CMS INTERNAL DOCUMENT

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum:
Electronic Health Record (EHR) Demonstration

Leader: Administrator Kerry Weems

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2:00 pm ET

Operator: Good afternoon. My name is (Rebecca) and I will be your Conference Facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on the Electronic Health Records Demonstration.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a Question and Answer Session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you Ms. Highsmith. You may begin your conference.

Natalie Highsmith: Thank you (Rebecca) and good day to everyone. And thank you for joining us for this special Open Door Forum to discuss the CMS 5-Year - the CMS-Developed 5-Year Demonstration Project designed to foster the implementation and adoption of health - electronic health records and health information technology.

The EHR demonstration is focused on small to medium-sized primary care physician practices to use electronic health records to improve quality of patient care. The demonstration is designed to show that widespread use of EHR will reduce medical errors and improve the quality of care.

CMS is soliciting partners interested in working with CMS to implement the EHR demonstration in their communities. Organizations seeking to partner with CMS to implement this demonstration in their regions must complete a Medicare Waiver Demonstration Application.

States or areas where Medicare already has a similar project and evaluations underway will be excluded from participating in this demonstration. I am joined here in Washington D.C. by our Acting Administrator, Mr. Kerry Weems. And I will turn the call over to him for his opening remarks.

Kerry Weems: Thank you very much. Good afternoon everybody. It's great to be here today for this Open Door Forum. And I'm also particularly grateful for the opportunity to have met many of you as we traveled around the country sort of seeking interest for you.

The fact that we're having this call and that you're willing to take time out of your schedules I think demonstrate that there's a great appetite for learning more and for participating in this demonstration project, which just in my mind—and many of you heard me say—it could be a real game changer for electronic health records.

So the purpose of this call today is to make available to you our experts to make sure that you get your questions answered about the demonstration project, about how you apply and about the selection criteria and what

happens after the selection process. Our experts can help answer those questions.

You know, just reflecting over the last three months we've held, you know, events in many of your communities encouraging (you) to be part of the demonstration.

I would say, you know, I learned much from you about your communities and about the way that medicine is practiced in your communities. And I've heard the Secretary and the Deputy Secretary say the same thing. This project has had value to us so far. We look forward to there being even greater value.

And I hope that your collaborations have continued since that meeting - that you're working together, that you're working with other private payers with the states, other local political organizations with large employers. And that, you know, you have a cohesive group that can bring forward a successful application.

Let's just all remember that in the end what this demonstration is about—adoption of electronic health records—the real end - the real thing that we are trying to demonstrate with this project is that we can have better healthcare—not just for Medicare beneficiaries—but for everybody who comes into contact with the health system. That's our ultimate goal. And that's what we're trying to demonstrate with this project.

So thank you very much for participating today. I'm going to turn this now back over to our panel of experts who can start answering your questions. So thank you.

Natalie Highsmith: Thank you Kerry. I'm joined here in D.C. by Mike Nelson who is the Director of the National EHR Initiatives. And in Baltimore we have (Jodi Blatt) and (Debbie Van Hoven) who are the Project Officers with the EHR Demo under the Medicare Demonstrations Program in our Office of Research, Development and Information. First I will turn the call over to (Jodi).

(Jodi Blatt): Thank you very much. This is (Jodi Blatt) and I'm a Project Officer for the EHR Demonstration. Our goal today is to provide you with a (halo) overview of the demonstration design. And then Mike Nelson will go over the application process. Finally we will wrap up with a timeline, the next steps and then open up for your questions.

If we don't have time to get everybody's questions today, we do - I want to make sure everyone knows that we do have a demonstration mailbox. It's DMS_EHR_demo@CMS.hhs.gov. And if you have any questions that we don't get to today or in the coming weeks, please feel free to e-mail us there.

I'm going to be speaking today from the set of slides that are downloadable from the Demonstration Web site. They should have been also part of the Open Door Announcement. If you don't have them again I welcome you to go back to the Demonstration Web site after today's conversation.

I want to preface my remarks about the demonstration design just quickly with the - this is one component of the Administration's broad HRT strategy in a effort to ensure that most Americans have access to secure, interoperable health records by 2014.

I want to clarify thought that this is not a grant program to pay for hardware or software but a pay-for-performance program to document the impact of financial incentives on the rate of adoption of electronic health records and an

effort to show that we can get better value for our healthcare dollar through the use of technology.

The demonstration is modeled on the Medicare Care Management Performance Demonstration - another P4P Program that has an HRT component. That demonstration started July 1 and is operational in four states—California, Massachusetts, Arkansas and Utah—with almost 700 small to medium-sized primary care practices including almost 2300 physicians.

There are some key differences, however. This is a five-year demonstration that will be implemented in two operational phases each of which will be five years. We will be implementing this demonstration in up to 12 sites. And a site may be a state or region. And it will involve up to 2400 total practices to be included - approximately 200 per site.

But because it is a research project there will be a randomized design. And 1200 practices will be randomly selected to participate in the treatment or demonstration groups and 1200 practices will assigned to the control group. And we'll talk a little bit more about that in a few moments.

Also - as we mentioned before this is for small to medium-sized practices that in general that means approximately up to 20 providers per practice and that includes no only physicians but nurse practitioners or physician's assistants who may bill Medicare independently.

One of the questions that has come up with regards federally qualified health vendors or rural health vendors and whether they can participate. We are still evaluating that question. It relates to how they submit claims to Medicare and

the data that is on those claims and whether we can work around the data that are not on those claims in order to implement the demonstration.

So we do have a - we hope to have an answer for you in a couple of weeks regarding that. We will definitely have an answer long before we start to recruit individual practices. So again we have not yet determined the issue of eligibility for health centers.

The focus is on primary care practices. That includes internal medicine, family practice, general practice, gerontology. It does not include pediatric. It does not include ob-gyn because in general those providers do not provide primary care to Medicare beneficiaries.

It may potentially include some medical sub-specialists such as cardiology or endocrinology. But there is a clinical quality measure reporting component to this demonstration which we'll talk about in a few moments which is a physician is not operating as a primary care provider they may not be able to report on those Clinical Quality Measures.

So the focus really is on primary care providers or potentially those sub-specialists who provide primary care as a predominant component of their practice.

In addition in order to be eligible to participate in the demonstration, the practice must have at least 50 Medicare beneficiaries who use the practice for most of their primary care visits.

And I do want to qualify and clarify there's been some questions regarding whether practices can have an electronic health record in order to participate in the demonstrations. And they may. There are no restrictions as to whether a

practice can have an electronic health record at the time it applies to the demonstration or not.

The only requirement is that for those practices that are assigned to the demonstration or the treatment group by the end of the second year of the demonstration they will be required to implement a (unintelligible) or certified EHR by the end of the second year. But again at the time of application there are no requirements.

CMS has developed a beneficiary assignment algorithm that retrospectively assigns fee-for-service beneficiaries to practices based on where the patient's receives the most primary care visits during a particular reporting period. And this is an analytic process only. It doesn't affect where a patient can receive care.

And a patient assigned to one practice this year may be assigned to another practice in another year. It truly is a reflection of where they receive their Medicare services.

So again when we look at whether a practice has 50 or more Medicare beneficiaries that have received the predominant number of their primary care visits from a practice, we look at where patients in a given geographic area had all of their Medicare claims. And we look at claims for primary care providers and only those claims that relate to services that we deem to be primary care related services.

The demonstration is for fee-for-service Medicare beneficiaries only. So when we were looking at that 50 minimum we are excluding those patients that a provider may see that are enrolled in a Medicare Advantage Plan whether it be an HMO, PPO or a private fee-for-service plan.

And because the demonstration must be budget neutral (and tests) and other demonstration costs must be covered through the savings and the savings therefore must accrue to the Medicare program. So Medicare must be primary. And the beneficiaries must have A and B in order to be counted in that 50 minimum.

So physicians have patients that are not covered under Medicare Part B, for example, or they have patients who - for whom Medicare is not primary, they won't go into that 50 minimum calculation.

Finally beneficiaries that may have elected the hospice benefit are not counted, because often the primary care physicians have handed over the remaining care or the predominant amount of the care for those patients to the hospice-based physician.

