

Moderator: Bill Finerfrock
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1:00 pm CT

Operator: Good day everyone and welcome to the RHC technical assistance national teleconference. As a reminder, today's call is being recorded.

At this time, I'd like to turn the conference over to Mr. Bill Finerfrock; please go ahead.

Bill Finerfrock: Thank you, operator. And as she said, my name is Bill Finerfrock. I'm the Executive Director of the National Association of Rural Health Clinics and I will be the speaker for today's call.

I want to welcome everyone to the presentation on electronic health record incentives that were included in the economic stimulus bill. Today's program is scheduled for an hour. The first 45 minutes will be devoted to my presentation followed by about 15 minutes for question-and-answer.

Prior to the start of my presentation, however, we will have a brief presentation by the Office of Rural Health Policy on a project that they are working on that they wanted to get some information out to you.

The purpose of today's call is to provide rural health clinics with valuable technical assistance and RHC specific information. Today's call is the 30th in our series which began in 2004. And during that time over 6200 individuals have participated on the bimonthly national teleconferences. As you know there is no charge to participate in this series and we encourage you to refer others who might benefit from this series to sign up to receive announcements regarding dates, topics, and speaker presentations at www.ruralhealth.hrsa.gov/rhc and you can go there to download the slides for today's presentation if you did not receive them or if you have misplaced them.

At the conclusion, as I said, we will have a question-and-answer period and we ask that you please identify yourself by name and the state that you're calling from just so that we get a sense of the geographic distribution of where folks are calling in from. And as I mentioned, we have a short presentation here, some comments from the Office of Rural Policy from Nancy Egbert with Office who wanted to talk to you about a project they're working on. So Nancy, please talk to the folks and let them know what's going on.

Nancy Egbert: All right. Great. Thanks Bill for giving me a little – a few minutes to talk to everyone about the pharmacy – the patient safety and clinical pharmacy services collaborative. We started – HRSA started this last year. I've been involved. Our office has been involved. We've contributed money and basically we want to try to recruit rural teams. So I'm going to give you a very brief summary of what the collaborative is about and try to encourage you to think about enrolling. And the slide deck that I provided will give you additional information including Web sites.

So let's start. First of all, you'll notice that Krista M. Pedley's name is on this PowerPoint and her contact information is at the end. And she's one of the leaders of the collaborative. So if you have any questions afterwards you can give her – contact her or you can also contact me

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. But let me ...

Bill Finerfrock: Yes, let me – I'm not sure that the slides have actually gotten delivered yet. So they may not get out until after the call is over.

Nancy Egbert: OK. I'm actually not going to go through every slide. The slides were just a reference. I'm just going to take a few choice ones just to try to give you a flavor of what we've been doing for almost a year. This collaborative I will say is groundbreaking. We've – no one's every done a pharmacy clinical pharmacy services collaborative before.

IHI is really interested in the outcomes and we're learning a lot. We've had 68 teams, 20% of those teams are coming from rural. And these are multi organization, multi disciplinary teams. And they represent the care continuing for the patient. So for example, it might be a hospital in a rural area. It might be a hospital primary care site such as a rural clinic or an FQHC. The primary care home has to be the main applicant. So that's why the rural health clinics are so important because obviously critical access hospitals don't always have a primary care clinic attached to them. So you're really important as potential participants in this.

So what is the collaborative? This collaborative is designed to improve patient safety and improve health outcomes through the integration of clinical pharmacy services. And there are several slides that define clinical pharmacy services, so I won't really go over that. But I'll just say that you don't necessarily have to have a pharmacist on site but a relationship with a pharmacist would be ideal.

Why are we doing this? Well, the most talked about or very common book around this was the report that IOM put out was "To Err Is Human" and that found that medication errors are the most common cause of patient safety issues. They injure 1.5 million people

annually and they cost billions. So it's a really important issue and we decided to try to tackle it.

As I said before the cornerstone of this collaborative is the clinical patient – or the clinical pharmacy services. And those are services that are very patient centered. They promote the appropriate selection and utilization of medications to optimize the patient experience. And I talked a little bit about the teams. We've had teams in 37 states. They're all over the United States including two teams that came from Puerto Rico.

So why am I talking to you about it now? We just finished the third learning session of the first collaborative. And we're getting ready to talk about and start the next collaborative which will start in this fall. So the participation package or the application is coming out this week and I just wanted you to be aware of it and know how to access it in case you're interested or at least you want more information. Essentially, the timeline will be the applications come out this week. They'll be due at the end of July. You'll be expected to form a team. Again, it's multi organizational team including or course this medical care home. And there will be some pre work that will happen before the first learning session which will be in September/October.

The cool thing that we're going to do this year is we're going to have the fourth learning session for the first collaborative and the first session for the second collaborative at the same time. So it will really give you a chance to hear what teams have been doing. It's been very, very exciting. I think teams have learned a lot. And we're really looking forward to have some more rural clinics participate. And with that I just want to point out that again, there are the Web sites at the end and the participation package is on the patient safety – the one with the patient safety Web site.

So I'm going to turn it back over to Bill and thank you very much, again.

Bill Finerfrock: Thanks, Nancy. And if you haven't gotten those slides you will within relatively a short period of time. And that will have all of the information that Nancy was referencing where you can go to follow up if you have questions, et cetera, on this initiative. And I want to reiterate, I think this is something that would be good for rural health clinics take a look at and consider participating in, in terms of bringing some of this stuff to your patients.

Thank you, Nancy.

