APPENDIX A. MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS

This appendix provides a general overview of the Medicare and Medicaid EHR Incentive Programs, although it is not a complete summary of program requirements. Program highlights are presented in table format followed by a narrative description. The last section of the appendix includes a summary of the proposals advanced by various stakeholder groups to extend EHR incentives to health care provider types that are currently ineligible to receive incentive payments under the Medicare and Medicaid EHR Incentive Programs.

A. Program Highlights

Authority and Funder	Description	Recipient: State Provider	Geographic Location	Ineligible Provider Type Impacted	Amount (if known)
Direct Incentives: Financial					
CMS Medicare EHR Incentive Program[a]	HITECH Medicare EHR Incentive Program Voluntary payment incentive program to use Certified EHR Technology (CEHRT) in a meaningful way. Eligible professionals receive up to $44,000 over 5 years if begin in 2011 or 2012. Eligible hospitals receive $2M base amount adjusted by Medicare discharges, charity care and a transition factor that gradually phases the incentive out over 4 years. Payment adjustments begin in 2015.	Provider Eligible Hospitals Eligible Professionals	All eligible providers in the U.S. and D.C.	Stage II requires increased electronic coordination of care efforts by eligible providers and hospitals	
CMS Medicaid EHR Incentive Program[b]	HITECH Medicaid EHR Incentive Program. Medicaid State Plan authority for reimbursement to providers. Voluntary incentive payments for eligible professionals and hospitals who first adopt and then "meaningfully" use CEHRT. Volume thresholds for Medicaid apply. Eligible professionals can receive up to $63,750. Eligible hospitals use a similar formula as under Medicare substituting Medicaid discharges. No payment adjustments in the Medicaid program.	State pays incentives to Eligible Hospitals Eligible Professionals; Federal Government shares in state's costs	All eligible providers in the U.S. who meet specific Medicaid volume thresholds	Stage 2 requires increased electronic coordination of care efforts by eligible professionals and hospitals	

a. See https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/#BOOKMARK1.
b. See https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/#BOOKMARK2.

B. Summary

HITECH Medicare EHR Incentive Payments

The American Recovery and Reinvestment Act of 2009 (ARRA) was enacted February 17, 2009. It includes the HITECH Act, which outlines the requirements for the EHR Incentive Program, designed to incent Medicare and Medicaid eligible hospitals (EHs), Critical Access Hospitals (CAHs) and eligible professionals (EPs) to electronically collect, store, transmit, and use health care information in a meaningful, secure, and timely way with other health entities and government agencies.[1] Priority areas include e-prescribing, and the exchange of lab results and clinical summaries.[2]

The EHR Incentive Program, which aligns financial incentives with five health goals (improving care coordination, improving quality, efficiency and patient safety and reducing health disparities, promoting public and population health, engaging patients and families and ensuring privacy and security), has specific and different timelines and requirements for eligibility for Medicaid and Medicare financial incentives. CMS is mandated to operate the Medicare EHR Incentive Program. EPs may receive either the Medicare or Medicaid incentives, but not both for the same payment year. To be eligible, among other requirements, at least 50 percent of an EP's patient encounters during the EHR reporting period must occur at locations equipped with CEHRT. EHs may receive both Medicare and Medicaid incentives for the same payment year.

Table A1 identifies certain requirements applicable to the Medicare and Medicaid EH and EP EHR Incentive programs. The table identifies maximum EHR incentive payment amounts, the period of time over which incentives are available, whether downward payment adjustments are applied for failure to be a meaningful user, and factors that determine or adjust that payment rate.

To implement the EHR Incentive Programs, CMS publishes rules regarding Meaningful Use (MU) requirements that eligible professionals and hospitals must meet to be considered meaningful users of CEHRT. Currently eligible professionals attest to using CEHRT to meet 15 "Stage 1 MU" core objectives and five out of ten menu objectives (for a total of 20 objectives), in addition to six clinical quality measurements (CQMs) (three core or alternate core, and three from a list of 38 additional CQMs).[3] Eligible hospitals must attest to 14 core objectives and five from a menu of ten objectives (for a total of 19).

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[1] The Office of the National Coordinator for Health Information Technology. Electronic Health Records and Meaningful Use. http://healthit.hhs.gov/portal/server.pt?open=512&objID=2996&mode=2. Accessed 5/1/12.

[2] Ibid. Accessed 5/1/12.

[3] Centers for Medicare & Medicaid Services. Clinical Quality Measures (CQMs). https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html. Accessed 5/19/12.

CMS issued a Final Rule for Stage 2 MU in September 2012, which delays the start date of Stage 2 requirements until 2014 and establishes more rigorous requirements for the meaningful use of CEHRT. Eligible Professionals still have 20 objectives, but 17 are core and three are from a menu of six and the total of objectives for Eligible Hospitals (EHs) remains at 19, with 16 core and three from a menu of six. CMS increased the total number of clinical quality measures regardless of stage of meaningful use to nine out of 64 total and 16 out of 24 for eligible professionals and eligible hospitals, respectively.

HITECH Medicaid EHR Incentive Program

Participation in the Medicaid EHR Incentive Program by States and Territories is voluntary. As of May 2012, with the exception of one state (Hawaii) all states and territories had set up programs.[4] For states and territories that do participate, there is a 90 percent federal financial participation (FFP) match for administrative functions and 100 percent for payments to EPs and EHs. States must receive approval of their State Medicaid Health Information Technology Plan (SMHP), which must address individuals in long-term care settings; aged, blind and disabled individuals; and coordination of care across multiple service providers, funding sources, settings, and patient conditions in order to receive FFP for infrastructure development. States must also gain approval of their Health Information Technology Planning Advance Planning Document (HIT PAPD) and Health Information Technology Implementation Advance Planning Document (HIT IAPD) in order to received FFP for infrastructure.[5]

When registering, eligible professionals must designate which state and which program (Medicare or Medicaid) they are seeking eligibility for EHR incentive payments. Hospitals may be eligible for both Medicare and Medicaid incentive payments, and if a hospital demonstrates meaningful use for purposes of the Medicare incentive payment program, it will be deemed to have done so for purposes of the Medicaid incentive payment program. The hospital must still meet the patient volume and other requirements of the Medicaid EHR Incentive Program. Medicaid EHR incentives for Meaningful Use, unlike Medicare, include funding to adopt, implement or upgrade (AIU) as well as incentive payments for demonstrating the MU of a certified EHR system.[6]

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[4] Centers for Medicare & Medicaid Services. Medicaid State Information. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/MedicaidStateInfo.html.

