



Office of Vermont Health Access,  
Division of Health Care Reform

State of Vermont General  
Assembly

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## **Health Information Technology Payment Reform Workgroup**

**Final Report - August 31, 2009**

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## Executive Summary

### *Purpose*

House Bill 441 Sec. E.102.1 of the 2009-2010 General Assembly<sup>1</sup> charged the Commissioner of Information and Innovation with the responsibility to convene a workgroup to “explore ways to use and fund health information technology to achieve health care payment reform in this state.” The bill required the workgroup to consider the use of smart card technology and other mechanisms that could potentially enable real-time eligibility determinations and claims adjudication within a health care professional’s office or hospital. The bill further required that the workgroup identify potential sources of funding, develop one or more proposals for grant funding (including ARRA), and create an implementation plan for initiatives identified for further action by the group. The bill required the workgroup to submit its final report to the General Assembly by August 31, 2009. Pursuant to that bill, the Commissioner established the Health Information Technology Payment Reform Workgroup, which met a number of times throughout the summer.

### *The Problem Statement*

The current system of checking health insurance eligibility and processing health care claims consumes significant resources at the provider practice level. Today, eligibility verification and claims adjudication processes require patients to present and providers to verify and process information for every individual patient-provider interaction with their particular insurance company or companies. This ultimately results in providers employing people or contracting with third party firms in order to communicate back-and-forth with one or more insurance carriers each and every time a patient presents for treatment. This process is laborious and time consuming for the medical practices, the patients, and the insurance companies.

### *Our Current System*

Today our health care payment system does not operate as efficiently as it does in other sectors. In evidence of this assertion the workgroup presents the following facts:

1. Health care costs including administrative costs, are rising at an unsustainable rate. Any effort that we can make to reduce unnecessary costs related to administration will not only reduce costs but also increase time available to focus on clinical concerns.
2. The patient – Today, when an insured patient makes an appointment, receives a service, and departs from their physician’s office with care instructions and/or a prescription to be filled at the local pharmacy they rarely know how much it costs or what they are responsible for. Most people do not know what the coinsurance amount, if any, will be

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<sup>1</sup> The full text of H. 441 Sec. E.102.1 can be found in appendix number one.

or what the remaining deductible is. This is because today's system adjudicates claims after the patient has left the office and gone home.

3. The provider – Today, when an insured patient makes an appointment, receives a service, and departs from their office the provider rarely knows if that patient is eligible for the services delivered without undertaking a manual process to verify eligibility. This process today requires a provider to submit patient information one at a time over the web, to call an eligibility verification line specific to the insurer, or to submit an electronic eligibility verification inquiry directly to the insurer. The provider rarely knows how much they will be paid for the services provided. This is not known until hours, days, weeks, and in rare instances months later because today's claims adjudication system is batch based and retrospective.
4. The insurer – Today, when an insured patient makes an appointment, receives a service, and departs from their physician's office the insurer rarely knows what services have been provided. It is not until hours, days, weeks, and in rare instances months later when a request for payment is received from the provider that the insurance company knows that one of their insured has received specific services and that a claim is adjudicated allowing payment to be made.
5. This system is inefficient for patients, providers, and payers primarily because it does not provide real time transparency and consistency that is routinely provided in other sectors of our economy.

### *Vision*

Based on these facts, the workgroup agreed that the vision for a statewide initiative would be to reduce administrative costs through the provision of a comprehensive point-of-service eligibility and electronic adjudication of health care claims using a token based system and starting in physician offices/ambulatory care centers.

The workgroup chose to focus its work, as a starting point, on physician offices/ambulatory care centers (not on hospital settings). The workgroup committed significant time to understanding the current system which we will call the "as is" process and its impacts on patients, providers and payers and devoted substantial time to forming the vision of a future system which we will call the "to be" process. The workgroup recommends that a number of important activities be undertaken as the next steps in the implementation process. These items include:

- Producing a thorough report on the current administrative costs for Vermont's healthcare expenditures to provide a basis for evaluation of the effectiveness of this process improvement.

- Conducting comprehensive research on the use of real time eligibility and claims adjudication systems in other parts of the country.
- Completing a thorough analysis of the differences between Vermont's current state and the vision.

### *Recommendations*

The workgroup deliberated in full group meetings and in subgroup meetings to determine realistically achievable goals within the given timeframe, the next steps, and at length regarding the current "as is" workflows and the ideal "to be" workflows. The workgroup concluded:

1. The State of Vermont should move forward with the planning necessary to implement a statewide initiative that will reduce administrative costs through the provision of a comprehensive point-of-service eligibility and electronic adjudication of health care claims using a token based system and starting in physician offices/ambulatory care centers.
2. Any implementation planning on a statewide level requires broad and representative participation. In the 7-week timeframe, the process was not as inclusive as necessary for the implementation planning process. The workgroup recommends a staged implementation process including; a planning process that includes a complete literature review and a thorough contemplation of the solution that includes a gap analysis and, that the first stage of implementation begin operations within six months of project inception. The workgroup further recommends that the following groups must be represented in addition to those already present on the workgroup.
  - a. Providers must be well represented, not by surrogates but in person.
  - b. All of the major insurance carriers must be represented.
  - c. Practice Managers as well as clinicians must be part of the process.
3. The implementation planning process should be focused on the creation of a central exchange for the adjudication of eligibility and claims information in real time at the point-of-service.
4. The exchange should be based on the principal that it is closed. This means that the information moves from point-to-point and is not available to third parties without substantial protections and secondary policies developed for the release of information. The exchange must meet all applicable federal and state privacy and security standards.
5. All work in this regard should be aligned with any ARRA/Stimulus requests for funding that are made by the State of Vermont.

6. The messaging for eligibility transactions should be compliant with HIPAA standards for electronic eligibility and response and the messaging for claims adjudication should be compliant with HIPAA electronic claims submission and remittance advice standards.
7. Taking into account the immediacy of ARRA funding with regards to real time eligibility verification and real time claims adjudication and the importance of assigning responsibility to an entity of state government, responsibility for this project, to the extend funding is made available, should be vested within the Office of Vermont Health Access/Health Care Reform, in collaboration with Vermont Information Technology Leaders (VITL).

The workgroup was able to make significant forward progress in planning for real time eligibility verification and real time claims adjudication and is able to make recommendations based on the substantial work review that has been accomplished. The workgroup further recommends that the immediate next steps include the identification of specific sources of funding (beyond ARRA funding), and the development of grant funding proposals (in coordination with overall health care reform and as specifics surrounding the stages necessary for a successful implementation become available).

#### *The Workgroup composition*

House Bill 441 Sec. E.102.1 of the 2009-2010 General Assembly<sup>2</sup> created the Workgroup. The law established the members of the workgroup<sup>3</sup> as follows:

- (1) The commissioner of information and innovation.
- (2) Two members of the Vermont general assembly, one appointed by the speaker of the house of representatives and one appointed by the president pro tempore of the senate who shall jointly chair the work group.
- (3) The secretary of administration or designee.
- (4) The director of the office of economic stimulus and recovery.
- (5) The director of the office of Vermont health access or designee.
- (6) A representative from the Vermont Information Technology Leaders, Inc.
- (7) A representative from First Data.
- (8) A representative from IBM.
- (9) A representative from each of the three largest health insurers licensed to do business in Vermont.
- (10) Other interested stakeholders, such as health care professionals, hospitals, and academic institutions.

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<sup>2</sup> The full text of H. 441 Sec. E.102.1 can be found in appendix one.

<sup>3</sup> A listing of workgroup participants can be found in appendix two.

## Introduction

House Bill 441 Sec. E.102.1 of the 2009-2010 General Assembly<sup>4</sup> charged the Commissioner of Information and Innovation with the responsibility to convene a work group to “explore ways to use and fund health information technology to achieve health care payment reform in this state.”

The Health Information Technology Payment Reform Workgroup is required to:

- (1) Explore opportunities for using health information technology to achieve health care payment reform in Vermont, including consideration of the use of smart card technology and mechanisms to enable real-time eligibility determinations and claims preparation, submission, and adjudication at a health care professional’s office or a hospital.
- (2) Identify potential sources of funding, including grants and other federal funds.
- (3) Develop one or more proposals for appropriate grant funds, including those available under the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5.
- (4) Create a working plan for implementation of the health information technology payment reform initiatives identified for further action by the work group.

Finally, the law requires that the workgroup submit its recommendations to the Joint Fiscal Committee no later than 90 days after the effective date of the act, August 31, 2009.

The workgroup was convened on July 8, 2009. At the first meeting the group established meeting times and organized to produce recommendations in the 7 week timeframe allowed. Meetings were scheduled for July 22, 2009 and August 26, 2009. At the July 22, 2009 meeting both a group Vision and Goal were discussed and agreed to and two subgroups were established in order to facilitate the development of workflows explaining the “as is” and “to be” environments.<sup>5</sup> First Data presented a webinar on July 17, 2009.<sup>6</sup> A second webinar was held where IBM demonstrated proposed workflows and system architecture that could be put in place in Vermont. The IBM demonstration was held on July 29, 2009.<sup>7</sup> The “as is” and “to be” subgroups each met two times on August 10<sup>th</sup> and 14<sup>th</sup>. At these meetings the “as is” subgroup examined in detail the workflows associated with the current process for verifying eligibility and the current process for adjudicating claims. During the “to be” meetings the subgroup discussed detailed examples of what is and is not working in the system today and outlined what a new process would offer to providers, patients, and payers.<sup>8,9</sup> The following represent the agreed upon Vision and Goal of the workgroup:

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<sup>4</sup> The full text of H. 441 Sec. E.102.1 can be found in appendix one.

<sup>5</sup> A listing of the participants in the “as is” and “to be” subgroups can be found in appendix two.

<sup>6</sup> The First Data webinar is included in appendix 16.

<sup>7</sup> The IBM webinar is included in appendix 14.

<sup>8</sup> The meeting minutes for all workgroup and subgroup meetings are included in appendices seven through thirteen.

<sup>9</sup> The handouts from each meeting of the workgroup and the subgroups are included with the corresponding meeting minutes in appendices seven through thirteen.

The Vision of the work group is the implementation of a statewide initiative that will reduce administrative costs through the provision of a comprehensive point-of-service eligibility and electronic adjudication of health care claims using a token based system and starting in physician offices/ambulatory care centers.

The Goal of the work group is to deliver a report by the end of August that describes the vision and details the specific opportunities and potential barriers to implementing it. The report will outline next steps for the implementation of the first stage within the initial six months after project inception and the continued implementation planning process for a statewide rollout.

Using the Vision and Goal as guides for the meetings the workgroup carefully considered its ability to make sound recommendations on all the fronts envisioned by the legislation within the allotted time. To that end, the workgroup made some decisions that focused the scope of work completed. Specifically, the workgroup choose to:

1. Focus on physician offices/ambulatory care centers and not on hospitals for the first stage of the implementation planning process.
2. Exclude Workers Compensation from consideration and inclusion during the six-week review. However, the workgroup recommends the inclusion of Workers Compensation in the longer planning process.
3. Postpone the identification of funding sources and the development of proposals until such time as the overall health care technology plan is submitted to federal authorities under ARRA guidelines. The workgroup determined that the best course of action was to align both the pilot and the planning process for Real Time Eligibility Verification and Real Time Claims Adjudication with the State of Vermont submission under the Health Information Technology provisions contained within the federal ARRA legislation. Therefore, immediate responsibility for this initiative should be placed within The Office of Vermont Health Access/Health Care Reform to assure a coordinated application to the federal government.

## **Vermont's Health Care Reform**

From groundbreaking universal coverage legislation to a publicly funded Health Information Exchange (HIE) network supporting a transformative primary care medical home and community health team infrastructure, Vermont is recognized nationally as a leader in Health Care Reform. From the Healthiest State in the Nation with the highest immunization rates among children to one of the earliest and most expansive public children's coverage initiatives in the land, Vermont has been in the forefront of health care reform for two decades. In the past two years Vermont has merged the Office of Health Care Reform with the State's Office of Vermont Health Access, the state's Medicaid and public health insurance programs office. This

merger has centralized responsibility for all aspects of Health Care Reform, including oversight and coordination of HIT planning and policy implementation.

Vermont's accomplishments include:

1. reducing the percentage of the population that is uninsured from 9.8% in 2005 to 7.6% in 2008,
2. authorizing and funding a single statewide Regional Health Information Organization (Vermont's Information technology Leaders - VITL) and empowering that organization to build and maintain the single Health Information Exchange (HIE) for the state and to support the proliferation of Electronic Health Records (EHR) within primary care physician offices,
3. funding the only state-wide multi-insurer chronic care disease prevention and care coordination initiative that combines performance driven financial reform realigning payment incentives, subsidies to community based, multi-disciplinary care support teams, delivers shared health information technology solutions to community health teams and local physicians offices, and connects front end delivery and payment change to true evaluation in order to measure effective change at the community and state-wide levels,
4. passing legislation that places statutory authority for planning and oversight of state HIT-HIE within the Office of Vermont Health Access and incorporating authority for review of ONC, HRSA, AHRQ, & HHS HIT related grant submissions within the Office.
5. passing legislation authorizing BISCHA to implement the Vermont Healthcare Claims Uniform Reporting & Evaluation System that collects, consolidates, and analyzes eligibility and claims data for Vermont residents enrolled in comprehensive health benefit plans.
6. enacting legislation in 2003 that required the annual production of the Health Resource Allocation Plan by the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA). This document is a treasure trove of comprehensive information on Vermont's health care system. As such it is a core resource in developing public health care policy. The HRAP can be distilled down to two basic requirements;
  - a. "the HRAP legislation requires an inventory of specified services: hospital, nursing home, and other inpatient services; home health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services, including primary care resources,

federally qualified health centers, and free clinics; major medical equipment; and health screening and early intervention services.”<sup>10</sup>

- b. “the enacting legislation requires that the HRAP contain recommendations for the appropriate supply and distribution of health care services, as well as options for implementing such recommendations.”<sup>11</sup>

All of the collaborative and unifying work that has come before provides Vermont with a superb vantage point from which to identify opportunities to leverage multiple health care system opportunities making the potential for demonstrable transformation a realistic goal on a state-wide basis. It is with this in mind that the workgroup embarked on the review required and it is with the knowledge of what has heretofore been accomplished that the workgroup crafted the recommendations contained in this report.

## Vermont Demographics

Vermont is a small state with just over 630,000 residents. The entire health care system is a \$4.2 billion dollar industry. The state’s public health insurance programs provide primary coverage to 16% of the population. Private insurance provides primary coverage to 59.9% of Vermont residents. Medicare represents primary coverage for 14.2 percent of Vermonters. The uninsured make up 7.6% of Vermonters and military coverage represents 2.4% of all covered Vermonters<sup>12</sup>. The state has fourteen (14) Community Hospitals. In addition to these institutions Dartmouth Hitchcock Medical Center resides in New Hampshire on the Vermont boarder and represents 14% of all Vermont resident discharges’<sup>13</sup>.

