DELOITTE

Moderator: Elena Lipson
August 28, 2009
11:46 am CT

Coordinator: Your lines have been placed on a listen only mode until the question and answer portion of today's conference. If you would like to ask a question, please press star 1.

I would like to remind all parties the call is now being recorded. If you have any objections to please disconnect at this time. I would now like to turn the call over to Mr. Matt Kendall. Thank you sir you may begin.

Matt Kendall: Thank (Elonne). I'd like to first of all thank everybody for tuning in to this call. We know that it was a little rushed in begin scheduled. But I appreciate people taking time out, you know, what is surely a busy time of year, to attend this technical assistance call for the program.

The agenda today is going to be fairly straight forward. We're going to have a presentation by Dr. (Farzad Mustoshari). And then we're going to have an opportunity for people to ask questions about the funding opportunity announcement.

The process - we'd prefer if people would submit questions in writing using the functionality that's described on the top of your screen. But there will also be at the end of this call an opportunity for people - for us to take live questions.

This call is being recorded. And the slides will be posted on our Web site, along with frequently asked questions which we will be updating periodically. I would encourage people to periodically check the Web site to see the updated information as it posted.

With that - with those instructions, and without further a due, I'd like to hand it over to Dr. (Farzad Mustoshari) to provide an overview of our program. Thank you very much.

(Farzad Mustoshari): Hi. Good afternoon - for those of you not on the West Coast. I'm (Farzad Mustoshari). And we're going to be talking today about the Health Information Technology Extension Program.

First thing to acknowledge is the incredible amount of interested and I hope excitement that accompanies this - be sure that we feel the same excitement and purpose at (ONC). And it's really gratifying to finally be able to announce the program and to be able to work with all of you in making this happen.

By this we mean the widespread adoption and meaningful use of electronic health records. The High Tech Act authorized new grant programs that can help providers reach meaningful use.

And for those of you who have seen the recommendations of the Policy Committee around meaningful use, you'll I hope have recognized, not just the

directionality that it provides, but also the specifics of how to get there in 2011 and 2013.

And recognize for those of you who have had the scar tissue as they say, how challenging it's going to be. The Policy Committee wants to walk that line between making the narrow gap between what is currently in the vendor products and in the capabilities and in the work flows of practices, and the vision for the future.

And the outcome of that is - strikes a balance that is aggressive, but achievable. Particularly achievable we hope through the assistance of the extension program.

The extension program has two parts to it. There's the National Health IT Research Center - the HITRIC. And then the regional extension centers. And we can go to the next slide please.

So the purpose of the regional centers is to furnish assistance. And that's education, its outreach, its technical assistance to help the providers select, successfully implement and meaningful use certified EHR technology.

The question is, well what do we do? And to whom do we offer the support?

There is a requirement to offer the educational aspects to all providers in the region. And in this, the providers will be helped through the HITRIC, the materials and the Web resources and other support of the HITRIC - National HITRIC.

The bulk of the work though we expect to be in the direct technical assistance. And in that work priority's going to be given to primary care.

And this is a strategic policy decision that was made to make sure that as soon as possible we get the primary care providers in this country and help reach the goal of every American having an electronic health record.

The groups and the settings to be prioritized include individual and small group practice with ten or fewer professionals, where the majority of primary care in this country -- some 80 or 85% is already being provided.

But also public and critical access hospitals and primary care providers who practice in community health centers, rural health clinics and other settings that serve medically uninsured populations.

Important point here, and we've already gotten some questions about this, and we're going to be coming out with some further guidance on is the minimum size requirement.

There were some - I think 1,000 and climbing number of folks who were trying to get on this call. There's obviously an -- people I think are still being logged in as we speak.

There's going to be a great deal of interest in this program. That's a wonderful thing.

But we need to make sure that given the limited resources that we have, and really the need for scale of the program, that there isn't - there's an adequate resources to support the extension center programs. And that implies a certain minimum size.

So, we picked a size of about 1,000 primary care providers that we can serve over the two year period -- about 500 a year. We know that this is going to be difficult in some areas. In some areas it's going to require larger geographic areas to be included than other areas.

We also -- the goal here is to move at least 100,000 primary care providers over the two year period of the program to be meaningful users. That's the target that we're setting for these -- so the -- distributed among 70 centers. That comes out to an average about 1,500 providers over the two years.

One hundred thousand compared to about the 240,000 primary care providers total in the country is a significant portion. And similarly we expect that the populations served by each extension center is a significant portion - at least 20% of all the primary care providers in their region.

This limitation was also introduced to make sure that we don't have a strong, but relatively small program - kind of laying claim to an entire state or region and making sure that other good applicants are not in the sense blocked out of serving an area. Next slide please.

So what are the services that they're going to be offering? Its education and outreach - disseminating the knowledge about the effective strategies in practices that we talked about.

It's participation in the national learning consortium. It's important to note that these are cooperative agreements. And under that form of grant there is a tight working relationship between not only the national coordinator and the grantees, but also between the grantees themselves. And with the grantees and the HITRIC.

So, participation in the national learning consortium that's facilitated by the HITRIC, and sharing tools and materials is a key part of what we're expecting the extension centers to do.

We really, you know, we're on this mission together. And we really have to help each other. Certain groups are going to do a great job at certain aspects of this.

And that knowledge needs to be shared as quickly as possible with other extension centers. And really with the public at large, and with providers. Even those not in - not within the extension center program.

There's also an important component of workforce support. We hope to announce another grant program dealing with workforce as mandated by the legislation.

And we hope to have strong connections, not only between this extension program and the state HIE grants, but also with the local workforce grants that would be coming out.

And those as well, leveraging whatever the local resources are on workforce. For example, community colleges to make sure that their internship opportunities or teaching opportunities, there's employment opportunities and so forth.

The next item is practice and workflow re-design. Not just about the technology, it's about changing the practices to make sure that we get the gains out of the technology.

The function interoperability and information exchange, making sure that the information exchange occurs and providing that focus, and making sure that whatever comes out of the meaningful use information exchange requirements can be met by the practices in using the scale and leverage, not just of the extension program, but of the extension center locally. But also of the extension program nationally to bring some pressure to there on the trading partners as it were of the practices.

Let me talk a little bit about vendor selection and group purchasing. We think that this is not just in the legislation. It’s actually a critically important part of this.

This has been one of the reasons why there has been so much difficulty in HIE adoption - the information asymmetry between providers and vendors. And one of the really important functions that the extension centers and the extension program as a whole, we hope will provide is greater transparency and support for leveling the playing field as it were.

The concern - one concern to be honest that we do have is that these extension centers not be - become kind of proxies for a particular HIE vendor.

And that is why as you’ll see there’s a lot of discussion in the (FOA) about the need to be unbiased. The need to avoid entering into business arrangements creating an actual apparent conflict of interest.

