Health News & Notes

Our Mission is to eliminate health disparities and improve the quality of life of American Indians and Alaska Natives by supporting Northwest Tribes in their delivery of culturally appropriate, high quality healthcare.

A Publication of the Northwest Portland Area Indian Health Board **July 2011**

MEANINGFUL USE OVERVIEW

By Angela Boechler, Portland Area Meaningful Use Consultant for the Indian Health Service

You may have heard a lot of talk within the last few months about Meaningful Use of certified electronic health records (EHR). You may even have questions about what the programs are about. The Centers for Medicare and Medicaid Services (CMS) provide incentive payments to Eligible Professionals (EPs) as they adopt, implement, upgrade, or demonstrate Meaningful Use of certified EHR technology.

The American Recovery and Reinvestment Act (Recovery Act) of 2009 authorizes CMS to make incentive payments to Medicare and Medicaid EPs who are meaningful users of certified EHR technology. Eligibility for the EHR incentive programs is determined by law, and eligibility is based on the individual, not the facility or practice.

First of all, what is Meaningful Use? Meaningful Use is using a certified EHR technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- Maintain privacy and security

Meaningful Use refers to how well the certified EHR is incorporated into the EPs everyday care delivery. For example, how many prescriptions are generated and transmitted electronically? How many patients have an up-to-date problem list in the EHR? EPs are responsible for demonstrating Meaningful Use.

CMS provides these incentive payments to promote adoption and Meaningful Use of a certified EHR. There are three components of Meaningful Use:

- Use of a certified EHR technology in a meaningful manner (e.g., e-prescribing)
- Use of a certified EHR technology for electronic exchange of health information to improve quality of health care
- Use of a certified EHR technology to submit Clinical Quality Measures (CQM) and other such measures (Core and Menu Set Measures)

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In This Edition

EXECUTIVE DIRECTOR'S LETTER

I hope that readers of the Health News & Notes are noticing the changes in format and content to our quarterly newsletter. The NPAIHB staff has made a deliberate effort to reformulate the manner in which we provide you information, including soliciting articles from the experts in the field in order to provide you the highest caliber information in a timely manner.

Our contributors to this edition of the newsletter provide a focus on a range of information regarding the federal HITEC (Health Information Technology) implementation and the incentive payments that are included in the Affordable Care Act following successful establishment of the Meaningful Use (MU) Core measures.

Angela Boechler provides an overview of the MU programs in both Medicaid and Medicare, including the timelines for which providers are eligible for incentive payments, provided they meet the implementation of the Core measures. Included in the article, Angela provides a list of the types of providers that are eligible for the MU incentive payments. Additional detail is provided by Rosario Arreola Pro, from the California Rural Indian Health Board on the specific core measures and the thresholds required for incentives.

Taking a step out of the details, we have a discussion of some of the policy implications by both NPAIHB's Jim Roberts and Hobb, Straus, Dean & Walkers Starla Roels. Jim will lead you through an excellent discussion of the history and funding levels of the HITECH Act, while Starla points out the important privacy implications of HIPAA and the steps taken to increase the protections in the HITECH Act of 2009.

All of this can be confusing, so in an effort to provide you a place to get some of your questions answered we have a discussion led by Tom Kauley of the National Indian Health Board and NPAIHB's Don Head that review the Regional Extension Center's (REC) role and our subcontract with NIHB to assist the REC. If all of these articles and guidance toward answers wasn't enough, we also included some commonly asked questions in a Q&A format that might stimulate discussion into matters that are more specific to your needs.

I look forward to your feedback, not only on the content and issues related to this article, but on all matters related to Indian Health. If you have specific topics in mind for future articles, please do not hesitate to contact me at jfinkbonner@npaihb.org with your suggestions, or just talk to me when you see me at the quarterly board meeting.

Hy'shqe' Si'am.

CHAIRMAN'S LETTER

Andy getting the IHS Director's Special Recognition Award for important contributions to the mission of the Indian Health Service

Improving the nation's health care through health information technology (HIT) is a major initiative for the Department of Health and Human Services (HHS) and in turn Indian Health Service. A key element in this process has been the award of a HITECH Regional Extension Center (REC) grant to the National Indian Health Board (NIHB). The award to NIHB establishes a REC to work solely with the Indian health system. This edition of the newsletter includes a series of articles dedicated to HITECH issues, meaningful use and Medicaid incentives.

A couple of weeks ago, I attended the IHS Tribal Consultation Summit in Bethesda, Maryland. The summit provided an opportunity to learn about many of the issues that our health programs deal with. It also allowed tribal leaders to hear about all the policy issues that the various IHS workgroups are working on. While the planning for the session did not provide much lead time for many to make it to the meeting we did have a good representation of Northwest Tribes. Our Board had packets prepared with position papers on almost all issues or letters in response to Dr. Roubideaux's requests for input on consultation issues.

The collection of position papers assisted us as Tribal leaders to be able to discuss the issues with IHS and Dr. Roubideaux. It also made me realize how involved the Board is on issues from Contract Health Service, Indian Health Care Improvement Fund, data sharing agreements, behavioral health and SAMHSA issues, diabetes and TLDC work, and many more issues. It also makes me realize how important it is to support the work of the Board.

The NIHB Regional Extension Center will also include a sub-award to our Board to assist tribes to implement electronic medical records and to meet meaningful use requirements so that we can receive Medicare or Medicaid incentive payments. This means a new project at the Board with a new Clinical Application Coordinator that will be working with our Tribes. We look forward to gearing up the new project and I hope the HIT articles in this edition are beneficial to our Tribes and help to understand this complicated issue.

Andy Joseph, Jr.

MEANINGFUL USE OVERVIEW

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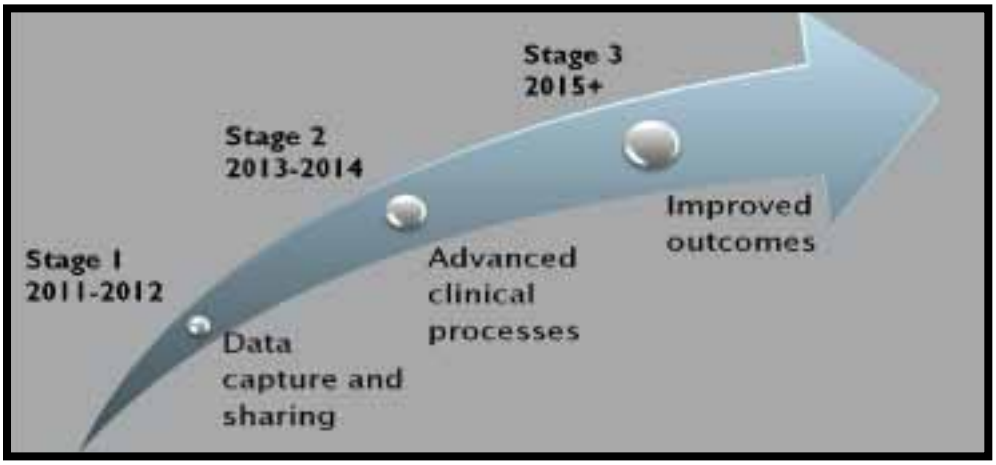
There are three stages of Meaningful Use:



As time goes on, there will be more requirements in order to meet Meaningful Use, so now is the time to start meeting the measures because there will be more added as the program progresses.

EPs must use a certified EHR technology that is certified by the Office of National Coordinator (ONC). Certified EHR technology gives assurance to purchasers and other users that their EHR system or component offers the necessary technological capability, functionality, and security to help them meet the Meaningful Use criteria. Certification also helps providers and patients be confident that the electronic health information technology products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information.

EPs who meet the eligibility requirements for both the Medicare and Medicaid EHR Incentive Programs may participate in only one program, and must designate the program in which they would like to participate. EPs may switch between the two programs any time prior to their first payment; after that, you may only switch once before 2015.