“In 2006, the most recent year for which data is available, 1,730 physicians provided patient care in Vermont, including 1,680 medical doctors and 50 doctors of osteopathy for a total of 1,240 full time equivalents (FTEs)...”<sup>14</sup>

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<sup>10</sup> Health Resource Allocation Plan, July 2009, page 2

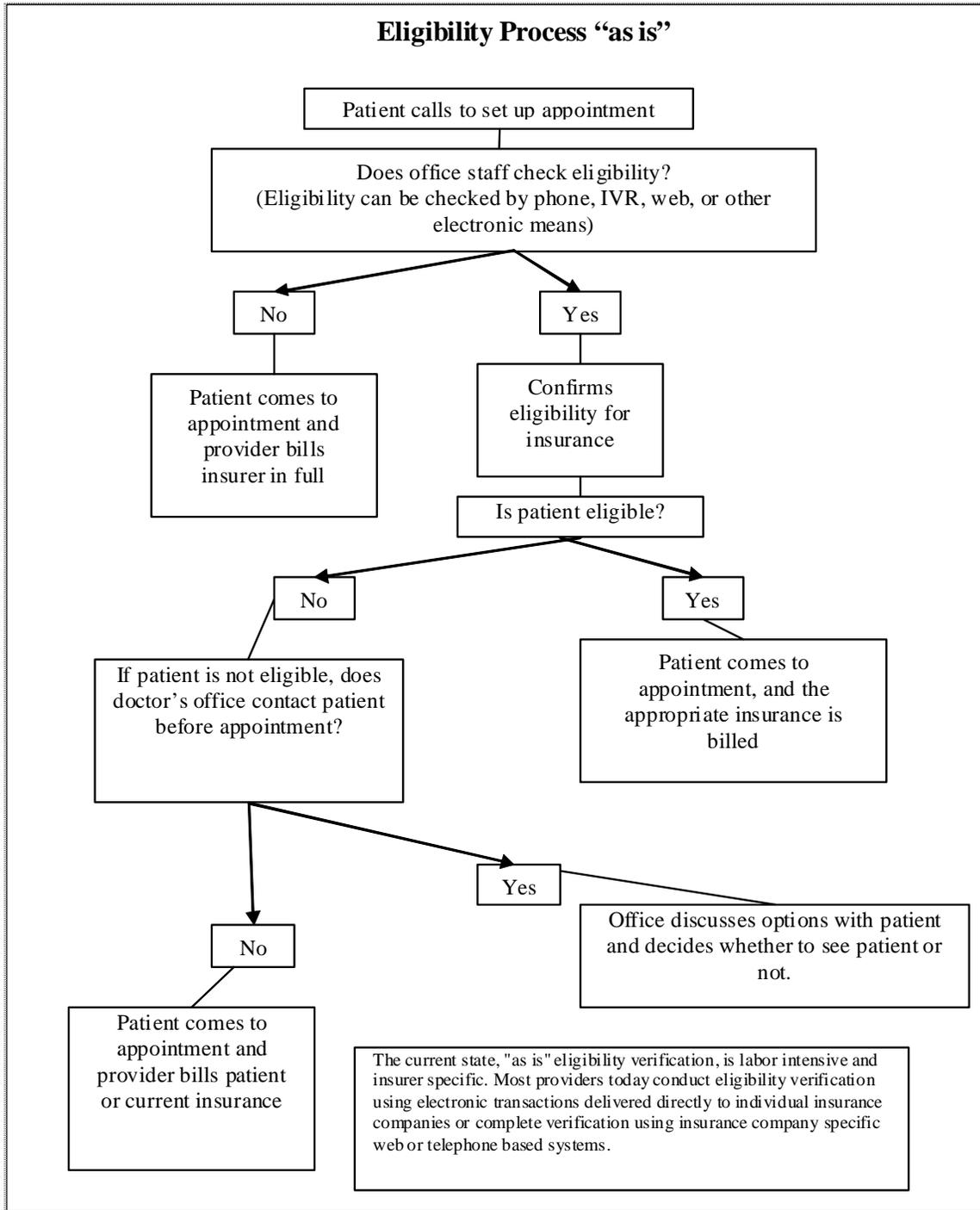
<sup>11</sup> Ibid.

<sup>12</sup> 2008 Vermont Household Health Insurance Survey

<sup>13</sup> Health Resource Allocation Plan, July 2009, page 58

<sup>14</sup> Health Resource Allocation Plan, July 2009, page 21

## Vermont's "as is" Environment - What is going on today - eligibility



It is a fact that eligibility verification is not required at the point-of-service in Vermont today. However, according to recent Medicaid information less than one percent of claims are denied based on an individual receiving the service being ineligible for coverage. Current Medicaid

information available at the time of this writing would further indicate that just one percent of all eligibility verifications that are processed are done via the existing Voice Response system. To complete the picture, it is true today in Medicaid that 66% of all eligibility transactions are received via the Web and 33% are received electronically utilizing HIPAA compliant 270/271 transactions. It is interesting to note that over 80% of Medicaid providers verify eligibility. It is further interesting to note that of the Vermonter's receiving medical treatment that was paid for by Medicaid that over 80% of them had eligibility verification run by their provider.<sup>15</sup>

According to BCBS from Jan 1, 2009 through June 30, 2009 there were 126,819 eligibility inquiries via the web. Those inquiries were from 615 different provider practices. BCBS received 1,833 eligibility inquiries via the phone from Jan 2009-June 2009.

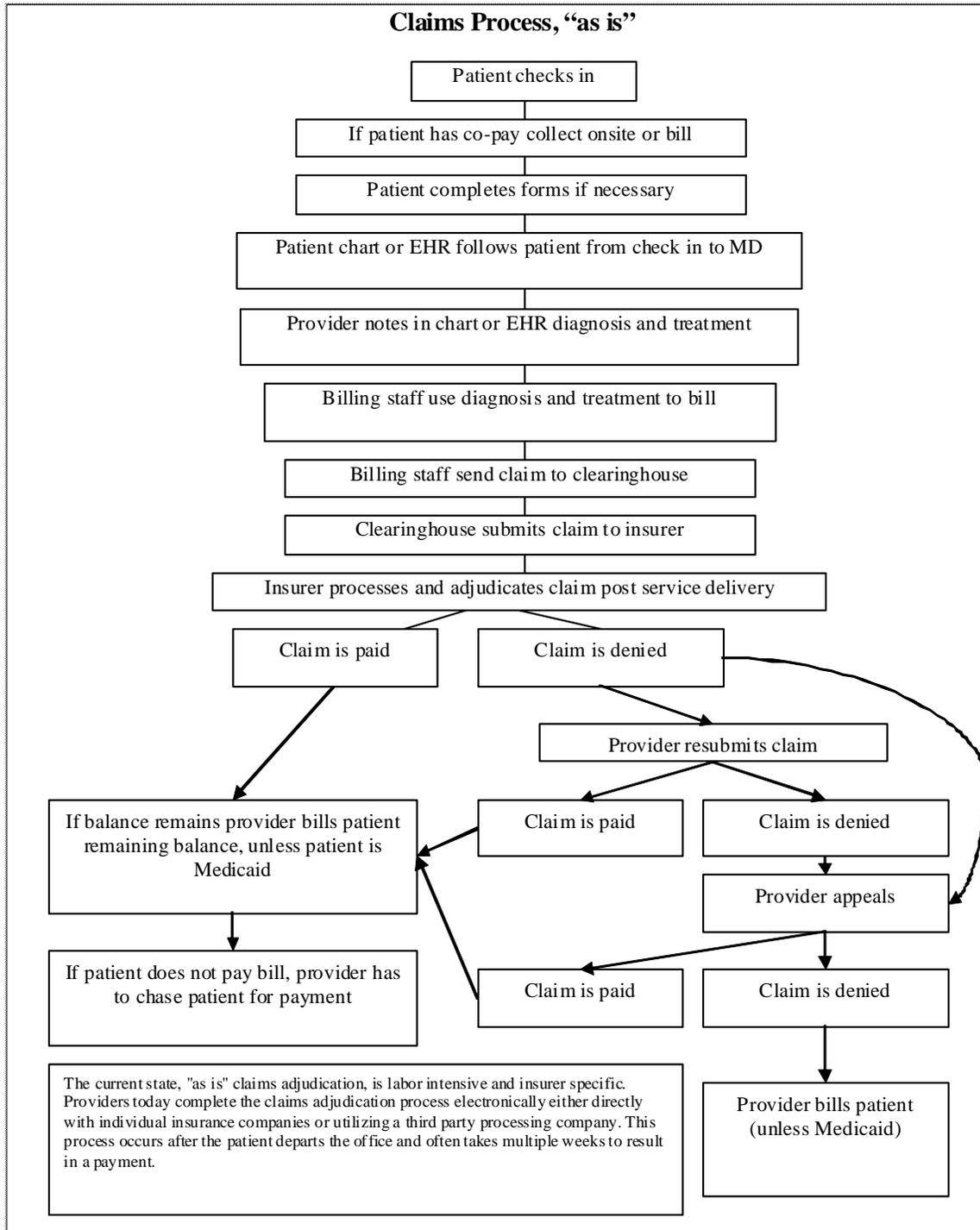
From the data above it appears as though denial of coverage based on eligibility is not a significant issue at this time (at least based on the available Medicaid and Blue Cross of Vermont information). This said it is true that only a small minority of providers beyond the largest institutions and practice settings utilize automated electronic means to verify eligibility. Finally, it is true in only a handful of instances where electronic verification is in place today that it is fully integrated into the practice management system within the office.<sup>16</sup> Therefore, there is a significant opportunity to increase the efficiency with which eligibility is verified.

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<sup>15</sup> During the most recent four week period 1,805 providers provided services to Medicaid beneficiaries and 1,495 of those providers ran eligibility verification on the individuals for whom they provided services (83%). During the same four week period 45,803 unique individuals received services and of those 38,169 had their Medicaid eligibility verified (85%). Email communication from Medicaid 8-20-2009.

<sup>16</sup> According to MBA Healthgroup there are two practices currently using I-Verify, a third party service that is bundled with AllScripts Practice Management System, to accomplish electronic verification of eligibility. These practices have been using this system for less than three months.

Vermont's "as is" Environment - What is going on today - claims



In Vermont today, as in the vast majority of the country, claims are processed by insurers on a batch basis. That is, they are submitted at a point in time by providers and are processed en masse by the insurer. This process works differently for each insurer. It has resulted in an industry that batches and submits claims for small providers and in significant administrative capacity being built within larger providers to accomplish the submission, adjudication, and payment process. Since each insurer has its own series of requirements the claims must be batched from individual providers to individual insurers. This is time consuming and labor intensive. The best automated systems available today nonetheless require manual intervention on a significant minority of claims.

While Vermont does not have a current estimate of unnecessary administrative costs in the system, since at least 2006 there have been state-wide comprehensive efforts to address the “frustration and unnecessary costs resulting from the health insurance claims administration system.”<sup>17</sup> In a report to the Legislature issued January 15, 2008 the Common Claims Workgroup made multiple recommendations around process improvements across the spectrum of claims administration that were intended to improve efficiency and lower administrative costs. In 2009 the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) created the Vermont Claims Administration Collaborative (VCAC) to implement the multiple recommendations. Their current work plan<sup>18</sup> includes eight different changes that are in the process of being implemented. However, all of the foregoing activities are incremental in nature and work within the boundaries of the existing system. Taken in their best light they make the current system more efficient and transparent than it is today but they do not hold the hope of transforming the current system in any truly meaningful way.

Our analysis of the current system for eligibility verification and claims adjudication leads to the following conclusions:

1. Health care costs including administrative costs, are rising at an unsustainable rate. Any effort that we can make to reduce unnecessary costs related to administration will not only reduce costs but also increase time available to focus on clinical concerns.
2. In the health care system services are often provided without knowledge by the provider regarding who is ultimately responsible for payment. Conversely, services are often provided without knowledge by the Insurance Carrier that they are occurring.
3. Services are provided without knowledge regarding the final payment amount that will be received by the provider. In the same vein services are provided without knowledge by the purchaser (the patient) as to their ultimate liability for the service.

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<sup>17</sup> Memo to the Members of the Commons Claims Work Group from Commissioner Paulette J. Thabault, February 28, 2008 (included in appendix number three)

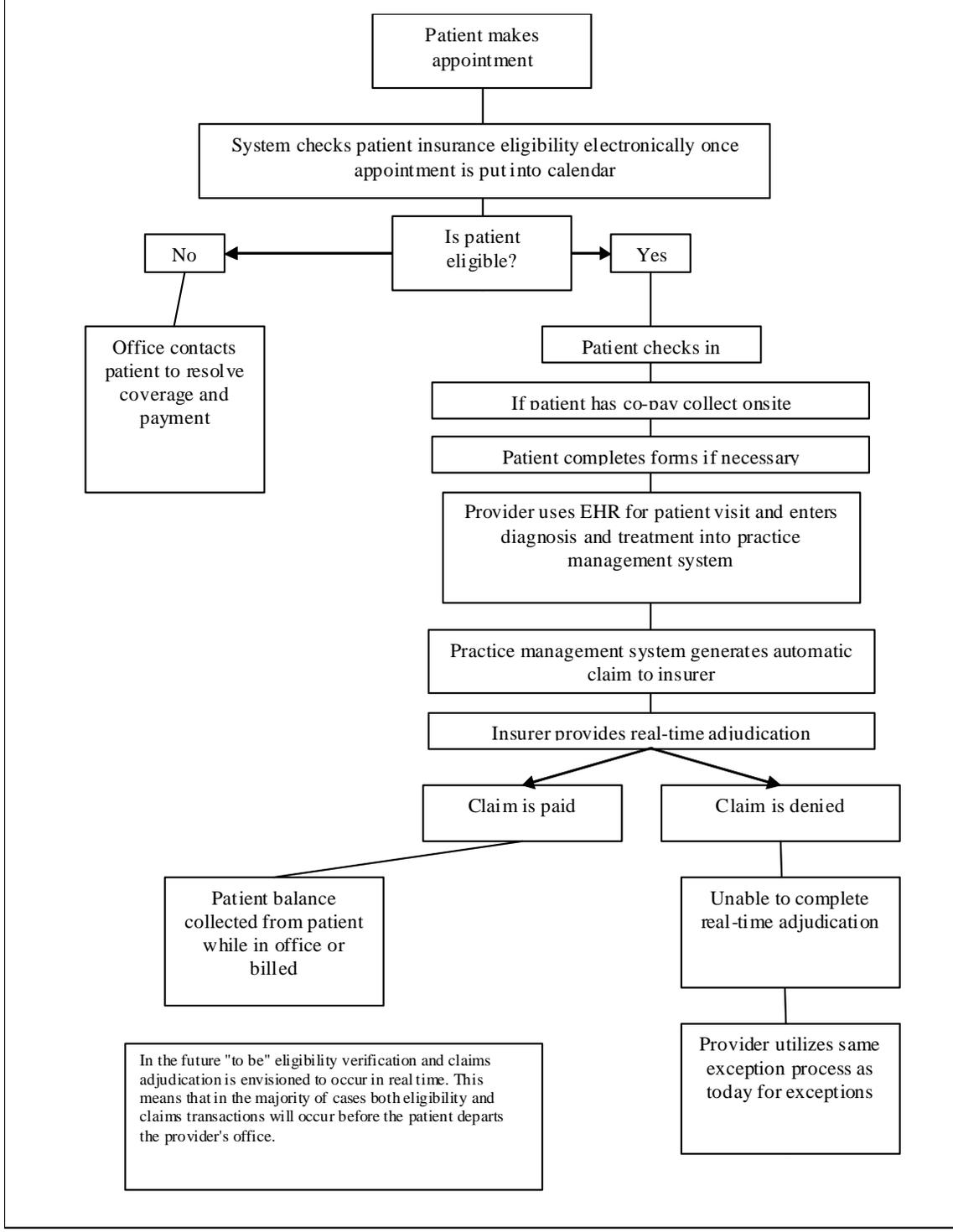
<sup>18</sup> Vermont Claims Administrative Collaborative Workplan 2008-2009 (included in appendix four)

4. While many claims are paid in a timely manner, some claims are paid weeks and even months after they are provided. The payments come in multiple forms, from different sources, and over an extended period of time.
5. This system is inefficient for patients, providers, and payers primarily because it does not provide transparency and consistency that is routinely provided in other sectors of our economy.