The need for open and transparent processes for selection of systems, and the need to include members of the target community in the selection committees for the vendor selection.

I don't want to imply that there's -- at all -- that there's an adversarial relationship with vendors. The vendors are absolutely essential partners in this with the extension centers. But it has to be kind of a relationship of equals is what we're looking for. And the stance here for the extension centers is to be on the side of the providers. Next page.

Privacy and security best practice, I think in a way of beautifully captures the dichotomy between certification of technology and practice is kind of obvious. That you can have technology that has encryption audit trails, you know, and all the rest - rural based access, and yet is not implemented in a way that yields the privacy and security really required to keep the public's trust.

So one of the specific tasks we want to call out for the extension centers is work with the practices to ensure that best practices in privacy and security and in using the tools effectively to safeguard patient privacy and security are implemented on the ground.

And implementation project management is - this is something particularly for the smaller practices, that is a key need. Is just the end-to-end project management, and we think this is going to be a lot of what the extension centers do is individualized and on-site where needed - coaching, consultation and really importantly trouble shooting.

The process is going fine, that's okay. But being - monitoring the situation and being prepared to step in an resolve issues, whether it's with vendors, with technology, with a practice and so forth to the extent that they can.

And finally, progress towards meaningful use. The end goal here again, you know, we want to avoid the patterns of the past. The goal is not adoption of

technology is necessary, but not a physician's pre-condition for meaningful use.

We really expect the extension centers to be knowledgeable and to be able to be reflecting to the community authoritatively what does meaningful use mean? Interpreting that, being trained to interpret that, and to help the practices monitor their progress towards meaningful use, and get them there. Next slide.

So eligibility - pretty straight forward. It's in the legislation. Got to be a non-profit or a group there of. I know there's going to be lots of questions about this, and we'll issue more guidance to address any questions people have.

The other point is, in terms of what the geographic areas. We intend to have one extension center per geographic area. So, that geographic area can be an area within a state. It can be a metropolitan statistical area that crosses state boundaries. It could be an entire state in some cases.

And we have allowed for the possibility of multiple contiguous states. Although I think this will be both the statewide and the multiple contiguous states will have a high barrier to demonstrate that they can effectively provide booth on the ground support to all - to the - all the providers in their region, and to meet the target of 20% of all primary care providers in their area.

We aren't saying that you cannot apply to serve and area that is already being served under a cooperative agreement. There is going to be some adjustments, particularly when there are multiple groups that are proposing to serve overlapping areas. And that's part of what the cooperative agreement negotiation process is going to be.

But as you'll note, we've - we have three separate cycles that we describe in - in detail in the (FOA) itself. And really the goal here is to have those who are ready to stand up right now.

There are those of you who are already doing this work, who are ready to absorb the funding and are ready to go - to go with no delays. And to really serve as the early testing grounds and help feed the other applicants in the regions - in the broad region that you're located in. And we have a very aggressive timelines for the first cohort of folks who go through.

It should be noted that here is a first mover advantage here. If you already have proposed and been approved to serve an areas, then you know, in a sense, other - other folks cannot propose to serve that same area and they have to propose a different area.

So there is an encouragement certainly of what we mean to - which was intentional to urge people who are ready to work through the - very hard over the next couple months to get applications in by November - well the full applications in by November 3rd and hit the ground running.

The other two cycles will start thereafter. There'll be enough time to know who got funded and what areas they're serving in time for the next preliminary round. In all there's going to be three rounds.

We are guessing how many folks are going to be funded in each of the three cycles. It's possible that we're going to have not that many people coming in the first cycle. It's possible that we're going - judging by the interest of this call, there may be a great number - more than expect folks who are ready to hit the ground running and that would be wonder - this is just - just wonderful if that happens.

So this next slide shows the details of the anticipated funding. But again, it's more successful applications come in There is no reason these distribution of the funds is really our best guess, but is not fixed in any way. The more successful applications we can get out sooner, the better as far as we're concerned.

There will be the total of -- it's a smidge under $600 million available for these. And these are going to be four year cooperative agreements with two budget periods.

There's a legislatively mandated bi-annual evaluation. So the 598 represents the funding that will - that's being budgeted for the first two years of these four year cooperative agreements.

The very minimum possible - if you did nothing, if you could sign up, you know, basically not a single doctor was signed up - and we don't expect that to happen here.

But the award floor therefore would be $1 million, which is we're providing basically in core support for the, you know, the outreach and educational activities and the grant program management, and participation in the learning network.

The absolutely ceiling we think is going to be about $30 million with an average award of about $8.5, $9 million. Most of that funding is going to be tied to the direct support that is offered to the practices.

And this includes both practices who have already implemented EHRs, but maybe are not helping them to get to meaningful use. And also practices who

have not adopted EHRs and helping them first get them to go live status on an EHR with quality reporting and e-prescribing, and then onto meaningful use.

We are going to be tying - asking to tie the budget as well as the disbursement of the funds to a quarterly attainment of the provider specific milestones. How many providers have been signed? How many providers are live? And how many providers are at meaningful use?

So, a word on the preliminary. So we're having a two phase application process. This is partly to minimize the amount of work for if there's a great number - if there is, you know, if we have 1,000 people again or more on the call today.

We really don't want to have 1,000 people necessarily doing the full app - going through the full application process. And I think a lot - a lot of people put a work in to be - be disappointed if they don't have really the ability to meet the scope and the (position) alignment, the experience and so forth -- the multi-stakeholder commitment to be able to be effective in this.

So, we are asking for our preliminary application should be relatively simple to fill out. We're not expecting this to take, you know, hundreds and hundreds of hours of at least writing.

Although getting some of the multi-stakeholder commitments I think is going to consume - and should, really consume a lot of time and effort. There is going to be an Excel version of the preliminary application that's going to be posted.

And we really are encouraging folks to use this format to make sure that all the information that's requested is collected in a standardized way. It can be compared.

And again, applicants that don't receive funding or don't get their preliminary application approved in one cycle can certainly reapply in future cycles.

The overview, there's basically four sections to the preliminary application. The first section - and this has about 30 points in the evaluation of the preliminary application.

It pertains to geographic diversity. The number of primary care providers in the area. The potential for synergy with some of the other (ONC) federally funded activities. Next slide.

The second set of information deals with the scope of services that are going to be offered. The number of practices, the number of providers that are going to be served by the various functions that we're hoping are going to be part of the scope. That's worth 20 points.

The third section worth 30 points is the mission capability and experience based on their current - the organization's current service offerings and capabilities. How well is the mission aligned with the mission of the extension center program? What is the experience? How many practices and providers for example have been helped in HIE implementation or quality improvement, interfaces and information exchange and hardware and network infrastructure? The nuts and bolts of this and how many FTE staff as a proxy for the current capabilities and involved in each of those activities?

