

“Tips for Overcoming the Gray Areas of Meaningful Use Stage 1 for Safety Net Providers”

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Panelists:

- **Lisa Rawlins-South Florida REC**
- **Amy Rosa-South Florida REC**
- **Phillip Dearing-Stratis Health**
- **Jessica Kahn-Centers for Medicare and Medicaid Services**
- **Carrie Feher-Centers for Medicare and Medicaid Services**
- **Susan Brown-Telligen**
- **Sarah Cottingham-Telligen**
- **Toni Nie-Telligen**

Lieutenant Michael Banyas: Good evening to all our participants on this Tuesday afternoon. My name is Lieutenant Michael Banyas. I'm a Public Health Analyst in HRSA's Office of Health Information Technology and Quality. Welcome to our last webinar of 2011 and just before I introduce the Director of HRSA's Office of Health Information Technology and Quality, for her introduction, I just want to make a few announcements. The first is HRSA would like to highlight two free health IT workforce resources for the safety net community. The first is (inaudible) job line for safety net providers, which allows free job postings for HRSA grantees and safety net providers and the second is vouchers are available for safety net providers to take the free competency exam for help IT professionals. More information, people can email. The email address is listed on the slide for more information about these resources. Next, the first HRSA Health IT and Quality webinar for 2012 will be entitled: Tips for Engaging Safety Net Patients Using Health IT, and it will be held on Friday, January 20th at 2:00 p.m. Eastern Standard Time. Registration is now open.

Next, HRSA would like to highlight two new grantee spotlights on the quality improvement website and the health IT website. On the quality improvement website, the National Health Service Corp is - - grantees are featured and their diabetes prevention work. On the health IT website, HRSA would like to highlight the maternal and child health bureaus, grantees and their work and their effective follow-up program for newborn screenings. These two grantees can - - the stories of these two grantees can be found on the HRSA Health IT and the Quality Improvement website, as well as in the new HRSA November, December Health IT and Quality newsletter, which is now online. One correction I would like to point out is HRSA will be issuing a correction to the newsletter that went out yesterday regarding the ICD10 version 5-10 deadline. The deadline is still January 1, 2012 and not the March date listed. For more information, please see HRSA's ICD10 webpage or email the HRSA health IT mailbox.

Now I'd like to introduce Dr. Yael Harris, the Director of HRSA's Office of Health Information Technology and Quality.

Dr. Yael Harris: Thank you so much, Michael. I want to take a moment to thank all HRSA grantees and members of the safety net community, as well as others, for taking the time to join us today for this month's health resources and services administration Health Information Technology and Quality

monthly webinar. This month's webinar is entitled: Tips for Overcoming the Gray Areas of Meaningful Use Stage 1. Since the Health Information Technology for Economic and Clinical Health Act, the HITECH Act of 2009, the U.S. government has been working to help improve the health of Americans, increase safety and reduce healthcare costs for the expanded use of electronic health records. The HITECH Act actually establishes programs which allow eligible health professionals and hospitals to qualify for incentive payments under Medicare and Medicaid when they adopt a certified electronic health record system and use it to achieve specific objectives, which demonstrate the meaningful use of this technology. As part of this process, HRSA established a nationwide network of regional extension centers to assist providers in adopting and meaningfully using certified electronic health record technology. The regional extension centers, also known as RACs, are especially focused on providing assistance of small physician practices and rural hospitals, which need more help in making the conversion from paper to electronic medical system. As the RACs have provided technical assistance, they've encountered some ambiguities or gray areas that are not as clearly understood in the Stage 1 of meaningful use regulations and part of the goal that's covered is to provide additional clarification to help better understand these areas. This technical assistance webinar will provide tips and examples of how safety net providers such as health centers, critical access hospitals, and rural health clinics can address these supposed gray areas by -- of meeting meaningful use Stage 1 objectives. In addition, this webinar will include a presentation by CMS staff, Ms. Jessica Kahn, the Technical Director for Medicaid Meaningful Use on adopt, implement, and upgrade of electronic health records and what this means. Today's speakers have experience working with safety net providers in a variety of environments and will review these problem areas based on previous comments and questions that have been received by them or directed directly to HRSA, CMS and ONC staff.

Before I introduce this afternoon's presenters, I am required to read a disclaimer. I'd like to add that this webinar is intended to serve as a technical assistance resource based on the experience and expertise of independent consultants and HRSA grantees and its contents are solely the responsibility of the authors and do not necessarily represent the official use of HRSA. In addition, HRSA does not endorse any health IT vendor or software system, including any of those that may be featured in today's webinar.

Now let me take a minute to introduce this afternoon's presenters. Ms. Jessica Kahn serves as a Technical Director for Health IT and Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services. Here she contributes to health IT and electronic health policy drafting regulations and guidance, Federal health IT coordination, and oversight of the states of limitation of Medicaid, EHR Incentive Program. Jessica serves on multiple technical expert panels around health IT, Medicaid and quality improvement. She also serves as the project officer for the health IT focused Medicaid transformation grants and is a Center for Medicare and Medicaid Services lead for the CHIPRA funded project to develop a model pediatric electronic health record format in partnership with colleagues at the Agency for Healthcare Research and Quality. Following Ms. Kahn, we'll have Phil Deering from the North Dakota Regional Extension Center. Mr. Deering is the Regional Coordinator with the Regional Extension Center for Minnesota and North Dakota known as REACH. He and his staff assist providers at clinics and hospitals in reaching meaningful use and have been active in developing tools and techniques to clarify client needs and deliver effective consulting services. REACH's clients include integrated health

delivery organizations, critical access hospitals and rural health centers, as well as community clinics and federally qualified health centers. Prior to his work at REACH, he spent 15 years assisting clients with major change in issues, including Enterprise software implementation, quality initiatives and mergers and acquisitions.

Next, we're fortunate to have Lisa Rawlins from the Florida Regional Extension Center. She is the Executive Director for the South Florida Regional Extension Center and has over 20 years experience in the healthcare industry, working as a Director of the Florida Center for Health Information and Policy Analysis for the state's agency for healthcare administration. Ms. Rawlins also worked on implementing Florida's first transparency initiative, which began publicly reporting in 2005 on hospital quality indicators, hospital procedure pricing, health plan customer satisfaction rates, and retail pharmacy pricing information. It was highlighted as a national model at the 2006 National Governor's Association workshop. Lisa has also served as the Executive Director for the Governor's Health Information Infrastructure Advisory Board, which began Florida's journey on creating a statewide health information exchange. Ms. Rawlins has held several notable national leadership roles, including serving as the nation's first attempt in creating the criteria for certifiable health information exchanges as a member of the CCHIT, the Certification Commission for Health IT, Health Information Exchange Work Group. She also served as a member of the National Quality Forums additional hospital priorities for 2007.