What exactly does that mean? There are two separate incentive programs; the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program.

Within the ***Medicare*** EHR Incentive Program, EPs can receive up to $44,000 over a five year period. Incentive amounts are based on Fee-for-Service allowable charges. There is a 10% bonus if you are practicing in a Health Professional Shortage Area (HPSA). To get the maximum incentive payment, Medicare EPs must begin participation by 2012. Also, participation must be consecutive over a 5 year period. As of 2015, EPs that do not successfully demonstrate Meaningful Use will have a payment adjustment in their Medicare reimbursement.

For the ***Medicaid*** EHR Incentive Program, incentive payments will be provided to EPs as they adopt, implement, upgrade, or demonstrate Meaningful Use of certified EHR technology in their first year of participation, and demonstrate Meaningful Use for up to the five remaining participation years participation does not need to be consecutive. (i.e. if you qualify for Meaningful Use in 2011 and 2012, but cannot meet the requirements in 2013 and 2015, there will be no penalties and you can continue on participating in the program). EPs can receive up to $63,750 over the six years that they choose to participate in the program. There are no payment adjustments under the Medicaid EHR Incentive Program.

Those who qualify as an Eligible Professional are as follows:

Medicare Eligible Professionals include:

- Doctors of Medicine or Osteopathy
- Doctors of Dental Surgery or Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry

MEANINGFUL USE OVERVIEW

- Chiropractors

Medicaid Eligible Professionals include:

- Physicians
- Nurse Practitioners
- Certified Nurse-Midwives
- Dentists
- Physician Assistants (PAs must meet additional requirements)

For the ***Medicare*** program, there is not a Patient Volume requirement, but for Medicaid, there is. To be eligible to receive an incentive under the ***Medicaid*** program, an EP must meet a minimum Patient Volume threshold as shown below:

Eligible Professional (EP)	If EP does not practice predominantly at FQHC/RHC: Minimum Medicaid patient volume thresholds	If EP does practice predominantly at FQHC/RHC: Minimum needy individual patient volume thresholds
Physicians	30%	30%
Pediatricians	20%	30%
Dentists	30%	30%
Certified Nurse-Midwives	30%	30%
PAs when practicing at an FQHC/RHC that is led by a PA	30%	30%
NPs	30%	30%

To calculate the Medicaid Patient Volume threshold for your first reporting year, you would need to take your total number of Medicaid patients seen in the previous calendar year by each EP during any consecutive 90 day period and divide that number by the total number of patients seen by the same provider during that same 90 days-see below:

$$\frac{\text{Total Medicaid patient encounters for the EP in any representative continuous 90-day period in the preceding calendar year}}{\text{Total patient encounters for the EP in the same 90-day period}} * 100$$

For Stage 1, 15 Core Performance Measures, 5 out of the 10 from the Menu Set Performance Measures with at least one being a public health measure must be met. Some of these measures require yes/no attestation (e.g., implement drug-formulary checks; implement one clinical decision support rule), while others require meeting a specific target (e.g., record smoking status for more than 50% of patients 13 years old and older). In addition to the Core and Menu Set Measures, 6 total Clinical Quality Measures must be met in order to show demonstration of Meaningful Use.

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MEANINGFUL USE OVERVIEW

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The following is a table that shows a side-by-side comparison of the payment schedule.

Table 1: Maximum EHR Incentives Payments byProgram Based on the First Calnedar Year (CY) for Which the EP Recieves Payment

CY	2011		2012		2013		2014		2015			
	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare	Medicaid
2011	18000	21250										
2012	12000	8500	18000	21250								
2013	8000	8500	12000	8500	15000	21250						
2014	4000	8500	8000	8500	1200	8500	12000	21250				
2015	2000	8500	4000	8500	8000	8500	8000	8500		21250		
2016		8500	2000	8500	4000	8500	4000	8500		8500		21250
2017				8500		8500		8500		8500		8500
2018						8500		8500		8500		8500
2019								8500		8500		8500
2020										8500		8500
2021												8500
Total	44000	63750	44000	63750	39000	63750	24000	63750	0	63750	0	63750
(If LP does not swithc programs)												

Note: Midacre EP may not receive EHR incentive payments under both Medicare and Medicaid.

Note: The amount of the annual EHR incentive payment limit for each payment year will be increased by 10% for Eps who predominatly furnish services in an area that is desingated as an HPSA.

Clinical Quality Measures:
If the Core Clinical Quality Measures cannot be met, then the Alternate Core must be used. In addition, there are three Clinical Quality Measures that must also be reported on.

Core Set:

- Hypertension: Blood Pressure Management
- Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention
- Adult Weight Screening and Follow up

OR

Alternate Core Set:

- Weight Assessment and Counseling for Children and Adolescents
- Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old or Older
- Childhood Immunization Status

Menu Set: The first 3 that must be reported on for Stage 1 are:

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening

Medicare Incentive Payment Overview

- Incentive amounts based on Fee-for-Service allowable charges
- Maximum incentives are $44,000 over 5 years
- Incentives decrease if starting after 2012

MEANINGFUL USE OVERVIEW

- Must begin by 2014 to receive incentive payments
- Last payment year is 2016
- Extra 10% bonus amount available for practicing predominantly in a **Health Professional Shortage Area** (HPSA) (identified by zip code or county, areas lacking sufficient clinicians to meet primary care needs)
- Receive one (1) incentive payment per year

Medicaid Incentive Payments Overview

- Maximum incentives are $63,750 over 6 years
- Incentives are same regardless of start year
- The first year payment is $21,250
- Must begin by 2016 to receive incentive payments
- No extra bonus for practicing in a health professional shortage area
- Incentives available through 2021
- Receive one (1) incentive payment per year

If you are an EP in Washington, begin registration now at https://ehrincentives.cms.gov/hitech/login.action and then register with Washington State. Please note that registration for Washington should begin in early July and they are estimating that first year payments will be made beginning September, 2011.

Angela Boechler is the Portland Area Meaningful Use Consultant for the Indian Health Service. She has been in the healthcare field for fourteen years, including five years in the U.S. Navy as a Hospital Corpsman, and eight years working with Electronic Health Records. She has her Bachelor's Degree in Business Administration and Healthcare Management and has worked in a variety of patient care and administrative positions over the course of her career.

She is on a National team with fifteen other consultants who cover other areas of Indian Country. Angela works with and communicates with Federal, Tribal, and Urban facilities in the Portland Area to determine state-specific requirements for health information exchange and EHR financial incentive programs for Medicare and Medicaid. Angela assists facilities with using the tools that are added to RPMS EHR for reporting of Meaningful Use measures. She assists facilities not using RPMS EHR with information about the measures that must be reported back to the state in order to demonstrate Meaningful Use. She is excited to be working on a team of talented individuals to help the Federal, Tribal, and Urban facilities qualify for Meaningful Use.