### **“To Be” Vision**

The vision of the workgroup is the implementation of a statewide initiative that will reduce administrative costs through the provision of a comprehensive point-of-service eligibility and electronic adjudication of health care claims using a token based system and starting in physician offices/ambulatory care centers.

### “to be” Claims and Eligibility



The gains from the vision are assumed to impact providers, patients, and payers all in positive ways. However, there are complex interrelationships throughout the health care system and initial assumptions are often confounded once details are revealed. Because of this perpetual issue in health care the workgroup has determined that a staged implementation is necessary in order to provide a transparent and inclusive process that moves the state forward and leverages available funding sources. This section will describe the above graphic which lays out, at a very high level, the ideal “to be” state. This paper will not delve into all the details that will need to be fully explored during the implementation planning process. The basic premise is a simple one:

*Make the system more transparent, work in real time, and become standards based and it will become more efficient.*

The ideal “to be” state in its simplest form accomplishes two things;

1. it assures eligibility for services prior to or at the time of service, and
2. it provides transparency in coverage, pricing, and liability for payment at the time of service delivery.

The ideal “to be” state attempts to achieve the above by moving the point at which information is known to all parties, payers, patients, and providers from post ambulatory care visit to point-of-service. This change in the point at which information is available in our current fee-for-service system is accomplished by using a token-based system and creating a centralized hub for the real-time exchange and settlement of eligibility and claims related transactions. This can be accomplished using a centralized system akin to the Health Information Exchange in operation today in Vermont. Without getting too technical, the concept is that within the current HIPAA compliant framework eligibility can be electronically verified by transmitting a compliant 270 eligibility request from existing practice management systems to the hub and thence to the appropriate insurer. The insurer then returns a HIPAA compliant 271 electronic eligibility response message to the hub and thence to the practice management system. On the eligibility side there are existing third party software options that integrate with existing practice management systems and provide this service today. When we move to the claims side of the equation, the side where more opportunity may exist to create efficiencies, the process can quickly become very complex. For the purposes of our conversation here we will keep it very simple. The concept is essentially the same as in the eligibility use case above; the practice management system produces a HIPAA compliant 837 claims submission and delivers it to the hub and thence to the insurer. The insurer receives and processes the 837 and returns a HIPAA complaint 835 electronic remittance advice to the hub and thence to the practice management system. Because there are multiple practice management systems and multiple payers in the

marketplace a centralized hub facilitates the delivery and translation of messaging across multiple platforms.

While the claims adjudication side of this exercise becomes complicated by medical reviews, non-covered services, out-of-network providers, and other not insignificant issues it remains true that the majority of all claims received today by an insurer electronically pass through the system and are approved for payment upon presentation without any delays. In all of these instances a system such as the one described above would allow the payer, patient, and provider to all know their liability and payment amounts, respectively instantly instead of weeks after the point-of-care delivery. Additionally, the ideal “to be” state would allow the majority of all claims to pay in a matter of one or two days instead of the current average of 2-4 weeks (depending on insurer, plan, and provider). All of this is accomplished using a few key principles:

1. a centralized Hub;
2. transparency;
3. compliance with HIPAA compliant electronic submission standards, and
4. alignment with ARRA requests and overall Health Care reform planning.

### **Examples from other parts of the country**

During the summer process the Workgroup identified a number of other states where activity around Real Time Claims Adjudication and Real Time Eligibility Verification is occurring. In Florida, South Carolina, Ohio, and Minnesota there are efforts in different stages of planning and implementation.

One of the next steps will be to conduct a full literature review and to identify examples of what is being planned and implemented in other parts of the country. This information should be presented in detail to the full planning group during the full implementation planning process.

As one example of the value that could be derived from a comprehensive review we cite here the report produced by the State of Ohio earlier this year. Ohio passed legislation allowing for a six month process to review and make recommendations regarding real time claims adjudication and real time eligibility verification. In the executive summary of the final report produced by the Ohio group they began by qualifying their work as follows;

“The Advisory Committee focused on the issues surrounding the exchange of eligibility information rather than real time claim adjudication. Creating standard rules for simple transactions such as the exchange of eligibility information is a necessary first step to address more complicated claim

adjudication transactions. Given the current state of electronic communications in the healthcare sector, it was premature to focus on real time claim adjudication.”<sup>19</sup>

The complexities of the issues “to be” addressed demand a careful, comprehensive, inclusive, and transparent process.

## **Implementation Planning Phase**

There are a number of important questions to consider during planning process. Below are listed a number of those questions, in no particular order of priority:

- What percentage of health care spending in Vermont is attributable to administrative costs in the system? Of that administrative spending, what percent is potentially avoidable based on system improvements and simplifications?
- Are eligibility problems related to actually verifying and does POS system improve it? Or are there underlying issues (e.g., Medicaid churn or employer delay in reporting change in employee status to carriers) that have greater impact on provider practices?
- If able to do for part of the system (e.g., Medicaid and big three commercial carriers) does it solve problem? What is impact if Medicare and other carriers (including worker’s comp) are not part of the solution?
- What are the questions that should be included in a provider survey of the “as is” process to confirm our understanding of the current state and value of the “to be” document?
- What is the “as is” process for eligibility and claims adjudication for workers compensation? Is the “to be” vision a positive solution to provider issues with processing workers compensation claims?
- Are there reasons why providers would need to maintain legacy systems (e.g., out of state payers) and, if so, at what cost?
- Might other health care reform changes (such as proposed use of ACO’s or capitation) impact the need for a design of a real-time eligibility verification and claims adjudication system?
- What are barriers to implementation? For instance, will there be resistance from providers to implement and if so what might be some concerns?

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<sup>19</sup> Ohio House Bill 125 Advisory Committee on Eligibility and Real Time Claim Adjudication Final Report, January 2009, page one (the entire report is available at: <http://www.insurance.ohio.gov/documents/RTEandCA/HB125-FinalReport.pdf>)

- What are the costs of implementing a pilot program? What are the costs of implementing a centralized Hub? Will there be savings in the first stage and/or system-wide savings and if so, how much?
- What are the questions that should be included in a Request For Information (RFI) to prospective vendors to design and implement the “to be” process?

### Staged Implementation

In order to move forward the workgroup is recommending a staged implementation process. Due to the high degree of variation in the current “as is” environment and recognizing the potential for significant efficiencies even in the most efficient practice systems operating today the workgroup makes the recommendation that a staged implementation begin as soon as practical. In the first stage, to the extent that the implementation planning group determines it is appropriate to conduct a staged implementation, the workgroup recommends that no more than ten physician offices and a minimum of two insurers, one public and one private, will participate in testing the assumptions that are embedded in the workgroup Vision of real time eligibility verification and real time claims adjudication. This first stage will focus on practices with existing practice management systems and electronic health record systems that have been in operation for at least 12 months. The state will phase the concept of managing messaging first for eligibility between both insurers and the selected practices. Upon successful implementation and operation of the eligibility messaging for three consecutive months the state will begin claims routing in real time between the insurers and the practices. This second phase of the first stage will be aligned with the implementation planning for the statewide rollout in order to leverage the benefits of the learning in the first stage to the benefit of the statewide implementation. Recognizing the chicken and egg nature of this endeavor (without a functioning system how does one prove the value of such a system and without proof-of-concept how does the state obtain core funding) the state should consider proceeding with the first stage as described above in order to move forward the proof-of-concept in the mid-term (6-12 months) while future stages continue to be planned.

The first order of business for the next iteration of the workgroup is the establishment of clear goals for the first stage of implementation along with the development of a detailed budget for both the first stage implementation and the planning process. For this report a few basic assumptions are laid out below regarding the costs for the first stage implementation and the overall implementation planning process

### First Stage Implementation and Planning Process Costs

In order to assure the production of a comprehensive and detailed implementation plan that is developed utilizing a broadly representative workgroup the process must be provided both time and money from a variety of sources including Federal ARRA and private funding. It is

estimated that a comprehensive planning process allowing for the first stage implementation to begin within six months of project inception will cost \$958,000 to accomplish<sup>20</sup>. In arriving at this estimate the workgroup assumed a steering committee meeting once a month over a twelve month period, four subcommittees meeting an average of four times each, a total of six focus groups meeting a total of ten times. The workgroup further assumed the need to complete grant applications, produce complex financial models, and to review both federal actions and those of other jurisdictions around the country to assure the proper timing and a detailed understanding of the environment in which Vermont is building the real time eligibility verification and real time claims processing system.

The workgroup recommends the expansion of the existing workgroup membership as identified earlier in the report.

The process will allow for the use of small focus groups to delve into the complex issues around transforming the claims adjudication process and utilizing a central hub that all providers and all payers will need to connect through.

The process will assure alignment with ARRA timing and overall health care reform implementation in Vermont.

The implementation will include the roll-out of stage one within six months of inception of the project. This timing will allow for the development of the implementation plan to a point where the first stage can be relied upon to be productive. The first six months worth of activities will allow for a complete literature review, for ARRA funding to become available<sup>21</sup>, and for the expanded workgroup to delve into a significant number of detailed questions regarding the preparation of Vermont providers and insurers that will be necessary for a successful launch.

The first stage of the project (described earlier in this report) can be refined and targeted during the first six months, as appropriate, and could be expected to launch with a thoughtful planning process that is integrated with overall health care reform and aligned with ARRA funding.

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<sup>20</sup> This is an estimate based on multiple factors which may change over-time and with experience. The estimate is based on VITL experience with EHR implementation around practice transformation (\$15,000 per practice), project management (\$15,000 per practice), Health Information Exchange development costs (\$460,000 in the first year), and interface development (\$2,000 per interface) both at the provider practice (2 per practice) and at the insurer (2 per insurer) levels. The estimate includes a cost estimate of \$150,000 for the ongoing planning implementation process. This \$150,000 estimate is based on the need for 12 expanded steering committee meetings, up to 16 subcommittee meetings, 10 focus group meetings, and retaining professional staff for specialized financial modeling and legal analysis.

<sup>21</sup> ARRA funding is currently anticipated "to be" available in February 2010 based on the initial guidance released by the Office of the National Coordinator on August 20, 2009.

## Federal actions

As the federal government focuses on health care reform, one aspect of their focus is on increased funding of state activities related to health information technology and related infrastructure.

*ARRA funding proposal (information released August 20, 2009 by HHS)*

The Office of Vermont Health Access/Health Care Reform is the state entity responsible for coordinating and submitting the State of Vermont's funding proposal. Funding will become available in February 2010. The planning for and implementation of a statewide, real-time eligibility and claims adjudication system is consistent with the activities allowed under the federal funding.

The federal government, through the Office of the National Coordinator for Health Information Technology within the Department of Health and Human Services released additional information on potential federal funds on August 20, 2009.<sup>22</sup> This funding opportunity is intended to lay-out the guidelines for states to implement Health Information Exchange that allows for achievement of meaningful use standards by providers throughout the health care system. The funding announcement clearly indicates that the technical infrastructure "to be" supported by the federal funding must include a plan by the state to develop or facilitate the development of electronic eligibility and claims transactions.

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<sup>22</sup> See Funding Opportunity Announcement, "State Health Information Exchange Cooperative Agreement Program, August 20, 2009, attached in appendix six.

While Congress continues to work on health care reform legislation, there are early indications that the final bill may include language that is directly relevant to the Workgroup report, requiring for specific and consistent standards for financial and administrative transactions within two years of the bill passage.<sup>23</sup>

### *Conclusion*

The correspondence of the Health Care Reform legislation standards adoption process and the ONC funding requirements provides clear indication that the workgroup Vision is fully aligned with federal policy. Vermont stands in position to move forward in meeting the requirements and timelines at the federal level as long as the state level planning and implementation process continue to move forward.

### **Conclusion and Next Steps**

In order to move the process forward the workgroup makes the following recommendations;

1. The State of Vermont should move forward with the planning necessary to implement a statewide initiative that will reduce administrative costs through the provision of a comprehensive point-of-service eligibility and electronic adjudication of health care claims using a token based system and starting in physician offices/ambulatory care centers.
2. Any implementation planning on a statewide level requires broad and representative participation. In the 7-week timeframe, the process was not as inclusive as necessary for the implementation planning process. The workgroup recommends a staged implementation process including; a planning process that includes a complete literature review and a thorough contemplation of the solution that includes a gap analysis and, that the first stage of implementation begin operations within six months of project inception. The workgroup further recommends that the following groups must be represented in addition to those already present on the workgroup.
  - a. Providers must be well represented, not by surrogates but in person.
  - b. All of the major insurance carriers must be represented.
  - c. Practice Managers as well as clinicians must be part of the process.
3. The implementation planning process should be focused on the creation of a central exchange for the adjudication of eligibility and claims information in real time at the point-of-service.

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<sup>23</sup> See language from H.R. 3200, attached as appendix seven.

4. The exchange should be based on the principal that it is closed. This means that the information moves from point-to-point and is not available to third parties without substantial protections and secondary policies developed for the release of information. The exchange must meet all applicable federal and state privacy and security standards.
5. All work in this regard should be aligned with any ARRA/Stimulus requests for funding that are made by the State of Vermont.
6. The messaging for eligibility transactions should be compliant with HIPAA standards for electronic eligibility and response and the messaging for claims adjudication should be compliant with HIPAA electronic claims submission and remittance advice standards.

#### *Next Steps*

The recommendations in this report must be acted upon by the Administration and the State Legislature in order to move this from plan to project. It will be six months from funding and accountability assignment until the first stage of the project can reasonably be expected to begin.