So that covers basically the eligibility of practices and the beneficiaries for the demonstration. I'd like to move on to Slide 6 and talk a little bit about the incentive payments. I mentioned this is a pay-for-performance demonstration. There's really two components or incentive payments under performances that we're measuring.

The first is an HIT incentive payment for performance as measured by an office systems service. And I'll talk a bit more about that in a moment. The second type of incentive is a quality based incentive for recording and performance on 26 Clinical Quality Measures relating to the care for diabetes, congestive heart failure, coronary artery disease and preventive care services.

Let's talk a little bit first about the HIT related incentive. During the course of the demonstration, practices will be asked to complete a survey that will take

probably about 30 to 40 minutes. It's an—what we call an Office Systems Survey—that will measure the degree to which they are using an electronic health record and how they are using it in their offices.

Because we want to move practices no only from a paper chart to an electronic health record, but we want to see them move along the continuum to more sophisticated uses of that electronic health record. We know that there are practices the have EHRs but they may be using them, quite frankly, more like electronic file boxes.

So we really want to move them to more sophisticated uses. So they're using registries. They're using alerts and best practices. And this Office System Survey will get at that. The idea being that the score on that Office Systems Survey will be directly tied to the level of incentive that they receive.

So that those practices that score higher—because they are using more sophisticated uses of their electronic health records—will receive higher incentives. And again that will - survey will be done every year during the course of the demonstration.

At the end of the first year if they haven't implemented a CCHIT certified EHR - and CCHITs for those who are not familiar with this is certification commission for health information technology. They have developed standards for ambulatory care EHRs. And there's probably about 80 or so products that meet that standard. And again in order to get credit for having an EHR it must be a featured Certified EHR.

If they haven't implemented by the end of the first year that's okay. But by the end of the second year they must have implemented the CCHIT certified EHR

in order to get credit for (that). Practices that haven't will be terminated from the demonstration.

Control group practices -- and we'll talk again a little more about this later one when I talk about the evaluation -- will be asked to complete the Survey at the end of the second and fifth year only.

By the end of the second year they will be required not only to have a CCHIT certified EHR implemented but using it for core, minimum functionalities. And that is the documentation of patient visits or progress notes, the ordering of lab and diagnostic tests as well as recording of those results and the recording or prescriptions.

Now we don't mean that they necessarily need to be - have online ordering directly to the lab or online receipt of results directly from the lab or even full e-prescribing. So that at least there is documentation in the electronic health records that those services were ordered, what the results were and that particular prescription has been ordered.

And, in fact, to the extent that practices are using the EHR in a more sophisticated way -- such as having full online interconnectivity with the lab or full e-prescribing -- they will score better on the Office Systems Survey and earn a higher incentive. Bu there are - those are the four minimum functionalities that they will be required to have.

Moving on to Slide 9 and the Clinical Quality Measures - we are using the same Clinical Quality Measures - 26 of them that we're using in the Medicare Management Performance Demonstration. Seven of the 26 measures can be collected using claims data. But 19 do require data from the medical chart. And practices will be required to submit this data.

CMS has developed a data collection tool -- or the Performance Assessment Tool or PAT -- and we are successfully using that in two other demonstrations: the Physician Group Practice Demonstration -- which is of large group practices -- and the Medicare Care Management Performance Demonstration which is with small group practices just like those that will be participating in this demonstration.

We don't have the time to go into detail about the tool or all the measures now although I'm happy to answer as many questions as you'd like. For those who are interested we have the detailed specifications for all of these measures on the Medicare Care Management Performance Demonstration Web site. And again if you e-mail us at the EHR_demo Web site we'll be happy to send you as much detail as you'd like regrading that.

In the - at the end practices will not be reporting on these clinical quality measures until after the second year of the demonstration. And in that first year it's just going to be a paper reporting incentive.

The idea is to get practices used to the clinical measures, get them to understand the measures and what data is required and get them used to the reporting tool without having to worry about how well they score.

In years three to five, however, it will be a pay-for-performance incentive so that the measures will be scored. And their incentives payment will be directly tied to their scores on those measures with those scoring higher getting higher incentive payments.

So moving onto Slide 10 - this slide summarizes the payments by year. And again the payments will go to the practice - not to the individual physician. So

if there are eight doctors in the practice it will be one payment to the practice not to each physician.

And practices may use the money in any way they see fit. They can use it to invest in more EHR. They can use it as bonuses to the physicians. It's really up to them.

But to summarize - in Year 1 the incentive is purely for performance based on the Office Systems score. If they don't have any EHR at that point and they're not - and/or they do but they're not using it for the minimum functionalities, they won't get an incentive payment but they can stay in the demonstration.

By the end of the second year they must meet that minimum standard for use of their featured certified EHR in order to get an incentive and stay in the demonstration. And they must also report on the 26 Clinical Quality Measures.

In years three to five they will get, again performance based on their - incentive based on their performance on the Office Systems Survey for the use of their EHRs. But they will also get an incentive for their performance on the clinical qualities measures.

I will say that they - regardless of their score on the Office Systems Survey, if they don't achieve a minimum score on the Clinical Quality Measures they will not receive any incentive for their use of EHR. And the reason for that is we see the need of EHR truly as a tool to improve the quality of care provided to not only Medicare beneficiaries but all Americans.

And so if the end isn't there -- the improvement in quality -- we're not going to reward a practice for at least the minimum (measures) in terms of - as

measured by performance on these measures, they won't receive a reward for having the software.

Slide 11 summarizes the maximum potential payment to - per physician and per practice in each of the five years of the demonstration. And as you can see the total potential payment over the five year course of the demonstration is up to $58,000 per physician, up to $290,000 per practice.

And again the degree to which a practice scores on the Clinical Quality Measures and scores higher on the Office Systems Survey will determine the level of incentive that they get. Also want to point out that, again, payments are retrospective and practices can, again, use the funds as they feel appropriate for their practice.

Let's just talk briefly on Slide 12 about the evaluation. This is a recent demonstration. And there will be an independent evaluation. Mathematical Policy Research has been awarded the contract for that evaluation.

Key questions for the evaluation will include the impact of financial incentives on the rate of EHR adoption, the impact of EHR adoption on clinical quality performance as measured by our 26 Clinical Quality Measures and the relationship between EHRs and Clinical Quality Measures and cost to the Medicare program. A detailed Evaluation Design Report is going to be completed over the next several months.

As I mentioned earlier on half of the eligible practices that apply to this demonstration will be randomly assigned to the control group. The control group will not have any restrictions or requirements. They're not going to be required to commit to Clinical Quality Measures. So while they don't receive

any incentive payments, they also don't have any reporting burden in that way.

We will ask them to complete the Office Systems Survey at the end of the second and fifth year. And they will be paid a modest honorarium for the time it takes them to complete that survey. It's really not a very burdensome survey. Its time to complete is about 30 or 40 minutes.

There - otherwise there are no requirements for implementing or not implementing an EHR by the control groups. They would do what they would normally do in the absence of the demonstration.

Similarly there is no limitation on either the demonstration treatment groups practices or the control group practices in terms of participating in other similar pay-for-performance or HRT incentive programs. In fact we hope one of the impacts of the demonstration is to encourage other payers to implement similar programs and thereby have a greater impact on care in the community.

And so to the extent that there are other practices -- both treatment and control group practices -- or other programs by that treatment and control group practices will be encouraged to participate.

I know that was really quick. And again if we haven't addressed questions please feel free to ask them when we open up the phone lines. And again we have the demonstration Web site. I'm going to turn it over to Mike Nelson right now who's going to talk a little bit about the site selection process. Mike?

Mike Nelson: Thank you very much (Jodi) - great overview. I just wanted to tell everybody who's on the call that I will continue to follow the slides continuing on Slide 13 with Site Selection for those who are following along.

As Kerry Weems mentioned at the beginning, we've been traveling around the country inviting communities to apply to be part of this demonstration project. The community application period is open now. And applications are due at close of business May 13. We anticipate announcing 12 communities that will participate in the demonstration project around the middle of June.

