



**CMS 2010 Tri-Regional Plan Compliance Conference**  
*Dallas Hilton Lincoln Center, May 19-20, 2010*

**A MOSAIC of More: More insight, More answers, More compliance...**

Verbatim Transcript

Incentive Programs for Electronic Health Records and e-Prescribing

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Travis Broome, Special Assistant to the Consortium Administrator,

Quality Improvement and Survey & Certification Operations; Moderator: Bob Gibson

**Part 1**

>> GOOD MORNING.

THANK YOU FOR JOINING US  
FOR THIS BREAKOUT SESSION

ON ELECTRONIC HEALTH RECORDS.

THE HEALTH INFORMATION  
TECHNOLOGY ACT, HITECH, REQUIRES

GOVERNMENT LEADERSHIP TO DEVELOP  
A ELECTRONIC NATIONWIDE SYSTEM

OF SHARING INFORMATION, AND AS  
PART OF THAT, HITECH ESTABLISHES

THE PROCESS OF  
ELECTRONIC PRESCRIPTIONS.

IN ADDITION, IT PROVIDES  
INCENTIVES TO DOCTORS

AND HOSPITALS SO THAT THEY CAN  
ADOPT AND PROVIDE MEANINGFUL USE

OF HEALTH INFORMATION  
TECHNOLOGY, AND WITH THAT,

WE HAVE TWO LEADERS IN THE



HITECH INITIATIVE WITH US TODAY.

DR. DAVID NILASENA IS THE CHIEF  
MEDICAL OFFICER OF THE CMS

DALLAS REGIONAL OFFICE.

HE IS THE REGIONAL LEAD  
FOR VALUE-BASED PURCHASING

INITIATIVES AND IS THE LEAD  
CONTACT FOR ELECTRONIC HEALTH

RECORDS INCENTIVE PROGRAMS.

DR. NILASENA IS BOARD-CERTIFIED  
IN GENERAL PREVENTIVE MEDICINE,

PUBLIC HEALTH, AND HAS MASTER'S  
OF SCIENCE DEGREES IN BOTH

PUBLIC HEALTH AND  
MEDICAL INFORMATICS.

TRAVIS BROOME IS SPECIAL  
ASSISTANT TO THE CONSORTIUM

ADMINISTRATOR AND A  
MEANINGFUL USE TEAM LEADER.

ABOUT THREE YEARS AGO, TRAVIS  
JOINED CMS AS A PRESIDENTIAL

MANAGEMENT FELLOW.

HE HAS LED A WIDE RANGE OF  
PROJECTS AND ACTIVITIES ACROSS

ALL THE REGIONAL  
DIVISIONS OF CMS.

TRAVIS HOLDS MASTER'S DEGREES IN  
BOTH PUBLIC HEALTH AND BUSINESS

ADMINISTRATION, AND WITH THAT,  
WE'LL START WITH DR. NILASENA,

AND AFTER HIS PRESENTATION,  
WE'LL ALLOW TIME FOR TWO OR  
THREE QUESTIONS.

THANK YOU VERY MUCH.  
>> OK.

THANKS, BOB, AND I APPRECIATE  
THE OPPORTUNITY TO SHARE SOME  
INFORMATION WITH YOU ABOUT OUR  
E-PRESCRIBING INCENTIVE PROGRAM.

IT'S PART OF THIS AND ALSO THE  
HITECH PROGRAM AS PART OF OUR

VALUE-BASED PURCHASING  
INITIATIVES WITHIN CMS,

SO I WANTED TO START WITH  
TALKING ABOUT THAT JUST

FOR A MOMENT.

IN MEDICARE AND IN CMS,

WE TRADITIONALLY HAVE BEEN

A PASSIVE PAYER OF HEALTH CARE.

WE PAY BASED ON THE VOLUME AND

INTENSITY OF SERVICES, AND WE'VE

BEEN REALLY TRYING TO MOVE OVER

THE LAST SEVERAL YEARS TO BECOME

MORE OF AN ACTIVE PURCHASER,

FOCUSING ON VALUE

IN HEALTH CARE.

THE WAY WE DEFINE VALUE IS THE

QUALITY OF HEALTH CARE DIVIDED

BY THE COST OF SERVICES, AND WE

HAVE A VARIETY OF INITIATIVES

AND PROGRAMS THAT ARE TRYING

TO MOVE US IN THAT DIRECTION.

WE ALSO SEE THAT THERE ARE A  
VARIETY OF TOOLS THAT WE HAVE  
AT OUR DISPOSAL TO HELP PUSH US  
FORWARD TOWARDS GREATER VALUE.

THESE INCLUDE THINGS LIKE  
PAY FOR PERFORMANCE, PAY  
FOR REPORTING, AND MORE  
RECENTLY, PROMOTION

OF ELECTRONIC INFORMATION  
TECHNOLOGY IN HEALTH CARE,  
AND SO THAT'S WHAT WE'LL  
BE TALKING ABOUT TODAY.

SO AS PART OF THIS, WE HAD  
E-PRESCRIBING, AND SO WHAT  
IS E-PRESCRIBING?

BASICALLY, IT'S THE COMPUTER-  
BASED ELECTRONIC GENERATION,  
TRANSMISSION, AND FILLING  
OF PRESCRIPTIONS.

IT APPLIES TO BOTH NEW  
PRESCRIPTIONS AND TO REFILLS,

AND THE IDEA IS THAT THIS TYPE  
OF SYSTEM WOULD REPLACE THE

TRADITIONAL PAPER OR FAX-BASED  
PRESCRIPTIONS THAT ARE

CURRENTLY IN PLACE.

THERE ARE A VARIETY OF TYPES  
OF E-PRESCRIBING SYSTEMS THAT

ARE AVAILABLE.

SOME OF THESE ARE STAND-ALONE  
SYSTEMS WHERE ALL THEY DO IS

PRESCRIPTION GENERATION  
AND TRACKING, AND SOME ARE

COMPONENTS OF A MORE FULLY  
DEVELOPED ELECTRONIC HEALTH

RECORDS SYSTEM, AND CERTAINLY,  
BOTH OF THESE HAVE THEIR

BENEFITS, ALTHOUGH, AS YOU'LL  
HEAR LATER IN THE PRESENTATION,

WE ARE REALLY PUSHING TOWARDS  
A MORE INTEGRATED SYSTEMS.

SO WHY ARE WE INTERESTED  
IN E-PRESCRIBING?

WELL, THERE'S A NUMBER OF  
BENEFITS THAT HAVE BEEN

DEMONSTRATED AND ARE ANTICIPATED  
FROM THE MOVEMENT TOWARDS THIS

TYPE OF SYSTEM.

THE FIRST IS, IT CAN LOWER  
ADMINISTRATIVE COSTS RELATED TO

PRESCRIPTION  
GENERATION AND FILLING.

IT REDUCES VERBAL  
MISCOMMUNICATIONS THAT OFTEN

OCCUR WHEN PRESCRIPTIONS ARE  
COMMUNICATED OVER THE TELEPHONE

OR EVEN IN PERSON.

IT'S ALSO A BIG PROBLEM OF  
ILLEGIBLE OR DIFFICULT-TO-READ

HANDWRITTEN PRESCRIPTIONS.

IT CAN REDUCE DUPLICATE  
PRESCRIPTIONS FOR THE SAME

PATIENT FOR THE SAME OR SIMILAR  
DRUGS BY DIFFERENT PROVIDERS,

AND ALSO, YOU CAN CHECK  
FOR THINGS LIKE DRUG-DRUG

INTERACTIONS, DRUG  
ALLERGY INTERACTIONS.

ANOTHER POTENTIAL OF  
E-PRESCRIBING IS, IT CAN REDUCE

CONFUSION AT THE TIME OF  
TRANSITIONS OF CARE BETWEEN

SETTINGS SO THAT THE PATIENT'S  
MEDICATIONS ARE CORRECTLY

TRANSMITTED BETWEEN  
THOSE SETTINGS OF CARE.

E-PRESCRIBING SYSTEMS CAN ALSO  
GENERATE A VARIETY OF WARNINGS

AND ALERTS RELATED,  
AS I MENTIONED, TO DRUG-DRUG

INTERACTIONS, ALLERGIES.

IT CAN LOOK AT INTERACTIONS  
WITH LABORATORY VALUES OR DOSING

ALERTS, ET CETERA.

IT CAN REDUCE THE TIME SPENT BY  
PHYSICIAN STAFF ON THE PHONE

WITH PHARMACIES AND ALSO THE  
TIME SPENT FAXING AND RE-FAXING

PRESCRIPTIONS TO THE PHARMACY.

IT CAN AUTOMATE AND, THEREBY,  
IMPROVE EFFICIENCY OF RENEWALS

AND AUTHORIZATIONS RELATED

TO PRESCRIPTIONS, AND IT CAN

IMPROVE THE ADHERENCE TO  
ESTABLISHED FORMULARIES,

BUT DESPITE ALL OF THESE  
ADVANTAGES, THERE ARE

SIGNIFICANT BARRIERS TO ADOPTION  
OF E-PRESCRIBING SYSTEMS.

ONE OF THE BIG BARRIERS IS  
THE INITIAL COST OF PURCHASING

AND INSTALLING THE SYSTEMS  
IN THE PRACTICE SETTING

AND THE LACK OF CLARITY ABOUT  
THE RETURN ON INVESTMENT

OF THESE SYSTEMS IN A CERTAIN  
PRACTICE SETTINGS AND HOW LONG

IT WILL TAKE TO  
REALIZE THAT RETURN.