HHS Region 10 Tribal Consultation

Cheryle Kennedy, Grand Ronde, Susan Johnson, HHS Region X Director, and Pearl Capoeman-Baller, Quinault Nation

Julia Davis-Wheeler, Nez Perce Tribe and Jackie Mercer, NARA Director

Jim Sherrill, Cowlitz, Bill Riley, Jamestown S'Klallam, and Kim Zillyett-Harris, Shoalwater Bay

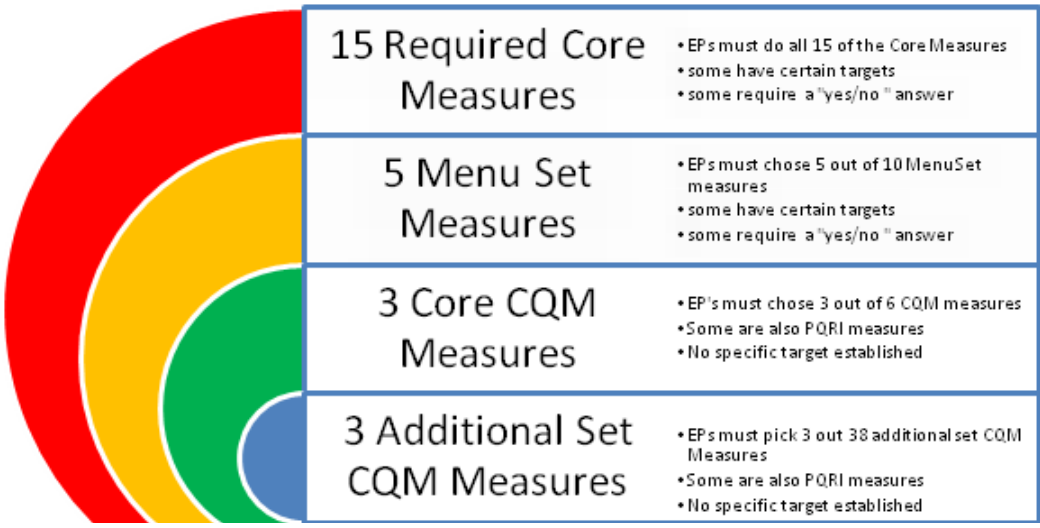
STAGE 1 MEANINGFUL USE MEASURES FOR ELIGIBLE PROFESSIONALS

By Rosario Arreola Pro, CRIHB/ National Indian REC-CA

In order to qualify for the Medicare and Medicaid EHR incentives, along with having a certified EHR, all Eligible Professionals (EPs) will have to meet Meaningful Use measures which are being rolled out in stages: Stage 1, Stage 2, and Stage 3.

For Stage 1, EPs must meet a total of 20 MU measures (15 core set measures, and 5 out of 10 menu set measures) and report on 6 Clinical Quality Measures (CQM). Some of these measures require yes/no attestation (e.g., implement drug-formulary checks; implement one clinical decision support rule), while others require meeting a specific target (e.g., record smoking status for more than 50% of patients 13 years old and older; provide patient-specific education resources for more than 10% of patients).

CMS has finalized (CQMs) for EPs for the 2011 and 2012 reporting periods. EPs are required to report summary data for six CQMs. In order to qualify as meaningful users, EPs are only required to report on CQMs as required; they are not required to meet any targets.



STAGE 1 MEANINGFUL USE MEASURES FOR ELIGIBLE PROFESSIONALS
15 Required Core Measures (EPs must do all 15)
1. Record Patient Demographics
2. Record Vital Signs & Chart Changes
3. Maintain Up-To-Date Problem List & Active Diagnosis
4. Maintain Active Medication List
5. Maintain Active Allergy Medication List
6. Record smoking status for patients 13+ yrs
7. Provide Clinical Summary
8. On Request, Provide ePHR
9. Generate & Transmit ePrescriptions
10. Computer Provided Order Entry (CPOE) for Medications
11. Implement Drug/ Allergy Interaction Check
12. Implement Prov./Pt. Exchange of Clinical Information
13. Implement & track One Clinical Decision Support Rule
14. Implement System to Protect Privacy & Security PHI
15. Report Clinical Quality Measures to CMS/ State
Menu Set (EPs must pick 5 out of 10)
1. Implement Drug Formulary Check
2. Incorporate Lab Results In Structure Data Format
3. List Patients by Condition for Quality Improvement, Research
4. Identify Patient-Specific Resources and Provide to Patients
5. Perform Medication Reconciliation Between Care Settings
6. Provide Summary of Care Record for Patients Referred
7. Submit Electronic Immunization Data to Registries
8. Submit eSyndromic Surveillance Data to Public Health Agencies
9. Send Reminders to Patients for Preventive/ Follow-up Care
10. Provide Patients with Timely ePHR Access
Core Care Quality Measures (CQM) (EPs must pick any 3 out of 6)
1. Hypertension: Blood Pressure Measurement
2. Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention
3. Adult Weight Screening and Follow-up
4. Weight Assessment and Counseling for Children and Adolescents
5. Preventive Care and Screening: Influenza Immunization for Patients50 Years Old or Older
6. Childhood Immunization Status
Additional Set CQM–EPs must complete any 3 out of 38
List includes: Diabetes, Pneumonia Vaccination for Adults, Breast/Prostate Cancer Screening, Smoking/Tobacco Cessation Assistance, Use of Appropriate Meds for Asthma, just to name a few.

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THE HITECH ACT: INCENTIVE PAYMENTS

By Jim Roberts, NPAIHB Policy Analyst

It's been over two years since President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) on February 17th, 2009. The stimulus bill is unprecedented in its level of funding and an extraordinary response to the economic crisis unlike any since the Great Depression. It included measures to modernize our nation's infrastructure, enhance energy independence, expand educational opportunities, preserve and improve affordable health care. The Recovery Act provides significant opportunities to improve health care through health information technology (HIT). The Recovery Act HIT provisions are found in Title XIII, Division A, Health Information Technology, and in Title IV of Division B, Medicare and Medicaid Health Information Technology. These titles together are cited as the Health Information Technology for Economic and Clinical Health Act or the HITECH Act.

The HITECH Act included $19 billion to promote the meaningful use of electronic health records (EHR) through Medicare and Medicaid incentive payments. Of the amount provided, $2 billion was directed to states and other entities for HIT infrastructure, training, telemedicine, inclusion of HIT in clinical education, and dissemination of best practices. The remaining $17 billion will be used to establish Medicare and Medicaid HIT incentive payments for hospitals and physicians over several years. The $17 billion Medicare and Medicaid incentive payments will encourage providers and hospitals to implement EHR systems. The incentive payments are triggered when a provider or hospital demonstrates it has become a "meaningful EHR user." The incentive payments will be phased in over time, with larger payments in the early years and lower payments later in the implementation process. These payments could total as much as $48,400 for eligible professionals and up to $11 million for hospitals, with complex payment schedules.

The Medicare and Medicaid hospital incentive payment calculations start with a $2 million base, but that is only a small part of a complex payment calculation. For Medicare hospitals, it is based on the percent of inpatient bed days for Medicare patients, so if you have a low Medicare patient population, your incentive will be very low. For example, if you only have a 5% Medicare population, your incentive payment for year one would be approximately $100,000. For Medicare critical access hospitals, it is based on EHR costs and again is also based on your Medicare population. For Medicaid, it is based on the Medicaid population or the number of needy individuals served. Needy individuals are patients that received medical assistance from Medicaid or the Children's Health Insurance Program, are furnished uncompensated care by the provider, or were furnished services at either no cost or reduced cost based on a sliding scale.

In addition to the incentives, the legislation establishes penalties through reduced Medicare reimbursement payments if they do not become meaningful users of EHR by 2015. The CMS rule requires that providers and hospitals not only report on clinical quality measures, but also approximately 25 EHR performance measures (referred to as Health IT Functionality measures). Providers and hospitals must meet stated targets for the majority of the EHR measures, whereas for stage 1 meaningful use they only need to report performance on quality measures, but are not required to meet stated targets. ARRA also authorizes HHS to provide competitive grants to states to make loans available to health care providers to assist them with HIT acquisition and implementation costs.

Most important for those IHS Areas that do not have hospitals will be the Medicaid incentives.

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THE HITECH ACT: INCENTIVE PAYMENTS

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ARRA also establishes 100 percent Federal Financial Participation (FFP) for States to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate (including support services and training for staff) certified EHR technology. It also establishes 90 percent FFP for State administrative expenses related to carrying out this provision. States are not required to participate in the Medicaid incentive program. Those states that do not participate, will not offer incentive payments to providers or hospitals. Eligible professionals include non-hospital based physicians, dentists, certified nurse midwives, nurse practitioner, and physician assistants practicing in rural health clinics or Federally-Qualified Health Centers (FQHC) led by a physician assistant. Providers will have to elect to be reimbursed by Medicare or Medicaid, but not both. Medicaid providers will be required to sign an affidavit certifying they are not also collecting Medicare incentive payments.