[5] Centers for Medicare & Medicaid Services. Health Information Technology Implementation Advanced Planning Document (HIT IAPD) Template. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Medicaid_HIT_IAPD_Template.pdf. Accessed 6/1/2012.

[6] Centers for Medicare & Medicaid Services. EHR Incentive Programs. http://www.cms.gov/Regulations-and-Guidance/legislation/EHRincentiveprograms/. Accessed 5/1/12.

TABLE A1. Medicare and Medicaid EHR Incentive Program[a]				
	Medicare		Medicaid	
	EPs	EHs	EPs	EHs
Maximum Payment	$44,000 over 5 years if begin in 2011 or 2012	Up to 4 years of payments $2M base amount plus a discharge-related amount, adjusted based on the Medicare share and a transition factor that decreases from 1 to ¼ over 4 years.	$63,750 over 6 years	3-6 years of payments Sum over 4 years of a $2M base amount plus a discharge-related amount, adjusted based on the Medicaid share and a transition factor that decreases from 1 to ¼ over 4 years.
Patient Volume Requirement	No specific patient volume requirement	No specific patient volume requirement	EPs: 30% Medicaid Patient Volume Pediatricians: 20% Medicaid Patient Volume EPs practicing predominantly in an FQHC/RHC: 30% Needy Individual Patient Volume	Acute: 10% Medicaid Patient Volume Children's: no patient volume requirement
Payment Adjustments	To avoid the 2015 payment adjustment the EP who is demonstrating meaningful use for the first time in 2014 must attest no later than October 1, 2014 which means they must begin their 90 day EHR reporting period no later than July 2, 2014 Payment adjustment as % of Medicare Physician Fee Schedule: – 2015: 99% (or 98% if also subject to e-prescribing penalty in 2014) – 2016: 98% – 2017: 97% – 2018: 97% except can go down to 96% in certain circumstances. – 2019 and thereafter: 97% except can go down to 96 or 95% in certain circumstances.	To avoid the 2015 payment adjustment the hospital that is demonstrating meaningful use for the first time in 2014 must attest no later than July 1, 2014 meaning they must begin their 90 day EHR reporting period no later than April 1, 2014 Decrease in the Percentage Increase to the IPPS Payment Rate that the hospital would otherwise receive for that year: 25% 2015, 50% 2016, 75% 2017 and thereafter	No payment adjustments in the Medicaid Program If a meaningful EHR user under Medicaid, will also be considered a meaningful user for purposes of avoiding Medicare payment adjustments for that period.	No payment adjustments in the Medicaid Program
Payment for Adopt, implement, upgrade (AIU), or meaningfully use EHR technology	No AIU	No AIU	Yes	Yes
EHR reporting period (note: the EHR reporting periods in 2014 are not reflected)	1st Year continuous 90 days Calendar Year	1st Year continuous 90 days Federal Fiscal Year	1st Year continuous 90 days Calendar Year	1st Year continuous 90 days Federal Fiscal Year
Eligibility	Either Medicare or Medicaid	Both	Either Medicare or Medicaid	Both

TABLE A1 (*continued*)				
	Medicare		**Medicaid**	
	EPs	**EHs**	**EPs**	**EHs**
Provider Definitions	Must be a physician (defined as MD, DO, DDM/DDS, optometrist, podiatrist, chiropractor) Must have Part B Medicare allowed charges Must not be hospital-based Must be enrolled in Provider Enrollment, Chain and Ownership System (PECOS) and in an 'approved status'	Subsection (d) hospitals, as defined under section 1886(d)(1)(B) of the Social Security Act, located in one of the 50 states or D.C. Critical Access Hospitals	Must be one of the following: – Physician; – Dentist; – Certified nurse-midwife; – Nurse practitioner. – Physician assistant practicing in a Federally qualified health center (FQHC) led by a physician assistant or a rural health clinic (RHC), that is so led by a physician assistant. Must: – Have ≥30% Medicaid patient volume (≥20% for pediatricians only); or – Practice predominantly in an FQHC or RHC with ≥30% needy individual patient volume Licensed, credentialed No OIG exclusions, living Must not be hospital-based, unless qualifying as predominantly practicing at a FQHC/RHC	Acute care hospital with at least 10% Medicaid patient volume includes general, short-term stay; cancer; Critical Access Hospitals) Children's hospitals

a. An Introduction to the Medicare EHR Incentive Program for Eligible Professionals. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Beginners_Guide.pdf.

TABLE A2. Stage 2 CMS MU Objectives[a]			
Health Outcomes Policy Priority	**Stage 2 Objectives**		**Stage 2 Measures**
	Eligible Professionals	**Eligible Hospitals and CAHs**	
Core Set			
Improving quality, safety, efficiency, and reducing health disparities	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local and professional guidelines	Use CPOE for medication, laboratory and radiology orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local and professional guidelines	More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.
	Generate and transmit permissible prescriptions electronically (eRx)		More than 50% of all permissible prescriptions, or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT.
	Record the following demographics – Preferred language – Sex – Race – Ethnicity – Date of birth	Record the following demographics – Preferred language – Sex – Race – Ethnicity – Date of birth – Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.
	Record and chart changes in vital signs: – Height/length – Weight – Blood pressure (age 3 and over) – Calculate and display BMI – Plot and display growth charts for patients 0-20 years, including BMI	Record and chart changes in vital signs: – Height/length – Weight – Blood pressure (age 3 and over) – Calculate and display BMI – Plot and display growth charts for patients 0-20 years, including BMI	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data
	Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data

TABLE A2. (*continued*)			
Health Outcomes Policy Priority	**Stage 2 Objectives**		**Stage 2 Measures**
	Eligible Professionals	**Eligible Hospitals and CAHs**	
Improving quality, safety, efficiency, and reducing health disparities (*continued*)	Use clinical decision support to improve performance on high-priority health conditions	Use clinical decision support to improve performance on high-priority health conditions	1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent 4 clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the 5 clinical decision support interventions be related to improving health care efficiency. 2. The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug drug and drug allergy interaction checks for the entire EHR reporting period.
	Incorporate clinical lab-test results into CEHRT as structured data.	Incorporate clinical lab-test results into CEHRT as structured data	More than 55% of all clinical lab tests results ordered by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in CEHRT as structured data.
	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least 1 report listing patients of the EP, eligible hospital or CAH with a specific condition.
	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminder, per patient preference.		More than 10% of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.
		Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).	More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.