THERE ARE ALSO SIGNIFICANT  
CHANGES IN STAFF WORKFLOW THAT

ARE REQUIRED TO SUCCESSFULLY  
IMPLEMENT THESE SYSTEMS

BECAUSE IT'S QUITE DIFFERENT  
THAN THE TRADITIONAL METHOD

OF HANDLING PRESCRIPTIONS  
THAT I'LL TALK ABOUT

IN JUST A MOMENT.

THERE HAVE BEEN ISSUES WITH  
THE USE OF THESE SYSTEMS

FOR CONTROLLED SUBSTANCES.

RECENTLY, THE DEA HAD AN  
ABSOLUTE PROHIBITION AGAINST

USING THESE SYSTEMS  
FOR SCHEDULED DRUGS.

THERE'S BEEN RECENT RULEMAKING  
THAT PROPOSES WAYS THAT

SCHEDULED CONTROLLED SUBSTANCES  
CAN BE PRESCRIBED IF A CERTAIN

RESTRICTIONS ARE ADHERED TO,  
AND THE STANDARDS THAT ARE

IN USE FOR THESE SYSTEMS HAVE  
BEEN IN A STATE OF EVOLUTION,

AND IT'S BEEN A LITTLE BIT  
DIFFICULT FOR PEOPLE TO FIGURE

OUT WHICH STANDARDS WOULD  
APPLY IN DIFFERENT SITUATIONS,

AND THAT'S LED TO CONFUSION IN  
TERMS OF SELECTING A SYSTEM.

OTHER CHALLENGES AT THE  
PROVIDER LEVEL ARE, PROVIDERS

AND PRESCRIBERS ARE UNSURE  
OF WHICH SYSTEM TO BUY.

THERE ARE A LARGE NUMBER OF  
SYSTEMS THAT ARE OUT THERE

ON THE MARKET, AND THERE'S NOT A  
STANDARD CERTIFICATION PROCESS,

SO THEY CAN'T SORT OF LOOK FOR  
THE SELECT SET THAT HAVE BEEN

CERTIFIED BY SOME SINGLE BODY.

WE'RE HOPING TO CHANGE THAT  
IN THE FUTURE, AS TRAVIS WILL

MENTION IN HIS TALK, BUT AT THIS  
POINT IN TIME, WE DON'T HAVE

THAT IN PLACE.

I MENTIONED THE RESTRICTION  
ABOUT CONTROLLED SUBSTANCES,

AND ALSO E-PRESCRIBING SYSTEMS  
HAVE NOT BEEN DEVELOPED FOR ALL

SETTINGS OF CARE.

THEY PRIMARILY HAVE BEEN FOCUSED  
ON AMBULATORY CARE SETTINGS,

SOME IN EMERGENCY ROOMS, SOME  
IN HOSPITAL SETTINGS, BUT OTHER

SETTINGS, SUCH AS LONG-TERM  
CARE, HAVE NOT BEEN AS QUICKLY

TO DEVELOP THEIR SYSTEMS.

ALL RIGHT, SO THIS SLIDE SHOWS  
SORT OF THE TRADITIONAL WAY THAT

PRESCRIPTIONS ARE HANDLED IN  
THE PRE-E-PRESCRIBING ERA,

AND MOST OF YOU, I THINK,

YOU KNOW,  
IF YOU'VE EVER BEEN TO A DOCTOR,

YOU PROBABLY HAVE  
EXPERIENCED THIS.

YOU GO. YOU SEE YOUR DOCTOR.

HE SAYS,  
"I NEED TO PRESCRIBE YOU

MEDICATION," SO HE WHIPS OUT  
HIS PRESCRIPTION PAD, AND HE

HAND-WRITES THE PRESCRIPTION  
FROM HIS MENTAL DRUG LIST OF

WHAT YOU NEED FOR YOUR  
PARTICULAR CONDITION.

SO HE HAS TO REMEMBER THE  
NAME OF THE DRUG, THE DOSE,

AND THE FREQUENCY AND  
WRITE ALL THAT DOWN.

HE HANDS YOU THE PRESCRIPTION.

YOU TAKE IT OVER  
TO YOUR PHARMACY.

THE PHARMACIST LOOKS AT IT AND  
SAYS, "I HAVE NO IDEA WHAT'S

"WRITTEN ON HERE.

I BETTER CALL THE  
DOCTOR'S OFFICE."

SO THEY CALL, AND THEY VERIFY,  
"WHAT'S THE NAME OF THE DRUG?

"ARE YOU SURE ABOUT THE  
DOSE AND FREQUENCY?

IS IT THE RIGHT PATIENT?"

SO ONCE THE PHARMACIST GETS  
ALL THAT INFORMATION, THEY HAVE

TO VERIFY WITH YOUR PRESCRIPTION  
DRUG PLAN THAT THEY CAN ACTUALLY

GIVE YOU THIS MEDICINE AND  
HOW MUCH THEY'RE GOING TO

CHARGE FOR IT.

IF IT'S NOT ON THEIR FORMULARY,  
THEY MAY HAVE TO CALL

THE PHYSICIAN BACK AND SAY,  
YOU KNOW, "WE NEED TO GET

A DIFFERENT DRUG," UNLESS  
THEY'RE ALLOWED TO SUBSTITUTE

IT, AND ALSO, IT MAY BE THAT  
THE CO-PAY ASSOCIATED WITH THAT

IS NOT WHAT THE PATIENT IS  
EXPECTING, AND SO THE PATIENT

MAY ACTUALLY NOT EVEN FILL  
THE PRESCRIPTION

IF THE CO-PAY IS TOO HIGH.

AFTER ALL THAT'S DONE AND THE  
PATIENT DOES GET THE DRUG--

OR, ACTUALLY, BEFORE--

THE PHARMACIST ACTUALLY HAS TO  
TYPE IN THE INFORMATION INTO

THEIR DATABASE SO THAT THEY  
CAN TRACK IT AND GENERATE

THE APPROPRIATE CHARGE.

SO THERE'S ALL THIS MANUAL  
PROCESSING THAT TAKES PLACE.

IT CAUSES A LOT OF DELAYS ON THE  
PATIENT'S PERSPECTIVE AND A LOT

OF STAFF TIME TO PROCESS THIS.

NOW WE MOVE FORWARD TO AN  
E-PRESCRIBING SYSTEM WHEN

EVERYONE IS USING  
E-PRESCRIBING.

UNDER THIS SYSTEM, AT THE POINT  
OF SERVICE WHEN THE PHYSICIAN IS

SEEING THE PATIENT, THEY CAN  
LOOK UP THE MEDICATION THAT THEY

INTEND TO PRESCRIBE.

THEY CAN MAKE SURE THAT THE  
DOSE IS AN ACCEPTABLE DOSE.

IT CAN GET SOME WARNINGS IF THE  
PATIENT HAS AN ALLERGY TO

THE MEDICATION, AND THEN THEY  
CAN ALSO COMMUNICATE DIRECTLY

WITH THE PHARMACY BENEFIT  
MANAGER TO MAKE SURE THAT

THE DRUG IS ON THE FORMULARY,

WHAT THE AMOUNT OF THE CO-PAY

WILL BE FOR THE PATIENT, WHETHER  
THERE ARE ALTERNATIVE DRUGS THAT

MAYBE WOULD BE LESS COSTLY  
TO THE PATIENT THAT THEY MAY

PREFER, AND ALL THIS CAN BE DONE  
SORT OF INSTANTANEOUSLY AS

THE PHYSICIAN IS GENERATING  
THE PRESCRIPTION.

ONCE EVERYTHING IS APPROVED,  
THEY CAN SEND IT DIRECTLY OVER

TO THE PHARMACY IN AN  
ELECTRONIC FORMAT, SO THERE'S NO

UNCERTAINTY ABOUT WHAT THE  
MEDICINE IS OR THE DOSE,

AND SO THE PHARMACY CAN  
ACTUALLY BE WORKING ON FILLING

THAT PRESCRIPTION BEFORE  
THE PATIENT GETS THERE,

AND THE PATIENT CAN JUST SHOW UP  
AND PICK UP THE PRESCRIPTION.

SO THIS IS SORT OF THE VISION,  
AND THEN AT THE PHARMACY LEVEL,

AGAIN, THEY DON'T HAVE TO  
WORRY ABOUT ILLEGIBLE SCRIPTS,

AND THERE'S REDUCED WAITING  
TIME FOR THE PATIENT

AT THE PHARMACY END.

THERE'S ALSO NO NEED FOR  
REDUNDANT DATA ENTRY BY

THE PHARMACY STAFF.

SO THIS IS SORT OF THE VISION  
THAT WE ARE LOOKING FOR

FOR E-PRESCRIBING, AND THAT'S  
WHY THERE'S SUCH GREAT INTEREST

IN THESE TYPES OF PROGRAMS.

SO THE BIG PICTURE IS, THERE IS  
A TREMENDOUS POTENTIAL FOR COST

SAVING WITH WIDESPREAD  
IMPLEMENTATION OF THESE SYSTEMS.

IT CAN REDUCE ADVERSE DRUG  
EFFECTS THROUGH ERROR CHECKING

AND ALSO IMPROVE WORKFLOWS AND  
REDUCE STAFF TIME AND PATIENT

WAITING TIME.

