core, but we do have some in the menu here, so incorporating clinical lab tests as structured data. And you might wonder what do we mean by structured data? Structured data is data that's put into systems in a way that the system knows what it is and knows its attributes and, therefore, can use that information. I can type the word *aspirin* into Microsoft Word; it knows it's a word; it know – even knows how to spell it. But that's not structured data, that's just text. Putting *aspirin* into a certified EHR technology—specifically, in an RX norm format, which is the standard vocabulary for medication—now, that technology not only knows that it's a word, and it knows how to spell it maybe, but it knows that it's a drug, and it's a drug with certain attributes: that it thins out blood, so maybe it shouldn't be combined with other blood thinners, and things like that. So that's what we mean by structured data.

Engaging your patients, more engaging your patients' items: sending reminders, providing timely electronic access (that becomes redundant in 2014), patient education resources as identified by technology. And then, finally, improving public and population health: so, having the ability to send syndromic surveillance information electronically, having the ability to send immunization information electronically.

So Slide 10 is a little different for our hospitals. Our hospitals have fewer core objectives, but the same number of menu objectives and then differences in clinical quality.

So, on slide 11, we can see the core objectives for hospitals. Hospitals don't have e-prescribing, so that kind of explains one of the differences in the number of core objectives, but they still have computerized provider order entry, clinical decision support, drug – drug data is the same, as you would suspect; you know, if we want hospitals and physicians to be able to talk to each other, we need to be structuring the data and collecting the data in similar ways.

Patient engagement: again, making that patient information available online starting next year; this year and previous years, just providing that electronic copy upon request. Obviously, hospitals also subject to the HIPAA privacy rule, so have the same requirement for that security risk assessment.

Menu objectives, again, are going to look very, very familiar. An additional data element for hospitals: advance directive recording, slightly different engaging your patients, timely – like I said, timely electronic access moving to core.

The patient-specific education resources and public health: you have the additional measure of submitting reportable lab results, as well as immunizations and syndromic surveillance data.

So obviously, I didn't tell you everything you need to know about every objective. That would take more time than we have, and I'd probably lose you along the way. But if you have questions about any individual objective, we encourage you to go to our website and look up what we call our Meaningful Use Specification Sheets. So when you're into these sheets, it will tell you how it's measured, what the threshold is. It will link you to any Frequently Asked Questions about that particular measure and really give you the information you need to know on meeting those measures.

The other thing to keep in mind is when you're doing your implementation, when you're actually implementing your EHR, there's going to be lots of questions you're going to have about your individual implementation that we can't even fit on a spec sheet, much less on a Provider Call. When you're faced with those decisions, always move upstream. So the way Meaningful Use is structured is there's a measure that's linked to an objective, that's linked to a goal. When you're making all those decisions about how to implement, say, computerized provider order entry, well, the purpose of that is to get licensed health care professionals doing the order entry using computer assistance in the EHRs. The goal is to improve safety, efficiency, and quality for that one.

So when – if you defer, when you're doing – answering those questions about implementation, you know, ask yourself, "All right, if I go this way or I go this way, which one do I think, you know, will improve efficiency better? Which one is going to make the ordering process safer?" You can't go down that path necessarily every time you have that question, but if you go down that path most of the time when you have that as a question, you'll find yourself in a good place for Meaningful Use.

All right, moving on to clinical quality measures. The biggest thing to know about clinical quality measures that isn't on this slide is they are not dependent on what stage of Meaningful Use you are. They're dependent on the year, as indicated there on the slide. So this is slide 14 for those following along.

This year, three core CQMs or three alternate cores, and then three CQMs from a list of 38. Next year, life gets a little simple – simpler. There's a list of 64; you need to pick 9 out of that 64, covering three care domains. There is no secret to the care domains. There's actually six in total, so you need to cover three out of six. Every measure is on our website, and every measure is linked with a specific care domain. So, no mystery about whether you're covering the domains or not. There is no performance threshold; you're just giving us the numbers.

We always want you to report directly out of your certified EHR. One of the main points of having this is as part of Meaningful Use is to try and automate and radically reduce the effort required to do clinical quality measurement. So always give us the report directly out of your certified EHR, even if that might not be the most accurate piece.

Reporting of zeros is acceptable. You know, if you have a zero in the denominator or a zero in a numerator, that's fine, that's just your practice.

And there may not be CQMs applicable to everyone. Some specialists, even among the list of 64, much less the shorter list of 38, may not find one. That's OK. You can still be a Meaningful User. You just – when you go on to the system, you pick some, and just zero across the board.

But again, always report out of your EHR. That might not be exactly reflective of other data sources you have, that isn't – what you do in that situation does not changed what you report to us. You still report whatever came out of your certified EHR. What you should do in that situation is then work with your EHR developer to try and make what's coming out automatically more reflective of your practice. Because, as I said, no thresholds; you don't have to worry about that.

Up in – on slide 15, it should say EH (sorry about that) clinical quality measures. Twenty thirteen, it's a 15 out of 15 proposition. Starting in 2014, the list got longer, but the number hospitals have to do only got up – went up by one, so it becomes of piece 16 of 29, again, covering three care domains. Again, zero is acceptable, no thresholds, always report directly out of your EHR.

And with that, I'll turn it over to my colleague from ONC to talk about the certification program.

Certification of EHR Technology

Asara Clark: Thanks Travis. This is Asara Clark from ONC. So we're just going to start off and get right into the information on slide 16. The – we're going to talk today about the ONC Health IT Certification Program, formerly referred to as the Permanent Certification Program.

