



The Health Information Technology for Economic and Clinical Health (HITECH) Act was signed into law on February 17, 2009 as part of the American Recovery and Reinvestment Act (ARRA) of 2009. The final rule for ARRA/HITECH Meaningful Use incentives for Stage 1 was released on July 13, 2010 and published into the Federal Register on July 28, 2010, effective 60 days later. The final rule identifies the Stage 1 Meaningful Use criteria that eligible professionals (EP) and eligible hospitals (EH) will need to meet in order to qualify for payment under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program. MEDITECH customers are well positioned to meet the current challenge of demonstrating Meaningful Use of EHR.

This document outlines the Meaningful Use criteria for Stage 1, MEDITECH's product requirements for ARRA compliance, and details on timelines, calculations, and incentives. MEDITECH's goal is to help you understand what is expected of your organization and to assist you in achieving Meaningful Use. You will notice when reading this document that the government's requirements align with MEDITECH's strategy for deploying an integrated system and our emphasis over the past decade on deployment of Advanced Clinical Systems.

Meaningful Use Criteria Stage 1

Final Requirements for Eligible Hospitals and Critical Access Hospitals (CAHs)

For 2011 and 2012, the final rule identifies a "core set" of mandatory requirements and a "menu set" of optional criteria, of which five criteria must be met, with one of the five coming from population/public health reporting.

General Instructions from Centers for Medicare & Medicaid Services (CMS) for Inpatient Measures

"Anyone admitted to the inpatient department would count in the denominator (of all the patient measures) regardless of whether the hospital has certified EHR technology in the inpatient department or not. To meet problem list, medication list, and medication allergy list, certified EHR technology must be available for 80 percent of the patients in the denominator or the hospital has no possibility of meeting the meaningful use."

For the Calculation

- Inpatients (POS 21) must always be included in the denominator.
- Eligible hospitals and Critical Access Hospitals must select one of the methods below for calculating Emergency Department admissions to be applied consistently to all denominators for the measures.
- The denominator is either:
 - Inpatients plus those patients who present to the Emergency Department and receive observation services or are admitted.
 - Inpatients plus all those who visit the Emergency Department (POS 23).

Please see the Web site in the link below for Centers for Medicare & Medicaid Services Frequently Asked Questions and Clarifications: <http://questions.cms.hhs.gov/app/answers/list/p/21,26,1058>.

Please see Centers for Medicare & Medicaid Services Meaningful Use registration information and incentive programs details are available at: <https://www.cms.gov/ehrincentiveprograms/>.

Please see ONC FAQs on key certification and Meaningful Use criteria are available at: http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163.

Below, we have outlined the Stage 1 Meaningful Use criteria for eligible hospitals. The "core set" is listed first, followed by the "menu set."



All three of MEDITECH's platforms--MAGIC, Client/Server, and 6.0--are certified through the Drummond Group, under the Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) program. Hospitals running MEDITECH's certified solutions have the software tools needed to meet the Stage 1 Meaningful Use measures required to qualify for funding under the American Recovery and Reinvestment Act (ARRA).

Core Criteria for Eligible Hospitals

Objective	Measurement
Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	More than 30 percent of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23) have at least one medication order entered using CPOE.
Implement drug-drug and drug-allergy interaction checks.	The eligible hospital/ Critical Access Hospital has enabled the drug- drug and drug-allergy interaction check functionality for the entire EHR reporting period.
Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients admitted to the eligible hospital's or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Maintain active medication list.	More than 80 percent of all unique patients admitted to the eligible hospital's or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Maintain active medication allergy list.	More than 80 percent of all unique patients admitted to the eligible hospital's or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Record demographics: preferred language, gender, race, ethnicity, date of birth, and date and preliminary cause of death in the event of mortality in the eligible hospital or Critical Access Hospital.	More than 50 percent of all unique patients admitted to the eligible hospitals or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23) have demographics recorded as structured data.
Record and chart changes in vital signs: height, weight, blood pressure; calculate and display BMI; plot and display growth charts for children 2-20 years, including BMI.	For more than 50 percent of all unique patients age two and over admitted to the eligible hospital's or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23) height, weight, and blood pressure are recorded as structure data.
Record smoking status for patients 13 years old or older.	More than 50 percent of all unique patients 13 years old or older admitted to the eligible hospital's or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23) have smoking status recorded as structured data.
Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule.