THE ESTIMATES ARE ON THE ORDER  
OF \$27 BILLION A YEAR THAT COULD

BE SAVED THROUGH THE WIDESPREAD  
USE OF THESE SYSTEMS, AND FROM

THE MEDICARE PERSPECTIVE,  
THIS HAS TREMENDOUS POTENTIAL

IMPACT ON OUR PART D

SYSTEM, AND WE HOPE THAT THESE  
SYSTEMS WILL IMPROVE NOT ONLY

THE ACCURACY OF THE PRESCRIBING  
FOR OUR MEDICARE BENEFICIARIES,

BUT ALSO REDUCING OUT-OF-POCKET  
EXPENSES AND REALIZING

ADDITIONAL BENEFITS RELATED  
TO THE PRESCRIBING PROCESS.

**Part 2**

>> ALL RIGHT. SO WITH ALL

THIS IN MIND IN THE INTEREST  
IN E-PRESCRIBING,

CONGRESS  
AUTHORIZED US IN 2008 THROUGH

THE MIPPA LEGISLATION TO  
BEGIN AN INCENTIVE PROGRAM TO

ENCOURAGE MEDICARE PROFESSIONALS  
TO ADOPT THESE SYSTEMS.

IN THE LAW, IT DEFINED  
THE INCENTIVE FOR ELIGIBLE

PROFESSIONALS WHO ARE SUCCESSFUL  
ELECTRONIC PRESCRIBERS,

AND THE EP MUST REPORT AT  
LEAST ONE OF OUR E-PRESCRIBING

MEASURES AS DEFINED BY THE  
SECRETARY OF HEALTH AND HUMAN

SERVICES TO BE  
CONSIDERED A, QUOTE,

"SUCCESSFUL E-PRESCRIBER."

THIS PROGRAM BEGAN  
IN JANUARY OF 2009.

IT WAS A SEPARATE PROGRAM FROM  
THE PQRI REPORTING PROGRAM,

ALTHOUGH WE DID MAKE USE OF  
THE PQRI E-PRESCRIBING MEASURE

IN THE IMPLEMENTATION OF THIS  
PROGRAM, AND SIMILAR TO PQRI,

THE REPORTING PERIOD FOR THE  
PROGRAM IS A CALENDAR YEAR

ON WHICH THE INCENTIVE  
PAYMENT IS BASED.

NOW I SHOULD POINT OUT THAT  
THIS PROGRAM, SIMILAR TO PQRI,

IS ONLY RELEVANT FOR THE  
PHYSICIANS AND ELIGIBLE

PROFESSIONALS WHO BILL UNDER  
THE PART B FEE-FOR-SERVICE

SCHEDULE, AND SO IT WOULD NOT  
APPLY TO THOSE PHYSICIANS WHO

ARE WORKING THROUGH MEDICARE  
ADVANTAGE PLANS AND BILLING

IN THAT WAY.

THE AMOUNT OF THE

INCENTIVE FOR 2010 IS 2%.

THIS IS 2% OF THE ESTIMATED

ALLOWED TOTAL PART B

CHARGES THROUGH THE

FEE-FOR-SERVICE SCHEDULE.

FOR 2010, WE HAVE THREE

WAYS THAT THE PROFESSIONALS

CAN REPORT.

INITIALLY, WE JUST HAD A

CLAIMS-BASED SUBMISSION PROCESS,

BUT FOR 2010, WE'VE ADDED

OPTIONS FOR USING A QUALIFIED

REGISTRY TO REPORT THE MEASURE

OR QUALIFIED ELECTRONIC

HEALTH RECORD.

THE REPORTING PERIOD,

AS I MENTIONED, IS A FULL

CALENDAR YEAR, FROM JANUARY TO

DECEMBER 31,

AND IN TERMS OF HOW WE DEFINED

A SUCCESSFUL  
E-PRESCRIBER, IN 2010, WE SAY

THAT THEY MUST REPORT THE  
E-PRESCRIBING MEASURE

FOR AT LEAST 25 UNIQUE  
REPORTABLE ELECTRONIC

PRESCRIBING EVENTS.

THIS IS QUITE A REDUCTION FROM  
THE FIRST YEAR OF THE PROGRAM,

WHERE THEY HAD TO REPORT ON 50%  
OF THE ELIGIBLE PATIENT VISITS,

AND THAT TURNED OUT TO BE  
TOO HIGH OF A LEVEL FOR MANY

OF THE PARTICIPANTS, AND SO  
WE'VE SCALED IT BACK

QUITE A BIT.

WE THINK THIS IS STILL OK  
BECAUSE, YOU KNOW, MOST

OF THE CHALLENGE TO IMPLEMENTING  
E-PRESCRIBING IS SELECTING

THE SYSTEM, IMPLEMENTING IT,  
MODIFYING YOUR PATIENT AND STAFF

WORKFLOWS, AND SO WE BELIEVE  
THAT ONCE PHYSICIANS HAVE

REACHED THAT POINT, THEY ARE  
GOING TO CONTINUE TO USE THE

SYSTEM THAT THEY'VE IMPLEMENTED,  
AND SO THEY'RE NOT JUST GOING TO

USE IT FOR 25 PATIENTS  
AND THEN STOP USING IT.

I MENTIONED THE THREE WAYS OF

REPORTING THE MEASURE UNDER

THE PROGRAM.

ALSO IN 2010, WE HAVE A GROUP  
PRACTICE REPORTING OPTION,

WHICH IS FOR THOSE PRACTICES  
THAT ARE MORE THAN 200 ELIGIBLE

PROFESSIONALS WHO HAVE BEEN  
APPROVED EARLY IN THE YEAR,

AND THEY CAN ALSO GET A 2%  
INCENTIVE BASED ON THEIR ENTIRE

GROUP'S PART B  
FEE-FOR-SERVICE CHARGES.

ALL RIGHT.

IN 2010,

I MENTIONED THEY HAVE TO DO THIS

25 TIMES DURING THE YEAR.

WHAT THEY ARE REPORTING TO US

IS THE E-PRESCRIBING MEASURE,

WHICH CONSISTS OF A NEW G-CODE

FOR THE MEASURE'S NUMERATOR,

WHICH I'LL SHOW IN THE NEXT

SLIDE, AND THEN FOR 2010,

WE'VE EXPANDED THE SET OF

DENOMINATOR CODES FROM A SET

OF JUST AMBULATORY CARE CODES

TO NOW INCLUDE THINGS LIKE HOME

HEALTH, DOMICILIARY CARE,

AND NURSING HOME CODES.

SO WE WANTED TO REALLY GIVE  
THEM A LARGE OPPORTUNITY TO  
PARTICIPATE IN THIS PROGRAM,  
AND ALL THE DETAIL  
SPECIFICATIONS OF THIS MEASURE  
ARE AVAILABLE ON OUR WEBSITE.

THE NUMERATOR FOR THE MEASURE,  
I MENTIONED, IT'S A NEW G-CODE,

AND THE WAY THAT CODE IS  
DEFINED IS THAT AT LEAST ONE

PRESCRIPTION CREATED DURING  
THE ENCOUNTER WAS GENERATED

AND TRANSMITTED  
ELECTRONICALLY USING A QUALIFIED

E-PRESCRIBING SYSTEM.

SO THERE'S A COUPLE OF KEY  
THINGS IN THIS DEFINITION.

THE FIRST, IT'S, WE'RE ONLY  
LOOKING AT DURING THE ENCOUNTER,

SO WE'RE ONLY LOOKING AT  
PRESCRIPTIONS THAT WERE

GENERATED WHILE THE PATIENT  
WAS IN THE OFFICE

WITH THE PHYSICIAN.

IT HAS TO BE TRANSMITTED,  
OR AT LEAST AN ATTEMPT TO

TRANSMIT IT, ELECTRONICALLY.

WE ARE NOT REQUIRING THAT  
THE PHARMACY ON THE OTHER

END RECEIVE IT AND USE IT,

SINCE THE INCENTIVE PROGRAM IS

BASED ON THE PRESCRIBING  
PROFESSIONAL, AND THEN FINALLY,

THERE HAS TO BE A QUALIFIED  
E-PRESCRIBING SYSTEM,

AND ON THE NEXT SLIDE,  
WE'LL TALK ABOUT THAT.

SO A QUALIFIED E-PRESCRIBING

SYSTEM MUST MEET ALL FOUR

OF THE CRITERIA ON THIS SLIDE.

IT MUST BE CAPABLE OF GENERATING

A COMPLETE ACTIVE MEDICATION

LIST FOR THE PATIENT, MAKING

USE OF DATA FROM PHARMACIES

AND PHARMACY BENEFIT MANAGERS.

YOU MUST BE ABLE TO

SELECT MEDICATIONS, PRINT

PRESCRIPTIONS, AND,

MOST IMPORTANTLY, ELECTRONICALLY

TRANSMIT THOSE PRESCRIPTIONS

TO THE PHARMACY AND CONDUCT

A VARIETY OF ALERTS ON THE

PRESCRIPTIONS, SUCH AS ALLERGY

CHECKS AND DRUG-DRUG

INTERACTIONS.