Now as part of this application process what we're inviting communities to do is to come together collaboratively to complete the application. Each applicant will be identifying a community partner that will assist CMS with outreach, education, recruitment of physician practices.

This is a very important part for us as we recognize the resources that you have at the local level will be very instrumental in helping CMS to do those activities and efficiently recruit the 2400 physician practices that we will be recruiting nationwide.

Following the announcement of the 12 communities CMS is going to sit down with each of the community partners to develop the best recruitment strategy for their community. And so in completing the application right now we ask that you not focus on physician recruitment but simply in completing your community application.

I want to make it clear that there is no funding for the community partners. We're looking -- in terms of qualities, qualifications for the community partner -- we're looking for partners that have the ability, of course, to assist

CMS with this outreach, education and recruitment activities. In doing so they should reflect the community stakeholders at large.

Again we're encouraging communities to work collaboratively together and have all of the stakeholders at the table. Of course, to help with the physician recruitment they should have clear ties with the primary care physicians in their community.

I want to talk briefly also about the criteria that we'll be using to select the 12 communities. On the slides here this is the minimum - or the mandatory minimum criteria that I'll be talking about.

One thing that is obvious is that there can be no competing or conflicting CMS demonstration going on. If you've got on the Application Instruction document that's on the Web site, at the end of this document it has a list that shows all of the excluded areas that have competing or conflicting areas. So please reference that before you begin this process.

Communities need to have, of course, the geographic area that has sufficient number of practices. We're going to be looking to identify 200 primary care practices within each. And so, you know, the community that you define should have sufficient practices within it.

We are also going to be looking for defined community collaboration. This can be in terms of chartered value exchanges, BQI, other types of formal collaboration that's going on in the community level. And we allow you to elaborate on that in your application and show us how effective that collaboration has been and what you've done in the past.

Another big component that we're looking at is the extent to which there's private sector support for this project or for EHR adoption in general. You know, we do not have the ability to go to the private payers of healthcare in your communities and say we want you to replicate with your money projects similar to this. But what we're hopeful for is that they'll see the value of the model in which we've created and that similar incentive programs can be offered at the local level.

This can be in terms of similar incentive payments. This can be in terms of helping facilitate the adoption for the primary care physicians in your area or physicians at large. But what we'll be looking for in this area is just what type of private support is there or public support from the state government as well.

There's some desirable criteria that we mentioned as well. One of which is involving the idea of health information exchanges. We mentioned specifically or NHINs or National Health Information Network sites. (REO)s can be part of this as well.

What we're looking for is that in creating the vision for implementing EHRs in your community that you're also creating information exchange so that we get down that road.

Geographic area includes underserved populations. There's preference given to communities that have that as part as well as preference given to communities that include both rural and urban populations in their application.

So those are the things that we'll be looking for as we review the applications. The application is available right now online on the CMS Web site that's available in that PowerPoint that's there.

I would note we've had a handful of questions regarding the application itself. The application that is listed online is actually a general application that is used by CMS for multiple demonstration projects.

I would refer you to the Application Instruction as really your guide in completing the application. It will walk through step-by-step the areas that you do not need to complete. And it will give you - it will walk you through what we're looking for specifically. So please use that Application Instruction as your guide in completing the application.

Having said that I know that (Jodi) mentioned earlier the e-mails. If you have questions as you're completing your application, please do not hesitate to e-mail us and we will respond as quickly as we can to make sure that you're not being held up by lack of getting your questions answered.

So I will pause and I believe I'm going to be turning the time now to (Debbie) to talk about once the 12 communities are identified some of the activities that will follow after that. Thank you.

(Debbie Van Hoven): Okay thanks Mike. Next we want to talk about -- this is Slide 19 -- the implementation time frame for implementing the demonstration.

As we mentioned we're going to be announcing the 12 selected community partners and sites in June. Phase 1 we will also be indicating what sites will be in Phase 1. Four sites in Phase 1 we envision with the remaining eight to be implemented a year later for Phase 2.

The phasing of these sites really is a function of resources. We want to try to -- because of limited resources -- we're trying to limit the number of sites in the first year. And we're really going to try to identify the strongest

collaboration partners for those four sites and may consider other issues. But we will -- when we announce the sites -- be indicating which sites we would like to go with for Phase 1 and Phase 2.

We hope to automate some processes in Phase 2 including the application process for physician practices. So - and that's part of the reason why we're hoping to handle a larger volume for the Phase 2 sites.

In Phase 1 we have a schedule where we're hoping to begin recruitment of the practices later this fall of 2008 with the demonstration actually beginning in the spring of next year.

Once the sites are announced in June we do immediately want to turn our attention to working with the partners in those specific four sites to begin thinking about recruitment activities. We're hoping for a meeting in July here in Baltimore - a real good working session with the selected partners again for those four sites.

Oh okay. I'm sorry. (Jodi) was just pointing out we're actually on - I'm getting ahead of myself. And we're looking at Next Steps.

We'll be - we're talking about a kick-off meeting in July with the partners in the four sites that we identify for Phase 1. And it's really - we plan on it being a really productive working session.

This will be an opportunity to introduce the partners to staff and contractors -- there are multiple contracts associated with this demonstration -- and begin to talk about the design in more detail - the design of the demonstration and time frames. And we're really looking to work with individual partners to figure

out what might work in terms of recruitment strategies as we move into that phase of the process later in the summer and into the fall.

For Phase 2 we do want to specifically mention that we're going to put those sites on hold until next spring. And we'll basically undergo the same process a year later with a kick-off meeting including those sites.

And the reason for this is we really do want to focus on the first four sites. Part of the selection of the sites of Phase 2 it will again be for those that might need some time to develop their activities - to develop what it is they're doing in their particular state.

So again we are trying to separate the Phase 1 sites -- those four sites -- from Phase 2 in terms of the efforts that we put into this over the coming summer and fall.

And the last slide you'll see information links. We've talked about our e-mail box. Please, please feel free to send e-mails even if you're just looking for a link to the EHR Web site. We'd be happy to respond as quickly as we can. And again that is EHR_demo@cms.hhs.gov. Both of our phone numbers are there. We're very happy to get back to you as soon as we can if you do have individual questions.

One thing that I do think will be very helpful and I do think Mike and (Jodi) both alluded to this, if you look at the demonstration Web site there is a lot of information on the Web site. And particularly the Frequently Asked Questions document I think would be very helpful in understanding what is required in this initiative and the time frame and where we intend to go with this.

So with that I think we're finished with the formal presentation.

Natalie Highsmith: Okay (Rebecca) we are ready to go ahead and move into our open Q&A portion of the call. If you could just remind everyone on how to get into the queue. And everyone please remember when it is your turn to restate your name, which state you are calling from and what provider or organization you are representing today.

Operator: At this time I would like to remind everyone if you would like to ask a question, press star then the number 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A Roster.

Your first question comes from (Gregory Suinaga). You have the floor sir.

(Gregory Suinaga): Hello this is (Gregory Suinaga) from (Mele) Associates calling from Honolulu, Hawaii. I actually have three questions that I'd like to jam in here.

I did look at the FAQ number - a couple of days ago. And this might have been answered. But the first question is on your research contract with Mathematical Policy Research. Is that a strict research protocol that needed to go through scientific review and how strict those guidelines are for following that particular protocol?

Also I have a question on the physician side. If a physician was recruited and implemented the EHR with the understanding that he would get some incentives for participating but was placed in the control group, how would he be notified of that and when and if by implementing an EHR if he would be appropriately compensated for that?

And finally regarding your community partner initiative if there was any other - what would be the incentive other than getting the physicians into an EHR

program -- which we already have -- what other incentives would there be for the community partners to participate in this particular program when you have stated that there is no funding.

(Jodi Blatt): This is (Jodi). I'll try to answer them and I may pass some of them off to Mike if he wants to add on.

Let me take the second question first and that is regarding physicians who may implement an EHR but are assigned to the control group and what the process for that is.

We hope to start recruiting -- along with our partners -- in September individuals practices to participate in the demonstration. And the recruitment process will probably be about two months. We will go through a detailed process of reviewing and analyzing the applications to make sure that practices in fact meet the eligibility requirement.