We're now operating fully in the ONC Health IT Certification Program. The temporary certification program sun set October 4th, 2012, effectively launching the ONC Health IT, quote, "Permanent," unquote, Certification Program.

A lot of the same objectives with the two programs. The ONC Health IT Certification Program is just a second part of ONC's two-part approach to establish a transparent and objective certification process. Objectives are kind of twofold here. As you see in the lower boxes, we want to give providers and patients confidence that the electronic health IT products and systems they are using are secure and can work with other systems to share information accurately.

Moreover, we want to provide a defined process to ensure that EHR technologies meet the standards and certification criteria adopted by the HHS Secretary to assist providers with—and hospitals with—achieving Meaningful Use objectives and measures established by CMS.

We're going to move on to the next slide, slide 17. This gives an overall structure of the ONC Health IT Certification Program. Main things that have changed from the temporary program to our new, more permanent, the health IT certification program, is that, one, ONC has added a layer between ourselves and the testing and certification entities. We have accreditation bodies that now oversee test labs and certification bodies.

And then, the other thing is that the actual testing and certification is done separately. That said, an organization can get accredited to perform testing, as well as to perform certification, but it's through a totally separate accreditation process, and it has to be, of course, a firewall between the two functions for this one organization.

NVLAP, the National Voluntary Laboratory Accreditation Program, accredits the testing laboratories, and the ONC-approved accreditor, which is ANSI, the American National Institute of Standards and Technology, accredits the certification bodies.

The accreditation bodies are held to the International Standard 17011, as the test labs are held to International Standard 17025. Plus, there's a NIST handbook—there's an overall handbook for test labs as well as a NIST handbook that's specifically for the Health IT Certification Program, and that will be the 15031 that you see listed there on the left-hand side. The certification bodies are held to ISO – International Standard Guide 65.

So these are the regulations that we have in place, enforced by the final rules, and what we basically structure our program based on for moving forward for the operations of the certification program.

So, moving on to slide 18, where we kind of show the sequence for the ONC Health IT Certification Program; whereas, again, the organizations that perform testing and certification was performed together as one entity, it's a little bit different now with the permanent program.

The developer or the vendor creates a product. They take it to the accredited testing laboratory, have it tested. Once it successfully passes certification, it is then sent to the ONC-authorized certification body, and then they, you know, the certification body determines whether – or makes the final determination on certification for those particular products.

The products that successfully pass certification are submitted to ONC by the ACB for posting on the CHPL. ONC validates, posts to the CHPL. The providers can go in and see, you know, what products are certified, choose their product, confirm a product has been certified that they're currently using, so on and so forth, generate their EHR Certification ID for submission to CMS for attestation for Meaningful Use. And CMS actually goes back and validates those EHC – EHR Certification IDs from the CHPL.

Moving to slide 19, I'm going to talk a little about the CHPL—or quite a bit about the CHPL, because there have been updates made to the CHPL, and sometimes it gets a little confusing when using the CHPL. And just based on feedback, we wanted to make sure we provided some clarification on the new structure and the new uses and the new capabilities.

The CHPL still provides an authoritative, comprehensive listing of all certified complete EHRs and EHR modules that have been certified under this ONC Temporary Certification Program, as well as the ONC Health IT Certification Program. It's managed by ONC. We're currently in CHPL 3 – the CHPL is currently in – version of the CHPL is 3.0. Version 3.0 of the CHPL was launched in January of 2013. It supports 2011-edition testing and certification, 2014-edition certification, as well as a combination of 2011 and 2014, and we'll talk about that in a little bit.

It also allows downloadable CHPL Product Information report. We update it weekly and it contains all – and this report is – this report is updated weekly and it contains all CHPL data.

We're moving on to slide 20. This is on – this just touches on the various CHPL users. The CHPL is intended to be just a list of certified products, but they have many users and they – and who use the CHPL for different reasons.

The CHPL is used by EHR vendors who have been certified, and they want their products listed on the CHPL, and it proves that they've been certified under our program, under the ONC Certification Program.

They also have the use from the providers – the eligible professionals, which include providers, hospitals. And they can find products, confirm a product they're using is certified, get their EHR Certification ID, and so on and so forth.

And then CMS also uses the CHPL to validate EHR Cert ID and to track certain trends as it relates to the data on the CHPL as far as the vendor product, practice type, ACB that certify the product, complete versus modular. It's become kind of a data tracker, as well.

Moving on to slide 21. The CHPL also supports 2014 certification. Starting in 2014, all EHR incentive program participants will have to adopt certified EHR technology that meets ONC standards and certification criteria adopted for 2014-edition testing and certification. This includes the base EHR – the –EHR, which for 2014 certification, eligible professionals must have EHR technologies with capabilities certified to meet the base EHR definition. I'll talk about the definition of base EHR in just a couple of slides. Essentially, everything that is certified to the base EHR definition will appear on the CHPL.

The CHPL also demonstrates and allows you to see the clinical quality measures that are met, core and menu measures. As Travis stated earlier, he went into great detail about this, so I really don't have to go into it, but basically, your approach to meeting the menu and core set of measures varies based upon your practice setting and the edition of certification that you seek to meet for attestation.

We published the 2014-edition test method in December of 2012. You can find that on our website that lists all the test procedures, test data, test tools associated with the 2014 edition test method. But the biggest thing is, for 2014, we implemented the base EHR definition, and again, I'll talk about that in just a couple of slides.