The fourth and final section is the multi-stakeholder commitments. That's actually not on the Power Point here. But it is in the Excel template. The ability of the - and the demonstrated - demonstration of multi-stakeholder commitments that are going to be really necessary to sustain and support these extension centers in the out years to the health plans, the hospital systems, medical professional societies and so forth.

Before I close, let me say a word about sustainability. This is going to be a big challenge. And we don't want to -- we make no bones about that. The construct here where we're hoping for is that the extension centers are going to prove their worth.

And that they're going to be a variety of options for providers to choose from. The HIE payments under meaningful use, the $44,000 under Medicare and $64,000 under Medicaid should create a market for exactly these types of services.

There should be a variety of options that providers can chose from in receiving these (climate) services to get them to meaningful use and get them to the point where they can receive the payment.

This is a subsidized option for the priority providers in the first two years. Mostly before the incentive payments actually kick in. The extension centers should therefore have a head start. And should therefore have an ability to have demonstrated, and we are really going to, you know, count on transparency here to be able to show that you have added value to the provider and provider community. And that the assistance that you're offering the practices is worth something to them.

So that is the expectation. That's the assumption. We could end up being wrong about that. And I'm sure we're going to be wrong about - about many things.

We can't see the future so well. But that is - that is the assumption that underlines this model here. Where we're going to have the support really front loaded in the first two years. And then in the out years, this really - support limited to the core learning community and grant project management transparency activities.

I'm sure we're going to get a lot of questions about that. But I just wanted you to know where we're coming from here. Matt?

Matt Kendall: Okay (Farzad). Well we've been getting a lot of questions from people online. We've got over 50 questions it looks like at the moment.

But why don't we start off by getting a couple of the questions from people on the phone - the verbal questions? W

While we pull together these things and try to harmonize them? (Elonne)? Is it possible to get three callers to answer - to ask questions please?

Coordinator: Certainly. At this time if you would like to ask a question, please press star 1 on your touch tone phone. You will be prompted to record your name. And to withdraw your request, star 2.

Once again, to ask a question please press star 1. Our first question today is from (Anthony Quoara).

(Anthony Quoara): Hello. Question of course for (Farzad). Actually I have two questions. But let's go with the first one first. You said you envision most of these regional extension centers being non-profit organizations that are currently in existence, that may have the capability or currently be doing this kind of work. Is that correct?

(Farzad Mustoshari): That's correct.

(Anthony Quoara): And can you give me an example of an org - of a non-profit that may be doing this type of work?

(Farzad Mustoshari): Well, we have a lot people who are on the call right now. Who I think imagine - hope that they are the - they are kind of organization that can do this.

There are a number of folks who have been doing this. There are quality improvement organizations obviously. There are groups that are - have been - started to do your quality improvement or HIE adoption.

There are -- in some cases information exchanges or e-health initiatives or state designated entities for e-health that would be appropriate candidate. There are grant-funded programs.

We have a question here about the (RWG) funded aligning forces for quality. Just to give one example that might be credible sources for this. I come from a program in New York. A primary care information project that was a municipally funded project that has a non-profit associated with it that would - that could apply for that.

There's a large number of examples here. I'm not mentioning any in particular. Just other than to be, you know, you asked for examples. I'm giving you some specific examples.

But to a large extent, we are very interested to see what comes out. We don't really know what's out there and who all - we hear and are sometimes pleasantly surprised. My goodness we didn't know this group was doing this great work here. And part of the call here is to get those people to step up.

(Anthony Quoara): Just as a follow up. A lot of those organizations you mentioned are probably receiving some sort of government grants and funding. Is there any conflict there? Or is it sort of the more the merrier? If they're on some - they've got some grants coming, they can get these grants? And is there any conflict there?

(Farzad Mustoshari): The one thing that I'll mention is the cost sharing requirement. There is a - there was in the legislation a 50% cost sharing requirement that could be waived upon determination by the Secretary. That it would be detrimental given current national conditions. Economically it would be detrimental to the program.

The Secretary did waive the 60% requirement for the first two years, but did ask there be at least a 10% cost share. That cost share can come from many sources. Including program income that is generated from the project, for example in the form of fees that are charged.

(Alignment) fees, participation fees charged to providers can also be fulfilled through other grants - not Federal grants, but state, local, foundation grants and the like. So, I think to that extent, that we can leverage other activities, that that is a great thing.

(Anthony Quoara): Thank you.

(Farzad Mustoshari): The other thing I want to mention. Example is the health center controlled networks. Our colleagues at (Hersa) have been supporting the health center controlled networks.

And if those health center controlled networks are able and willing to extend their activities to small practices in their area, or as part of a consortium that would do that, that would be entirely appropriate. Any other questions?

Matt Kendall: (Elonne) next question please?

Coordinator: Our next question is from (Pamela White). And please state your organization.

(Pamela White): Sunnybrook University Medical Center. Can you hear me okay?

(Farzad Mustoshari): Yes.

(Pamela White): Okay. First of all I wanted to know if there's going to be a medium for submitting questions that are not answered during today's call?

Matt Kendall: Absolutely. All questions that are submitted to our email will be responded to. The email address is on the first slide. But it is - and is also on the Web site. But for those on the call it is just (regional-center-applications@kersa.gov). And we will get that information on there.

(Pamela White): I'm sorry. (-applications@what)?

Matt Kendall: We're going to pull this up and leave it on the screen. So if you're logged into the Web screen you'll be able to see it.

(Pamela White): Okay. And then two questions. Can a single entity submit applications in different cycles covering different geographies? And would they be subject to a single award cap if they're applying for different geographies in each cycle?

(Farzad Mustoshari): I think that is something that we would like to discuss and get back to you on with guidance that'll be publicly available.

The concern there is that if one organization, you know, from first principles, you know, it seems like it should be okay. But there may be some problems if one organization lends its resources to multiple applications, and multiple applications are awarded, then they would not be able to provide the promise for resources to all the other successful applications. So we need to figure out a way of accounting for that and we'll get back to you.

(Pamela White): Okay. And then would money unspent from year one and two be allowed to roll over into the following years?

(Farzad Mustoshari): There will be a mandatory evaluation of the programs that will look at their extent to which they participate in the cooperative agreement and the learning collaborative. And importantly, the extent to which they are able to achieve meaningful use in the providers.

There is the possibility that those funds will be permitted to continue - to be kind of rolled over. Or some of them may be de-obligated and shifted to other extension centers.

(Pamela White): Okay. And what would be the milestones for providers who already have EHRs?

(Farzad Mustoshari): Meaningful use.

(Pamela White): Okay. Thank you.

Matt Kendall: (Elonne) one more question and then we're going to ask some questions that were taken from the online submissions.

Coordinator: Certainly. Our final question is from (Jenny Wilson). And please state your organization.

(Jenny Wilson): Hi. I'm with the University of Chapel Hill.

(Farzad Mustoshari): Hi.