Core Criteria for Eligible Hospitals

Objective	Measurement
Report hospital clinical quality measures to CMS or the States.	For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of this final rule. For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule.
Provide patients with an electronic copy of their health information (including: diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request.	More than 50 percent of all patients of the inpatient or Emergency Departments of the eligible hospital or Critical Access Hospital (POS 21 or 23) who request an electronic copy of their health information are provided it within three business days.
Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	More than 50 percent of all patients who are discharged from an eligible hospital's or Critical Access Hospital's inpatient department or Emergency Department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.
Capability to exchange key clinical information (for example: discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results) among providers of care and patient authorized entities electronically.	Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1), implement security updates as necessary, and correct identified security deficiencies as part of its risk management process.

Menu or “Optional” Eligible Hospitals*

Objective	Measurement
Implement drug-formulary checks.	The eligible hospital/ Critical Access Hospital has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
Record advance directives for patients 65 years old or older.	Hospitals must record at least 50 percent of inpatients 65 years old or older an indication of an advance directive status recorded.
Incorporate clinical laboratory test results into certified EHR technology as structured data.	More than 40 percent of all clinical laboratory test results ordered by an authorized provider of the eligible hospital or Critical Access Hospital 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 or numerical format are incorporated in certified EHR technology as structured data.

Menu or “Optional” Eligible Hospitals*

Objective	Measurement
Generate lists of patients by specific conditions to Use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the Eligible hospital or Critical Access Hospital with a specific condition.
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients admitted to the eligible hospitals or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23) are provided patient-specific education resources.
The eligible hospital or Critical Access Hospital 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 Critical Access Hospital performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or Critical Access Hospital's inpatient or Emergency Department (POS 21 or 23).
The eligible hospital or Critical Access Hospital who receives a patient from another setting of care, or provider of care, or believes an encounter is relevant, should provide summary of care record for each transition of care or referral.	The eligible hospital or Critical Access Hospital who transitions or refers their patient to another setting of care, or provider of care, provides a summary of care record for more than 50 percent of transitions of care and referrals.
Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.*	Perform at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or Critical Access Hospital submits such information have the capacity to receive the information electronically).
Capability to submit electronic data on reportable (as required by state or local law) laboratory results to public health agencies and actual submission in accordance with applicable law and practice.*	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable laboratory results to public health agencies and follow up submission if the test is successful (unless none of the public health agencies to which eligible hospital or Critical Access Hospital submits such information have the capacity to receive the information electronically).
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.*	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or Critical Access Hospital submits such information have the capacity to receive the information electronically).

* Five menu or "optional" criteria must be selected and demonstrated; however, all eligible professionals and hospitals must choose at least one of the population and public health measures to demonstrate as part of the menu set.

MEDITECH Product Requirements

Products Required for Stage 1

Stage 1 requires use of the following solutions in conjunction with our integrated EHR. Core products include: Admissions, Health Information Management, Management Information System, Pharmacy, Laboratory and Microbiology, Departmental or Imaging and Therapeutic Services, Order Entry/Order Management, Patient Care Inquiry/Enterprise Medical Record, Nursing/Patient Care Systems, and Physician Care Manager.

The complete set of products above play an integral role providing the key interactions for not only data, but also clinical decision support, alerts, rules, and other requirements from the Meaningful Use criteria. In addition, the components listed below allow you to meet additional core set and menu set Meaningful Use criteria:

- Emergency Department
- Data Repository for clinical quality reporting (if not using another vendor product or reporting service)
- CCD/CCR interoperability interfaces
- Interoperability interfaces for public health:*
 - Syndromic surveillance interface
 - Immunization interface
 - Reportable labs interface.
- *Menu or “optional” criteria, but must select at least one for Stage 1.
- Patient Discharge Instructions (your own, Thomson Reuters, or EBSCO Publishing)
- Scanning and Archiving for data not electronically collected.

