



# FACTS OF THE MATTER

*Stimulus Package & HITECH Act  
Summary and FAQ's*

**January 2010**



# Summary

Benchmark Systems embraces the Health Information Technology for Economic and Clinical Health (HITECH) Act recently signed by President Barack Obama. This act, part of the Stimulus package known as the American Recovery and Reinvestment Act, will allocate approximately 19.2 billion dollars to accelerate the use of Electronic Health Records (EHR) by physicians and hospitals.

Starting in 2011, qualified physicians and hospitals may be eligible to receive incentive funds for demonstrating meaningful use of a certified EHR solution. While the definition of “meaningful use” is still being developed, the HITECH Act outlines that physicians and hospitals must:

- Demonstrate meaningful use of a certified EHR technology which includes the use of electronic prescribing as determined appropriate by the Secretary of Health and Human Services.
- Demonstrate that the certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, the electronic exchange of health information.
- Report on clinical quality measures, as specified by the Secretary of Health and Human Services.

Incentive funds will be made available to qualified physicians through Medicaid or Medicare and will span over a 5 year period with the highest payments made in the early part of the program. Physicians may choose only one incentive program in which to participate.

### Estimated Medicare Payments *(Eligible professionals may receive up to):*

Year EHR is demonstrated	Annual amount physician is eligible to receive						
	2011	2012	2013	2014	2015	2016	Total
2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$44,000
2012	\$0	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$44,000
2013	\$0	\$0	\$15,000	\$12,000	\$8,000	\$4,000	\$39,000
2014	\$0	\$0	\$0	\$12,000	\$8,000	\$4,000	\$24,000
2015 and after	\$0	\$0	\$0	\$0	\$0	\$0	\$0

### Estimated Medicaid Payments *(Eligible professionals may receive up to):*

2011	2012	2013	2014	2015	2016	2017	2018	Total
\$25,000	\$10,000	\$10,000	\$10,000	\$10,000				\$65,000
	\$25,000	\$10,000	\$10,000	\$10,000	\$10,000			\$65,000
		\$25,000	\$10,000	\$10,000	\$10,000	\$10,000		\$65,000
			\$25,000	\$10,000	\$10,000	\$10,000	\$10,000	\$65,000
				\$25,000	\$10,000	\$10,000	\$10,000	\$55,000
					\$25,000	\$10,000	\$10,000	\$45,000

\*\*\*Based on the first year that meaningful use of EHR is demonstrated (must begin by 2016)\*\*\*



# Summary

Don't delay in learning how a certified EHR solution will help you take full advantage of the stimulus package incentives. For more information on Benchmark's **CCHIT** certified MD-Navigator Clinical EHR status, and to assess your readiness call **(800) 779-0902** or email [info@benchmark-systems.com](mailto:info@benchmark-systems.com).

## How does the American Recovery and Reinvestment Act impact me and my practice?

This act will allocate approximately 19.2 billion dollars to accelerate the use Electronic Health Records (EHR) by physicians and hospitals. The benefits to your patients and practice are:

- Reduced healthcare costs
- Enhanced quality of healthcare
- Expanded coordination of care among physicians office, hospitals, and labs
- Improved patient health information security

## Are the stimulus incentives per practice or per provider?

The incentives are determined on a per provider basis.

## Who qualifies as an eligible professional?

“Eligible professionals” under the **Medicare** HIT incentive program are limited to physicians as defined in the Social Security Act (§1861(r)), which includes:

- A doctor of medicine or osteopathy
- A doctor of surgery or of dental medicine
- A doctor of podiatric medicine
- A doctor of optometry
- A chiropractor

To receive **Medicare** incentive payments, the physician must:

- Not be hospital-based;
- Demonstrate meaningful use of a certified EHR

.The **Medicaid** HIT Incentive program expands the definition of “eligible professionals” to include:

- Certified nurse mid-wife
- Nurse practitioner
- Physician assistant (under certain circumstances)

To receive **Medicaid** incentive payments, eligible professionals must:

- Not be hospital-based;
- Demonstrate meaningful use of a certified EHR; and
- Treat a patient population, of which at least 30% receive medical assistance (or 20% if the physician is a pediatrician).

There are no distinctions between specialty and primary care physicians in terms of the incentives. Hospital-based physicians do not qualify for the physician incentives.

