

## **CAPITOL ASSOCIATES**

**Moderator: Bill Finerfrock**  
**March 4, 2010**  
**3:00 pm CT**

Operator: Good day, ladies and gentlemen, and welcome to today's rural health clinic's Technical Assistance National teleconference, "EHR; Meaningful Use Proposed rule." Today's call is being recorded. At this time, for opening remarks and introductions, I would like to turn the conference over to Mr. Bill Finerfrock. Please go ahead, sir.

Bill Finerfrock: Thank you, operator. And I'd like to welcome everybody to today's presentation on the Meaningful Use proposed standards for rural health clinics and others to receive the EHR incentive payments. I am Bill Finerfrock, and I am the Executive Director of the National Association of rural health clinics. And I'll be the moderator for today's call.

We have two presenters with us today from the Centers for Medicare and Medicaid Services, (Jessica Conn) and (Michelle Mills), who will go over the proposed standards for qualifying for the EHR incentive payments, timetables, and other relevant issues. Their presentation will last approximately 45 minutes, and then we'll open it for questions from the audiences.

Just as a reminder, this call series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health policy, and is presented in conjunction with the National Association of rural health clinics. This is the Rural Health Clinic Technical Assistance conference call series. And this is the thirty-third call in that series, which began in late 2004.

As you know there is no charge to participate in this series. And we encourage you to refer others who might benefit from this call, to sign up and receive announcements regarding the call dates, topics, and presentations. If you want that information, you can go to the Government Web site, at [www.ruralhealth.hrsa.gov/RAC](http://www.ruralhealth.hrsa.gov/RAC).

During the questions with our speakers, we will ask that you identify yourself by name and from where you are calling. And if you have questions or ideas for future topics that you'd like to pass along, then please send an e-mail to [info, I-N-F-O, @narhc.org](mailto:info@narhc.org).

We will try to get to all questions and answers. If there are questions for today that are unable to be answered in the time that we have allotted, and folks still want to submit a question, then you can send it to that address. We will forward it on to the folks at CMS and try to get an answer for you. Please follow along. Hopefully, everyone has received the slides for today's call.

With that, I'd like to turn over control to (Jessica) and (Michelle). It's all yours. Thanks for being with us today.

(Jessica Conn): Thank you very much for inviting us. I'm (Jessica Conn). I'm a technical director for HIT here at CMS, in the Medicaid area. And, today, (Michelle) and I – and I'll let her introduce herself in a moment – (Michelle) and I are going to talk to you about the Notice of Proposed rulemaking for high-tech – which is the act within the Recovery bill that was signed almost a year ago, in 2009. So this is the part that focuses on health information technology.

And, within that, there were some provisions specifically for EHR incentive programs, for Medicaid and Medicare. And we're going to talk to you today about the Medicaid provisions because we think those are the ones that are most applicable for the rural health centers.

So again, just a little overview of high-tech – but I think that, probably, most of you are familiar with this as it is, so we're not going to go too much into it or we'll be preaching to the choir. But the overview of high-tech – the purpose of this is to improve outcomes and reduce costs, and to simplify care, facilitate access, and all of the things that we believe that health information technology can do for healthcare services. So that's the long-term goals.

The short-term goals of this program are to actually make incentive payments, as this is part of the Stimulus bill. And the thought is that, by encouraging broad EHR adoption through the incentives, we'll get to our longer-term goals that I described a moment ago.

For Medicaid, there are some particularities for our program, which we are going to get into. But then under the Federal level, we have an additional role, which has to do with policy development, enforcement, and regulation writing. And that's the process that we're in right now.

And so our hope is that, by offering you this presentation today and answering what questions we can, that can help you in making some informed comments because we do really want to hear from the rural health centers' perspective what you feel about this EHR incentive program, how achievable is it, and where you might have some areas of concern or suggestions.

But we also have to think about what is the strategic vision for Medicaid, how this fits in with other quality programs we have, other health information technology programs we have, and even those within other HHS and other federal agencies. We work very closely with (HRSA) and have, obviously, a lot of federally qualified health centers, and rural health centers are Medicaid providers. And so, at the local level, these are invisible silos, we hope. So we're looking at our vision and how it comports with our federal partners.

And then (we'll be) defining things that have to do with operations, and making sure we're leveraging the resources that are available to us and to states. And we're going to talk a little bit

about where this has particular interest for rural health centers, whereas the rest of our presentation is fairly general and is true across all populations. And we'll explain to you where there are differences.

So the caveat, of course, is that this is proposed policy. We put out a Notice of Proposed rulemaking on January 13. The comment period will close on March 15, on the ides of March. And so it's all subject to change in the final rule. And all comments should be made through [www.regulations.gov](http://www.regulations.gov). And with regard to any questions or comments that you have with us today, though we really appreciate them and find them very useful, we want to make sure that you would also submit them to [www.regulations.gov](http://www.regulations.gov), so that they can be officially noted.

OK, so what is not in our proposed rule? This is not the rule that talks about the requirements for certification of electronic health records, or the standards for an electronic health record, or the process by which electronic health records will become certified and by whom.

Those are all addressed in "rulemaking" from the Office of the National Coordinator for HIT. They have a Notice of Proposed rulemaking that was just issued on Tuesday. And they also have an Interim Final rule that was issued at the same time as ours, in January, that covered these two topics.

There is no information in our rule about applying for HIT or (e-grants), or cooperative agreements. Again, those were allocated funds through the Office of the National Coordinator. And you can go to their Web site at [www.healthit.gov](http://www.healthit.gov) for information about funding opportunities that have been awarded or might be coming in the future.

And our reg does not talk about any changes to HIPAA that were also enacted as part of the high-tech legislation. So now, I'm going to turn it over to (Michelle), who is going to go over the eligibility questions for who can participate and receive an incentive.

(Michelle Mills): Hi, everyone. My name is (Michelle Mills). I'm a health policy analyst here at the Centers for Medicaid and State Operations.

I'm going to cover eligibility and payment policies first. And between Jessica and myself, we might discuss terms and concepts that sound confusing at first. But our goal is to tie them together at the end of the presentation. So you should make sure that you're taking down any questions and notes as we go through the presentation so that, if we don't get your questions answered throughout the presentation, then you can ask them at the end.

I'm going to stay out of the weeds for our justifications as much as possible today. And to those interested, if you haven't already, you should read the preamble. That's really the best way to get informed on our thinking for the proposed policies that we're going to talk about.

Again, as (Jessica) just said, please submit your questions formally through [www.regulations.gov](http://www.regulations.gov). We want to make sure that our final rule is the best product possible. And, again, this is just proposed thinking, now en route, talking to folks like you about this so that you can understand what our proposed thinking is and then make informed comments by March 15.