Timelines and Incentive Details

EHR Incentive Program Timeline

January 2011	<ul style="list-style-type: none"> • Registration for the EHR Incentive Program begins. • For Medicaid providers, states may launch their programs if they so choose.
April 2011	Attestation for the Medicare EHR Incentive Program begins.
May 2011	EHR incentive payments begin.
November 30th 2011	Last day for eligible hospitals and Critical Access Hospitals to register and attest to receive an incentive payment for FFY11.
2015	Medicare payment adjustments begin for eligible professionals and eligible hospitals that are not Meaningful Users of EHR technology.
2016	<ul style="list-style-type: none"> • Last year to receive a Medicare EHR incentive payment. • Last year to initiate participation in Medicaid EHR Incentive Program.
2021	Last year to receive Medicaid EHR incentive payment.

Who Qualifies for Incentive Payments?

Medicare Eligible Hospitals

- Acute Care Hospitals.*
- Critical Access Hospitals.

* Subsection (d) hospitals that are paid under the PPS and are located in the 50 States or Washington, DC. Hospitals located in the US territories or Puerto Rico are not eligible.

Medicare Advantage (MA) Eligible Hospitals

- MA-Affiliated Eligible Hospital will be paid under the Medicare Fee-for-Service EHR Incentive Program.

Medicaid Eligible Hospitals

- Average length of patient stay is 25 days or fewer.
- Acute Care Hospitals, including Critical Access Hospitals.
- CCN that has the last four digits in the series 0001 through 0879 or 1300-1399.
- Children's Hospitals.*
- Cancer Hospitals.

** The government defined a Children's Hospital for purposes of the HIT incentive payment program as "a hospital that is separately certified as a Children's Hospital, with a CCN in the 3300-3399 series and predominantly treats individuals under the age of 21. We used the term 'predominantly' to recognize that not all patients of the Children's Hospital are in fact under age 21."*

How will Hospital Payments be Calculated?

In order to be eligible for Medicare incentive payments, hospitals must be subsection (d) hospitals, which excludes any hospital not paid under the Inpatient Prospective Payment System (IPPS).

Medicare eligible hospital incentive amounts are calculated each year based on data from the hospital's cost report from the previous fiscal year. Under the proposed rule, a hospital will be distinguished by the CMS certification number ("CCN" or OSCAR codes) used for cost reporting purposes.

Also note the following decisions in the final ruling:

- The earliest possible payment is anticipated to be in May 2011.
- Single CCN remains as billing criteria; there is currently no allowance made for multi-hospital systems using a single CCN.
- Total hospital discharge calculation and total acute bed days calculation necessary for the payment process will be amended before the FY2011 payment year via Medicare's updated cost report.

Hospitals that do not annually demonstrate Meaningful Use and report before FY2016 will be subject to reductions to their annual Medicare "market basket" update. Medicare market basket payment updates will be reduced (on a non-cumulative basis) by one-fourth, one-half, and three-fourths for FYs 2015, 2016, and 2017 and later, respectively, for eligible hospitals that are not Meaningful Users of certified EHR technology.

Meaningful Use for Hospitals that Qualify for Both Medicare and Medicaid Payments

Applicable for subsection (d) hospitals that are also Medicaid acute care hospitals (including Critical Access Hospitals) can seek both Medicare and Medicaid incentives. For Medicaid incentives, hospitals will attest/report on Meaningful Use to CMS for the Medicare EHR Incentive Program. If all criteria are met for Medicare, eligible hospitals will also be deemed Meaningful Users for Medicaid (even if the state has CMS approval for the Meaningful Use flexibility around public health objectives).

Medicaid Incentives

Medicaid incentives are administered by the respective state. Medicaid incentive payments for hospitals are based on the Federal fiscal year and are essentially calculated the same way as under Medicare (using Medicaid share in place of Medicare share). States will connect to the CMS EHR Incentive Program Web site to verify provider eligibility and prevent duplicate payments. States will ask providers for additional information in order to make accurate and timely payments. Please note that some states may have more stringent criteria than ONC/HHS. There are no Federal Medicaid payment adjustments as with Medicare. Medicaid hospitals cannot initiate payments after 2016.

Medicaid Eligible Hospitals Exception: Adopt/Implement/Upgrade

If a Medicaid eligible hospital has adopted, implemented, or upgraded (A/I/U) certified EHR technology in the first payment year, the eligible hospital does not need to demonstrate Meaningful Use until the second payment year.