(Jenny Wilson): Hi. My question is when you reference primary care providers, are emergency medical service providers included within that, and therefore qualify for a regional center?

Woman: Ambulance.

(Jenny Wilson): Meaning Ambulance personnel?

(Farzad Mustoshari): No. The primary care providers would be - would include family practice, geriatrics, pediatrics, internal medicine and the like. People who actually provide primary care outpatient services. Not emergency medical technicians.

(Jenny Wilson): Okay. Thank you.

Matt Kendall: Great. We're going to go back to the calls in a moment. But I just want - we've been getting a lot of similar questions, so I just want to start off with a question about eligibility first off.

We're getting a lot of questions about not for profit organizations, and what we mean by that. Can you please clarify?

(Farzad Mustoshari): Well we have the guidance on that we kind of flash up there, and these slides will be available later for people to go back to. But, it's, you know, either an IRS tax exempt certificate or a statement from a state taxing body, state Attorney General certifying the applicant organization has non-profit status.

A certified copy of the certificate of incorporation that clearly establishes non-profit status and so forth. (501C3) obviously, but obviously potentially other non-profits such as (501C6) would also be eligible.

Matt Kendall: Great. We also have a question about whether physician assistants are eligible for the grants.

(Farzad Mustoshari): They are. They are. Those that are providing primary care.

Matt Kendall: Exactly. We have a question about whether or not an EHR needs to be CCHIT certified in order to participate in the program?

(Farzad Mustoshari): Well, the - I think the question gets to meaningful use. Which is meaningful use of a certified EHR product. And yes, in order to be a meaningful user you have to use a certified EHR product.

We are in the process of drafting regulations around what will constitute a certified EHR product. And so we can't speak about the specific, you know, whether it's CCHIT or what the process will be for certification at this point.

There are recommendations from the FACA Committee that deal with this to the National Coordinator. But for the purposes of this program, I think if I could just say that it will be meaningful use of certified EHR products.

Matt Kendall: Great. We have one question that asks is the program only focused on primary care providers? What about specialists?

(Farzad Mustoshari): The program is focused on primary care providers.

Matt Kendall: Okay.

(Farzad Mustoshari): Let me add a little more detail on that. There is nothing to stop an retention center from providing services to specialists. They may actually generate program income from providing services to specialists.

There may be specialists who are part of a community health center that is assisted. And that's all great.

But in terms of the funding that is coming for the purpose of this program, our goal is to get 100,000 primary care providers to meaningful use through this program.

Matt Kendall: Great. We have another question about the support from Medicaid agencies. And the question is for organizations forming collaboratives within a state, is the Medicaid agent be expected to select one organization?

(Farzad Mustoshari): So I think the question can be interpreted multiple ways. Let me kind of try to answer it comprehensively.

There is a section in the High Tech Act scenario that permits for year one Medicaid payments, which are the only part of the HIE incentive payments that are not directly tied to demonstration and meaningful use - $21,250 for year one of the Medicaid incentive.

Those funds should be paid directly to the provider, or to the provider elect - to the practice that the provider's a part of, or to an adoption entity designated by the state.

So, that is up to the state to designate what we expect to be certainly some extension centers as the adoption entities who the provider chooses could be a recipient of the year one HIE incentive payments in return for providing produce services and so forth to the practices. And there's no prohibition on the number adoption entities that the state may thus designate.

There's another way in which the question could be asked which is if you are applying for an entire state, we are requiring that there be a letter from the state Medicaid Director - multiple states we're requiring that there be a letter from the state Medicaid Director.

We have not put any limitations again on whether the state Medicaid Director may want to provide that letter to one or two or more entities who apply and that is up to the state Medicaid Director.

Matt Kendall: Great. Let me ask two more questions and then we'll go back to the phone call. First of all we have a couple questions about how to define a service area. And whether it needs to be a specific (SMA)?

(Farzad Mustoshari): The service area can be defined as a sub-state region. Give us a list of zip three different zip codes. It can be, you know, counties within a state. It could also be a metropolitan service area that crosses even state boundaries. It could be an entire state as I said or multiple contiguous states. So no, it does not have to be in a state.

Matt Kendall: Great. And the last question before we go to line is the goal - its clarification. The goal to move at least 1,000 private providers to meaningful use in the next year - two years?

(Farzad Mustoshari): That's the goal for the extension centers to - in their area to take 1,000 providers to meaningful use by the end of the two year period.

And again, it can include providers who already have EHRs implemented today, as well as those who do not.

Matt Kendall: Great. (Elonne) can we get another couple phone calls please?

Coordinator: Certainly. Our next question is from (Lisa Wynn). And please state your organization.

(Lisa Wynn): Oklahoma Foundation for Medical Quality. Can you clarify critical access hospitals is the assistance for (EMR) adoption for the hospital system? Or only for any associated ambulatory clinics?

(Farzad Mustoshari): It - it's for the associated ambulatory clinics and primary care providers who practice in that critical access hospital.

Matt Kendall: Can we have the next call please?

Coordinator: Our next question is from (David Katz). And please state your organization.

(David Katz): I'm from El Camino Hospital in Mountain View, California. I've got a question about how the funding works. I've been trying to piece this together from the documentation. And so I'll tell you what I think and you can tell me if I've got it right.

As I understand it, there is a two year grant to each center that is core funding that is between 500 and $750,000 per year. And that's to cover the basic activities of the center.

And then beyond that there's variable funding that is based on the number of priority primary care providers who meet the three benchmarks.

(Farzad Mustoshari): Correct.

(David Katz): And as I piece that together, there's $500 million available for 100,000 physicians that are going to be connected. So that looks to me to be about $5,000 per targeted physician. Is that correct?

(Farzad Mustoshari): That is the average. In some areas it may - depending on their approach and their cost, we are asking people to propose what their costs would be to bring each provider to meaningful use in the different - and there may be differences in taking someone who already has an EHR to meaningful use, compared to someone who doesn't. But that is - you are accurately analyzed within the (FOA).

Matt Kendall: (Elonne) can we have the next question please.

Coordinator: Certainly. Our next question is from (Jim Clark). And please state your organization.

(Jim Clark): (Visionary Healthware). My question was addressed earlier somewhat. And it relates to the certification. I know there's a lot of anticipation of the certification process. And I just wondered if there was a timeline, when (hersa) and others will recognize meaning - a meaningful use certification? If there's a timeline on that? I know CCHIT has gone out and said they'll start in October. Any - any more detail on that?

(Farzad Mustoshari): I'm afraid that the - we're not in a - an extension center program is not in a position to offer further clarification on that for you.

(Jim Clark): Okay.

Matt Kendall: Thank you. Next question please.

Coordinator: Our next question is from (Mark Wine). And please state your organization.

(Mark Wine): Hi. This is (Mark Wine) (unintelligible). Thank you for taking my question. What performance criteria will be used to measure the success of the successors? And who will be conducting the tracking in their performance moving forward?

