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American Recovery and Reinvestment Act (ARRA) of 2009

An In-Depth Look into the Revolution of Health IT

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July 27, 2009 revised
March 11, 2010

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I. INTRODUCTION TO ARRA

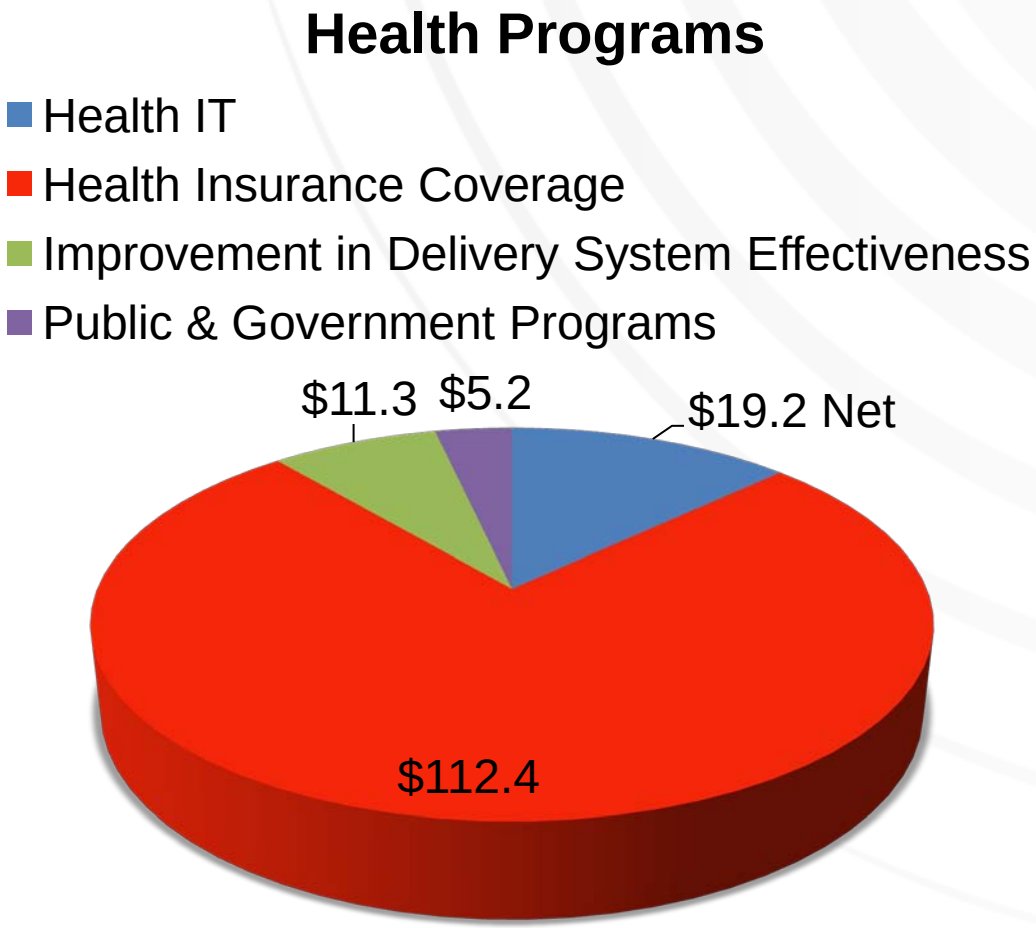
What is the Objective of ARRA?

The objective of the American Recovery and Reinvestment Act (ARRA) is to stimulate the economy through the investment of $787 billion between 2009 and 2019 in five key areas:

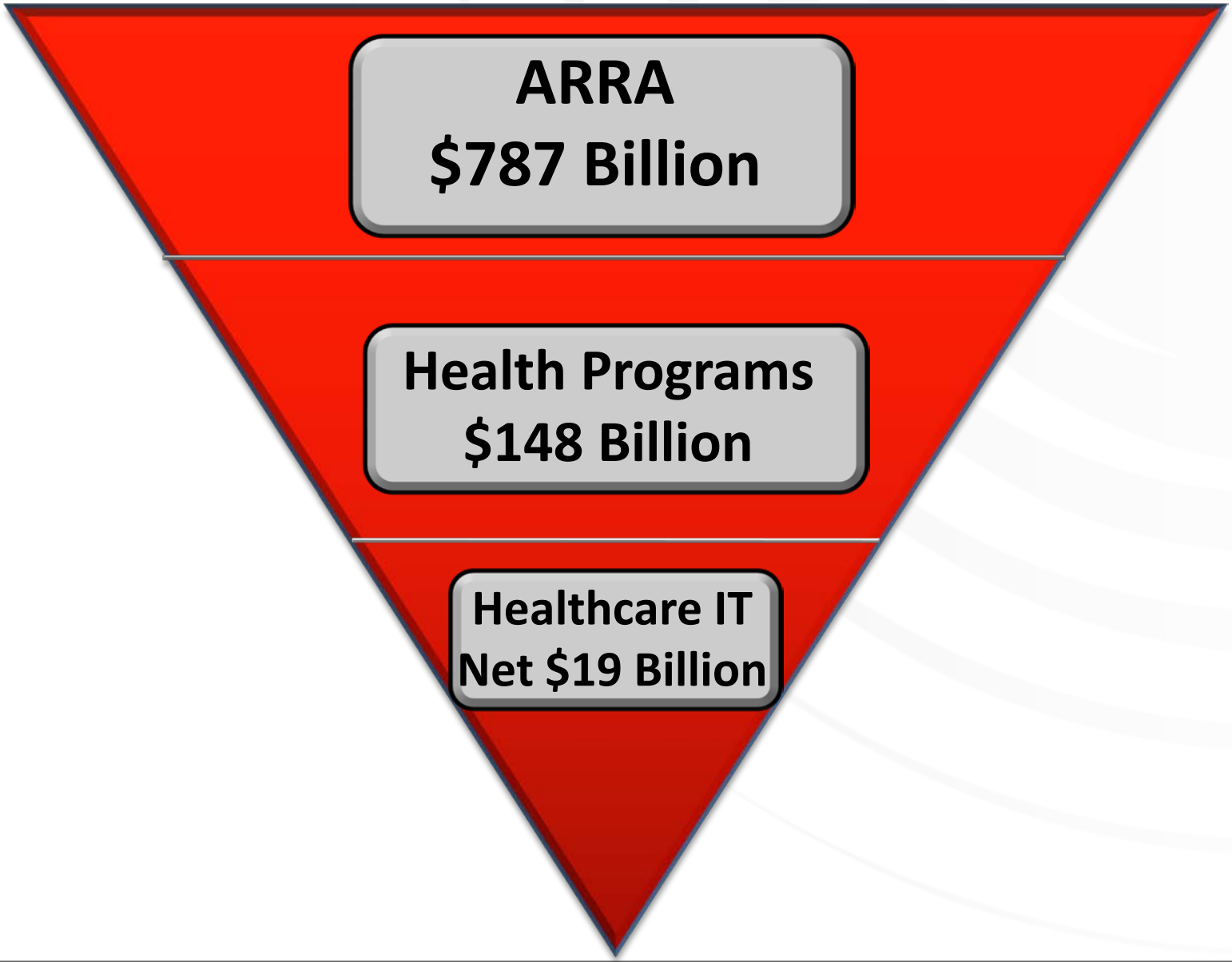
1. Healthcare
2. Education
3. Infrastructure
4. Unemployment Benefits
5. Transportation

ARRA and the Healthcare Industry

Approximately $148 billion is dedicated to the healthcare industry



How the Money is Allocated



Health Information Technology (HIT)

- **$2 billion** to the Office of the National Coordinator for Health Information Technology (ONC) to develop, plan, and promote HIT adoption

- **$17.2 billion** in incentives through the Medicare and Medicaid reimbursement systems to health care providers to assist in adopting Electronic Health Records (EHRs)

- **$19.2 billion** in net total HIT spending

HITECH Act

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

- A separate act within ARRA which provides over $36 billion of the $787 billion ARRA stimulus towards health information technology, health information exchange, privacy, and security
- Builds on existing federal efforts to encourage HIT adoption and use
- Provides financial incentives for HIT use among health care providers
- Strengthens enforcement of the HIPAA privacy rule and creates a right to be notified in the event of a breach of identifiable health information

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II. Hospital Incentives

Hospital Incentives - Requirements

What must hospitals do to receive incentive payments?

- Demonstrate "meaningful use" of certified EHR technology[1] to the Secretary of the Department of Health and Human Services (Secretary)
- Connect EHR technology in a manner that provides for the electronic exchange of health information and care coordination
- Submit information on clinical quality measures and other measures as selected by the Secretary

[1]**Certified EHR technology** meets standards put forth by the HIT Standards Committee and includes: Patient demographic, Clinical health information, Clinical decision support, Information Storage on healthcare quality, Ability to exchange and integrate electronic health info with other sources

Hospital Incentives - Requirements

- Eligible hospitals must convert their record management systems to an Electronic Health Record (EHR) system to achieve “meaningful use”

- If eligible hospitals demonstrate “meaningful use” of certified EHR technology, the hospitals can receive:
  - Financial incentives
  - Loans/grants to help offset any costs associated with HIT

- Up to 4 years of incentive payments – starting fiscal year 2011 through 2015 – can be paid out to eligible hospitals demonstrating meaningful use of a certified EHR system

Hospital Incentives - Penalties

- Eligible hospitals which are not demonstrating meaningful use, by FY 2015 will face financial penalties under Medicare

- Penalty
  - Reduction in the Medicare Inflation Adjustment in FY 2015 and 2016, with elimination in each subsequent FY until compliance
    - Fiscal year 2015 – 33.33%
    - Fiscal year 2016 – 66.66%
    - Fiscal year 2017 and each subsequent fiscal year – 100%
    - For example, please refer to appendix

Hospital Incentives - Calculation

- Maximum incentive payments for a hospital:
  - $6.37 million in the first year
  - $15.9 million over four years
- Must become certified EHR technology users before FY2012 to achieve the full incentive amount
- Incentive amount is calculated using three factors

Hospital Incentives - Calculation

- **Initial Amount**: Base + Discharge Related
  - $(\$2\ mil) + \{200 \times (D)\}$
  - D = every discharge above 1,150, but not exceeding 23,000; Maximum D = 21,850