Last but not least, we are fortunate to have Sarah Cottingham, who is a Quality Improvement Advisor with Telligen, the Iowa Health IT Regional Extension Center. She has been a professional in health information technology since 1993, first working as a registered health information technician. She then became a certified professional in healthcare quality in 2005. Ms. Cottingham is a member of the National Association for Healthcare Quality and will become president for the Iowa Association for Healthcare Quality in 2012. She is also a member of the American Health Information Management Association, serving as co-chair of the Quality Data and Secondary Initiatives Practice Council.

I want to take a moment to thank the HRSA grantees and Safety Net Community for their participation and to the wonderful presenters here, who have taken their time to share their insights with us today. Now let me turn this over to Mrs. Kahn.

Jessica Kahn: Thank you, Yael. Thanks everyone. I'm going to talk about adopt, implement and upgrade in particular because most of the eligible professionals, who work in federally qualified health centers, rural health centers, are going to come through the Medicaid program to receive an EHR incentive payment and hopefully know, but we'll get into this, that the bar for receiving an EHR incentive payment from Medicaid is lower in the provider's first year. So we're going to go through a little bit about what AIU means and what you could expect from the states that you work in.

So I'm going to move to the next slide, which talks about all of the high tech pieces and hopefully they all will float in here together. Okay, here we go. So under high tech, as Yael mentioned, there were several pieces of funding that came through different federal agencies to support our goals. They all were meant to work together. No one of these - - well, what happened there, sorry - - they are all meant to work together to support the goals. No one of these programs alone has all of the pieces, and that's

important because sometimes we're asked to say, "Well, this money isn't enough for adopting an EHRR," or "This time the (inaudible) isn't sufficient," or "There's still this piece and that piece," and my answer generally to that question is: you have to look at it as a composite, as a whole, and see where all of the pieces are put together. That's not saying that even there we have perfection, but we do have a more cohesive picture when you look at high tech as a whole. So what we're driving towards here, moving from the top rectangle to the bottom, is you're starting off with adopting in the HR. You really can't get very good at using a piece of technology if you don't actually have it yet. So let's start with adoption and there's three particular areas of high tech that are driving towards adoption, and they are the regional extension centers funded through the Office of National Coordinator for Health IT. There is the Medicaid EHRR Incentive Program first year incentive, which is what I'm talking about today and workforce training, which is also meant to provide people in the community, who can help support adoption and vendor selection and so forth. Then we get to meaningful use. So now you actually have it. Now you have to show that you know how to use it most effectively and the carrot there, and I guess there's some penalties as well, are the incentives, so under Medicare, it is a five-year program and there are incentives for those five years and then penalties for those two do not demonstrate meaningful use. Under the Medicaid Program, it is a ten-year program. You can - - there's no federal penalties, so that's the good news. You can come in anytime as late as 2016 and initiate the program and receive a payment over six years. Then there's exchange and by that we mean health information exchange. Back when we all drafted this slide, we were the only exchange in town. Now there's also health insurance exchange but here, we're referring to health information exchange, which is a key part of meaningful use and a key part of all of our goals and something I think that community health centers have actually figured out a long time ago in terms of how to really have coordinated care is to have that communication about each patient move between all of the providers on that care team. I think that's something that's probably resonated within your medical model and your clinical model for a long time.

So moving to the next slide, let's talk about where we are, and this actually should be 41 states. We have 41 states out of the 56 states and territories that have launched as of December, and hopefully you know if your state has launched or not. That information is all on the CMS website, but I thought most often I'm asked, "Who's missing?" as opposed to being asked to rattle off 41 states off the top of my head. So here's who's missing and this is again as of the end of this year, so for the calendar year: Colorado, Virginia, Kansas, Idaho, New Hampshire, Nevada, Hawaii, Nebraska, Washington D.C., Minnesota, Puerto Rico, the U.S. Virgin Islands, Guam, and Samoa. Of the 41 states that launched as of December, there are 29 that are making payments currently. We expect to have a few more come in later this month, so by the end of the year, we should end up with more but that's important to note also because states are allowed to stage their program and I'll talk about that in just a moment, what I mean by that.

So there's really three phases of the EHR Incentive Program. The first is registration. The second is attestation and the third is payment. So active registration, this is as of our October data or November data should come out later today or tomorrow, but this is October data. We have thousands right now of eligible professionals, who've registered for the program and this is Medicare. I'm sorry, this is the Medicaid numbers and then there are hospitals that are eligible for both and then there are some

hospitals that are eligible only for Medicaid. Now a key thing to note about, the \$37,000-plus Medicaid eligible professionals, who have registered and hopefully you all know this already, but you can't register if your state hasn't launched its Medicaid EHR Incentive Program yet. You could register for Medicare if that's your past way to incentive payment, but if you're selecting Medicaid, an eligible professional won't find that state in the dropdown menu, so you don't have - - if you're in Colorado right now, you can't pull down Colorado from the dropdown menu and register, so it's really not a great depiction of overall national intent. I always caution people. It's great to look at by state, and you can break this down by state on the CMS website, both on registration and payment. So to date, state Medicaid agencies, again this is only the subset of those that I mentioned to you that are paying, have paid over \$711 million. So in 12 months, they've put out a tremendous amount of money, and I think that by the end of the calendar year, we'll be closer to \$1 billion, just Medicaid alone. That's phenomenal and it's all, for the most part, there's some (inaudible) 16:03 with the duly eligible hospitals but, for the most part, it's as an incentive for providers for having done adopt, implement, and upgrade. So let's talk about adopt, implement and upgrade 101, so that you can get in on some of the - - some of that money.

So here's a question for you. What's the "I" in AIU? Clearly, we talk about adopt, implement and upgrade and everyone understands that has something to do with either acquiring, adopting an EHR, certified EHR because you didn't have one, or upgrading because you had one and now you have the newly certified version. But what does the "I" really stand for and what do you have to do related to the "I"? Well, there's good news and that's that you can forget about the "I". When Congress created adopt, implement and upgrade, there was a clause in the High Tech Act that talked about the net average allowable cost to certify to use our technology and that Medicaid providers were going to have demonstrate that they had contributed at least 15% of that and so the importance of implementing at that point was we were going to allow them to consider all of the implementation cost towards that 15%: training, REC fees, work flow, data migration, all that great stuff. But really, it's gone now because in December 2010, Congress passed the Medicare and Medicaid Extenders Bill, which eliminated that requirement for the EHR Incentive Program for Medicaid, so now we don't think at all about net average allowable cost. We don't talk about Medicaid providers having to demonstrate 15%. That's all out the door, so went the "I", so you don't have to worry about the "I". We are now only talking about adopting, certify EHR technology or upgrading to it.