TABLE A2. (*continued*)			
Health Outcomes Policy Priority	**Stage 2 Objectives**		**Stage 2 Measures**
	Eligible Professionals	**Eligible Hospitals and CAHs**	
Engage patients and families in their health care	Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.		1. More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. 2. More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.
		Provide patients the ability to view online, download, and transmit information about a hospital admission.	1. More than 50% of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge. 2. More than 5% of all patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period.
	Provide clinical summaries for patients for each office visit.		Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50% of office visits.
	Use CEHRT to identify patient-specific education resources and provide those resources to the patient	Use CEHRT to identify patient-specific education resources and provide those resources to the patient	Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period. More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by CEHRT.
	Use secure electronic messaging to communicate with patients on relevant health information		A secure message was sent using the electronic messaging function of CEHRT by more than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

TABLE A2. (*continued*)			
Health Outcomes Policy Priority	**Stage 2 Objectives**		**Stage 2 Measures**
	Eligible Professionals	**Eligible Hospitals and CAHs**	
Improve care coordination	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).
	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.	The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.	1. The EP, eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. 2. The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either--(a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. 3. An EP, eligible hospital or CAH must satisfy one of the two following criteria: (A) Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) and for eligible hospitals and CAHs the measure at §495.6(l)(11)(ii)(B)) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or (B) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

TABLE A2. (*continued*)			
Health Outcomes Policy Priority	**Stage 2 Objectives**		**Stage 2 Measures**
	Eligible Professionals	**Eligible Hospitals and CAHs**	
Improve population and public health	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.
		Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic reportable laboratory results from CEHRT to public health agencies for the entire EHR reporting period.
		Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.
Ensure adequate privacy and security protections for personal health information	Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process.
Menu Set			
Improving quality, safety, efficiency, and reducing health disparities		Record whether a patient 65 years old or older has an advance directive	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.
	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	More than 10% of all tests whose result is one or more images ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are accessible through CEHRT.
	Record patient family health history as structured data	Record patient family health history as structured data	More than 20% of all unique patients seen by the EP or admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for 1 or more first-degree relatives.

TABLE A2. (*continued*)			
Health Outcomes Policy Priority	**Stage 2 Objectives**		**Stage 2 Measures**
	Eligible Professionals	**Eligible Hospitals and CAHs**	
Improving quality, safety, efficiency, and reducing health disparities (*continued*)		Generate and transmit permissible discharge prescriptions electronically (eRx)	More than 10% of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.
	Record electronic notes in patient records	Record electronic notes in patient records	Enter at least 1 electronic progress note created, edited and signed by an eligible professional for more than 30% of unique patients with at least 1 office visit during the EHR reporting period. Enter at least one electronic progress note created, edited and signed by an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) for more than 30% of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with searchable text notes under this measure.
		Provide structured electronic lab results to ambulatory providers	Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20% of electronic lab orders received
Improve Population and Public Health	Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice		Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period
	Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.		Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period
	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.		Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.

a. See http://www.regulations.gov/#!documentDetail;D=CMS-2012-0022-1128.

TABLE A3. 2014 Edition Certification Criteria for Base EHR Definition[a]	
Base EHR Capabilities	**2014 Edition Certification Criteria**
Includes patient demographic and clinical health information, such as medical history and problem lists	Demographics §170.314(a)(3) Problem List §170.314(a)(5) Medication List §170.314(a)(6) Medication Allergy List §170.314(a)(7)
Capacity to provide clinical decision support	Clinical Decision Support §170.314(a)(8)
Capacity to support physician order entry	Computerized Provider Order Entry §170.314(a)(1)
Capacity to capture and query information relevant to health care quality	Clinical Quality Measures §170.314(c)(1) through (3)
Capacity to exchange electronic health information with, and integrate such information from other sources	Transitions of Care §170.314(b)(1) and (2) Data Portability §170.314(b)(7)
Capacity to protect the confidentiality, integrity, and availability of health information stored and exchanged	Privacy and Security §170.314(d)(1) through (8)
a. Office of the Federal Register. "Health Information Technology, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology." https://www.federalregister.gov/articles/2012/09/04/2012-20982/health-information-technology-standards-implementation-specifications-and-certification-criteria-for#table_of_tables.	

C. Proposals to Extend EHR Incentives to Ineligible Provider

The following table identifies some of the actions that some stakeholders have stated are needed to extend the EHR Incentive Programs under HITECH to include many provider types that are currently ineligible to receive incentive payments under those programs, such as long-term and post-acute, and behavioral health providers. This summary is not intended to be a complete list of options that have been proposed to extend the EHR Incentive Programs to ineligible provider types. Rather the list serves to highlights some of the suggestions by some stakeholders of extending these incentive programs. Further, this list is not intended as endorsement of any one of these options. Instead, the summary serves only to list some of the actions that have been proposed that could support the use of EHR technology by ineligible providers. The text in the table below quotes from the referenced documents.

Stakeholder Group	Source and Statement of Proposed Action
State Medicaid Directors Association (NASMD) NASMD a bipartisan, professional, nonprofit organization of representatives of state Medicaid agencies (including D.C. and the territories).	**March 15, 2010: Comment letter on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program proposed rules, published in the January 13, 2010 Federal Register.** **"GUIDING PRINCIPLES" (p.3)** "(1) The provider incentive program should ensure that we are not creating a two tiered system in which Medicaid is not fully integrated into the improved care delivery system enabled through this initiative…. (3) The provider incentive program should foster EHR adoption and meaningful use among eligible Medicaid providers pursuant to the NPRM, and strive towards including non-eligible providers that are critical to improve the quality and value of the Medicaid program, such as long-term care and behavioral health providers." **"Provisions in the Proposed Rule: Alignment of Medicare and Medicaid" (p.4)** **"Alignment of Medicare and Medicaid"** The states support alignment across Medicare and Medicaid; however, the current clinical measures do not reflect key clinical services and issues for the Medicaid population, including behavioral health, dental, long-term care, and care coordination (particularly across physical and behavioral health care). The states recommend that CMS work with the Medicaid Medical Directors and ONC and consider the development and inclusion of clinical and non-clinical quality measures that are more representative of the Medicaid population." **"State Match Requirements" (p.7)** "The states request that CMS allow in-kind contributions--such as state staff 'on loan' to the Medicaid program for the provider incentive program--as part of the 10% state match. In today's economic reality of severe state deficits, states may otherwise not be able to secure the funding needed to participate in this program." **"Eligible Medicaid Providers" (p.9)** The states request that CMS recognize that the Act excludes many relevant and key providers from participating in the incentive program. Specifically, the states argue that community mental health centers and other behavioral health providers, nursing homes, community long-term care providers, and home health care providers should be eligible for incentive payments as they are critical partners in improving the quality and coordination of care for the Medicaid population. The states recognize that this is a statutory issue, but feel strongly that exclusion of these critical providers impacts Medicaid's ability to improve the quality and efficiency of care. The states recommend that CMS allow states and the regional extension centers (RECs) to provide education and training, technical assistance, and infrastructure as relevant to support these excluded providers pursuant to the 90/10 funding. By including these excluded providers in education and training, the states can set the stage for eventually achieving the long-term goal of helping all providers serving Medicaid exchanging data and be meaningful users of EHRs."
American Medical Directors Association (AMDA) AMDA represents approximately 5,200 medical directors, attending physicians, and others who practice in the long-term care continuum.	**AMDA: comments on the proposed rule *Medicare and Medicaid Programs; Electronic Health Records Incentive Program--Stage 2*.** **(p.1)** "While the proposed rule does not preclude long term care physicians from adopting health information systems to achieve meaningful use, AMDA encourages the Centers for Medicare & Medicaid Services (CMS) to include language that supports and encourages adoption of electronic health records (EHR) in long-term/post-acute care settings (LTPAC)...To meet nationally stated goals of a) improving quality, safety, efficiency, and reduce health disparities; b) improving care coordination; and c) engaging patients and families, the health care team caring for a patient/resident must be able to electronically exchange meaningful clinical information throughout the entire spectrum of care, which includes LTPAC."