Since many IHS and Tribal health facilities Medicaid patient caseload exceeds the minimum requirements, and as long as their providers are not hospital-based, most will be eligible for Medicaid incentive payments. Many IHS and Tribal health programs have also begun to implement EHR systems and can now qualify for funding to off-set costs associated with implementing EHR systems. In order to be eligible, non-hospital based health professionals must have at least a 30% patient volume in the Medicaid program and/or physicians who practice in FQHCs, or rural health clinic programs must have a Medicaid patient volume of at least 30 % or an FQHC must provide services to at least 30% needy individuals.

CMS recently modified and updated its position that originally required Tribal clinics to be paid as FQHCs in order to be treated as FQHCs and use the "needy individual" criterion for the Medicaid EHR Incentive Program. CMS will now allow all Tribal clinics to be treated as FQHCs with respect to the Medicaid EHR incentives. This means that eligible professionals in Tribal clinics may be subject to the needy individual patient volume threshold, rather than the Medicaid patient volume threshold, which should make it easier for these eligible professionals to qualify for the incentives.

The Medicaid incentive payment program begins January 1, 2011 and spreads payments over a 6-year period with a first-year payment of up to $21,250 and five subsequent annual payments of up to $8,500. The eligible professional must demonstrate meaningful use of a certified EHR by the second payment year.

Many IHS and Tribal sites have already begun to implement EHRs and may wonder how their investment will fit with the Medicaid incentive program. The rule allows Medicaid EPs who have already adopted, implemented, or upgraded certified EHR technology and meaningful use by the first incentive payment year the same maximum payments, for the same period of time, as the Medicaid EP who merely implemented the same in the first year.

IHS/NPAIHB Injury Prevention Level I Course
May 2011 - Portland, Oregon

Standing (Left to Right): Lee Ann Dixey-Avila, Bridget Canniff, Celeste Davis, Lorena Gray, Iola Hernandez, Jennifer Skarada, Gloriana Woodie, Stephanie Coffey, Kathleen Marquart, Gloria Point, Helen Stafford, Patti Lillie

MEANINGFUL USE Q & A

If the EHR incentive program is voluntary, why is it important to demonstrate MU?

The financial incentives offered by CMS will help recover some costs for implementing and maintaining EHR systems. Beginning in 2015, Eligible Professionals (EPs) that do not demonstrate Meaningful Use will have reduced Medicare reimbursements. Demonstrating Meaningful Use requires using the EHR in routine health care delivery, which increases efficiency and limits risk. The Meaningful Use criteria are all focused on improving the safety and quality of patient care. The criteria for Meaningful Use are likely to become industry standards well beyond the life of the EHR incentive program.

For the 2011 payment year, how and when will incentive payments be made?

For EPs, incentive payments for the Medicare EHR Incentive Program will be made approximately four to eight weeks after an EP successfully attests that they have demonstrated Meaningful Use of certified EHR technology. However, EPs will not receive incentive payments within that timeframe if they have not yet met the threshold for allowed charges for covered professional services furnished by the EP during the year. Payments will be held until the EP meets the $24,000 threshold in allowed charges for calendar year 2011 in order to maximize the amount of the EHR incentive payment they receive. If the EP has not met the $24,000 threshold in allowed charges by the end of calendar year 2011, CMS expects to issue an incentive payment for the EPs in March 2012. Payments to Medicare EPs will be made to the taxpayer identification number (TIN) selected at the time of registration, through the same channels their claims payments are made. The form of payment (electronic funds transfer or check) will be the same as claims payments. Please note that the Medicaid incentives will be paid by the States, but the timing will vary according to each State.

Can Tribal clinics be treated as Federally Qualified Health Centers (FQHCs) for the Medicaid Electronic Health Record (EHR) Incentive Program?

CMS will allow any such Tribal clinics to be considered as FQHCs for the Medicaid EHR Incentive Program, regardless of their reimbursement arrangements.

I am a Commissioned Officer. Am I eligible to participate in the EHR incentive programs?

Yes, if you meet other eligibility requirements.

Under the Medicaid EHR Incentive Program, can a qualifying eligible professional (EP) who is an employee of a federally-owned Indian Health Services facility (other than a tribally-owned facility or Federally Qualified Health Center) assign his/her incentive payment to the federally-owned facility in the same way as other EPs?

Yes, EPs are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EPs covered professional services, including a federally-owned Indian Health Services facility.

Can eligible professionals participate in the 2011 Physician Quality Reporting System (formerly called PQRI), 2011 Electronic Prescribing (eRx) Incentive Program, and the EHR Incentive Program (aka Meaningful Use) at the same time and earn incentives for each?

The Physician Quality Reporting System, eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs.

The Physician Quality Reporting System incentive can be received regardless of an eligible professional's participation in the other programs.

There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

- If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are also able to receive the eRx incentive.
- If participating in the Medicare or Medicare Advantage options for the

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MEANINGFUL USE Q & A

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EHR Incentive Program, EPs must still report the eRx measure to avoid the penalty but are only eligible to receive one incentive payment. EPs successfully participating in both programs will receive the EHR incentive payment.

EPs should continue to report the eRx measure in 2011 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2011 will be analyzed to determine if a 2012 eRx Payment Adjustment will apply to the EP.

If an EP successfully generates and reports electronically prescribing 25 times (at least 10 of which are in the first 6 months of 2011 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2013 eRx payment adjustment.

If I am receiving payments under the CMS Electronic Prescribing (eRx) Incentive Program, can I also receive Medicare and Medicaid Electronic Health Record (EHR) incentive payments?

No, if an EP earns an incentive under the Medicare EHR Incentive Program, (s)he cannot receive an incentive payment under the eRx Incentive Program in the same program year, and vice versa. However, if an EP earns an incentive under the Medicaid EHR Incentive Program, he or she can receive an incentive payment under the eRx Incentive Program in the same program year.

When calculating Medicaid patient volume or needy patient volume for the Medicaid EHR Incentive Program, are (EPs) required to use visits, or unique patients?

There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume. Generally stated, a patient encounter is any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service. The requirements differ for EPs and hospitals. In general, the same concept applies to needy individuals. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume.

What are the requirements for dentists participating in the Medicaid EHR Incentive Program?

Dentists must meet the same eligibility requirements as EPs in order to qualify for payments under the Medicaid EHR Incentive Program. This also means that they must demonstrate all 15 of the core meaningful use objectives and five from the menu of their choosing. The core set includes reporting of six clinical quality measures (three core and three from the menu of their choosing.) Several Meaningful Use objectives have exclusion criteria that are unique to each objective. EPs will have to evaluate whether they individually meet the exclusion criteria for each applicable objective as there is no blanket exclusion by type of EP.

Are mental health practitioners eligible to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Mental health providers would only be eligible for incentive payments if they meet the criteria of a Medicare or Medicaid EPs.

If an EP sees a patient in a setting that does not have certified EHR technology, but enters all of the patient's information into certified EHR technology at another practice location, can the patient be counted in the numerators and denominators of Meaningful Use measures for the Medicare and Medicaid EHR Incentive Programs?

Yes, an EP may include patients seen in locations without certified EHR technology in the numerators and denominators of Meaningful Use measures if the patients' information is entered into certified EHR technology at another practice location. However, EPs should be aware that it is unlikely that they will be able to include such patients in the numerator for the measure of the "use computerized provider order entry (CPOE)" objective or for the e-prescribing measure.

What if an EP works at multiple locations?