So here's the next question. Remember what I just said about the "I". Do you have to have implemented certified EHR technology in order to qualify for an incentive payment? I'll let you think about that for a second and guess what? It's good news. The answer is no. This is the question that we get all the time where you might have a federal qualified health in our network that has a contract with a vendor for certified EHR technology, and they are doing a phase rollout implementation where they're starting clinic A and you're clinic G and you're wondering, "Can I go into my - - can my eligible professionals go in and attest to this program?" We don't have it yet. They're still implementing it in clinic A and they're not going to get to us until say April, but the reality is if you as an organization, as a network, have a contract for that certified EHR technology, then even if it hasn't been implemented yet in your site, you have a legal and/or financial commitment to certify the EHR technology and, therefore, you've met the

requirement for adopt, implement and upgrade. You don't have to be using it. You don't have to have taken it out of the box. You don't have to actually have it on site. You just have to have a legal and/or financial commitment, so some of the questions that we hear around vendor delays and so forth are really important for meaningful use, but they're not as important for AIU. If you've signed on the dotted line and you have a contract and you know it's coming, then you can get your incentive payment, so hopefully, for many of you, that's good news. So that said, what's the bar for proving that you've done AIU or if I could just call it AU, I would but it's too late in the game to change the acronym. People would think I love being from Alabama and really, I'm a UT fan. So what's the bar for proving AIU, and here's your answer, kind of a good answer, in about answer. It's a good answer in the sense that it's fairly consistent based on our language. It's a challenging answer in that we do allow states some flexibility here, but these are some examples of the kinds of things that states are saying to demonstrate that they have - - a provider has met AIU. If there's a contract or purchase order, a user license agreement, a receipt, anything that demonstrates binding, you can't have received just bids but not paid for anything. You can't print out a list of available EHRs from your Best Buy. You have to have something that shows that you've made that legal and/or financial commitment or your employer has. We see a lot of vendor letters and what that is, if you're not familiar is, where vendor X has on their letterhead something that says, "Justcon* has adopted our certified version, number 2.0 on March 1st and this is our EHR certification number. Well, that's helpful for the state so that they know what to look for if they're going to audit you, but it doesn't actually prove anything. In fact, you could probably make it up on your own, so we need something that actually stands up to the sniff test to give you \$21,250, so we need something to go with that vendor letter such as, as I mentioned, a contract or purchase order, a user license or a receipt, something like that. So because you're a federally qualified health center or rural health centers, what you have, the scenario is, is that your clinic leadership is the one that has that information. You have the documentation. You're eligible professionals probably do not have that on hand. Where I work, nobody gives me a copy of whatever agreement we have between us and Microsoft. That's just something that our IT people have, so you have a piece of information that you're eligible professionals need in order to be able to attest and that's that documentation. The nuance here is there are some free EHRs out there, and we asked many states how they are asking for the documentation. It turns out, when we followed up with a few of them, there is still a user agreement. It's not financial because this is free, but it is still legal. There is still a legal agreement, a user license agreement between the user and that free EHR vendor, so that should suffice. So what if, going back to my earlier scenario, the certified EHR technology, that version, won't be pushed out to my clinical site until spring of 2012? Can I do AIU and get an incentive payment now? I wish I could do a show of hands in this webinar, but just pretend you're raising your hands because this is a question again that we get a lot where I have something, but this new version is not going to come out to me, the push won't come until the spring. The answer is "yes". You can get an EHR incentive payment for AIU if you have a legal and/or financial commitment to that certified version. So if you haven't actually upgraded your contract to get that certified version, then no. If you have upgraded your contract and you're just waiting because they're going through some process and they have a queue, then it's fine. Again, it doesn't even have to be in your physical possession. You just have to have a legal or a financial commitment so it should attest to AIU. It's really quite an easy bar. So is AIU binding and by that I mean let's say I do AIU now in 2011. It's December 13th. I want to squeak in under the wire before the end of the month, and

I'm going to get to AIU and I'm going to get my check for \$21,250 and do some Christmas shopping and who knows what else. Do I have to get to meaningful use next year? Is someone going to come back and take my AIU money back? The answer is every year is a new year, which is really fitting for a December webinar, right? Every year is a new year. Every incentive is based on what you demonstrated that year for that requirement, so you demonstrate your eligibility for each incentive payment for that year. So if this year in 2011 I qualify, I'm eligible and I receive my \$21,250 for having adopt, implement and upgrade in this year, next year, we want me to do meaningful use. That's the goal. That's what's going to avoid a penalty if I also take Medicare. That's what's going to get me to improved care regardless if I want to participate in health information exchange, afford accountable care organizations. There's a lot of reasons to move towards meaningful use, but it's not binding and that's important for you to understand also because what if your eligibility changes next year. Next year, you don't have 30% Medicaid patient volume or needy individual patient volume. Again, each year stands on its own.

So now let's talk about how states would audit, adopt, implement and upgrade. Most states are requiring that providers upload their documentation at the point of attestation. So it's as if you were doing your taxes online, and they ask you to upload a PDF version of your W2. It kind of comes in with your attestation. Some states don't have that functionality right now and are just asking providers to retain that documentation were you to be audited. So they still should be very clear and explicit with you about what you would need, but you don't actually have to upload it at the time of attestation. You just would hold onto it similar to your box of receipts with the IRS were you to be audited. With that, I think we're going to hold our questions to the end around AIU and some of the subsequent presentations. So I'm going to turn it over to my colleague from the REC from Minnesota and North Dakota, but I'm here and we'll do questions afterwards. Thank you. When I do Q&A, I'll speak louder, sorry.

Phil Deering: Thank you very, very much, Ms. Kahn. That was terrifically helpful and I know many people in the client group that we represent will be really, really helped out by that additional information so thanks. So indeed, my name's Phil Deering. I'm a Regional Coordinator with REACH, which is the regional extension center for Minnesota and North Dakota. Our mission is to help our clients improve patient safety, care quality, and clinical efficiency through the meaningful and what we say effective use of EHR technology. REACH is an entity that was created by a larger entity which is called "The Key Health Alliance". The Key Health Alliance is a partnership of Stratus Health, which is the QIO for Minnesota. The National Rural Health - - excuse me - - National Rural Health Resource Center and the College of St. Scholastica. Then the regional extension program is actually run also with our collaborative partners in North Dakota, which include North Dakota Health Care Review and the University of North Dakota, Center for Rural Health. Just a tiny bit about our safety net clients. We currently have enrolled in our program about 120 rural health centers, about two-thirds of which are in Minnesota, similar sort of division between our critical access hubs but elsewhere we have just about 90 of them. Then we also have in Minnesota 17 of our federally qualified health centers enrolled and in North Dakota, 4. In addition to those, there are other less specific types of entities that become our clients, including some free clinics, teen and reproductive health clinics, and so we're representing all those people. One of the interesting things in both Minnesota and North Dakota, the great majority of our clients are already

have EHR technology and are using it. Of course, there is a much higher bar with meaningfully using it, and so that's where REACH has been able to be effective working with our clients. There are some that still needed to go through the whole select and implement EHR technology as well. So far, we have six of our critical access hospitals, and actually I believe this is now updated to 7 and a couple of them have actually received a check. So again, the program actually is working and for anyone who isn't enrolled in the program, let me just encourage you to go ahead because it really does work.