Once we have the group of all eligible practices, we will do a stratified random sampling. And by sampling I mean we want to make sure they are as matched as possible. So we might stratify based on number of physicians in the practice, whether a practice if rural or urban, whether they're starting with an EHR or not and some other factors that our evaluation contractor will look at.

We will - we plan to complete the stratification and randomization assignment process probably toward the end of February. So we will then notify practices that have applied whether they have been assigned to the treatment or the control group.

At that point practices that are assigned to the treatment or the - or to participate in the demonstration will be sent some documentation, some Terms and Conditions. And they will be invited to participate in a regionally-based kick-off meeting.

So that means in the state where the demonstration is being held at a location to be determined with our partners in terms of what makes the most sense. So that's how that will go.

Practices that are in the control group if they have an EHR already or for whatever reason implement one in that time frame they are not eligible for any incentive. And keep in mind we are not paying for the full cost of an electronic health record. We are not buying hardware, software for a practice here.

It's not - it shouldn't be really considered as reimbursement for their hardware or software. They really should be committed to this. We hope they are. We think that this will improve greatly the quality of care that's provided to patients. And we think they should feel that as well.

And we do, however, think that the incentives are such that they could provide - defray some of that cost. So if they've incurred that cost already unfortunately there is no incentive payment available under this demonstration.

If there are other incentive programs available through their hospital, through their medical society, through the state or other private programs they may participate in those. The only payment under the demonstration that a practice can participate in would be the reimbursement for completing the Office Systems Survey.

So the question exists why should they even apply? Well if they don't apply in the first place they can't - they don't have the 50/50 chance of getting assigned to the treatment group. So that's one reason why a practice should apply.

But I think most physicians really understand the importance of research. And the reality is (there's) - one of the reasons for having a control group is to be able to do a good research project and determine the impact of financial incentives.

And if we can successfully document an impact I'm not making any up front commitments but that could impact future programs that might broaden the demonstrations in Medicare or provide incentives for other private or other public programs to do something similar.

So I, you know, I hope people -- and physicians in particular -- who are into (unintelligible) research too appreciate the need for good evaluation. And the control group is just part of that. So I hope people will understand that.

In terms of the research design itself one of the things we do to keep the research truly a good research and have a good, independent evaluation is we have another project (unintelligible) actually manage the whole evaluation.

And if you have questions regarding the research design or the steps that are going to be taken, please e-mail us at the EHR demo mailbox. And I will forward that to a colleague of mine who is managing the evaluation component of the demonstration.

I will tell you that if there are surveys we go through the Paperwork Reduction Act. They're published. We have to get approval for those. So there are a variety of procedures that we undergo to ensure that the research is appropriate.

In terms of community partners and the fact that there is no funding and why they should participate, I mean clearly we are looking for community partners that are committed to this even in the absence of the demonstration. That they're doing things whether it be a (REO) or a Charter Value Exchange, NHI Insight - they're committed to expanding the use of health information technology. If it's a medical society that's involved hopefully they're interested in bringing the opportunity to earn incentive payments to their member practices.

We realize there's not funding involved. I want to emphasize that CMS staff and our contractors are doing all of the administrative work required to implement this demonstration. So community partners - their role is going to be primarily one of helping us to develop a recruitment strategy.

The types of things that might be expected of them might be if they can host meetings where physicians can come where we can talk about - maybe come out and talk about the meeting or perhaps help us do conference calls or WebExs. Or we can talk more about the demonstration and help us recruit. If they have access to a newsletter or a mailing list and can help with mailings, it's that kind of work.

But once the demonstration starts all of the processing and administrative work we're going to do. So we're not going to be putting that kind of burden. So I hope the financial impact on any of our partners will not be that substantial in that way. The other role of our community partners will be to

help leverage this in the community and encourage other activities that Mike referred to.

Mike or (Debbie) would you like to add anything to that?

Mike Nelson: I will not try to improve on what you've just said (Jodi). Thank you very much.

(Debbie Van Hoven): Well I'll add -- not that it will improve -- but I think as (Judy) - (Jodi) alluded to I think this effort -- especially for established stakeholder collaborations I think really aligns with their efforts and their mission to advance the goal of widespread EHR adoption. So I do think that that's key and that getting started with supporting us at the front end of an initiative such as this.

(Gregory Suinaga): Okay thank you very much.

Operator: Your next question comes from the line of (Jerry Edson). You have the floor sir.

(Jerry Edson): Thank you. Yeah this is (Jerry Edson). I'm Technology Consultant with an evolving health information exchange here in the great state of Maine.

My - (Jodi) may have already answered my question. My question was going to be specifically - I understand there's no, you know, funding involved with this until it pays-for-performance. But my question was going to be whether there were any technical resources from CMS that were going to be made available.

(Jodi) you mentioned staff and administrative resources. So could you just elaborate just a tiny bit on…

(Jodi Blatt): Sure.

(Jerry Edson): …what kind of resources that would be available from you.

(Jodi Blatt): And I want to separate this into resources that might be available to work with community partners and resources separately with practices. Because there have been some questions about resources that might be available to practices in terms of implementation of EHRs.

In terms of the community partner role, the way we envision this working out -- and again we're hoping -- is as (Debbie) mentioned we will convening a meeting here in early July to which the community partners from the first four sites will be brought out. We'll go over in detail the demonstration design, answer questions that people have.

And begin to sit down and roll up our sleeves and say okay, what's the best way to reach out to all of those primary care practices in your community however you've defined it. Is it mailing lists? Is it a meeting that you have monthly with your practices?

We'll develop an application package -- we did this for the Medicare Care Management Performance demonstration -- which will have an Application Form, a document describing in a fair bit of detail the design of the demo, the payment methodology and (Qs&A). So we'll develop that.

The question is how do we get out to doctors? I mean if we were to just send a mailing list to all Medicare providers that are - that submit claims you and I

both know that's going to go if not in the top of the garbage (spot) on someone's In Box and just sit there.

So we feel - the reason we're working with you is that we feel that you probably have the best access and, frankly, the best credibility to help us get access to pitch the demo to practices so that they'll apply.

So our resources in that are (Debbie), myself and staff here at CMS will be working with you on that. The other resources that once the applications are submitted, they will come to a contractor we have.

It's going to be Actuarial Research Corporation. They are working with us on the (MCMP) demonstration. They will do all of the processing of the applications, the validation, the information on the applications - all of that work. Your work in terms of recruitment really is finished at the point the physician submits the application.

Now the next step on that is what resources are available to practices. And we've gotten that question. We are not going to be providing as part of this demonstration technical assistance to practices in implementing an EHR and how to pick an EHR, what things to look for, how to develop contracts, how to transition.

Quite frankly there are a lot of other entities out there that can do it a lot better than we do. CCHIT has available templates and documents on their Web site. My guess is many of the medical societies have staff who are able to do that. The QIOs have staff. They were doing that now through the (Dock It) Program. There's DOCQ.

There are a lot of other resources and technical information available to the practices in terms of implementing EHRs that, quite frankly, can do a lot better job of it than we can. And they can help practices in the control group as well as in the demonstration group.

The training that we will provide to the treatment group or the demonstration practices is we will be having WebExs on how to submit the Clinical Quality Measures, what they are, how to use our Performance Assessment Tool.

We will be - what we've been doing - and we did that with the Medicare Care Management Performance demonstration. We've learned a lot from that so we hope to learn from our experience there and make it - do it even better in this demonstration.

We'll have periodic question and answer sessions with practices. If they have questions about either the application process or the data collection process, the clinical measures. One of the things we do - and we just got finished doing baseline clinical quality measure collection for the Medicare Care Management Performance Demonstration Practices.

And we had a Q&A conference call session for them about, you know, the - we prepared reports for them and what's on those reports, how to read those reports, how to use them. And we do as many as needed in whatever time zone is needed. Most of those are recorded. If it's a WebEx they're usually available for downloading going forward so that they can listen to them at their leisure.

So that's the kind of technical assistance that we have available. Does that answer your question?

(Jerry Edson): Yes it does. Thank you very much.

Operator: Your next question comes from the line of (Cindy Hillstead). You have the floor ma'am.