IT NEEDS TO BE ABLE TO PROVIDE

INFORMATION ABOUT LOWER-COST

BUT THERAPEUTICALLY APPROPRIATE  
ALTERNATIVE DRUGS AND ALSO  
INFORMATION ABOUT FORMULARIES,  
TIERED FORMULARIES, AND PATIENT  
ELIGIBILITY FOR THE DRUG AND  
AUTHORIZATION REQUIREMENTS,  
AND SO THE REASON WE REQUIRE  
ALL OF THESE FOR OUR QUALIFIED  
SYSTEMS IS, WE WANT  
THE SYSTEM TO BE,  
AT LEAST POTENTIALLY, ABLE  
TO TAKE ADVANTAGES OF MANY  
OF THE THINGS THAT I DESCRIBED  
EARLIER IN THE PRESENTATION.  
ALL RIGHT, SO THE INCENTIVE  
FOR THOSE WHO ARE SUCCESSFULLY  
PRESCRIBERS UNDER THIS PROGRAM  
FOR THE LAST YEAR AND THIS YEAR,  
IT'S 2% OF THEIR TOTAL PART B  
CHARGES.  
THAT BEGINS TO DROP OFF STARTING  
NEXT YEAR, WHERE IT GOES DOWN TO  
1% FOR THE NEXT TWO YEARS AND  
THEN FINALLY DOWN TO .5% BEFORE,  
IN 2014, THE

INCENTIVE PAYMENTS STOP.

NOW, BEGINNING IN 2012 FOR

THOSE WHO ARE NOT SUCCESSFUL

E-PRESCRIBERS, THEY WILL

ACTUALLY HAVE A DEDUCTION TO

THEIR PART B

CHARGES, OR THE AMOUNT THAT

THEY GET REIMBURSED FOR THOSE

CHARGES, BEGINNING AT 1% AND

GOING UP TO 2% IN THE YEAR 2014.

NOW, AFTER 2014, THERE WILL NOT

BE ANY INCENTIVES OR REDUCTIONS

BECAUSE THIS PROGRAM WILL BE

SORT OF SUBSUMED BY THE

HITECH INCENTIVE PROGRAM THAT

TRAVIS WILL DESCRIBE TO YOU.

ALL RIGHT.

I MENTIONED THE GROUP REPORTING

OPTION UNDER THE E-PRESCRIBING

INCENTIVE PROGRAM.

THIS WAS ADDED IN 2010, AND

THE ATTRACTIVENESS OF THIS

FOR THE GROUPS IS THAT,

WHILE THERE'S A LIMITED NUMBER

OF PRESCRIPTIONS THAT THEY

NEED TO GENERATE TO QUALIFY,  
THE AMOUNT OF THEIR INCENTIVE  
IS BASED ON THE TOTAL PART B  
CHARGES FOR THE ENTIRE GROUP.  
SO IF THEY HAVE, YOU KNOW,  
SOME PHYSICIANS WHO DO A LOT  
OF PRESCRIBING AND THEN A LOT  
OF OTHER PHYSICIANS WHO DON'T  
PRESCRIBE A LOT BUT THEY  
GENERATE A LOT OF PART B  
CHARGES, THE INCENTIVE FOR  
THE GROUP CAN BE MUCH HIGHER.  
THE REQUIREMENT, THOUGH,  
IS HIGHER FOR THE GROUP.  
THEY HAVE TO REPORT THE MEASURE  
AT LEAST 2,500 TIMES AMONG THEIR  
ELIGIBLE PROFESSIONALS DURING  
THE REPORTING YEAR TO BE  
CONSIDERED A SUCCESSFUL  
E-PRESCRIBING GROUP.  
ALL RIGHT, SO ONE OTHER  
THING ABOUT BOTH OUR PQRI  
AND E-PRESCRIBING PROGRAM.  
WE DO INTEND TO PUBLICLY REPORT  
THE NAMES OF THOSE ELIGIBLE  
PROFESSIONALS AND GROUPS WHO

ARE SUCCESSFUL UNDER THESE TWO

INCENTIVE PROGRAMS.

WE WILL BE POSTING THOSE ON  
OUR CMS WEBSITE, AS REQUIRED

IN THE STATUTE, AND WE THINK  
THAT THIS WILL BE SORT OF

AN ADDED INCENTIVE IN ADDITION  
TO THE PAYMENT INCENTIVE THAT

THEY CAN BE RECOGNIZED FOR SORT  
OF BEING LEADERS IN MOVING US

TOWARDS ADOPTION OF  
INFORMATION TECHNOLOGY.

SO THE BOTTOM LINE IS THAT  
E-PRESCRIBING IS THE FUTURE.

WE ARE DEFINITELY MOVING  
IN THAT DIRECTION.

IT'S INCORPORATED INTO OUR  
DEFINITION OF MEANINGFUL USE

FOR EHR THAT TRAVIS WILL  
DESCRIBE, AND ALTHOUGH THERE ARE

CHALLENGES TO IMPLEMENTING  
E-PRESCRIBING, THINK WE NEED TO

VIEW THIS AS AN OPPORTUNITY TO  
ACHIEVE EFFICIENCY IN THE WAY

THAT THESE PRESCRIPTIONS ARE  
GENERATED, IMPROVE THE QUALITY

AND THE ACCURACY OF  
THOSE PRESCRIPTIONS,

AND HOPEFULLY REDUCE COSTS  
RELATED TO PRESCRIPTION

GENERATION AND FILLING  
THROUGHOUT OUR HEALTH

CARE SYSTEM.

WE HAVE SOME RESOURCES ON OUR WEBSITE RELATED NOT ONLY TO THE

E-PRESCRIBING INCENTIVE PROGRAM, BUT ALSO TO THE PART D

E-PRESCRIBING STANDARDS THAT ARE ALSO A REQUIREMENT UNDER THE

MEDICARE PROGRAM, AND SO IF YOU'RE INTERESTED IN THOSE,

THESE ARE THE TWO WEBSITES, AND WITH THAT, I WILL TAKE A FEW

MINUTES FOR QUESTIONS.

UNFORTUNATELY, I CAN'T STAY TILL THE END OF THE PRESENTATION

BECAUSE THEY SWITCHED THE SCHEDULE ON ME, BUT I CAN TAKE

QUESTIONS ON E-PRESCRIBING, AND THEN TRAVIS CAN HANDLE HIS

QUESTIONS ON HIS PORTION OF THE PRESENTATION.

>> QUESTIONS?

>> YES?

>> I THOUGHT I HAD READ SOMEWHERE WHERE THE

E-PRESCRIBING IS JUST ALSO AN INCENTIVE PROGRAM

FOR THE MEDICARE ADVANTAGE ORGANIZATIONS.

YOU INDICATED THAT IT'S ONLY FOR PHYSICIANS THAT BILL

PART B, SO--

>> YEAH,  
AND THE QUESTION IS HOW THIS

APPLIES TO THE MEDICARE  
ADVANTAGE PROGRAM,

AND ORIGINALLY AND IN THE  
STATUTE, IT'S CLEARLY DEMARCATED

FOR THE PHYSICIAN FEE-FOR-  
SERVICE, YOU KNOW, SCHEDULE

UNDER PART B.

NOW, WE DISCOVERED--ACTUALLY,  
THROUGH PQRI, BUT IT WILL APPLY

TO THE E-PRESCRIBING PROGRAM--  
THAT, EVEN THOUGH YOU'RE

A MEDICARE ADVANTAGE PLAN,  
SOMETIMES YOUR PATIENTS RECEIVE

CARE THROUGH NON-CONTRACTED  
PROVIDERS OR, IF YOU'RE

IN A PRIVATE FEE-FOR-SERVICE  
PLAN, IT'S SORT OF A SEPARATE

WAY THAT THOSE CASES ARE  
REIMBURSED, AND UNDER THE RULES

OF MEDICARE, THAT CARE HAS TO  
BE REIMBURSED IN AN EQUIVALENT

MANNER TO THE PART B  
FEE-FOR-SERVICE SCHEDULE.

SO THERE'S THIS SMALL OVERLAP  
IN CARE THAT THE PLAN IS SORT

OF RESPONSIBLE FOR REIMBURSING,  
AND AS PART OF THAT, YOU ARE

ALSO OBLIGATED TO PAY AN  
INCENTIVE ON THAT SMALL

COMPONENT OF YOUR CARE, AND THE  
WAY THAT THIS WORKS FROM A CMS

PERSPECTIVE IS, WE IDENTIFY  
WHICH ELIGIBLE PROFESSIONALS

QUALIFIED FOR THE INCENTIVE.

WE CAN TELL FROM OUR CLAIMS  
WHICH OF THOSE PATIENTS ARE

ACTUALLY IN YOUR PLAN MEMBERSHIP  
AND HOW MUCH YOU ARE SORT OF

ON THE HOOK TO PROVIDE, AND THEN  
MY UNDERSTANDING IS, WE SEND YOU

A FILE THAT LISTS THE INDIVIDUAL  
PROVIDERS AND THE AMOUNT THAT

YOU'RE SUPPOSED TO PAY THEM.

MY UNDERSTANDING IS,  
THE RECEIVED THAT FOR PQRI LAST

YEAR, AND YOU'LL BE GETTING  
SOMETHING SIMILAR TO THAT

FOR THE E-PRESCRIBING PROGRAM  
IN THIS YEAR AND NEXT YEAR.

>> ARE THERE ANY OTHER  
QUESTIONS FOR DR. NILASENA

BEFORE HE LEAVES?

>> OK. WELL, THANK YOU  
FOR YOUR ATTENTION.