So what I'm going to talk about is a series of issues that affect safety net providers, particularly those in HRCs and the rural FQHCs. I'm going to touch a little bit on the issue associated with RHC providers and incentive payments. We'll talk a little bit about dealing with vendors and how the regional extension center might be able to help with some of those issues. We're going to talk about the unique challenges, especially in rural areas of getting - - make sure that the staff now is able to support and maintain the more complex technology and reporting and project management concerns.

Finally, we're going to - - I'm going to give you a little tutorial, online tutorial in how to get more information or if you have a complex meaningful use requirement, some of the places you can go. So on this slide, I've got sort of the gloomy side and the sunny side, and we know that there is the - - whether or not providers who work at RHCs are eligible for the incentive payments is a really complex and nuance question. What we're going to do today in the interest of time is not delve into that, but I do want to touch on a couple points. That whether or not all the EPs that work in an RHC are eligible for the incentive payments. One thing that we're hearing is that many of those EPs and their clinic management are nonetheless very much dedicated to trying to reach the meaningful use requirements. There's a couple reasons that people are doing this. First of all, I think anybody who has looked at the meaningful use requirements understands that they are well aligned with best clinical practices, so (inaudible) 30:52 an updated problem list, updated med and med allergy list, a great after-visit summary, making sure that over time, you can effectively exchange data. All those things are best practices and, of course, all our providers in rural health centers know that and are interested in moving in that direction. So meaningful use provides a really good guide for clinical direction.

The second thing is that whether or not EHR incentive payments actually are able to touch everybody in the RHCs, many of our RHC clients fully expect that other payers over time will demand the meaningful use standard. Again, I think this makes sense. Since the standards represent best practices and since they are sweeping the nation, it will begin to affect all providers, not just those that are covered this specific incentive program or the varieties of incentive programs.

Finally, we're finding with some of our RHC clients in especially those that are relatively closer to larger urban areas where their patients may have a choice of where they receive their healthcare that they see a competitive advantage in keeping up with those maybe more urban centers that are reaching meaningful use and are beginning to use that in their publicity. A really good piece of news there is whether or not the incentive payments and the full ability to qualify on the standard CMS incentive website is available to RHC providers, the regional extension centers have meaningful use attestation facility and so if rural RHC folks can send us the reports that would back up their attestation of meeting

the meaningful use requirements, we can enter that in them and “certify” those providers as meaningful user. Again, we have a number of clients who are already moving in that direction.

So I’m going to slip over - - skip over these sort of detailed discussion of provider eligibility and move along to my next issue, which is about vendor issues and here what we’re seeing and I just know if I could see you all that many of you are nodding your head in agreement that many people in the safety net area are beginning to find that even when they have adopted the technology and are working as hard as they can to implement it, they’re running into vendor issues. They’re finding their vendors to be very non-responsive. Second, what we’re seeing in the rural health areas is that vendors of software that has been widely adopted by rural health providers are tending to put a lower priority on ambulatory versions of that software and so that despite the desire to use certified EHR technology, that isn’t always available. So that’s the gloomy side. On the sunny side, what are some things that can maybe make that a little bit more bearable? First, I want safety net folks to know that you’re not unusual. There’s a lot of that going around, just like when you wander into the doctor’s office during flu season. You know, “I’m sorry that you’re suffering, but everybody’s suffering.” We work with some quite a bit larger and more wealthy entities, and they also are having a tremendous amount of trouble getting response from their vendors. So I think it’s also important that we take a moment to understand what the vendors are confronting and if you realize how quickly the concept of meaningful use came about and the changes that had to be built into the software and the need to get that tested and working well, that I think it’s reasonable to understand how vendors could be behind right now and that many, many of their clients are demanding many, many things. It’s really a tough time for them. Nonetheless, there are some things that can be done about it and one of the things that we’ve found and maybe some of the other regional extensions are also helping form is collaboratives. Two examples of these that we’ve built out is one for rural health centers and the other for teen and reproductive clinics. So some successes that we’re seeing here is that we had four critical access hospitals come together. They were able to share information when they saw things that were jointly vendor problems. They were able to address those and put some pressure on the vendor that was stronger and a little bit more focused than if it came from individuals. We brought together six very small clinics. These are clinics with one or two providers, who have very small budgets, often teen clinics or clinics that are meeting in church basements, those kinds of things. They had very little buying power, but by working together as a group, they were able to get the attention of vendors, do a joint RFP and identify product and negotiate really excellent terms.

We’ve seen those same collaboratives, both of them work together because they are using similar software, and they can drive down and share training costs and resources. One more point there is that we’re seeing that together with REC, so us as REACH, can be the really reliable expert on interpreting meaningful use requirements and sometimes we can contradict or clarify some statements that come out on the vendors, and then arm our clients with the correct information, so then as a group, they can go back together. So then I just - - I always have loved this metaphor here, and I think many people in the safety net community are familiar with principles of community organizing or group organizing and certainly there is always power in numbers and to the extent that we can work together and come

together with similar needs and pressure those people that need to deliver software to us, then I think we're in much better shape.

I'm going to talk a tiny bit about staffing issues, and I think that people understand that. It's tough, especially in rural areas to find and maintain the staff necessary to support the new level of health information technology that we need to have and remember that there's the 90 - - of course, with the Medicaid program, there's a longer stage to this but in the end, meaningful use is forever, meaning you can't just add staff and get through the meaningful use hump; but these kind of transactions in reporting will continue to be a mandate on all folks in the safety net community and providers across the nation. Furthermore, not only are they demanding now, but they will continue to be more demanding over time. So with Stage 2 meaningful use, with accountable care, with healthcare homes, there will be ongoing and more complex reporting requirements and need to make sure that the EHR is always running and is updated with the latest functionality. So on the sunny side there, one of the things that we're seeing is that there is money available now for developing a workforce and what we're seeing is that because we have worked relatively closely with our community college, and we're seeing both folks that came with a clinical background and now are trained up on technology and, second, folks who had a tech background are getting trained up on clinical practices. Because of the weight of the recession, there are large numbers of people, who are very, very eager for an opportunity and we've been able to help work through some internship programs as a way to help introduce people into the safety net communities and also we've seen that using - - our collaboratives have also been able to share some of these tremendous resources that are coming out from the workforce development program.