An EP who works at multiple locations, but does not have certified EHR technology available at all of them would:

-Have to have 50% of their total

MEANINGFUL USE Q & A

patient encounters at locations where certified EHR technology is available.

-Would base all Meaningful Use measures only on encounters that occurred at locations where certified EHR technology is available.

Do providers register only once for the Medicare and Medicaid EHR Incentive Programs, or must they register every year?

Providers are only required to register once for the Medicare and Medicaid EHR Incentive Programs. However, they must successfully demonstrate that they have adopted, implemented, or upgraded (first participation year for Medicaid) or meaningfully used certified EHR technology each year in order to receive an incentive payment for that year. Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds.

What information will you need when you register?

Registering for the Medicare and Medicaid EHR Incentive Programs is easy when you have the following information available during the process:

Eligible Professionals

- National Provider Identifier (NPI)
- National Plan and Provider Enumeration System (NPPES) User ID and Password
- Payee Tax Identification Number (if you are reassigning your benefits)
- Payee National Provider Identifier (NPI)(if you are reassigning your benefits)
- Enrollment in Provider Enrollment, Chain and Ownership System (PECOS) if participating in the Medicare program

Regarding third-party registration: In April 2011, CMS implemented functionality that allows an EP to designate a third party to register and attest on his or her behalf. To do so, users working on behalf of an EP must have an Identity and Access Management System (I&A) web user account (User ID/Password), and be associated to the EP's NPI. States will not necessarily offer the same functionality for attestation in the Medicaid EHR Incentive Program. Check with your State to see what functionality will be offered.

How will I attest for the Medicare and Medicaid Incentive Programs?

Medicare EPs will have to demonstrate Meaningful Use through CMS' web-based Registration and Attestation System. In the Medicare & Medicaid EHR Incentive Program Registration and Attestation System, providers will fill in numerators and denominators for the Meaningful Use objectives and clinical quality measures, indicate if they qualify for exclusions to specific objectives, and legally *attest* that they have successfully demonstrated Meaningful Use. A complete EHR system will provide a report of the numerators, denominators and other information. Then you will need to enter that data into our online Attestation System. Providers will qualify for a Medicare EHR incentive payment upon completing a successful online submission through the Attestation System—immediately after you submit your results you will see a summary of your attestation, and whether or not it was successful.

When can I attest?

To attest for the Medicare EHR Incentive Program in your first year of participation, you will need to have met Meaningful Use for a consecutive 90-day reporting period. If your initial attestation fails, you can select a different 90-day reporting period that may partially overlap with a previously reported 90-day period. To attest for the Medicare EHR Incentive Program in subsequent years, you will need to have met Meaningful Use for a full year. Please note the reporting period for EPs must fall within the calendar year.

Under the Medicaid EHR Incentive Program, providers can attest that they have adopted, implemented or upgraded certified EHR technology in their first year of participation to receive an incentive payment. Medicaid EHR Incentive Program participants should check with their state to find out when they can begin participation.

Will CMS conduct audits?

Any provider attesting to receive an EHR incentive payment for either the Medicare EHR Incentive

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MEANINGFUL USE Q & A

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Program or the Medicaid EHR Incentive Program potentially may be subject to an audit. Here's what you need to know to make sure you're prepared:

Overview of the CMS EHR

Incentive Programs Audits

- All providers attesting to receive an EHR incentive payment for either Medicare or Medicaid EHR Incentive Programs should retain ALL relevant supporting documentation (in either paper or electronic format used in the completion of the Attestation Module responses). Documentation to support the attestation should be retained for six years post-attestation
- Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes.
- CMS, and its contractors, will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers.
- States, and their contractors, will perform audits on Medicaid providers.
- CMS and states will also manage appeals processes.

Preparing for an Audit

- To ensure you are prepared for a potential audit, save the supporting electronic or paper documentation that support your attestation. Also save the documentation to support your Clinical Quality Measures (CQMs). Hospitals should also maintain documentation to support their payment calculations.
- Upon audit, the documentation will be used to validate that the provider accurately attested and submitted CQMs, as well as to verify that the incentive payment was accurate.

Details of the Audits

- There are numerous pre-payment edit checks built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting and payment.
- Post-payment audits will also be completed during the course of the EHR Incentive Programs.
- If, based on an audit, a provider is found to not be eligible for an EHR incentive payment, the payment will be recouped.
- CMS will be implementing an appeals process for EPs that participate in the Medicare EHR Incentive Program. More information about this process will be posted to the CMS Web site soon.

States will implement appeals processes for the Medicaid EHR Incentive Program. For more information about these appeals, please contact your State Medicaid Agency.

For more information or questions regarding Meaningful Use please contact Angela Boechler at Angela.Boechler@ihs.gov Office: (503) 414-5579 or Cell: (971) 221-8057

Resources: http://www.cms.gov/EHRIncentivePrograms/

Portland Area participants at the IHS Tribal Injury Prevention Cooperative Agreement Program (TIPCAP) Meeting in Rockville, Maryland, June 29-30

Left to right: Karin Knopp (PAO/Bremerton), Bridget Canniff (NPAIHB), Stephanie Coffey (PAO/Bellingham, NWWIHB), LCDR Celeste Davis (PAO/Portland), Luella Azule (NPAIHB)

For more information about NPAIHB's Injury Prevention Program, please contact Luella Azule, Project Coordinator, at lazule@npaihb.org or 503-416-3275.

NEW HIPAA PRIVACY REQUIREMENTS

By Starla Roels, Partner Hobbs Straus Dean & Walker, LLP

Over the past several years, Tribal health care providers have settled into their implementation practices for protecting the privacy of their patients' health information consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These HIPAA-related practices have been integrated into privacy protections offered by tribes under their own laws and policies, as well as other federal privacy requirements that might apply to particular tribal programs or services. Recently, the Department of Health and Human Services (DHHS) has been taking new steps toward the national policy of increased privacy protections for health care patients, in part under the direction of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), enacted as part of the American Recovery and Reinvestment Act of 2009 (PL 111-5), which could affect or change the way in which tribal health providers handle privacy issues.

In particular, DHHS recently proposed a new set of privacy regulations that could significantly increase the burden on health care providers to keep track of their uses and disclosures of a patient's protected health information (PHI) under HIPAA. If adopted, the new regulations could result in providers having to implement new procedures, and possibly having to acquire or upgrade software programs, in order to comply with the law. Additionally, DHHS has stepped up its enforcement activities and is more regularly imposing significant penalties against health care providers who have or have allegedly violated HIPAA. This article briefly reviews the HIPAA privacy requirements and discusses these two recent developments.

The HIPAA Privacy Rules

DHHS published the initial rules on privacy of individually identifiable health information under HIPAA in 2000 and 2002. The regulations implement the privacy standards required by HIPAA for the confidentiality of medical records and are intended to protect a patient's PHI relating to past, present or future physical and mental health conditions, the provision of health care, and any payments for health care by health care providers, health plans and healthcare clearinghouses (known as "covered entities").

Under the regulations, the Indian Health Service program is specifically mentioned as a covered entity that is subject to HIPAA. While the HIPAA statute and the DHHS's HIPAA privacy regulations never expressly mention Indian tribes as being covered entities, many tribes are subject to the HIPAA privacy requirements as health care providers or as health plans. For Tribes, this means not only dealing with implementation of the HIPAA rules governing such use and disclosure, but many tribes have also agreed in their Indian Self-Determination and Education Assistance Act contracts or compacts to comply with the procedures spelled out in the federal Privacy Act, and tribal health care providers also have to comply with additional limitations as entities receiving federal funding on the disclosure of drug and alcohol records (42 C.F.R. Part 2). Some tribes also have their own privacy protections under tribal law and some may have agreed to comply with certain state privacy laws as conditions of state funding. The landscape for complying with these various requirements can thus sometimes be complicated.