### **What if we are already using a CCHIT certified EHR solution, such as MD-Navigator Clinical?**

Great! You are already a step ahead of other providers in qualifying for incentives. Immediate incentives are available for you to take advantage of from PQRI bonuses and e-Prescription utilization; however you are required to wait until 2011 to submit for bonus payments. *Once a provider starts collecting incentive payments for meaningful use of an EHR (whether in 2011 or beyond), he or she can continue to collect PQRI payments but cannot continue to collect e-Prescribing payments.*

### **If I am not currently using a CCHIT certified EHR solution, should I wait until all the details are announced before purchasing?**

We recommend that you begin your search for a certified solution soon to ensure your practice is ready to meet the reporting provisions to qualify for the maximum incentives from this act. In order to demonstrate “meaning use” of EHR, enough time must be allotted for system evaluation, purchase, implementation and training.

### **What are the penalties if I do not demonstrate use of an EHR after the incentives are in place?**

For office-based physicians who do not adopt such technology by 2015, **Medicare** payments will be reduced by the following factors in the years specified:

- 2015: 1%
- 2016: 2%
- 2017 and beyond: 3%
- 2018 and beyond: Health and Human Services Secretary may decrease one additional percent per year (up to 5%) if 75% of office based physicians don't adopt technology by 2018

No penalties have been published for **Medicaid** payments for lack of adoption

### **When will more details be announced regarding a definition of “certified EHR?”**

December 31, 2009 is the deadline for the Secretary to adopt an initial set of HIT standards, implementation specifics and certification criteria. It is anticipated that **CCHIT** standards will be used as the starting point for determining “certified” criteria. Benchmark is a trusted **CCHIT** solutions provider and is committed in keeping up to date w/ certification criteria as it becomes defined.

### **Why is it important to place my trust in a company like Benchmark Systems?**

Benchmark Systems has been a trusted healthcare solutions provider for over 30 years. Benchmark has achieved the Certification Commission for Healthcare Information Technology (**CCHIT**) and will continue to pursue achievements in certifications as they become defined by the Secretary of Health and Human Services. Our certification is an assurance to you and your practice that our products meet the criteria for functionality, interoperability and security.



**“Meaningful Use: A Definition”**  
**Recommendations from the Meaningful Use Workgroup to the Health IT Policy Committee**  
**June 16, 2009**

The American Recovery and Reinvestment Act authorizes the Centers for Medicare & Medicaid Services (CMS) to provide a reimbursement incentive for physician and hospital providers who are successful in becoming “meaningful users” of an electronic health record (EHR). These incentive payments begin in 2011 and gradually phase down. Starting in 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with the “meaningful use” definition or they will be subject to financial penalties under Medicare.

#### FRAMEWORK FOR DEFINITION

In 2008, the National Priorities Partnership, convened by the National Quality Forum (NQF), released a report entitled “National Priorities and Goals” which identified a set of national priorities to help focus performance improvement efforts. Among these priorities were patient engagement, reduction of racial disparities, improved safety, increased efficiency, coordination of care, and improved population health. These priorities were used to create the framework for “meaningful use” of an electronic health record. An additional area related to privacy and security has also been included to emphasize the importance of preserving patient protections and ensuring patient trust in the use of electronic health records. The matrix represents a set of objectives and care processes that the workgroup believes should inform the ultimate definition of meaningful use .

#### PROGRESSION TOWARDS ULTIMATE GOAL

We recommend that the ultimate goal of meaningful use of an Electronic Health Record is to enable significant and measurable improvements in population health through a transformed health care delivery system. The ultimate vision is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities. This "north star" must guide our key policy objectives, the advanced care processes needed to achieve them, and lastly, the specific use of information technology that will enable the desired outcomes, and our ability to monitor them. For example, demonstrating improved performance and reduced disparities in blood pressure control among patients with diabetes will require a host of new care processes for many outpatient providers (e.g., monitoring medication adherence, use of evidence-based order sets, clinical decision support tools at the point of care, patient outreach and reminders). In order to effectively use the tools that undergird these processes, and to monitor progress towards the outcomes of interest, key information generated in the delivery of care (vital signs, problem lists, medications, procedures, lab tests) must be digitized and queryable. We recognize that changing products and changing workflows will be an evolving process, but providing a clear roadmap of the future (as we have attempted to do in this proposed definition of meaningful use) will help give purpose and meaning to these activities. We recommend a progression similar to the Electronic Health Record demonstration initiated by the Centers for Medicare and Medicaid (CMS) in 2008, wherein “meaningful use” is ultimately linked to achieving measurable outcomes in patient engagement, care coordination, and population health.



In developing the recommended criteria and prioritizing the progression towards a fully interoperable health information system, we have found it necessary to balance the competing goals of encouraging provider participation while promoting progress towards reform of our current health care system. We seek specific stakeholder feedback on whether the recommended timeline of requirements is overly aggressive based on the current state of technology and the demands on new provider workflows, or not challenging enough to result in significant transformation, in light of the declining level of Medicare incentives in future years.

