MINUTES

Massachusetts Health Information Technology Council Meeting
October 14, 2009
3:00 – 5:00 pm

Matta Conference Room
One Ashburton Place
Boston, Massachusetts

MINUTES
MASSACHUSETTS HEALTH INFORMATION TECHNOLOGY COUNCIL

October 14, 2009

Attendees:

Council Members

JudyAnn Bigby, MD - *(Chair) Secretary of Health and Human Services*
(Jay Gonzalez - *Secretary of Administration and Finance)***
Represented by: Marcie Desmond
(Terry Dougherty – *Acting Director of Medicaid)***
Represented by: Philip Poley
Deborah Adair - *Director of Health Information Services / Privacy Officer at Massachusetts General Hospital*
Karen Bell, MD - *Senior Vice President of HIT Service at Masspro*
Lisa Fenichel, M.P.H. - *E-Health Consumer Advocate*

Other

David Martin (EOHHS)
James Daniel (MDPH)
Kimberly Haddad (Committee on Health Care Financing - Senate)
Bert Ng (Committee on Health Care Financing - House)
James Fuccione (Home Care Alliance)
Jessica Long (Conference of Boston Teaching Hospitals)
Karen Welsh (Student)
Kevin Schwartz (Concordant)
Bob Strong (Pro Caseo, Inc)
Edward Gott (Dextrys)
Natasha Greco (NaviNet)
Foster Kerrison
Moira Meehan (Consultant)
Monica Cunningham (Individual Certified Health IT Professional)

MTC Staff

Mitchell Adams
Dr. Richard Shoup
Glen Comiso
Bethany Gilboard
Judy Silvia
Barbara-Jo Thompson

Deloitte Staff

Michael Marino
Kevin Carr, MD
John Skowron
Alex Contreras
Jyotin Gambhir
Hussein Jaffer
Esther Ndungu
Giao Le

The Sixteenth meeting of the Massachusetts Health Information Technology Council was held on October 14th, 2009, in the Matta Conference Room at One Ashburton Place in Boston, Massachusetts.

Secretary Bigby called the Meeting to order at 3:08 p.m.

AGENDA ITEMS

I. Approval of September 30th Minutes

After a brief conversation regarding the minutes of the last Council meeting, motions made and seconded, it was unanimously agreed to accept the draft minutes as the official minutes of the September 30th meeting (with two minor edits).

II. HIT Council Membership – Dave Szabo's departure

Secretary Bigby explained to the Council members that Dave Szabo approached her after the last meeting. He stated that it is with great regret that he must resign. His world is overlapping with the work here. He is very saddened with this decision, as he has immensely enjoyed the work with the Council. We are in the process of finding a replacement in the role of Privacy issues.

Lisa asked, if an individual resigns in this manner, are they eligible for participation in ad hoc groups. Secretary Bigby explained that due to the ethics reasons discussed, they would not be.

Secretary Bigby then asked Dr. Richard Shoup to give an update on the application process.

III. Update on the Grant Application Process:

- REC
- Workforce Development
- HIE

Dr. Shoup started with a brief walk through of the day's agenda. He then gave a high-level overview of the process to date.

Our preliminary application for the Regional Extension Center was approved and we have been asked to submit a full application for the next round. Sixty applications of the 100 that were submitted to ONC were asked to submit full applications. The Federal Funding for the REC will be used for:

<u>Core Funds Support</u>

Outreach and educational activities, grants and program management, local workforce support, and participation peer-learning and knowledge-transfer activities facilitated by

the Health Information Technology Research Center (HITRC). ($500,000 to $750,000 per Regional Center per year for the first two years)