So a few more details there. We connect our clients with the HIP training program from our community, local community college. One thing that we're seeing is that a fair amount of the technology folks who are in there, they might not have a strong clinical background, but they have terrific project management skills. If you think about it, one of the biggest barriers in, especially small and safety net clinics, is getting this sort of - - just the blocking and tackling of project management going to get through that implementation of software or to manage the program to get to meaningful use. These people have tremendous skills. Also, we have a longer term example of another Northern Minnesota group of SQHDs, who pool resources. They have - - they share the same - - they use the same software. They each have their own instance. None of them could afford a report writer or a loan, but by pooling their resources, they've been able to buy report writer and they're getting really, really tremendous reports. I don't want to make it light like everything's okay now, but they've done some really exciting things, especially around helping clinicians see where they stand with best practices.

The last thing I was going to take us through and I'll try to do this pretty quickly is the notion of being able to find answers and understand, interpret complex meaningful use requirements. Actually, this is a case where the CMS information services that the way that CMS is now helping us understand stuff has really, really gotten terrific and actually, almost anybody can really find great answers. So basically, there's a long URL here. This will be sent out but I'll tell you how to find it in a search engine on the next slide, so basically you go to the site, you find the requirements; you review this very clear and well written detailed guidance and then you can also check for FAQs. So I'm just going to take you through some screen shots that would show you how to do that. So if you want to know what should go on a

clinical summary and there's been a little confusion between: are the numerators and denominators unique patients or office visits for that clinical summary or after visit summary? So to start off, navigate to that URL I said or what you can do is, at least in Google, I just search meaningful use, table of contents, core. I put those words in and this CMS guidance page came up. These are probably a little bit tough for you to see, but each of the meaningful use core and menu requirements are listed here, so you would scroll down and number 13 is the one that has to do with that after visit or clinical summary. Click on that and you come up with a couple pages or depending on the requirement, you will see one, two, three or so pages that provide you both the requirement and detail but also great information like definition of terms. So you want to be careful and read this definition of terms, both the notion of a clinical summary and all the things that have to be in it are there, as well as information about what constitutes an office visit. Once you've read that, you can scroll down. Oh, I'm clicking on the wrong button there. You can scroll down a little bit further, and there the numerator and denominator are clarified here. If you can see this, it makes it very clear that the numerator and denominator are made up of office visits, not unique patients, and so you've got your first answer there. Then second, there's been a tremendous amount of questions about what is the minimum and, in general, what needs to be on an after-visit summary and if you read the additional information, you will find that clear list of the minimum elements that have to be on an after-visit summary. Suppose you were to want to know, "Well, do I only have to do the minimum or if my certified EHR technology can do more than the minimum, what would I need to do?" Well, then you could proceed and click through and read FAQs that will give you answer for that. I'm not going to do that. That's everyone's assignment and it's in - - the answer to that is in those FAQs. So enough from us in Minnesota and North Dakota, and I'll pass it to the next presenter.

Lisa Rawlins: Okay, Phil, thank you very much. This is Lisa Rawlins with the South Border Regional Extension Center and I'd just like to give a big thank you to HRSA and, in particular, Lieutenant Michael Banius for inviting us to share with you our vision for the future, as well as our experience in the federally qualified health center environment. Hopefully, by sharing some of our experiences with you today, you'll be able to glean some best practices in your vision and journey to meaningful use. We like to say in South Florida and in the regional extension center environment, if you've seen one regional extension center business model, you've seen one regional extension center business model. Although we have similar objective and key goals, the way we get to our objectives and key goals vary from REC to REC. The mission of the South Florida Regional Extension Center is to provide assistance in the adoption of health information technology to all the healthcare providers in our community. Our vision will be able to continually provide outreach, education, and direct technical assistance services to regional healthcare providers through perceived added value of services and adequate target market support and penetration.

One of the key successes, I think, of the South Florida Regional Extension Center, we are housed in what's known as a help center controlled network. Our network is Health Choice Network and Health Choice Network has been providing services to federally qualified help centers for the last 15 years. I joined Health Choice Network back in May when we were awarded the funding to create the regional extension center. With that, my observation was that the federally qualified health centers within our

network had really been working toward meaningful use before it became vogue or before the incentive dollars were attached to improving quality and efficiencies in the healthcare delivery market.

With that, one of our key successes of the South Florida Regional Extension Center is - - has been in our engagement of the local community. Although the Health Choice Network we service 25 federally qualified health centers in Florida. We also serve 25 federally qualified health centers throughout the United States, so our network expands beyond the boundaries of Florida into Hawaii, Utah, West Virginia, as well as Rhode Island and several other states. But for today's presentation, I'm going to focus mainly on our successes within the regional extension center environment and with that, we've been very fortunate to have our community supporting our endeavors. You can tell by this slide, this is what I like to call my circle of trust, and we have engaged the healthcare industry within South Florida and what I mean by the healthcare industry, all aspects (inaudible) the use of the healthcare industry from the large healthcare, public hospital providers, Broward Health, Jackson, which is a large public hospital here in Miami. We've also engaged our academic partners, FIU, Miami Day College, Broward College, as well as our professional associations, the Ford Academy of Family Physicians have been instrumental in working with us in our outreach and education, as well as our local county medical associations. So as I mentioned earlier, we have been on the road, the federally qualified health centers within the regional extension centers have been on the road to EHR adoption for quite awhile. (Inaudible) using the EHRR comes easy in Florida with the system and support that we have created. We have a monthly meeting with all of our medical directors in the federally qualified health centers that come together to look at best practices and address issues in clinical performance, as well as outcomes. We have QI support staff in place to provide clinical informatics and analysis to identify areas both of best practices and those areas that may need improvement. So we're working with our federally qualified health centers across the board on a number of clinical outcomes and issues through our QI team. Some of the barriers that we've run into across the nation, and we heard a little bit about this from Jessica, not all state Medicaid sites are available as of yet and, in some cases, the states may have their site up but the money may not be available. We also see a lack of local resources for support of additional operations. Eligible - - one of the other major barriers that we've experienced and probably some of you had experienced as well on this call, we're seeing eligible providers or professionals moving from site to site. In some cases, from state to state and that's an issue that we have internally been working toward, but I would say and defer to Mrs. Kahn to deliberate and to expand on the regulatory side of how to address those particular issues. I think that's one really great advantage of the regional extension center is that we have our direct connect to both CMS and to ONC, and they're really the subject matter experts as it relates to eligibility and certainly are on-call, so to speak, when we have an issue that we have deal with. So that's been a real success in our relationship with our federally qualified health centers in working as the liaison between CMS and ONC and the federally qualified health centers.