## Appendices Listing

1. The full text of H. 441 Sec. E. 102.1
2. A listing of all workgroup and subgroup participants
3. Memo to the Members of the Common Claims Work group from Commissioner Paulette J. Thabault, February 28, 2008
4. Vermont Claims Administrative Collaborative Workplan 2008-2009
5. Funding Opportunity Announcement, "State Health Information Exchange Agreement Program, August 20, 2009"
6. Excerpted language from H.R. 3200
7. Workgroup Meeting Minutes July 8, 2009
8. Workgroup Meeting Minutes July 22, 2009
9. "as is" Subgroup Meeting Minutes August 10, 2009
10. "to be" Subgroup Meeting Minutes August 10, 2009
11. "as is" Subgroup Meeting Minutes August 14, 2009 (including attachments)
12. "to be" Subgroup Meeting Minutes August 14, 2009 (including attachments)
13. Workgroup Meeting Minutes August 26, 2009
14. IBM webinar July 29, 2009
15. IBM Workflows for eligibility and claims
16. First Data webinar July 17, 2009
17. Proposal for the Establishment of a Healthcare Information Exchange to Support Real-Time Transaction Services

**Appendix 1 - The full text of H. 441 Sec. E. 102.1**

H.441

Sec. E.102.1

#### HEALTH INFORMATION TECHNOLOGY FOR PAYMENT REFORM WORK GROUP

(a) The commissioner of information and innovation shall convene a work group to explore ways to use and fund health information technology to achieve health care payment reform in this state. The work group shall consist of:

- (1) The commissioner of information and innovation.
- (2) Two members of the Vermont general assembly, one appointed by the speaker of the house of representatives and one appointed by the president pro tempore of the senate who shall jointly chair the work group.
- (3) The secretary of administration or designee.
- (4) The director of the office of economic stimulus and recovery.
- (5) The director of the office of Vermont health access or designee.
- (6) A representative from the Vermont Information Technology Leaders, Inc.
- (7) A representative from First Data.
- (8) A representative from IBM.
- (9) A representative from each of the three largest health insurers licensed to do business in Vermont.
- (10) Other interested stakeholders, which may include health care professionals, hospitals, and academic institutions.

(b) The work group shall:

- (1) Explore opportunities for using health information technology to achieve health care payment reform in Vermont, including consideration of the use of smart card technology and mechanisms to enable real-time eligibility determinations and claims preparation, submission, and adjudication at a health care professional's office or a hospital.
- (2) Identify potential sources of funding, including grants and other federal funds.
- (3) Develop one or more proposals for appropriate grant funds, including those available under the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5.
- (4) Create a working plan for implementation of the health information technology payment reform initiatives identified for further action by the work group.

(c) No later than 90 days following the effective date of this act, the work group shall submit to the joint fiscal committee its recommendations for using health information technology to achieve payment reform, as well as the grant proposals and working plan required in subsection (b) of this section.

## **Appendix 2 - A Listing Of All Workgroup And Subgroup Participants**

## **Legislative Summer work group on Health information Technology for Payment Reform Participant Listing**

Senator Bill Carris, Co- Chair. (full group, As Is, and To Be subgroups)  
Representative Anne O'Brien, Co-Chair, (full group, As Is, and To Be subgroups)  
Hunt Blair, Deputy Director for Health Care Reform, OVHA (full group, As Is, and To Be subgroups)  
Tom Murray, Commissioner, Dept. of Information and Innovation, (full group)  
David Gruppo, IBM, (full group, As Is, and To Be subgroups)  
Wendi Monahan, IBM, (full group)  
Jim Hester, Vermont Healthcare Reform Commission Director (full group)  
John Grubmuller, VP Health and Human Services, First Data, (full group, As Is, and To Be subgroups)  
Jean Landsverk, Gov't and Education, First Data, (full group)  
Don George, President and CEO, Blue Cross and Blue Shield (As Is subgroup)  
Neil Sarkar, University of Vermont, (full group and To Be subgroup)  
Dawn Bennett, BISHCA, (full group)  
Paul Forlenza, VITL, (full group and As Is and To Be subgroups)  
David Cochran, CEO, VITL, (full group)  
Alex MacLean, Senator S. Staff (full group)  
Kathy Merchant (interested party)  
George Eisenberg, IBM, (full group and As Is and To Be subgroups)  
Hans Kastensmith, Capital Health Associates (full group and As Is and To Be subgroups)  
Rob Willey, IBM, (full group and As Is and To Be subgroups)  
Carla Colenzar  
Kevin Goddard, VP for External Affairs, Blue Cross and Blue Shield (full group)  
Craig Jones, M.D., Vermont Blueprint for Health, (full group)  
Ajay Asthana, IBM (by phone), (As Is and To Be subgroups)  
Sandy Bechtel, MBA Health Group, (As Is and To Be subgroups)  
Sue Keenoy, BCBSVT: Don George, BCBSVT, (As Is and To Be subgroups)  
Lauren Parker, MBA Health Group, (As Is and To Be subgroups)  
Debbie Austin, OVHA, (As Is and To Be subgroups)  
Steve Kappel, Joint Fiscal Office, (full group and To Be subgroup)  
Nolan Langweil, Joint Fiscal Office, (full group)

**Appendix 3 - Memo to the Members of the Common Claims Work  
Group from Commissioner Paulette J. Thabault, February 28, 2008**



# *Vermont . . .*

## **Department of Banking, Insurance, Securities and Health Care Administration**

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To: Members of the Common Claims Work Group  
From: Paulette J. Thabault, Commissioner  
Date: February 28, 2008  
Cc: Governor Jim Douglas  
Members of the Commission on Health Care Reform  
Members of the House Health Care Committee  
Members of the Senate Health and Welfare Committee

Re: The Commissioner's Adoption of the Final Report of the Work Group

The Common Claims Work Group was formed pursuant to Sec. 55, of Act 191 (2006), as part of Vermont's comprehensive health care reform legislation. While programs such as Catamount Health insurance and the Premium Assistance Program are the visible centerpieces of reform, the Catamount Health legislation also contained a number of significant system reform initiatives. These system reform initiatives will play a large role in creating an environment and the infrastructure necessary to achieve success in Vermont's universal access, cost containment and quality goals. These system reform initiatives include the Blueprint for Health, adverse event reporting, multi-payer data collection, health information technology modernization, healthy lifestyles insurance discounts, price and quality transparency, and the claims administration reform initiative.

What is truly unique about health care reform in Vermont, as compared to some other states, is an acknowledgement by all participants in this state that our efforts to achieve universal access must be supported by efforts to contain costs and foster a healthier population.

The claims administration initiative in particular was intended to address one of the most vexing problems facing Vermont's health care system: the frustration and unnecessary costs resulting from the health insurance claims administration system.

The Commissioner wishes to commend the hard work and dedication of the Work Group that has produced the recommendations contained in the Final Report. The Commissioner is satisfied that these recommendations, if fully implemented in a timely manner, will begin the process of fulfilling the stated goals of the claims administration reform initiative:

- Simplifying the claims administration process for consumers, health care providers, and others so that the process is more understandable and less time-consuming; and
- Lowering administrative costs in the health care financing system.<sup>1</sup>

The Commissioner's response to each recommendation contained in the Final Report of the Work Group follows:

**A. Amendment of BISHCA's administrative rules.**

In accordance with the process established by Act 191, therefore, it is now the duty of the Commissioner of BISHCA to adopt by administrative rule "the recommendations of the Final Report \* \* \* as the Commissioner deems appropriate in his or her discretion."<sup>2</sup>

**The Commissioner, therefore, hereby directs the Department to commence, on or before June 1, 2008, the administrative rule-making process to implement the following recommendations of the Final Report:**

1. Electronic Claims Transactions. The Final Report recommends that the Commissioner "develop an ongoing, collaborative process, similar that used by UHIN (the Utah Health Information Network) to aggressively seek electronic solutions to improve efficiency, reduce costs, and improve [the] timeliness of electronic transmissions."<sup>3</sup>

**The Commissioner adopts this recommendation of the Work Group. The Department will use the administrative rule-making process to establish a entity to implement a collaborative process to simplify the health insurance claims adjudication process and other administrative processes, and to lower per transaction administrative costs. The entity could be called "the Vermont Claims Administration Collaborative" ("VCAC"). VCAC will be a transparent, inclusive organization, with hospitals, providers, payers, consumers, public health programs, and regulators as participating members, designed to improve administrative efficiencies, lower transaction costs, and simplify the claims adjudication process and other administrative processes. As VCAC develops uniform standards for claims adjudication and other administrative processes, the uniform standards will form the basis for administrative rules to be adopted by the Commissioner.**

2. Member Identification Cards. The Working Group has recommended that member identification cards contain certain essential information, for the purpose of enhancing provider interactions with patients, reducing the number of rejected claims, and increasing the efficiency of claims processing.

**The Commissioner concurs with this recommendation, and the administrative rule-making process which will commence on or before June 1, 2008 will include provisions requiring that, no later than 2010, all health insurers will include on member identification cards the following information:**

- o Copay of Services
- o Subscriber ID
- o Primary Care Physician
- o Effective Date of Policy
- o Subscriber Name (even on dependent cards)
- o Billing Address
- o Group or Account Number

- **Subscriber Date of Birth (on all cards)**
- **Dependent Member Code**

3. Simplification of Explanation of Benefits (EOB) and Patient Bills. The Work Group devoted a great deal of time and effort to produce recommendations for consistent, consumer-friendly, and understandable explanations of benefits and hospital and physician office billing statements. The results of this time and effort are standards for an insurer Explanation of Benefits form, a hospital billing statement form, and a physician office billing statement form, all of which have been attached to the Final Report. It is the Commissioner's understanding that affected parties concur with the recommendations of the Work Group on this matter.

**The Commissioner concurs with the recommendations of the Work Group. Accordingly, the administrative rule-making process that will begin on or before June 1, 2008 will include:**

- **A requirement that Vermont health insurers adopt a uniform Explanation of Benefits terms, definitions and format no later than March 1, 2010.**
- **A requirement that Vermont hospitals use a uniform hospital billing statement no later than March 1, 2010.**
- **A requirement that Vermont physician offices with five or more physicians use a uniform physician office statement on or before March 1, 2010.**

4. Prior Authorization Project. The Work Group made some specific recommendations relating to prior authorization procedures designed to reduce or eliminate unnecessary time and expense associated with these procedures. After these recommendations are implemented, there may be additional opportunities to streamline the prior approval process which can be addressed through the Vermont Claims Administration Collaborative.

**Accordingly, the administrative rule-making process that will begin on or before June 1, 2008 will include the recommendations of the Work Group:**

- **A requirement that health insurers develop a web-based prior approval process on or before March 1, 2009.**
- **A requirement that health insurers transfer information between utilization management and claims adjudication systems within 72 hours of the authorization, no later than September 1, 2008.**

5. Improving the Efficiency and Fairness of the Claims Adjudication Process. One of the goals of the Work Group was to make progress towards eliminating unnecessary time and effort with respect to the claims adjudication process. Provider representatives on the Work Group in particular were concerned that different health insurers have different claims adjudication rules, and that the lack of consistency causes payment delays, appeals, and additional administrative burdens. Issues of concern include, but are not limited to:

- Retrospective audits and denials of paid and approved claims.

- Consistent and fair claims processing, including coding rules, overpayment rules, and network participation obligations.
- Fair and transparent provider contracting, including notice of payment terms, and prior notice of contract amendments.
- Timely credentialing.
- Timely and cost-effective mechanisms to resolve contract disputes.

The Final Report of the Work Group reveals that members of the Work Group as a whole have not been able to achieve consensus on this important issue. Legislation is currently being considered in the Vermont Legislature to address some of these issues. If this legislation is not enacted, or if some issues relating to the efficiency and fairness of the claims adjudication process are not addressed in the legislation, the Vermont Claims Administration Collaborative established pursuant to Para. A., above, can be used as an appropriate vehicle to establish uniform standards in this area in a consistent and non-duplicative manner.

## **B. Other recommendations of the Work Group**

The Work Group made other recommendations on a variety of topics which do not call for the adoption of administrative rules.

1. Consumer Tools to Track Out-of-Pocket Costs. The Work Group correctly observed that, as health insurance plans increasing include benefit designs with large deductible amounts, consumers have a need for a quick and simple way to determine the cost and quality of health care services, especially when the consumer has not yet reached annual deductible limits. The Department is in the process of adopting a Health Care Price and Quality Transparency Rule. Included in this proposed Rule is a requirement that health insurers develop a system to inform consumers of their out of pocket expenses, and the out of pocket cost limitations in the consumer's health insurance plan.<sup>4</sup> Therefore, the Working Group's recommendations concerning the tracking of out of pocket costs can be adequately addressed in connection with the adoption of BISHCA's Health Care Price and Quality Transparency Rule.

2. Credentialing. The Work Group made several recommendations designed to simplify and streamline the credentialing process.

First, members of the Work Group were concerned about a particular aspect of the credentialing process established by the Council for Affordable Quality Healthcare (CAQH), and adopted as a uniform process in Vermont by law. The online CAQH form currently calls for the use of Social Security Numbers by providers. The Work Group recommends that BISHCA continue to request that CAQH end its practice relating to the use of Social Security Numbers.

**The Commissioner accepts this recommendation and will communicate Vermont's request to CAQH.**

Second, the Work Group recommended that health insurers and hospitals should work together to implement a voluntary, 60-day processing goal for credentialing applications.

**The Commissioner notes that this recommendation is directed at health insurers and hospitals, and as such it does not recommend the adoption of an administrative rule. Nevertheless, the Commissioner will direct the Vermont Claims Administration Collaborative to monitor the credentialing process, and if it appears that there is unnecessary delay in processing credentialing applications, VCAC will be directed to consider the adoption of a uniform application completion period.**

Third, the Work Group recommended that CIGNA and OVHA adopt policies similar to BCBS and MVP and allow for direct billing of physician assistants and advanced nurse practitioners.

**The Commissioner notes that this recommendation is directed at health insurers, and as such the Final Report does not recommend the adoption of an administrative rule. Nevertheless, the Commissioner will direct the Vermont Claims Administration Collaborative to evaluate and consider whether the adoption of uniform standards for direct billing by ancillary health care providers in appropriate circumstances will further Vermont's goals of administrative simplification, and administrative cost reduction.**

3. Workers' Compensation Claims Adjudication. The Work Group made several recommendations designed to simplify and expedite the claims adjudication process for workers' compensation medical claims. The recommendations of the Work Group were embodied in proposed legislation attached to the Final Report. It is not necessary, therefore, for the Commissioner to consider the adoption of administrative rules to implement the recommendations of the Work Group relating to workers' compensation.

## **Conclusion**

In conclusion, the Commissioner expresses her appreciation for the efforts of the Work Group. The Commissioner looks forward to the participation by members of the Work Group in the administrative rule-making process called for by Act 191 to implement the recommendations of the Final Report, together with any other measures that can be implemented to simplify the claims administrative process, and reduce administrative costs.