Now, with our regularly scheduled presentation. It's on the electronic health record incentive payments that are available as a result of the economic stimulus package or I should say will be available. Beginning in 2011, that's 2011, there will be incentive payments available for a variety of providers including rural health clinics, community health centers, FQHC's, critical access hospitals, hospitals and physicians for what is defined as the meaningful use of a certified electronic health record system.

Under the Medicare portion of the incentive program only physicians and hospitals are eligible to receive payments. Rural health clinics as a specific entity under Medicare would not be eligible for incentive payments. Physicians, nurse practitioners, nurse midwives, rural health clinics, FQHC's and some physician assistants are eligible for electronic health records incentive payments under the Medicaid program.

What I'd like to do is go through and highlight and outline some of the criteria that you will need to meet in order to be eligible for those incentive payments. I want to reiterate and this will be on the third slide in that you have to be a meaningful user of a certified electronic health records system. It's not based upon when you purchased the system. A lot of folks have contacted me and said, well we purchased our electronic health record or we all ready have a system, does that mean that we're not eligible for the incentive payments. And the answer is that it is not based on when you bought the system. So the fact that you may all ready have an electronic health record system in place and you're currently using it does not prohibit you from obtaining the incentive payments because those are for meaningful use of a certified system.

Now, the problem that folks who have a system now may encounter is whether or not the system you have today will meet the certification standards that will be in place by 2011. Those certification standards are going to change and there will be new certification standards. So the issue isn't when you purchase the system but rather your ability to demonstrate that your system meets the certification standards.

For physicians who are not working in rural health clinics they must choose whether to receive a Medicare incentive payment or a Medicaid incentive payment but you cannot get both. For a hospital based physicians also are not eligible. Now, we are expecting that if you are a rural health clinic that is part of a hospital, you are a provider based rural health clinic, the incentive payments will flow through the hospital's incentive payments rather than to you individually as a rural health clinic.

So just as hospital based physicians are not eligible we are anticipating that the hospital based rural health clinics and the providers who work in those rural health clinics will not be eligible individually for the EHR incentive. It is the – you will be operating under the hospital system and therefore, part of the hospital's incentive payment process and I will go into that in a little bit. But right now, what they have defined and identified as hospital based physicians are anesthesiologists, pathologists, and emergency medicine physicians. And then the secretary has the authority to identify other providers as hospital based that would then be ineligible for a separate incentive payment and that's where we would anticipate that the rural health clinics that are provider based will see the money flow into the hospital and then into the rural health clinic through the hospital.

For physicians who are eligible for the Medicare payments those payments will flow either on a quarterly basis or at an end of year lump sum basis as long as they can identify that they are meaningful users of a certified EHR system. The amounts of the payment will be based on their allowed charges. So if there are practices here who are not listening in who are not part of a health clinic or you may have some practices if you're in a

system that are RHCs, some that are not RHCs, your physicians would be eligible for individual Medicare incentive payments.

In order to be considered certified, that means that it is a qualified electronic health record that meets the standards that will be and I want to emphasize will be adopted by the Secretary of Health and Human Services that are applicable to the type of record involved such as an ambulatory electronic health record for office based physicians. Now, we don't know even at this point who the standard setting organization will be whether they will use one of the existing private organizations.

One, for example, is CCHIT which is a health information technology certification organization. Or whether the government will set up its own independent government based certifying entity for purposes of evaluating the electronic health records and certifying them. I want to emphasize this is an absolutely critical point because I've had communications and conversations with many folks who have been approached by vendors who said "buy our system, we're certified." And that is probably true that they are certified meeting the existing certification standards in place in 2009. But those certification standards, as I said, will change.

I use the analogy for those of you who are old enough to remember back in the 80s there used to be two types of tapes available if you wanted to use your VCR we had beta and we had VHS. And I unfortunately was somebody who bought a beta tape and then they came out and said we're not going to have beta any more, we're only going to make VHS tapes. And so I had a piece of equipment that was essentially meaningless because I couldn't buy a tape any more that would work in the VCR that I had purchased. You don't want to buy beta in a VHS world. And I would just caution people to be very deliberate in making a decision on either if you have not yet purchased an EHR or if you all ready have one to work very closely with your vendors to ensure that your vendor is going to be able to meet the certification standards that are going to be coming down in the next year.

One of the key components of those new certification requirements will be that your system will have to be interoperable. That means that your EHR is going to have to be able to talk to all other EHRs around the country so that if you had a patient that went to a different state, a different region of the country, had to be admitted to the hospital, that hospital wanted to have access to your electronic health records so that they could see what was going on, that the system that you had was accessible by that provider in the other part of the country because it was interoperable.

There are currently no standards for the interoperability function of an EHR so that's why I tell people there's no guarantee that any existing system will be able to meet the certification standards because we don't know what the interoperability requirements will be.

In addition, in order to be certified your system is going to have to have an e-prescribing component. If you don't currently have an e-prescribing component to your EHR then

you're going to need to look to either add that through the certification process or purchase a system that has e-prescribing again as part of this certification process.

Next, once you've determined that your system is certified and you meet the certification criteria all entities that seek to obtain the EHR incentive payments will have to demonstrate that they are meaningful users of the EHR system. What the statute says is the eligible professional demonstrates to the satisfaction of the secretary during the period of time, so beginning in 2011 the professional is using certified EHR technology in a meaningful manner which as I mentioned, shall include the use of electronic prescribing. The eligible professional has to demonstrate to the satisfaction that during such period of certified EHR use that you're connected in a manner that provides for the electronic exchange of health information. This is the interoperability provision I was talking about to improve the quality of health care such as promoting care coordination.