With that, I'm going to start on slide 5, which talks about providers that are eligible for the Medicaid incentives. When we talk about eligible providers and Medicaid, there are two groups – the eligible professionals, or EPs, as we call them, and eligible hospitals.

There are five different practitioner types that we think of when we say EPs, and those are the physicians, nurse practitioners, certified nurse midwives, and dentists. And then physician's assistants are eligible for this program only when practicing at a federally qualified health center or a rural health clinic that is so led by a physician's assistant. So we want to make sure that we're clear on that last one.

And then hospitals are eligible for this program insofar as they are acute-care hospitals or children's hospitals, so all of those are eligible providers in Medicaid.

So moving to slide 6, "Eligible Hospitals." When we say an "eligible hospital," what do we mean? Well, a hospital will have a CMS certification number. So we've proposed that one CMS certification number equals one hospital for purposes of participating in this program.

Early on, we had a question from the community asking, "If they had a separate tax ID number from the hospital, then does that make them eligible to participate in this program for purposes of an incentive?" And the answer to that question would be, "No." You need to have one CMS certification number for purposes of participating in this program.

So the statute identified that acute-care hospitals and children's hospitals would be eligible for incentives, but didn't define either of those facilities. So in the NPRM, we proposed that an acute-care hospital would be a facility where the average length of stay were 25 days or fewer, and the CCN fell within the range specified there on the slide. This includes the 11 cancer hospitals nationally.

Children's hospitals, we proposed, would be the 78 children's hospitals nationally, where the CCN fell within the range specified there on the slide. And it's notable that this does not include the pediatric wings of larger hospitals.

Moving to slide 7, patient volume is probably the largest indicator of eligibility for this program. And Medicaid EPs can be eligible by one of two ways. The first is in the middle column here, and that's not being hospital-based. And then the EPs can meet these patient volume requirements shown in the middle part of the slide. That, or EPs can practice predominantly in an FQHC or RHC and serve needy individuals.

So for example, if I am a nurse practitioner, then I can participate in this program when I have 30% of my patient volume derived from the Medicaid population, or I can practice predominantly in an FQHC or an RHC and have 30% of my patient volume derived from needy individuals.

I'm going to describe on the next slide here in just a minute what I mean by "practices predominantly" and "needy individuals." Additionally, acute-care hospitals must have 10% patient volume to be eligible to participate. And children's hospitals do not have any patient volume requirements.

So moving to slide 8, the statute doesn't define "practices predominantly." And we proposed that an EP does so when the clinical location for more than 50% of their patient encounters over a 6-month period occurs at an FQHC or an RHC.

Furthermore, "needy individuals" is specified in the statute. But we wanted to highlight it here. And it includes the groups that are listed here on the slide, which are Medicaid and CHIP enrollees, patients furnished uncompensated care by the provider, or furnished free or sliding-scale services.

Moving to slide 9, the statute does exclude most hospital-based eligible professionals. And the statute defines the term "hospital-based eligible professional" to mean a professional who furnishes substantially all of the individual's professional services in a hospital setting, whether inpatient or outpatient, and through the use of the facilities and equipment of the hospital, including qualified EHRs.

The determination of whether an eligible professional is hospital-based shall be made on the basis of the site of service and without regard to any employment or billing arrangement between

the EP and any other provider. I'm sure that a lot of folks on the call are very familiar with this and have read the statute carefully.

The important terms here to clarify in the NPRM included substantially all hospital settings and site of service. So moving to slide 10, the way that we proposed to resolve some of those terms from the statute in the NPRM included the following ...

"Site of service" would be resolved by using the Place of Service codes on the CMF-1500 Claims Form. "Substantially all" would be met when more than 90% of the threshold of services are delivered in a hospital setting. The "hospital setting" would be any combination of services in an inpatient or outpatient setting, including the ER.

From the Medicaid perspective, states would include their methodology in their State Medicaid HIT plan. And, in the second part of my discussion today, I'll cover what a State Medicaid HIT plan is.

So moving to slide 11 – EPs at rural health clinics. We know that we have a lot of providers on the phone today from rural health clinics. And now that we've covered all of the ways that a provider can participate, we wanted to make sure that we drilled down and were specific about how practitioners at rural health clinics can participate in this program.

So for any of the EPs that we talked about on slide 5 – so doctors, nurse practitioners, certified nurse midwives, dentists, or PAs insofar as they practice predominantly in the RHC that is so led by a PA – they could participate in the program by the two ways that we talked about on slide 7 – by meeting the patient volume requirements.

For example having 30% of their practice derived from Medicaid and not being hospital-based – or they can also participate by practicing predominantly in an RHC like we talked about on slide 8.



Again, this is just talking about with respect to providers at RHCs. Like all other providers, professionals in RHCs must meet all of the other program requirements. For example, they can't be sanctioned, and they must be licensed appropriately.

So moving to slide 12, now we're going to cover payments. We're going to stay at the 30,000-foot level because we could spend hours talking about the payment requirements. However, in the NPRM, we cover a number of areas such as registration requirements, hospital payments, the derivation of the incentive payments for EPs. And we have begun rolling out the requirements to the states with how they will register and enroll providers in the program.

So moving to slide 13, just briefly to cover some issues with payments with regard to timing, we have made efforts to align the Medicaid program with Medicare. Medicare has a statutory implementation date of 2011. Medicaid did not have a statutory implementation date.

You'll see many places in the Notice of Proposed rulemaking where we did make program alignment policy suggestions. Another place where we did this was where we proposed that EPs would be paid on the calendar year while hospitals would be paid on the federal fiscal year. We thought this made sense for providers wishing to possibly change between the programs. It made sense for us and states in terms of explaining the program.

Additionally, we proposed that, for states that are ready to make early payments for Adopt, Implement, and Upgrade – this is not for meaningful use – they would be able to make payments earlier than 2011 if they have certain safeguards in place. So that is one place where we did deviate from Medicare.

(Jess) is going to talk a little bit more about “Adopt, Implement, and Upgrade”, and “meaningful use.”

(Jessica Conn): OK, so now you know who is eligible for an incentive and who's not, to some extent.

And you know that they need to use a certified EHR. And I hope that everyone is clear that the process by which EHR-certified is under ONC's rulemaking. But then you actually have to do one of two things in order to receive the incentive payment with that EHR.

For Medicaid – and this is for only Medicaid – the bar for the professional's or the hospital's first year of participating in the program is not meaningful use. The bar that has to be met in order to receive a payment, if you've met all of these other eligibility criteria, is adopt, implement, or upgrade. And that's from the statute. But in our proposed rule, we define those things. So I'm going to go through them and explain what they mean, and then I'll talk you through, from there to how you get to meaningful use.