We have actively been pursuing the dental application in regards to the dentist and in the behavioral health environment. As I mentioned earlier, the South Florida Regional Extension Center's parent company Health Choice Network has over 25 federally qualified health centers in Florida and 25 across the nation. The majority of which are using a dental EHRR, Dentrix, and we have currently 15 databases that support the dental side of healthcare and most of our facilities have been on the Dentrix Enterprise

System for the last ten years. We have over 518 concurrent licensed throughout the nation that we support. Again, very similar to the medical quality side, we have what we call our QI, our dental QI board, and that's where we're bringing in the providers on a regular basis to talk about quality improvement as defined by HRSA, the Healthy Smiles Program, and other grant initiatives. We look at oral hygiene instructions, post visit, the risk assessment and the preventative measures performed in relationship to dental health. We've also developed dashboards through our Amalga HIE for the federally qualified health centers so that our providers have the opportunity to compare their outcomes with their colleagues. So the federally qualified health centers have been utilizing the dental EHR and we've had a lot of success with that. Some of the barriers that we're experiencing with the federally qualified health centers in regards to meaningful use is the lack of resources for clinical transformation. The South Florida Regional Extension Center educates the provider that this will be an ongoing operation and that they will have to establish a point person at the office. Just as in any process improvement initiative, you need to have a key person in each of your facilities to help through this transition. The South Florida REC is working with the local QIO or state QIO to inform provider members that this is an ongoing quality initiative and that - - a quality initiative and educating resources about quality measuring and reporting.

Number three: Understanding the value outside of the incentives. That's been a big initiative for us in regards to improving healthy - - improving patient outcome. Some of the other barriers, understanding the definitions and meaning behind equality measures, we've heard that I think over and over in the presentations earlier today. Time of course is always a barrier, time management, change management, and the cost of EHR's, although we're starting to see the market drive down those costs, it still is a barrier in our smaller practices.

Okay and with that, I'd just like to say thank you; it's been a pleasure speaking with you today. We've had a lot of great successes working with a federally qualified health center both in Florida and across the nation, so thank you. And I'll turn it over to Gary.

Toni Nie: Good afternoon everyone. This is Toni Nie at Telligen REC, along with Sarah Cottingham, and today we'd just like to - - this is not going to be Dave Letterman's Top 10, but it's going to be the Telligen Top 10 Gray Areas of Meaningful Use for CAH's and Rural EP's. And first of all, I'd just like to quick let you all know that last Thursday, on December 8th, we met our recruitment goal of 1200, so we're all pretty excited here now, and now we're just going to continue to move our clients towards the meaningful use.

We're going to start with Number 10, and I'm going to move swiftly through 10 through 6, and then we'll go through questions at the end; and I apologize.

Sarah Cottingham: So have I switched slides, we should be on Number 10, which is Multiple Locations. If an EP sees a patient in a setting that does not have certified EHR technology but enters all of the patient's information into certified EHR technology as another practice location, can the patient be counted in the numerators and denominators for meaningful use measures for the Medicare and Medicaid EHR Incentives Programs?

Toni Nie: Yes, that patient may be counted in the numerator and the denominator as long as the EP is registered with that practice for either Medicaid or Medicare EHR Incentive Program.

Sarah Cottingham: Okay, Number 9: How will EPs be required to show that they are meeting the Medicaid or needy individual patient volume thresholds of 30% for the Medicaid EHR Incentive Program?

Toni Nie: Well, for Medicaid, and this is in Iowa, but they will be asked where the data came from when they attest: Their practice management system, electronic health record, or it could be manually calculated. If the EP is audited, they will be asked to upload the information to show the proper data source.

Sarah Cottingham: What is a unique patient?

Toni Nie: If a patient is seen more than once during the EHR reporting period, then for the purpose of measurement, that patient is only counted once in the denominator for that measure.

Sarah Cottingham: Number 7, we're on to MAC Guidance. MACs are not uniformly reviewing things. So, what we would suggest, this is an FAQ that references reasonable cost, but also please reach out to your specific state MAC and your state Regional Extension Center so that you can receive the specific guidance for your state MAC. We have provided here an example of what WPS, which is Iowa's MAC, has for the CAH EHR Incentive Program Payment Listing, and how to break out reasonable costs.

Number 6: this refers to Exchange of Key Clinical Information. What forms of electronic transmission can be used to meet the measure of the objective?

Toni Nie: You may use any means of electronic transmission according to any transport standards, which could be an SMTP, FTP, a REST, a SOAP, and et cetera, regardless of whether it was included by an EHR technology developer as part of the certified EHR technology. And you notice we also have up at the top a FAQ from CMS for you.

Our top five, Number 5, Problem Lists: How do you maintain an up-to-date problem list of current and active diagnoses?

Sarah Cottingham: This is focused on hospitals for Critical Access Hospitals, but really the main issue is the hospital has to identify the workflow. Organizations must develop clear policies and guidance regarding the structure and use of problem lists in order to ensure reliability and integrity of the process. So within your policy, the components that you would want to have would be identified who has the ultimate responsibility for maintain the problem list. Identify who is authorized to add update and resolve problems. Determine the purpose and scope of the problem list. Identify who has ultimate responsibility for maintaining the problem list, and provide a detailed workflow for developing the problem list. I've also provided a reference to the AHIMA Book of Knowledge, where they provide a policy template for hospitals to develop in regards to problem lists.

Toni Nie: Number 4: Clinical Quality Measures. To what attestation statements must an EP or an EH agree in order to submit an attestation, successfully demonstrate meaningful use, and receive an incentive payment under the Medicare EHR Incentive Program?

Sarah Cottingham: Okay, this is an FAQ which was released by CMS in October 18th, however, I'm going to defer to Mrs. Khan in regards to a more recent up-to-date FAQ, which I was unaware of. The number of that FAQ is 10839, and IF - - would you like to comment further on that, Ms. Khan?

Jessica Khan: Sure, thanks for referring everyone to that number, they can go on the CMS EHR Incentive Program website and type that in. And it essentially phrases it like this, the question is: Does the provider have to record all the clinical data in their certified EHR in order to accurately report complete medical quality measure data then incentive program? And the answer and the focus that people really need to understand the distinction, is that we recognize that providers are concerned with workflow processes and it's a transition process, so where they might not be able to capture all the data right now in their EHRs. So what we are hinting this on, what our requirement is, is that providers report the clinical quality measured data exactly as it is generated as output from the certified EHR technology. So, if your certified EHR says 1/100, that's what you attest to, 1/100. Is it perhaps true that there's some other data available to your team that's not in the EHR that would, if it was calculated across your whole practice regardless of what technology or paper chart or this system or that system, would it be 1/100? Maybe not. But we're talking about meaningful use of your certified EHR technology, and so we are - - our requirement is limited to what was generated as output of your certified EHR technology for this (inaudible) and that's of course the (inaudible) clarifies which I think perhaps is much less frightening than our initial language. I'll turn it back to you all.