(Farzad Mustoshari): I think the question was how will we be - what metrics will be used to look at the performance of the extension centers? The - kind of the bottom line is really the portion of the providers with signed agreements who got to meaningful use. Or the number who got to meaningful use. That's really kind of the bottom line.

You said you were going to get 1,000 providers say to meaningful use at the end of two years, how many did you get there? That's the bottom line.

There are obviously other measures, including the collaboration activities, the participation in the national learning consortium, the integration with the workforce program and then some of the other processes in terms of how well they did in terms of recruiting practices.

There may be - and we have to define the - further there may be some provider information from the providers in terms of the services that they received and so forth. But the bottom line one is going to be achievement of meaningful use criteria.

Matt Kendall: Great. (Elonne) next question please.

Coordinator: Our next question is from (Nina Davis). And please state your organization.

(Nina Davis): (Nina Davis) (Alimante Health Services). My question has been answered already. Thank you very much.

(Farzad Mustoshari): Thank you.

Matt Kendall: Thank you. (Elonne) next question please.

Coordinator: And as a reminder, to withdraw your request star 2. Our next question is from (Charles Homer). And please state your organization.

(Charles Homer): Hi thanks. (Charlie Homer) from the National Initiative for Children's Healthcare Quality. Sort of a process question.

We like I suspect many others on the call are able to provide some of the services these centers should provide, but not all of them, and are interested in finding others that we could collaborate with.

Is there a mechanism in the submission process where we could - our service could be made available? Or we could find out who are other bidders that might be looking for components?

(Farzad Mustoshari): That is a great question. And I wish I could tell you that we were smart enough to figure out a mechanism to do that match making speed dating.

I wish I could tell you that we do. We don’t have a mechanism to do that right now. But if anyone wants to step forward and create the match making Web site and publicize it, we would be very happy if someone were to do that.

There may be regional meetings that are held by the first round folks who get awards in the first round. And those regional meetings might be a place we may open up those regional meetings to kind of a broader group of interested folks to come and attend. And those may be networking opportunities. But beyond that we really haven’t gotten too far. But great question. Thank you.

Matt Kendall: (Elonne) next question please.

Coordinator: Our next question is from (Mark Stevens). Please state your organization.

(Mark Stevens): Hi. (Mark Stevens) from the Pennsylvania E-Health Initiatives. Can you hear me okay?

(Farzad Mustoshari): Yes. Perfect.

(Mark Stevens): Great. My question was specifically about the matching funds requirement. And would sort of those funds are you including in kind?

In terms of the organizations that are applied, both for staff time, for overhead? That they'll use themselves as an organizations? And could that possibly also include cost incurred for applying for funds?

(Farzad Mustoshari): Can include in kind. It cannot include funds that were extended prior to the award.

(Mark Stevens): Great. Thank you.

Matt Kendall: (Elonne) I'm actually going to take a few questions from the computer first before we get back to the folks online. (Farzad) we have one question that comes up in a couple different ways.

But it is a question about the matching funds. And the question is how much will centers be able to charge providers in terms of fees? And can centers use stimulus funds to support those fees?

(Farzad Mustoshari): There - as I mentioned, there will be likely a market place out there for these services. And I think the market place will offer some guidance in terms of what providers are willing to pay for this.

And I think that answer will depend. It'll depend on the area. It'll depend on the type of provider. And most importantly, it'll depend on the services and the credibility of the organizations offering them.

We are not requiring a set formula in terms of what the provider fees are. Although I think for the sustainability of the project, it's a very good idea to

have in the formal agreements - contracts with the practices some commitment - some real commitment about the, you know, - often talked about skinning the game up front.

And potentially some funding that kicks in or, you know, payment that kicks in upon receipt of the meaningful use payments by the practice. That all seems to make sense to me.

What that, you know, what the market will bear for that I can't answer. Was there a second part to that question Matt?

Matt Kendall: It was - it was about the dollars that practices can get from stimulus, and whether those could be potential sources for the fund?

(Farzad Mustoshari): Well in a sense yes. That is what we're doing. Is that we are subsidizing the fees that a for-profit entity would charge for those services to get practices to meaningful use.

The government is providing an up-front subsidy to enable the priority primary care providers in particular to get off the ground quickly prior to 2011.

Matt Kendall: Great. Another question is can funds be used to pass directly to practices to support EHR or hardware acquisition?

(Farzad Mustoshari): That's a good question. We are conceiving of this direct technical assistance. This to be funding direct technical assistance to the practices. And the budget should reflect technical assistance services to the practices.

There are other - there's nothing to say that the extension centers cannot do group purchasing and bundling where they would - as kind of a separate line of business.

They would be providing the software and hardware to the practices and be receiving payment. Either direct payment or as I mentioned earlier the - turning over the year one Medicaid payment to the extension centers.

But these funds, the budget that we're expecting the allowable costs should pertain to the cost of providing the scope of services that was laid out in the (FOA). Which includes a variety of technical assistance, but not the hardware and software costs themselves. But good question.

Matt Kendall: Final question before we get back to the phone lines is about the timing of the application - September 8th. And what happens to a practice if they choose not to apply for preliminary application?

(Farzad Mustoshari): So it's very aggressive. We're sorry. We know it's very aggressive. And it's been very aggressive all along. And I think we really feel a sense of urgency at (ONC) to get these and other projects off the ground - started as soon as possible.

We - I will note a couple of things. One is that the full application isn't due until November 3rd. So, let's see. That's a little over two months from now - two months and a week.

So, for those who, you know, fill out the preliminary application and if you're feeling good, I wouldn't wait to hear back from us to start thinking about what you're going to say on the full application.

The second is that the preliminary application we really tried to make it as you'll see as streamlined, as quantitative, you know, give us your mission statement, tell us how many providers and practices you've helped. And how many FTE staff you have and so forth.

So, again, we recognize. We acknowledge the very short timeframe. But the preliminary application should be relatively straight forward.

There is a first mover advantage here. In that if you, you know, if you're not selected in the first round and someone else in your area is, you will not be able to apply for that area in the following cycle.

But if there is nobody in the first cycle who is funded in your area, there will be other chances.

Matt Kendall: Great. So (Elonne) can we take another question from the call please?

Coordinator: Certainly. Our next question is from (Greg Smith). And please state your organization.

(Greg Smith): Hi this is (Greg Smith) from (PHSE) in the city of (Industry), California. And I was call - I was asking how tightly can states control who should and should not be participating in the reg process?

By that I mean, can the state say only this entity is authorized? And that's how you will view it? Or is there a disconnect there?

(Farzad Mustoshari): The (FOA) says if you want to apply for a whole state or for multiple states, then yeah, the state Medicaid Director has to endorse your application. If you're not, then there is no requirement.

There's no, you know, veto power. Although we would hope that the extension centers do have the support of the state. That they do fit into the state plan for HIE. That they do have the support of the state officials, the HIE Program etc.