Adopt, implement, and upgrade; I'm on slide 14 – well, now I'm moving, I guess, ahead to slide 15. But I'll go back to slide 14 in a moment. So for adopting, we're talking about activities that demonstrate that the provider has acquired or installed an electronic health record.

This is not, as we like to joke here, surfing the 'net to see what's there, walking around the exhibition hall at (Hemms) last week, or wandering through Best Buy. This is actually making concrete and demonstrable actions toward the acquisition and installation of certified electronic health record technology.

Or implementation; "implementation" could mean that you already have it but haven't taken it out of the box. And so now you need to train your staff on it, you need to do the data entry for all the patient demographics, you need to write data use agreements or business partner agreements for your HIPAA treating with the personal health information. You need to actually start to use it and optimize what you have already adopted.

Or the third part of Adopt, Implement, and Upgrade is the upgrading piece. And this is really, in my mind, the slam-dunk for everyone in Medicaid, in the early part right now. This is – say, 2011, 2012 – because, right now, let's be clear that there are no certified electronic health records for meaningful use on the market – none. This is because the proposed rule for the Office of the National Coordinator has not been made final. They are going through comments, and then they will finalize the rule around the same time as ours, in late spring.

And the process by which they are going to certify EHRs was just released in an NPRM and is likewise not finalized. So while there might be certified EHRs out there through another process, those that are certified for meaningful use, which is the kicker for this program, do not yet exist.

So everyone who is already using something that they've already adopted and they've already implemented must upgrade to this new certified EHR in order to be able to get the EHR Incentive program, so all of the EHRs on the market that want to play in this space must obtain certification.

So upgrading to what I have on the slide is Version 2.0, but it could be 10.0 – it doesn't matter what they call it – but just by upgrading from what you have to the EHR-certified version for meaningful use, you will have met the Adopt, Implement, and Upgrade bar. And assuming that you've met all of these other eligibility criteria, there is your check. I think that's really important for people to understand because, for Medicare, they have to meet meaningful use right out of the gate.

So now let's talk about meaningful use. "Meaningful use" is not just having the electronic health record and just entering the patient demographic data, or just doing the staff training, but that you're really still focusing on what's going on inside your provider's office. You kind of pick and choose which functions you want to use. And it's not really going to get you at the end of the day to improve quality of care.

The analogy that we like to use – and forgive me if you've heard me say this before – is the cell phone. So everyone has a cell phone, and they use it to make calls and maybe occasionally text (though hopefully not while you're driving). But that's all you really do with it. That's the cell phone. That would be my grandmother, by the way. So that's what it is, and she likes the big buttons.

Then there are the people who have the smart phones. Right? So you know who you are. The smart phone has GPS on it. It can capture your e-mail. It has all kinds of apps to do amazing things. You can play light saber, you can play games on it. It connects to the Internet. It transforms your life. It helps you to remember things. It connects you when you are outside of your home or office. It's enabling you to do things in your life that you wouldn't otherwise do if you were just using the cell phone like my grandmother does to answer the phone and occasionally text. I mean, nowadays, they can even take video. It's amazing.

This is talking about the difference between just having something and having something that you meaningfully use that is truly changing your life. So how do you get from Adopt, Implement, and Upgrade of a certified EHR to meaningful use of an EHR?

Well, Congress had at least three ideas about this that they put into the statutes. So regardless of comments, these three elements are going to be there in the final rule. And on slide 16, I say what those are.

The first is e-prescribing. E-prescribing, by the way, is not just the ability to send a prescription electronically from the provider's office to the pharmacy. E-prescribing can also involve matching what is being prescribed to a formulary, making a suggestion to the provider if there is a generic alternative, alerting the provider if there are allergies or dose-to-dose interactions that are potential contraindications that are based upon what is known about that patient's medication history.

So EHR has a real potential – and there is already an evidence base – to show an improvement in healthcare quality outcomes in reducing the risks of adverse events and reducing costs. The second is the electronic exchange of health information. This is not about digitizing health records that you can make more space in your office, no more filing cabinets.

This is about being able to take the health information and move it with the patient to everywhere that they go, so that when they go to the hospital and the ER, their data are there. They don't have to remember what the medication is, whether it's a blue pill, a yellow pill, what dose it was; it's all right there in the hand of the practitioner in the ER.

Or if they are referred some place to another provider for specialty care, that new provider can see what their lab results were. So the data is moving in and out of the different provider settings. And that is critical to get to where we want to go for health reform and for our healthcare setting.

The third element is clinical quality measures. So this is, again, tying the use of the EHR to the actual clinical quality data so that it can drive provider behavior change. And so it's written in the statute that the provider would submit the clinical quality measures in a form and manner approved by the Secretary. And we've proposed that, for Medicare, they would go to CMS and, for Medicaid, they would be submitted to the State.

Now moving to slide 17, I'm going to talk about those clinical quality measures very quickly. For an eligible professional, we propose that there are three core measures that all EPs would have to report on. But I want to point out here that, if your patient population is not in the denominator of these, then they don't apply to you. They are tobacco screening, blood pressure management, and medication management to the elderly.

So if you're a pediatrician who is working at a rural health center, you are not going to be obliged to report the clinical quality measures on medication management in the elderly because that's not in the denominator, or you do not serve those patients.

What we propose that all EPs would have to do is, in addition to those core measures that apply, you would select from a set of specialty measures. So if you're a pulmonologist, a pediatrician, a primary care provider, or a cardiologist, there are all of those in the proposed rule, and you would pick from those. And our goal is – and it says this in the preamble – to narrow those lists down to a smaller set of specialty measures for each of those. So that's why we're soliciting comments on those that are there.

Hospitals, we propose, must report on all of the clinical quality measures that apply to the patients, regardless of payer, during the reporting period. However, the list, as you can see, is fairly, shall we say, over 21-centric. So we proposed an alternative list for Medicaid, which includes some newborn measures and pediatric measures because, as you remember, children's hospitals are specifically included in our Medicaid program.

I should also say that we propose in the rule that states may receive the clinical quality measures starting in 2012. But, in 2011, if they so choose, they can accept a provider's attestation on this data.

For hospitals, on slide 18, you'll see that some of them may receive an incentive from both Medicare and Medicaid. So in subsection D, acute-care hospitals might actually receive a payment for both. And hospitals that meet the Medicare meaningful use requirements might be deemed as having met them for Medicaid so that they don't have to jump through the hoop twice for the same thing.