Direct Assistance Support

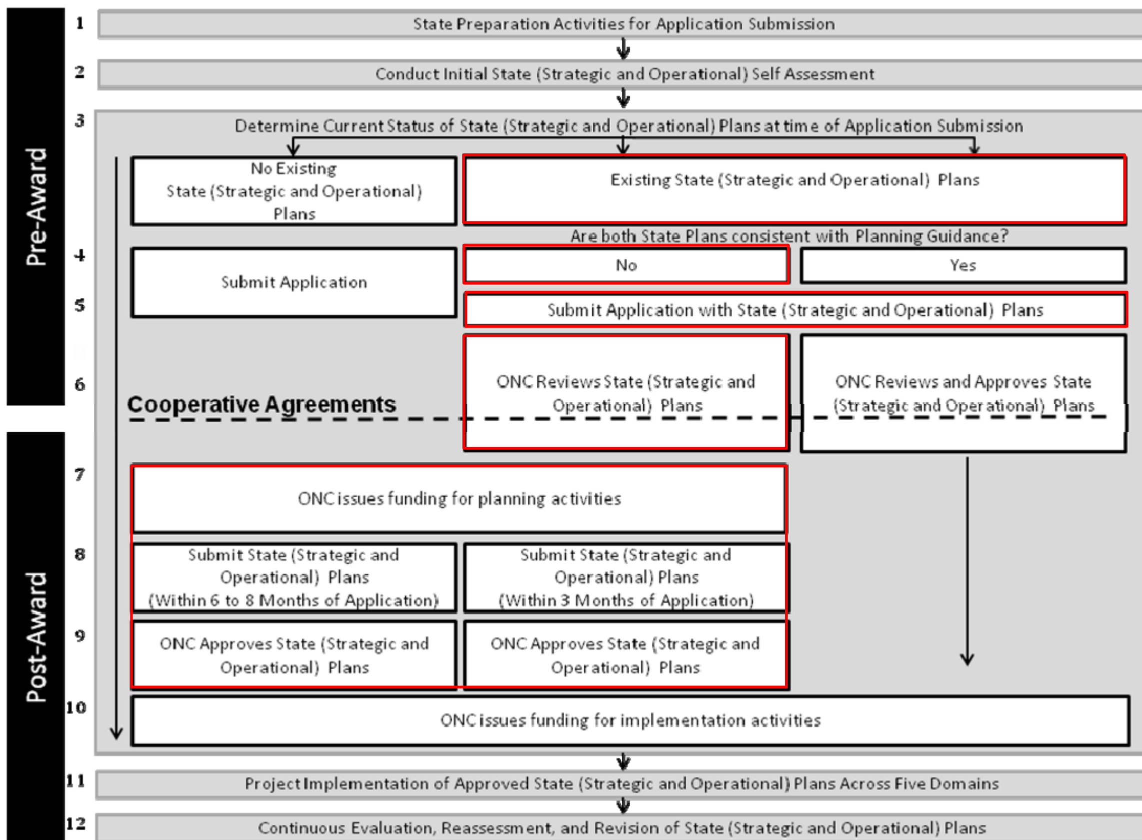
Funds direct onsite technical assistance to providers. This will be tied to the number of providers supported through the Regional Center. Approximately $500 million will be allocated among the successful applicants in proportion to the numbers of priority primary-care providers to receive direct technical assistance.

To illustrate the process Dr. Shoup referred to the table pasted below, that explains the 3 levels of funding offered by the ONC

Initial Cycle	Approx Funding	Preliminary Application	Preliminary Approval	Full Applications	Negotiations Begin	Decisions to Award
1	$189,000,000	8-Sep-09	29-Sep-09	3-Nov-09	19-Nov-09	11-Dec-09
2	$225,000,000	22-Dec-09	19-Jan-10	2-Mar-10	16-Mar-10	27-Apr-10
3	$184,000,000	1-Jun-10	22-Jun-10	3-Aug-10	17-Aug-10	28-Sep-10
Total Amount of Funding Available:				$598,000,000		
Award Floor/Ceiling:				$1,000,000 to $30,000,000		
Approximate Number of Awards:				70		
Program Period Length:				Four-year project period with two budget periods		

Secretary Bigby asked Dr. Shoup to also give an update on the Workforce Development Grant. Dr. Shoup explained that October 5th the Executive office of Health and Human Services applied for a Workforce Development Grant for $ 4.9 million. This was in concert with the Department and Labor and the Department of Education. The three offices are working together to create new training programs in order to have HITECH workers on the ground. Others that provided support included: EHR vendors, hospitals, and any organization that will need technology support to achieve “meaningful use”. For planning purposes this grant included an eLearning environment, with video conferencing capabilities and also would include internships.