(Cindy Hillstead): Thank you. This is (Cindy Hillstead) from the Wisconsin Medical Society. And thank you so much for hosting this special Open Door Forum.

I have three questions. One has to do with the technical specifications for the denominator on the Quality Measures. I cannot find those on the Web site. Are they available?

(Jodi Blatt): Yes they are. And they're available in as much minutiae as you would like. If you go onto the Medicare Care Management Performance Demonstration Web site, if you want to e-mail me at the EHR demo I'll send you that link because it's a real long URL.

I want to clarify. The measures we are using -- there are 26 measures -- most of them are (old) or if that's the correct word by the NTQA, the AMA -- a couple of them are CMS measures. We are not reinventing new measures.

We want to stay away from that because we don't - one of the things we want to work toward is consistency which is again one of the reasons the EHRs must be feature certified.

We know many practices participate in (HITA) submissions or other submissions for other health plans. And our goal is to keep these measures the same so it's easier on the practices. So we are using the definitions that the measure owners use.

We will update them as appropriate as the measure owners update them. There may be a couple of situations -- because due to the large institutional comparisons we don't -- but by and large we are using the measure owner's specifications.

And all of that detailed information is available on the Medicare Care Management Performance Web site. We are working with IFMC -- the Iowa Foundation for Medical Care -- in collecting that data. They also have a bulletin board that gets into detail about that.

The (pad) tool that we have developed -- just to let folks know -- has an import capability. And so practices have the option - first of all we're going to tell them who to report on based on the patients who are assigned to them.

They won't have to have the ability to identify which of their diabetics are the ones they need to report on. And if they're larger practices, we'll identify the patents up to a specified sample number. And we'll put it in a particular order. We'll develop a randomized order so (they can't) (unintelligible).

We are concerned about the fact that this is a research project. And we'll pre-populate this Performance Assessment Tool with all of the information about the beneficiaries they need to report on.

We'll give not only demographic information but any information that's available on claims that might answer some of the measures that are - can be calculated using claims space. They can still amend.

And the example I use is if you - we have a woman that we think needs a mammogram because we don't have a claim for a mammogram and that's a claims space measure but the provider knows that the woman had a bilateral

mastectomy at the age of 63 before she was a Medicare beneficiary, but the physician knows that. So the patient should be taken out of the denominator.

We - the practice has the option to do that because we fully recognize claims are not perfect or complete even with claims space measures. So all of that detail is out there.

But the (pad) tool does have the ability to import a (path or delimited) file. And I hope I'm not getting too detailed for some of you. But given practices will be required to have an electronic health record at the time they will be asked - by the time they'll be asked to do any reporting.

We are hoping that many of the EHRs will have the functionality within them to create tab delimited files. And one of the reasons we keep our specs out there is we are encouraging vendors -- because it is in their, quite frankly, competitive interest -- to make it easy to practices that might want to purchase their products to make it easy for them to report.

So we are hoping by the time this demonstration is up and running that since they've seen we are using this tool with the Physician Group Practice Demonstration, with the MCMP Demonstration and now with 1200 practices in this demonstration, they will see it in their competitive best interest to make it - to develop some of the tab delimited files and reports necessary to make it quite easy for practices, hopefully, to report. Or at least as much as possible reduce any administration burden.

(Cindy Hillstead): Thank you. So you're saying that CMS will be identifying the patients who…

(Jodi Blatt): Yes.

(Cindy Hillstead): …who comprise the denominator…

(Jodi Blatt): Yes we will.

(Cindy Hillstead): „,for the practices. Well that help I think is a very helpful thing. You'll be running the algorithm so no practice would have to buy the…

(Jodi Blatt): No.

(Cindy Hillstead): …specifications.

(Jodi Blatt): Yes. For example diabetes measures only allow - people must be under 75. There are some congestive heart failure measures that require an admission during a certain period. The benefit of having all the claims is we can do all of that.

(Cindy Hillstead): Okay. And that applies to the Chart Review Measures as well as the…

(Jodi Blatt): Absolutely.

(Cindy Hillstead): Okay. And then related to the technical specifications for the Office Systems Survey, is it the same one that was used for the (Dock It) Project?

(Jodi Blatt): It's very - it's going to be very similar. We're using that as a base. We're taking out some questions from that survey that don't relate to the demonstration. We're adding some other enhancements to it. But it should be very similar.

(Cindy Hillstead): Okay and is that available?

(Jodi Blatt): It's not complete yet. We are currently in the process of developing it. And then we will develop the scoring system. It should be complete or very close to final by the time we are ready to start recruiting physicians.

(Cindy Hillstead): Great. Thank you. Then we have 17 counties in our state that are not eligible because of the PGP Demonstration.

(Jodi Blatt): Correct.

(Cindy Hillstead): And I understand that you don't want to mingle the two demonstrations and have one affect the research results of the other. However, within some of the counties that are excluded we have two large group practices. And one of them relates to the Marshville Clinic that's participating in the PGP Demo. And the other large system is not participating in the PGP Demo but is in a county where there are also providers that are part of the Marshville system.

Is there any flexibility in including healthcare professionals that aren't participating in the PGP Demo and live and practice in a county that is part of the PGP Demo?

(Jodi Blatt): No.

(Cindy Hillstead): Okay.

(Jodi Blatt): The reason for that is it's not just practices that are participating in the demo. It's the various comparisons that we use for control group practices. Even if that practice isn't participating in the demo one of the things that goes into determining payments in that demo is what's happening in the rest of the market.

(Cindy Hillstead): Okay. Thank you. And then the last question I have relates to your expectations after the community partners help you with the recruitment process.

(Jodi Blatt): The - we want you to stay involved. But I think after the practices are recruited the second part of your role really takes front and center stage and that is the leveraging of this demonstration to increase its impact in the community through a whole variety of ways.

As Mike mentioned whether it's encouraging other private payers to do similar programs, whether it's stepping up to the plate and maybe providing technical assistance to the practices. That role really takes front and center stage once you're recruited the practices.

(Cindy Hillstead): Okay and there's no - okay so there's - I guess I got a little…

(Jodi Blatt): We're flexible on that.

(Cindy Hillstead): …because, you know, in the spec - or in the application it talks about that, you know, once the recruitment is done CMS is going to take over on the operations. But there isn't any prohibition in terms of the community partners who help you do the recruitment staying involved to help the practices be successful.

(Jodi Blatt): Absolutely not. We welcome your participation, your input, excuse me. But there isn't a fixed sort of administration role there.

(Cindy Hillstead): Okay. I'm a little concerned about, you know, the reliance on WebExs and technology because we have some experience here in small practices. And my experience is that they are less inclined to take advantage of those sorts of

resources. And they may have - even though they are - will be implementing an EHR they are - their culture is a little bit different in terms of…

(Jodi Blatt): I hear what you're saying. We've, you know, working with almost 700 practices in the Medicare Care Management Performance Demonstration has brought forth all of the issues - issues of sophistication, issues of even if they're sophisticated your key person in training might be a nurse manager or medical assistant who's going to work on abstracting data.

But if somebody else doesn't show up the day of the training that they plan to attend, they're pulled to…

Woman: Taking care of patients.

(Jodi Blatt): …because that's their primary responsibility.

(Cindy Hillstead): Right.

(Jodi Blatt): And we're well aware of that. It's a challenge and it's - and quite frankly there's no easy (answer). We could have meetings and do things hands-on, you know, straight on. But going to a central city to come to meetings is not practical.

The benefit of WebExs is that people can play things back afterwards if they want to re-listen to something or they can't go during the day because, you know, a certain nurse didn't show up that day and they've got to cover. Or something else happened.

So we're open to whatever - I mean those kinds of suggestions of what will work in your community are absolutely welcome. And the challenges we know are there.

We will be work - our data collection - one of the roles of our data collection contractor will be to develop a Help Desk. They'll have lots of help over the phone with things. We won't be able to necessarily go out to the practices and hold their hands. To the extent that you can or want to we're more than happy to (watch). But we don't necessarily expect you to do that either.

We're open to, you know, again suggestion. WebExs and conference calls seem to be good because you can tape them and replay them but…

(Cindy Hillstead): Thank you very much.

Operator: Your next question comes from the line of (Roger Horde). You have the floor sir.