The reason that is important, and what I'm talking about on this slide when I talk about an "expanded definition of meaningful use," is that we did propose that states have the ability to propose to CMS, subject to our approval, tweaking of the meaningful use definition for their specific state needs. So this is not expanding the functionality EHR beyond the EHR certification criteria because that would render moot the whole idea of having an ONC "Good Housekeeping" seal of approval on each EHR.

The idea is that they all need to be able to do the same things; that's the whole idea of having this national certification. But perhaps you would want to do something specific in your state, where you would point to a particular health information exchange or point to a particular immunization registry, or you would focus on producing lists of diseases for particular conditions that you feel like prioritizing for the population in your state. So a state might request a CMS for which they would want to tailor the meaningful use definition.

I should also say at this point that this is a 10-year program. They might not all want to do that in 2011. They might feel like this stage 1 definition of meaningful use that we've proposed is only 2 inches off of the ceiling as it is; this floor definition for Medicare and Medicaid. So there's not really wiggle room for there. But once they have more in place and have gotten more established, maybe 3 or 4 years from now, then they might come back to us and say, "OK, we want to add some particularities to the "meaningful use" definition," whichever it is that is defined at that point – probably stage 2 at that point.

The other thing to let us talk about is that I'm not sure if you are all as familiar with (CHIPRA), but it was enacted around the same time as high-tech, in 2009. It's the Children's Health bill. And one of the things that it asked of CMS is that we develop, along with a lot of external stakeholder input, some pediatric core measures. And those have to do not necessarily with just measuring pediatric care in a provider setting but also on a population level, and to think broadly about that.

In December of 2009, we published in the “Federal Register,” a core set of 25 initial measures. And, at the same time, we were developing the meaningful use definition. So we thought that it would behoove us, given that the same pediatric providers are going to be reporting clinical quality measures under (CHIPRA) and under high-tech, we would try to find an overlap between those two where we could.

Well, not all measures are ready for electronic extraction. They haven’t been defined, or perhaps they haven’t been endorsed by the National Quality Foundation, or they’re not things that would normally ever even be captured in an electronic health record or a paper health record for that measure. So what we came up with are four that are listed on slide 19.

I’ll just preempt the question, because we received it before, of why specifically these four. And the reason isn’t because we thought the BMI was the best thing since sliced bread; it was because, like I said, we had to pick from a list of pediatric measures – and I think that most people would agree that it’s not a really long list right now – that are endorsed national consensus measures that have been what we call retooled for electronic extraction from electronic health records.

So they are mapped in such a way that we can extract them from EHR’s apples to apples to apples regardless of EHR in a standardized fashion, using a standardize vocabulary. So it’s not a very long list. And so this is what we came up with and proposed for both the stage I definition of “meaningful use” and the initial core set for (CHIPRA). And we hope to evolve that as we move along and continue that alignment where appropriate.

The reason we think that we have so much runway ahead of us is because this is a 10-year program. We go through 2021. Medicare goes through only 2016. The latest that a Medicaid provider can initiate the program is 2016. And, like I said, they can initiate the program under the Adopt, Implement, and Upgrade bar at any time. But then in their second and all of their



subsequent years in the program, they must meet meaningful use, and they must meet the definition of meaningful use that's in place at that time.

So right now, we've proposed to stage 1. But our goal is that, by 2015, both Medicare and Medicaid, everybody would be at stage III. And stage III, as we describe in the preamble, is a much stronger focus on outcomes as opposed to data collection.

Now, (Michelle) is going to come back to tell you a little bit more about what are the conditions for the state and the funding that CMS makes available for them to enable this program.

(Michelle Mills): For this part, I just want to say that, hopefully, your eyes don't glaze over. We wouldn't talk to you about this part if we didn't think it was important. We really want providers to have a global understanding of how this program works and what the states are going to be responsible for doing to get you your money, because we think it will help with, first of all, your making informed comments on the Notice of Proposed Rulemaking.

But, also, the states are required to get stakeholder input for some of their requirements. So we think that your having a global understanding of the whole program will greatly help with the stakeholder input process, as well. With that, on slide 21, I'm going to talk about conditions for state participation.

First, the way in which we like to talk about this is that the states get two buckets of money if they decide to participate in this program. The first bucket is a 90% federal match for administration of the EHR Incentive program. And then the second bucket is a 100% federal match as reimbursement for payments to providers for the incentives. In other words, the Feds are going to reimburse the State for the money that the provider gets for the actual incentive. And then we're going to give a 90% federal match for the states administering the entire programs.

This money is to ensure proper and efficient use of high-tech dollars. CMS will use what we call the Medicaid Management Information System – or MMIS – expenditure and approval system that we currently have in place for our systems or sort of IT programs. So when you see advanced planning document, or APD, it might look familiar to some folks because we currently use this process in other places, in our Medicaid program.

For high-tech states – states that do decide to participate in this program, because, again, it is voluntary – states will request money for reasonable administrative expenses at a 90% match for planning activities for this program. The vehicle for that will be the planning APD, or what we're calling here the PAPD. And then states will create a state Medicaid HIT plan, or a state Medicaid health IT plan. I told you earlier that I would explain that, and I'm still going to get to that.

So states will draft this state Medicaid health IT plan as a deliverable of their PAPD. We currently have 35 PAPDs approved, and four are pending here at CMS right now, so most states are getting those in. States are going to draft that state Medicaid HIT plan as a deliverable of their planning APD. And they must consider certain principles that we've laid out for them.

When states are ready to implement their state Medicaid HIT plan, they will request funding through an implementation APD, or an IAPD. The IAPD will outline states' implementation activities for the Incentive program and request funding at the 90% federal match for reasonable administrative expenses for implementation activities.

The federal financial participation, or the money that we give states, cannot flow without approval of these documents by CMS. So just to recap, states must do some planning to get ready for all of this. And we are very generous, so we are going to pay 90% of the planning costs. But we want to know all of the particulars of what they plan to do, so we've outlined what they have to do to request that planning money in a PAPD.

The deliverable of the PAPD is a state Medicaid HIT plan. And we can't have the states out in the wilderness just planning in perpetuity with no results, so we said that they have to get a state Medicaid HIT plan back to us; so that's the deliverable.

The next step is that the State has to have this detailed state Medicaid HIT plan. And there are a lot of requirements associated with that. When they determine how much it's going to cost to implement this program – say it's \$100 million – they have to request that money from us, through an IAPD. So that's the implementation APD. And we have to know why they're requesting \$100 million. So we'll review the IAPD and the state Medicaid HIT plan to make sure that they're going to be able to meet all of the requirements in the program to successfully implement the incentives.

We'll release the 90% federal match for the \$100 million if we agree that that's what they need to meet the program requirements. And then, as the incentives come up, then we'll release the 100% cost, as well. So that's going to be the actual money that the State will pay to the providers.