Stakeholder Group	Source and Statement of Proposed Action
Leading Age (formerly known as AAHSA (American Association for Homes and Services for the Aging)) Leading Age 5,800 member organizations, many of which have served their communities for generations, offer the continuum of aging services: adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes.	**AAHSA Public Policy Priorities 2008 (pp.8-9)** "One thing is clear: Technology will make a tremendous difference in quality and cost…We therefore will advocate for:…Creating and standardizing private, and portable Personal and Electronic Health Records, which take into account the unique requirements of aging services, to be available to every senior (or citizen) in America to ensure continuity of information, continuity of care, reduced unnecessary interventions and errors, and increased ownership of one's medical history. **Statement for the Record. Investing in Health IT: A Stimulus for a Healthier America. January 15, 2009 (p.3)** "HITECH…recognizes that hospitals and physicians need serious incentives to encourage adoption of information technology, and allocates $20 billion in incentive payments. However, it is critically important that we not allow the long-term side of the health care system to languish while the acute-care side is built up. We need to build both sides at the same time, if we are to ensure that patients are not lost in the process. We therefore urge you to include long-term care providers in any incentives you adopt, including direct bonuses, so as to enable long-term providers to prepare their information and communications infrastructure and deploy new technologies, including Health Information Technologies (HIT) and interoperable EHR systems, as well as other technologies enabling direct care workers to document their patients' care. Secondly, we urge that any data collection by the Centers for Medicare and Medicaid be through interoperable systems. We will not be able to achieve the goal of interoperability by 2014 if data collection in long-term care is done through a proprietary format, as CMS plans to do with the new MDS 3.0. This will inevitably set back the efforts to integrate long-term care data collection with the rest of the health care system and ultimately increase cost of making all systems interoperable by 2014…. Such HIT infrastructure and EHR systems, that are interoperable across provider settings, ensure the continuity of information, and thus the continuity of care, and can lead to reducing medical errors, duplicative procedures and expenditures, while improving care quality, especially for the aging population." **AAHSA Public Policy Priorities 2010** AAHSA supports (p.11) – "Standards for electronic health records (EHR) that include long term services and supports. Pilot projects for EHR technology should be on-going in aging services; – Federal funding to advance technology applications in aging services including funds from the American Recovery and Reinvestment Act; and – Development of large-scale technology adoption projects involving aging services providers." **AAHSA Public Policy Priorities 2011 (p.4)** LeadingAge supports – "Advancement of technology applications in long-term services and supports; and – Inclusion of this sector in federal programs to encourage broad use of health information technology" **Financing (p.6)** "Financing aging services also requires support for infrastructure, including access to capital for construction and improvements that add value and cost-saving efficiency, such as technology." **Technology (p.8)** "The application of technology in aging services can help people to continue living in the community, delaying entry into expensive nursing home care. Technology can help to reduce costs associated with chronic conditions such as diabetes. It also can reduce costs by making services more efficient, both in nursing homes and in the community. The Affordable Care Act provides for a number of exciting opportunities to better integrate acute and post-acute care services through collaboration among a variety of health care providers. This kind of collaboration will require extensive data sharing to ensure continuity and quality of services. Data collection and sharing, in turn, will absolutely depend on the use of health information technology.