(Robert Horde): Yes hi thanks. Most of my questions have actually been answered. But I just wanted to get some more clarification on the denominator that the previous caller was asking about.

You said that you all will be tracking the Medicare patients by the claims that get submitted. And so that will be our population of patients that we're then reporting on is that correct?

(Jodi Blatt): Oh let me go through the assignment algorithm that we do. We determine - we have what we call a Beneficiary Assignment Algorithm that we use to not only determine whether practices meet the 50 minimum. But on an ongoing

basis -- on an annual basis -- we determine what patients are quote/unquote assigned to that practice.

What we do is we go through all of the - we go through all claims records for all beneficiaries residing in the location, however you define it. We look at all of their claims for primary care services.

And for purposes of the demonstration primary care is defined as a range of E&M, CPT codes, certain office visits or home-based visits and by certain specialty physicians, primary care providers.

We then look at where a given patient received the greatest number of such services. And the patient then gets quote/unquote assigned to the practice. It's totally a retrospective process that doesn't at all influence where a patient goes.

And MaryJoe is maybe assigned to Practice A this year and next year end up getting assigned to another practice. We then use that - we then look at - determine all the patients that were assigned to the practice.

We then go back and get all of that patient's claims whether it be to the primary care practice participating in the demo to a specialist, to a hospital halfway across the country, wherever. We get all of their medical care claims and we look to the diagnoses on those claims.

And based on the algorithm related to those measures we go back and determine whether the patient had diabetes, congestive heart failure, coronary artery disease or a range of other chronic care diseases. And those patients are used for the preventive care measures.

We then subsequently go further down and go to the detailed specifications for each of the Clinical Quality Measures. That means we go to the NCQA or the AMA specs for - depending on who owns the measure.

So, for example, in the diabetes specs we will not only look at who is assigned to the practice, we then look - go back two years and look to find whether there are certain types of claims with diabetes diagnoses. And we get kick out gestational diabetes and some other things that aren't - so we don't cloud the data.

And then we subsequently go down and pull out anybody who is over 75 because the spec - the measures aren't measured on people over 75. And there are other requirements. In the congestive heart failure cases I mentioned, the beneficiary must be - must have had - in one of the measures they must have had a prior hospitalization.

In some of the preventive care measures there are age requirements. Mammography, for example, is only measured on women up to age 69. So there's a whole host of specifications detailed for each of the measures.

We then take all of that data and pre-populate it into this Performance Assessment Tool. And at the time of collection every practice is sent its own unique database and software with all of the data on all of the patients categorized by condition and measures so they know exactly who they need to report on.

And they - also in that tool is data that might help them report. For example, one of the preventive measures relates to colon cancer screening. And because of the lead time in doing colonoscopies, for example, it's not a totally claims-based measure.

That said we know in the claims we've got lots of data about colonoscopies. So we pre-populate the tool with a lot of the data that a practice might need to help them report.

So again we send that data - every practice will get its own unique database each year to - and we'll identify the patients to report on. If it is a very large practice such that they have 1000 diabetics, they will not have to report on 1000 diabetics. We will have determined a specifically valid sample size. And we will randomly choose up to a certain number of patients that they need to report on.

(Robert Horde): Okay. And then - so with this pad tool that we receive and the database how do we then - I mean - I'm in IT here and I support - and I didn't indicate I'm at Mercy Medical Center here in Baltimore, Maryland.

But, you know, we have an analytics - we already have an EHR. We have an Analytics Tool that is capable of reporting on this data as well. So I mean how do we then match up the data that we're able to report out of our system with what goes into the pad? I mean are - is there a way we can import the data into that?

(Jodi Blatt): Yes the pad tool has an import function. So as long as you can create a tab delimited file - and our specs - we have detailed specs on what needs to be in that file - you can basically press a button and import it. And import any tab delimited file or (cell) file or (access) file - whatever format works.

And we do have technical staff that are available for our contractors that can work with your technical staff. We've gone through this process with many of the MCNB practices. And I'm hoping that for those of you on the line that

may represent smaller practices, one of the things that we're encouraging people to do is ask their vendors what are you doing to help me.

Because many of the vendors that are beginning to (unintelligible) - now that people are using this more and more are stepping to the plate to be able to, you know, have these canned reports that will create the tab delimited files so that the MCNB pad tool can import it.

(Robert Horde): Is it possible to see that pad tool now?

(Jodi Blatt): We will actually - one of the agenda items on our kick-off meeting with the practices - actually I could send you a Web site. I am trying to think - is there a demo on the IFNC bulletin board?

We have a demonstration bulletin board for the Medicare Care Management Performance Demonstration. And I think there's probably a demo of it up there. And if you send me an e-mail at EHR or anybody at underscore demo I will send you - with what you're interested in. We'll send you all the URLs. And you can get as much detail as you want.

(Robert Horde): What was that e-mail address again?

(Jodi Blatt): EHR_demo@cms.hhs.gov - tell me what you want and we will e-mail back all of the URLs that you need to click on to get to the details.

(Robert Horde): Okay…

(Jodi Blatt): And then…

(Robert Horde): Thank you and then just one other quick question is what defines a practice for this demonstration purposes? Is it a single tax ID or is it just a number of physicians? I mean it says under 20.

(Jodi Blatt): It's under 20. And it's up to the practice itself to self-define. It's a challenge. It isn't a tax ID number. We asked, for example, in the MCMP demonstration some very large practices - Intermountain Healthcare, for example, in Utah has many, many practices across the state of Utah. They all bill under the same tax ID number but they have numerous health - numerous physician offices geographic locations that operate more or less autonomously.

And some of them applied and are participating in the MCMP demonstration, some are not. So as part of the application process we will ask practices to define themselves using their tax ID number and their Medicare provider identification number of individual (MPI).

As long as we can identify you uniquely that way, you can be a practice. And usually it's a geographic location. Where we have some problems is if Dr. Smith practices on Monday at Site A and on Tuesday at Site B. And he sees the same patients at either site depending on what day of the week it is and what's convenient for him and the patients. Then those two sites might want to apply as one.

But usually it's a practice is a geographic, somewhat autonomous site. But again we allow practices to identify themselves. The key thing is our being able to identify the physicians or nurse practitioners -- or PAs if they bill independently -- at the site. The claims and it is absolutely critical that providers bill with the correct identification numbers on the claim.

That mantra you will hear us repeating throughout. And that we can link that to the claims and the beneficiaries. As long as we can define it and is on the claims we can - you can define your practice that way.

(Robert Horde): Okay but I guess, you know, I'm sorry to keep on this…

(Jodi Blatt): No it's okay.

(Robert Horde): But as long as there's 20 doctors and you have 20 (MPI) numbers we cannot exceed that number. Is that correct or…

(Jodi Blatt): That's our guideline.

(Robert Horde): Okay.

(Jodi Blatt): And again if we have more applications in a geographic area then we can handle that are eligible, priority will be given to those - to the smaller practices. And priority -- just so people know -- if we have more than we can accept will be given to those practices that don't have EHRs.

Twenty is our guideline. We don't have enough applications and somebody comes with 21 are we going to allow you in? We may.

(Robert Horde): Okay.

(Jodi Blatt): (We're flexible).

(Robert Horde): Thank you.

(Jodi Blatt): We want practices to participate. And we will be as flexible and reasonable as possible. And we will work with you if you have any questions about how to define a practice in your unique set up because it's confusing.

(Robert Horde): Okay thanks.

Operator: Your next question comes from the line of (David Barclays). Sir you have the floor.

(David Barclays): Thank you. Yes is (David Barclays) and I work for a federal agency called the U.S. Access Board. And I'm following up on an e-mail I sent earlier.

My question is are you aware of any efforts to address accessibility of electronic health records, personal health records and related information technology?

And for clarification I'm referring to specifically to products conformance with the Section 508 standard. As you may know Section 508 is a federal statute that addresses the design of health information technology to ensure that it's usable by people with disabilities. Thank you.

(Jodi Blatt): I think that question is probably best to refer to CCHIT or (OP). (Debbie) do you want to have a…

(Debbie Van Hoven): And then - again we require CCHIT certification.