Moving to slide 22, we talk here about the 90% match versus the 10% money that the State has to put forward itself. So we just talked about the two buckets of money, one being the 90% bucket for administering the program. But in order to get that money, states must do three things. The first is to administer the incentives. That includes tracking meaningful use by eligible professionals and eligible hospitals.

The second is to conduct oversight, including routine tracking of (out of) stations and reporting mechanisms. The third is to pursue initiatives to encourage the adoption of certified EHR technology for the promotion of healthcare quality and the exchange of healthcare information.

So the first two seem relatively straightforward, but the third one is the straight-out-of-statute. It's one of those things that Congress came up with for us to implement here. We thought long and hard about what that means and how we can provide some flexible but transparent guidance for states. So we have publicly put forward some information for states about exactly what those things mean. And we are working with states so that they can get that into their planning documents.

On slide 23, we're going to talk about state Medicaid HIT plans. The state Medicaid HIT plan must include three key elements. The first is what is the current landscape in the state, or the as-is world, as we call it.

Next is what is the state's HIT vision for the next 5 years. We also call this the to-be world. We expect the State to use benchmarks along the way. The last element is how will the State implement and oversee a successful EHR program.

So once the State establishes its baseline assessment, they can plan the steps necessary to transition toward achieving some of the objectives in high-tech, such as improving both quality and healthcare outcomes, which will get them to their to-be world.

In considering the third element of the state Medicaid HIT plan, the State must include detailed information about their verifiable data sources that they will use to determine provider eligibility. This is important for providers. They will look at everything from patient volume to whether the EPs are hospital-based, to whether providers are sanctioned.

We would further expect a detailed plan in the state Medicaid HIT plan for calculating and dispersing payments, coordinating the stakeholders, contracting with health plans, privacy and security, curtailing fraud and abuse, et cetera. CMS views the state Medicaid HIT plan as a lynchpin to the states' success for this program.

Moving to slide 24, we talk about financial oversight and program integrity, which is definitely becoming more of an important issue at CMS. Over the last several years, it has become an increasingly important issue. And, most recently, we're going through some organizational changes here at CMS that have definitely put that in the limelight. So you'll expect to see that as a very important issue here.

With all of this money that we're giving to states, there is some great responsibility. And we at CMS and the states will be continuing to develop audit strategies for how we will make sure that the funds are expended properly within the new and existing rules. The high-tech statute requires that there be no duplication of payment between Medicare and Medicaid. And in our regulations, we also said that there will be no duplication of payment between states, as well.

So we accomplished this in one setting by proposing that there be a national-level repository or a single front door for providers to register and pick either Medicare or Medicaid; then, if you pick Medicaid, you would pick one state. And we believe that this will eliminate any duplicate of payments between the programs or between states. Additionally, CMS is moving forward with how we are going to implement that national-level repository and integrate the system with state systems.

Moving to slide 25, we talk about the differences between Medicare and Medicaid here. And this slide is really for your reference. But it shows the notable policy differences between the two programs. We just wanted to highlight a couple.

The eligible professionals are paid different amounts. You get more in Medicaid. The program lasts longer in Medicaid, through 2021. And there are no federally mandated payment adjustments or penalties, as some people call them, in the Medicaid program for people who are not meaningful users.

Moving to slide 26 – “What’s Next?” As we’ve talked about a couple of times here, we’re nearing the end of our public comment period. The last day that you can submit comments for the Notice of Proposed rulemaking is March 15.

We really hope that you will submit comments. If you have them, it will make the final rule a better product. We have many states and territories, like I said earlier, with approved PAPDs, and then they are now working on their state Medicaid HIT plans. We are very excited to be providing them technical assistance in working on that process with them.

We expect to issue new guidance soon on the implementation APDs. And we are continuing to work with our federal partners and a number of agencies, both inside and outside of HHS. So this does, of course, include our partners at the Office of the National Coordinator, but also our partners at HRSA and (ARC), and many other agencies. That includes the FCC. That might be of importance to folks in the rural areas. They are coordinating some broadband grants.

On slide 27, we just, again, direct folks to where they can make comments for this Notice of Proposed rulemaking. So with that, I think that we finished up in just under 45 minutes.

Bill Finerfrock: Thank you, both (Jessica) and (Michelle). It was very helpful. Operator, what I would like to do is to open it up for questions. If you could, give folks the instructions for how to ask a question.

Operator: Certainly. Ladies and gentlemen, the question-and-answer session will be conducted electronically. If you would like to ask a question, you may do so by pressing the star key followed by the digit 1 on your touchtone telephone.

If you are using your speakerphone, please release your mute function to allow your signal to reach our equipment. Also, a voice prompt on your phone line will indicate when your line is open to ask your question. We ask that you please state your name and your location before posing your question. Again, that is star 1 to ask a question.

Bill Finerfrock: Thanks. And while we're waiting for the questions to line up, you mentioned that, I believe, 35 states had already obtained approval for their plan, and four were pending. Is that list available so that folks can know that their states are prepared to offer the incentive payments for the adoption, implementation, and upgrading of their EHR?

(Michelle Mills): Sure. Actually, CMS issues a press release every time we approve a planning – advanced planning document. So if you go to the CMS Web site and click on “Newsroom,” you can see the press releases. Sometimes, we've done them in bulk. For example, last week, we issued one that announced the approval of 13 states altogether. But you can certainly go back and see historically which are the 35 states. We hope to have the other four out by the middle of next week.

And then, for the other states that don't have one approved, we are working with them to help them to go onboard, and are providing them technical assistance. But the states and the dollar amounts are all listed in the press releases.

Bill Finerfrock: OK. Operator, do we have any questions?

Operator: We do. Your first question will come from – caller, please state your name and your location.

(Ron Gleason): Hi, my name is (Ron Gleason), and I'm calling from Great Falls, Montana.

At the beginning of the program, there was an assumption made that the important program for rural health clinics was the Medicaid side of this. In Montana, we are a very large number of small farming communities with very high Medicare populations and very low Medicaid populations. So the Medicare program side is what is important to us, not the Medicaid side.

Secondly, we in Montana operate almost exclusively in these rural communities with provider-based rural health clinics. And it's my understanding that the Medicare program will not reimburse provider-based rural health clinics that operate as a department of a critical-access hospital. So the vast majority of Montanans that live in rural areas will not be covered by electronic health records because there is no money to do it.

I'm just kind of curious as to how that will be addressed.

(Michelle Mills): That's a great question. And (Jessica) and I work for the Medicaid Center at CMS. And we were invited to come and talk about the Medicaid portion of the NPRM. But if the folks working on this call were interested in arranging for another call with the Medicare folks or another call where we talk – we've done this before – where we talk about, globally, the high-tech issues. I'm sure that we could arrange that, as well.