**Part 3**

>> I'M GOING TO TALK ABOUT THE  
EHR-BASED INCENTIVE

PROGRAM THAT WAS PART OF THE  
RECOVERY & REINVESTMENT ACT.

TOLD THE LAST GROUP I'D MAKE A  
DEAL WITH THEM, SO I'LL MAKE

THE SAME DEAL WITH YOU.

AS YOUR CONSIDERATION  
THAT MY M.A.

KNOWLEDGE CONSISTS OF SPEED

DIAL NUMBER THREE ON MY PHONE,  
WHICH IS FRANK SOVINSKY AND  
CPC AND RAILROADING COLLEAGUES  
IN THE DALLAS REGIONAL OFFICE  
IN THE HALLWAY, MY CONSIDERATION  
IS, I'M GOING TO ASSUME THAT  
MOST OF YOU PROBABLY DON'T WANT  
TO GET INTO THE CONVERSATION OF,  
YOU KNOW, WHETHER LOINC CODES  
ARE READY FOR STRUCTURED DATA  
IN LAB RESULTS, WHICH IS ONE  
OF THE OBJECTIVES  
OF MEANINGFUL USE.  
CERTAINLY, IF YOU WANT TO TALK  
TO ME ABOUT THAT, I'D BE GLAD  
TO, BUT WE'LL SAVE THAT  
FOR QUESTIONS AND ANSWERS  
OR AFTERWARDS.  
SO, LIKE I SAID, RECOVERY ACT  
IN FEBRUARY 2009 WAS PASSED  
AND HAD THE HITECH  
PROVISIONS, OF WHICH, WELL,  
CBO ESTIMATED 27 BILLION OR SO  
WAS FOR EHR INCENTIVE PROGRAMS.  
CMS WAS CHARGED WITH DESIGNING  
THAT PROGRAM AND DEFINING  
MEANINGFUL USE.  
THAT REGULATION CAME OUT,  
THANKFULLY, ON THE 30th INSTEAD  
OF THE 31st, SO I GOT TO DO MORE  
FUN THINGS ON THE 31st, AND THEN  
WE HAD A PUBLIC COMMENT PERIOD  
THROUGH THE END OF MARCH 15,  
WHICH, OBVIOUSLY,  
HAS SINCE CLOSE.

WE HAVE REVIEWED THOSE COMMENTS.

WE'RE IN THE PROCESS OF  
DRAFTING REVISIONS TO THE RULE.

WE'RE HOPING THE FINAL RULE WILL  
COME OUT BY THE END OF JUNE.

SO WHAT IS IN THE CMS PROPOSED  
RULE AND IN THE PROGRAM?

THE BIG THING IS DEFINITION OF  
MEANINGFUL USE.

NEARLY ALL THE INCENTIVES ARE  
BASED ON MEANINGFUL USE

OF CERTIFIED EHR TECHNOLOGY.

WASN'T ABLE TO CONVINCE ANYBODY  
THAT WE COULD JUST LOOK THAT UP

IN THE WEBSTER'S DICTIONARY AND  
WRITE THAT DOWN, SO MEANINGFUL

USE HAS BECOME QUITE  
THE DEBATING POINT.

THE NEXT BIG THING WAS SOMETHING  
CALLED DEFINITION OF

HOSPITAL-BASED ELIGIBLE  
PROFESSIONALS.

THAT'S ACTUALLY GOTTEN LESS BIG.

ORIGINALLY, IT WAS HOSPITAL-  
BASED ELIGIBLE PROFESSIONALS

WERE NOT GOING TO GET AN  
INCENTIVE INDIVIDUALLY

BECAUSE THEY WERE PART OF THE  
HOSPITAL, AND THE STATUTE USED

TO SAY INPATIENT,  
OUTPATIENT EHR.

WELL, IF YOU THROW IN  
OUTPATIENT THERE, YOU GET A LOT

OF PROVIDER-BASED CLINICS AND

THINGS LIKE THAT THAT PEOPLE

WEREN'T HAPPY ABOUT.

CONGRESS FIXED THAT FOR US.

THEY GOT RID OF THE OUTPATIENT  
PART, SO NOW IT'S JUST

INPATIENT EHR,  
SO THAT'S MUCH LESS BIG DEAL.

THE NEXT THREE THINGS WE TALK  
ABOUT IS HOW TO GET YOUR MONEY.

IF YOU'RE UNDER ONE OF THESE  
PROGRAMS, THIS IS HOW MUCH MONEY

YOU GET AND HOW YOU GO ABOUT  
GETTING IT, AND THEN FINALLY,

YOU KNOW, THE STANDARD  
PRA STUFF AND IMPACT.

SO THINGS THAT AREN'T IN THE CMS

NPRM, THERE ARE LOTS OF STUFF

IN HITECH BESIDES THE

EHR INCENTIVE PROGRAM.

MOST OF THE OTHER THINGS ARE RUN

THROUGH WHAT'S CALLED THE OFFICE

OF THE NATIONAL COORDINATOR OF

HEALTH INFORMATION TECHNOLOGY.

YOU KNOW, THE EXCEPTION IN THE

PUBLICATION OF THIS PROPOSED

RULE, WHEN YOU HEAR ABOUT

HITECH, IT'S USUALLY FROM THEM,

AND NOT FROM CMS.

THEY'RE THE ONES WHO PUT OUT ALL

THE GRANTS FOR THE STATE HEALTH

INFORMATION CHANGES.

THEY'RE PUTTING OUT ALL THE  
GRANTS TO TRAIN, TO DEVELOP  
COLLEGE PROGRAMS TO TRAIN  
PEOPLE IN HEALTH INFORMATICS.  
THEY'RE PUTTING OUT GRANTS TO  
WHAT'S CALLED REGIONAL EXTENSION  
CENTERS, WHICH ARE GOING TO BE  
THE ACTUAL TECHNICAL ASSISTANCE.  
YOU KNOW, WE'LL GLADLY ANSWER  
QUESTIONS ABOUT THE PROGRAM,  
BUT IF YOU HAVE A PROBLEM WITH  
YOUR EHR AND HOW IT WORKS,  
CMS IS NOT EQUIPPED TO DEAL  
WITH THAT, BUT THESE REGIONAL  
EXTENSION CENTERS WILL BE,  
AND MOST IMPORTANTLY TO US  
AND TO THE INCENTIVE PROGRAM IS,  
THEY DEFINE WHAT CERTIFIED EHR  
TECHNOLOGY IS.

THEY HAD THEIR OWN RULE THAT  
CAME OUT AT THE EXACT SAME TIME.  
THEY'LL HAVE A FINAL RULE THAT  
COMES OUT AT THE EXACT SAME  
TIME AS OURS.

IT REALLY FOCUSES ON,

"ALL RIGHT.

HOW ARE WE GOING TO CERTIFY

EHRs SO THAT WE KNOW FOR SURE

THAT THEY CAN ACTUALLY

DO MEANINGFUL USE?"

SOME THINGS WE TRIED TO DO IN  
THE END NPRM,

LINK IT CLOSELY  
TO CERTIFICATION.

WE TRIED TO MAKE MEANINGFUL USE  
MEAN THE SAME IN MEDICARE,

MEDICARE ADVANTAGE,  
AND MEDICAID.

THE H.I.T. POLICY COMMITTEE,  
I ALWAYS LIKE TO GIVE THEM KUDOS

BECAUSE, BEING A KIND OF  
A STAFF-LEVEL PERSON--OR,

ACTUALLY, I JUST DO THE  
TYPING OF THE WRITING--

I HAVE GREAT SYMPATHY FOR THE  
PEOPLE WHO COME UP

WITH THE FIRST DRAFT.

I CONSIDER THAT THE HARDEST  
PART, WHEREAS, YOU KNOW,

IT'S MUCH EASIER TO SIT THERE  
WITH YOUR RED PEN ON SOMEBODY

ELSE'S FIRST DRAFT.

THE H.I.T. POLICY COMMITTEE  
CAME UP WITH THE FIRST DRAFT

OF THE DEFINITION  
OF MEANINGFUL USE.

I'M GOING TO COORDINATE WITH  
CMS QUALITY INITIATIVES, PQRI,

E-PRESCRIBING FOR M.A. PLANS,  
YOU KNOW, HIAs AND THOSE

PROGRAMS, AND WE'RE GOING TO  
STAGE IMPLEMENTATION OVER TIME,

AND THAT'S WHERE I'LL REALLY  
TALK ABOUT MEANINGFUL USE,

IS WHEN WE TALK ABOUT  
THAT STAGING.

ELIGIBILITY, WE HAVE MORE SLIDES  
THAT GO INTO DETAILS, SO WE'LL

JUST USE THOSE.

SO UNDER THE MEDICARE FEE-FOR-  
SERVICE PROGRAM, YOU HAVE EPs

AND YOU HAVE ELIGIBLE HOSPITALS,  
AND YOU HAVE CAHs.

EPs ARE ESSENTIALLY

YOUR DOCTORS.

IF YOU HAVE A DOCTOR OF

WHATEVER, THEN YOU ARE AN EP--

MEDICINE, OSTEOPATHS, DENTAL,

ALL THOSE UP THERE.

ELIGIBLE HOSPITALS, CAHs,

AND THEN, ACUTE CARE--

ACUTE CARE IS DEFINED IN

THE STATUTE AS WHAT'S CALLED

A SUBSECTION D HOSPITALS.