- **Medicare Share**:

$$MS = \frac{\mathrm{I_{MA}} + \mathrm{I_{MC}}}{\mathrm{I_T} + \frac{(C - X)}{T}}$$

- **Transition Factor:**
  - Payments will be reduced by 25% each year after the first payment year
  - Example - 1st year = 1; 2nd year = ¾; 3rd year = ½; 4th year = ¼; 5th and succeeding years = 0

Transition Factor Schedule

Transition Factor Schedule					
Fiscal Year	Fiscal Year That Eligible Hospital First Receives the Incentive Payment				
	2011	2012	2013	2014	2015
2011	1.0	-	-	-	-
2012	0.75	1.0	-	-	-
2013	0.50	0.75	1.0	-	-
2014	0.25	0.50	0.75	0.75	-
2015	-	0.25	0.50	0.50	0.5
2016	-	-	0.25	0.25	0.25

Stage 1	Stage 2	Stage 3

Hospital Incentives - Calculation

- The incentive payment structure for hospitals has been proposed in the notice of proposed rule making
- The payment may be in the form of a single consolidated payment or periodic installments as determined by the Secretary
- The first-year incentive payment will be assessed using the “2011 Measures” for all first payment years before 2015

Hospital Incentives - State Loans

- Grants may be awarded to a state, by the Secretary, ***if*** the state agrees to make funds available toward the cost of the grant
- Grant money will be used to conduct activities to facilitate and expand the electronic movement and use of HIT among organizations

Fiscal Year	States' Contribution	Federal Funds Awarded
2010	$1	Secretary's Discretion
2011	$1	$10
2012	$1	$7
2013	$1	$3
2014	$1	$0

Hospital Incentives - State Loans

- Competitive grants may be awarded to a state
- Grants will be used to establish programs to distribute loans to hospitals
- Grants will be deposited in the states' Certified EHR Technology Loan Fund
- Hospitals must provide a strategic plan that identifies the intended uses of the loan money

Hospital Incentives - State Loans

- Hospitals can obtain loans from their State's Certified EHR technology Loan Fund to carry out such activities as:
  - Facilitate the purchase of certified EHR technology
  - Enhance the utilization of certified EHR technology
  - Train personnel in the use of certified EHR technology
  - Improve the secure electronic exchange of health information

Meaningful Use Timeline for Hospitals

First Payment Year	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015 and later**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015 and later*					Stage 3

*Avoids payment adjustments only for EPs in Medicare EHR Incentive Program

**Stage 3 criteria of meaningful use or a subsequent update to criteria if one is established

Clinical Quality Measures for Eligible Hospitals

- Hospitals are required to report summary data on 43 clinical quality measures to CMS
- Hospitals only eligible for Medicaid will report directly to the States
- For hospitals in which the measures don't apply, they will have the option of selecting an alternative set of Medicaid clinical quality measures

III. CRITICAL ACCESS HOSPITALS (CAHs)

CAH Differences

Payment Formula for Hospitals

- Initial Amount
- Medicare Share
- Transition Factor

Payment Formula for Critical Access Hospitals

- Initial Amount
- Medicare Share - add 20 percentage points to final sum; cannot be larger than 100%
- Transition Factor

*See slides 13 &14 for more details

CAH Differences

- Eligible CAHs which are not demonstrating meaningful use, by FY 2015 will face financial penalties under Medicare
- Penalty
  - Elimination and fine in the Medicare Inflation Adjustment in FY 2015 and 2016, with an elimination in subsequent FYs until compliance
    - Fiscal year 2015 – 100.66%
    - Fiscal year 2016 – 100.33%
    - Fiscal year 2017 and each subsequent year – 100%
    - For example please refer to appendix

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IV. PHYSICIAN INCENTIVES

Physician Incentives - Requirements

- What must physicians do to receive incentive payments?
  - Demonstrate "meaningful use" of certified EHR technology[1] to the Secretary of the Department of the Health and Human Services (Secretary); including e-prescribing
  - Connect EHR technology in a manner that provides for the electronic exchange of health information and care coordination
  - Submit information on clinical quality measures and other measures as selected by the Secretary

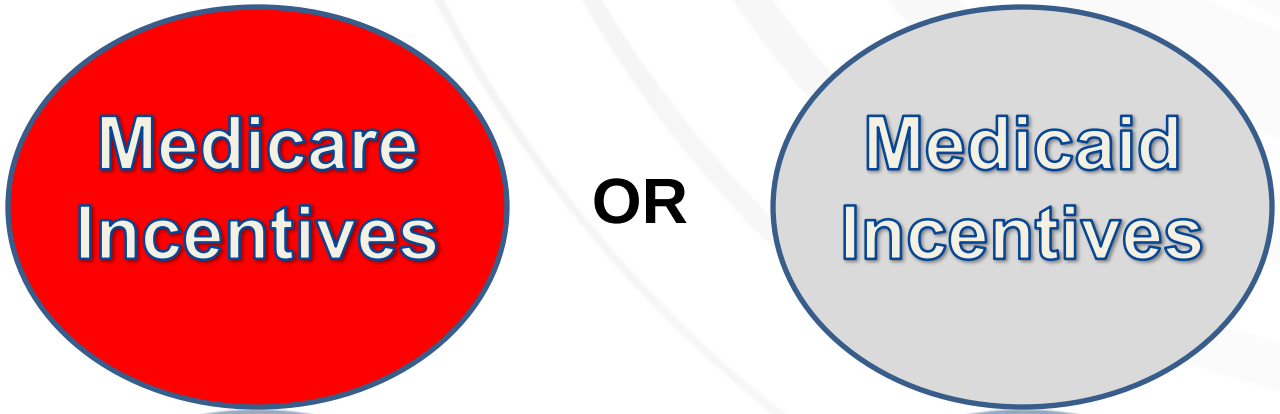
[1]**Certified EHR technology** meets standards put forth by the HIT Standards Committee and includes: Patient demographic, Clinical health information, Clinical decision support, Information Storage on healthcare quality, Ability to exchange and integrate electronic health info with other sources