However, with respect to your question about the hospital-based requirements, I think that there have been a number of stories reported about how the Notice of Proposed rulemaking requirements will negatively impact provider-based clinics. And there is a legislative (6) that had been proposed in the Jobs bill.

And I don't think that I'm saying anything wrong here by talking about that because it's public information right now. It, of course, hasn't been signed or passed completely yet, so we'll wait and see what happens with that. At CMS, we are eager to see there be a (6) that would correct where we see our hands being tied right now by this statutory language.



(Ron Gleason): Yeah. Whichever of these facilities are critical-access, hospital-based, then the only logical solution is to just have them as another department of the hospital and pay them just like the rest of the critical-access hospital. It's the only logical solution.

(Michelle Mills): Well, we hope that folks who have solutions, as they see them, would propose them through the comment period. We put forward a number of solutions in the NPRM as we saw them, and then we asked for comments in that section. So ...

(Jessica Conn): And, (Ron), when you're making your comments, if you want to speak specifically to any data that you have in Montana, then that would be very helpful.

(Bill Finerfrock): Fine. Can I just add to that that, as they've alluded to, several of these issues that you've raised are a reflection of the way that the statute was written. These were not proposals or recommendations that necessarily came from the association or the RHC Community. We were asked to respond to different proposals that were presented to us.

We did raise the Medicare issue that, for many RHCs, the Medicare population is the more significant population than Medicaid. But the decision was made in the political environment to restrict it to the special RAC to the Medicaid portion.

If you want to send me an e-mail, I'd be happy to talk to you more because, being from Montana, as you know your senator is a key participant in these discussions, and I'd be happy to try and get you in touch with his staff so that you can articulate your concerns to them directly.

But as was also mentioned, there is legislation that is pending for inclusion in the Jobs bill that would address the provider base issue on the Medicare side in the same way that relief is available for overall health clinics on Medicaid side.

(Michelle Mills): If I could just clarify, both Medicare and Medicaid are impacted in the same way right now, which is that provider-based clinics are excluded.

(Ron Gleason): (For health)?

(Michelle Mills): Yeah, and so the Jobs Bill – the language would propose a fix for both. And so for folks who are interested in, again, reviewing what we've written in the NPRM, it starts on page 1904. And we do clarify exactly what is a statute and where we had discretion. And we put out a couple of proposals and then asked for comments. And so we'd love to have your comments. That would be great.

Bill Finerfrock: Next question, operator?

Operator: And that question will come from – caller, please state your name and location.

(Heather Paulson): Hi, my name is (Heather Paulson), and I'm in a provider-based rural health clinic attached to a critical-access hospital on the North Coast of California, in Fort Bragg, California.

My question has kind of already been asked by (Ron) in Montana. We also have the largest proportion of our patients being Medicare patients. And we are also attached to a critical-access hospital. And we are a multi-specialty clinic. We have about 15 providers who provide services here to the Coast.

Without an electronic medical record, we are unable to connect to our hospital in a meaningful way. And I just think it's critical that the provider-based clinics be included, as well. It makes no sense to me that it wouldn't be covered under any branch of the incentive funding.

Bill Finerfrock: Thanks, (Heather). Next question?

Operator: The next question comes from ...

Bill Finerfrock: Go ahead, caller.

(Tom): This is (Tom), and I'm calling from (Popper) Bluff, Missouri. I have a question on the patient volumes. The minimum Medicaid patient volume – is that based on patient visits or discrete patients? The other question is, on the predominantly needy individuals, would that include dual eligibles, like patients who have both Medicare and Medicaid?

(Jessica Conn): Sure, those are great questions. Let me take those questions separately, I guess. The way that we've proposed the language right now in the NPRMs, I would actually refer you to the proposed regulations, which is where we state that the encounter would be covered by Medicaid.

(Michelle Mills): So an "encounter" is the unit of analysis ...

(Tom): The visit is the unit rather than the total number of patients. OK ...

(Michelle Mills): The denominator is total number of visits or encounters, and then the numerator is what proportion of those are Medicaid. However, we do suggest and solicit comments if there are other ways to define this, such as provider panel or a proportion of costs and so forth. So we do solicit comment on other means to define "patient volume."

(Tom): And then what about the dual eligibles?

(Jessica Conn): Oh, right, and so the dual eligibles – again, since you – the patient encounter would need to be covered by Medicaid. And so ...

(Michelle Mills): Those are needy individuals. It's both.

(Jessica Conn): So you're asking if they were a dual Medicare/Medicaid?

(Tom): Yes, if an individual is a dual Medicare/Medicaid, then would they qualify as a Medicaid patient for either the Medicaid 30% threshold or the need threshold since they are at least being partially covered by Medicaid?

(Jessica Conn): Yes.

(Tom): So they would be countable as a Medicaid patient if they are dual eligible?

(Michelle Mills): Yes.

(Tom): OK.

Bill Finerfrock: Thank you very much. Next question, operator?

Operator: And that will come from ...

Bill Finerfrock: Go ahead, caller.

(John Hanson): This is (John Hanson) from Washington State. Some statutory language makes a distinction between hospitals and critical-access hospitals. When you refer to acute-care hospitals, does that include CAHs?

(Jessica Conn): CAHs are not included in acute-care hospitals. On the slide you have in front of you, there is a list of CCNs that are included, and CAHs have CCNs that are not included in that range.

(John Hanson): OK. I have a second question, and that is ...

(Jessica Conn): And that is our proposed thinking right now. So if you have comments about why – because critical-access hospitals should be included, then you should review why we proposed acute-care hospitals to be defined the way they are and then make comments on that.

(John Hanson): OK, we'll do that. You also mentioned that RHCs can be eligible for PAs if they are PA-led. Does that mean PA-owned or in charge, or what?

(Jessica Conn): We're silent on that. That's statutory language that just says "PA-led." And if you have comments or questions, or suggestions about that then you should include that formally through regs.gov.

(Michelle Mills): We expect that that term will be clarified in the final rule, which is why we think it's important to comment on that.

(John Hanson): OK.

Bill Finerfrock: Yeah, (John), what I was going to say is that that is one of the areas where it is noticeably silent. And I do think that it's important for folks to comment. The Association will be commenting on that as to what we believe constitutes or should be defined as a PA-led clinic.

(John Hanson): OK, great. Thanks very much.

(Jessica Conn): Thank you.

Bill Finerfrock: Next caller?

Operator: And that will come from ...

(Steve McGee): (Steve McGee), Lake Village, Arkansas. I have two questions, Bill. One, we implemented our EHR in 2004. And, of course, we've done several upgrades. But how will this affect the incentive payments? Will we still be eligible for those?