For the first participation year only, Medicaid providers can apply for reimbursement of HIT proving that they have:

- Adopted – acquired and installed (i.e., evidence of installation prior to incentive application).
- Implemented – commenced utilization of HIT (i.e., staff training, data entry of patient demographic information into EHR).
- Upgraded to certified EHR technology or added new functionality to meet the definition of certified EHR technology.

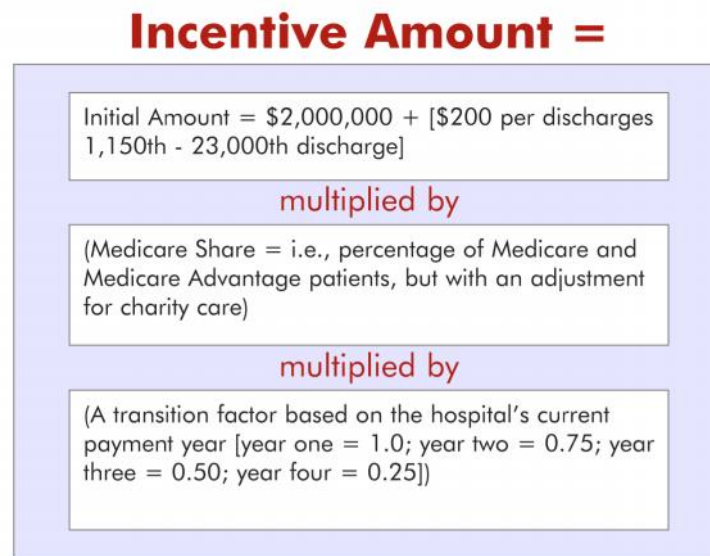
During Year 1, there is no requirement to report on implementation or upgrade; eligible hospitals must report on costs of acquisition. In Year 2, eligible hospitals must report utilization for 90 consecutive days. In subsequent years, eligible hospitals must report utilization for a full 12 months.

Calculation Methods

The following applies for Medicare Incentive Payments for eligible hospitals:

- Federal Fiscal Year starts in October 2010.
- 2M base + per discharge amount (based on Medicare/Medicaid share).
- There is no maximum incentive amount.
- Hospitals meeting Medicare Meaningful Use requirements may be deemed eligible for Medicaid payments.
- Payment adjustments for Medicare begin in 2015 for those not demonstrating Meaningful Use.
- No payments after 2016 for Medicare hospitals.

Incentive Calculation for Eligible Hospitals



Medicare Share Calculation

$$\frac{\text{Medicare}}{\text{Total} \times \text{Charity Care}} = \frac{M}{T \times C}$$

M = [# of Inpatient Bed Days for Part A Beneficiaries] + [# of Inpatient Bed Days for MA Beneficiaries]

T = [# of Total Inpatient Bed Days]

C = [Total Charges – Charges for Charity Care]/[Total Charges]

Incentive Payments for Critical Access Hospitals

Critical Access Hospitals must meet the same Meaningful Use criteria and adoption stages as hospitals paid under the IPPS. As with Medicare, the Act provides for a downward payment adjustment for hospital services provided by Critical Access Hospitals, which are not Meaningful Users of certified EHR technology for cost reporting periods beginning in FY 2015.

The Medicare HIT incentive payments for Critical Access Hospitals differ from the HIT incentive payments for IPPS hospitals because Critical Access Hospitals are paid 100 percent of allowable costs by the Medicare program. Critical Access Hospitals will receive Medicare HIT incentive payments based on the actual capital costs associated with the purchase of certified EHR technology. Critical Access Hospitals will be allowed to expense the Medicare share of the capital costs associated with the purchase of certified EHR technology in a single year, rather than depreciating these costs over a period of years. The Medicare share of these capital costs will be determined in the same manner as IPPS hospitals, based on the CAH's Medicare percent of patient days—adjusted to account for charity care. The Medicare share is then increased by up to 20 percent, not to exceed a maximum Medicare share of 100 percent.

Medicare HIT incentive payments will be made to Critical Access Hospitals for a maximum of four consecutive years. The first year Critical Access Hospitals can qualify for Medicare HIT payments is FY 2011 (October 1, 2010). Payments to Critical Access Hospitals will be via a single CMS contractor. Critical Access Hospitals must attest it is a Meaningful User and submit its documentation to its Fiscal Intermediaries and Medicare Administrative Contractor (FI/MAC) to support costs incurred for the certified EHR system. Upon review by the FI/MAC, CMS will direct release of a single payment. Payments begin in May 2011.