## TRANSFORMED HEALTHCARE

As a result of increased effective use of health information technology, considerable improvements will be realized in the prevention and management of chronic diseases including diabetes and heart disease, preventing hundreds of thousands of unnecessary amputations and premature deaths. Medication errors will be averted. Patients will be able to promptly access their own health information, and their end of life preferences will be heard. The nation will be better prepared for the next pandemic. Health care disparities will be systematically identified and addressed. This transformed healthcare delivery system will also enable and amplify the effectiveness of a host of new reimbursement models that will reward more organized, more coordinated, and more efficient care.

## PROVIDER TYPE

The recommended definition of “meaningful use” will depend on the healthcare setting in which it is employed. Thus, some features and capabilities will be recommended as required in an ambulatory setting before similar functions are expected to be widely used in the hospital. This reflects both the availability of the technology in these different settings as well as the potential impact of these features on the health of the population served. Although some recommended measures used to assess meaningful use in 2011 may apply to specific chronic diseases, the recommended 2011 objectives are meant to establish a foundation for affecting a more comprehensive set of health outcomes in the future. Many of the current proposed EHR-generated quality measures apply to primary care providers and are derived from NQF-endorsed measures. New measures under development, by NQF, and other recognized organizations will also address the work of specialists. The Workgroup anticipates that future recommended meaningful use objectives and measures will reflect emerging national priorities.

## MEASURES

In identifying potential criteria for “meaningful use” of an electronic health record, it became apparent that there are considerable gaps in EHR-generated measures available to monitor key desired policy outcomes, (e.g., efficiency, patient safety, care coordination). While these measures will not be required for Medicare and Medicaid incentive payments until 2013, the Workgroup is seeking feedback

on how to best frame these measures including measurement of key public health conditions, measuring health care efficiency, and measuring the avoidance of certain adverse events. These comments will be used to help revise the recommended measurement strategy to include more extensive and refined outcome measures for “meaningful use” in 2013 and beyond.

**MEANINGFUL USE MATRIX**

Health Outcomes Policy Priorities	Care Goals	2011 Objectives <i>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</i>	2011 Measures	2013 Objectives <i>Goal is to guide and support care processes and care coordination</i>	2013 Measures	2015 Objectives <i>Goal is to achieve and improve performance and support care processes and on key health system outcomes</i>	2015 Measures
<p><b>Improve quality, safety, efficiency, and reduce health disparities</b></p>	<ul style="list-style-type: none"> <li>• Provide access to comprehensive patient health data for patient’s health care team</li> <li>• Use evidence-based order sets and CPOE</li> <li>• Apply clinical decision support at the point of care</li> <li>• Generate lists of patients who need care and use them to reach out to patients (e.g., reminders, care instructions, etc)</li> <li>• Report to patient registries for quality improvement, public reporting, etc</li> </ul>	<ul style="list-style-type: none"> <li>• Use CPOE for all order types including medications [OP, IP]</li> <li>• Implement drug-drug, drug-allergy, drug-formulary checks [OP, IP]</li> <li>• Maintain an up-to-date problem list [OP, IP]</li> <li>• Generate and transmit permissible prescriptions electronically (eRx) [OP]</li> <li>• Maintain active medication list [OP, IP]</li> <li>• Maintain active medication allergy list [OP, IP]</li> <li>• Record primary language, insurance type, gender, race, ethnicity [OP, IP]</li> <li>• Record vital signs including height, weight, blood pressure [OP, IP]</li> <li>• Incorporate lab-test results into EHR [OP, IP]</li> <li>• Generate lists of patients by specific condition to use for quality improvement, reduction of disparities, and outreach [OP]</li> <li>• Send reminders to patients per patient preference for preventive /follow up care [OP, IP]</li> <li>• Document a progress note for each encounter [OP]</li> </ul>	<ul style="list-style-type: none"> <li>• Report quality measures, including: <ul style="list-style-type: none"> <li>- % diabetics with A1c under control [OP]</li> <li>- % hypertensive patients with BP under control [OP]</li> <li>- % of patients with LDL under control [OP]</li> <li>- % of smokers offered smoking cessation counseling [OP, IP]</li> <li>• % of patients with recorded BMI [OP]</li> <li>• % eligible surgical patients who received VTE prophylaxis [IP]</li> <li>• % of orders entered directly by physicians through CPOE</li> <li>• Use of high-risk medications in the elderly [OP, IP]</li> <li>• % of patients over 50 with annual colorectal cancer screenings [OP]</li> <li>• % of females over 50 receiving annual mammogram [OP]</li> <li>• % patients at high-risk for cardiac events on aspirin prophylaxis [OP]</li> <li>• % of patients with current pneumovax [OP]</li> <li>• % eligible patients who received flu vaccine [OP]</li> <li>• % lab results incorporated into EHR in coded format [OP,IP]</li> <li>• Stratify reports by gender, insurance type, primary language, race, ethnicity [OP, IP]</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Use evidence-based order sets [OP, IP]</li> <li>• Record clinical documentation in EHR [IP]</li> <li>• Generate and transmit permissible prescriptions electronically [IP]</li> <li>• Manage chronic conditions using patient lists and decision support [OP, IP]</li> <li>• Provide clinical decision support at the point of care (e.g., reminders, alerts) [OP, IP]</li> <li>• Report to external disease (e.g., cancer) or device registries [OP (esp. specialists) [IP]</li> <li>• Conduct medication administration using bar coding [IP]</li> </ul>	<ul style="list-style-type: none"> <li>• Additional quality reports using HIT-enabled NQF-endorsed quality measures [OP, IP]</li> <li>• % of all orders entered by physicians through CPOE [OP, IP]</li> <li>• Potentially preventable Emergency Department Visits and Hospitalizations [IP]</li> <li>• Inappropriate use of imaging (e.g. MRI for acute low back pain) [OP, IP]</li> <li>• Other efficiency measure (TBD) [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>• Achieve minimal levels of performance on quality, safety, and efficiency measures</li> <li>• Implement clinical decision support for national high priority conditions [OP, IP]</li> <li>• Medical device interoperability [OP, IP]</li> <li>• Multimedia support (e.g. x-rays) [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical outcome measures (TBD) [OP, IP]</li> <li>• Efficiency measures (TBD) [OP, IP]</li> <li>• Safety measures (TBD) [OP, IP]</li> </ul>