Now, there will be additional criteria that will be developed and published by the Secretary and we anticipate that those will be done in a proposed rule making that will allow the community an opportunity to comment on the standards so that there will be a chance – we will know ahead of time what it will mean to be a meaningful user of the EHR system that has met your certification. So you have to have a system that is certified. And you have to demonstrate that you are meaningful user of that system in order to be eligible for the incentives.

Physicians who are not rural health clinics and seek to get the Medicare incentive payments will be eligible also for a 10% bonus payment if they – their practice is located in a health professional shortage area. So now we're going to look at what the actual dollar values of the incentive payments are. And they are incentive payments but then we'll get into there are also disincentives or penalties that will be paid if you do not adopt an EHR by a specific time period.

Beginning in 2011 for physicians who are opting for the Medicare incentive payment they would be eligible for up to a maximum of \$18,000 in incentive payments per physician through the Medicare program for the meaningful use of a certified EHR. Now, as I mentioned these payments can be paid either quarterly or in a lump sum basis at the end of the calendar year in this case 2011. So you could get \$18,000 per physician beginning in 2011.

If you adopt – if you don't first start using until 2012, in other words, you've got your EHR but you don't start using it until 2011 you can get \$18,000 if you're the – if you're starting your process in 2011 you can get \$18,000 for that year. If 2012 is your second year so you started in 2011, now it's 2012 you're in your second year of EHR use you get \$12,000 your second year. And the amount of the incentive declines over the next several years until 2015 when you would be eligible for \$2,000 in 2015 if you started in 2011. If you don't start until 2012 you only get incentive payments for 4 years. So you're encouraged to be what they refer to as an early adopter. The practices or the physicians who adopt in 2011 will get the maximum amount of incentive payments over the 5 years through which they're available. And it goes from \$18,000 the first year, \$12,000 the

second, \$8000 the third, \$4000 the fourth and \$2000 the fifth. But if you don't start until 2012 you only get 4 years 18, 12, 8, 4 you lose out on that last \$2000 in that final year.

If you do not begin using EHR by 2015 then you could be subject to a reduction in your Medicare payments unless you can demonstrate to the Secretary that doing so would represent a hardship to the provider. We don't know what those criteria for hardship will be but you are strongly encouraged to start using an EHR by 2015.

If you do not start using an EHR by 2015 you will be subject to a reduction in your Medicare payments starting in 2015. In 2015, if you do not demonstrate meaningful use of a certified EHR then you would only get 99% of what you would have otherwise been eligible to – for Medicare. By 2016, that would drop you'd only get 98%, 2017 97%, 2018 96% and it would hold at 96% until you demonstrated meaningful use of an EHR. And if you never use EHR or do not qualify for the hardship you're only going to get 96% of what you were eligible for under Medicare.

For hospitals and as I mentioned, this is where a significant number of the provider based rural health clinics will receive their benefit from the EHR incentive program. Beginning in 2011, hospitals and critical access hospitals are eligible for Medicare incentive payments for the meaningful use of a certified EHR system. And again, those meaningful use and certification standards will be out and published and available so that you'll know what you have to do.

If your hospital, this is not a critical access hospital, the law makes a distinction between a hospital and a critical access hospital. So what I'm about to talk about right now is only for the hospital would receive an incentive payment that is the sum of a base amount of \$2 million plus \$200 per discharge above the threshold level of 1149 discharges. So every hospital in America that is not a critical access hospital will get beginning in 2011 will get \$2 million if they can demonstrate that they are using a certified – meaningful user of a certified EHR system. And then an additional \$200 per discharge above the threshold level of 1149 discharges. So every hospital will get that \$2 million plus.

If you are a critical access hospital you will have to go through a calculation that will be hospital specific and I want to encourage the critical access hospital community to review the language here and speak with your accounting professionals to determine how you will qualify and the amounts that you can potentially qualify for as a critical access hospital. The reason the critical access hospitals are being treated differently is that you are all ready reimbursed 101% of your cost. The assumption is that the purchase of an EHR system is an allowable cost and therefore is being reimbursed all ready through your cost reporting methodology. But there was a recognition that some of those costs may not be fully captured and there may be a cash flow issue.

So the Secretary under the statute is charged with computing reasonable costs through an expense methodology in a single payment year and using a depreciation method over a period of years which shall include costs from previous cost reporting periods to the extent that you have not fully depreciated your EHR costs. Now, we're getting into a very

technical area here and that's why I'm encouraging you to work with your accountants for your hospital, your critical access hospital to see exactly how this works. I am not an accountant. I can give you the words but I can't explain what they mean because you don't want me going into an accounting area. But you are eligible as a critical access hospital for EHR incentive payments if you meet the accounting requirements that are laid out in the statute. And again, as with hospital – RHC's who are part of hospitals the EHR incentive the assumption is that those will flow through to the RHC that is affiliated with a critical access hospital as well.

What I'd like to do is while in no case will you get any kind of an incentive payment for the hospitals or the critical access hospitals, again, after 2015 and in know case will you be eligible for those incentive payments after that period of time. So you want to start looking at the accounting principles that are available for you as a critical access hospital. And with regard to the cost reporting periods and how you are to do those depreciations over the next several years – beginning in 2011.