Critical Access Hospitals that are not Meaningful Users of HIT by FY 2015 will be subject to reductions to their allowable Medicare cost reimbursement percentage.

Transition Factor for Eligible Hospitals

The transition factor phases down the incentive payments over the four-year period. The final rule states that the applicable transition factor equals one for the first payment year, three-fourths for the second payment year, one-half for the third payment year, one-fourth for the fourth payment year, and zero thereafter.

Maximum Medicare Health I.T.	If the first qualifying year is:					
	2011	2012	2013	2014	2015	2016
2011	100%	0	0	0	0	0
2012	75%	100%	0	0	0	0
2013	50%	75%	100%	0	0	0
2014	25%	50%	75%	75%	0	0
2015	0	25%	50%	50%	50%	0
2016	0	0	25%	25%	25%	0
2017	0	0	0	0	0	0

For the first year of payment, it is proposed that the EHR reporting period will be any continuous 90-day period within that first payment year; only three months of demonstrating Meaningful Use will be required. For all subsequent years, Meaningful Use must be demonstrated over the entire year.

MEDITECH's Summary in Table 2 shows the reporting years and payment distribution in conjunction with the fiscal year time periods, and the "must be LIVE" requirements.

Table 2: MEDITECH's Summary

*Please note Meaningful Use criteria may be increased and is still to be determined.

First Reporting Year & Payment Distribution	Fiscal Year Begin - End	Stage 1 LIVE on or Before
2011 2011 = 1.00 2012 = 0.75 2013 = 0.50 2014 = 0.25 2015 = 0	10/1/2010 - 9/30/2011	6/30/2011 (Must be LIVE for 90 days before end of fiscal year.)
2012 2012 = 1.00 2013 = 0.75 2014 = 0.50 2015 = 0.25 2016 = 0	10/1/2011 - 9/30/2012	6/30/2012 (Must be LIVE for 90 days before end of fiscal year.)
2013 2013 = 1.00 2014 = 0.75 2015 = 0.50 2016 = 0.25	10/1/2012 - 9/30/2013	6/30/2013 (Must be LIVE for 90 days before end of fiscal year. MU criteria may be increased.)
2014 2014 = 0.75 2015 = 0.50 2016 = 0.25	10/1/2013 - 9/30/2014	6/30/2014 (Must be LIVE for 90 days before end of fiscal year. MU criteria still to be determined.)
2015 2015 = 0.50 2016 = 0.25	10/1/2014 - 9/30/2015	Stage 1 Not Applicable

“Skipping” Years in Medicare Incentive Program

If an eligible professional, eligible hospital, or CAH achieves Meaningful Use in one year, but does not achieve it the subsequent year, that “skipped” year counts towards the maximum program years allowable. For example, an eligible hospital achieves Y1 Meaningful Use in FFY11, but not in FFY12. CMS considers FFY12 the eligible hospital’s second year of program participation. Therefore, FFY13 is Y3 for the eligible hospital.

Registration for Incentives

Starting in January 2011, all eligible hospitals must:

- Register via the CMS EHR Incentive Program Web site (see requirements below).
- Be enrolled in Medicare FFS, MA, or Medicaid (FFS or managed care).
- Have a National Provider Identifier (NPI).
- Use certified EHR technology to demonstrate Meaningful Use.
- All Medicare providers and Medicaid eligible hospitals must be enrolled in PECOS.

Registration Requirements

The following lists the requirements for registration:

1. Name of the eligible professional, eligible hospital, or qualifying CAH.
2. National Provider Identifier (NPI).
3. Business address and business phone.
4. Taxpayer Identification Number (TIN) to which the provider would like their incentive payment made CMS Certification Number (CCN) for eligible hospitals.
5. Medicare or Medicaid program selection (may only switch once after receiving an incentive payment before 2015) for eligible professionals.
6. State selection for Medicaid providers.