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<sup>1</sup> Sec. 55, subsection (c) of Act 191 (2006)

<sup>2</sup> Sec. 55, subsection (a) of Act 191 (2006)

<sup>3</sup> Common Claims Work Group Final Report (hereinafter "Final Report", page 4

<sup>4</sup> HCA Proposed Rule - Health Care Price and Quality Transparency Rule (H-2007-5), Section 4(e)(2).

**Appendix 4 - Vermont Claims Administrative Collaborative  
Workplan 2008-2009**

## Vermont Claims Administration Collaborative Work Plan 2008-2009

TOPIC of RECOMMENDATION	ANTICIPATED MEETING DATE for DISCUSSION	TARGET DATE for FINALIZING RECOMMENDATION	TARGET DATE for FILING RULE or AMENDMENT*	IMPLEMENTATION DATE of STANDARD**
1. VCAC structure & operating procedures	Nov. 7, Dec. 1, Dec. 15,	Dec. 31, 2008	Done	Upon rule being final
2. Standards for a. Explanation of benefits b. Patient bills	Jan. 12, Feb. 2, March 2, April 13, 2009	April 13, 2009	Within 10 business days of recommendation receipt	On or before October 1, 2010
3. Standards for member identification cards	April 13, 2009	April 13, 2009	Within 10 business days of recommendation receipt	Renewals on or after July 1, 2010
4. Develop timeline for VCAC to draft recommendations for standards for maximization of electronic transfers & improving the efficiency of claims administration	April 13, 2009	April 13, 2009 (NOTE: task to be completed by 4/13 is development of the timeline, not the recommendations themselves.)	N/A	N/A
5. Standards for uniform credentialing (including issues pertaining to credentialing of mid-level practitioners)	May 11, 2009	May 31, 2009	Within 10 business days of recommendation receipt	On or before July 1, 2010
6. Standards for web-based prior approval processing (including attention to timeliness between utilization review processes & claims payment)	June 8, 2009	June 30, 2009	Within 10 business days of recommendation receipt	On or before July 1, 2010
7. Standards for maximization of electronic transfers	<i>Topic requires clarification before dates can be established</i>		Within 10 business days of recommendation receipt	On or before July 1, 2010
8. Standards for improving the efficiency of claims administration	<i>Topic requires clarification before dates can be established</i>		Within 10 business days of recommendation receipt	On or before July 1, 2010

\* Drop dead date for filing all amendments is September 1, 2009

\*\* July 1, 2010 is the target date for implementation of standards. More complex projects may require additional time.

**Appendix 5 - Funding Opportunity Announcement, "State Health  
Information Exchange Agreement Program, August 20, 2009"**

American Recovery and Reinvestment Act of 2009, Title XIII -  
Health Information Technology, Subtitle B—Incentives for the  
Use of Health Information Technology, Section 3013, State  
Grants to Promote Health Information Technology

State Health Information Exchange Cooperative  
Agreement Program

Funding Opportunity Announcement

Office of the National Coordinator for Health Information Technology  
Department of Health and Human Services

**2009**

**American Recovery and Reinvestment Act of 2009:  
State Health Information Exchange Cooperative Agreement Program**

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## Opportunity Overview

Department of Health and Human Services (HHS)

Office of the National Coordinator for Health Information Technology (ONC)

Office of Programs and Coordination

**Funding Opportunity Title: American Recovery and Reinvestment Act of 2009, State Grants to Promote Health Information Technology Planning and Implementation Projects**

**Announcement Type: Initial**

**Funding Opportunity Number: EP-HIT-09-001**

**Catalog of Federal Domestic Assistance (CFDA) Number: 93.719**

Item to Submit	Date <sup>1</sup>	Section Reference
Letter of Intent	September 11, 2009, by 5:00pm EST	Section IV.B.1 – Application and Submission Information
Application	October 16, 2009 by 5:00pm EST	Section IV – Application and Submission Information
Award Announcements	December 15, 2009	IV.A – Award Administration Information
Anticipated Project Start Date	Beginning January 15, 2010	IV.A – Award Administration Information

## Executive Summary

The State Cooperative Agreements to Promote Health Information Technology: Planning and Implementation Projects are to advance appropriate and secure health information exchange (HIE) across the health care system. Awards will be made in the form of cooperative agreements to states or qualified State Designated Entities (SDEs). The purpose of this program is to continuously improve and expand HIE services over time to reach all health care providers in an effort to improve the quality and efficiency of health care. Cooperative agreement recipients will evolve and advance the necessary governance, policies, technical services, business operations and financing mechanisms for HIE over a four year performance period. This program will build off of existing efforts to advance regional and state level HIE while moving towards nationwide interoperability.

Total funding for this initiative is \$564,000,000. States (including territories) or their non-profit SDEs may apply, as designated by the state. No more than one award will be made per state. States may choose to enter into multi-state arrangements.

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<sup>1</sup> The announcements and start dates are approximate.

## I. Funding Opportunity Description

### A. Background

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (ARRA). This statute includes The Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act) that sets forth a plan for advancing the appropriate use of health information technology to improve quality of care and establish a foundation for health care reform. The Office of the National Coordinator for Health Information Technology (ONC) was statutorily created by the HITECH Act within the U.S. Department of Health and Human Services (HHS). ONC serves as the principal federal entity charged with coordinating the overall effort to implement a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information.

The HITECH Act authorizes the Centers for Medicare & Medicaid Services (CMS) to administer incentives to eligible professionals (EPs) and hospitals for meaningful use of electronic health records (EHRs).<sup>2</sup> These incentives are anticipated to drive adoption of EHRs needed to reach the goal of all Americans having secure EHRs. To achieve the vision of a transformed health system that health information technology (HIT) can facilitate, there are three critical short-term prerequisites:

- Clinicians and hospitals must acquire and implement certified EHRs in a way that fully integrates these tools into the care delivery process;
- Technical, legal, and financial supports are needed to enable information to flow securely to wherever it is needed to support health care and population health; and,
- A skilled workforce needs to support the adoption of EHRs, information exchange across health care providers and public health authorities, and the redesign of work-flows within health care settings to gain the quality and efficiency benefits of EHRs, while maintaining individual privacy and security.

**Priority Programs.** The HITECH Act also authorizes the establishment of several new grant programs that will provide resources to address these prerequisites. Together, they are intended to facilitate the adoption and use of EHRs by providing technical assistance, the capacity to exchange health information, and the availability of trained professionals to support these activities. These priority grant programs are:

- Health Information Technology Extension Program (Extension Program), authorized by Section 3012 of the Public Health Service Act (PHSA) as amended by ARRA - will establish a collaborative consortium of Health Information Technology Regional Extension Centers (Regional Centers) facilitated by the national Health Information Technology Research Center (HITRC). The Extension Program will offer providers across the nation technical assistance in the selection, acquisition, implementation, and meaningful use of an EHR to improve health care quality and outcomes.
- State Grants to Promote Health Information Technology (State Health Information Exchange Cooperative Agreements Program), authorized by Section 3013 of the PHSA as amended by ARRA - to promote health information exchange (HIE) that will advance mechanisms for information sharing across the health care system. This is the topic of this Funding

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<sup>2</sup> Definitions are detailed in Section I.F.4(Consensus Definitions).

Opportunity Announcement. Complete statutory language for this section is available in Appendix A of this document.

- Information Technology Professionals in Health Care (Workforce Program), authorized by Section 3016 of the PHSA as amended by ARRA - to fund the training and development of a workforce that will meet short-term HITECH Act programmatic needs.

**Meaningful Use Incentives and Related Criteria.** The priority grant programs are fundamental to realizing the promise of meaningful use of HIT that leads to improved quality, efficiency and safety of health care. Under the HITECH Act, an eligible professional or hospital is considered a "meaningful EHR user" if they use certified EHR technology in a manner consistent with criteria established by the Secretary, including but not limited to e-prescribing through an EHR, and the electronic exchange of information for the purposes of quality improvement, such as care coordination. In addition, eligible professionals and hospitals must submit clinical quality and other measures to HHS.

Meaningful use incentives will be available to healthcare providers beginning in FY 2011 based on their Medicare and Medicaid coverage status and other statutorily defined factors. This includes eligible health care professionals and acute care hospitals and takes into consideration adjustment factors for children's hospitals and critical access hospitals. The detailed criteria to qualify for meaningful use incentive payments will be established by the Secretary of HHS through the formal notice-and-comment rulemaking process.

The HITECH Act also requires these meaningful use criteria to become more stringent over time. In 2015, providers are expected to have adopted and be actively utilizing an EHR in compliance with "meaningful use" or they will be subject to financial penalties under Medicare. The information exchange requirements for the meaningful use EHR incentives, as specified in the regulation currently under development, will inform a strategic framework for this program. Any goals, objectives and corresponding measures of meaningful use that require HIE over time will be the reference point for states and/or SDEs as they develop and update their plans to build capacity for HIE for all providers across their states.

The implementation of the HITECH Act provides requirements for meaningful use of EHRs that will guide both state and federal efforts to advance HIE in ways that enable eligible health care providers to qualify for Medicare and Medicaid incentives and improve the quality and efficiency of health care.

## **B. Purpose**

Widespread adoption and meaningful use of HIT is one of the foundational steps in improving the quality and efficiency of health care. The appropriate and secure electronic exchange and consequent use of health information to improve quality and coordination of care is a critical enabler of a high performance health care system. The overall purpose of this program, as authorized by Section 3013 of the PHSA, as added by ARRA, is to facilitate and expand the secure, electronic movement and use of health information among organizations according to nationally recognized standards. The governance, policy and technical infrastructure supported through this program will enable standards-based HIE and a high performance health care system.

This program will be a federal-state collaboration aimed at the long-term goal of nationwide HIE and interoperability. To this end, ONC intends to award cooperative agreements to states or SDEs to meet local health care provider, community, state, public health and nationwide information needs. Each state's cooperative agreement award will be for both planning and implementation, except for states that have a plan approved by the National Coordinator prior to award in which case they would only receive implementation funding.. ONC will award no more than one

cooperative agreement per state; however groups of states may combine their efforts into one application. The cooperative agreement approach allows for a greater level of coordination and partnership between ONC and states or their SDEs. **Please note:** For purposes of this program agreement, “state” includes the District of Columbia and the U.S. territories – Puerto Rico, U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

The cooperative agreements will focus on developing the statewide policy, governance, technical infrastructure and business practices needed to support the delivery of HIE services. The resulting capabilities for healthcare-providing entities to exchange health information must meet the to-be-developed Medicaid and Medicare meaningful use requirements for health care providers to achieve financial incentives.

### **C. The Roles of State Government, Federal Government, and the Private Sector in Advancing Health Information Exchange**

State government, federal government and the private sector will all play important roles in advancing HIE among health care providers, public health and those providing patient engagement services (such as Personal Health Records) in a state enabled by this grant program. Many states have already made significant progress in developing governance, policies, and technical capacity for HIE among health care providers. Moving forward, states will continue to play a critical leadership role by determining a path and a model for exchange of health information that leverages existing regional and state efforts and is based on HHS-adopted standards and certification criteria. States will develop and implement Strategic and Operational Plans that will ensure that a comprehensive set of actions will result in adoption of HIE to enable providers to meet the HIE meaningful use criteria to be established by the Secretary through the rulemaking process (for up-to-date publicly available information on meaningful use, see: <http://healthit.hhs.gov/meaningfuluse>).

States will also be expected to use their authority, programs, and resources to:

- Develop state level directories and enable technical services for HIE within and across states.
- Remove barriers and create enablers for HIE, particularly those related to interoperability across laboratories, hospitals, clinician offices, health plans and other health information trading partners.<sup>3</sup>
- Convene health care stakeholders to ensure trust in and support for a statewide approach to HIE.
- Ensure that an effective model for HIE governance and accountability is in place.
- Coordinate an integrated approach with Medicaid and state public health programs to enable information exchange and support monitoring of provider participation in HIE as required for Medicaid meaningful use incentives.
- Develop or update privacy and security requirements for HIE within and across state borders.

States will have the option to designate a non-profit entity to assume most of these responsibilities, however; state government at a minimum is expected to coordinate activities across Medicaid and state public health programs, so as to not duplicate efforts and to ensure integration and support of a unified approach to information exchange.

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<sup>3</sup> Barriers and enablers include but are not limited to the following categories: technical, legal, financial, organizational.

The federal government will continue to advance interoperability and health information exchange through a variety of regulatory and programmatic activities. HHS will:

- Collaborate with states and SDEs to promote, monitor and share efficient, scalable and sustainable mechanisms for HIE within and across states.
- Conduct a national program evaluation and offer technical assistance for state-level evaluations in an effort to implement lessons learned that will ensure appropriate and secure HIE resulting in improvements in quality and efficiency.
- Harmonize and regulate standards and certification criteria to enable interoperability and HIE.
- Provide technical assistance to states and SDEs.
- Coordinate efforts across states and regions in effort to support nationwide HIE.
- Advance standards-based HIE through the development of the Nationwide Health Information Network (NHIN).<sup>4</sup>
- Establish a governance mechanism for the NHIN informed by HIE activities across states, and regions, including entities participating in the NHIN.

The private sector will participate in state level strategic planning and develop innovative solutions to HIE among health care providers. States will need to specify the role of various health care stakeholders in their Strategic and Operational plans and hold stakeholders accountable for their contributions to the development and universal adoption of HIE. For example, a state could rely on HIT vendors to develop and operate state level network services for HIE, health plans to provide incentives to clinicians and hospitals for HIE, and Regional Centers to provide technical assistance to health care providers to help them implement the workflow and technical changes to the providers' processes needed to successfully connect to the available HIE infrastructure.

Medicare and Medicaid meaningful use incentives are anticipated to create demand for products and services that enable HIE among eligible providers. States can use convening, regulatory, procurement, and other policy levers to also incentivize information exchange for the "trading partners" (e.g., laboratories, pharmacies, radiology) of eligible providers. The resulting demand for health information exchange will likely be met by an increased supply of marketed products and services to enable HIE, resulting in a competitive marketplace for HIE services. It is also important for the private sector to develop innovative products and approaches for HIE that meet the provider demands and needs over time, while enabling the measurement and improvements in health care quality and efficiency.

## **D. Program Structure and Approach**

### **1. Summary of Program**

This program is focused on preparing states to support their providers in achieving goals, objectives, and measures related to HIE. Information exchange is both a statutory requirement for meaningful use incentives and critical to enabling care coordination and other improvements to quality and efficiency. States participating in the State HIE Program will begin at different stages of maturity working towards interoperable HIE. Some will be fully operational, while others will just be starting to build the necessary capacity.

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<sup>4</sup> *The NHIN defines the essential components and provides an operational infrastructure necessary for nationwide health information exchange including standards, specifications, implementation guidelines, policies, and trust agreements.*

ONC will award up to one cooperative agreement per state to cover both planning and implementation of statewide health information exchange. However, groups of states may combine their efforts into one application.

The process of building HIE capacity begins with states assessing their current state of readiness. Once a state determines from where it is starting, it can begin to map out a critical path to developing HIE for all health care providers throughout the state.