Health Outcomes Policy Priorities	Care Goals	2011 Objectives <i>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</i>	2011 Measures	2013 Objectives <i>Goal is to guide and support care processes and care coordination</i>	2013 Measures	2015 Objectives <i>Goal is to achieve and improve performance and support care processes and on key health system outcomes</i>	2015 Measures
<b>Engage patients and families</b>	<ul style="list-style-type: none"> <li>Provide patients and families with access to data, knowledge, and tools to make informed decisions and to manage their health</li> </ul>	<ul style="list-style-type: none"> <li>Provide patients with electronic copy of- or electronic access to- clinical information (including lab results, problem list, medication lists, allergies) per patient preference (e.g., through PHR) [OP, IP]</li> <li>Provide access to patient-specific educational resources [OP, IP]</li> <li>Provide clinical summaries for patients for each encounter [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>% of all patients with access to personal health information electronically [OP, IP]</li> <li>% of all patients with access to patient-specific educational resources [OP, IP]</li> <li>% of encounters for which clinical summaries were provided [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>Offer secure patient- provider messaging capability [OP]</li> <li>Provide access to patient-specific educational resources in common primary languages [OP, IP]</li> <li>Record patient preferences (e.g., preferred communication media, advance directive, health care proxies, treatment options) [OP, IP]</li> <li>Documentation of family medical history [OP, IP]</li> <li>Upload data from home monitoring devices [OP]</li> </ul>	<ul style="list-style-type: none"> <li>Additional patient access and experience reports using NQF-endorsed HIT-enabled quality measures [OP, IP]</li> <li>% of patients with access to secure patient messaging [OP]</li> <li>% of educational content in common primary languages [OP, IP]</li> <li>% of all patients with preferences recorded [OP]</li> <li>% of transitions where summary care record is shared [OP, IP]</li> <li>Implemented ability to incorporate data uploaded from home monitoring devices [OP]</li> </ul>	<ul style="list-style-type: none"> <li>Access for all patients to PHR populated in real time with data from EHR [OP, IP]</li> <li>Patients have access to self-management tools [OP]</li> <li>Electronic reporting on experience of care [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>NPP quality measures related to patient and family engagement [OP, IP]</li> <li>% of patients with full access to PHR populated in real time with EHR data [OP, IP]</li> </ul>
<b>Improve care coordination</b>	<ul style="list-style-type: none"> <li>Exchange meaningful clinical information among professional health care team</li> </ul>	<ul style="list-style-type: none"> <li>Exchange key clinical information among providers of care (e.g., problems, medications, allergies, test results) [OP, IP]</li> <li>Perform medication reconciliation at relevant encounters [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>Report 30-day readmission rate [IP]</li> <li>% of encounters where med reconciliation was performed [OP, IP]</li> <li>Implemented ability to exchange health information with external clinical entity (specifically labs, care summary and medication lists) [OP, IP]</li> <li>% of transitions in care for which summary care record is shared (e.g., electronic, paper, eFax) [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>Retrieve and act on electronic prescription fill data [OP, IP]</li> <li>Produce and share an electronic summary care record for every transition in care (place of service, consults, discharge) [OP, IP]</li> <li>Perform medication reconciliation at each transition of care from one health care setting to another [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>Additional public reports using NQF-endorsed HIT-enabled quality measures [OP, IP]</li> <li>% of transitions where med reconciliation was performed [OP, IP]</li> <li>% of encounters where fill data accessed [OP]</li> <li>% of encounters where clinical information is shared with external clinical entities [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>Access comprehensive patient data from all available sources</li> </ul>	<ul style="list-style-type: none"> <li>Aggregated clinical summaries from multiple sources available to authorized users [OP, IP]</li> <li>NQF-endorsed Care Coordination Measures (TBD)</li> </ul>