Stakeholder Group	Source and Statement of Proposed Action
Leading Age (*continued*)	A report by the LeadingAge Center for Aging Services Technology (CAST) discusses the ways in which technology can change the culture, delivery options and financing of health care and long-term services and supports. We support incorporating aging services technologies into accountable care organizations, medical homes and other innovative service delivery systems to help realize cost savings and quality improvements." **LeadingAge supports:** – "Standards for electronic health records (EHR) that include long-term services and supports. Pilot projects for EHR technology should be on-going in aging services; – Federal financial incentives to advance technology applications in aging services; – A pilot program to provide incentives for home health agencies across the country to use home monitoring and communications technologies, giving seniors greater access to the care they need."
Centers for Aging Services Technology, Homecare Technology Association of America (CAST) CAST is leading the charge to expedite the development, evaluation and adoption of emerging technologies that can improve the aging experience. CAST has become an international coalition of more than 400 technology companies, aging services organizations, research universities, and government representatives.	**"IMPEDIMENTS TO THE ROLL-OUT OF IT HEALTHCARE STRATEGIES (pp.1-2)** Interoperable Electronic Health Records (EHR) & Personal Health Records (PHR) in Long-Term Care. The development of interoperable electronic health record and personal health records is critical to the success of technology implementation. We support the national initiatives to develop EHRs and encourage work on PHRs. These activities form the foundation for the future vision of how networked health care systems will operate between older adults, caregivers, family members and health care providers.…Key to maximizing the benefits of such networked healthcare system is the inclusion of long-term care settings, such as assisted living, skilled nursing, home health, home care and specialty services providers…[and] necessitates that the standards for such electronic record systems take into account the requirements of the long-term care providers, including functional assessment data and patient summaries, to allow the electronic exchange of critical health information among different care providers, including long-term care providers. Lack of interoperability is one of the important barriers to the adoption of these technologies… More incentives, in the form of grants, tax-credits and low-interest loans, are needed to enable long-term providers to prepare their information and communications infrastructure and deploy new technologies, including Health Information Technologies (HIT) and interoperable EHR systems, and other technologies including technologies for care documentation by direct care workers that improve the quality of care. Such HIT infrastructure and EHR systems, that are interoperable across provider settings, ensure the continuity of information, and thus the continuity of care, and can lead to reducing medical errors, duplicative procedures and expenditures, while improving care quality, especially for the aging population."
National Association of Home Care (NAHC) **Home Care Technology Association of America (HCTAA)** HCTAA is a wholly-owned affiliate of the NAHC, and is organized to advance the accessibility and use of technology in home care and hospice settings. HCTAA was established to unite the home care technology industry into a stronger, more effective voice to Congress, the Administration, state legislatures, the home care industry, consumers, and the media. HCTAA believes that home care and hospice providers that are properly equipped with technological solutions will serve a central role in the delivery of healthcare by ensuring quality, efficiency, and patient care coordination.	**NAHC and HCTAA: comments on the definition of "Meaningful Use" of Electronic Health Records (EHR), as required by the American Recovery and Reinvestment Act of 2009" (June 25, 2009):** **(pp.2-3)** "…in fashioning the "meaningful use" definition, the Office of the National Coordinator for Health Information Technology (ONCHIT) should bear in mind that neither true health care reform nor our national goal of creating an effective and inclusive nationwide health information network can be achieved without an expansion of its current scope of work to include health care sectors. We urge that home care and hospice be specifically identified as components of the health information network and be included as equally important partners in the delivery of comprehensive quality healthcare." "...the home care sector is still lacking the support and inclusion that would make our providers, and consequently the overall health care system, meaningful users of HIT." "We specifically would urge the ONCHIT to ensure that: – HIE grant funding be made to RHIOs/HIEs emphasize the need to include and support home health care providers to effectively facilitate the electronic exchange of health information across different care settings; – Grants and loans be made available to home health care providers to plan for and implement certified, interoperable HIT solutions; – Regional Extension Centers provide technical assistance for home health care providers seeking integration into the health information network, in addition to other acute care providers in their regions; – CMS adopts HITSP-accepted interoperability standards as it goes forward with new patient assessment requirements for home health agencies and other provider settings to accelerate the adoption and use of interoperable EHRs by these providers; and – Adopts HIT incentives, similar in principle to those offered currently to other acute care providers, to be extended to home health care providers…."

Stakeholder Group	Source and Statement of Proposed Action
NAHC and HCTAA (*continued)*	"…as we have stated, the goal of care coordination requires the exchange of timely health information among all care providers. This goal cannot be achieved unless it is inclusive of home health care and hospice providers. With appropriate resources for implementation and standardization of EHRs, further steps can be taken by the home care and hospice community to meet the objectives of the meaningful use of EHRs and care coordination." "NAHC/HCTAA is also exploring strategies to obtain incentives such as small business loans, tax incentives and grants that could be available to LTPAC providers for the adoption of EHRs." **NAHC and HCTAA comments on the proposed rule to define the "meaningful use" of Certified Electronic Health Records (EHR) technologies and to establish evaluation criteria that facilitate the flow of incentive payments to eligible professionals (EPs) and eligible hospitals participating in Medicare and Medicaid programs (March 15, 2010) (pp.1-2):** – "Recognize that the common definition of "meaningful use" that serves as the standard for providers participating in the Medicare…EHR incentive program and … the Medicaid EHR incentive program affects the process of establishing standards of meaningful use of EHRs for non-eligible health care providers (such as home health care and hospice providers) and that future redefinitions of meaningful use should consider applying criteria for meaningful use more broadly to inpatient and outpatient hospital settings and long-term post acute care (LTPAC) providers." – "Consider that the standards for Certified EHR technologies and the means by which EPs and eligible hospitals demonstrate meaningful use should work for all provider types; including home health care and hospice to ensure the maximization of the functionality of EHRs." – "Recognize that standards for improved care coordination and the exchange of meaningful clinical information among the professional health care team should involve all health care provider types (including health care professionals who are defined within the scope of home health care service providers, such as: physician assistants, nurse practitioners, registered nurses, physical therapist, and clinicians)." – "Encourage stakeholders to conduct demonstration projects that test the exchange of meaningful clinical information between EPs, eligible hospitals and home health care and hospice providers and provide data on the outcomes and cost effectiveness of care coordination and the sharing of clinical data amongst a broad scope of health care providers." – "Encourage EPs (physicians) and hospitals in future rulemaking to partner with other health care providers, as defined by Section 3000(3) of the HITECH Act, by directly linking the formation of collaborative partnerships with home health care and hospice providers with the demonstration of meaningful use or by some other incentivizing means." – "Consider expanding clinical quality measures in future rulemaking to include both long-term care and post acute care. **NAHC/HCTAA comments on the 2011- 2015 Federal Health Information Technology Strategic Plan (May 6, 2011):** **(p.2)** "In describing the barriers that have slowed the acceptance of EHRs and widespread health information exchange the ONC noted that providers in small and medium-sized practices do not have sufficient capital to adopt EHR systems. We also share this experience within the home care and hospice industry and because of our non-incentivized status within the meaningful use program; we are also cognizant that these barriers are most problematic to all providers who serve underserved communities in rural and urban areas. Therefore, we recommend that you provide clear details regarding the government's plan to develop technology and policy solutions that build on meaningful use and fit the unique needs of ineligible providers, including home care and hospice providers…." **(p.2)** "It is promising that the RECs will work with the community-based organizations and we hope that if this partnership extends to home care and hospice agencies that we will be able to help the RECs better serve not only underserved and communities of color but also disabled persons. The ONC should advise the 62 Regional Extension Centers across the country to extend their guidance and technical assistance on certified EHR adoption and utilization to ineligible providers, including home care and hospice providers. This strategy would foster a business model for RECs that supports all health care providers and will enable them to operate without federal grant funds beyond 2015."