(Michelle Mills): That's a great question. And you would be a prime candidate for the upgrade part of the Adopt, Implement, and Upgrade. So if you have an EHR, whatever version it is now, whichever brand – whether it was self-developed, open-source, or something that you bought or developed off of the shelf – you have to get it certified for meaningful use.

And so what the Office of the National Coordinator has proposed is a process by which that will happen. And EHRs are basically for those that already exist, they would do an analysis between what the capacity of that EHR currently is and the proposed definition of meaningful use, and then the EHR would have to meet that gap – fill that gap in order to get certified.

So if your EHR were to do so and get certified, and you upgraded to that new certified version, then you would have met the Adopt, Implement, and Upgrade bar for your first participation year, and you'd be all set and on your way to meaningful use.

(Steve McGee): OK, my second question is the maximum incentive under Medicaid is \$63,750.

(Michelle Mills): Right.

(Steve McGee): That is per provider, is that correct?

(Michelle Mills): Per eligible professional. Hospitals have a different incentive methodology.

(Steve McGee): OK, and that's over a 5-year period, is it?

(Michelle Mills): It's over a 6-year period. Your first year – as we proposed, you have your first year where you Adopt, Implement, and Upgrade, and then 5 following years of meaningful use.

(Jessica Conn): And the Adopt, Implement, and Upgrade, the first year, is the biggest chunk. It's \$21,000 in change. And then the subsequent years is a lesser amount. The Medicare, as well, the way that they proposed to allocate their incentive payment, the payments are larger in the earlier years.

Bill Finerfrock: The Medicaid side, however, talks about allowable costs.

(Jessica Conn): Yes.

Bill Finerfrock: In a case of a clinic that is upgrading, how will the allowable costs be calculated? In other words, the maximum – it's 85% of \$24,000. Will they have to show receipts or costs that equate to \$24,000 in order to get the full value, or is it going to be assumed that, in the course of upgrading their existing system, they had costs at that level?

(Michelle Mills): We expect that states will make calculations for providers to comply with the net average allowable costs and the average allowable cost requirements. And we also expect states, as we have laid out in our proposed regulations, to have audit requirements in place. And so, beyond that, each state will have different requirements, probably, for what they will request of providers for how they comply with these requirements.

(Steve McGee): So providers make the advice to either keep receipts or keep documentation of cost for training of staff? So if you're upgrading your system, then the actual cost of the upgrade, anything of that nature, in the event that, as part of this, you are required to provide documentation?

(Michelle Mills): I think that's safe. I mean, you're going to be, at some point, attesting to meeting certain requirements. And I'm sure that there will be some lengthy statement about "upon penalty of tar and feathering," the State will come out and audit you at some point, or you're potentially attesting to meeting these things and knowing that the State could audit you.

I would assume, just like when we file our taxes that those are potential methods that the State may employ.

(Jessica Conn): So if I were the director of a rural health clinic that was making a certified EHR available to the professionals who work at that clinic, then I would think about being able to safeguard that information on behalf of the eligible professionals because, again, they're receiving – they're qualifying receiving these payments themselves, the clinic is not. But if the clinic has furnished them with access to the EHR, then it would certainly facilitate them getting their payments if the clinic were to take that on, and it would probably be a much more streamlined way of handling it.

(Michelle Mills): But just to be clear, we don't address that in the NPRM. And if people have comments or suggestions about way that states should or could audit the provider for complying with those requirements, then we'd love to hear it.

Bill Finerfrock: A couple of things. Do you guys have a few minutes? I suspect we still have questions that we can go over. I don't know what your time constraints are.



(Jessica Conn): I think we can go 5 minutes over.

Bill Finerfrock: OK, operator, do we still have questions in the queue?

Operator: Yes, sir, we do.

(Pete McGee): Bill, this is (Pete McGee). I've got a follow-up question.

Bill Finerfrock: (Pete), just so we get some other people in with some other questions, can you follow up with me, and we'll try and get an answer for you for whatever your follow-up is?

(Pete McGee): OK, great.

Bill Finerfrock: Thanks. Go ahead, operator. Next question?

Operator: Your next question will come from ...

Bill Finerfrock: Go ahead, caller.

(Brian Cochran): Yeah, this is (Brian Cochran) calling from (Whitten), Indiana. My question was also about the PAs. There are very strict guidelines in Indiana versus a nurse practitioner on the guidelines they have to follow in a rural health clinic. My question is how they're going to quantify that as physician-led, as well. It sounds like I just need to make a comment.

(Michelle Mills): Yeah, I would encourage you to make a comment about how that specifically comports with Indiana, if there are specific state laws and regulations. Again, that's the kind of information that we need to know, is how does this play out with existing state rules and definitions of these terms.

(Brian Cochran): OK, thank you.

(Michelle Mills): I think that, in this case, Bill, is when people who know more about the genesis of the PA-led language than we do. But our opportunity to change anything in the proposed rule is only as far as we have substantial comments or informed comments to that effect.

(Brian Cochran): And, unfortunately, you're right. I probably do know more than I'd like to know about how this thing hauls off. But we'll get it worked out.

Bill Finerfrock: Next question, operator?

Operator: And that will come from ...

Bill Finerfrock: Go ahead, caller.

Operator: The line is open.

(Helen Whittington): Hi, this is (Helen Whittington) from (Coralside) Family Clinic in (Coral), Texas. And I think that mine is a follow-up question because someone just asked. We were wondering if the incentive payment was per provider. We are an independent rural health clinic. Or is it just for the facility?

(Jessica Conn): No, the payments don't – they are not per facility. They are per provider or per eligible professional. And they will assign the payment to an eligible tax ID number. However, the eligible hospitals – the acute-care hospitals and the children's hospitals, it is per facility for those.

(Michelle Mills): So just to be clear because this continues to be a question, no institution is eligible for an incentive payment aside from as proposed to children's hospitals and acute-care hospitals. Otherwise, this is a program about eligible professionals who have the voluntary option of assigning their payment to employers. And that is discussed in the NPRM. Or they can keep it themselves, and we don't get involved in how they use their payments.

(Helen Whittington): So if we have four providers, one being a PA, only three are EPs because our facility or rural health clinic is not led by a PA.

(Jessica Conn): If the other three EPs meet that (Michelle) went through, then that would be correct.

(Helen Whittington): OK, thank you.

Bill Finerfrock: The only thing that I would say is that we don't know what "PA-led" means at this point, so we can't presume that you wouldn't be able to meet that depending upon how it's defined. It sounds like you might not be able to, but it's conceivable that there would be a definition under which even your PA could be classified as being covered.