Achieving Meaningful Use

- Utilize “certified EHR technology”
- Demonstrate MU for 90 consecutive days in the first payment year
- Can start as early as **1/1/11**
- Would have to start demonstrating MU by **10/1/11** to be eligible for **2011** payment
- 11/1/11 to 1/31/12 is not an acceptable reporting period
- In order to maximize incentives, MU must be demonstrated by 10/1/12

Physician Incentives - Payouts

- Eligible physicians can begin to receive incentive payouts for either Medicare or Medicaid beginning FY 2011 – 2015



- Up to $44,000 over 5 years

- Up to $63,750 over 6 years
- Payments of up to 85% of EHR technology costs

Meaningful Use Timeline for Physicians

First Payment Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015 and later*					Stage 3

*Avoids payment adjustments only for EPs in Medicare EHR Incentive Program

**Stage 3 criteria of meaningful use or a subsequent update to criteria if one is established

Physician Incentives - Medicare

- Eligible physicians can earn up to $44,000 through Medicare incentives

  - To achieve the full Medicare incentive, physicians must begin demonstrating meaningful use of EHR technology prior to FY 2012

Physician Medicare Incentive Schedule						
	CY 2011	**CY 2012**	**CY 2013**	**CY 2014**	**CY 2015**	**Penalty***
2011	$18,000					None
2012	$12,000	$18,000				None
2013	$8,000	$12,000	$15,000			None
2014	$4,000	$8,000	$12,000	$12,000		None
2015	$2,000	$4,000	$8,000	$8,000	$0	99%
2016	$0	$2,000	$4,000	$4,000	$0	98%
2017	$0	$0	$0	$0	$0	97%
TOTAL	**$44,000**	**$44,000**	**$39,000**	**$24,000**	**$0**	

  - A 10% increase in payout will be awarded to eligible physicians in a health professional shortage area (HPSA)
  - Hospital based professionals cannot receive Medicare payments

*Penalty – reduction in potential Medicare reimbursements; If 75% of all physicians are not using EHR by FY 2018, the Medicare penalty reductions can continue to decrease by 1% and may go as low as 95%

Physician Incentives - Medicaid

Medicaid payments

- Providers can obtain funds in advance of purchasing EHR technology or demonstrating meaningful use
- States will make payments ≤ 85% of costs for certified EHR technology for no more than a 6-year period
  - First year costs of up to $25,000 include:
    - Purchase
    - Initial implementation
    - Upgrade
  - Second year and beyond costs of up to $10,000 include:
    - Operation
    - Maintenance
    - Usage

Physician Incentives - Medicaid

Eligible Provider	% of patients receiving Medicaid	Max Medicaid Payment for 1st Year	Max Medicaid Payment for Years 2-6	Maximum Incentive Payments
Non-Hospital-Based Physician (non-pediatricians)	≥ 30%	$21,250	$8,500	$63,750
Non-Hospital-Based Pediatricians	≥ 20%	$14,025	$5,610	$42,500

Eligible Provider	% of Needy Individual Patients	Max Medicaid Payment for 1st Year	Max Medicaid Payment for Years 2-6	Maximum Incentive Payments
Physician Practicing in a Federally-Qualified Health Center or Rural Health Clinic	≥ 30%	$21,250	$8,500	$63,750

Eligible Providers includes:

- Physicians
- Dentists
- Certified nurse midwives
- Physician assistants in rural health clinics or Federally-qualified health center

Physician Incentives – State Loans

- Eligible physicians can obtain loans from their State's Certified EHR Technology Loan Fund to carry out such activities as:
  - Facilitate the purchase of certified EHR technology
  - Enhance the utilization of certified EHR technology
  - Train personnel in the use of certified EHR technology
  - Improve the secure electronic exchange of health information

Physician Incentives - E-Prescribing/PQRI

E-Prescribing (e-RX)

- Incentive payment of 2% of all of their Medicare Part B (Fee-for-Service, or FFS) allowed charges for services furnished during the reporting period.

Physician Quality Reporting Initiative (PQRI)

- Incentive payment of 2% of all of their Medicare Part B (Fee-for-Service, or FFS) allowed charges for services furnished during the reporting period.