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<b>Improve population and public health</b>	<ul style="list-style-type: none"> <li>Communicate with public health agencies</li> </ul>	<ul style="list-style-type: none"> <li>Submit electronic data to immunization registries where required and accepted [OP, IP]</li> <li>Provide electronic submissions of reportable lab results to public health agencies [IP]</li> <li>Provide electronic syndrome surveillance data to public health agencies according to applicable law and practice [IP]</li> </ul>	<ul style="list-style-type: none"> <li>Report up-to-date status for childhood immunizations [OP]</li> <li>% reportable lab results submitted electronically [IP]</li> </ul>	<ul style="list-style-type: none"> <li>Receive immunization histories and recommendations from immunization registries [OP, IP]</li> <li>Receive health alerts from public health agencies [OP, IP]</li> <li>Provide sufficiently anonymized electronic syndrome surveillance data to public health agencies with capacity to link to personal identifiers [OP,IP]</li> </ul>	<ul style="list-style-type: none"> <li>% of patients for whom an assessment of immunization need and status has been completed during the visit [OP]</li> <li>% of patients for whom a public health alert should have triggered and audit evidence that a trigger appeared during the encounter</li> </ul>	<ul style="list-style-type: none"> <li>Use of epidemiologic data [OP, IP]</li> <li>Automated real-time surveillance (adverse events, near misses, disease outbreaks, bioterrorism) [OP, IP]</li> <li>Clinical dashboards [IP, OP]</li> <li>Dynamic and Ad hoc quality reports [OP, IP]</li> </ul>	<ul style="list-style-type: none"> <li>HIT-enabled population measures TBD [OP]</li> <li>HIT-enabled surveillance measure [OP, IP]</li> </ul>
<b>Ensure adequate privacy and security protections for personal health information</b>	<ul style="list-style-type: none"> <li>Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law</li> <li>Provide transparency of data sharing to patient</li> </ul>	<ul style="list-style-type: none"> <li>Compliance with HIPAA Privacy and Security Rules and state laws</li> <li>Compliance with fair data sharing practices set forth in the Nationwide Privacy and Security Framework<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>Full compliance with HIPAA Privacy and Security Rules</li> <li>An entity under investigation for a HIPAA privacy or security violation cannot achieve meaningful use until the entity is cleared by the investigating authority</li> <li>Conduct or update a security risk assessment and implement security updates as necessary</li> </ul>	<ul style="list-style-type: none"> <li>Use summarized or de-identified data when reporting data for population health purposes (e.g. public health, quality reporting, and research), where appropriate, so that important information is available with minimal privacy risk</li> </ul>	<ul style="list-style-type: none"> <li>Provide summarized or de-identified data, when sufficient, to satisfying a data request for pop. health purposes</li> </ul>	<ul style="list-style-type: none"> <li>Provide patients, on request, with an accounting of treatment, payment, and health care operations disclosures</li> <li>Protect sensitive health information to minimize reluctance of patient to seek care because of privacy concerns</li> </ul>	<ul style="list-style-type: none"> <li>Provide patients, on request, with a timely accounting of disclosures for treatment, payment, and health care operations, in compliance with applicable law</li> <li>Incorporate and utilize technology to segment sensitive data</li> </ul>

<sup>1</sup> The Nationwide Privacy and Security Framework was released by The Department of Health and Human Services in December 2008. It is anticipated that further revisions may be made to this document during the calendar year 2010.