So, while we're making sure that the CHPL can support the changes in certification for 2014-edition certification, there's a period in 2013 where providers and hospitals can meet the definition of complete certified EHR technology by using a combination of 2011-edition certified products and 2014-edition certified products. So the CHPL has to also support that capability.

When you go into the CHPL now, you'll see that there are different – you can go in under 2011 edition, 2014 edition, or 20 – a combination of 2011 and 2014 edition. What that means is that

everything that's been certified to 2011-edition certification is going to appear under the 2011-edition door. Everything that's been certified under 2014 edition is going to appear under the 2014 door. But the combo door is going to list everything that's been certified under both.

And the EHR certification – the CMS EHR certification IDs that are generated from each door are different. Even if a product that's the same – that's certified to 2011 edition, the same exact version is under the combo door, it's going to generate a different certification ID based on the fact that it's being used in a combination of products that are using both editions.

So we get a lot of questions about why is the cert ID different when you go in this door versus the other. That's why. It's to make a distinction that this product is being used along with products from the other edition that is currently available. That will drop off, of course, when that option is no longer available, but right now the CHPL has to support that.

So while it's a little confusing, it's – it's – we try to put, you know, instructions on the front – on the home page of the CHPL to explain it, and we're open to taking questions about that, but that's the gist of it.

This – slide 22 actually kind of gives an equivalency table which is offered and available in the final rule for 2014 edition standards and certification criteria, which kind of gives you a cross-reference of what the certification criterion name is, how it's met in 2014, what's the criterion number for 2014 versus 2011.

Move on to slide 23. This is – touches on a definition of a base EHR. Travis touched on the differences in the requirements for clinical quality measures for eligible providers versus hospitals. This just breaks it down for you again in a different way, in how the CHPL generates IDs based on the – the base EHR definition. I'll move on since we covered this more so earlier on.

The test method, which I talked about a little earlier for 2014, was released recently—December 14, 2012, to be exact. This slide just kind of breaks down the differences in the test method from 2011-edition certification and 2014-edition certification. For 2011, the test method was aligned to Stage 1 of Meaningful Use. There were 42 certification criteria; 20 criteria required standards, and 14 criteria had test data associated with it, and we had two test tools.

For the 2014 edition, it's aligned with Stage 2 Meaningful Use, and everything has increased a bit. There are 49 certification criteria, 28 criteria require standards, 29 criteria have test data – we provide test data, and there are 9 test tools. This adds a bit more rigor. It increases clarity on requirements and what's needed to – you know, we try to eliminate some of the ambiguities and give clarity on what exactly we're looking for, and the use of test tools and standards increases the efficiency in testing. And those were our goals. So that's just a little bit of data that gives you the comparison between the two test methods.

Moving on to slide 25: So, for test procedures it's required by regulation that we offer unit-based testing, which basically covers each and every criterion – certification criterion adopted by the Secretary. Twenty eleven-edition testing only allow for individual testing of each certification

criteria – criterion, which is this unit-based testing, independent data and results, and basically, you know, made it so – it makes it so we can offer the modular certification, but we could – we only had test procedures to do unit-based testing.

The 2014 edition, we have proposed an optional approach—and I've just moved on to slide 26—an optional approach which incorporates scenario-based testing. We still have to offer unit-based testing for 2014-edition testing, but we've proposed this approach as a scenario-based testing. We've got – gotten a lot of feedback from external and internal stakeholders, basically saying, you know, once the product is being implemented in the clinical environment, it's difficult to work – for providers to work in the workflow – the clinical workflow that they use in their day-to-day use.

So what we have tried to do is create scenarios with the test procedures – the individual test procedures that will result in a more threaded test scenario, where it makes sense for the provider and how data is entered in and exchanged in the EHR.

So our goal is to provide a more clinically plausible workflow for the implementation environment in doctors' office and hospitals, and when used in these environments, for the workflow to be more efficient and time efficient, and so on and so forth.

This also allows for – if you have a scenario where you maybe don't need to test one of the parts, one of the procedures that are in there for you to kind of plug it in and plug it out and you can still have that work flow for you. Say you don't need – you're going for gap certification, and you don't need one part of the scenario because you've already been certified to that particular criterion included in that scenario, you can enter the data that you have from that particular test without actually testing for it.

So we're working this through. This is all under development. We've done some pilots and it's still coming. But I just wanted to kind of let the providers on the call know that we are working towards trying to present more clinically plausible test procedure scenarios for implementing in the actual clinical environment.

And that said, I'll pass the call back over to CMS on the next few slides of the presentation.

Travis Broome: Thank you.

Keypad Polling

Diane Maupai: Thank you, Travis and Asara. At this time, I'm going to pause for a few – for a minute or two to complete keypad polling, so that we have an – CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results. So, Victoria, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using only one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if there is only one person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Thank you. I would now like to turn the call back over to Ms. Diane Maupai.

Diane Maupai: Thank you, Victoria. And I'm now in turn going to turn the call back over to Travis, who's going to say a few words about how certification fits into registration and attestation for the incentive.

Presentation (continued)

How Certification Fits with Registration and Attestation for the EHR Incentive

Travis Broome: Well, thanks.

So on slide 27, you can see our login screen. So this is what you first see when you come into the registration attestation system. For you it's really just a website. You will log in using your NPPES and NPI web user account name. So if you're acting on behalf of a provider, you still use your own accounts, but the providers for whom you are linked to their NPI will show up on the next screen. Or certainly if you are the eligible professional themselves, then you're – obviously, will show up on the next screen after you log in with your own credentials.