Next Dr. Shoup explained that the third Federal Grant that MeHI is applying for is for the Healthcare Information Exchange. MeHI Will Submit the HIE Application on October 16th. That process is illustrated as follows:



* Path for MeHI Highlighted in Red. Will submit Strategic Plan on October 16th, and will need to create Operational Plan over a 4-6 month period.

Next Dr. Shoup gave an update on the Strategic Planning.

IV. Update on Strategic Planning

- High level overview of comments received

Dr. Shoup explained that when MeHI and the Council contracted with Deloitte it was agreed there would be two major deliverables: 1) a deck of slides (300 pages) to use as we need; and 2) the HIT plan and summary document. We are very close to a completion of both. We cannot give out copies until all edits have been received internally. Included in the summary is a consumer component, Medicaid, and summary of next steps. There is a lot of rich content in both the summary and in Power Point slides.

The thought is that we would circulate to the Council. Once they have had a chance to review and comment, it would then be posted for public comment

Ms. Adair asked how people would be notified about the posting. Dr. Shoup responded that we would use a few methods including an email blast with email addresses obtained from those that were involved in stakeholder meetings and it would also be posted on the

MeHI website www.maehi.org. Mr. Adams added that the list MeHI currently has is about 500 people and growing.

Ms. Fenichel suggested letting *The Boston Globe* know about this work so that the public at large would be apprised of the document's existence and location and broad public input be attempted.

One portion of the statewide plan is to collaborate with Medicaid, so Dr. Shoup then asked Philip Poley of the office of Medicaid to speak on the next few slides.

V. Medicaid Collaboration

Mr. Poley began by explaining to the Council that Medicaid began its discussions with Rick and MeHI. This was to see how Medicaid could work with the summary document that he just spoke about. They also discussed more work that needs to be done on the ultimate plan. That goal includes a virtual medical home. Whether we are talking about a medical home or not, we need to know that care is available, to use technology to enhance quality and efficiency of care; this was the organizing principle when working on the plan.

How they touch in many settings, what is available what is not? Another part would involve quality reporting and analysis. We have a lot of data but we don't know what to do with this data. How do we find out who are our diabetics who we know are paying for insulin.

Four components of State Medicaid HIT Plan

Administrative simplification is important to Medicaid. There may also be an opportunity for Medicaid to receive 90/10 in Federal funds to help support the development of the HIE for Medicaid transactions.

What do you have today, what do you want tomorrow, how are you going to get there?

With payments from MeHI, how many Medicaid providers are we covering? These providers must get to meaningful use.

Our commitment and our working plan is that we create a statewide plan that is as integrated as possible. Ultimately to include long term care facilities and pediatricians who must have 20 % Medicaid enrollees to receive federal incentives.

Mr. Poley also mentioned the great meeting that took place last week. It didn't just include Medicaid but also the State's Chief Information Office and the CIO from EOHHS. The meeting touched upon the following areas:

As-Is Environment – current HIT landscape assessment

CMS Guidance

- Current range of HIT activities occurring within the state today
- Detail current HIT activities and their impact on Medicaid beneficiaries
- Extent of HIT and HIE activities currently underway within the Medicaid enterprise, including EHR technology adoption and relationships with other entities in the state
    - MMIS capabilities or functionalities
    - Summary of MITA State Self-Assessment
    - Environmental scan of existing and/or duplicative health related legacy systems that need updating or replacing
    - Leveraging other existing opportunities such as Medicaid Transformation Grantees and lessons learned
- Examine data to assess current rates of EHR adoption

To-Be Environment – vision of the HIT future

CMS Guidance

- What does the state's to-be HIT landscape look like in 2014
    - Public & behavioral health, child welfare, education, long term care, vocational rehabilitation, etc.
    - Outside government including health care/safety net providers, associations, universities, foundations, other Medicaid stakeholders
    - Develop a common vision of how Medicaid's provider incentive program will operate in concert with the larger health system and statewide efforts
- Include a description of this vision in the SMHP