2% Incentives Ends Dec. 31, 2009

EHR Medicare or Medicaid Incentives

- Up to $44,000 and $64,000 respectively
- Providing quality data and e-RX required

Incentives Begins FY 2011 – 2015

Specialty Quality Measures for EP's

- EP's will need to select one of the following specialties:

Cardiology
Pulmonology
Endocrinology
Oncology
Proceduralist/Surgery
Primary Care
Pediatrics
Nephrology
Obstetrics and Gynecology
Neurology
Psychiatry
Ophthalmology
Podiatry
Radiology
Gastroenterology

Notable Differences Between the Medicare & Medicaid EHR Programs

Medicare

- Feds will implement (will be an option nationally)
- Fee schedule reductions begin in 2015 for providers that are not Meaningful Users
- Must be a meaningful user in Year 1
- Maximum incentive is $44,000 for EPs
- MU definition will be common for Medicare
- Medicare Advantage EPs have special eligibility accommodations
- Last year an EP may initiate program is 2014; Last payment in program is 2016. Payment adjustments begin in 2015
- Only physicians, subsection (d) hospitals and CAHs

Medicaid

- Voluntary for States to implement (may not be an option in every State)
- No Medicaid fee schedule reductions
- Adopt/Implement/Upgrade option for 1st participation year
- Maximum incentive is $63,750 for EPs
- States can adopt a more rigorous definition (based on common definition)
- Medicaid managed care providers must meet regular eligibility requirements
- Last year an EP may initiate program is 2016; Last payment in program is 2021
- 5 types of EPs, 3 types of hospitals

The Mechanics of Payment

- Payment is to the individual physician
- Physician can assign payment to group if there is a contractual relationship
- Associated with unique national provider identifier (NPI)
- Must choose either Medicare or Medicaid
- May switch once, but there is a cap
- Expected to be a lump sum per year
- Payable on a rolling basis once MU is established
- Cannot be split between practices / TIN's
- Payment year is calendar year (CY)

Maximum Incentive Payments for Medicaid EPs Who Are Meaningful Users in the First Payment Year

Calendar Year	Medicaid EPs who begin meaningful use of certified EHR technology in— 2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

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V. REGIONAL EXTENSION CENTERS (REC)

RECs – Purpose

- As part of the Health Information Technology Extension Program, Regional Extension Centers (RECs) are designed to provide assistance to all providers, but with priority given to the following specific types of providers:
  - Public or not-for-profit hospitals or critical-access hospitals
  - Federally qualified health centers
  - Entities that are located in rural areas
  - Entities that serve:
    - Uninsured
    - Underinsured
    - Historically underserved
    - Other special-needs populations

RECs - Purpose

- Encourage adoption of EHRs by providers
- Assist providers to become meaningful users of EHRs
- Assist and educate providers in helping them to select and successfully implement EHRs
- Increase the probability that adopters of EHRs will become meaningful users of the technology
- Use HIT to achieve reductions in health disparities by working with providers that prioritizes access to HIT

REC - Funding

- RECs anticipated average award values of $1 million to $2 million per center. The maximum award value anticipated for any one regional center is $10 million

- Initial awards for regional centers will begin as early as the first quarter of FY2010 and continue through the fourth quarter of FY2010

- The target timeframe for awards (2010-2012) is intended to enable regional centers to begin supporting provider adoption in time for providers to receive incentive payments

RECs - Requirements

- Define the geographic region and the provider population it proposes to serve
- Describe levels and approaches of support for prioritized providers
- Describe how the applicant would structure its organization to enable providers access to local HIT ‘‘extension agents’’
- Demonstrate capacity to facilitate cooperation among local providers, health systems, communities, and health information exchanges
- Demonstrate ability to meet the needs of prioritized providers
- Propose strategy to furnish expertise (organizational development, legal, privacy/security, economic/ financing, and evaluation) to providers

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VI. MEANINGFUL USE

Meaningful Use - Defined

- The definition of Meaningful Use has been provided in the Notice of Proposed Rule Making and will be finalized by mid to late 2010

- The most recent recommendations by the HIT Policy Committee on the definition of Meaningful Use was on December 30, 2009

Meaningful Use - Defined

Vision:

- To enable significant and measurable improvements in population health through a transformed health care delivery system

By 2015:

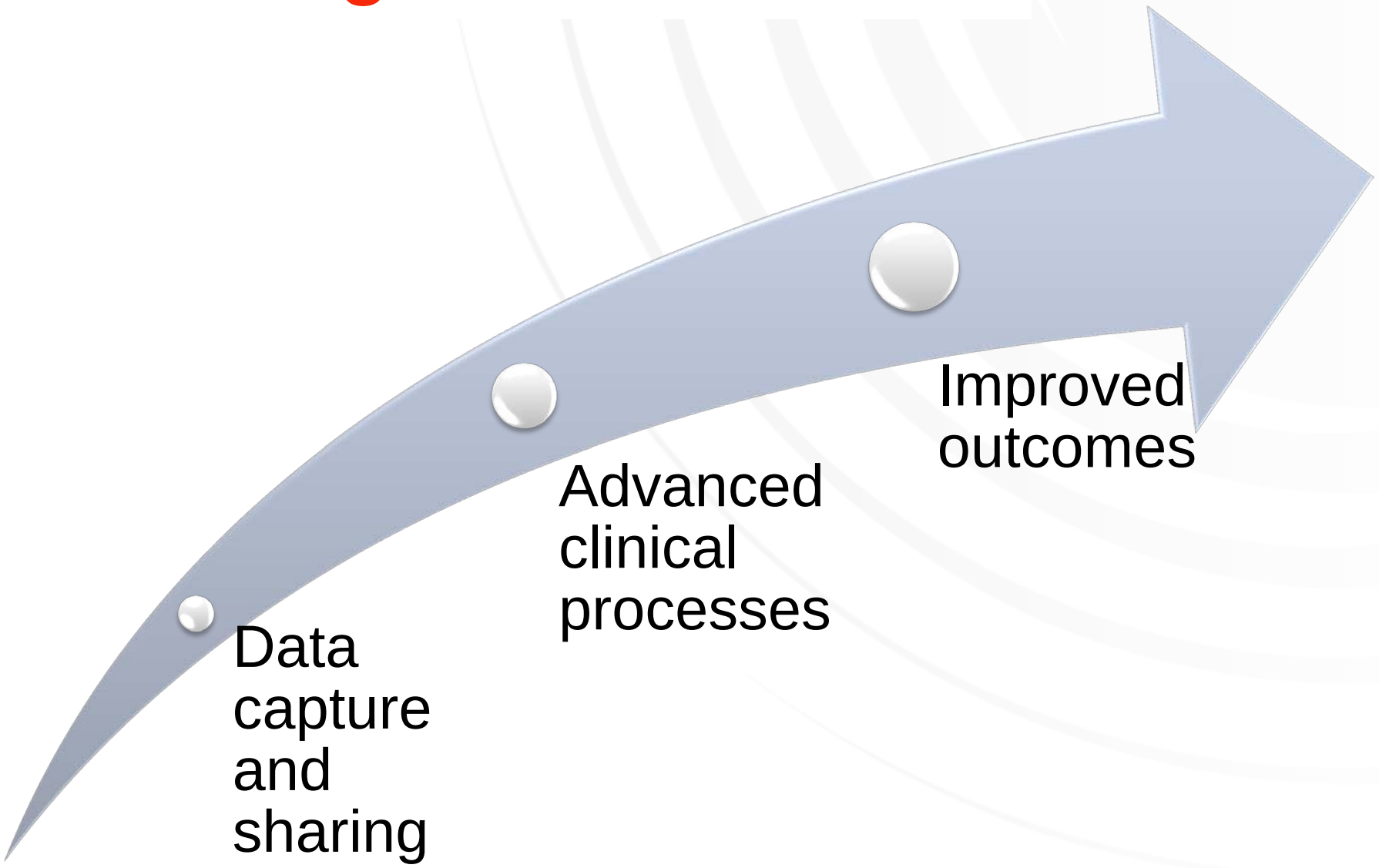
- **Prevention and management of chronic diseases**
  - A million heart attacks and strokes prevented
  - Heart disease no longer the leading cause of death in the US
- **Decrease medical errors**
  - 50% fewer preventable medication errors
- **Decrease health disparities**
  - The racial/ ethnic gap in diabetes control halved
- **Increase care coordination**
  - Preventable hospitalizations and re-admissions cut by 50%
- **Involve patients and families**
  - All patients have access to their own health information
  - Patient preferences for end of life care are followed more often
- **Improve Public health**
  - All health departments have real-time situational awareness of outbreaks

Meaningful Use Stages

- Meaningful Use will be defined in 3 stages through rulemaking
  - Stage 1 – 2011
  - Stage 2 – 2013*
  - Stage 3 – 2015*

*Stages 2 and 3 will be defined in future CMS rulemaking.

Conceptual Approach to Meaningful Use



Meaningful Use - Timeline

Meaningful Use

Meaningful Use Defined

[1] Capture and share data

- *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions*

Achieve advanced care processes with decision support

Realize improved outcomes

- *Goal is to achieve and improve performance and support care processes and on key health system outcomes*

Meaningful Use - HOPP

- 5 Health Outcomes Policy Priorities (HOPP) used to achieve meaningful use:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and families
  - Improve care coordination
  - Improve population and public health
  - Ensure adequate privacy and security protections for personal health information

There are objectives and measures associated with each

Meaningful Use – HOPP 1

Improve quality, safety, efficiency, and reduce health disparities

Care Goals:

- Provide access to comprehensive patient health data for patient's health care team
- Use evidence-based order sets and Computerized Physician Order Entry (CPOE)
- Apply clinical decision support at the point of care
- Generate lists of patients who need care and use them to reach out to patients (e.g., reminders, care instructions, etc.)
- Report to patient registries for quality improvement, public reporting, etc.