The work associated with enabling statewide HIE services is complicated and may become overwhelming if not broken down into manageable components. An "all at once" approach is not recommended, but instead this program will allow for an incremental approach to ensure continuous improvement and expansion of HIE capabilities. To further enable an incremental approach, the work necessary for realizing HIE falls into five domains. These domains of HIE include: governance, finance, technical infrastructure, business and technical operations, and legal/policy (these are further described below in Section I.D.1.b).

**a) *The Pathway to HIE***

The HITECH Act specifies that information exchange is required for meaningful use and that meaningful use measures become more stringent over time.

Based on these statutory requirements ONC recommends that a pathway for realizing statewide HIE be considered in a series of stages, consistent with the statutory requirements for meaningful use. Specific requirements and associated criteria for meaningful use will be proposed and advanced through a CMS rule-making process during Fiscal Year 2010.

Based on the rulemaking process, future program guidance will specify program requirements to achieve the statutory requirements set forth in the HITECH Act, which include e-prescribing, care coordination, quality reporting, and other HIE services that improve quality and efficiency.

**b) *Five Domains Supporting the Program***

Developing capacity for HIE is an incremental process that requires demonstrated progress across five essential domains: governance, finance, technical infrastructure, business and technical operations, and legal/policy. To realize HIE, states will need to plan, implement and evaluate activities across all five HIE domains. The goals, strategies and objectives of HIE will guide the implementation and evaluation activities. The extent to which states have to "implement" these activities will vary with their approach to HIE. In some cases, they will be overseeing and evaluating the development and implementation of network services undertaken by the private sector.

**Description of the Five Domains:**

- **Governance** – This domain addresses the functions of convening health care stakeholders to create trust and consensus on an approach for statewide HIE and to provide oversight and accountability of HIE to protect the public interest. One of the primary purposes of a governance entity is to develop and maintain a multi-stakeholder process to ensure HIE among providers is in compliance with applicable policies and laws.
- **Finance** - This domain encompasses the identification and management of financial resources necessary to fund health information exchange. This domain includes public and private financing for building HIE capacity and sustainability. This also includes but is not limited to pricing strategies, market research, public and private financing strategies, financial reporting, business planning, audits, and controls.

- **Technical Infrastructure** – This domain includes the architecture, hardware, software, applications, network configurations and other technological aspects that physically enable the technical services for HIE in a secure and appropriate manner.
- **Business and Technical Operations** – The activities in this domain include but are not limited to procurement, identifying requirements, process design, functionality development, project management, help desk, systems maintenance, change control, program evaluation, and reporting. Some of these activities and processes are the responsibility of the entity or entities that are implementing the technical services needed for health information exchange; there may be different models for distributing operational responsibilities.
- **Legal/Policy** – The mechanisms and structures in this domain address legal and policy barriers and enablers related to the electronic use and exchange of health information. These mechanisms and structures include but are not limited to: policy frameworks, privacy and security requirements for system development and use, data sharing agreements, laws, regulations, and multi-state policy harmonization activities. The primary purpose of the legal/policy domain is to create a common set of rules to enable inter-organizational and eventually interstate health information exchange while protecting consumer interests.

### *c) Continuous Improvement*

Section 3013(h) of the HITECH Act, requires the Secretary to complete an annual evaluation of the activities conducted under this program and, in awarding cooperative agreements under section 3013, implement lessons learned from the evaluations. This will shape future program guidance and enable continuous improvements to the program. Additionally, ONC will collaborate with the states and provide technical assistance in order to ensure that lessons learned are implemented in a way that promotes quality and efficiency improvement through secure and appropriate electronic exchange of health information.

## **2. Specific Requirements for the First Two Years**

The first two years of this program are critical for HIE capacity building. As such, it is expected that states and SDEs will make considerable progress in achieving a critical mass of providers participating in HIE. To this end, a majority of the funding will be available for drawdown in the first two years, based on milestones and specific measures achieved in this period.

The milestones and measures will be based in part on the progress made across the five domains of HIE. In the first two years, states or SDEs will be responsible for developing and implementing plans that take into account the necessary progress to be made in all five domains to assure HIE is sufficient to meet HIE meaningful use criteria to be established by the Secretary through the rulemaking process. It is anticipated that states or SDEs will build off of regional health information organizations where they exist and other HIE mechanisms that will ultimately enable full interoperability and exchange across the state.

While a state or an SDE may or may not be the entity to implement and operate technical services to support HIE, they are required to act as the governance entity responsible for ensuring that HIE capacity will be developed with appropriate oversight and accountability. Thus, the state or SDE must develop and implement a plan that provides reasonable assurance that the HIE requirements for meaningful use will be attained by 2015, when Medicare penalties begin for providers that have not achieved meaningful use of EHRs.

States' and SDEs' responsibilities include establishing multi-stakeholder support for a pathway toward statewide HIE among healthcare providers and determining the role of the private sector in providing and maintaining the services. To the extent that the private sector is responsible for

developing and implementing HIE services, the state or SDE must ensure that the responsible private organizations do so in a manner that is compliant with relevant HHS adopted standards and all applicable policies for interoperability, privacy and security. Additionally, the state or SDE must ensure the private sector efforts to advance HIE are efficient and scalable such that they will cover the providers in the state by 2015.

Key accomplishments to be met by the recipients in the first two years include:

### **Governance**

- Establish a governance structure that achieves broad-based stakeholder collaboration with transparency, buy-in and trust.
- Set goals, objectives and performance measures for the exchange of health information that reflect consensus among the health care stakeholder groups and that accomplish statewide coverage of all providers for HIE requirements related to meaningful use criteria to be established by the Secretary through the rulemaking process. .
- Ensure the coordination, integration, and alignment of efforts with Medicaid and public health programs through efforts of the State Health IT Coordinators.
- Establish mechanisms to provide oversight and accountability of HIE to protect the public interest.
- Account for the flexibility needed to align with emerging nationwide HIE governance that will be specified in future program guidance.

### **Finance**

- Develop the capability to effectively manage funding necessary to implement the state Strategic Plan. This capability should include establishing financial policies and implementing procedures to monitor spending and provide appropriate financial controls.
- Develop a path to sustainability including a business plan with feasible public/private financing mechanisms for ongoing information exchange among health care providers and with those offering services for patient engagement and information access.

### **Technical Infrastructure**

- Develop or facilitate the creation of a statewide technical infrastructure that supports statewide HIE. While states may prioritize among these HIE services according to its needs, HIE services to be developed include:
  - Electronic eligibility and claims transactions
  - Electronic prescribing and refill requests
  - Electronic clinical laboratory ordering and results delivery
  - Electronic public health reporting (i.e., immunizations, notifiable laboratory results)
  - Quality reporting
  - Prescription fill status and/or medication fill history
  - Clinical summary exchange for care coordination and patient engagement
- Leverage existing regional and state level efforts and resources that can advance HIE, such as master patient indexes, health information organizations (HIOs), and the Medicaid Management Information System (MMIS).
- Develop or facilitate the creation and use of shared directories and technical services, as applicable for the state's approach for statewide HIE. Directories may include but are not limited to: Providers (e.g., with practice location(s), specialties, health plan participation, disciplinary actions, etc), Laboratory Service Providers, Radiology Service Providers, Health

Plans (e.g., with contact and claim submission information, required laboratory or diagnostic imaging service providers, etc.). Shared Services may include but are not limited to: Patient Matching, Provider Authentication, Consent Management, Secure Routing, Advance Directives and Messaging.

#### **Business and Technical Operations**

- Provide technical assistance as needed to HIOs and others developing HIE capacity within the state.
- Coordinate and align efforts to meet Medicaid and public health requirements for HIE and evolving meaningful use criteria.
- Monitor and plan for remediation of the actual performance of HIE throughout the state.
- Document how the HIE efforts within the state are enabling meaningful use.

#### **Legal/Policy**

- Identify and harmonize the federal and state legal and policy requirements that enable appropriate health information exchange services that will be developed in the first two years.
- Establish a statewide policy framework that allows incremental development of HIE policies over time, enables appropriate, inter-organizational health information exchange, and meets other important state policy requirements such as those related to public health and vulnerable populations.
- Implement enforcement mechanisms that ensure those implementing and maintaining health information exchange services have appropriate safeguards in place and adhere to legal and policy requirements that protect health information, thus engendering trust among HIE participants.
- Minimize obstacles in data sharing agreements, through, for example, developing accommodations to share risk and liability of HIE operations fairly among all trading partners.
- Ensure policies and legal agreements needed to guide technical services prioritized by the state or SDE are implemented and evaluated as a part of annual program evaluation.

While recipients will be required to report on specific reporting requirements and performance measurements, ONC will make particular note of progress at the end of the first two-year period. See Reporting Requirements and Performance Measures on pages 30 and 31 in this document.

### **3. State Plans – Strategic & Operational Plan**

Section 3013 of the HITECH Act requires states or SDEs to submit, and receive approval of a “State Plan” in order to qualify for implementation funding. To carry out the intent of the Act, the State Plan is defined as consisting of two deliverables: A Strategic Plan and an Operational Plan. Both the Strategic and the Operational Plans must be approved by the National Coordinator for Health Information Technology.

Currently, there are various approaches across the country to advance standards-based HIE among health care providers, public health and those offering services for patient engagement and information access, as well as varying degrees of planning and implementation across states and regions. It is anticipated; therefore, that states’ plans will reflect the existing variety of HIE approaches and levels of readiness. Part of the application award process entails an assessment of the Strategic and Operational Plans to enable the federal government to enter into an appropriately tailored cooperative agreement with each state. To facilitate the consistent development or updating of Strategic and Operational Plans for the purposes of this program, please refer to detailed guidance in Appendix B.

**a) Plan Overview**

The Strategic and Operational Plans shall describe activities the state or SDE will complete to enable or implement HIE services that will allow for eligible providers to achieve success. Both the Strategic and Operational Plans shall be submitted by each state. For states that turn in multi-state plans, each state will be expected to have its own Strategic and Operational plan that demonstrate how the joint plan will unfold within that state's jurisdiction.

This section provides a brief overview of what needs to be included in the Strategic and Operational Plans. More details are provided in Appendix B.

**Strategic Plan**

Each state or SDE must have a Strategic Plan that addresses the vision, goals, objectives and strategies addressing statewide HIE development. Plans to support HIT adoption may also be included in the Strategic Plan. Inclusion of Health IT adoption in the Strategic Plan is valuable and provides for a more comprehensive approach for planning how to achieve connectivity across the state. The Strategic Plan must also address continuous improvement in realizing effective and secure HIE across health care providers.<sup>5</sup>

The Strategic Plan must address all five of the domains:

- Governance
- Finance
- Technical infrastructure
- Business and technical operations
- Legal/policy

A detailed description of the requirements for the Strategic Plan is provided in Appendix B.

**Operational Plan**

The Operational Plan must contain details on how the Strategic Plan will be executed to enable statewide HIE. The specific actions and roles of various stakeholders in the development and implementation of HIE services must be included. In addition, the Operational Plan must include descriptions of any implementation activities to date with an explanation of how these prior activities fit into the state's future plans for HIE.

The Operational Plan must address all five of the domains:

- Governance
- Finance
- Technical infrastructure
- Business and technical operations
- Legal/policy

A detailed description of requirements for the Operational Plan is provided in Appendix B.

Upon award of the cooperative agreement, funds may be available to recipients to develop, revise and improve their plans. There will be future technical assistance and guidance regarding

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<sup>5</sup> *ONC recognizes there may be state Strategic Plans that are already complete, currently being drafted or undergoing modification. ONC is not asking for a full restructuring of these plans, but rather that a state communicate and demonstrate that the required sections are covered.*

implementation and evaluation; however, the allocation of funds will be dependent on where states are in planning and implementation. This is further detailed in (Section I.D.1.a).

#### ***b) Ongoing Planning Requirements***

In order to ensure project success, recipients should periodically review their Strategic and Operational Plans and make updates to the plans based on new requirements for HIE as determined through CMS rule making for meaningful use incentives. However, other events may also require revisions of state plans. For example, recipients should reassess plans when relevant state law is changed, when ONC releases new or revised program guidance, or when the project has deviated significantly from its original path. Reassessments and updated Strategic and Operational Plans shall be submitted annually. These reassessments should be done in collaboration with ONC to maximize understanding of state actions and ease of processing of state requests for modifications.

### **E. State Plan Preparation Activities for Application Submission**

States with existing Strategic and Operational Plans should submit them as part of the application if they want to quickly move into implementation. State Strategic and Operational Plans will be a tool to monitor, communicate and track progress throughout the performance period. Though State Plans are not the only component of the application, they are critical.

#### **1. Self - Assessment of the State's Current Status**

During the application process, applicants will evaluate the status of any existing Strategic and Operational Plans. For multi-state applications, states may submit comparable coordinated Strategic and Operational Plans. When states submit multi-state applications, their plans will be evaluated at both the multi-state and individual state level. The multi-state plan will be evaluated as a whole, but state plans must be sufficient at the individual state level as well.

Based on the state's assessment of the status of its planning activities, each applicant must indicate in their application which of the following levels of planning most closely describes the state of their Strategic and Operational Plans. Based on the indicated levels of planning, states should proceed as described below.