Stakeholder Group	Source and Statement of Proposed Action
NAHC and HCTAA (*continued)*	**(pp.2-3)** "The ONC needs to recognize that establishing a criteria and process to certify EHR technologies for hospitals and eligible providers has created a trajectory that must be adhered to by all providers, even those that are non-incentivized, if they want to be able to participate in the capture and exchange of health information. The ONC should link the goals…to provide support and build awareness of not only ONC-ATCB Certified EHRs but also other certified EHRs, such as the CCHIT Certified EHR home health add-on, that is interoperable with the federal standards. Currently, the vendor community is not developing the home health add-on because there is no federal government support or financial incentives attributed to the home care end user." **(p.3)** "It would also be helpful if the ONC would help educate incentivized providers and hospitals about the benefits of accepting clinical information from home care and hospice providers so that the information they receive from the community is not devalued because it is not ONC Certified. Facilitating the exchange and receipt of health information between physicians, hospitals, and other clinical professionals within the care continuum will help to improve patient care coordination especially for those who are chronically ill." **(p.3)** "Although we understand that the major payers are focused on the physician population and hospitals that are being incentivized to adopt Certified EHRs, we do not believe that the private sector is providing incentives to home care or hospice providers to achieve meaningful use."
National Council for Community Behavioral Healthcare (NCCBHC) (aka The National Council) The National Council, a non-profit association representing over 1700 community mental health centers and other community-based mental health and addiction providers, is dedicated to fostering clinical and operational innovation and promoting policies that ensure that the more than 6 million low-income children, adults, and families our members serve have access to high quality services.	**March 12, 2010. The National Council comments on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program, Proposed Rule.** **(p.1)** "…we believe that the adoption and utilization of electronic health records is a vital component of the appropriate delivery of high-quality health care and builds upon previous advancements to better serve consumers." **(p. 2)** "The Federal government should encourage the ***widespread adoption of electronic health records***, computer-based clinical decision-support systems, computerized provider order entry, and other forms of information technology for M/SU [Mental Health and Substance Abuse] care by: – Offering financial incentives to individual M/SU clinicians and organizations for investments in information technology needed to participate fully in the emerging NHII. – Providing capital and other incentives for the development of virtual networks to give individual and small-group providers standard access to software, clinical and population data and health records, and billing and clinical decision-support systems. (emphasis added)1" Footnote: 1 Institute Of Medicine of the National Academies (2006) **Improving the Quality of Health Care for Mental and Substance-Use Conditions**, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders; Board on Health Care Services, The National Academies Press, Washington, DC. **(p.6)** "While the National Council is aware and supportive of SAMHSA's request of $4 million in new funds for BHC HIT for the Office of the National Coordinator in the 2011 budget, we strongly urge that this request not be viewed as adequate to close the gap, and should not be viewed as a alternative to our recommendations. Given that the Proposed Rule is meant to support the "Expanded use of health information technology (HIT) and EHRs [to] improve the quality and value of American health care," the EHR incentives should be readily accessible to CBHOs, whose providers treat many consumers with chronic health conditions."

Stakeholder Group	Source and Statement of Proposed Action
LTPAC Health IT Collaborative Collaborative of associations representing health information technology (HIT) issues for long-term and post acute care (LTPAC) providers, professionals, and support services in skilled nursing facilities, nursing facilities, assisted living, home health agencies, etc. Members include: American Health Care Association, American Health Information Management Association, Home Care Technology Association of America, American Society of Consultant Pharmacists, Center for Aging Services Technology, Leading Age, National Association of Home Care and Hospice, National Association for the Support of Long-Term Care, National Center for Assisted Living, Program for All Inclusive Care for the Elderly	**April 16, 2009. Inclusion of Long-Term Care Settings in ARRA Funded Projects Letter to the David Blumenthal (the National HIT Coordinator)** **(pp.1-2)** We are also aware of the ARRA-required investments in grants and loans programs that will be administered through your office to drive the adoption of interoperable HIT nationally. We are contacting you today to provide two recommendations designed to maximize the return on this significant one time investment in the national HIT infrastructure: 1. We recommend that ONC include language in the ARRA requests for HIT grant and loan proposals advising applicants of the benefits of and need to seek partners from different care settings, including long-term care and providing such help as may be necessary to help identify potential partners (such as providing lists of federally certified providers in various areas). 2. In addition, we recommend that ONC specify that one of the evaluation criteria for selecting grant/loan recipients will be a preference for those who do partner with long-term care providers (and other healthcare providers who will not receive financial incentives). We believe that implementing our ARRA recommendations would substantially help ensure that organizations likely to be primary drivers of adoption of standards-based EHRs and facilitators of health information exchange, such as Health Information Exchanges (HIEs), Regional Health Information Organizations (RHIOs) and Regional Health Information Technology Extensions Centers, are inclusive of all provider settings and serve broad and diverse populations, including persons requiring long-term care. Advancing policies that extend interoperable health information exchange and use to support the needs of persons requiring long-term care (including the use of standards for patient assessments) will be necessary to meet the ARRA goal that each person in the U.S. use an EHR by 2014. **June 11, 2009 Health IT Extension Program Comments. Letter to the David Blumenthal (the National HIT Coordinator)** **(p.1)** "Our collaborative has worked to ensure that long-term care is included in the health information technology (health IT) provisions in the American Recovery and Reinvestment Act (ARRA) of 2009 and Health Information technology for Economic and Clinical Health (HITECH) Act. Fully including this substantial sector of the health care community in interoperable electronic health records (EHRs) is critical to reforming the health care system." "The Extension Program includes provisions addressing the unique needs of providers of historically underserved populations including long-term care. In order to achieve the goals of HITECH, Regional HIT Extension Centers must offer technical assistance to long-term care providers (nursing homes, assisted-living, home health, PACE providers, etc.) as a priority group. This technical assistance is essential so that the health care community (both acute and post-cute) become "meaningful users", have the training and support necessary to create and implement the EHR infrastructure and exchange health information across care settings. Technical assistance to achieve meaningful user status will give acute care providers the opportunity to receive incentive payments under Medicare and Medicaid. Technical assistance will enhance long-term care providers' ability to further improve the quality of care for residents. Furthermore, we request that the scope of work for the Regional HIT Extension Centers require specific inclusion of long-term care providers as stakeholders, partners and an important priority group for receiving direct technical assistance. Excluding long-term care will slow down the adoption of interoperable EHRs for each person in the U.S. and cause harm to our most vulnerable citizens as they migrate through the health care system with numerous providers during single episodes of care and overtime across multiple episodes of care." **March 15, 2010: Comment letter on the Medicare and Medicaid Programs; Electronic Health Record Incentive Program proposed rules.** This rule proposes to define the "meaningful use" of Certified Electronic Health Records (EHR) technologies and to establish evaluation criteria that facilitate the flow of incentive payments to eligible professionals (EPs) and eligible hospitals participating in Medicare and Medicaid programs. (http://www.ltpachealthit.org/sites/default/files/MU%20Comments%20March%202010%20v4%205%20%284%29.pdf)