If you are a meaningful user, you are eligible whether you're a hospital or a critical access hospital or the physician. If you are not a meaningful user, as I said, by 2015 you are subject to a penalty. As you know those of you who are with a critical access hospital you currently are receiving 101% of your cost as a CAH for Medicare patients. If you do not adopt EHR by 2015 that amount would drop to 100.66. In 2016 if you're not a meaningful user of a certified EHR that would drop to 100.33%. And for fiscal year 2017 and beyond if you fail to adopt an EHR you will only get 100% of your Medicare costs. So you will be penalized if you fail to adopt an EHR system by virtue of a reduction in your Medicare payments.

As I mentioned at the outset there are separate payments for the Medicaid program and here's where the RHC's specific provisions come into play. EHR incentive payments through Medicare are available to physicians, nurse practitioners, nurse midwives, rural health clinics, federally qualified health centers and some physician assistants who work in rural health clinics. In order for a practitioner or provider to be eligible for the Medicaid incentive if you are a physician, nurse practitioner, nurse midwife, not working in a rural health clinic you must demonstrate that 30% of your patient visits are for Medicaid patients. So if you are a physician, nurse practitioner, nurse midwife outside of a rural health clinic your threshold test is that 30% of your patients must be Medicaid.

If you are a rural health clinic or a federally qualified health center you can receive bonus payments through your physicians, nurse practitioners or physician assistants if your rural health clinic is PA led. Only in the case of the PA it must be what the law refers to as a "PA led" rural health clinic. Otherwise, all of the other providers are eligible regardless of who owns the clinic. But the clinic must be PA led. For RHCs and FQHC's the threshold standard is you have to demonstrate that at least 30% of your patients the volume is attributable to what the law refers to as "needy" individuals. So it is a different threshold than the other Medicaid providers, the non-RHC, non-FQHC who have to demonstrate that 30% of their patients are Medicaid, for the RHC and the FQHC community the definition is a needy individual.

And the statute defines a needy individual as someone who is receiving assistance under the Medicaid program, someone who is receiving assistance under the S-CHIP or the State Children's Health Insurance Program. Someone who is receiving care for which you were not compensated. So your clinic did not receive any compensation or someone for whom charges are reduced by your clinic on a sliding scale basis based on the individual's ability to pay.

So you look at the aggregate amount of those, your Medicaid, your S-CHIP, your uncompensated care and your sliding fee scale. And if 30% of your patients add up to at least 30% when you combine those then you are eligible for the Medicaid incentive payment. So if you look at a typical rural health clinic for example according to survey data 25 – 20 to 25% of an RHC's patients would be Medicaid, you might have another 5% that are S-CHIP, you might have another 5% that are either uncompensated care or sliding fee which would give you a total of 35% of your patients fall into those categories or 40% fall into those categories, you would be eligible for the EHR incentive payment as a rural health clinic. So as long as you meet that threshold test.

Now, what is it that you can receive if you demonstrate that you meet that threshold test, you can receive an amount not in excess of 85% of the net average allowable cost for certified EHR technology including support services, maintenance, and training for the adoption and operation of such technology. It does not say when those costs have to be incurred. So if you've all ready purchased an EHR system you want to have your documentation of what your costs were for the purchase of the system as well as any costs that you incur for the maintenance of that system or the training of your staff and begin accounting and be able to demonstrate those costs. So that in 2011 when the incentive payments start to kick in you have all of those costs available and you can recoup up to 85% of the net average allowable cost. So let's say your cost were \$100,000 over the course of the incentive program you can recover \$85,000 of that \$100,000 outlay.

Under the statute the term average allowable cost means the average cost for the purchase and initial implementation or upgrades. So if you all ready have a system but you have to upgrade it in order to add a function to make it interoperable or to add an e-prescribing those would be allowable costs because that's part of an upgrade. And support services, as I said, including the training. And that's a critical component. What kind of training costs did you incur as a rural health clinic to educate your staff on the use of this system?

In terms of what it is that you are – would then be eligible for. Your net average allowable costs under the section of the first year of payment could not exceed \$25,000. So if your cost were \$85,000 you would get – your first year you would get \$25,000 of that back because you haven't exceeded the 85,000 threshold if your total costs were \$100,000. The next year you would get \$10,000, the following year \$10,000, the following year \$10,000, and the following year \$10,000. You can get 5 years of incentive payments \$25,000 for the first year \$10,000 for each of the next 4 years for a total of \$65,000 in recoupment. And again this is per provider so if you have a physician

and a nurse practitioner in your RHC you can – in theory you can get \$65,000 per provider up to 85% of your total allowable costs. So in the case of a clinic that has a physician and a nurse practitioner, if your outlays were a total of \$100,000 you're capped at 85, you get 65 for your physician. The remaining \$20,000 could be recouped through your nurse practitioner or vice versa so you can get up to your \$85,000 total or 85% of your total allowable costs.

So you need to know that you're calculating this on a per provider basis. Your aggregate cap is 85% of your total allowable costs but the incentive payments themselves are calculated per provider within the RHC.

Now, the one confusing aspect of this is what happens with regard to physician assistants. We went through a lengthy period of discussion and argument with the Congress over – that's the initial language did not include physician assistants in the incentive payment program. We argued that they should be fully included.

Unfortunately, we were not completely successful. But the language does allow incentive payments to be available if the clinic is what the statute refers to as PA led. We don't know, the statute does not define that. At a minimum, we believe it will be a clinic that is owned by a physician assistant. And there are about 3 or 4% of the RHC's in the United States are PA owned but beyond that we don't know if it means that if the PA is the dominant provider, in other words, that your physician assistant is there full-time and your physician is only there part-time how that would work if that would be defined as a PA led clinic. We don't know that. That's one of the issues that we'll have to get resolved here in the next couple of – in the next 12 months. But you are eligible. Physician assistant led clinics are eligible for these EHR incentive payments.