So, it's not a - it is only a requirement where you have a - the entire state or multiple states. But, you know, I think - we certainly hope that most of the extension programs do have support of the state officials.

Matt Kendall: Great. (Elonne) next question please.

Coordinator: Our next question is from (Amanda Parsons). And please state your organization.

(Amanda Parsons): Good afternoon. (Amanda Parsons) from the Primary Care Information Project. We had a question about the sustainability model for the extension centers.

Thinking through the meaningful use dollars and calculating the fact that for that physician would have to purchase their own hardware, their software, IT support.

And there's a burden of other logistical cost related to (EMR) adoption. And also weighing the fact that less than 10% of the value of an (EMR) adopted by a primary care practice wraps back to the physician him or herself.

We were wondering if we could think more broadly about other funding mechanisms? Including thinking through payers and their potential contributions to things like quality reporting.

And de-emphasize the sustainability model visa vie the payments from the providers, because we're having a - quite a difficult time meeting the sustainability metrics from our calculations there.

(Farzad Mustoshari): So very very good point there. And there's a couple of things in there. One is the up-front funding needed to get providers live on an EHR system. Those who are not already live on an EHR system live.

The market place I think is already showing that it will rapidly adapt to the new landscape with meaningful use. There are as you know vendors who are offering leasing options. There are loans. You know, subscription models - (ASP) and so forth that will reduce the cost - up-front cost to the practices.

There are also commercial loans and others that are beginning to come out to target the - anticipation of the meaningful use payments coming in. Which should meet the overall - should cover the cost, but just the financial cost on the systems purchase.

You do raise a good point that the providers, in particular the providers you're dealing with (Amanda), may not initially have the willingness to pay the extension centers or commit to pay the extension centers kind of full fare for the services that they are - they're receiving.

But I think the situation we hope will be different in two years, where a couple of things have happened. One of them being the meaningful use payments are actually starting to hit the street. And the second being the extension centers have had two years to show their ability to get practices to meaningful use.

And some transparency in the market around people maybe without - similar people without extension center support, how they have fared in achieving meaningful use.

So, all that is not to say that we do not encourage strong multi-payer support for the extension centers. And if you can find, you know, I don't think grants are going to really be a sustainability model for anybody.

But if they're - if you or others can (trail blaze) agreements with payers and bring them to the table with the - with this proposal as an opportunity to bring them in and say we will commit to help create a sustainable community infrastructure for quality improvement. You know, that's great.

Matt Kendall: Great. (Elonne) next question please.

Coordinator: Our next question is from (Kimberly Love). And please say your organization.

(Kimberly Love): University of Pittsburgh Medical Center.

(Farzad Mustoshari): Hi.

(Kimberly Love): Hello. Our question is regarding - obviously there's about 40 or so vendors in the market. And some of them will reach certification for meaningful use. And obviously some might not.

We're concerned about how can the regional extension centers deliver a cost effective and quality set of solutions to the provider community, and do that to maintain as many options to that provider community?

Is it possible that the regional extension centers can actually go through a selection process that's - involves the participating members, to get down to one or two preferred options?

(Farzad Mustoshari): Yes. We think that extension centers should do group purchasing for the providers. We think that there should be a - probably a smaller range of options for the extension center to really get familiar with offering support to them and to really have some leverage over the vendors.

There has to be more than one. That's in the (FOA). And the - (know), it's really up to the extension centers to - and I'm sure we're going to see lots of different models. And we will have an opportunity to evaluate the different models, and to share other learnings.

There will be different models where some extension centers will support every EHR product out there, and offer kind of generic support to the extent that's possible.

Others will have, you know, two or three preferred options and they'll work very tightly with those vendors. There is as I said a requirement that there be no business arrangements that have the appearance of conflict of interest.

That there be an open and transparent selection process and it would include members of the target community in that selection. But - but that having been said, I think that many extension centers will go that route.

Matt Kendall: Great. We're going to take some questions from the board real quick. First of all as general - we're getting a lot of questions about what do you mean specifically by primary care provider? What do you mean by meaningful use?

I'd like to alert everyone that we have a glossary of the terms in Appendix E. If you go to that section it actually spells out a lot of these questions. And I think that will answer a lot of the questions that we are getting.

We are also asking for clarification about the Excel formatted version of the preliminary application and what the status. We will be re-posting shortly an updated version that looks like - and this attachment, and that people will be able to use going forward.

So, other questions that we are getting are how can regions ensure that their area gets an extension center?

(Farzad Mustoshari): Put in a great application. Okay?

Matt Kendall: Other questions that we're getting are how can - are regional health information organizations eligible to apply to be extension centers?

(Farzad Mustoshari): They are. If they're a non-profit, they're eligible to apply. The question that they will have to answer just like anybody else is whether they have the mission statement that aligns with the mission of getting providers to meaningful use.

Whether they have the (booth) on the ground and the prior experience and competency in outreach, HIE implementation, quality improvement. Interface and information exchange I would imagine they have covered. But hardware and network infrastructure and so forth.

So, you know, do they have the - do the touch the practices of that - in that deep way already? And some of them do and would be great folks that we want to have in the program.

Matt Kendall: Fabulous. And another question we've gotten a couple different ways was whether a for-profit organization can sub-contract to a not for profit organization that is applying for extension center funding?

(Farzad Mustoshari): I think I did that already right? A non-profit can contract with a for-profit to do some or all - some part not all obviously, some part of the services that they provide.

Again though is, you know, hardware, IT services, software and so forth. There has to be a - an open and transparent procurement (property).

Matt Kendall: Great. (Elonne) we'd like to take another call from the - another call please.

Coordinator: Certainly. Our next question is from (Mark Casey). And please state your organization.

(Mark Casey): Yes hi. I'm from (Neon.com) in Colorado, formerly associated with (PSO) in Denver. How do we look at grants and other things from foundations to assist in this process? Do you have any thoughts on how you can see larger foundations in these states helping out?

(Farzad Mustoshari): You know, I think it's a great idea. I, you know, is that someone said how can we be sure that someone - that an extension center comes to our area? You know, that would be a great thing for - I think would be a marvelous thing for a foundation to do. And if folks on the line know foundations...

(Mark Casey): What role can they play?

(Farzad Mustoshari): Well I think they can sponsor and support an extension center. They can help provide whether it's the planning grants, but the in kind - the matching funds, provide some of the other funding that's needed aside from the technical assistance.

Whether it's some - a rotating loan fund for example for the hardware and software. Whether it's incentive dollars for achieving performance measures as Dr. (Parson's) had alluded to. Whether it's sponsoring some of the other quality improvement activities.

But I think it's - it's a great idea to have the area foundations orient some of their - their programming around getting an extension center in their area.

(Mark Casey): Will HITRIC have a function within itself to help this occur? Someone pointing towards foundations within HITRIC?