THESE ARE YOUR INPATIENT

PROSPECTIVE PAYMENT SYSTEM

HOSPITALS PLUS THE MARYLAND

HOSPITALS, BASICALLY.

THAT'S THE DIFFERENCE  
BETWEEN IPPS AND SUBSECTION D.  
MARYLAND GOT A PASS ON IPPS.  
MEDICARE ADVANTAGE.  
ELIGIBLE PROVIDERS ARE WHERE  
THE ACTION IS, SO WE'LL TALK  
ABOUT THAT SECOND.  
ELIGIBLE HOSPITALS, THERE  
ACTUALLY ISN'T GOING TO BE  
A SEPARATE M.A. PLAN UNDER THE  
PROPOSAL--YOU KNOW, WE'LL SEE  
WHAT'S FINALIZED  
IN SIX WEEKS HERE--  
BECAUSE THE FORMULA FOR  
HOSPITALS UNDER THE MEDICARE  
FEE-FOR-SERVICE SIDE COUNTS  
PART A DAYS AND PART C  
DAYS, SO THEY'RE ALREADY  
ACCOUNTING FOR ALL THE PART C  
DAYS AND GIVING THE INCENTIVE TO  
THE HOSPITALS UNDER THE  
FEE-FOR-SERVICE PROGRAM.  
SO ELIGIBLE PROFESSIONALS IS  
REALLY KIND OF WHERE, LIKE,  
THE ACTION IS, AND THERE'S TWO  
WAYS AND ELIGIBLE PROFESSIONAL--  
YOU KNOW, DOCTOR OF OSTEOPATH--

CAN BECOME AN M.A.

ELIGIBLE PROFESSIONAL.

ONE IS THEY WORK AT LEAST

MORE THAN HALF TIME DIRECTLY

FOR AN M.A. PLAN, YOU KNOW,

STAFF MODEL HMO, IF YOU WILL,

A QUALIFYING M.A. ORGANIZATION.

THE OTHER ONE IS, THEY ARE

EMPLOYED OR A PARTNER OF--YOU

KNOW, FOR THE DOCS WHO

OWN THEIR ENTITIES--

AN ENTITY THAT CONTRACTS WITH

A QUALIFYING M.A. ORGANIZATION

FOR 80% OF THEIR MEDICARE

PATIENT VOLUME.

SO THAT INCLUDES FEE-FOR-SERVICE

AND M.A. VOLUME.

DOES NOT INCLUDE

OTHER VOLUME, SO IF,

YOU KNOW, THAT'S ONLY 50%

OF YOUR PATIENT VOLUME

AND THE OTHER 50% IS PRIVATE,

THEN WE'RE ONLY FOCUSED ON THAT

MEDICARE 50%.

WHAT'S NOT ON THIS SLIDE

UNFORTUNATELY, IS WHAT IS

A QUALIFYING M.A. ORGANIZATION,  
SO I'M GONNA HAVE TO JUST TELL  
YOU THAT PART, AND, OF COURSE,  
IT'S IN THE NPRM ON 19:20,  
AND BASICALLY,  
THEY ARE THE HMOs.

ACCORDING TO THE STATUTE,  
IT WAS AN HMO AS DEFINED BY  
SECTION --WHAT DOES IT SAY?--

18:53 OF THE PUBLIC  
HEALTH SERVICE ACT.

WELL, IF YOU ACTUALLY READ  
THAT SECTION, IT BASICALLY SAYS  
AN HMO IS AN HMO THAT'S AN HMO  
BY VIRTUE OF BEING QUALIFIED BY,  
ONE, THE FEDERAL GOVERNMENT  
OR STATE GOVERNMENT.

IT'S MY UNDERSTANDING THAT THERE  
ARE VERY, VERY FEW FEDERALLY  
QUALIFIED HMOs.

THEY ARE ALMOST ALL AT THE STATE  
LEVEL, SO WE ARE REALLY LOOKING  
AT PEOPLE WHO ARE STATE-LEVEL.

WE ACTUALLY TOOK IT A STEP  
FURTHER IN THE NPRM PLAN,  
AND IF YOU ACTUALLY OFFER AN  
M.A. PLAN THAT IS IDENTIFIED AS

AN HMO PLAN, WE WILL DEEM YOU  
A QUALIFYING M.A. ORGANIZATION,  
AND EVEN IF YOU OFFER A PLAN  
THAT ISN'T IN NAME HMO BUT YOU  
FEEL IT FUNCTIONS THE SAME WAY,  
THEN YOU CAN SO ATTEST TO CMS,  
AND I DON'T KNOW IF THIS IS  
OPERATIONALLY GOING TO BE  
AT THE REGIONAL LEVEL OR AT CPC  
OR WHAT USED TO BE CPC, AND,  
YOU KNOW, CMS WILL BASICALLY  
WORK WITH YOU TO SEE WHETHER OR  
NOT THEY AGREE WITH THAT  
ATTESTATION, BUT IF YOU HAVE  
AN HMO PLAN THAT'S IDENTIFIED AS  
SUCH OR YOUR RECOGNIZED BY  
THE STATE OR FEDERAL  
GOVERNMENT AS AN HMO,  
YOU'RE QUALIFYING  
M.A. ORGANIZATION, OK?  
THE LAST GROUP IS THE MEDICAID.  
THE REAL DIFFERENCE BETWEEN  
MEDICAID, AS YOU CAN SEE, IS,  
WE GET SOME NON-PHYSICIAN  
GROUPS IN THERE--  
NURSE-MIDWIVES, NURSE  
PRACTITIONERS, PAs.  
SO THIS IS THE DOLLARS.

YOU KNOW, THIS IS THE  
BREAKDOWN BY YEAR.

BOTTOM LINE, YOU START IN 2011.

2012, YOU CAN GET  
UP TO 44 GRAND.

STARTS TO PHASE OUT.

YOU HAVE TO START BY 2014.

THAT'S UNDER BOTH MEDICARE  
ADVANTAGE AND MEDICAID

AND MEDICARE FEE-FOR-SERVICE.

IF YOU PRACTICE PREDOMINANTLY IN  
A HEALTH PROFESSIONAL SHORTAGE  
AREA, GET A LITTLE BONUS,  
JUST LIKE YOU DO ON PART B  
PAYMENTS.

THIS IS THE MEDICAID--

SORRY ABOUT THE SLIDE

SAYING "MEDICARE."

THIS IS THE MEDICAID

INCENTIVES CHART.

AS YOU CAN SEE, THEY GET

SIGNIFICANTLY MORE MONEY,

AND THEY ALSO HAVE A VERY

DIFFERENT BREAKDOWN, AND IT CAN

ALSO BE OVER A

LONGER TIME PERIOD.

IT'S A MUCH MORE GENEROUS

PROGRAM TO MEDICAID PROVIDERS.

OK, SO MEANINGFUL USE, THIS IS  
KIND OF MY BREAD AND BUTTER.  
THIS IS WHAT I'VE BEEN  
SPENDING THE LAST YEAR ON.  
BASICALLY, I WOULD DEFINE IT  
FOR THE NPRM AND THE VARIOUS  
SOURCES WE GOT,  
AND THIS IS KIND  
OF THE CONCEPTUAL APPROACH,  
YOU KNOW, THE THREE STAGES,  
REALLY-- DATA, STORING,  
AND CAPTURING.  
SO WE WANT TO GET  
WHAT'S ON PAPER--  
AND SOMETIMES IT'S NOT  
EVEN ON PAPER--  
IN AN EHR IN A WAY THAT A SYSTEM  
OR A COMPUTER OR MACHINE CAN  
RECOGNIZE IT, RIGHT?  
SO IT DOESN'T DO ME ANY GOOD  
TO TYPE "ASPIRIN," YOU KNOW,  
IN SOME FIXED FIELD.  
I WANT ASPIRIN TO BE IN A WAY  
THAT THE COMPUTER KNOWS THAT  
IT'S A MEDICATION.  
THAT'S KIND OF STEP ONE.  
STEP TWO IS TAKING THAT  
INFORMATION AND EXCHANGING IT  
AND ACTUALLY IMPROVING CLINICAL  
PROCESSES, AND THEN STEP THREE  
IS HOPING THAT BETTER

OUTCOMES COME FROM BETTER

PROCESSES, BUT YEAH.

THE DATA CAPTURE AND SHARING  
IS REALLY WHERE WE ARE AT NOW,

AND THAT IS GOING TO BE A HEAVY  
SITUATION INVOLVED WITH EPs

CHANGING SOME OF THE  
WAYS THEY DO THINGS.

I HAD A PHYSICIAN IN THE LAST  
GROUP WHO BASICALLY SAID,

"WELL, YOU KNOW, NURSES DON'T  
GET TO SPEND TIME AT THE BEDSIDE

AT THE HOSPITAL ANYMORE BECAUSE  
THEY'RE OFF TYPING ALL

THE TIME."

I SAID,

"WELL, WHAT WAS THE WAY

"THEY USED TO?

"I MEAN,

DO THEY WRITE THAT MUCH FASTER

"THAN THEY TYPE?

"DID THEY WRITE BY THE BEDSIDE?"

HE'S LIKE, "NO.

"AT OUR HOSPITAL, THEY DID  
DICTATION," AND, YOU KNOW,

I WAS KIND OF LIKE, "WELL,  
WHY DID YOU GET

"RID OF DICTATION?