Stakeholder Group	Source and Statement of Proposed Action
LTPAC Health IT Collaborative (*continued*)	**LTPAC Recommendations on "Meaningful Use" (pp.1-2)** – Recognize that the common definition of "meaningful use" that serves as the standard for providers participating in the Medicare Fee-for-Service and Medicare Advantage EHR incentive program and for EPs and eligible hospitals participating in the Medicaid EHR incentive program affects the process of establishing standards of meaningful use of EHRs for non-eligible health care providers (such as LTPAC providers) and that future redefinitions of meaningful use should consider applying criteria for meaningful use for LTPAC providers. – Recognize that the means by which EPs and eligible hospitals demonstrate meaningful use should work for all provider types. – Consider that the Certified EHRs technologies approved for use by EPs and eligible hospitals must be measured by their ability to successfully send and receive standards-based patient summary records and clinical information and share them with all health care providers types (including skilled nursing facilities, nursing facilities, home health, etc.) as defined by the HITECH Act. – Encourage EPs (physicians) and hospitals in future rulemaking to partner with other providers, as defined by Section 3000(3) of the HITECH Act, by directly linking the formation of partnerships with LTPAC providers with the demonstration of meaningful use or by some other incentivizing means. – Recognize that the standards of meaningful use of Certified EHRs for 2013 must, at a minimum, include a defined standard for the transfer of care documentation between all providers as defined by Section 3000(3) of the HITECH Act. The recommendation of the LTPAC is for this to be addressed in 2011 rulemaking so that the industry has sufficient time to implement these standards and support meaningful use Stage 2. – Recognize that improved care coordination and the exchange of meaningful clinical information among the professional health care team should involve all health care provider types and that demonstration projects should be devised to demonstrate the exchange of meaningful clinical information between EPs, eligible hospitals and LTPAC providers. – Consider expanding clinical quality measures in future rulemaking to include both long-term care and post acute care." **(p.2)** "To meet nationally stated goals of a) improving quality, safety, efficiency, and reduce health disparities; b) improving care coordination; and c) engaging patients and families, the health care team caring for a patient/resident must be able to electronically exchange meaningful clinical information between the professional health care team over the entire spectrum of care. This spectrum is not limited to physician practices and hospitals. Rather, it is inclusive of all provider settings, including LTPAC." **(p.3)** "Effective electronic health information exchange with LTPAC providers reduces hospital readmissions and medical errors, improves quality, supports the continuity of care, and reduces costs with the resultant higher quality of care and quality of life. Our country's health care system will only reach the primary goal of improved quality and care coordination, and hence meaningful use, when all providers across the spectrum of care are included in HIT initiatives." **(p.3)** "Even through LTPAC is not currently funded for financial incentives; it can be included in the demonstration of meaningful use by linking incentive payments to EPs and hospitals who partner with other providers including LTPAC. Without the engagement of LTPAC, the goals of HITECH won't be achieved since physicians and hospitals cannot become meaningful users in isolation." **(p.4)** "In summary, this regulatory effort to transform the health care delivery system and emphasize that this goal can only be realized if the health care system recognizes the vital role LTPAC plays in the full spectrum of care and thus the need to include LTPAC in the electronic exchange of health information to make the use of HIT truly meaningful. As our recommendations propose, LTPAC's inclusion in this initial meaningful use effort can be expanded without additional cost by refining the criteria is a way that will incentivize EPs and hospitals to partner with all provider groups as defined by the HITECH Act. Implementing these recommendations would ensure attaining a meaningful use of HIT across the total spectrum of care, as required by ARRA, achieving a meaningful return on ARRA funds invested, and meeting the ARRA goal that each person in the U.S. has an EHR by 2014."

Stakeholder Group	Source and Statement of Proposed Action
LTPAC Health IT Collaborative (*continued*)	**January 18, 2011. President's Council of Advisors on Science and Technology "Realizing the Full Potential of Health Information Technology to Improve Healthcare for Americans: The Path Forward" Letter to ONC.** **(pp.1-2)** "The report urges the Centers for Medicare and Medicaid Services (CMS) to focus on increasing health information exchange and to exercise its' influence as a major payer to drive health information exchange. While currently long term care providers are not eligible for Meaningful Use incentives for adoption of a certified electronic health record under ARRA-HITECH, CMS could leverage federally mandated LTPAC functional status assessments (such as MDS, OASIS and IRF-PAI) to accelerate the adoption of interoperable EHRs in this sector and increase the exchange of health information across health care provider settings. ONC should also support the creation of health data exchange programs that target and engage long-term and post-acute care providers." **(p.2)** "We strongly support the recommendation that CMS modernize their information systems and develop a strategy to use technology and standards that are consistent with the rest of the health care industry to leverage their influence and advance health information exchange activities for clinical, administrative, public health and research purposes and not deploy IT requirements that only fit CMS business processes." **May 6, 2011. LTPAC HIT Collaborative Public Comments on ONC Federal HIT Strategic Plan 2011-2015.** (http://www.ltpachealthit.org/sites/default/files/LTPAC%20HIT%20Collaborative%20Comments%20on%20ONC%20Federal%20HIT%20Strategic%20Plan%205_9_11_FINALv2.pdf) **(p.1)** "The LTPAC Health IT Collaborative is very supportive of the goals of this comprehensive strategic plan, and certainly applauds the ONC creating Strategy I.C.3. to support health IT adoption and information exchange in long-term/post-acute, behavioral health, and emergency care settings." **(p.1)** "…the Collaborative broadly recommends full inclusion of the LTPAC health sector in the Federal Health Information Technology Strategic Plan to improve quality and reduce care disparities through meaningful use and systematic exchange of health information among all providers in all settings." (**pp.2-5)** "The following comments build on what is contained in the Strategic Plan and further extend it to better meet the needs of the large population that LTPAC serves…. **OBJECTIVE I.A: Accelerate adoption of Electronic Health Records (EHR)** **STRATEGY I.A.7: Align federal programs and services with the adoption and meaningful use of certified EHR** – We applaud the ONC for planning to include methods to encourage providers that are not eligible for the incentive programs such as post-acute and long-term care to achieve meaningful use of IT as well. **OBJECTIVE I.B: Facilitate information exchange to support meaningful use of EHR** – Suggest including long-term and post-acute care settings" with any example of provider settings. **STRATEGY I.B.I: Foster Business models that create health information exchange** – Health Information Exchange strategies include the LTPAC community. – The ONC Direct engages a variety of providers in Health Information Exchange. Ensure that LTPAC providers are included in Direct Projects… – It is not readily apparent in the Strategic Plan that LTPAC is part of the Direct Project.