Once you log in, you'll see several tabs at the top. For registration, attestation, and checking your status of your application, you need the registration or attestation status. When you click on registration, it'll – like I said, all the information there at the bottom of the screen 29 comes in from your NPPES accounts.

If you did register for multiple accounts, you'll be able to multiple – register for multiple providers on their behalf, or if it's just one, it'll appear just as it does here.

As you go through registration, you will be given the option—it's circled there in red on slide 30—to enter your CMS EHR certification number, which you got from the CHPL. You do not have to put it in for registration, although you certainly can. If you do put it in for registration and want to change it later, because something happened or for whatever reason, that's fine, too. You must put it in before you attest, however.

Your CMS certification ID number comes from the CHPL, as you can see on – and then it goes into – and that's what the CHPL calls it; they call it the CMS EHR certification ID. And that is your EHR certification number in the registration and attestation system.

So when you go into the CHPL, you put those information in there. You will get one unique number that is unique to you and your combination of products. And then you will come over to our system and input that number in the field for EHR certification number, either optionally at registration or required at attestation.

And with that, I'd encourage you to move over to slide 32, where it just has some helpful resources on Meaningful Use and for certification. And I think we'll move onto the Q&A now.

Question-and-Answer Session

Diane Maupai: And that's right, Travis. So, before our experts take your questions, I want to let you know that we're going to be joined by Maria Michaels, who's an expert on clinical quality measures, and Jason McNamara, who's an expert on the Medicaid incentive program.

Before we begin, I like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization.

In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you'd like to ask a followup question, or have more than one question, you may press star 1 to get back into the queue, and we'll address those additional questions as time permits.

All right, Victoria. We're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to 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.

Please hold while we compile the Q&A roster.

Your first question comes from the line of DeeAnne McCallin.

DeeAnne McCallin: Hi, this is DeeAnne with CalHIPSO. I just want to check if you can hear me.

Travis Broome: We can hear you.

DeeAnne McCallin: Great, thanks. On the CQMs – great presentation today, by the way. On the CQMs, there was messaging from CMS a couple of weeks ago, I think about 2 weeks ago, that said, "However, all versions of the CQMs for Meaningful Use beginning with those finalized December 2012 will be accepted until Stage 3 rulemaking."

So that seemed to confuse us some. Is 2014, January 1st – is it that list of 60 – was it 64 and choosing 9? Or can people still use the 2011 through 2013?

Travis Broome: Starting in 2014, everyone, regardless of stage, will be using the 9 out of 64.

DeeAnne McCallin: Great. And most especially, because that's what the EHRs will be certified to be using.

Travis Broome: Exactly.

DeeAnne McCallin: OK, thanks.

Operator: Your next question comes from the line of Therese Kaag.

Therese Kaag: Hi, this question is for Travis also. Travis, I have a question for you on one of the menu measures out of Stage 2, regarding progress notes.

Travis Broome: Yes.

Therese Kaag: I wanted to verify that I'm interpreting that question – that measure correctly. If a progress note exists currently in the patient's electronic chart as of today in 2013, and we look to attest on that measure in 2014, am I understanding that the fact that a progress note exists that's been signed and is searchable would make that creditable?

Travis Broome: Yes. Presumably you would have seen that patient again for them to…

Therese Kaag: Correct.

Travis Broome: … even be in the denominator, but if you did see them again and for whatever reason didn't create a note for that visit, you know, the previous note would work. You know, this kind of is a thing I tell people when they're considering the measures is to not add what I call "ands," or adding ands to the measure. So the measure for this one is simply: in the denominator, have all the patients I saw during the reporting period, and I check their records to see if there is one progress notes that meets the criteria, and if I answer "yes," I'm done.

Therese Kaag: Great. That's what I thought and I just wanted to clarify. Thank you.

Operator: Your next question comes from the line of Molly Minehan.

Molly Minehan: Hi. Hi, this is Molly from ReportingMD. I saw on slide 9 it said "must choose"—for the public health menu objective—"must choose one or meet the exclusion for both." We have a client who is – who is the State does not allow them to submit electronic data to immunization registries. And we called into the EHR communications help line to just make sure that, if they're excluded from that first measure, that that satisfies their health/public health menu objective and counts towards their five menu objectives. And – but I'm just a little confused because your language said "or meet the exclusion for both." So…

Travis Broome: Right. So basically what that means is he can't meet the exclusion for one and choose to do that one if you can meet the criteria and attest "yes" to the other. In your situation, highly, highly, highly – I assume you're talking about eligible professional, not a hospital?

Molly Minehan: That's correct.

Travis Broome: Yes. Highly, highly unlikely that they have the ability to meet syndromic surveillance, or a public health agency that will allow syndromic surveillance. There's only a handful in the country, and those are…

Molly Minehan: OK.

Travis Broome: … even those – those places, it's very limited. So…

Molly Minehan: OK.

Travis Broome: … it's most likely they will meet both exclusions, but they do need to meet both exclusions. So…

Molly Minehan: OK.

Travis Broome: … to flip it around the other way…

Molly Minehan: Just the language – some of the language in one of the – some of the guides said something like in – starting in 2014, they will not be able to use that exclusion to count toward their menu objectives, and it just made it sound like you could get away with just doing the one exclusion, but hopefully, like you said, we will still be OK.