The HIPAA privacy regulations address the following requirements, among others:
(1) use of personal health information for treatment, payment and operations; (2) patient authorizations for certain disclosures; (3) mandatory disclosure of certain health information; (4) research; (5) marketing; (6) use and disclosure by business associates; (7) notice

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NEW HIPAA PRIVACY REQUIREMENTS

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of privacy practices; and (8) administrative requirements, such as designation of a privacy official and implementation of a compliance mechanism. HIPAA is in part known as governing the use and disclosure of a patient's PHI.

New, Potentially Burdensome "Accounting of Disclosures" Requirements

The HITECH Act of 2009 in part directs DHHS to modify the HIPAA privacy, security, and enforcement rules to strengthen the privacy and security protections for health information. On May 31, 2011, DHHS published a proposed rule in the Federal Register to change the existing HIPAA accounting provisions. The proposed rule, which implements a statutory provision from HITECH Act, dramatically alters the current HIPAA rule requiring accounting of disclosures of PHI, and would substantially increase the burdens on covered entities and business associates to record and account for such disclosures. The deadline for comments is August 1, 2011. The proposed rule may be viewed at the following link: http://www.gpo.gov/fdsys/pkg/FR-2011-05-31/pdf/2011-13297.pdf.

Under the existing HIPAA privacy regulations, health care providers and other covered entities must keep a record of certain disclosures made of an individual's PHI and, when requested by the individual, give him or her an "accounting" of the disclosures made. A "disclosure" is defined for these purposes as the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information. The "accounting" must include: (1) the date of the disclosure, (2) the name and address of the entity or person who received the protected health information, (3) a brief description of the information disclosed, and (4) a brief statement of the purpose of the disclosure or a copy of the written request for the disclosure. This accounting provision applies to disclosure of both paper and electronic PHI. Currently, health care providers are not required to keep track of disclosures made for treatment, payment, or health care operations purposes.

DHHS's newly proposed rule will increase the responsibilities of covered entities to account for disclosures and extend those requirements to the covered entities' business associates. In particular, the proposed rule would give an individual a right to an "access report," which would include information on electronic access by any person, including workforce members and persons outside the covered entity. The access report would provide information on who has accessed electronic PHI in a designated record set *including access for purposes of treatment, payment, and health care operations*. The right to an access report would only apply to PHI that is maintained in an electronic designated record set. The access report would cover a three-year period and would require the date, time, and name of the person or entity who accessed the information. It would also require the inclusion of a description of the PHI that was accessed and the user's action, to the extent such information is available. Covered entities will have to revise their Notice of Privacy Practices (and redistribute them to patients) to inform patients of their right to receive an "access report" in addition to an accounting of certain disclosures.

The proposed rule would require covered entities and business associates to comply with the modifications to the accounting of disclosures requirement beginning 180 days after the effective date of the final regulation. Furthermore, covered entities and business associates must provide individuals with a right to an "access report" beginning January 1, 2013, for electronic designated record set systems acquired after January 1, 2009, and beginning January 1, 2014, for electronic designated record set systems acquired as of January 1, 2009.

NEW HIPAA PRIVACY REQUIREMENTS

Increased HIPAA Enforcement Activities

DHHS also appears to be ramping up its HIPAA enforcement activities using the expanded civil monetary penalty enforcement provisions enacted in the HITECH Act. In late February, 2011, DHHS resolved two separate cases against covered entities for alleged HIPPA privacy violations. While neither case involved a Tribal health care provider, tribes may want to be aware that DHHS has become more serious about enforcing individual rights guaranteed by HIPAA.

In the first case, DHHS issued a "Notice of Final Determination" to Cignet Health of Prince George's County, MD (Cignet), imposing a civil money penalty of $4.3 million for violations of HIPAA and failure to cooperate with DHHS investigations. The HIPAA privacy regulations require that a covered entity provide a patient with a copy of her medical record within 30, and not later than 60, days of a request by the patient. Additionally, covered entities are required by law to cooperate with DHHS's investigations. DHHS found that Cignet violated 41 patients' rights by denying them access to their medical records when requested. This violation resulted in a civil money penalty of $1.3 million. DHHS also imposed an additional $3 million penalty for failure to cooperate with DHHS's investigations due to willful neglect.

In the second case, DHHS reached a "Resolution Agreement" with General Hospital Corporation and Massachusetts General Physicians Organization Inc. (Mass General) on February 24, 2011 for alleged violations of HIPAA. Under the Resolution Agreement, Mass General agreed to pay $1 million and to adhere to a three-year Corrective Action Plan (CAP), which requires the hospital to develop and implement a comprehensive set of policies and procedures that ensure PHI is protected when removed from Mass General's premises, to train workforce members on these policies and procedures, and to designate a Director of Internal Audit Services to serve as an internal monitor who will conduct assessments of Mass General's compliance with the CAP and render semi-annual reports to DHHS for a three-year period. The incident giving rise to the alleged violations occurred in March 2009 when a Mass General employee left documents on a subway train while commuting to work. The employee removed the PHI from Mass General for the purpose of working on the documents from home, and the documents were never recovered. They contained a patient schedule with names and medical record numbers for 192 patients, and billing encounter forms containing the name, date of birth, medical record number, health insurer and policy number, diagnosis and name of providers for 66 of those patients.

These enforcement actions highlight DHHS's view about strict compliance with the HIPAA privacy regulations, as well as the necessity of diligently and thoroughly cooperating with any investigation of alleged HIPAA violations.

Starla Roels is a partner with Hobbs, Straus, Dean & Walker, LLP in its Portland, Oregon office. Hobbs Straus was founded to represent and advance the interests of Indian and Alaska Native tribes and their people, and to promote and defend sovereign rights. Starla advises tribal clients on a wide range of health issues, including patient privacy and security of medical records under HIPAA, administration of tribal health facilities, Federal Tort Claims Act, and matters under the Indian Self-Determination and Education Assistance Act. She worked with the National Steering Committee of tribal leaders on the reauthorization of the Indian Health Care Improvement Act to develop legislative language and explore policy issues relating to tribal health facilities. She advises tribal clients on issues pertaining to Medicare/Medicaid and health care fraud and abuse, as well as the application of Medicare Like Rates in billing for contract health services. She also helps tribal clients with employment and personnel issues, as well as matters involving treaty fishing and native natural resources.

National Indian Health Board – American Indian/Alaska Native HITECH Center

Tom Kauley, NIHB REC Consultant

A recent article in the online addition of Indian Country Today stated, "While no way has yet been found to ensure that every Tribal interest or issue gets enough federal attention, coalition-building by like-minded Tribes has been one of the most successful strategies in recent times." The National Indian Health Board (NIHB) is successfully adept at building coalitions to improve health care outcomes for the Nation's American Indian and Alaska Native communities.

NIHB views health information technology (HIT) as a major development leading to improvements in healthcare for our Native People. As an organization, NIHB is poised to advocate for policy decisions that will produce optimal outcomes for deployment of health IT in Native communities. Through the initial collaborative efforts of NIHB staff working with Area Indian Health Boards and Regional Tribal Health Organizations, we are now placed with the collective responsibility and opportunity to establish and support a national HITECH Center to serve the health IT needs and interests of Native communities across the country.

Background

In 2010, the Office of the National Coordinator for Health Information Technology (ONC) funded 62 HITECH Regional Extension Centers (RECs) in every geographic region of the U.S. NIHB received a cooperative agreement award to establish the American Indian/Alaska Native (AI/AN) HITECH Center. While most RECs serve a single state, the AI/AN HITECH Center is the only national center serving tribes and urban Indian populations located in 37 states throughout the U.S. NIHB will need sustainable working partnerships with Tribes and Tribal Organizations, Urban Indian Organizations and the Indian Health Service (IHS) to make this project a success.