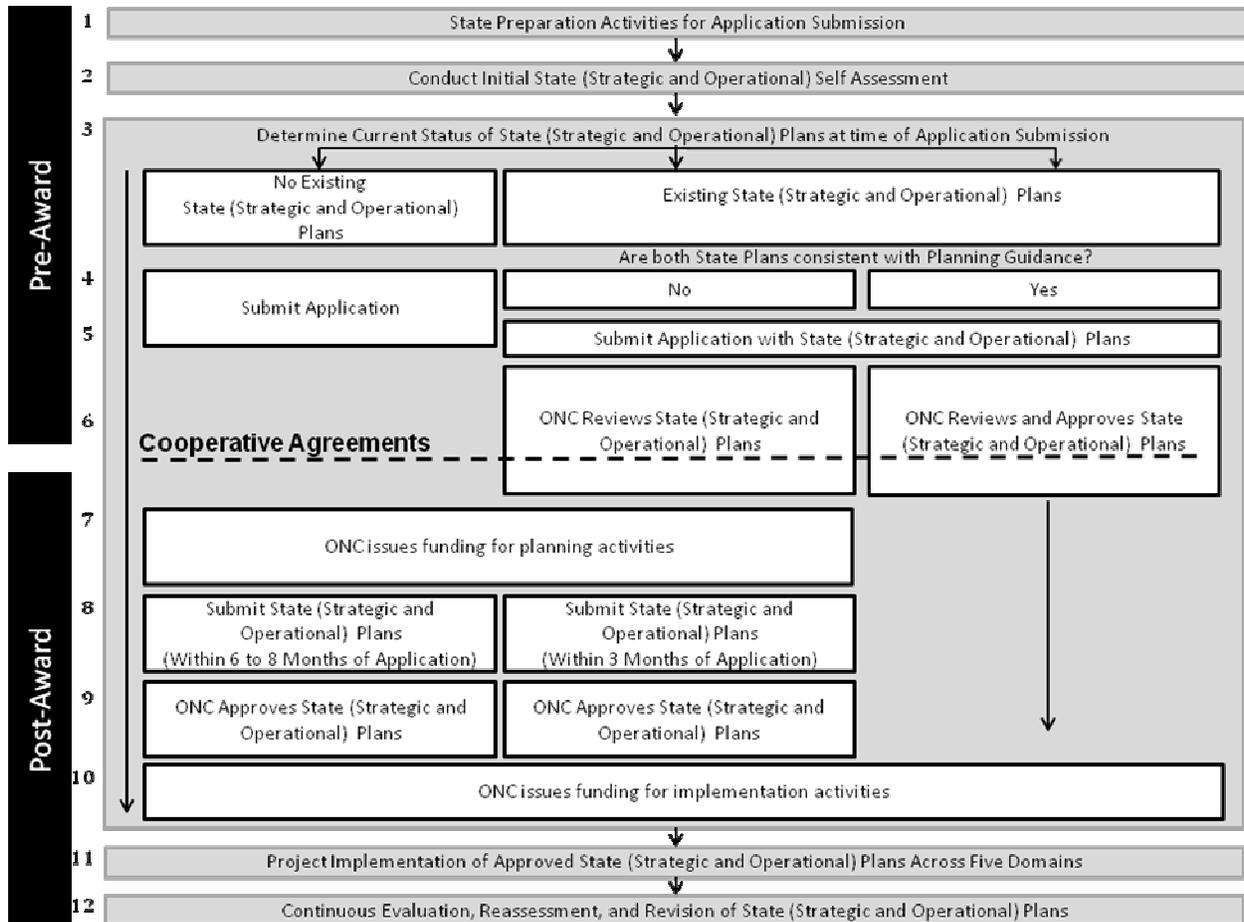
#### **Status of Planning Activity:**

- **No existing Strategic Plan** – Applicants must provide a detailed description of the activities needed to develop Strategic and Operational Plans as outlined in Appendix B and in future guidance. Recipients shall develop initial Strategic and Operational Plans and submit them within the first six to eight months of the project.
- **Existing Strategic Plan and/or Operational Plan that is not consistent with planning guidance** – Applicants shall provide: 1) their current Strategic and/or Operational Plan, 2) a detailed description of the gaps in their current Strategic Plan and/or Operational Plan in comparison to the parameters outlined in Appendix B, and 3) an outline of the activities contemplated to revise the plans to be consistent with planning guidance. For applicants in this category that have already begun implementation activities, their current Operational Plan must also include an explanation of how they will proceed with concurrent planning and implementation activities. States shall submit an updated Strategic and Operational Plan addressing the deficiencies of their existing plans within three months of award.
- **Existing Strategic and/or Operational Plan that is consistent with planning guidance** – Applicants shall submit their Strategic and/or Operational Plan for approval by the National Coordinator. For applicants that have already begun implementing a state HIT plan prior to receiving an award under this program, the Operational Plan shall also be submitted and must

contain a description of the implementation activities to date and explain how they plan to proceed with continued implementation of the operational plan.

**Sequence of Pre- and Post-Award Events throughout the Project:**

The status of the state’s plans will determine what steps the state shall complete in submitting their application and any accompanying materials. This diagram below depicts the activities that will take place before (Pre-Award) and after (Post-Award) a cooperative agreement is signed. This process and the use of funding will vary depending on the current status of a state’s plan at the time that the application and supporting plans are submitted.



**Figure E.1**

Figure E.1 (above) describes the following activities:

**Pre-Award Activities:**

- 1.) States will complete preparation activities in order to fill out their applications.
- 2.) One of the preparation activities is the completion of an initial state self assessment.
- 3.) In filling out applications, states will identify the current status of their state Strategic and Operational Plans.
- 4.) As discussed in Section – I.E.1 states may have: no existing state Strategic and/or Operational Plans, existing state Strategic and/or Operational Plans that are not consistent with planning guidance, or existing state Strategic and Operational Plans that are consistent

with planning guidance. The status of the state Strategic and Operational Plans, as well as the plans themselves must be included in the submission of the application.

- 5.) Following the submission of the application and accompanying state Strategic and/or Operational Plans, ONC will review and if appropriate, will approve the submitted plans. The review and approval by ONC may occur prior to, during, and/or after the cooperative agreement is awarded.

**Signing Cooperative Agreement Activity:**

- 6.) Following the submission of the application the states will enter into an appropriately tailored cooperative agreement with the federal government. If applicable, states may receive at Notice of Award prior to, during, or following the review and approval of their Strategic and/or Operational state plans.

**Post-Award Activities:**

- 7.) States that do not have approved state Strategic and Operational Plans will be issued funding by ONC for state planning activities. States that have approved state Strategic and Operational Plans may be granted funding for continued planning activities. In addition, states with approved Strategic and Operational State plans will be permitted to forgo activities #8 and #9 and move immediately to activity #10, upon receipt of a Notice of Award.
- 8.) States with no state Strategic or Operational Plans will have 6 to 8 months to submit their Plans. States with Strategic and Operational Plans that are not consistent with planning guidance will have 3 months to update and submit their Plans.
- 9.) If not already completed in activity #5, ONC will approve state Strategic and Operational Plans.
- 10.) Upon the completion of the state Strategic and Operational Plans, ONC will fund states' implementation activities.
- 11.) Funding will be used to conduct implementation activities in alignment with the approved state Strategic and Operational Plans, across the five domains associated with HIE.
- 12.) In addition, states will conduct continuous evaluation, reassessment, and revision of their state Strategic and Operational Plans as needed and/or required.

Status	Materials for Submission			Type of Funds Available at Award	
	Application	Strategic Plan	Operational Plan	Planning	Implementation <sup>6</sup>
No Existing Strategic Plan	X	-	-	Yes	No
Existing Strategic Plan and/or Operational Plan that is not consistent with planning guidance	X	X	X (as applicable)	Yes	No

<sup>6</sup> While implementation funding may not be available at award if plans are not complete or consistent with program guidance, implementation funding will be available at the agreed-upon milestone (which includes approval of plans consistent with program guidance).

Existing Strategic and/or Operational Plan that is consistent with planning guidance	X	X	X	Yes	Yes
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**Table E.1**

Once a state has submitted its application with the supporting Strategic and/or Operational Plans, ONC will review the Plans as one step in the overall application approval/response process. Recipients may receive awards prior to the Plans being approved. There could be adjustments required after the Plan evaluations are complete.

Not all states will meet all the criteria required of a Strategic or Operational Plan. ONC expects that most states will fall into one of the possible options outlined below. More detailed information regarding how to approach the application in each of these scenarios has been outlined above in Section I.E.2.

**Status:**

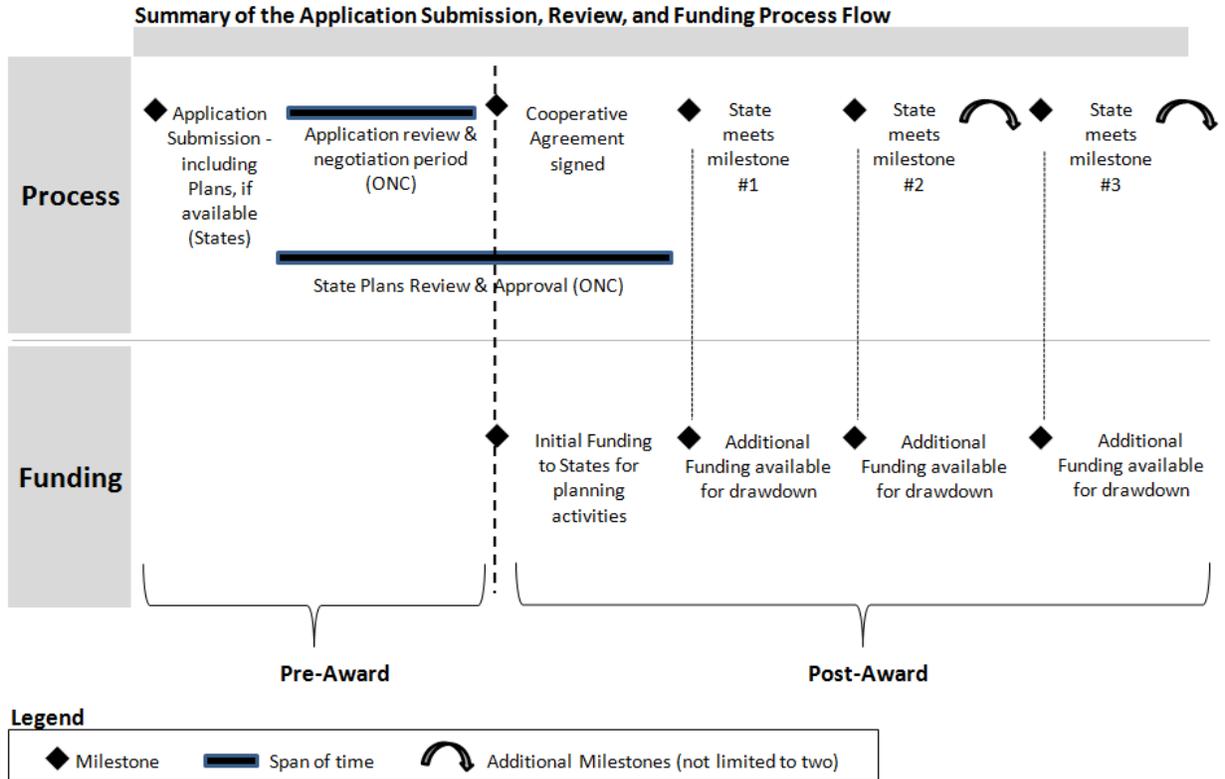
- No Existing Strategic Plan:
  - States that submit applications with no existing Plans are eligible for award funding for Strategic and Operational Planning Activities
- Existing Strategic Plan and/or Operational Plan that is not consistent with planning guidance:
  - Strategic Plan Only - States that submit applications with only Strategic Plans will be eligible for award and funding for Strategic and Operational Planning Activities.
  - Strategic Plan & Operational Plan - States that submit applications with both Strategic and Operational Plans will be eligible for award and funding for continued Strategic and Operational Planning activities.
- Existing Strategic and/or Operational Plan that is consistent with planning guidance:
  - Additional funding for implementation activities will be awarded when the National Coordinator approves submitted implementation plans.

ONC will work closely with each recipient to identify where they stand along the continuum from planning through implementation. Additionally, ONC will provide ongoing program direction to assist states and SDEs in the planning and implementation of the five domains to enhance the effectiveness of state HIE initiatives.

**2. Application Submission, Review, and Funding Process**

Below, Figure E.2 represents a high-level timeline of the Application Submission Review and Funding process flow. Immediately after a state submits an application that includes the accompanying Strategic and/or Operational Plans, review and negotiation period will take place between the state and ONC.

- Implementation funding will become available once the National Coordinator has approved the State Plan.
- Furthermore, additional funding available for drawdown will be determined by each state’s completion of agreed upon milestones and measures.



**Figure E.2**

## F. Key Considerations & Challenges for HIE Implementations

### 1. Medicaid and Medicare Coordination

Throughout this program, recipients are required to ensure that all activities are consistent with and enable the implementation of the Medicaid and Medicare meaningful EHR use incentives. This shall be reflected in their governance structure, policy framework, HIE services, progress tracking and outcomes. State Plans under this program shall be consistent with and complementary to Medicaid and Medicare plans for the implementation of meaningful use incentives as they are developed.

### 2. Privacy and Security

Privacy and security of health information, including confidentiality, integrity and availability of information, are integral to fostering health information exchange. States and SDEs must establish how the privacy and security of an individual’s health information will be addressed, including the governance, policy and technical mechanisms that will be employed for health information exchange.

As applicable, recipients are expected to incorporate the privacy and security provisions of the ARRA, HIPAA Privacy Rule, HIPAA Security Rule, Confidentiality of Alcohol and Drug Abuse Patient Records Regulations, and the HHS Privacy and Security Framework into the State Strategic and Operational Plans. In addition, recipients are expected to collaborate on privacy and security policies with neighboring states to the extent necessary to facilitate HIE across state boundaries.

- The ARRA includes specific privacy and security provisions related to security breach, restrictions and disclosures, sales of health information, consumer access, business associate obligations and agreements. Representative examples can be found in Appendix F.
- The HIPAA Privacy Rule specifies permitted uses and disclosures and individual rights related to protected health information. These provisions are found at 45 CFR [Part 160](#) and [Part 164](#), Subparts A and E. For more details, please refer to: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpregtext.pdf>
- The HIPAA Security Rule specifies a series of administrative, technical, and physical security procedures for covered entities to use to assure the confidentiality of electronic protected health information. These provisions are found at 45 CFR Part 160, and Part 164, Subparts A and C.C For more details, please refer to: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpregtext.pdf>.
- The Confidentiality of Alcohol and Drug Abuse Patient Records Regulation (42 CFR Part 2) specifies confidentiality requirements for substance abuse treatment programs as defined by 42 CFR § 2.11 that are “federally assisted” as defined by 42 CFR § 2.12(b)). For more details, please refer to: <http://www.hipaa.samhsa.gov>.
- The HHS Privacy and Security Framework establishes a single, consistent approach to address the privacy and security challenges related to electronic health information exchange through a network for all persons, regardless of the legal framework that may apply to a particular organization. The goal of this effort is to establish a policy framework for electronic health information exchange that can help guide the Nation’s adoption of health information technologies and help improve the availability of health information and health care quality. The principles have been designed to establish the roles of individuals and the responsibilities of those who hold and exchange electronic individually identifiable health information through a network. The principles are found in Appendix F.
- To the extent that states anticipate exchanging health information with federal health care delivery organizations, such as the Department of Veterans Affairs (VA), Department of Defense (DoD), and the Indian Health Service (IHS), it will be important for the state to meet various federal requirements for protection of health data, as applicable.
- As the program evolves over time, ONC plans to issue additional program guidance to further define the privacy and security requirements.

### **3. Interoperability**

Adoption of HHS interoperability standards will be an important programmatic and policy goal, facilitated by ongoing federal and state efforts to advance interoperability. Additionally, ONC envisions that the Nationwide Health Information Network (NHIN) will continue to evolve and provide key capabilities to foster interoperability.

### **4. Consensus Definitions**

In April 2008, ONC released a report providing consensus-based definitions of key health information technology terms in order to promote consistent usage of these terms during policy development, development of regulatory guidance, and implementation activities. The terms addressed in the report include Electronic Medical Record, Electronic Health Record, Personal Health Record, Health Information Exchange, Regional Health Information Organization and Health Information Organization. Please refer to the full report for a description of the methods used to develop these definitions, additional details for each definition, and for context-setting information about why consensus definitions are needed for health information technology activities. The full report is available by going to the link below:

[http://healthit.hhs.gov/defining\\_key\\_hit\\_terms](http://healthit.hhs.gov/defining_key_hit_terms).