Travis Broome: Yes, there is a change in 2014. It's not specific to public health.

Molly Minehan: OK.

Travis Broome: Right now, the way the menu works is, whether you meet an objective based on the measure, or whether you can exclude it, it counts towards the five. Starting in 2014, exclusions will no longer count towards the five.

So, let's – if we fast forward our situation to 2014, and let's say you still meet the exclusion for syndromic surveillance and for immunizations, you would need to pick five out the remaining eight for which your provider can actually do the measure, and those exclusions would no longer count towards your – the five you need from the menu. So that's the change.

Molly Minehan: OK, so even though they wouldn't have a public health objective met …

Travis Broome: Oh, yes, they'd still be fine.

Molly Minehan: OK. Thank you.

Travis Broome: You're welcome.

Operator: Your next question comes from the line of Mary Schrenker.

Mary Schrenker: Hi, this is Mary Schrenker. I'm from the Florida Medicaid agency that's responsible for the EHR Incentive Program. And I have a question about the combination of 2011 and 2014 certification.

Travis Broome: Sure.

Mary Schrenker: We're trying to figure out how to tell providers what they should do, which door on the CHPL website they go in to get a certification number. So, for example, if I had a system that was a complete system certified to the 2011 standards, and now my vendor has upgraded some – has – like, some module has now been upgraded for 2014, what do I do?

Asara Clark: So, when you go to the CHPL, if you're going to meet the Meaningful Use requirements using just the complete EHR that you had for 2011, you would go to 2011, through the 2011 door, because – just because a vendor upgrades a product and gets that upgraded product, that new version certified, doesn't decertify the previous version that went through certification.

So that would depend on whether you're just going to keep what you have and use the 2011-edition certified product, the complete EHR, or if you're going to keep that – let's say, the module that they updated—you like it and you'd rather use the functionality from that module—that's been certified under 2014 criteria, so you would go under the combo door, because you would want to put the complete EHR that you're using as well as the – from the 2011-edition certification, as well the module from the 2014-edition certification. Those would both be listed under the combination door, and your CMS EHR cert ID would reflect that.

Mary Schrenker: OK, so I could go through the combo door. OK, and so then that now gives me a certification number that is a 2014 certification number?

Asara Clark: It's going to give you a certification number that's reflective of the fact that you use the combination.

Mary Schrenker: Of what I pick.

Asara Clark: Yes.

Mary Schrenker: OK. And so then, when you do away with the three doors, what happens?

Asara Clark: Well, when everyone is going to be required to use 2014-edition testing and certification – well, let me take that back. When the option to use the combination goes away, after 2013, then that combination door will go.

Mary Schrenker: After 2013?

Asara Clark: Yes. We actually have an FAQ. It depends on if you're a hospital or a provider, and we have an FAQ on our website…

Mary Schrenker: Do you know what its number is?

Asara Clark: I believe it's 17. I will check really quickly and chime back in just to make that available before the call is over. But I believe it's a – I'm pretty certain it's FAQ 17 in our Regulations FAQ on ONC's website.

And it breaks down: prior to fiscal year 2014, after fiscal year 2014, and it also addresses calendar year—you know, how to meet the definition of complete EHR technology. And it breaks down when you can use the combination and when you have to switch over, and so on and so forth. But…

Mary Schrenker: I hate to, like, hog the call up here, but I'm still really, really confused, because – so, if I've got the 2011 complete, I've got my 2014-certified module, what has to happen for it to just be 2014? Do I have to get a whole new system?

Asara Clark: That there – that depends on what stage of Meaningful Use you want to attest to, that depends on what edition. If you're shooting to just attest to 2014-edition certification, then you would need to get it – a certified product that's been certified under the 2014-edition certification criteria.

Mary Schrenker: So I have to go get a whole new system? I've already spent all this money on one that was certified for 2011. My vendor has given me this upgrade that's 2014-certified. And now I have to go get a whole new system?

Asara Clark: Well, you mentioned that the 2014 certification was for a module.

Mary Schrenker: Right.

Asara Clark: Now, that doesn't qualify you for Meaningful Use. You have to use complete EHR – complete certified EHR technology. If they had upgraded to 2014 and that's to a complete EHR, then that's something different. But I was just responding based on you said that they had…

Mary Schrenker: Right. So, I've got this module…

Asara Clark: Right.

Mary Schrenker: …but that doesn't really give me 2014 certification by the module.

Asara Clark: It gives you 2014-edition modular certification.

Mary Schrenker: And I have to have 2014 complete certification?

Asara Clark: You can attest still to 2011. That – that's a business decision that, you know, we can't advise on. But if you wanted to attest to – with 2014-edition certified products, a 2014-edition certified module would not meet the requirements because it's a module.

Mary Schrenker: So, for 2014 – so we're talking for 2014, I'm trying to figure out what I need to do for 2014.

Diane Maupai: Can I – this is Diane, can I break in here for a second? It seems like this is maybe something that is just your issue, and maybe you could email us with your specific situation, and we can get back to you. An email address that you could use is nationalprovidercalls, and that's *calls* plural, @cms.hhs.gov. That's nationalprovidercalls, with an S, @cms.hhs.gov.

Asara Clark: And I encourage you to check out FAQ 17 on ONC's website under Regulations FAQs, because it really gives an indepth breakdown of how this all works.

Diane Maupai: Thanks, Asara. We'll move on to our next question.