Actions Necessary to Implement the EHR Incentives Program

CMS Guidance

- Provide preliminary details regarding the actions the state believes will be necessary
- Explain preliminary views regarding specific actions for defining and verifying eligibility for incentive payments, processing payments, and preventing duplicate incentive payments for Medicare and Medicaid

HIT Road Map

CMS Guidance

- To move from the current "as-is" to the desired "to-be" HIT vision
- Focus on the Medicaid agency role, describe how the state plans to oversee the 100% provider incentive payments, and identify clear, quantifiable benchmarks – minimally on an annual basis – that will allow the state and CMS to gauge progress towards the "to-be" vision
- Include the state's vision for Medicaid to become part of the existing or planned Federal, regional, statewide, and/or local health information exchanges (HIE) with projected dates for achieving objectives of the vision where appropriate
- Plans should build off of existing efforts to advance regional and state level HIE, facilitate and expand the secure, electronic movement and use of health information according to nationally recognized standards, and move towards nationwide interoperability
- Regarding MMIS, the state should consider the types of changes that may be needed to transform its current MMIS into one capable of accommodating this future vision in a manner consistent with the MITA Framework 2.0

Planning Activities Potentially Eligible for 90% Administrative FFP

According to CMS, the planning activities listed below are potentially eligible for 90% administrative FFP.

However, States are expected to receive prior approval from CMS for claiming the higher match rate for initial HIT planning, through submission and approval of a Recovery Act HIT Planning-Advance Planning Document (HIT P-APD).

VI. Operational Planning/ Next Steps

Dr. Shoup then went on to discuss immediate next steps.

Immediate Next Steps – HIE Operational Planning

Activity	Completion Date
Begin process of hiring HIE Program Manager	11/4/09
Complete draft RFI for existing HIEs in Commonwealth and offer public comment on content and approach	11/13/09
Council to appoint Ad Hoc Workgroup members (see below) per recommendations of the Strategic Plan, and create committee charters	11/23/09
Conduct kickoff meetings for Ad Hoc Workgroup members	11/30/09
Engage legal counsel and consulting firm to assist MeHI, Council and Ad Hoc Workgroups in governance, legal/policy and operational framework review	12/21/09
Establish workgroups for each of five HIE domains supported by MeHI staff	1/4/10
Schedule workgroup meetings	1/11/10
Formal kickoff of Operational Plan planning process at Council meeting	1/18/10
Hire HIE Project Manager	3/1/09
Compile recommendations and begin drafting Operational Plan	5/28/10

Review recommendations and draft Operational Plan with stakeholders and consulting organization	6/3010
Incorporate input from stakeholders, consulting organization and workgroups	7/2/10
Complete Operational Plan	7/30/10

We are calling these ad hoc work groups, and not advisory committees, because we do not want to preclude people from bidding on work.

Our expectation and hope is to leverage the Council's expertise to bring in the right people for the work groups.

Ms. Adair asked for clarity of IOOs and existing HIEs. Rick apologized for the slide as it has been updated since the Council Meeting documents were printed.

A Program Manager is a higher level as we are creating a Program Management office. It is good business sense that we are managing the IOO processes.

Program manager oversees project managers.

Primarily the work is to be done internally and MeHI is going to own this process. However, we may need outside consultants to fill in gaps.

Funding from the Federal Government will begin in January. The goal will be to complete the HIE operational plan by the end of July.

Coordination with ARRA Programs

Coordination and Interdependencies

- Develop a plan that describe specific points of coordination and interdependencies with relevant ARRA programs including:
    - Regional Center
    - Workforce development initiatives
    - Broadband mapping and access

HIE and REC Recipients

- Must specify how technical assistance will be provided to health care providers within the state
- Will provide estimates of geographic and provider coverage

Project Resource Planning

- Develop a resource plan that includes:
- How and when trained professionals from workforce development programs will be used to support statewide HIE.
- How and when broadband will be available to providers across the state according to current broadband maps and funded access efforts.

Dr. Shoup explained that in the recent application, MeHI mentioned their alignment with MTC which includes MBI and their mission to bring broadband to the underserved areas in the commonwealth.