Meaningful Use – HOPP 1

Improve quality, safety, efficiency, and reduce health disparities

Stage 1 Objectives

Eligible Professionals	Hospitals	Stage 1 Measures
Use CPOE	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	For EPs, CPOE is used for at least 80% of all orders, for eligible hospitals, CPOE is used for 10% of all orders
Implement drug-drug, drug-allergy, drug formulary checks	Implement drug-drug, drug-allergy, drug formulary checks	Function is enabled
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data
Generate and transmit permissible prescriptions electronically (eRx)		At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified HER technology

Meaningful Use – HOPP 1

Improve quality, safety, efficiency, and reduce health disparities

Stage 1 Objectives Continued

Eligible Professionals	Hospitals	Stage 1 Measures
Maintain active medication list	Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data
Maintain active medication allergy list	Maintain active medication allergy list	At least 80% of all unique patients seen, by the EP or admitted to the eligible hospital have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data

Meaningful Use – HOPP 1

Improve quality, safety, efficiency, and reduce health disparities

Stage 1 Objectives Continued

Eligible Professionals	Hospitals	Stage 1 Measures
Record demographics o preferred language o insurance type o gender o race o ethnicity o date of birth	Record demographics o preferred language o insurance type o gender o race o ethnicity o date of birth o date and cause of death in the event of mortality	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data
Record and chart changes in vital signs: o height o weight o blood pressure o Calculate and display: BMI o Plot and display growth charts for children 2-20 years, including BMI	Record and chart changes in vital signs: o height o weight o blood pressure o Calculate and display: BMI o Plot and display growth charts for children 2-20 years, including BMI	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20

Meaningful Use – HOPP 1

Improve quality, safety, efficiency, and reduce health disparities

Stage 1 Objectives Continued

Eligible Professionals	Hospitals	Stage 1 Measures
Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have “smoking status” recorded
Incorporate clinical lab-test results into EHR as structured data	Incorporate clinical lab test results into EHR as structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP or eligible hospital with a specific condition

Meaningful Use – HOPP 1

Improve quality, safety, efficiency, and reduce health disparities

Stage 1 Objectives Continued

Eligible Professionals	Hospitals	Stage 1 Measures
Report ambulatory quality measures to CMS or the States	Report hospital quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule. For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule
Send reminders to patients per patient preference for preventive/ follow up care		Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over

Meaningful Use – HOPP 1

Improve quality, safety, efficiency, and reduce health disparities

Stage 1 Objectives Continued

Eligible Professionals	Hospitals	Stage 1 Measures
Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3).
Check insurance eligibility electronically from public and private payers	Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital
Submit claims electronically to public and private payers	Submit claims electronically to public and private payers	At least 80% of all claims filed electronically by the EP or the eligible hospital

Meaningful Use – HOPP 2

Engage patients and families in their health care

Care Goal:

- Provide patients and families with access to data, knowledge, and tools to make informed decisions and to manage their health

Meaningful Use – HOPP 2

Engage patients and families in their health care

Stage 1 Objectives

Eligible Professionals	Hospitals	Stage 1 Measures
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours
	Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it

Meaningful Use – HOPP 2

Engage patients and families in their health care

Stage 1 Objectives

Eligible Professionals	Hospitals	Stage 1 Measures
Provide patients with timely electronic access to their health Information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP		At least 10% of all unique patients seen by the EP are provided timely electronic access to their health Information
Provide clinical summaries for patients for each office visit		Clinical summaries are provided for at least 80% of all office visits

Meaningful Use – HOPP 3

Improve care coordination

Care Goal:

- Exchange meaningful clinical information among professional health care teams

Meaningful Use – HOPP 3

Improve care coordination

Stage 1 Objectives

Eligible Professionals	Hospitals	Stage 1 Measures
Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
Provide summary care record for each transition of care and referral	Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals

Meaningful Use – HOPP 4

Improve population and public health

Care Goal:

- Communicate with public health agencies

Meaningful Use – HOPP 4

Improve population and public health

Stage 1 Objectives

Eligible Professionals	Hospitals	Stage 1 Measures
Capability to submit electronic data to immunization registries and actual submission where required and accepted	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
	Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)

Meaningful Use – HOPP 4

Improve population and public health

Stage 1 Objectives Continued

Eligible Professionals	Hospitals	Stage 1 Measures
Capability to provide electronic syndromic surveillance data to public health agencies and actual Transmission according to applicable law and practice	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)

Meaningful Use – HOPP 5

Ensure adequate privacy and security protections for personal health information

Care Goals:

- Ensure privacy and security protections for confidential information through operating policies, procedures, technologies, and compliance with applicable law
- Provide transparency of data sharing to patient

Meaningful Use – HOPP 5

Ensure adequate privacy and security protections for personal health information

Stage 1 Objectives Continued

Eligible Professionals	Hospitals	Stage 1 Measures
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary

Meaningful Use - Summary

- The definition of meaningful use has been proposed in the Notice of Proposed Rule Making and will be finalized by mid to late 2010
- Meaningful use is about achieving improved and measurable health outcomes, not about implementing the software or hardware
- Meaningful use will be determined by the objectives and measures
- Proposed meaningful use criteria for 2011 and beyond present increasing potential of HIT
- Meaningful use will attempt to transform the health system through HIT
- A complete HIT-enabled ecosystem will:
  - Capture coded data electronically
  - Adopt advanced care processes
  - Measure and improve outcomes
- Meaningful use of HIT will lead to an effective and efficient healthcare system
- Meaningful use will aid in the successful realization of health care reform