Stakeholder Group	Source and Statement of Proposed Action
LTPAC Health IT Collaborative (*continued*)	**OBJECTIVE I.C: Support health information technology adoption and information exchange for public health and populations with unique needs.** **STRATEGY I.C.3: Support health IT adoption and information exchange in long-term/post-acute, behavioral health, and emergency care settings** The Federal HIT Strategic Plan notes ONC is working with SAMHSA and HRSA to address the policies and standards concerning the unique needs of behavioral health IT adoption and information exchange. The LTPAC Health IT Collaborative supports the inclusion of the unique needs of behavioral health identified in the strategic plan and offers these recommendations below supporting the unique needs of the LTPAC community: – Support for effective care delivery which maintains health care quality outside of the hospital and acute care setting where most of the elder population--both Medicare and Medicaid beneficiaries as well as "dual eligibles" reside. – Policies, standards, and incentives for vital links between health care providers to be encouraged to accelerate the care process outside current settings being incentivized [eligible hospitals, CAH, eligible professionals]. – Policies, standards, and incentives to provide sustained effective care for the large numbers of vulnerable populations in settings outside acute systems. – Policies, standards, and incentives to develop communication between providers eligible for EHR incentive payments to establish and maintain connections supporting data exchange with those outside agencies who are NOT EHR incentive payment eligible to support consumer centric care across the continuum that includes the longitudinal care planning being discussed by HIT Policy Committee for inclusion in the future stages of Meaningful Use. – Support for effective electronic health information exchange with ALL health professionals involved in delivering LTPAC needs of the consumer including *include Home Care services such as Care Management, Private Duty, and Skilled Nursing--and also the personal care needs, infusion, nutrition, rehabilitation, PT, OT, Speech therapy as well as durable medical equipment providers.* – Support for Longitudinal assessments across the continuum which identify the patient's story…. – Health information exchange from LTPAC facilities to hospitals and vice versa to facilitate better transitions to meet unique needs. – Support for services or service delivery structure to the current EHR that provide a means to track unique needs of patients transitioning between settings. This includes patient care services--not just medical decision making. – Support for the concept of a problem that is not disease specific or a medical problem; examples of other issues that need to be addressed include transportation, personal care, activities of daily living (ADLs), financial issues which are barriers to sustained effective care beyond acute care and often result in hospitalizations, re-hospitalizations and greater medical costs. – Support for health care delivery for of ALL levels of care and prevention--not just support for traditional health care delivery episodes of care "check in to check out" or "admission to discharge". **OBJECTIVE II.A: Support more sophisticated uses of EHRs and other health IT to improve health system performance** **STRATEGY II.A.1: Identify and implement best practices that use EHRs and other health IT to improve care, efficiency, and population health.** – Consider enhancing current language to "Clinical decision support (CDS) systems are tools that leverage EHRs to improve clinical processes--ADD NEW--"across ALL venues of care including LTPAC, behavioral health, and emergency care settings". – Usability is a critical issue that needs to be addressed in this GOAL so that systems providing clinical decision support provide consistent messaging and alerting across the continuum from acute care to long-term and post-acute care. **OBJECTIVE II.D: Support new approaches to the use of health IT in research, public and population health, and national health security** **STRATEGY II.D.1: Establish new approaches to and identify ways health IT can support national prevention, health promotion, public health, and national health security.** – Include a plan to integrate LTPAC. Include clinical decision support systems integrated across the continuum to consistently support meaningful use by all care providers, not just providers currently eligible for the EHR Incentive Program. – Collaboration with LTPAC providers to define supporting strategies, policy and standards needed regarding risk assessment and clinical decision support in a long-term or post-acute care setting. – Support for a link between quality and core processes important across the continuum which include medication reconciliation, care transitions, change of condition, and risk identification.

Stakeholder Group	Source and Statement of Proposed Action
LTPAC Health IT Collaborative (*continued*)	– Support for health records associated with the longitudinal care plan and outcomes of care in various care settings that capture the essence of an individual's life in the community which are vital to the continuum of care. A more specific plan should be included for including these records in the near term meaningful use plans. This is particularly important for populations served by LTPAC. – Support for family histories which are a vital and rich part of the longitudinal care plan and unique assessment of the nursing home and long term or post-acute care environment.

EHR PAYMENT INCENTIVES FOR PROVIDERS INELIGIBLE FOR PAYMENT INCENTIVES AND OTHER FUNDING STUDY

Files Available for This Report

Main Report
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI.shtml
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI.pdf

APPENDIX A. Medicare and Medicaid EHR Incentive Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendA
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendA.pdf

APPENDIX B. Definitions and Certification of EHR Technology
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendB
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendB.pdf

APPENDIX C. Public Health Service Act Section 3000(3) as Added by HITECH Section 13101 -- Provider Analysis
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendC
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendC.pdf

APPENDIX D. Ineligible Provider Characteristics
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendD
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendD.pdf

APPENDIX E. Long-Term and Post-Acute Care Provider Profiles
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendE
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendE.pdf

APPENDIX F. Behavioral Health Provider Profiles
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendF
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendF.pdf

APPENDIX G. Safety Net Provider Profiles
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendG
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendG.pdf

APPENDIX H. Other Health Care Provider Profiles
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendH
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendH.pdf

APPENDIX I. Table Summary of Patient Protection and Affordable Care Act Provisions with Relationship to Ineligible Providers and Health IT Use
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http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendI.pdf

APPENDIX J. Behavioral Health Provider Analysis
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendJ
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendJ.pdf

APPENDIX K. Grant, Demonstrations and Cooperative Agreement Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendK
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendK.pdf

APPENDIX L. Loan Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendL
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendL.pdf

APPENDIX M. Technical Assistance Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendM
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendM.pdf

APPENDIX N. Administrative Infrastructure Building Programs
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendN
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendN.pdf

APPENDIX O. Anti-Kickback Statute EHR Safe Harbor Regulations
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendO
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendO.pdf

APPENDIX P. Private Sector Programs to Advance Certified EHR Technology
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendP
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendP.pdf

APPENDIX Q. Regulations for Medical Records
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendQ
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendQ.pdf

APPENDIX R. Technical Advisory Group Summary
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendR
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendR.pdf

APPENDIX S. Evaluating Benefits and Costs of New Incentives for EHR Adoption by Ineligible Providers
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendS
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendS.pdf

APPENDIX T. CIO Consortium EMR Cost Study Data
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APPENDIX U. Abbreviations and Acronyms
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendU
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APPENDIX V. References
http://aspe.hhs.gov/daltcp/reports/2013/EHRPIap.shtml#appendV
http://aspe.hhs.gov/daltcp/reports/2013/EHRPI-appendV.pdf