Operator: Your next question comes from the line of Joel Schaefer.

Joel Schaefer: Hello, this is Joel. Can you hear me? Hello? Hello?

Travis Broome: Yes, we can hear you. Joel?

Joel Schaefer: Sorry about that. I guess I just put mute on. Anyway, originally I was thinking Stage 2 consisted of 17 core, and 3 out of 6 menu items. Now I see it's 13 core, 5 out of 9 menu items. But then – and I'm referring to eligible professionals, not EHs – but then when I count the core objectives on slide 8, I see – 1, 2, 3, 4 – anyway, one less than 13 – no, 14. So …

Travis Broome: So – yes, the slide is for Stage 1. There aren't any slides in here for Stage 2. You are right on your Stage 2 count; it is 17 core, and 3 out of 6. But the slides here are all for Stage 1, which is 13 core, and 5 out of 10 menu.

When you look on slide 8, you know, be sure you don't double-count the two in engaging your patients, because one is only available for 13, and the other for 14. So 1, 2, 3, 4…

Joel Schaefer: OK. So that's referring to Stage 1. Well, that clarifies that. OK, so my real question is in regards to Stage 2. The CPOE measure consists of three separate pieces, right— 60 percent on medication, 30 percent on labs, and 30 percent on radiology. The question is, is that an either/or? In other words, if I'm doing greater than 60 percent on medications, do I need to report on the other two measures?

Travis Broome: Yes, they're each treated separately. So yes, you would need to report on, kind of, all three. And they have different thresholds to reflect the fact that some of them are new and

some of them are old. So you have to do all three—radiology, lab, and medication—unless you're in a situation where you just don't order, say, radiology at all. And the thresholds for radiology and labs, our new ones, is 30 percent, and the threshold for an old one, medications, is 60.

Joel Schaefer: Yikes. So if you do order radiologies, maybe every now and then, and you do order – well, everybody orders labs, but the ordering interfaces for the systems are going to be the hard ones. I mean, the radiology order interface is just really hard to come by as far as EHRs. So…

Travis Broome: Well, one thing to keep in mind for CPOE, that there isn't necessarily a transmit – there isn't – not "necessarily," there just flat out *isn't* a transmission requirement. So I completely agree that CPOE is most beneficial when you can both enter the order into the system and have the system talk to the radiology department or the lab. But that second part isn't necessarily required. So, you know – so it might be that you have to basically – you enter it into the system, but to actually get it to go to the lab, you know, it might go by eFax or something. Or worse case…

Joel Schaefer: Got it.

Travis Broome: …you print it and mail it or whatever. Obviously you don't mail it, but, yes.

Joel Schaefer: Got you, OK. So, just keeping track of it in the EHR meets the requirements. Actually having it generated or electronically transmitted is not necessarily required, but…

Travis Broome: Yes.

Joel Schaefer: … I do need to report on the three.

Travis Broome: Correct.

Joel Schaefer: And there's no exclusions?

Travis Broome: Well, like I said, there is an exclusion. I was trying to look it up for you real fast – there's certainly an exclusion if you have zero. I was trying to think if there – I was trying to remember off the top of my head. Yes, it's actually for less than 100. So if you write or order less than 100 medications or less than 100 radiology orders or less than 100 labs in a given reporting period, then you can meet the exclusion for that individual measure.

Joel Schaefer: OK, and I hate to – hate to continue on this, but on the less than 100, that was kind of the exclusion for Stage 1 as well. But I've been asked a lot lately, for people that are in Year 2, Stage 1, is it still the 100 threshold? It was …

Travis Broome: It's still 100. We had put in our Stage 1 rule and no – nobody really looked at it, but we pretty much said in the Stage 1 rule that we were setting the threshold for a year, and basically giving a gift to the folks in the 90 days so that they didn't have to remember two

thresholds, depending on where they were. But the 100 was designed with the year in mind, not with the 90 days in mind.

Joel Schaefer: OK.

Travis Broome: All right.

Joel Schaefer: Thank you.

Travis Broome: You're welcome.

Operator: Your next question comes from the line of Beth Hall.

Beth Hall: Hi, this is Beth Hall from NJ-HITEC. We heard that EPs who can demonstrate that they fund the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for Meaningful Use without reimbursement from an eligible hospital or CAH—in lieu of using the hospital's CEHRT—can be determined non-hospital-based and potentially receive an incentive payment.

Travis Broome: Yes.

Beth Hall: Can you verify this and tell me when this was implemented?

Travis Broome: Yes, you can do that. So, the keyword is – there is "in lieu of." So you have to be using – when you're in the hospital, you have to be using that EHR *instead* of the hospital's, not *in addition to.*

But if you are in that circumstance, that was implemented at the beginning of this year, and we are anxiously awaiting our first person to apply for it. So if you would like to be that person, and are in that situation, I'll have Diane give the email address again here for you, and you can contact us and we'll get you rolling on that process.

Beth Hall: OK, thank you.

Diane Maupai: Yes, that email address: nationalprovidercalls@cms.hhs.gov. Next question?

Operator: Your next question comes from the line of Grace Escobar.

Grace Escobar: My question was already asked – answered. Thank you very much.

Operator: Your next question comes from the line of Lili Gipson.

Travis Broome: Hi, Lily can…

Lili Gipson: Yes, I have a question. A lot of the criteria for the Meaningful Use core and the Meaningful Use menu measures are all geared towards medicine, and I'm in a chiropractic field.