In no case will Medicaid make incentive payments beyond 2021. So there will – there is an opportunity to get these incentive payments up until 2021 through the Medicaid program for your RHC but it will cease after 2021. But unlike the physician payments, if you start your first year you would get the \$25,000 whether that's 2011 or 2012 or 2013. You have a longer period of time to make the decision and to get the incentive period when it's – payments when it starts. But in no case will you get more than – incentive payments for more than 5 years or no later than 2021 if that comes sooner. So if you didn't start until 2018 and then you only get 2018, 2019, 2020 and 2021 you would lose out on that fifth year because it absolutely ends in 2021.

I want to emphasize that there is no double dipping permissible. That a provider cannot get incentive payments from both Medicare and Medicaid. And you cannot – you will not be able to get hospital incentive payments for the providers. So if your clinic is in a hospital we're not anticipating that – although it's not spelled out in the legislation we would not anticipate that RHCs that are part of hospitals or critical access hospital would get separate payments by being RHCs if you are a part of a hospital or a critical access hospital. Again, that would be considered to be double dipping.

But there is money out there. There is money that will be available beginning in 2011 for RHC's. And I want to encourage you all to take advantage of the resources that are going to be out there and available. My cautionary note as I've said on a couple of occasions is make sure that the system that you're going to buy meets the certification standards. And we will get information out to you as soon as those standards are developed and made public. We will share those with the RHC community. But if you have a system it is one that you purchase from a vendor. I would encourage you to contact your vendor find out what steps they are taking, what steps they will take to ensure whatever system – if you have their system that it will be able to meet those certification standards. And whatever assurances or guarantees whether they be a financial incentive or financial guarantee, contractual guarantee that you obtain those from your vendors because the last thing that you want as I mentioned earlier is to have bought a beta when VHS becomes the standard.

I'd be happy to take the rest of the time for questions if I can answer whatever questions you may have about the incentive program that's available so operator, if you want to go ahead and give the instructions we'll open up the phone line and take questions.

Operator: Thank you. Ladies and gentlemen, if you would like to ask a question, you may do so by pressing star 1 on your touch-tone telephone. Please keep in mind if you're using a speakerphone to make sure your mute function turned off to all your signal to reach our equipment. Again, that is star 1 at this time to ask a question.

We'll take our first question, caller, please go ahead.

Bill Finerfrock: Hi, Caller.

Female: Yes, I'm – my – I have a couple of questions. The first one is the PA led I just want to make sure that I understand that completely. The PA's will only receive payment if they're working at an organization that is run and organized by physician's assistants?

Bill Finerfrock: Well, it's – I mean I think your question is similar to the ones we've raised. They came back and said we will allow the incentive payments if it is a PA led clinic. And we said what does that mean? And they didn't provide us with any additional information. So we're going to have to try and get that from the Secretary in terms of additional clarification.

I think at a minimum, it means a clinic that is owned by a physician assistant – a rural health clinic that is owned by a physician assistant. Anything more than that at this point would be speculation although it would be our hope that clinics where the physician assistant is the dominant for most – in terms of the hours worked would be qualified as a PA led clinic but we don't know the answer to that. Can you tell us where you're from, caller?

Female: Hood River, Oregon.

Bill Finerfrock: OK. And you had another question?

Female: Yes, actually the two more dental. You haven't mentioned anything about whether dental hygienists which are similar to nurses and nurse practitioners in a medical practice, has there been any clarification on dental EMRs and how they qualify for this?

Bill Finerfrock: No. There are dental EMR – there's a dental component to the EMR system. I didn't go into that because we weren't focused on that.

Female: OK.

Bill Finerfrock: And I have not seen any additional clarification on those standards.

Female: OK. And then my final question is we have several physicians but very few of them are full time. Is it possible to roll up and have a cumulative number of FTE and use that? So we employee 13 people but when you roll up all of their time together it's really only about seven FTE.

Bill Finerfrock: I think that's going to be one of the questions, again that we'll have to get clarification for. There is some language that makes reference to works predominantly in a rural health clinic and it's not clear what that means and whether or not – and I think the kind of circumstance you describe is something that we'll want to try and get clarified during the rule making process here as to how that will be calculated. And I think your example of 13 individuals cumulatively would relate to seven FTEs would be a good example of who are we exactly going to calculate this.

Female: And do you have a timeline for this rule making process and when the applications will actually be released?

Bill Finerfrock: We don't. It won't be an application. What it will be is an incentive payment that will flow through either your cost report as an RHC, as a pass through at the end of the year and probably as part of your RHC reconciliation, year end reconciliation or for the physicians it will be linked to their fee schedule payments for those that bill through the fee schedule.

And there will be – it will be based as we understand it on code. So there will be some code processing as the claims are going in that you will have identify that we'll send a message that you are a meaningful user of a certified EHR. So it will not be an application process. You will identify it as best we can figure. You'll identify the EHR system that you are using. That will be deemed assuming they will have a list of those that are certified. And then you will demonstrate through your claims filing and your cost report that you're a meaningful use. And our expectation is that it will through some type of an end-of-year reconciliation for the RHC.

Female: OK. Thank you very much.

Operator: We'll move to our next question, caller, please go ahead.

Bill Finerfrock: Caller, go ahead. If you could identify who you are and where you're calling from.