Looking Ahead: Meaningful Use in Stage 2 and 3

Meaningful Use criteria will be updated on a biennial basis. Stage 2 is expected at end of 2011, and Stage 3 is expected by end of 2013. The stages represent an initial graduated approach to arriving at the ultimate goal. The following is a summary of what to expect in Stage 2:

- Stage 1 menu set will be transitioned into the core set for Stage 2 (and will be required).
- e-Prescribing and increased CPOE use.
- Incorporating structured lab results.
- e-Transmission of patient care summaries.
- All thresholds and exclusions to be re-evaluated.
- Criteria may be more broadly applied to outpatient hospital settings, not just the Emergency Department.
- Will include greater emphasis on health information exchange across institutional boundaries.

Other Important Considerations

Vendor Certification

MEDITECH's MAGIC version 5.6.4, Client/Server version 5.6.4, and 6.0 version 6.05 Electronic Health Record have received complete EHR inpatient certification through the Drummond Group, under the Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) program.

Hospitals running MEDITECH's certified solutions have the software tools needed to meet the Stage 1 Meaningful Use measures required to qualify for funding under the American Recovery and Reinvestment Act (ARRA). In addition to complete EHR certification, MEDITECH is seeking modular certification of our EHR. The previously certified complete EHR version represented all MEDITECH applications needed to meet all Meaningful Use criteria. We propose the breakdown below, which will allow customers to achieve Meaningful Use in a modular fashion:

The Required set includes: Admissions, Health Information Management, Management Information System, Report Writer, Pharmacy, Laboratory, Order Entry/Order Management, Departmental or Imaging and Therapeutic Services, Patient Care Inquiry/Enterprise Medical Record, Nursing, and Physician Care Manager. Additional solutions needed to supplement the required set above include: Emergency Department, Data Repository, CCD (Interoperability), and Public Health Interfaces of: Laboratory Reporting, Immunization Reporting, and Surveillance.

For more certification information, please visit MEDITECH's Interoperability & EHR Initiatives portal at:

<http://www.meditech.com/interoperability/ehrhme.htm>.



Interoperability

Interoperability specifications were outlined for communication formats to satisfy the menu item of Public Health interfaces and the required CCD/CCR interoperability interfaces (capability to exchange key clinical information). MEDITECH has experience delivering similar versions of these interfaces to our customers, and is in the process of ensuring compliance with the mandated HL7 and ANSI releases.

Reporting

Measures and calculations specific to Meaningful Use criteria will be calculated using a combination of standard reports, NPR reports, Report Designer reports, and Data Repository.

For Meaningful Use Functional Measures: (e.g.: 30% CPOE) NPR or Report Designer reports have been created for each functional measure. These reports can be downloaded from: <http://www.meditech.com/interoperability/ehrhome.htm>.

For Stage 1 Quality Measure Reporting: Stroke, VTE and ED Throughput - a Data Repository is needed. MEDITECH created SQL reports for each measure.

Best Practice Guidance Documents and Reports for the Functional Measures and Quality Measures can be downloaded from: http://www.meditech.com/AdvancedClinicalResources/pages/bp_main.htm. A customer password is needed for these documents.

In the first qualifying year (2011), all Meaningful Use will be by attestation. After 2011, electronic submission of quality data will be required in addition to attestation statements.

HIPAA

The NPRM issued by HHS on July 14, 2010, *Modifications to the HIPAA Privacy, Security, and Enforcement Rules under the Health Information Technology for Economic and Clinical Health Act*, further addresses the recent statutory amendments under the HITECH Act. These amendments focus on the strengthening of the privacy and security protection of health information, and to improve the workability and effectiveness of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. We anticipate MEDITECH's core functionality will continue to be able to address all of these requirements. A comprehensive review of our products is underway. We encourage our customers to check out the updated [HIPAA Web page](#) which features ARRA-related materials.

Next Steps

We encourage all customers to discuss their ARRA plans with their MEDITECH sales and service representatives and begin formulating your strategy for achieving Meaningful Use. Customers will need to assess their situations, evaluate the solutions and resources MEDITECH has available to fulfill the mandate, understand the timeframes involved for implementing new components, and further understand how each state is responding to the stimulus bill and grant opportunities.

MEDITECH will continue monitoring the Meaningful Use requirements and updating our materials as Stage 2 and Stage 3 are established. We encourage our customers to monitor the [Interoperability & EHR Initiatives portal](#) for updates. For more detailed information on data sharing and our interoperability capabilities, please visit our [Sharing Electronic Health Records document](#). For questions and comments, please send a message to our [stimulus mailbox](#).