(Helen Whittington): Thank you very much.

Bill Finerfrock: Thanks. Next question, caller?

Operator: And that will come from ...

(Jenny Tuft): Yes, I'm (Jenny Tuft) with Moab Utah Independent Rural Health Clinic. I had a question regarding the voluntary first states to implement with the Medicaid Program. Is there anything providers can do to facilitate their state in going forward with that?

(Michelle Mills): Concerned citizens can always get involved.

(Jessica Conn): Great. We haven't heard that there is a state that is going to wholesale not participate.

That said, as (Michelle) described, we're giving only 90 cents on the dollar. And some states are in real, as you know better than we, dire financial straits. So, for me, it's not so much are they going to participate or not, but the extent of participation and in what year. Are they going to do it right away or later? Is this going to be a priority or not? And how is it going to go? A lot of it has to do with how they can come up with that 10% match in addition to, of course, other factors.

But I do think that demonstrating provider interest in helping with the planning, the stakeholder involvement, addressing issues such as security and consent, and provider outreach and so forth – all of those resources brought to bear probably make it a more tenable situation for state Medicaid agencies. They knew that they had that assistance.

(Jessica Conn): I would absolutely say a critical mass of providers demanding that this Program take place will move mountains.

Bill Finerfrock: The other thing that I think to keep in mind is that, whenever your state adopts the Plan – whether it's in 2010 or 2011, or 2012 – you are eligible for that first-year for the adopt, implement, and upgrade, that larger payment absent meaningful use, regardless of what year your state moves ahead. Is that correct?

(Jessica Conn): That's correct.

Bill Finerfrock: So if your state is behind other states, other than getting the benefit of having an EHR, you'd lose nothing financially if your state doesn't do this until next year. It just means that you won't start – your first year may not be until 2011 or 2012, whereas another state might be 2010.

But, in the end, as a provider, you're going to get the same amount regardless of what state you're in, as long as you meet all the criteria.

(Jenny Tuft): OK, so if our state decides not to join until next year, then we would still be eligible for payment – or even let's say 2012, we would still be eligible or get back payment for 2011? Is that what I'm understanding?

Bill Finerfrock: Well, you wouldn't get – you get a first-year adopt, implement, and upgrade, and 5 years of meaningful use under Medicaid regardless of when it starts. So it wouldn't be a back funding. So if you went 2012, you'd go 2012 adopt, implement, and upgrade, and then 5 years of meaningful use to – what would that be on my – 2018, versus another state that might start in 2010, then that provider's incentive payments would expire in 2016.

(Jenny Tuft): OK. Any suggestions on the best way to contact our state? Or whom would we contact within our state?

Bill Finerfrock: That would be through an e-mail. We can talk about that, and I could give you some ideas. Send an e-mail to me at [info@narhc.org](mailto:info@narhc.org).

(Jessica Conn): And, (Jenny), I was just on a panel with your state's CIO yesterday, and I think that he's extremely interested and engaged. He's the CIO for your Health and Human Services Agency, and he's very, very interested. So I wouldn't worry about Utah.

(Jenny Tuft): Good. I didn't see them on the list, so I just thought I'd check. Thank you.

Bill Finerfrock: We're going to have to make the next one the last question in order to be respectful of the time for our guests and the fact that they have gone over. So, operator, what's our next question?

Operator: Your final question will come from – caller, please state your name.

(Martie Bennett): Hi, (Martie Bennett) from Riverside Family Medicine in South Louisiana. Since there is no certification criteria yet established for meaningful use, is there any – if you were to guess, is there an estimated timeframe in which we might see that forthcoming?

(Jessica Conn): Sure. We're all planning – ONC and CMS are planning to finalize all three of these proposed rules or interim final rules in late spring. And I just want to remind everyone that, technically, spring goes through the end of June. So I would probably hang your hat there.

So the goal is to have them all finalized in late spring. And then, because the ONC rule about EHR certification was an interim final, it actually already is in effect. It went into effect 30 days after its publication in January. But it might get changed because our meaningful use definition might get changed, and, also, the results of their public comments.

That said, the reason I say that is because the vendors, I think, are already responding, and they're already working on this. But the domino effect – the backward dependencies are that these rules have to be made final in late spring. EHRs, the vendors or whoever is developing them have to then take that criteria, integrate that into their EHRs if there is a gap. And then they have to go to the certifying bodies that are proposed by the Office of the National Coordinator and receive their certifications. So they get their little stamp – "That's it, you're done. You're great. You have the best EHR."

And then the providers have to adopt, implement, and upgrade to it, so all of that has to happen. And then you would demonstrate to the State that you had a done so. So you can see that there is a lot of interdependency on the markets and on the process by which EHRs will be certified before you can even get there.

In the meantime, we feel like states can get a lot of the IT, policy, and other systems ready. The use case for why to adopt HIT and (E) can be discussed. You can talk about the value of it. You can talk about how you would integrate it into your workflow.

I mean, just thinking about (Pete) from Arkansas, who has been doing this since 2004 – he'll probably tell you that it's not so easy. There is a challenge to get it going. So all of those are things that you could be discussing and starting to think about while you're waiting for your State to be ready and for the market to be ready to actually adopt or upgrade.

(Martie Bennett): I just want to thank you. This has been an exceptionally informative forum. And it has answered some longstanding questions. I appreciate your time today.

(Jessica Conn): Sure. Thank you, (Martie).

(Michelle Mills): Well, we hope that you guys will be able to submit some good comments for the NPRM. We think these issues are very important, and we hope to address them in the final rule.

Bill Finerfrock: And I would encourage you individually to do that. We as an organization will be taking advantage of the opportunity to do so.

I want to thank both of our speakers today – (Jessica) and (Michelle) – for the time that they've spent with us in trying to help answer questions and help people better understand what is out there with regard to the meaningful use criteria and the opportunities for rural health clinics.

I also want to thank all of our participations and the Office of Rural Health Policy for sponsoring this series.

A transcript and an audio recording of today's call will be made available on the RAHP Web site, hopefully, in the not-too-distant future. We have a process of review and clearance that we have to go through to get that posted.

I want to encourage you to encourage others to participate in this series as we become available. If you're not on our list-serve to get information about it, the Web site address that I gave you earlier can give you instructions on how to sign up so that you receive the information.

We will be setting the next Rural Teleconference for April. And, hopefully, back on our Tuesday, 2 o'clock Eastern schedule. But we will get information out on that. Again, I want to thank all of our participants and thank our speakers for the valuable information. And we look forward to talking to you on our next call.

Thank you. Operator, we are clear.

Operator: Ladies and gentlemen, that does conclude today's presentation. We do thank everyone for your participation.

END