Another area of planning that he mentioned includes coordination with the other New England states establishing areas to work collaboratively. This includes an Information exchange, consent management, monthly calls with the other six New England states.

Governance and Policy Structure:

Ongoing Development

- Create reports describing the ongoing development of the governance and policy structures
- Reports will be created on a x basis (weekly, monthly, etc): TBD

We have a requirement to annually update our plan. There will be many stakeholders at the table. This will need to evolve over time.

VII. Other

Dr. Carr gave an update on the working document, "MeHI Health Information Technology Plan: Final Recommendations Summary"

These are the same slides that have been used through out the planning process, and they are near completion. Dr. Carr began by thanking the Council members that gave updates on all the slides from the last meeting.

Rather than going through the whole deck, Dr. Carr just highlighted the slides that have changed. He started with the Stakeholder Engagement slide and explained that the main change was there is no longer a body that oversees the work groups.

Ms. Fenichel questioned whether Privacy & Security were now separate or together. The response was that they may be together or separate as the need warrants. MeHI will work with the Council to determine.

The next change was in regards to a Customer Relationship manager. What is the relationship; and how much time to develop a relationship vs. the IOO developing the relationship. They updated the title and phrasing that MeHI would support the Customer Relationship Managers.

Dr. Carr spent some time explaining how it can go up or down based on budget implications and whether it was staffed by MeHI or supported by MeHI.

This update gives MeHI more flexibility in the planning process.

Detailed Description:
- MeHI will staff and operate Regional Extension Center Program Management Office (2-5 FTEs).
- MeHI will identify eligible providers, link them to certified IOOs, and track provider progress towards Meaningful Use.
- MeHI will provide CRM services on each certified IOO implementation. CRMs are key client-facing individuals handling responsibilities at implementation sites, including facilitating collaboration between IOOs and the provider clients, ensuring compliance with state and MeHI policies and effective use of MeHI-appropriated funds.

Implications:
- Allow provider engagement with MeHI.
- MeHI is the accountable organization across implementation efforts.
- CRMs ensure fluid communication between IOOs and providers to allow for optimal outcomes

There is not a significant change in concept but it grants flexibility.

The Council had a discussion about the CRM roles. CRM does NOT entail being intrusively onsite in Physician's offices to track what is going on. It's a virtual process, not intrusive on staff time that allows you to track what is happening in multiple offices efficiently and effectively. Dr. Bell made reference to the NYC Medicaid program that used this approach to track progress among the Physician offices that implemented then effectively used their EHRs.

Ms Fenichel commented that the CRM with the IOO should be multi directional – the text explains but the graph doesn't reflect that.

Proposed MA HIE Interoperability Guiding Principles

<u>Patient Centric</u>
Synthesize patient data from multiple sources in order to provide a unified, consolidated view of data to providers and patients.

<u>Usability</u>
Ensures data is easy to access and use by multiple stakeholders

<u>Adaptability</u>
MA HIE can be modified and expanded to integrate with newly introduced architectural components, additional services, interfaces and functionalities

<u>Sustainability</u>
MA HIE standards and requirements for participation are not onerous or overly complex, allowing for greater participation; secure storage and updates to information

Scalability
Enables addition of new participants and functionalities (expansion of the HIE) with no impact to existing functions.

Portability
Attributes of software that bear on the opportunity for its adaptation to different environments, ease of installation, and interaction with other software

Patient Controlled
Patient will be able to control who can access their data and under what circumstance

Reliability
Ensures that patient data is authentic and is the same at point of origin as point of exit

Extensibility
Incorporates federal standards for interoperability so information can be shared beyond a given state

Nationwide Privacy & Security Framework for Electronic Exchange of Individually Identifiable Health Information - Principles

MeHI will leverage the existing Nationwide Privacy & Security Framework, including the following principles:

INDIVIDUAL ACCESS
Individuals should be provided with a simple and timely means to access and obtain their individually identifiable health information in a readable form and format

CORRECTION
Individuals should be provided with a timely means to dispute the accuracy or integrity of their individually identifiable health information, and to have erroneous information corrected or to have a dispute documented if their requests are denied

OPENNESS AND TRANSPARENCY
There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their individually identifiable health information

INDIVIDUAL CHOICE
Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their individually identifiable health information

COLLECTION, USE, AND DISCLOSURE LIMITATION
Individually identifiable health information should be collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately

DATA QUALITY AND INTEGRITY
Persons and entities should take reasonable steps to ensure that individually identifiable health information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner.