"YOU COULD HAVE DICTATION.

"YOU KNOW, YOU USED TO DO  
DICTATION, AND IT GOT PUT INTO

"RECORD, PAPER RECORD.

"THERE'S NO REASON WHY THE  
DICTATING COMPANY COULDN'T PUT

IT INTO THE EHR INSTEAD  
OF THE PAPER RECORD."

SO THERE ARE DEFINITELY A LOT  
OF PROCESS RISKS WITH THIS

FIRST STEP.

THIS IS JUST PUTTING YEARS TO  
THE STAGES, SO THREE STAGES--

2011, 2013, 2015.

THESE ARE THE PRIORITIES FOR  
MEANINGFUL USE FOR THE STAGE

ONE, AND REALLY, THE ONLY  
THING I WANT PEOPLE TO NOTE

ON THIS ONE IS,  
IT'S NOT JUST THE TOP ONE.

WE ARE ALSO LOOKING TO  
ENGAGE PATIENTS AND FAMILIES.

WE ARE LOOKING TO IMPROVE  
CARE TRANSITIONS, POPULATION,

AND PUBLIC HEALTH, AND THEN,  
OF COURSE, PRIVACY AND SECURITY

IS A BIG CONCERN.

WE DON'T WANT ALL THIS  
INFORMATION, YOU KNOW, SHOWING

UP AT THE RESULT OF  
A GOOGLE SEARCH.

THAT JUST GIVES YOU A BETTER  
BREAKDOWN OF HOW THE STAGES

ALIGN FOR MEANINGFUL USERS.

THIS IS A LITTLE SUMMARY OF WHAT  
IT ACTUALLY IS, AND BASICALLY,

IT'S JUST A SERIES OF  
OBJECTIVES, ALL OF WHICH ARE

UNDER KIND OF RECONSIDERATION  
FOR THE FINAL RULE THAT SPEAK TO

THOSE PRIORITIES.

THERE ARE BASICALLY TWO TYPES.

THERE'S ONE WHERE YOU  
JUST SAY, "YEP.

I'M DOING THAT,"  
OR, "NO.

I'M NOT DOING THAT," AND THERE'S  
OTHERS WHERE WE ACTUALLY TRY

AND COUNT THINGS, LIKE THE  
E-PRESCRIBING THING, WHERE WE

ACTUALLY SAY, "WE WANT YOU TO  
DO THIS 25% OF THE TIME, AND,

"YOU KNOW, HERE'S HOW YOU  
CALCULATE

THE NUMERATOR AND  
THE DENOMINATOR."

#### **Part 4**

>> CLINICAL QUALITY  
IS ONE OF THE OBJECTIVES.

THIS IS A BIG AREA, AND IT'S  
ALSO ONE OF THE AREAS WHERE M.A.

DIFFERS A LITTLE BIT.

UNDER CLINICAL QUALITY UNDER  
FEE-FOR-SERVICE AND MEDICAID,

WE HAVE OUR NEW SET OF MEASURES,  
AND THE HR IS GOING TO CALCULATE

THAT FOR THEM, AND THEY ARE  
GOING TO REPORT IT TO US

IN A NEW WAY.

UNDER M.A., IF THE MEASURES  
ALREADY EXIST UNDER HEDIS OR

HEALTH OUTCOME SURVEY OR

CONSUMER ASSESSMENT, WE'RE

ACTUALLY GOING TO TRY AND  
USE THAT SO YOU DON'T HAVE TO

DUPLICATE-REPORT IT.

IF THE MEASURE DOESN'T EXIST,  
THEN WE'LL HAVE TO GET IT

THROUGH ANOTHER WAY, BUT THERE  
IS THAT KIND OF ATTEMPT TO NOT

DUPLICATE REPORTING UNDER M.A.

THIS TALKS A LITTLE BIT MORE  
ABOUT THE MEASURES.

I NEED TO GO--TOO MUCH IN.

SO DIFFERENCES BETWEEN

MEDICARE AND MEDICAID, I ALREADY

HIGHLIGHTED THE MONEY.

THE OTHER BIG DIFFERENCE

IS THE THIRD ONE DOWN.

IN YEAR ONE, IF YOU'RE MEDICARE

ADVANTAGE OR FEE-FOR-SERVICE,

YOU GOT TO DEMONSTRATE

MEANINGFUL USE FROM THE GET-GO.

IF YOUR MEDICAID, YOU CAN GET

AN INCENTIVE FOR JUST ADOPTING,

BASICALLY BUYING AND INSTALLING

EHR, AND THE NEXT YEAR,

YEAR TWO, THAT'S WHEN YOU

HAVE TO START DEMONSTRATING

MEANINGFUL USE.

THAT'S PROBABLY THE

BIG DIFFERENCE THERE.

>> QUESTION.

>> YEAH.

>> SO IF A PROVIDER IS BOTH A  
MEDICARE AND MEDICAID PROVIDER--

>> THEY PICK.

>> THEY COULD PICK EITHER ONE.

>> MM-HMM, AND, YES, IT

WOULD SEEM LOGICAL THAT THEY

WOULD PICK MEDICAID.

NOW, THERE'S PATIENT

LIMITS TO MEDICAID.

YOU HAVE TO HAVE A

CERTAIN PATIENT VOLUME.

THAT'S 30%, IS THE

KIND OF EASY ONE.

THERE IS SOME LOWER PERCENTAGES

FOR, LIKE, PEDIATRICIANS

AND OTHER SPECIAL PROVIDERS,

BUT, YET, THAT'S OUR ASSUMPTION.

YOU KNOW,

YOU DON'T HAVE TO PICK MEDICAID,

BUT IT'S KIND OF

WHY WOULDN'T YOU?

SO I MENTIONED WE HAD THE  
PUBLIC COMMENT PERIOD.

IT ENDED UP BEING 2,281 COMMENTS

CAME IN FROM CONSUMER GROUPS,  
FROM VENDORS, FROM HOSPITALS,  
FROM PLANS, FROM, YOU KNOW,  
PRETTY MUCH ANY  
STAKEHOLDER YOU CAN IMAGINE.  
WE HAVE REVIEWED THOSE COMMENTS,  
AND SO HERE'S SOME OF KIND  
OF THE THEMES.  
ONE IS JUST,  
MEANINGFUL USES TOO HARD.  
WE SAID, YOU KNOW,  
IF YOU THINK OF IT AS  
A BAR AND WHERE YOU  
CAN GET TO BY 2011,  
WHEREVER WE ARE NOW, IT'S  
WHERE WE SAID IN THE NPRM,  
THAT DISTANCE IS JUST TOO GREAT  
FOR TWO YEARS, AND THE WAY THEY  
WANTED TO LOWER IT  
WAS TO ESSENTIALLY ADD  
FLEXIBILITY TO IT.  
RIGHT NOW, THERE'S  
25 OBJECTIVES.  
MEET THEM ALL, OR NO INCENTIVE,  
OR 23 IF YOU'RE A HOSPITAL.  
THEY HAVE LOTS OF DIFFERENT WAYS  
TO ADD FLEXIBILITY TO THAT--  
YOU KNOW, MEET HALF, OR YOU

HAVE TO DO THIS SET, AND YOU DO

50% OF THE OTHER SET.

THERE'S CONCERNS ABOUT THE

ONES THAT REQUIRE PERCENTAGES

AND THE BURDEN OF COLLECTING

THE DENOMINATOR INFORMATION.

TO GIVE YOU THE MOST OBVIOUS,

THE MOST HATED EXAMPLE THAT I

CAN USE SAFELY, IS FOR A

COMPUTERIZED PHYSICIAN FOR ORDER

ENTRY, WE SAID, "ALL RIGHT.

"WELL, YOU KNOW, DO 10% AROUND

"THE HOSPITAL SIDE OF ALL YOUR

ORDERS," AND THEY BASICALLY CAME

BACK AND SAID, "HOW ON EARTH ARE

"WE POSSIBLY GOING TO

KNOW HOW MANY ORDERS?"

SO WE'VE BEEN DOING A LOT OF

REVISIONS TO THAT ON THAT.

THE LAST THING, SINCE THIS IS

PLANS IN THE ROOM THAT I WANT TO

MENTION BEFORE WE GET TO THE

QUESTIONS, ADMINISTRATIVE

MEASURES, THERE WERE TWO

WHAT HAS BEEN TERMED

ADMINISTRATIVE MEASURES,

AND THOSE ARE CHECK INSURANCE

ELIGIBILITY AND SUBMIT CLAIMS

ELECTRONICALLY USING CERTIFIED

EHR TECHNOLOGY.

I EMPHASIZE THAT "AND" PART

BECAUSE THAT'S THE PART THAT GOT

A LOT OF PEOPLE UPSET.

BASICALLY, COMMENTERS SAID,

"THAT'S NOT PART OF EHR

"TECHNOLOGY, WE THINK.

"WE HAVE OTHER SYSTEMS THAT DO

"THAT, AND WE DON'T WANT TO HAVE

TO GET THEM CERTIFIED."

SO THERE WAS KIND OF

OVERWHELMING COMMENTS TO GET RID

OF THOSE TWO OBJECTIVES.

ON THE QUALITY MEASURES SIDE,

BASICALLY THERE'S BIG CONCERN

THAT THE MEASURES JUST AREN'T

READY YET, AND THAT SEEMS TO

ALWAYS BE THE CONCERN WHENEVER

YOU IMPLEMENT A QUALITY

MEASURE PROGRAM.