(Jodi Blatt): We could try to follow up with appropriate folks to answer this. This is really not an issue that we can answer right now. Mike did you have anything more on that?

Mike Nelson: No.

(Jodi Blatt): (David) we will get back to you.

Operator: Your next question comes from the line of (Mitch Wyuker). Sir you have the floor.

(Mitch Wyuker): Hi good afternoon. This is (Mitch Wyuker) with the Palm Beach County Community Health Alliance in Palm Beach County, Florida. We're the (RIO) for the county.

And I was hoping that someone could answer definitely whether our community is excluded from participation due to other projects being run here.

(Jodi Blatt): All of the counties that are excluded are on the Application Information sheet. There's a table behind it. We're just looking it up now.

(Debbie Van Hoven): Palm Beach County is on that list so it is excluded.

(Mitch Wyuker): Okay thank you very much.

Operator: Your next question comes from the line of (Shannon Bradshaw). Ma'am you have the floor.

(Shannon Bradshaw): Thank you. This is (Shannon Bradshaw) with the Louisiana Healthcare Quality Forum. I was wondering if you could give me anymore information about what the application itself will look like for the practices that we help recruit. And in the physician practices (will they) fill out an application that is developed by you all.

(Jodi Blatt): (There) can - in fact that has gone to PRA approval. It was posted in the Federal Register about two or three months ago and it's going through the final phases now. It's going to look very much like what we're using for the MCMP demo.

It basically asks for some demographics. It asks for the location, their (unintelligible). (Debbie) what else?

(Debbie Van Hoven): It does specify the physicians that would be included as part of the applicant practice. And very importantly because we indicated that practices do not need to have implemented an EHR at the time of application we also - it's sort of baseline information.

We want to know what the status of your implementation will be - what your plans are. Because, of course, in order to be accepted you have to have plans to implement and be using the EHR within that two year period from the start of the demonstration.

So we do ask a bit about what your plans are if you haven't already implemented and if you have, what functionalities you're currently using.

(Jodi Blatt): One of the reasons that's important is -as I mentioned before there's going to be a stratified random sampling assigning practices to the demo and the control groups and some of that data will go into that.

(Shannon Bradshaw): Okay I have two follow up questions. One is can we - I mean you've referenced it as a public document. Can you just tell me where I can view that?

(Jodi Blatt): It's not finally approved. But I can send - if you send us an e-mail I can send you a copy of the MCMP demonstration application and it will look very much like that.

(Shannon Bradshaw): Okay and my last follow up is so that's the questions that we're asking, what will you - how will you make the determination of which ones to select?

(Jodi Blatt): Okay well the first thing - once the applications come in they are viewed for accuracy making sure the tax ID numbers are correct and the PINS and TINS. And you may or may not be surprised they are not always accurate. And so we match against claims to make sure we get complete information.

We look at the specialty information that they tell us. And we look at what we have in the Medicare database. And we make sure that matches and is accurate.

For example, we - in the MCMP demonstration we had people submit applications that said they were internists which is great. But on our system though they said they were emergency docs. And that's because the first time they submitted claims to the Medicare program was when they were Fellows. They were moonlighting in the ER and they never updated it to - they got in the demo.

But those are the kinds of things that we need to look at because one of the critical things is to make sure we have accurate enumeration data so we can match claims to who's participating. And then we go through our algorithm process to make sure they meet the 50 beneficiary minimum.

That's basically the issues. And we - and our staff and our contractors will be reviewing that. Once all the applications are required to be in and we go through that we'll determine who's eligible. We'll see how many we have.

If we have more than we can accept - and again the goal is 200. It may be a little less. It may be a little more depending on the area. But it's 2400 nationwide. We'll do our randomization and then we will notify the physicians.

(Shannon Bradshaw): So it will be a randomized process for selection if they meet the criteria?

(Jodi Blatt): Yes.

(Shannon Bradshaw): But you're targeting three to five (size practice) given preference in those without EHRs.

(Jodi Blatt): We are targeting practices with up to 20 physicians. And they may or may not have an EHR. But if we're inundated with applications in a given area, priority will be given to the smaller ones. And priority will be given to those without EHRs.

(Shannon Bradshaw): Okay thank you.

Operator: Your next question comes from the line of (Lamont Dupont). Sir you have the floor.

(Lamont Dupont): Hi I'm calling from Washington D.C. and I've got two questions. One is a follow up from the comment that (Robert) made with respect to tax ID for physician practices. Have you encountered any types of challenges with entities that are associates with IPAs?

(Jodi Blatt): There's no problem if they're associated with IPAs.

(Lamont Dupont): Okay. And then my second question is with respect to the actual disbursement of funds. Is the community partner involved in that or is that strictly being organized by CMS? And can you elaborate on the process?

(Jodi Blatt): It's organized by CMS. In fact we're going through that with our MCMP practices right now. But it will - the money goes to whomever the - or whatever entity the practice designates.

And I want to make that clear because we have some practices, for example, that from a claims basis it looks like three (fellow) doctors. They each (fill) under their own tax ID number.

From a day-to-day practice perspective they operate as a practice. They cover for each other. They share space. They share the nurse, whatever, the receptionist, whatever. And they may have a business entity that doesn't bill Medicare but that covers their overhead. And the money may go there. They get to tell us.

We ask practices to complete - the money is all transferred electronically. They complete an electronic transfer form that is totally separate in how they get their regular Medicare claims money. And we handle that. You don't have to deal with that at all. And we handle all 1099 reporting.

(Lamont Dupont): Great. Thank you (Jodi).

Operator: Your next question comes from the line of (Don Nelson). Sir you have the floor.

(Don Nelson): Thank you. (Don Nelson) - I'm calling from Iowa. I'm with Clinical Content Consultants.

I had a question about the experimental design. I think great idea to have a control group. But I'm having trouble understanding exactly what is the experimental variable here.

The experimental group is going to be required to implement an EHR. And they'll also receive incentive payments based on performance. Neither of those is going to apply to the control group. So if you find a difference in the experimental group how will you tell whether the difference is based on the mandate to implement EHR or on the pay-for-performance?

(Jodi Blatt): That's a very good question. We'll be collecting a lot of data. We'll be able to do a fair bit of multiple regression analysis and factor analysis and look at relevant components. We'll have longitudinal data as well as control versus treatment group data.

You know, so we hopefully will be able to do it by having a randomized assignment (unintelligible) as good as an analysis. Because we'll be able to look at not only practices in the control group that implement an EHR but those that don't.

We will have some clinical quality measures on the control group practices even though they're not supposed to submit we can use claims data and some other information to get at that.

We will have a full Evaluation Design Report available sometime in the next couple of months. And if you have specific questions - but the key variable

difference is the financial incentive and the impact of the financial incentive on the rate of adoption of EHRs.

And we'll be looking at dropout rates as well. You know, practices that may terminate. Hopefully because everybody has to be eligible and will have applied, any differential between practices in terms of, you know, intent to implement is the same because that baseline is the same.

But if you have specific questions about the evaluation we'll be happy to address them to our Evaluation Board.

(Debbie Van Hoven): And we'll also have some qualitative data from surveys, those at the practice level as well as beneficiaries.

(Don Nelson): I guess my question is if you're going to drop practices from the experimental group if they haven't implemented EHR at the end of two years, wouldn't it be fairer to do the same thing to practices in the control group?

(Jodi Blatt): That's one of the reasons - and we'll be looking at that. And that's one of the reasons that we are going to be doing the Office Systems Survey at the end of the second and fifth year for the control group practices as well. Because we'll know at the end of the second year not only who wouldn't have made it in the treatment group because we're going to drop them, but we'll also know in the control group as well.

We'll be following all of them. (Is it) absolutely secure? This is operational research. It's not absolutely secure but it's the best you can do within the design.

Operator: Your next question comes from the line of (Lynette Dixon). You have the floor ma'am. Ms. (Dixon) your line is open.

(Lynette Dixon): Oops sorry - (Lynette Dixon) from the Center for Rural Health at the University of North Dakota. Just with regard to the practice sites being recruited per site or per region so it's - you said the number is flexible with regard to 200 sites. And each one of those sites should be under 20 providers?