ACCOUNTABILITY
These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches

Source: *Nationwide Privacy and Security Framework For Electronic Exchange of Individually Identifiable Health Information*, December 15, 2008, Office of the National Coordinator for Health Information Technology

Lastly, Dr. Carr thanked the HIT Council for their help in fleshing out these principles.

Privacy is about Policy; Security is about Technology

"A key factor to achieving a high-level of trust among individuals, health care providers, and other health care organizations participating in electronic health information exchange is the development of, and adherence to, a consistent and coordinated approach to privacy and security." - *Nationwide Privacy and Security Framework For Electronic Exchange of Individually Identifiable Health Information, ONC, Dec 15 2008*

Privacy is about Policy
Privacy of individually identifiable health information centers on policies that assure patients have the ability to protect their data from being used or shared inappropriately or against their wishes. The privacy framework of the HIT Plan should include regulations, principles and protections that will guide the development of policy in this regard.

Security is about Technology
The security framework of the HIT Plan should focus on technical requirements that support privacy policies and allow for secure yet effective exchange of individually identifiable health information.

Dr. Carr mentioned that there needs to be more clarity how this aligns with federal standards.

In order to meet federal and state requirements (including Chapter 305) AND support health care reform initiatives, the HIE technical architecture must support:

Principles of the Federal Privacy Framework
The degree of anticipated patient control must be consistent with state and federal policy and will be key in selecting technical approaches for HIE (e.g. patient consent applied universally vs. patient control by provider/ geography/ provider group/ other)

Public Health Reporting
Current ESP pilots have successfully transmitted data to an HL-7 gateway, but additional investment is required to scale the solution to small office providers

Reporting for Quality and other Initiatives
The HIE must facilitate routing of appropriate data to appropriate reporting tools and support the possible linkage to registries in the future

Bi-Directional Data Exchange
Ultimately, HIE participants (including patients) must be able to contribute data, allowing others to retrieve data from the HIE (with consent applied). Potentially create a portal capability for those who are close to retirement, etc. and choose not to invest in full fledged EHR functionality before 2015

Exchange of standardized Clinical Data Summaries
In order to provide clinicians with actionable data at the point of care (integrated with provider EHRs) the HIE must adopt and use, and support the standards needed to exchange of summary data, including the CCD, among various clinical settings

Financial Sustainability
Given federal funds will not support the entire HIE infrastructure, the HIE must provide value to stakeholders willing to support it financially

Dr. Carr stated that at the last meeting there was a discussion on the federated vs. centralized vs. hybrid model. It has now been updated to reflect that the structure may be federated but portions would be centralized as required, therefore making it a hybrid.

Ms. Fenichel made a comment on the cons of the federated model; the Enterprise Master Patient Index (EMPI) and the RLS both contain identifying information that might make patients vulnerable so the use of these indices must be public and clearly explained Centralization or distribution is dependent on the specific requirements. For example, the HIE may facilitate pharmacy transactions within a distributed model while lab data is shared through a centralized database. Providers in hybrid architecture may decide to share patient data through a centralized data repository or through peer-to-peer means. Depending on the specific configuration, MPI is used to link patient records across the participant databases. Data from various sources can be displayed to users in a common user interface showing the patient record information.

Dr. Carr mentioned that in the Straw model for Statewide HIE, there is a lot of explanation.

Proposed MA HIE Services (based on feedback from stakeholders), this should be an exhaustive list as it stands today.