Sarah Cottingham: Okay, thank you very much for that update. Okay, number three, we're on Clinical Summaries. We have three different questions: Providing e-Copies of CCDs, Continuity of Care Documents, is a very confusing area. How can it be given thumb drive, burned CD, et cetera? Question B: If an EP offers a clinical summary, but the patient refuses to accept the clinical summary, may the EP include the refused clinical summary in the numerator? And lastly, C: What does one have to do to fulfill clinical summaries? The question always seems to be: what suffices as far as content goes and who/how it should be presented.

Toni Nie: And this is definitely a burning issue that we have seen out there and heard a lot of different things on it, so I'm going to cover A, B, and C here for you in the answers. The first one you know we're talking about how it can be given. So, the clinical summary can be provided through a patient health record, a patient portal on the website, secure email, electronic media such as, again, a CD or a USB, or a printed copy. If the EP chooses electronic media, they would be required to provide that patient a paper copy upon request. If an EP offers clinical summary but the patient refuses: When the EP provides a clinical summary to their patient and the patient refuses the clinical summary, the EP may included the refused clinical summary in the numerator as the EP has done their part to fulfill measure. And C: What does one have to do to fulfill the clinical measures? C: The final rule defines the clinical summary as: "An after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to. And I'm not going to read all those, you can see the information that is

there, anywhere from our patient name, provider's office information, to your medication update list, the reason for the visit, and the recommendations to the patient. And I want to just quick share with you, one of our providers, just like I said, this is one that we always see some pushback on. He seems to enjoy the clinical statement. He stated, "As he's sitting there talking to the patient and documenting, and now the patient is sitting there on the table." And we all know how patients love to share their family history, talk about whether it's their kids, their grandkids, or their dog, so while they're doing that, he's completing what he needs to in that clinical summary, and then he'll let them know at the end of the visit that that clinical summary is available at the front desk. It's printed out, and then he states that if the nurse or someone is talking to them afterwards, what it has done, it has helped because the patient is excited about going out and picking up that clinical summary to see what he's got there, that they're not stopping him in the hall when he's going into the next visit and say, "Oh, by the way, Doc, I forgot to ask you this or can I do this?" So, he said that's eliminated some of that traffic for him also. So, we found that very helpful. Now, keep in mind that is just one provider; that may not work for an office with multiple providers, but this provider seems to enjoy it and it works well for him.

The next issue that we're going to talk, Number 2, is going to be Privacy and Security.

Sarah Cottington: In Privacy and Security we're going to again refer you the provider to contact their state REC who can provide guidance with state and local laws and things in place. And also some REC's offer a Privacy and Security Risk Assessment as part of their services or as an add-on service, and we do provide a tool to our clinics and our hospitals, but we also have a more robust security risk analysis, which another section of our Health Management Telligen offers. Also, please refer to the provided link to Telligen REC Privacy and Security Webinar, where you may download the slides and listen to the recorded webinar. The webinar was presented on November 30th, by two of Iowa's privacy and security experts, JoEllen Whitney, and an attorney with Davis Brown Law Firm, and Mike Sinnwell, who's the information security officer at Telligen. Within that PowerPoint when you download it, there will be many, many resource slides with a hyperlink and websites available.

Toni Nie: And our number one top 10 is CPOE. Who can enter orders into the Computerized Provider Order Entry?

Sarah Cottington: An FAQ number 10134, which was released by CMS on September 22nd, clarified that any licensed healthcare professional can enter orders into the medical records for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local, and professional guidelines. So we'd like to refer you to that FAQ, again that's number 10134, but also from the Burning Issues, there was a specific question recently regarding CMA, Certified Medical Assistance, and the answer which was provided on that site stated: Our best advice is to contact your state medical board and state board of pharmacy to obtain in writing whether certified medical assistants are permitted to CPOE meds in your state.

Very quickly, we were asked to present a couple of slides regarding the attestation process. On our website also there are two different PowerPoint presentations and webinars recorded, which you may download or listen to the recorded webinar, one specific to EPs and another specific to CAHs, and so it's

basically 80 slides of information that we've tried to compress within these next three slides. We provide right here the link to the EHR Incentive Program Registration and Attestation website. The next link is to ONC's Certified Health CHPL list. You may have heard it referred to, where you may obtain the certified EHR ID number. Lastly, the website specific to the Iowa Medicaid Portal Access, where providers within Iowa would go to register for the state Medicaid program.

Toni Nie: And in this process what will I need to log into to the attestation system? If you're working on behalf of an EP, and EH, or a CAH, you will need an active National Provider Identifier. The same user ID and password are used to register, an EHR Certification Number from the Office of the National Coordinator. If you did not register the facility, you will need an Identity and Access Management system Web user account, user ID and password, and be associated to the organization NPI, if you're a user working on behalf of the eligible hospital or Critical Access Hospital. Create a login in the I&A System if you are working on behalf of an eligible hospital or Critical Access Hospital or an EP, and don't have an I&A web user account.

Register, Attest and Get Paid! Complete CMS EHR Incentive Program registration on the website. Go to the IMPA and complete the eligibility verification and attestation. Payments are made by the state no later than five months after you attest, most sooner. And the Iowa Medicaid has already distributed over \$21 million in incentive payments as of October of 2011.

Sarah Cottingham: So please feel free to contact Toni and I directly if you have any additional questions or concerns, and just speaking on behalf of Telligen REC, we have extensively used the HITREC Burning Issues Group, which is a subgroup of the meaningful use community of practice, as has been referenced previously as part of our direct connection to ONC in resolving some of these gray areas. So thank you.

Toni Nie: Thank you.

Alana Knudson: Excellent. Well, we have lots of questions for all of you presenters today, so why don't I start with Ms. Khan? And the first question is: How will rural health clinics or practice groups be reimbursed for each medical provider who is participating?

Jessica Khan: That's a good question. Just to clarify, the incentive program was designed for guidance into eligible professionals or to hospitals, not to clinics. There is a relationship between clinicians and the clinics in terms of the employer, employee, or contractor contractee, which is out of our scope, and as part of that relationship we see in many cases where an employer or a clinic is requiring as a terms of employment that the eligible professional will reassign that payment over to them. Again, that's out of our scope, but that is permissible under our program. Both Medicare and Medicaid allows reassignment to employer. So each eligible professional has to come in and demonstrate that they've met the requirements every year, and when they do so, they are giving us a tax ID number. It could be their tax ID number, or it could be the one of their employer or contractor, depending on (inaudible). So, it's individually negotiated in terms of employment, and that's where the money is sent.

Alana Knudson: Excellent, thank you. And I'll just have one more follow-up question for you then. What are the ICD-10 dates for outpatient billing?

Jessica Khan: Ah-ha, well, I don't actually know because I don't work on ICD-10, so I couldn't answer that question, but we would be glad to look into that and follow back up with you.