Travis Broome: OK.

Lili Gipson: So it's hard for us to answer. Most of them exclude us, and it's very – it's very scary to answer a question that – or to try to answer a question that you know clinically doesn't apply to you because you never take labs – you – in my practice…

Travis Broome: Sure.

Lili Gipson: … I rarely x-ray, and we don't refer out too often. It does happen, but mostly we get referrals. So are they adjusting the procedure to compensate, or to assist doctors that are not medical doctors?

Travis Broome: Well, the – I mean, as you pointed out, the way we kind of go about that is through exclusions. I can certainly understand the trepidation to hitting the button on, you know, things with phrases like "never," but, you know, I certainly encourage you – but, you know, our method, for now and certainly in the foreseeable future, is through the exclusion methods. So if you have...

Lili Gipson: … probably pretty much excluded from everything, just about. I mean, there's very little that we're included in …

Travis Broome: Sure. I mean, you know, as a chiropractor you're probably looking at – you know, if you don't order medications then, you know, then you're looking at no e-prescribing, no CPOE. (Inaudible), that piece you would actually have, but again, MedList you wouldn't have, you know, well, you wouldn't have – or, you know – so some of the things, you might end up with small numbers or nothing on the list. I mean, you – in my experience, you know – one piece of advice I give specialists that tell you "we don't collect all this information," a lot of them collect~~ed~~ it – you know, check out your new patient intake form. That's not in chiropracty in particular, but a lot of dentists kind of went, "I don't do any of this stuff," and then they took a look at their new patient intake form and went, "Oh, wait—half of this stuff is on here," you know, in regards to meds. So, I don't give meds, but I do ask them about it, so I have that in the MedList, et cetera, et cetera.

We certainly have had chiropractors, many – several – not many thousand, but well over 1,000 come in and successfully attest. But if you have any specific concerns about an individual objective, you know, just fire off that email to Diane, and we'll work it through you – with you. And certainly, if you run into one whether is no exclusion, but you don't feel like you can meet it, let us know that too, because that would be a first.

Lili Gipson: Well, I just went through an audit – I just went through the audit for my first year and...

Travis Broome: OK.

Lili Gipson: ...and it was real – it was terribly painful trying to prove that I was doing what I said I was doing because of not...

Travis Broome: Because you had so many low numbers and stuff that the auditor was not …

Lili Gipson: Yes, exactly. Exactly.

Travis Broome: That's a good point, and we'll take that – take that advice back and feedback back to our auditors and make sure that they're taking into consideration what type of provider they're asking this stuff of when they're...

Lili Gipson: Yes, because I was treated in the ...

Travis Broome: ...evaluating the information.

Lili Gipson: …treated in the medical field but not able to comply accordingly, and not that I didn't want to, but most of it does not apply to us.

Travis Broome: OK.

Lili Gipson: OK.

Travis Broome: Thank you for the feedback.

Operator: Your next question comes from the line of Kristan DeGraeve.

Kristan DeGraeve: Hi there. Thank you for your presentation today. My call, or my question, is specific to the 2014 objectives and the public health reporting for ELR.

The implementation guide indicates that what should be formatted, or the way that the results should be formatted, is in a specific, you know, HL7 2.5.1 format, and then that the content should include vocabulary sets for SNOMED CT and LOINC, which certified EHR can accomplish, but if you're utilizing a reference lab who is certified from a separate entity, and/or – you know, or submits as the performing lab under a different set of criteria, how is that accomplished?

I mean, does it – does that mean that those results are not – are excluded from the data set for ELR reporting? Or that – or do the reference labs have to send that data in the exact same format that is expected from the entire, or the complete EHR?

Travis Broome: I'm not 100 percent sure I follow your question, but the – yes, so the certification piece is to make these minimum of capabilities – you know, which specific data element and how they want it is really driven by the people who want it. Obviously they have to use the HL7 message wrapper because, you know, that's the whole idea.

But whether – you know, if you can't give it to them in LOINC, they don't want it at all, or they can't accept it whether it's in LOINC or not—you know, that would be dependent on, you know, which public health agency you're actually reporting to. Some of them, and you mentioned reference labs—some of them don't want reports from anybody but the person who did the lab.

So if you're using a reference lab, you wouldn't be the one reporting to them, the reference lab would be. If, you know, others will take it from, you know, downstream, if you will, in which case, you know, if your certification can add the LOINC in and that's what they want, great; if it can't, it can't.

But, you know, those specifics about what exact data comes out are really what's – would come from your public health agency—meaning, well, you know certification creates certain capabilities, and if, you know, you run into problems where your public health agency wants something beyond your capabilities, beyond a certified capability, that's when you're looking at an exclusion scenario.

But there isn't a requirement that because your EHR *can* add the codes, you *have* to add the codes if your public health agency doesn't want them.

Kristan DeGraeve: OK, so if – so just to clarify or make sure that I understand: If the – if I'm audited, then, I'm audited not based off of the ONC-established criteria for that objective, but rather, the public health agency who is accepting or receiving those results.

Travis Broome: Yes, and we're talking about a yes–no measure here. So, I mean, you know, the auditor in this case, is – if you're actually sending results, which it sounds like you are, you know, they're going to – they're basically going to say, you know, "Oh, you have a link to your public health agency? All right, give us a couple of examples of a couple submissions." You know, probably redacted, and that's it, and they move on.