Meaningful Use Summary

EP's	Eligible Hospitals and CAHs	Reporting Period
• 25 Objectives and Measures • 8 Measures require 'Yes' or 'No' as structured data • 17 Measures require numerator and denominator	• 23 Objectives and Measures • 10 Measures require 'Yes' or 'No' as structured data • 13 Measures require numerator and denominator	• 90 days for first year; one year subsequently

Meaningful Use - Summary

- The definition of meaningful use has been proposed in the 12/30/09 notice of proposed rule making
- Comment period lasts 60 days
- The earliest that we will have a final definition of meaningful use is March 2010
- The earliest that we will have a final rule is July 2010
- The earliest start date for an EHR reporting period is the first day of the payment year; January 1st, 2011 for eligible providers (EP's)
- Meaningful use will be determined by the objectives and measures
- Proposed meaningful use criteria for 2011 and beyond present increasing potential of HIT and have not yet been proposed

DIVURGENT

VII. APPENDIX

Appendix

A. Certification Commission for Healthcare Information Technology (CCHIT) Certified Hospital EMRs
B. CCHIT Certified Ambulatory EMRs
C. Medicare Penalty for Hospitals
D. Medicare Penalty for CAH
E. Resources
F. References

What is in the CMS EHR Incentive program NPRM?

- Definition of Meaningful Use
- Definition of Hospital-Based Eligible Professional
- Medicare FFS EHR Incentive Program
- Medicare Advantage EHR Incentive Program
- Medicaid EHR Incentive Program
- Collection of Information Analysis (Paperwork Reduction Act)
- Regulatory Impact Analysis

What is not in the CMS NPRM?

- Information about applying for grants
- Changes to HIPAA
- Office of the National Coordinator (ONC) Interim Final Rule – HIT: Initial Set of Standards, Implementation Specifications, and Certification Criteria for EHR Technology
- EHR certification requirements
- ONC NPRM - Establishment of Certification Programs for Health Information Technology
- Procedures to become a certifying body

What the NPRM Does

- Harmonizes MU criteria across CMS programs as much as possible
- Closely links with the ONC certification and standards IFR
- Builds on the recommendations of the HIT Policy Committee
- Coordinates with the existing CMS quality initiatives
- Provides a platform that allows for a staged implementation over time

Clinical Quality Measures Overview

- 2011 – Providers required to submit summary quality measure data to CMS by attestation
- 2012 – Providers required to electronically submit summary quality measure data to CMS
- EPs are required to submit clinical data on the 2 measure groups: core measures and a subset of clinical measures most appropriate to the EP's specialty
- Eligible hospitals are required to report summary quality measures for applicable cases

Core Quality Measures for EPs

- Preventive care and screening: Inquiry regarding tobacco use

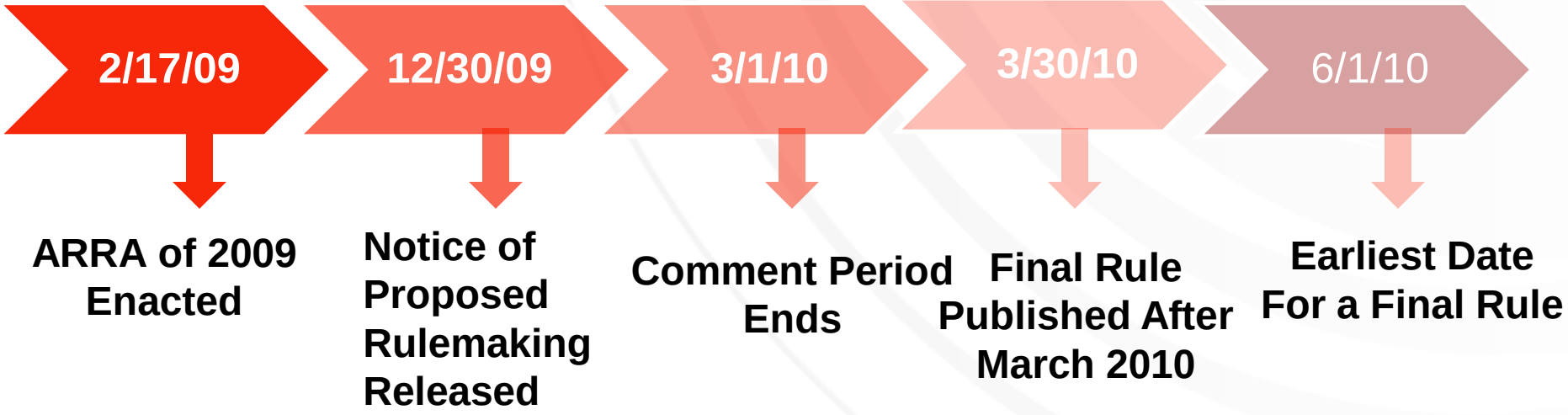
- Blood pressure management

- Drugs to be avoided by the elderly:
  - Patients who receive at least one drug to be avoided
  - Patients who receive at least two different drugs to be avoided

Incentive Payment Timeline

- Medicare can pay incentives to EPs no sooner than January 2011
- Medicare can pay eligible hospitals and CAHs no sooner than October 2010
- Medicaid EPs can potentially receive payments as early as 2010 for Adopting/implementing or upgrading

How We Got Here, Where we're going



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