Alana Knudson: Excellent, thank you. My next question is for Phil, and my question is: Does your Medicaid patient ratio have to be 30% to qualify for a meaningful use reimbursement?

Phil Deering: From the type of practice.... However pediatricians have a slightly lower bar, and that's 20%. (Inaudible) with that though is a reduction in payment.

Alana Knudson: Excellent, thank you.

Jessica Kahn: Just to clarify, pediatricians who demonstrate anywhere between 20 and 30, or 29% patient volume would receive \$14,167 in their first cure instead of 21,900.

Alana Knudson: And Phil, I'm going to have another follow-up question for you, and that is: With the many educational programs that are available through the community colleges and the universities, are there any internships or fellowships that are offered to these students for more experience so they can get that hands-on expertise before they start working in organizations?

Phil Deering: Sorry. I can only speak to the experience of here in Minnesota at Normandale Community College where there is an HIT Workforce Development Program. I have actively been working with the broad array of vendors, providers, consulting companies as well to create internship experiences. I would very much encourage providers around the nation to see if there is a workforce development program in their area, and then to directly contact that program and see if there are opportunities. I think it's a win-win.

Alana Knudson: Excellent, thank you. Now shifting gears to Lisa, I have a question for you, and the audience would like to know: How can dentists register for incentive payments when there is not currently a certified electronic dental records software?

Jessica Khan: There are actually two certified EHR's for dental providers on the software right now (inaudible). And we've actually paid hundreds of dentists to date, so I'll let Lisa maybe give some specific examples.

Lisa Rawlins: You said it nicely, Jessica, so you know the experts are have spoken and there are two platforms that are certified. And as mentioned in the earlier presentation by Jessica, adopt AIU, Adopt, Implement and Upgrade.

Jessica Khan: We've actually paid as of October, I don't have my November report in front of me, but as of October we've paid 333 dentists for meaningful use as well under Medicare. And basically what it comes down to, and this is true with a provider that perhaps has more of a specialist in a primary care focus, is that each of the meaningful use objectives should be evaluated independently because many of them have exclusion criteria. Either you don't perform a certain task or you don't see that kind of patient. And so if you go through each of the exclusion criteria, there is generally a pathway for every eligible professional to meet meaningful use. Especially to the point that was made during today's

presentation where you saw like an example of CPOE and many of the other objectives, it doesn't have to be that eligible professional who he or himself entered that information into the EHR, they just need to ensure that it's there for a X number of their visits. So particularly where we see dentist in Safety Net clinics where they are a part of a multidisciplinary clinic team, they are in that sense benefiting from what their primary care or colleagues are imputing into the EHR. So I would think in particular for this audience we would hope to see many dentists coming in who work in Community Health Centers and Rural Health Centers, and can participate.

Alana Knudson: Are the certified dental products listed on the ONC website?

Jessica Kahn: They are. That's the only source of truth for certified products as far as we're concerned, is the ONC website. And there's one that is MAC based, and there is one that came on more recently that is not MAC based. And I had a conversation with Henry Shine* last week and they are also in the process of getting certified for Dentrrix. So there's two out there, and there's a biggie coming.

Alana Knudson: Excellent, thank you. My next question is for Toni and Sarah. Can an eligible professional participating in the Electronic Prescribing Incentive Program report on the electronic prescription if she electronically prescribes the medication for a patient but the EMR sends it through the fax machine instead?

Toni Nie: No, I don't believe so. Can you repeat it one more time? I'm just trying to follow that question.

Alana Knudson: Yeah, it's a long one, I'm sorry about that. If you have an eligible professional participating who's in the Electronic Prescribing Incentive Program, if they electronically prescribes the medication for a patient and the EMR sends it through the fax machine, is that acceptable?

Jessica Kahn: I'm sorry, this is Jess jumping in. Is the beginning of that question having to do with the e-Prescribing Incentive Program?

Alana Knudson: That's correct.

Jessica Kahn: Okay, so that's not the EHR Incentive Program, that is the Medicare e-Prescribing Program that was authorized under MIPPA, and that's demonstrated to CMS through a G code on our claims tool, and that's a separate process. And what's considered e-prescribing under that program is defined in a separate regulation, so I just don't want to confound the two. We have an FAQ on our website to talk about e-prescribing and the role of faxes and so forth for meaningful use, and I would recommend that people go and look there if that's what they're looking for on meaningful use. It's just around the e-Prescribing Incentive under MIPPA they should go to part of the CMS website that talks about that program. But just as a note, you can't participate in both of those if you're seeking a Medicare incentive. You can only receive a MIPPA e-Prescribing Incentive and a Medicaid EHR incentive payment at the same time. For Medicare providers you have to choose between one or the other.

Alana Knudson: Excellent. Thank you.

Jessica Kahn: Thank you.

Alana Knudson: Going back to Ms. Kahn. Are there some confidentiality issues with EHR contracts that prohibit them from being shared with others, even with states?

Jessica Kahn: We have not heard that. We have heard some states... We haven't heard it directly. Some states have said that they have allowed providers to give them excerpts of contracts, so the signature page, the part that says what you signed up for and when, but perhaps not the middle, and that's really up to the state. However, again, if you are coming in and you are testing to something and the documentation that is required to support your payment is the contract, there's no require - - there's nothing that would stand between you and the state asking you for a copy of that documentation. This is part of the term for participation in this program, which is voluntary, but we need to make sure that people are actually using certified EHR technology and these kinds of legal and financial commitment documents are the only way to do so and do due diligence (inaudible) federal funding.

Alana Knudson: And just to be clear, how our states auditing the 20-to-30% patient volume threshold?

Jessica Kahn: Oh, that's a huge question. That's its own webinar. (Inaudible) invite back for a patient volume webinar. It really varies by state. There are a variety of ways to do this, depends on whether you're talking about fee-for-service claims or whether you're talking about managed care, whether you're talking about a state that has an all-payer claims database. Some states, I think it was even mentioned in one of the presentations today, some states are asking providers to indicate what their data source is. Perhaps they have a practice management system or something that can generate a report or through their billing agent. It really varies. There are some suits that are using claims and counter data as a proxy. I would just have to say that people should look at their state Medicaid agency's website there state Medicaid HIT Plan should be posted. It's meant to be a public document, and it does talk about patient volume and their plans to validate patient volume and it's generally something that is not being done prepayment because it's quite complex. There perhaps could be some prescreening, prepayment, but for the most part it comes to me that it's only being validated after a payment.

Alana Knudson: Excellent. Well I think that's a good place to end. It sounds like we've got another opportunity for a very interesting webinar to follow, so thank you so much for the presenters taking the time to present and for your very thoughtful responses to the questions and also thank you to all of you participants for your participation in today's conference and especially for those of you who submitted conference call. Now I'll turn it back to the operator.