(Bill Russell): Hi, this is (Bill Russell) calling from Bandon, Oregon. I got the impression that if you start being a meaningful user in 2014 you get nothing is that correct?

Bill Finerfrock: No. If you are on the physician side, if you are on the physician seeking Medicare incentive payments and you are initially adopting and using in 2013 you would get an incentive payment but the financial value of that would be I think it's at the \$8000 level if you don't start first using until 2013. So if you first start using in 2011 you get \$18,000 and then ratchet down. If you don't start until 2013 you start out at the \$8000 level and then you would only get \$8000, \$4000 and \$2000.

For the RHC it works different than that. There is not incentive or disincentive as to when you first start. So as an RHC if you didn't start – first start until 2013 you'd get the full \$25,000, then 10, 10, 10, and 10 over the 5 year period because there it just – it ends in 2021 so you wouldn't have exceeded the 2021 and you had gotten the full 5 year window of opportunity within that time frame.

(Bill Russell): OK. Thanks. I had one other question, actually I'm working with a future RHC, they're not yet certified. But we also have an issue in our town about the hospital payment. That 1149 discharges that's over what period of time?

Bill Finerfrock: A year – 12 months.

(Bill Russell): Over that year?

Bill Finerfrock: I'm sorry.

(Bill Russell): Over that year?

Bill Finerfrock: Yes. Over that year. So if you're seeing an incentive payment for 2011 they would look at the discharges during 2011.

(Bill Russell): OK. Thank you very much.

Operator: Again, ladies and gentlemen, that is star 1 at this time to ask a question. Additionally, please state your name and location before posing your question. We'll move on to our next question, call, please go ahead.

(Ron Rain): Yes, this is (Ron Rain), (Cobalt Medical Group), how are you today?

Bill Finerfrock: Good. Where are you – (Ron) where are you located?

(Ron Rain): Poulsbo, Washington.

Bill Finerfrock: OK.

(Ron Rain): I'm going to go right back to the very start and the question here is only physicians are eligible for Medicare incentives and that's physicians not practicing in a rural health clinic, correct.

Bill Finerfrock: Correct.

(Ron Rain): OK. So rural health clinics can just take that one away. So rural health clinics are only eligible for the Medicaid portion.

Bill Finerfrock: Yes. We would like to see that change. We've encouraged Congress to provide an opportunity for RHCs to get incentive payments through either Medicare or Medicaid in the same way that physicians do. But as part of the economic stimulus they created a two parallel processes one for Medicaid and one for Medicare.

(Ron Rain): OK. So the Medicaid has that 30% needy component. That's the – those are the numbers that we need to concentrate on to find out whether we're eligible for this program then, right.

Bill Finerfrock: Originally, they wanted it to be Medicaid for the RHC's and we collaborated with the FQHCs to give us a broader definition for purposes of qualifying so that it's the needy definition rather than straight Medicaid.

(Ron Rain): OK. Very good. Thank you.

Bill Finerfrock: So it will allow RHCs to qualify.

(Ron Rain): Thank you.

Operator: We'll move to our next question. Caller, please go ahead.

Bill Finerfrock: Go ahead, Caller.

Female: Hi, I'm calling from Pine Medical Group in Fremont, Michigan.

Bill Finerfrock: Great.

Female: We are a multi specialty practice but we're an RHC. And I was wondering do our specialists qualify for the incentive?

Bill Finerfrock: Your specialists are part of your RHC or not?

Female: As I understand it just the family practice is RHC but we're a multi specialty group.

Bill Finerfrock: Your specialists, as I read it, should qualify for the incentive payments because they're billing off of the fee schedule. And their payments will flow through the fee schedule and they would qualify under that, the first set of incentive under the Medicare, the 18, 12, 8, 4, and 2 schedule that I mentioned in the early part of my presentation.

Female: OK. Thank you.

Operator: We'll move to our next question.

(Heather): Hi, this is (Heather) calling from North Coast Family Health Center in Fort Bragg, California. And that last question just kind of threw me a little bit so let me see if I can re-gather my thoughts.

We're a provider based rural health clinic associated with a critical access hospital. So is it correct that we would either need to go through that pathway, the critical access or the MediCal if we met the 30% needy?

Bill Finerfrock: The – say your question again. I'm not sure if I understood it.

(Heather): OK. We're a provider based rural health clinic.

Bill Finerfrock: Right. Part of a critical access hospital.

(Heather): Yes and the Medicare reimbursement that would come through the cost report ...

Bill Finerfrock: Medicaid.

(Heather): Sorry?

Bill Finerfrock: Medicaid or Medicare?

(Heather): I had thought it was Medicare that came through the critical access.

Bill Finerfrock: Right. The critical access is linked to your Medicare. Your RHC is linked through Medicaid potentially. But you're – because you're part of – the critical access hospital will have an accounting process through your Medicare cost report for determining whether or how much you would qualify for as an EHR incentive payment from Medicare.

Your overall health clinic will or – our expectation is again we don't have the details on this, because you are a provider based part – rural health clinic is provider based to the

critical access hospital the expectation is that the financial – the cost for anything of the RHC is flowing through the parent entity. The parent entity is getting an incentive payment for a system that the RHC is using because they're provider based. The RHC would not be eligible because that would be essentially double dipping. You'd be getting – the RHC would be getting money. The parent would be getting money for essentially the same system because you should all be operating under a uniform EHR because it's a provider based clinic to the CAH.

(Heather): OK. So we would go only through the critical access cost report process.