(Jodi Blatt): Correct. And we fully realize that - particularly for those of you who are in rural states maybe we can only recruit 175 or 180. Do I have a magic bottom line? No.

(Lynette Dixon): Okay that's just kind of averaging out so…

(Jodi Blatt): Yeah. We'd like to get as many as we can. And I'll be honest we will give priority to those - on the application to those community partners in areas that we think are most likely to generate the number of practices we need.

(Lynette Dixon): Sure.

(Jodi Blatt): So as you define your region, be big enough if you can to get more practices. But we realize that we - but we do also want an urban/rural mix. And that urban/rural mix may not be within each community partner but it may be across all 12 sites.

So if we don't get a full 200 out of one site -- maybe we only get 175 -- we may be able to recruit 225 from another site.

(Lynette Dixon): Okay so that's flexible to a certain extent.

(Jodi Blatt): We're flexible.

(Lynette Dixon): That's what we were concerned with our state, you know, with some of the CMS demonstration projects are we not even eligible because we don't have the population base.

(Jodi Blatt): We fully understand that. We also want more people to be aware that they can cross state lines if they think that would work for them.

(Lynette Dixon): (Right).

(Jodi Blatt): (That's one suggestion).

(Lynette Dixon): Okay.

(Jodi Blatt): That doesn't always work…

(Lynette Dixon): Right.

(Jodi Blatt): …but (that)…

(Lynette Dixon): And then my other question with regard to the community partners not having funding, you mentioned these kick-off meetings in Maryland. Now are there - would that be the community partner and they would be responsible for paying their way to these meetings also?

(Jodi Blatt): Unfortunately yes.

(Lynette Dixon): Okay because we've done that with the FCC also where there's meetings but then we're funding that too so just so we know. Okay thank you.

Operator: Your next question comes from the line of (Mark Groves). Sir you have the floor.

(Mark Grove): (Mark Grove) with Great Plains Clinic in Dickinson, North Dakota. (Lynette) thanks for asking the question earlier. That was my question number one.

But my second question comes - with the rural challenges here and collaboration being a problem with financial constraints for a lot of facilities, has CMS looked at facilities that have taken the initiative to purchase electronic medical records - have been using them for a couple years to include them in another type of a project or in another fashion where we can try to receive some incentive payments for taking on the EMR projects internally?

(Jodi Blatt): I'm not sure I totally understand because practices that have adopted electronic health records already are still eligible to participate in the demonstration.

(Mark Grove): Well if I have constraints within my state based on the practice size or anything I'm looking at is there any other considerations out there? I don't - I have the full EMR. And I'm wondering is there some type of a incentive project that you may have looked at or discussed that would take facilities right now utilizing EMR fully and try to pay the incentive payment to them versus going through all of the collaborative effort when you have other financial constraints with other potential partners that aren't willing to move forward with EHR at this point.

(Jodi Blatt): Right - no. Right now this is the only demonstration that we're working on besides the MCMP demonstration which is already operational in four states.

(Mark Grove): Okay thank you.

Operator: Your next question comes from the line of (Amy Jones). You have the floor ma'am.

(Amy Jones): Thank you. This is (Amy Jones) from Blue Cross and Blue Shield of Alabama in Birmingham, Alabama. And my question relates to the private sector collaboration. What level of documentation are you looking for in the application itself around the activities that will take place in the private sector?

(Jodi Blatt): Mike why don't you take that one.

Mike Nelson: Thank you very much. And it's a wonderful question. I think we're just asking for the communities to demonstrate what level of commitment there actually is.

So whether that be financial or whatever type of support, you know, an organization like Blue Cross Blue Shield is providing - there can be -- as I mentioned earlier -- you know, it could be to help physicians adopt or it could be to reward physicians like Medicare is doing for efficient use.

We would just ask you to demonstrate in your application process the extent to which that support goes.

(Amy Jones): Okay and let me ask a follow up question. If those activities or programs are in the development stages currently, is - are general terms enough?

Mike Nelson: Yeah I would get as specific as you can and then, you know, talk about where you hope that it's taking (you).

(Amy Jones): Okay thank you.

Mike Nelson: Yeah.

Operator: Your next question comes from the line of (Karen Wallenbrand). You have the floor ma'am.

Man: Hi my name is (unintelligible) and I'm answering for (Karen) on a question from Philadelphia, Pennsylvania. Do the community partners commit through all the interested practices? Or is there some selection criteria that they are using on their behalf to select partners?

(Jodi Blatt): I'm sorry. Are you asking about detail for the application itself?

Man: No I'm actually just asking what is the community partners using other than, you know, the fit and size of the practice to see who can enroll in this project. Or is it just interest only by the practices or, you know, what other criteria are they being instructed to use.

(Debbie Van Hoven): Well I think that, you know, hopefully whether it's a medical society, a Board of Registration Medicine in your state or whatever there's - or a medical group management such (unintelligible) general information in your area about how many practices are out there. And maybe there's some information about how many there are primary care are various sizes.

And I think that's what we're looking for in the application to give us an estimate of the potential population out there so to speak that we might go after to recruit. Does that - is that what you're asking?

Man: No actually what I'm asking is we're a practice. And we have a community partner who is - I assume who (we'll) be applying to.

(Debbie Van Hoven): Okay - no you'll be applying to us. And you'll be applying not until, you know, practices are not applying until fall. They're not applying right now. There's been some confusion there.

Right now what's going on is the competitive process to select our locations and the community partners we're going to work with in their locations. We will not start recruiting individual practices until September for the first four sites of the -- in September 2008 -- for the first four sites this year and then September 2009 for the remaining eight sites.

So - but the criteria for individual practices when that time comes will be number of doctors and specialty and be primary care. And then our rules of having that they have to have at least 50 beneficiaries for whom they provide the predominant amount of their primary care. And I don't think that's probably a problem for any internist or gerontologist or someone who provides care to adults.

(Jodi Blatt): No you - as part of the community partner applications they're - we do not want any listing of interested practices. What we want is information to sort of to document the defined community, if you will, can generate adequate numbers of practices. That's it.

(Debbie Van Hoven): For example, (if assigned) community based on information you get form your medical society or the Board of Registration or whatever you have says there's only 100 practices that are primary care that are small, medium-sized in that area, well we all know everybody is not going to be interested for whatever reason.

And so the likelihood is that, you know, whether it's 50% that are going to be interested or 20%, we're only going to recruit 20 or 50 practices. So my reaction if we were reviewing that application would be to say gee, there's not enough practices out there to make sense to pick that location.

So that's what we're looking for in the community partner application per se and then also where you get that information from so we can make sure it seems reasonable. We're not asking for a promise on the dotted line of these are the practices that are ready to sign up.

Man: Okay thank you.

Natalie Highsmith: Okay we have reached our 3:30 hour here on the East Coast. (Jodi), (Debbie) and Mike any closing remarks?

(Jodi Blatt): No I think again I don't know if there are other people on the line who have questions. We're happy to answer them. The slides - again EHR_demo - DEMO - @CMS.hhs.gov has the Web site. You may want to first check the Web site. There are FAQs - frequently asked questions there. There are (unintelligible) slides to these - this presentation.

If you still have questions after that, again submit your questions to e-mail. Our numbers are there. We're happy to talk with you. E-mail is always good because nobody likes to play phone tag. But if you want to call we're here.

Mike Nelson: Thank you. I would just - I would say thanks everybody for joining today and for your interest in this demonstration project.

You know, I'm hopeful that the process of working collaboratively with the stakeholders in your communities will be instrumental to the adoption of EHRs in your community for the long run. And I believe that communities that really embrace this collaborative process and work together to solve this problem will find greater success in their efforts.

So thank you everybody for taking the time to join us. As (Debbie) and (Jodi) said, if you have questions please send e-mails to us and we will get back to you as quickly as possible. Thank you very much.

Natalie Highsmith: Thank you everyone again. (Rebecca) can you tell us how many people joined us on the phone?

Operator: Five hundred fifty-nine ma'am.

Natalie Highsmith: Five fifty-nine - wonderful - thank you.

Operator: This concludes today's conference call. You may now disconnect.

END