Tribal Organization Participation

The support of Area Indian Health Boards, Regional Tribal Health Organizations and Urban Indian health organizations is necessary:

- To obtain signed agreements with Providers in their service Area and work with these same Providers to develop plans for delivery of local HITECH Center services.
- To implement work plans and activities to support the implementation and use of Electronic Health Records by Providers in their service Area.
- To implement work plans and activities to ensure Providers in their service Area meet Meaningful Use standards in their use of Electronic Health Records.

Why Should Tribal Health Organizations Support AI/AN National REC Activities? In order to:

- Build local capacity to implement and manage health IT systems.
- Support development of local plans to meet health IT needs.
- Support implementation of local health IT service delivery structures.
- Develop local health IT workforce to serve future Tribal needs.

NIHB REC Progress and Successes to Date

NIHB staff has engaged in numerous activities to successfully operationalize the AI/AN HITECH Center. Some of these activities include:

<u>ONC-NIHB REC Operations Plan</u>

NIHB has produced and received ONC approval for our national AI/AN HITECH Center Operations Plan. The numerous components of this plan are designed to:

- Support implementation and use of certified Electronic Health Records by Providers in Indian Health Service/ Tribal/Urban Indian (I/T/U)

National Indian Health Board – American Indian/Alaska Native HITECH Center

health facilities.
- Support Providers in I/T/U health facilities to achieve Meaningful use of Electronic Health Records.

Participation in Health IT Conferences in Tribal Areas Across the U.S.

AI/AN HITECH Center staff have presented at joint Area Indian Health Board and IHS-sponsored Meaningful Use Conferences around the country. NIHB staff have also provided HITECH presentations at conferences that included Tribal representation in the Northwest, Western, Great Plains, Southwestern, Southern, and Eastern areas of the U.S. including Alaska. NIHB has also participated in Tribally-sponsored health conferences such as the Montana/Wyoming Tribal Leaders Health Conference last month and Urban Indian-sponsored health conferences such as the National Urban Indian Health Leadership Conference in DC in April.

Partnerships with Numerous Health IT-focused Organizations

As a HITECH Center that is national in scope and serving Tribes located around the country, it is imperative that we develop solid working relationships with numerous organizations focused on the successful delivery of health IT-related services. The AI/AN HITECH Center has initiated working relationships with the following contacts:
- Tribal Organizations
- State Regional Extension Center Staff
- State Medicaid Agency Staff
- Health Information Exchange Organizations
- IHS Area Office Staff
- IHS Electronic Health Record and Meaningful Use Teams

Health IT Workforce Partnership with American Indian Higher Education Consortium

A joint Tribal and IHS health IT advisory committee, recently listed "Health IT Workforce" as one of the highest priorities to serve Native communities. The AI/AN HITECH Center has initiated discussions with the American Indian Higher Education Consortium (AIHEC) to provide initial funds for the development of a Native Health IT Workforce Training Program in AIHEC's network of Tribal Colleges and Universities. This workforce development program will support the training of local health IT staff to provide future health IT services for local communities.

Provider Sign Ups to Receive NIHB REC Services

All AI/AN HITECH Center funds to support direct health IT services must be earned by meeting ONC Milestones 1, 2 and 3. Milestone 1 requires the AI/AN HITECH Center to obtain signed Provider Agreement Forms from IHS, Tribal, and Urban Indian health Providers to work with our Center. To date, 1,033 Primary Care Providers in more than 100 IHS, Tribal and Urban Indian health facilities across the country have signed up with the AI/AN HITECH Center.

Sub Recipient Agreements

One of the highest priorities of the AI/AN HITECH Center is to implement a plan to provide the maximum amount of funds to Sub Recipient Organizations to provide direct health IT services to Primary Care Providers serving their Tribal communities. Sub Recipient Agreements are currently being implemented with eligible Tribal Health Organizations to implement local HITECH Center services. Sub Recipient Agreements currently in process are listed below.

United South and Eastern Tribes (USET)
- USET Sub Award in place February 2011
  - Nashville Area REC Services
  - Nine-Area RPMS EHR and MU Team
- Alaska Native Tribal Health Corporation (ANTHC)
  - ANTHC Sub Award in place in June 2011
- California Rural Indian Health Board (CRIHB)

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NPAIHB REC PROPOSAL

By Don Head, WTDP Project Specialist

At the January QBM, the NPAIHB Delegates voted to allow NPAIHB staff to pursue the proposal to establish a Regional Extension Center (REC) here in the Northwest that would provide services to the Northwest Tribes in their goal of implementing and using EHR in a meaningful way. The proposal would be submitted to the National Indian Health Board (NIHB), from which the funding would flow, and need to be approved by the Office of the National Coordinator for Health (ONC).

The NPAIHB proposal was delayed until the Centers for Medicare and Medicaid Services (CMS) ruled on the tribal proposal to designate Tribal health centers as FQHCs for purposes of determining eligibility of providers to participate in the Meaningful Use program. Initially, CMS had determined that each provider at Tribal health centers would need to meet at least a 30% volume of patients they provided care to in order to be enrolled in Medicaid. In the Northwest, this would have meant that only approximately 18% of the providers would have been eligible to participate in the MU incentive program. That level of funding for the reduced amount of eligible providers would not be enough to sustain REC activities. This did not mean that the Northwest Tribes would not be provided technical assistance for EHR implementation; it just meant that NPAIHB would not have been the one to do so.

However, once the CMS reversed its ruling, the proposal went forward, and a draft was sent to Tom Kauley, NIHB REC Consultant, to determine readiness for submission to NIHB and ONC. Once NPAIHB addresses the points within the proposal that need clarification or adjustments, NPAIHB will officially submit the proposal. Generally, it takes about four to six weeks from the date of submission for the ONC to approve proposals, and once approved, NIHB will forward $100,000 to NPAIHB to begin Northwest REC activities. The initial outlay of $100,000 will be reimbursed back to NIHB through signing up providers that meet the three benchmarks for determined Meaningful Use of EHR. Currently, there are four staff members from NPAIHB that will work directly for the REC, Katie Johnson, PharmD, Katrina Ramsey, MPH, Chris Sanford and Don Head. Katie, newly hired as the Integrated Care Coordinator for the Board, will take the lead on Meaningful Use and the activities of the Northwest REC.

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- CRIHB Sub Award project/ budget under review by ONC
- California Area REC Services
- National Commercial-off-the-Shelf (COTS) Team

• Northwest Portland Area Indian Health Board (NPAIHB)

- NPAIHB Sub Award project/ budget in development

National Indian Health Board

The NIHB, is a 501(c)(3) non-profit organization, that advocates and works on behalf of all 565 federally-recognized Tribes in the development of national Indian health policy and improved health care. Since 1972, the NIHB has advised the U.S. Congress, Indian Health Service (IHS) and other federal agencies in addition to private foundations on health care issues involving American Indians and Alaska Natives (AI/AN). NIHB staff maintains communication with Area Indian Health Boards, national and regional Indian organizations, and Tribes to ensure their participation and voice is maintained in national health policy decisions.

NEW FACES AT THE BOARD

Rachel Ford was hired by the NPAIHB in January to fill a new position, Public Health Improvement Manager. She is working on the CDC's National Public Health Improvement Initiative project aimed at increasing performance management capacity and improving the ability of public health departments to meet national public health standards. The Board's focus will be directed at providing education and technical support to increase the organizational capacity of its 43 member tribes. Rachel's work will include the facilitation of access to Quality Improvement (QI) education and training, whether from NPAIHB programs or outside sources, promoting the integration of a "QI culture" into tribal health departments, as well as linking quality improvement with public health accreditation.