Bill Finerfrock: That's the way it would read to me. Now, again, we don't have the details. It's conceivable that they could come out with something that would surprise us. But I think if you look at the way that they structured the incentive payments that the provider – anybody who is working through the hospital and the expectation is that the hospital is purchasing the EHR system or the critical access hospital is purchasing the EHR system that everyone in their system is using then individuals within that system would not be separately eligible for an incentive payment because it's the CAH or the hospital that is incurring the cost for the EHR not the individual parts of the system.

(Heather): OK. Thank you.

Operator: We'll go to our next question. Caller, please go ahead.

Bill Finerfrock: OK, Caller.

(Shelton Evans): Hello. My name is (Shelton Evans) calling from Baton Rouge, Louisiana. I was calling to – just trying to inquire whether or not the Medicaid agencies had the ability to set, I guess, penalties for non-use of EHR similar to Medicare?

Bill Finerfrock: The statute does not provide for that. So it does not indicate a disincentive through Medicaid or any kind of a penalty through Medicaid. But there would be the potential through the Medicare for some type of failure to use. So you may not suffer a penalty on Medicaid but you could suffer a penalty on Medicare for failure to use. There's no need to have a double penalty. In other words, I think the feeling is we've created a disincentive on the Medicare side of it. We're not going to do a double whack on you on the Medicaid side of it.

(Shelton Evans): OK. Thank you.

Bill Finerfrock: OK.

Operator: We'll take our next question. Caller, please go ahead.

Bill Finerfrock: Hey, caller.

Operator: Caller your line is open. Hearing no response we'll move to our next question, caller, please go ahead.

(Diane): Hi, this is (Diane) from Missouri.

Bill Finerfrock: Hi, (Diane).

(Diane): And I am calling. I had trouble printing the slides for the presentation. I was wondering if you could repeat the Web site.

Bill Finerfrock: Sure. If you got to www.ruralhealth-hrsa.gov/rhc you should see the slides are up. www.ruralhealth.hrsa.gov/rhc/. And just so you know that is also where we will post the transcript and recording of this call and it will be available probably in a week or so for those of you who want to go back and review the transcript or listen to the call again.

(Diane): OK. Thank you.

Operator: We'll go to our next question. Caller, please go ahead.

(Doug Bishall): Yes, (Doug Bishall). (Flugmore Clinic) in Moorefield, West Virginia.

Bill Finerfrock: Hi, go ahead.

(Doug Bishall): My question is we've had an EMR for 3 years fully functionally for the whole time. And, of course, over that period of time we've received payments – or received credits through our cost report. My question is do we still receive an incentive? And if so, do we still receive an incentive and report down on the cost report again? Or how do we get that?

Bill Finerfrock: You're a strictly overall health clinic?

(Doug Bishall): Yes, community and rural health clinic.

Bill Finerfrock: OK. The – unlike the CAH where they're all ready getting 101% of their cost and the assumption is that most of the CAH's to the extent that they have or will purchase an EHR would get those through some type of a fully reimbursable or a depreciation process on their cost report because there's no cap.

For the RHC community particularly the independent RHCs because you operate under a cap the expectation is that you're not really getting your full cost reimbursement. So at this point there has been no discussion about any kind of discounting or taking away of a part of the incentive because you may have incorporated part of those costs into your cost report. At this point, the way the language is written you would get the incentive payment regardless of whether or not a portion of that may have occurred in your cost report.

Now, that could change, again in whatever rules they come out with but at this point the statute treats rural health clinics differently than critical access hospitals even though you both are paid off of a cost report. But because RHC's independent have a cap we know that they're not getting fully reimbursed for all of their cost.

(Doug Bishall): OK. Thank you.

Operator: We'll move to our next question. Caller, please go ahead.

(Allison): This is (Allison) in Arizona. My question is about the critical access hospitals. Currently in their cost reports that they only get the reimbursement related to the proportion of Medicare patients that they serve but they're having to invest in 100% in electronic health records that also serve their Medicaid patients and their non-reimbursable patients as well as Medicare. Yet they only can report or get reimbursed for a portion of the Medicare patients. Does that mean that the cost come 2011 will continue only to get the Medicare reimbursement even though they ((inaudible)) for electronic health records that serve the entire patient population?

Bill Finerfrock: I don't know the answer to that question. ((inaudible)) mute your phone because we're getting a lot of bleed over from background noise there.

I don't know the answer to your question. The issue of how to deal with the critical access hospitals was a very contentious one. And as you point out on your cost report you're really only capturing that portion of your cost associated with your Medicare patients even though the cost to your system is for all of your patients. That is something that will probably have to be worked out through the rule-making process or the guidance process as to how that's going to work. I think the accounting principles that are laid out are an effort to try and help the critical access hospitals reduce or recoup some of those other costs. The extent to which they will, I don't know. As I said, I'm not an accounting person. I can't make heads or tails out of the way those were written. I suspect someone with an accounting background could sit and calculate for someone what it's actual value is.

But I think the questions and the point you raise were part of the discussion and part of the issue and why there was at least some willingness to provide an incentive payment for critical access hospitals because there were those who felt that there should be no incentive payment for the critical access hospital since they were getting 101% of costs albeit only for the portion of their costs associated with Medicare. So I don't know the answer to your question.

Next question.

Operator: We'll move to our next question. Caller, please go ahead.

(Jim Wing): This is (Jim Wing) calling from St. Francis in Escanaba, Michigan. Just a point of clarification we operate provider based rural health clinics but we are not a

critical access hospital. So if I understand correctly our only option at this point in time would be to access through the hospital the Medicare program not the Medicaid. Is that correct?