(Farzad Mustoshari): That's an interesting idea. We'll think about that.

Matt Kendall: Great. (Elonne) the next question please.

Coordinator: Our next question is from (Jane McGraff). And please state your organization.

(Jane McGraff): (Stratus Health). The question that I had was - again, it's probably a little bit more detail, and with regard to the provider definition. As we're looking at Attachment 1, you've spelled out - at least in the initial one that we were looking at the other day.

For hospitals, the number of hospitals (and sites), and the number of providers per hospital. And could you clarify a little bit more how you are defining the number of providers per hospital?

Because we're wondering about in particular smaller communities where the provider works in a clinic but they work at the hospital. How are you wanting us to count that so we aren't double counting?

(Farzad Mustoshari): We'll - we'll give you - we'll have more details. I don't want to be imprecise. And this is obviously something that requires precision. So we'll - we'll put that out as part of the FAQs.

(Jane McGraff): Okay. Thank you.

Matt Kendall: Great. (Elonne) can we get the next question please?

Coordinator: Our next question is from (Cathy Whitmire). Please state your organization.

(Cathy Whitmire): Yes. (Hometown Health). Just needed a quick clarification on the funding. Someone asked a question earlier - $500,000 to $750,000 per center, and then earlier in the presentation you said $1 million, the core to $30 million, averaging 8.5 to $9 million.

And so I was just trying to clarify per - what is the range of the average grant per extension center?

(Farzad Mustoshari): The range is between 1 and $30 million.

(Cathy Whitmire): Okay.

(Farzad Mustoshari): The average awarded amount is going to be 8.5. Of the $8.5 million, we're anticipating that around 500 to $750,000 a year, you know, the $1 million

over two years will be for the core support. And the rest will be tied to the milestone accomplishment on the direct.

(Cathy Whitmire): Oh I see. I understand. And I just wanted to make a recommendation. Our organization is 56 rural hospitals and more than 500 primary care docs in Georgia. And we have found very successful Wiki pages.

And it's a free very easy to set up for the collaboration and the networking partners and discussion. It's very simple. And you just might want to take a look at that. It's (wickiepages.com).

(Farzad Mustoshari): Well and I think that's a - it's great. And we hope to have the sharing between the extension centers and others around those kinds of tools to help the practices create support for each other. And maybe even extension centers could use them to share knowledge.

(Cathy Whitmire): We live in such a big country. And there are so many we don't want to re-create the wheel. So I just think it would be excellent to know what other people are doing all over the country.

(Farzad Mustoshari): Yep. And that's...

(Cathy Whitmire): And have a good open format. I'd love to...

(Farzad Mustoshari): Yeah.

(Cathy Whitmire): ...be able to help with that in any way possible. And I submitted that on the questions just as a suggestion. And with my contact information.

(Farzad Mustoshari): Thank you. I will just, you know, maybe not in direct reference to your - to your helpful point. But I will say though that I think there is a limit to what we can expect, particularly the providers in small practices.

How much we can expect them to engage with Web only tools. And there is - we expect there to be a need for kind of a personal touch including on-site interactions with the practices. I want to be clear about that.

(Kathy Whitmire): Oh I was talking about the organizations that are applying. I wasn't talking about the way to contact and communicate with the physicians, but, just for the people that are online today.

(Farzad Mustoshari): Thank you.

(Kathy Whitmire): Thank you.

Matt Kendall: (Elonne) can we get another question please?

Coordinator: Our next question is from (John Lynch). And please state your organization.

(John Lynch): The Connecticut Center for Primary Care.

(Farzad Mustoshari): Hi (John).

(John Lynch): Question is about the application process. The grants.gov site that you list when you go to it and pull down the application seems to be the full application. And it talks mandatory documents that appear to be the final app with budgets etc.

You're actual Page 17 for preliminary application content seems to have a very different level of content than is there in grants.gov. Are you going to clarify that?

(Farzad Mustoshari): Absolutely. On the - there is guidance on the (FOA) itself, that lays out the application process for the two different parts of the application - the preliminary application and the full application.

The preliminary application is going to be submitted by email. And the full application is submitted through grants.gov.

(John Lynch): And the Appendix Z certification of conflict, it looks like you're supposed to list a particular HIE vendor as part of the preliminary application. What if you don't know what the 10 vendors are? Are you supposed to list 10 of these as 10 separate pages?

(Farzad Mustoshari): In - if you do not know who the vendor is, you can simply say to be determined. And as you identify those vendors, you will submit updated forms.

(John Lynch): Thank you.

Matt Kendall: Okay (Elonne) one more question please.

Coordinator: And our next question is from (Paul Raymond). And please state your organization.

(Paul Raymond): (Lyman Group). Thank you. So a follow on to the question just a moment ago. It's - it looks like there's an estimated $5,000 that could go to the primary care providers out of the $598 million average.

Can that 5 - it's a two part question though. Can that $5,000 - or whatever the actual amount ends up to be per provider be used for acquisition of technologies that will be needed for meaningful use EHR? And if not, what would be some anticipated examples of how those funds would be used?

And the second part is how do the providers apply to the centers for those funds? Is that future guidance that's coming? Or is that already defined somewhere?

(Farzad Mustoshari): The - if you look at the scope that we're expecting the regional centers to provide - education, outreach, participation in the national learning consortium, group purchasing, implementation, project management, practice and workflow re-design, functional inter-operability assistance and health information exchange, privacy and security best practices in progress towards meaningful use in integration of local workforce support. That's what the money should go towards.

(Paul Raymond): So that's - okay. So I guess that's - as I read that is others have that I've discussed this with. They anticipated - that was money that the center was using to deliver those services. But what I just - I believe what I just heard you say is in fact, that's what the provider will be paying for those types of services.

(Farzad Mustoshari): The program is subsidizing the cost of the extension centers to be delivering these services to the providers. So the budget that you draw up that says it's going to cost me X amount to deliver these services, and I'm going to get, you know, $1,000 of it from the provider in the form of a signing - just as an example right?

You might say if it's going to cost me $6,000 a provider to deliver this range of services, I'm going to charge the provider $1,000 for participation signing agreement and I'm going to ask you the Federal Government for $5,000 to deliver the services. Does that make sense?

(Paul Raymond): Yes. I think what I just heard was there's actually - there's zero amount of these dollars are going to end up in the providers hands. That's going to come through the Medicare Medicaid incentive reimbursements.

(Farzad Mustoshari): Yes. Yes. Absolutely. Right.

(Paul Raymond): Okay.

(Farzad Mustoshari): These monies do not flow into, you know, no checks will be written to providers from these funds.

(Paul Raymond): That's great. That's what I was trying to clarify.

(Farzad Mustoshari): I understand.

(Paul Raymond): Very good. Thank you.