Activity	Description
Connection to a Nationwide Health Information Network (NHIN)	A set of services that allows stakeholders to connect to data seekers and data providers by connecting to a national "network of networks," thereby enabling health information exchange to occur at a national level
Patient Identifier Services	A methodology and related services used to uniquely identify an individual person as distinct from other individuals and connect his or her clinical information across multiple providers
Record Locator Services	A mechanism for identifying and matching multiple patient records together from different data sources
Audit Trail Services	A mechanism for tracking when, where and what data was accessed and who accessed the data through an HIE entity
Cross-Enterprise User Authentication Services	A mechanism for identifying and authenticating clinical system users to validate their right to access clinical information based upon privacy rules, patient consent and individual user and organizational roles
Portal	A web-based service offered to participants for accessing, viewing and downloading data available from sources connected to an HIE
Terminology Services	A service that ties together technology, nomenclature, data-element or coding-transactions standards across disparate systems, normalizing (among others) HIPAA-standard transaction sets including HL7 and ANSI, LOINC, SNOMED CT, RxNorm, ICD, NCPDP, HCPCS, CPT, and document terminology
Patient Consent Management Services	A process for defining levels of patient consent and for tracking those consents and authorizations to share personal health information through an HIE entity
De-identification Services	A mechanism for removing demographic and other person-identifying data from personal health information and other health care data so that they can be used for public health reporting, quality improvement, research, benchmarking and other secondary uses
Data Transformation Services	A mechanism for facilitating the intake of data in multiple formats in real time through the use of an integration engine, which transforms the data into a useable format
Population Health Services	A set of services that fulfill various state and federal public health and chronic disease management practice requirements – such as biosurveillance, predictive modeling and health risk assessment – by leveraging and aggregating data available through an HIE entity
Benchmarking and Quality Reporting	A set of services that define and deliver a set of reports that leverage data available through an HIE entity and provide the

Activity	Description
Service	public and provider organizations with information that can be used to fulfill pay-for-performance or Medicare and Medicaid incentive requirements, facilitate process improvement, etc.
Advance Directives Management Services	A set of services that maintain and exchange a patient's legal documentation such as a living will, durable power of attorney for health care, etc.
Patient Registry Connectivity Services	A set of services that establish group purchasing or licensing agreements for, and assist with implementation of electronic health record applications for interested providers
Clinical Decision Support Services	A mechanism for distributing standardized clinical rules that can be incorporated into electronic health record systems or e-Prescribing systems in support of clinical decision making at the point of care
Medication History Exchange	Delivery of CCD documents to providers and other stakeholders participating in the HIE
Lab Results Exchange	A mechanism for facilitating the delivery of patient lab results for use in clinical care
Personal Health Record Exchange Services	A mechanism for facilitating the electronic delivery of personal health information to individual patients' personal health records

The Council then had a Certification discussion including Self Attestation. It was noted that further discussions would be had regarding how it could be set up and that the slides, as presented, were only the starting point for those discussions.

Dr. Carr explained the costs involved and when it is better to self attest vs. MeHI providing a certification.

Public Health and Quality Reporting

The deck has been updated to remove any reference to ESP, but an ESP-type. If ESP moves quickly it may be this, but it may not.

Workforce Development, there was a slight update to the key skills required for the Prioritized Healthcare IT Roles

Funding and Loan Process

Based on Council feedback, some of the amounts were changed to TBD as they are still in discussion and unknown.

Proposed Source	Proposed
Chapter 305 Funding	$15 M
Federal Government Funding	$25 M
State Bonds	$50 M
Payers/Employers	TBD
Medicaid	TBD
REC Income - Projected	Linked to Additional Services Provided by MeHI
Total	TBD

Dr. Carr mentioned that there were also a few minor changes to the amounts for Summary of MeHI Programs to be supported.

Program	Target	Estimated Costs - 4 Years (Millions)
MeHI Loan Program	Primary Care Physicians (Medicare Incentive Eligible)	$10M
MeHI Loan Program	Select Hospitals	$22.5M
HIE Implementation/Operations	All Providers	$45M
Regional Extension Center (Year 1 and 2 only)	Primary Care Physicians, Health Care Centers	$15.5M
Regional Extension Center (Year 3 and 4 only)	Primary Care Physicians, Health Care Centers	TBD
Meaningful Use Center of Excellence	Select Hospitals	$5M
Medicaid Funding	Medicaid	TBD
Other (including consumer outreach and education)		$5 M
TOTAL		**TBD**

Since there were no more questions or comments, the meeting adjourned at 4:22 p.m.