Bill Finerfrock: That would be the way I would read it. You're going to get – your hospital is going to get \$2 million plus \$200 per discharge over 1149 threshold. And that that money is the incentive payment that the hospital would get. There would not be an additional amount available because you had a rural health clinic.

(Jim Wing): OK. Now – but if we happen to have practices that were not designated as rural health but still owned by the hospital then those would be eligible for the ...

Bill Finerfrock: Are those additional practices provider based? Or they just happened to be hospital owned?

(Jim Wing): They just happened to be hospital owned.

Bill Finerfrock: My guess would be that those would be eligible because they're not considered provider based. But once you are provider based as you know one of the criteria for being provider based is that the clinic is fully integrated into the operations of the parent hospital and operated as if it is a department of the hospital. Since it's operated as if it's a department of the hospital the system – what the hospital purchases would be available to the RHC. Because those other practices are not required to be fully integrated I would think that there would be an opportunity.

Now, it will hinge on, as I mentioned, the Secretary has the authority to define or classify other physicians as being hospital based. It – a lot may depend on how much time they're spending in the hospital, how much of the work is occurring in the hospital versus outside of the hospital. So I don't know that it's an absolute given. But I think that there is a possibility that those other physicians would be eligible for incentive payments separate and distinct from the hospital.

(Jim Wing): OK. Thank you.

Operator: We'll move to our next question, please go ahead.

Bill Finerfrock: Operator, how many do we have in the queue?

Operator: We have two questions left.

Bill Finerfrock: OK. Why don't we take those and then that will have to be it.

Operator: OK. Caller, please go ahead.

(Kevin): This is (Kevin) from Otsego Memorial Hospital in Gaylord, Michigan. And we are a provider based RHC. And one of the assumptions that you mentioned is that the systems should be a shared system for the hospital and for the rural health clinics.

Bill Finerfrock: Correct.

(Kevin): In our case, we have two separate systems. I'm just wondering how does that play into this particular equation.

Bill Finerfrock: Well, I would question how is it that you're provider based if you're not demonstrating, you're fully integrated and you're operating on a separate system. I would think that you would – the provider based designation would be put into question if you're not on a fully integrated system with the hospital.

(Kevin): And we are doing some things to make it – the systems interoperable. We're going to some HL7 interfaces in between the two to share demographic information, share lab results, X-ray and so on.

Bill Finerfrock: But if you're not all ready doing that I would think that – how did you get provider based status if you weren't able to demonstrate that at this point?

(Kevin): I don't know. That's a good question. I'm not sure why that wasn't taken into account at that time.

Bill Finerfrock: I think you're an anomalous situation I believe because inherent in being provider based, as I said, is that you're supposed to demonstrate that you're fully integrated, financially, clinically, medically, with the parent hospital and you're operated as if you were a department. So I mean it would be as if I went to the ER within the hospital and they were not at all, even though they're physically located within the four walls of the hospital not at all integrated that would be – I mean it's counterintuitive and counter to the way it's supposed to operate.

So I don't have an answer to your question because I think you're an outlier and I'm not sure how – I would encourage you to get integrated as much as possible so that someone doesn't question why you're provider based.

(Kevin): OK. All right. Thank you.

Bill Finerfrock: Yes.

Female: We'll take our final questions. Caller, please go ahead.

(Amy): Yes, hello. This is (Amy) from Kansas.

Bill Finerfrock: Hi, (Amy).

(Amy): Hello. Hey, we are an independent RHC with less than 30% needy. So does that mean that we are not eligible for any incentives?

Bill Finerfrock: I would say that yes. How – are you sure you've calculated your needy? Or how are you calculating you're needy?

(Amy): Yes, we are a largely Medicare population but not a large Medicaid population.

Bill Finerfrock: Right. What about S-CHIP or uninsured or uncompensated care?

(Amy): Not 30% no.

Bill Finerfrock: So when you add it all up you don't reach a 30% threshold?

(Amy): No. We do not.

Bill Finerfrock: We – I mean this is – your situation is the point that we've made to the Congress which is that we have many RHCs that will meet the 30% threshold, but in a rural community it would not be unusual to have a disproportionately high percentage of Medicare given the demographics of a rural community particularly relative to the Medicaid population. So we have asked Congress to go back and see if we cannot create an incentive payment through the Medicare side of the program parallel to what it is available through Medicaid that will require additional legislation that's not there.

So if you don't meet the 30% threshold then you would not be eligible.

(Amy): OK. Thank you very much.

Bill Finerfrock: OK. That concludes. I want to thank all of you who asked questions today and who listened in. And I also want to thank the Office of Rural Health Policy, Nancy Egbert. As I said, you will get the slides for the project she was talking about, the pharmacy project she was talking about. A call – a transcript of today's call and a recording of the call should be available in about a week. We will send out a notice indicating its availability. It will be on the Rural Health Policy Web site address I gave you earlier. And I wanted to – our next call will be in 2 months. It will be – it is tentatively planned for information on a new initiative out of the federal government and around the states called a teen screen program which is how to do a better job of screening for depression amongst your teen patients. I will get information on that and the slides out prior to that call and the date and affirming of that.

Today's call as I said was our 30th in the series and we appreciate everyone who has participated and particularly the Office of Rural Health Policy who sponsors this series and makes it available to you free of charge. Thank you for your participation. And we look forward to having you on the line for our next call in July. Thank you very much.

Operator: Ladies and gentlemen, that does conclude today's call. Thank you for your participation.

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