HOSPITALS, THE BIG ISSUE ON THE

HOSPITALS WAS THE HOSPITAL-BASED

ELIGIBLE PROFESSIONALS,

AND THAT'S BEEN RECTIFIED

BY CONGRESS.

TIMELINE.

NPRMs OUT, AND SO IF YOU CAN  
START TO REGISTER IN JANUARY

2011, IT'S A 90-DAY  
REPORTING PERIOD,

SO YOU CAN COME IN IN APRIL  
AND POSSIBLY GET PAYMENT IN MAY,

AND, LIKE I SAID, LATE JUNE  
IS THE TARGET.

SO I'LL BE HAPPY TO TAKE ANY  
QUESTIONS ANYBODY HAS ON THAT.

HA HA! YOU GET TO GO FIRST.

>> ON THE SLIDE, I THINK SLIDE  
10, YOU HAVE THE REIMBURSEMENT

WITH THE INCENTIVE  
PAYMENTS FOR MEDICARE EPs.

IS THAT HER PROVIDER, OR HOW--

>> YES. YEAH.

IT'S ACTUALLY A FORMULA WHERE  
YOU GET 75% OF YOUR PART B

CHARGES OR, IF YOU'RE ON THE  
M.A. SIDE, OF THE CHARGES TO

THE M.A. SIDE, AND THOSE  
ARE THE MAXIMUMS.

AT 75%,  
YOU ONLY NEED 24,000 IN CHARGES

TO MAX OUT, SO THE ANTICIPATION  
IS THAT ANYBODY WHO QUALIFIES IS

ESSENTIALLY GOING TO  
MAX OUT BECAUSE IT'S NOT

JUST PRESCRIPTIONS.

IT'S ANYTHING--

VISITS, ALL THAT CHARGES.

>> SO IF I'M IN M.A.  
ORGANIZATION AND WE HAVE

PHYSICIANS ON OUR--

BASICALLY, WE ARE IN HMO.  
WE OWN OUR PHYSICIANS.

>> YEAH, STAFF MODEL.

>> SO DOES THE M.A.  
ORGANIZATIONS GET PAID

18,000 PER PROVIDER?

>> YEP, AS LONG AS THEY'RE  
MEANINGFUL USERS.

>> NICE.

[LAUGHTER]

>> WE'RE ALL GOING  
WITH THE GREAT IDEA.

>> I HAVE A COUPLE  
QUESTIONS FOR YOU.

WE'VE NOTICED--

AND THIS MAY FALL INTO MORE  
OF THE STAGE II

OF THE MEANINGFUL USE--

BUT WE'VE NOTICED THAT A LOT  
OF OUR RURAL PHYSICIANS AND,

LIKE, OUR MOM-AND-POP  
PHARMACIES, THEY DON'T ACCEPT

E-PRESCRIBING, AND WE CAN ENTER  
IT INTO THE EHR, AND THEY STILL

HAVE TO PRINT IT OUT AND FAX IT  
OR GIVE IT TO THE PATIENT TO

TAKE INTO THE PHARMACY.

SO ARE THOSE PRESCRIPTIONS  
BASICALLY HELD AGAINST US,

OR IS IT A PERCENTAGE OF  
THE TOTAL MAYBE, AND ALSO

ON THE OTHER SIDE, IS THERE ANY  
INCENTIVES FOR PHARMACIES TO

BEGIN ACCEPTING?

>> RIGHT. YEAH.

THAT'S DEFINITELY ONE OF THE BIG  
CONCERNS BECAUSE THE EXPENSE TO

E-PRESCRIBING IS ACTUALLY MORE  
SIGNIFICANT ON THE PHARMACIST

SIDE THAN IT IS ON THE DOCTOR  
SIDE, AND, UNFORTUNATELY,

THERE ARE NOT IN THE LAW ANY  
INCENTIVES FOR PHARMACISTS.

TO ANSWER YOUR PRIOR QUESTION,  
OR YOUR FIRST QUESTION,

IN THE NPRM, YES, IT WOULD  
BE ALL PRESCRIPTIONS EXCEPT

FOR THOSE ONES THAT DEA  
SAYS CAN'T BE PRESCRIBED.

HOWEVER, YOU ARE CERTAINLY NOT  
ALONE IN THAT COMMENT YOU MADE,

AND THAT IS ONE OF THE  
POLICIES WE ARE RECONSIDERING

FOR THE FINAL.

>> ANY OTHER  
QUESTIONS FOR TRAVIS?

>> IN THAT SENSE ABOUT WHETHER  
OR NOT THAT CONSIDERATION,

PARTICULARLY ON THE RURAL SIDE--

WE ARE OUT IN NEW MEXICO--

IT COULD BE A CONCERN WITH US.

THE PHARMACISTS ARE JUST NOT

GIVING UP AT ALL IN SMALL,

LITTLE TOWNS, AND DO YOU HAVE A  
SENSE WHETHER OR NOT THAT POLICY

WILL BE RECONSIDERED?

>> YOU KNOW, UNFORTUNATELY,  
I CAN'T SAY FOR SURE.

I MEAN,  
WE DEFINITELY GOT TONS

OF COMMENTS ON THAT, AND,  
YOU KNOW, UNFORTUNATELY THIS

WOULD BE A MUCH MORE  
INTERESTING TALK SIX WEEKS FROM

NOW, BUT--

>> IS THIS A POSSIBLE  
APPLICATION FOR A GRANT?

>> YEAH. I MEAN,  
THERE ARE LOTS OF GRANTS THAT

HAVE COME THROUGH ONC, ALTHOUGH  
I ASSUME MOST OF THEM HAVE BEEN

AWARDED, BUT AGAIN, YOU KNOW,  
THE BIG CONCERN ON THIS ONE, IS,

LIKE I SAID, THE BARRIER IS THE  
PHARMACIST, AND WE DON'T HAVE

INCENTIVES FOR THE PHARMACIST.

>> HI.

I HOPE I AM NOT THE ONLY  
ONE THAT'S TOTALLY CONFUSED.

IF I AM, I APOLOGIZE  
FOR TAKING UP YOUR TIME.

DID WE JUST TALK ABOUT TWO  
SEPARATE DIFFERENT PROGRAMS?

>> YES.

>> OK,  
SO ONE IS THE ELECTRONIC

PRESCRIBING FROM A PHYSICIAN'S  
OFFICE THROUGH THE PHARMACY

AND ALL THAT.

THAT HAS NOTHING TO DO WITH  
MY PLAN, FOR EXAMPLE.

THIS IS THE ELECTRONIC  
MEDICAL RECORD WHICH

INCLUDES PRESCRIBING?

>> YES. SO THERE ARE  
25 OBJECTIVES.

PRESCRIBING IS ONE, AND THERE  
ARE 24 UNDER FUNCTIONALITIES

FOR EHRs THAT ARE PART OF IT.

>> OK, SO NOW,

WE ARE IN MAPD PLAN WHICH CMS  
HAS CORRECTLY DECIDED IS AN HMO.

WE DON'T MAKE THAT DECISION.

TEACH ME HOW THIS SECOND  
PART APPLIES TO US.

WE DO NOT HAVE  
EMPLOYED PHYSICIANS.

WE HAVE NETWORKS.

MOST OF OUR PROVIDERS ARE--

>> THE FIRST THING YOU GOT A  
LOOK AT IS TO SEE IF YOU HAVE

ANY PHYSICIANS IN YOUR NETWORK  
THAT WOULD ACTUALLY MEET THAT

80% THRESHOLD IN THEIR MEDICARE,  
AND THE OTHER THING TO CONSIDER,

TOO, IS IF THEY MAX OUT  
UNDER FEE-FOR-SERVICE.  
SO IF THEY ALSO BILL PART B

AND THEY MAX OUT  
UNDER FEE-FOR-SERVICE,

THEY GET THE FEE-FOR-SERVICE  
INCENTIVE.

WE'RE ONLY WORRIED ABOUT  
THOSE ELIGIBLE PROFESSIONALS

ON THE M.A. SIDE WHO HAVE SO  
FEW PART B CHARGES THAT THEY

WOULDN'T MAX OUT AND, THEREFORE,  
MIGHT GET MORE MONEY IF THEY

WENT THROUGH THEIR M.A. PLAN.

SO YOU'D REALLY HAVE TO LOOK AT  
YOUR NETWORK PHYSICIANS AND LOOK

AT THE 80% AND THEN GET AN IDEA  
OF HOW MUCH THEY BILL PART B.

DO THEY NEVER BILL PART B?  
THAT'D BE EASY.

DO THEY BILL PART B SOMETIMES?

THEN THE SOMETIMES THINGS,  
OF COURSE, YOU GET

IN TROUBLE, RIGHT?

YOU KNOW, HIGH REIMBURSEMENT  
PHYSICIANS WILL PROBABLY MAX OUT

WITH A COUPLE PATIENTS,  
YOU KNOW, WHEREAS LOW PRIMARY

CARE REIMBURSEMENT TYPE THINGS  
MIGHT TAKE A LOT OF SIGNIFICANT

VOLUME TO MAX OUT.

>> I THINK I'LL LEAVE IT UP  
TO THE FINANCE PEOPLE.

>> ANY OTHER QUESTIONS?

WELL, THANK YOU, TRAVIS.

>> YOU'RE WELCOME.