Matt Kendall: All right. I think we want to ask - answer a couple questions that we've gotten from online. One is can you please describe the role of the health information technology research center? What will it do?

(Farzad Mustoshari): The research center is, you know, as I said, this is a cooperative agreement. And it's going to be a collaboration between the Office of the National Coordinator and the HITRIC which will be through contract with the - with the (ONC) and the applicant.

So, it's a collaboration. And the HITRIC will provide the extension centers with a variety of forms of support that includes knowledge support, materials that will be nicely produced and available. That'll be, you know, a collection of best practices from the literature, from surveys, as well as from the extension centers themselves.

There will be networking support, where there will be meetings, there will be tool - Web tools such as what was mentioned and other networking opportunities to help the collaboration process.

The HITRIC may also provide support for some IT services, evaluations, some of the software, client management tracking software that the extension centers are expected to use and so forth. Does that help?

Matt Kendall: Great. Another question is what if a regional center fails to deliver services? Will the funds be rescinded?

(Farzad Mustoshari): Well, the - kind of the design of this is that if you don't deliver the services, you don't invoice for them because they're - you don't get paid, because it's on a - most of it is based on the milestones.

So, if you can't get providers to sign commitments - contracts with the extension center, then you don't get that (traunch) of the money that's triggered by that.

If you don't get to go live status with e-prescribing and quality reporting you don't get that (traunch). If they don't get to meaningful use you don't get the third (traunch).

So, I think we worked hard to try to make sure that everyone's interests are aligned in the same direction. The practice has an interest in getting to meaningful use as the extension center.

Maybe one day, hopefully vendors will have incentive if they're aligned to get practices to meaningful use as well.

Matt Kendall: Great. We're wrapping up. I mean we're running out of time here. However, (Elonne) we want to take two more questions please from the calls.

Coordinator: Our next question is from (Bridgette McKeig). And please state your organization.

(Bridgette McKeig): Hi. I'm with (Primaris). My question is about the letter from the state Medicaid Director. If we are applying for a statewide application, and we're unable to secure the letter by the September deadline for the first round, do we go ahead and submit if we can get the letter by the time the full application is due? Or will the proposal be thrown out?

(Farzad Mustoshari): The proposal will have been deemed not to meet the preliminary application screening criteria. And it will not be reviewed.

(Bridgette McKeig): But then we would just want to wait for the next round?

(Farzad Mustoshari): Correct. Unless, you know, and, you know, if somebody else wins the, you know, the - is awarded that in that and that - then you may not have the opportunity to.

(Bridgette McKeig): Right. Understood. Thank you.

Matt Kendall: Great. One more question please.

Coordinator: And our final question is from (Lawrence Romuno). And please state your organization.

(Lawrence Romuno): (NACQF) - the Medicare (QA) from New Hampshire, Vermont. It's about the Medicaid question Director letter again. We heard you loud and clear that (ONC) believes that state or regional applications will have a high bar to meet.

And one of them I think you can probably surmise from the questions is the Medicaid Director. That is, would the Medicaid Director provide more than one letter? Can they? The way the format is proposed, they may not want to.

Another obvious question, at least to people in the field are, that many (HIEs) have Medicaid Directors on their Boards. How has (ONC) deemed the conflict of interest problem of someone writing a letter of support for an organization they're a member of? Even part of the governance of?

And there - by extension, may not write a letter for a potentially competing organization, even though they may be more qualified. There doesn't seem - this does not seem to be addressed in the (FOA) at all. And it's a concern.

(Farzad Mustoshari): I hear your concern. And, you know, this is the - this is a very important relationship between the extension centers and Medicaid providers are obviously key constituents that we hope the extension centers to serve.

And that was the reasoning behind if there's going to be a statewide proposal, that there should be support from the state Medicaid Director.

I think, you know, you identified a potential conflict. And, you know, we hope that the state Medicaid Directors will be acting in the best interest of the Medicaid providers.

And, you know, (HIEs) will also have a high bar to meet in terms of having the (booth) on the ground and the experience with quality improvement. And in an ideal world, there would be a consortium that brings together all the skills needed and the support together.

But this is something that was also brought up on the state HIE grant call. The state grants do identify state HIE coordinators as being a requirement for their grants process.

And depending on how this process goes in the first round, and the deliberations within (HHS) including (CMS), once every state has a state HIE coordinator, in future rounds we may be able to broaden the possibility of having it be the state Medicaid Director and or the HIE coordinator. But for the first round, I think that this is what we're dealing with.

(Lawrence Romuno): So - so there's no provision to deal with a conflict of interest of a member of an organization providing a support letter? Since by any reasonable legal tenant, this is including (HHS), this is a conflict of interest. That's a problem I would say.

But, the other sort of follow up to that is I think we're failing to see what is the critical role that Medicaid is playing in this program as opposed to any other - in clear preference as a stakeholder, as opposed to any other potential stakeholders.

Such as the Primary Care Association, such as other very relevant stakeholders that have - may be bringing more patients to bear, more under-served to bear than even Medicaid? Can you explain that - the answer to the first conflict issue, and answer the role of the Medicaid Director?

Because we're failing to see the connection here. Maybe there's been some information we don't have.

(Farzad Mustoshari): So we will run this by General Council. And see what they say in terms of the issue you raised.

In terms of Medicaid, obviously, when we're talking about public and critical access hospitals, uninsured, under insured, (unintelligible) population, community health centers, rural health clinics, state Medicaid has a critical role in assuring services for those populations. And they do have funds that are being - the Medicaid HIE payments are being administered through the state Medicaid program.

That is a very important connection to the extension centers. The state Medicaid Directors will - hopefully designate extension centers as adoption agencies, able to receive year one payments. That's a very important connection.

So I think that we, you know, while I hear what you're saying, we also have to acknowledge that there is a role for Medicaid in the extension center program.

We are over time. How many total participants did we have? 1,250 participants on the call. Wow! Or by another measure, 1,450.

So this is a - this has been extraordinary. I really - I'm really excited about the range of voices we heard from on the phone. The keenness of the questions, the obvious passion here.

And I want to tell you, we really want to go on this march into this with you. And we want to be there with you side by side. We want to support you. And we hope that you will be the standard (bearers) for this transformation of the healthcare delivery system.

It's a very exciting time for us here at (OMC). And I hope you'll put in your preliminary applications. You'll deal with - whatever you have to do to get - to get the programs off the ground locally and get the support locally that you need to make the program a success.

And I will commit to you that we will do whatever we can to help you. Thank you so much. Matt?

Matt Kendall: Just in closing, I want to let everybody know that we will be posting the audio portion of this conference call on our Web site. And we will also be posting the slides and frequently asked questions - updated, taking from all the questions that we couldn't get to today online. Summarizing them and providing them.

So those will be available on our Web site. Check in periodically to get the latest update. And thank you all very much. That ends the call.

Coordinator: And this concludes today's conference. You may disconnect at this time.

END