Rachel grew up in the Columbia Gorge area, living on both sides of the Columbia River, but spending most of her years in Skamania County. After graduating high school in 1995, she went to the University of Oregon and in 1999 attained her Bachelor of Arts degree in Psychology and Business Administration. At that point she moved to Portland working a variety of service and health related jobs, and was most recently employed with Tualatin Valley Fire & Rescue while working on her graduate degree. Last year she received her Master of Public Health degree from Portland State University. She is excited to be integrating her education and life experiences into her work with the 43 tribes of Idaho, Oregon and Washington.

Katie Johnson was born and raised in Dodge City, Kansas (yes, it is a real town). She went to the University of Kansas to study pharmacy and play softball for the Jayhawks. Her husband is also from Kansas, and they moved to Madras, Oregon right out of college in 2004 where Katie completed a pharmacy practice residency at Warm Springs Health and Wellness Center. In 2005, they moved to Whiteriver, AZ where Katie worked at Whiteriver Indian Hospital. They've spent the last 6 years in Arizona, exploring and enjoying the Southwest and starting a family. They have 2 little girls and Katie's husband quit his job as a school teacher to stay home with the kiddos. They love the outdoors and are very excited to be back in the Pacific Northwest.

STAGE 1 MEANINGFUL USE MEASURES FOR ELIGIBLE PROFESSIONALS

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Important note regarding Certified EHRs and Meaningful Use Measures:

In order to have a certified EHR, each vendor had to demonstrate that they were able to report out on a minimum number of measures, not on all of the measures. Please check with your EHR product vendor to find out which measures your certified EHR is able to report on.

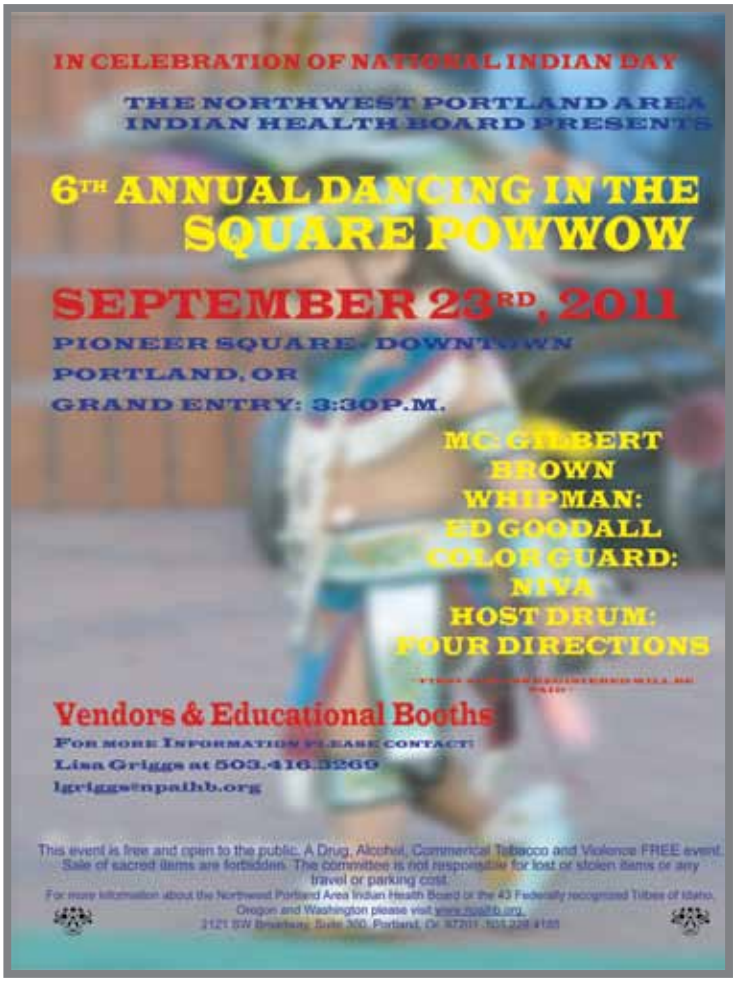
This information was adapted from the Centers for Medicare and Medicaid website on EHR Meaningful Use Overview. For more information regarding Meaningful Use requirements, please go to: http://www.cms.gov/ncentivePrograms/30_Meaningful_Use.asp

Rosario Arreola Pro is the Health Systems Development Director of the Sacramento-based California Rural Indian Health Board, Inc. (CRIHB). CRIHB is a network of Tribal Health Programs that are controlled and sanctioned by Indian people and their Tribal Governments founded in 1969. CRIHB provides Program Development, Legislation and Advocacy, Organization Development, Financial Resources Management, Training and Technical Assistance, and Networking and Consensus-Building. Ms. Arreola Pro has spent over 10 years working in the non-profit health care sector in program planning and development and is committed to increasing access to health care resources to medically underserved communities.

In her current position, Ms. Arreola Pro currently oversees a variety of technical assistance initiatives supporting member rural tribal health programs throughout California, including: pharmacy, dental, electronic health records implementation, IT, health information management support, and serves as the Project Director of the National Indian Regional Extension Center in CA.

Most recently, Ms. Arreola Pro has been working with various stakeholders throughout California and the Indian Health Service to bring better understanding of the Medicare and Medicaid Electronic Health Record Incentives program to tribal health programs and increasing awareness of EHR Meaningful Use and its impact in Indian Country.

Ms. Arreola Pro holds a Bachelor of Arts in Molecular and Cell Biology from the University of California at Berkeley and a Master of Public Health from Columbia University.



UPCOMING EVENTS

JULY

July 18 - July 30
CHR Basic Training Course
Airway Heights, WA

July 25 - July 30
CHR Refresher Training Course
Airway Heights, WA

AUGUST

August 1 - August 4
IHS/BIA/BIE/SAMHSA Action Summit for Suicide Prevention
Scottsdale, AZ

August 3 - 4
Native Fitness VIII
Beaverton, OR

August 15 - August 19
2011 Nurse Leaders in Native Care Conference
Albuquerque, NM

August 16 - August 18
Direct Service Tribes National Meeting
Nashville, TN

August 22 - August 23
CDC/ATSDR Tribal Advisory Committee
Suquamish, WA

August 24
CDC/ATSDR 7th Bi-annual Tribal Consultation Session
Suquamish, WA

August 24 - August 25
NEW IHS Tribal Self-Governance Training
San Francisco, CA

SEPTEMBER

September 5
Federal Holiday - Labor Day

September 26 - September 29
NIHB 28th Annual Consumer Conference
Anchorage, AK

September 23
2011 6th Annual Indian Day Celebration
Downtown Portland, OR

OCTOBER

October 10
Federal Holiday - Columbus Day

October 11 - October 12
IHS TSGAC and DOI SGAC Meeting
Washington, DC

October 16 - October 20
Intensive Case-Based Training in Palliative Care Conference
Rochester, MN

October 30 - November 4
NCAI 68th Annual Convention
Portland, OR

October 30 - November 2
2nd Annual Sprirt of Giving Conference
Portland, OR

NOVEMBER

November 2
National American Indian and Alaska Native Heritage Month Event
Washington, DC

November 11
Federal Holiday - Veterans Day

November 24
Federal Holiday - Thanksgiving Day

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NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD'S APRIL 2011 RESOLUTIONS

RESOLUTION #11-03-01
Comprehensive Center of Excellence

RESOLUTION #11-03-02
Dietary Influence on the Human Health Effects

RESOLUTION #11-03-03
Sexual Assault Training Program

RESOLUTION #11-03-04
Support for Renewal of NW EpiCenter

RESOLUTION #11-03-05
President Obama to Amend and Reissue Executive Order 13175; or Clarifying Tribal Concerns through a Statment of Administrative Policy

RESOLUTION #11-03-06
Recommend HHS Secretary and STAC Evaluate AI/AN Health Disparities in Healthy People 2010 and use Finding to Develop Action Plan for Healthy People 2020

RESOLUTION #11-03-07
Cancer BRFSS Project