There's no thresholds, there's no numbers where they're going to be like, "Oh, I need, you know, 1,000 of them and, you know, 800 needed to be coded." That's not how the public health measures work. They're simply going to look to establish that electronic communication. Once they establish that electronic communication, they're done and going home or moving on.

Kristan DeGraeve: OK, thank you.

Travis Broome: No problem.

Operator: Your next question comes from the line of Ivy Baker.

Ivy Baker: Hello. Travis, first of all I want to tell you that we love you. We think you rock, and we really enjoy these calls and appreciate the time you guys put into putting them together.

Travis Broome: Thank you.

Ivy Baker: They help us a lot. My question is related to the statement that follows many measures in the additional information section that says, "The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology."

This becomes critical to us because we deal with nursing facilities, and they require us to write all of our orders for their facilities. We can't submit them to them electronically. We can't record it in our electronic system and hand it to them. We have to handwrite it. So we're doing a lot of duplicate entries where we're entering it in the EHR and handwriting it.

Can you just clarify? Does that mean the patient – what – just clarify that statement to me. How would that…

Travis Broome: Well, so that statement means if you don't keep the records for the patient in EHR at all, then you don't have to include them for those measures. It's not a measure-by-measure determination, though, so I don't know how helpful it will be to you in your situation.

So, it's not like you can say, "Oh, for CPOE, I keep 'they're in,' for problem list they're out." It's an all-or-nothing, across-all-the-measures thing. You know, your – you know, in that situation with the nursing home, especially with a nursing home that's so back there that they're actually having you handwrite as opposed to…

Ivy Baker: Yes.

Travis Broome: … just using paper, you're probably looking at more of our multiple location thing where – but that – with that being said, I don't know what your volume in the nursing home is. So, the multiple location piece…

Ivy Baker: A hundred percent is in 45 different nursing facilities. We are the physician, we have an EHR system, but it has nothing to do with the facility. But what I'm hearing you say is to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

Travis Broome: It's across the board.

Ivy Baker: But I couldn't maintain any part of their record electronically.

Travis Broome: Right.

Ivy Baker: And the reason I'm asking this is because there's a clarification for Stage 2 regarding CPOE. It's a comment on the CMS website, and it says, "Commenters that oppose the proposed denominator did so for one of two reasons. Either they were concerned with the burden associated with counting paper or other orders that are never entered into CEHRT, or that require a higher performance." And then the answer is, "However, as discussed previously, we are leaving open the option for limiting certain measures to only those records maintained in CEHRT. As this is one of those measures, there is no reason to change the measure to

accommodate patient records not maintained, as the provider can choose to not include records not maintained in the denominator," which made it sound more like, "OK, we maintain the problem list electronically, but we don't necessarily maintain the prescription or lab orders electronically."

Travis Broome: Yes. So, yes. The fact that it was linked to CPOE really just has to do with CPOE came first. You know, I know, in your situation that doesn't – you know, you have kind of a unique situation that if you want to talk more about it, feel free to send an email to the thing.

But yes, it is across the board. Otherwise, you can imagine, you know, that that would just become a loophole of gynormic proportion, because anybody could just choose not to do CPOE because they would just say, "Oh, we don't – we do that part on paper, so we don't have to worry about it."

Ivy Baker: Right. But – so the limitation really doesn't help you at all because you're required on 80 percent of your population to maintain…

Travis Broome: Yes, the limitation…

Ivy Baker: … no matter what.

Travis Broome: Absolutely.

Ivy Baker: So you're only able to exclude, then, 20 percent of your population in order to qualify for the program.

Travis Broome: Yes. The limitation was really created back in the beginning of the program to deal with, you know, things like workers' comp, where – you know, a small piece were for whatever reason, you might have to keep paper – you know, complete paper records.

Ivy Baker: Yes.

Diane Maupai: Well, listen, thank you, everybody.

Travis Broome: You tell those nursing homes. Tell them it's – it's the digital age.

Ivy Baker: It's something.

Travis Broome: All right.

Additional Information

Diane Maupai: Listen, thank you everyone. This is Diane. I'm afraid that's all the time we have for questions today. If we didn't get to your question, please see slide 32, which contains links to further information—one to the ONC web page and one to the CMS Incentive web page.

And if you go to that CMS link on slide 32, the last tab on the left is FAQ for Frequently Asked Questions. You can often find what you're looking for there. A registration and attestation question can be directed to the EHR information center. Their number is 1-888-734-6433. Again, that's 1-888-734-6433.

I'd like to thank everyone for participating in today's call. Don't forget to mark your calendars for the other calls in this series. Next one is Tuesday, July the 23rd, at 1:30: Clinical Quality Measures; Wednesday, July the 24th, 1:30: Stage 2; Thursday, August the 15th, 1.30: Payment Adjustments.

On slide 34 of the presentation you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential. And we actually do really pay a lot of attention to this, and have made a lot of changes to our process as a result of your feedback. Registrants for today's call will receive a reminder email from CMS National Provider Calls Resource Box within 2 business days regarding the opportunity to evaluate this call. You can disregard this email if you've already completed the evaluation. Please note that the evaluations will be available for completion for 5 business days from the date of today's call. Again, we appreciate your feedback.

An audio recording and written transcript of today's call will be posted soon on the CMS MLN National Provider Calls web page.

Again, my name is Diane Maupai, and it's been my pleasure serving as your moderator. I'd like to thank Asara Johnson and Travis Broome for presenting today, and have a great day, everyone.

Operator: This concludes today's conference. Presenters, please hold.

END