These terms shall be consistently applied throughout the application:

**Records Terms**

- Electronic Medical Record (EMR) – an electronic record of health-related information regarding an individual that conforms to nationally recognized interoperability standards and that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.
- Electronic Health Record (EHR) – an electronic record of health-related information regarding an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.
- Personal Health Record (PHR) – an electronic record of health-related information regarding an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

**Network Terms**

- Health Information Exchange (HIE) - The electronic movement of health-related information among *organizations* according to nationally recognized standards. *For the purposes of this program, organization is synonymous with healthcare providers, public health agencies, payors and entities offering patient engagement services (such as Patient Health Records) .*
- Regional Health Information Organization (RHIO) - A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.
- Health Information Organization (HIO) - An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.

**G. Statutory Authority**

The statutory authority for awards under this Funding Opportunity Announcement is contained in Section 3013 of the Public Health Service Act (PHSA), as amended by the American Recovery and Reinvestment Act of 2009 (ARRA), Division A—Appropriations Provisions, Subtitle B—Incentives for the Use of Health Information Technology. The statutory language of Section 3013 of the PHSA is included in Appendix A of this document.

**II. Award Information**

**A. Summary of Funding**

Type of Award:	Cooperative Agreement
Total Amount of Funding Available	\$564,000,000
Award Floor <sup>7</sup> :	\$4,000,000
Award Ceiling:	\$40,000,000
Approximate Number of Awards <sup>8</sup> :	50

<sup>7</sup> This award floor applies to states, the District of Columbia, and the Commonwealth of Puerto Rico. The amount for remaining Territories will be determined based on population size and needs.

Program Period Length	4 years
Anticipated Project Start Date	January 15, 2010

ONC anticipates awarding not more than one cooperative agreement to fund activities in each state. Applications may cover a single state or consortium of more than one state. If a consortium applies, one state must take the lead role in applying for the cooperative agreement and in executing the work.

These cooperative agreements are intended to hasten the availability of the HIE capacity necessary for providers to qualify for the HITECH Act Medicare and Medicaid meaningful use incentive payments. To help the states and SDEs meet this critical need quickly, cooperative agreements will have a four-year project period, states will need to plan to use these funds in the most appropriate way possible to stay current and to build a sustainable HIE infrastructure that will succeed beyond the period of the cooperative agreement.

Funding, during the performance period, shall be contingent upon recipients' ability to meet the matching requirements (outlined in further detail in Section III.B Matching Requirements), ability to meet agreed upon project milestones, compliance with other applicable statutory and regulatory requirements, and demonstrated organizational capacity to accomplish the program's goals.

## **B. Type of Awards**

Awards will be in the form of cooperative agreements to individual states, multi-state consortia, and SDEs. Terms and conditions for this cooperative agreement are found in Section VI.D. ONC will work closely with each recipient as planning and implementation progresses in a collaborative way.

During the approval process, appropriate project milestones and specific metrics will be agreed upon. As a project meets these milestones and measures, it will progress with additional funds available for drawdown. Funds will be made available to all applicants initially to address needed planning activities. (See Section IV.G.3. Other Funding Information – Performance-Based Funding). To obtain funding for implementation, the recipient must submit a Strategic and an Operational Plan and the plans must receive approval by the National Coordinator. ONC will evaluate the State Plans against the requirements outlined in Section I.D.3 and Appendix B.

ONC reserves the right to announce an additional round of funding in the future to provide for advanced implementation for those that have met all milestones in a timely manner within the project period, have distinguished themselves as leaders in the effort, and can provide leadership and document successes for national use.

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<sup>8</sup> While the total number could be 56 awards, it is anticipated that multi-state or multi-state-territory applications will be submitted such that the number of awards is estimated to be approximately 50.

### III. Eligibility Information

#### A. Eligible Applicants

Either a state or a SDE may apply for cooperative agreements under this program. Multi-state efforts may also apply; however, one state or SDE must act as the responsible fiscal agent.<sup>9</sup>

Any entity applying for a cooperative agreement must satisfy the following criteria:

- Be either:
  - A component of state government, or
  - A not-for-profit entity<sup>10</sup>.
- Be designated by the state through a letter from the Governor (See Appendix D). For multi-state applications, a letter from the Governor (or equivalent) designating the partnering state or SDE must be received on behalf of each state participating in the proposed project.
- The applicant must demonstrate that the program includes a multidisciplinary board or commission in an advisory or governing capacity with broad stakeholder representation that:
  - Represents a public/private partnership (Public and Private Sector Models for Governance can be found in Appendix H), and
  - Represents state and local needs, and
  - Retains the necessary authority to execute approved State Plans.<sup>11</sup>
- One of the principal goals of the applicant organization is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information.
- The applicant certifies that it has adopted nondiscrimination and conflict of interest policies that demonstrate a commitment to transparent, fair, and nondiscriminatory participation by stakeholders.
- The state government (or governments for multi-state applications) has appointed a State Government HIT Coordinator who is a state official and will coordinate state government participation in HIE.

ONC will not accept more than one application from a single state or territory.

In the event that an application is not submitted on behalf of a state, by either the state or an SDE, ONC will encourage these states to seek inclusion in a neighboring state application, or to find a qualified not-for-profit organization to submit an application on its behalf. If there are geographic areas still not covered by activities of this program, ONC will consider other options to ensure activities are in place to meet the goal of nationwide HIE capacity.

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<sup>9</sup> For purposes of this program agreement, unless otherwise indicated “state” also includes the District of Columbia and the U.S. territories – Puerto Rico, U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

<sup>10</sup> For applicants awaiting not-for-profit status determination, ONC will work individually with these applicants on a case by case basis.

<sup>11</sup> For state agency applicants, alternative methods for governance will be considered to ensure adequate mechanisms exist for multi-stakeholder input, public accountability, and oversight of health information exchange.

## B. Matching Requirements

ONC and Congress, as evidenced by the stated objectives in ARRA through the HITECH Act, recognize the urgency in expanding the use and availability of electronic health information on a nationwide scale. The HITECH Act requires a match to federal monies awarded to states beginning in fiscal year 2011. ONC and Congress also recognize that securing commitment and funding from other sources will strengthen a state’s sustainability plan and lead to greater success. Matching requirements can be provided through cash and/or in-kind contributions. The HITECH Act requires an increasing level of match for each year of the program:

Fiscal Year of Funding	Match Required
2010	None
2011 (begins Oct. 1, 2010)	\$1 for each \$10 federal dollars
2012 (begins Oct 1, 2011)	\$1 for each \$7 federal dollars
2013 (begins Oct 1, 2012)	\$1 for each \$3 federal dollars

### 1. Example Match Computation

For FY 2011, the applicant’s match requirement is \$1 for every \$10 federal dollars. In other words, for every ten dollars received in federal funding, the applicant must contribute at least one dollar in non-federal resources toward the program’s total cost. This “ten-to-one” ratio is reflected in the following formula that can be used to calculate minimum required match:

$$\frac{\text{Federal Funds Requested}}{10} = \frac{\text{Minimum Match Requirement}}$$

For example, if \$100,000 in federal funds is requested for FY2011, then the minimum match requirement is \$100,000/10 or \$10,000. In this example the **program’s total cost** would be \$110,000.

If the required non-federal share is not met by the award recipient, ONC will disallow any unmatched federal dollars. For the purposes of this program announcement, no match is required during fiscal year 2010. Beginning in fiscal year 2011, recipients will be required to match federal dollars as described in the table above. Demonstration of this match will be shown in quarterly financial reports. In preparing the application budget, applicants should consider these cost-sharing requirements and account for a match on their best estimate of expenditures for each period. For example, in year one of the project, there will be eight months where no match is required and four months where a 1-to-10 match is required. See table below for more information.

Ratio of Recipient to Federal Funding Share by Month														
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Fiscal Year Start Begins	Oct	Nov	Dec	Jan	
FY 2010	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0			1 to 10	1 to 10	1 to 10	1 to 10
FY 2011	1 to 10			1 to 7	1 to 7	1 to 7	1 to 7							
FY 2012	1 to 7			1 to 3	1 to 3	1 to 3	1 to 3							
FY 2013	1 to 3			1 to 3	1 to 3	1 to 3	1 to 3							

## C. Responsiveness and Screening Criteria

### 1. Application Responsiveness Criteria

Applications that do not meet the following responsiveness criteria will be administratively eliminated and will not be reviewed. The successful applicant will be an organization that meets the following criteria:

- The application is the only application received from the state.
- The applicant submitted a timely Letter of Intent as outlined in Section IV.C.1.
- The applicant has met all applicable eligibility criteria as required by Section III.A – Eligible Applicants.
- The applicant has submitted a complete application that includes all required components and attachments.

### 2. Application Screening Criteria

All applications will be screened to identify applications that do not meet criteria outlined below. These will be contacted by ONC and asked to revise their applications to meet the criteria; however, this could delay availability of funds.

In order for an application to be reviewed, it must meet the following screening requirements:

- Applications must be submitted electronically via [www.grants.gov](http://www.grants.gov) by 5:00 p.m., Eastern Time, October 16, 2009.
- The Project Narrative section of the Application must be double-spaced, on 8 ½” x 11” plain white papers with 1” margins on both sides, and a font size of not less than 11.
- The Project Narrative must not exceed 40 pages. NOTE: The Letters of Intent and Support, and Resumes of Key Project Personnel are not counted as part of the Project Narrative for purposes of the 25-page limit.
- If applicable, proof of not-for-profit status, or application for this status if the determination has not been made.

## IV. Application and Submission Information

### A. Award Administration

For purposes of this program, ONC has partnered with the Assistant Secretary for Preparedness and Response (ASPR) to act as ONC’s official grants management office. As such, applicants and recipients will work closely with ONC as well as ASPR. This will include pre-award activities such as application submission and review, and award notices. Post-award activities will include adjustments to cooperative agreements, budget support, and technical support using Grantsolution.gov.

### B. Address to Request Application Package

Application materials can be obtained from <http://www.grants.gov> or [www.GrantSolutions.gov](http://www.GrantSolutions.gov).

If you have difficulty obtaining the application materials from the sites above, please email ONC at [StateHIEgrants@mailto:hhs.gov](mailto:StateHIEgrants@hhs.gov).

Please note that ONC is requiring applications for all announcements to be submitted electronically through [www.grants.gov](http://www.grants.gov). The Grants.gov registration process can take several days. If your organization is not currently registered with [www.grants.gov](http://www.grants.gov), please begin this

process immediately. For assistance with [www.grants.gov](http://www.grants.gov), please contact them at [support@grants.gov](mailto:support@grants.gov) or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time. At [www.grants.gov](http://www.grants.gov), applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.

Applications submitted via [www.grants.gov](http://www.grants.gov):

- You may access the electronic application for this program on [www.grants.gov](http://www.grants.gov). Applicants must search the downloadable application page by the Funding Opportunity Number (**EP-HIT-09-001**) or CFDA number (**93.719**).
- At the [www.grants.gov](http://www.grants.gov) website, applicants will find information about submitting an application electronically through the site, including the hours of operation. ONC strongly recommends that you do not wait until the application due date to begin the application process through [www.grants.gov](http://www.grants.gov) because of the time delay.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). Applicants should allow a minimum of five days to complete the CCR registration.
- Applicants must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the grants.gov compatibility information and submission instructions provided at [www.grants.gov](http://www.grants.gov) (click on “Vista and Microsoft Office 2007 Compatibility Information”).
- Applications must comply with any page limitation requirements described in this Program Announcement.
- After applications are submitted electronically, applicants will receive an automatic acknowledgement from [www.grants.gov](http://www.grants.gov) that contains a grants.gov tracking number. ONC will retrieve applications form from grants.gov.
- After ONC retrieves applications form grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by grants.gov.
- Each year organizations registered to apply for federal awards through [www.grants.gov](http://www.grants.gov) will need to renew their registration with the Central Contractor Registry (CCR). Applicants can register with the CCR online and it will take about 30 minutes (<http://www.ccr.gov>).

Applicants must have a Grantsolutions.gov account to apply for this opportunity. Registration and user information can be found at [www.grantsolutions.gov](http://www.grantsolutions.gov).

## **C. Content and Form of Application Submission**

### **1. Letter of Intent**

Applicants are required to submit a letter of intent (electronically or by mail) to apply for this funding opportunity to assist ONC in planning for the independent review process. For multi-state applications, only one letter of intent should be submitted. This letter should be submitted by the state or SDE that will act as the applicant on behalf of all states involved in the proposed project. The letter of intent should be no longer than 5 pages. The letter of intent must be received by 5:00 pm, EST, September 11, 2009. The required content for this letter is included in Appendix C. Letters of intent should be sent to:

David Blumenthal MD, MPP  
National Coordinator for Health Information Technology  
Department of Health and Human Services

200 Independence Avenue, S.W.  
Washington, DC 20201  
Tel: (202) 690-7151  
**StateHIEgrants@<mailto:hhs.gov>**

## **2. DUNS Number**

The Office of Management and Budget (OMB) requires applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for federal grants or cooperative agreements on or after October 1, 2003. It is entered on the SF 424. It is a unique, nine-digit identification number, which provides unique identifiers of single business entities. The DUNS number is free and easy to obtain, though applicants should allow a minimum of five days to complete the CCR registration.

Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide:  
[https://www.whitehouse.gov/omb/grants/duns\\_num\\_guide.pdf](https://www.whitehouse.gov/omb/grants/duns_num_guide.pdf).

## **3. Tips for Writing a Strong Application**

Tips for writing a strong application can be found at HHS' GrantsNet site at  
<http://www.hhs.gov/grantsnet/AppTips.htm>.

## **4. Project Abstract**

Applicants shall include a one-page abstract (no more than 500 words) of the application. This abstract is often distributed to provide information to the public and Congress and represents a high-level summary of the project. Applicants should prepare a clear, accurate, concise abstract that can be understood without reference to other parts of the application and which gives a description of the proposed project, including: the project's goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, products, and duration. Detailed instructions for completing the summary/abstract are included in Appendix L of this document.

The Project Abstract must be double-spaced with a font size of not less than 11 point.

The applicant shall place the following information at the top of the Project Abstract (this information is not included in the 500 word maximum):

- Project Title
- States/territories included in the application
- Applicant Name
- Address
- Contact Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable
- Congressional districts within your service area
- Brief explanation of where the state is in achieving statewide HIE among healthcare providers

The Project Abstract must include a brief description of the proposed cooperative agreement, how the activities support and will enhance HIE services across all health care and public health stakeholders, the current status of the state's efforts, the need(s) to be met with the funds, the design and scope of the state's plan.

## 5. **Project Narrative**

The Project Narrative is the most important part of the application, since it will be used as the primary basis to determine whether or not the application meets the minimum requirements for funding. The Project Narrative must provide a detailed picture of the current state of HIE in the state (and at the multi-state level, if applicable) and must describe the needs of specific geographic areas of the state to achieve greater availability and use of electronic health information exchange. The Project Narrative is in addition to the outlined State Plan (Strategic and Operational). The narrative must provide the reader with an understanding of the state's current efforts and what activities are planned through the State HIE Program to implement health information exchange across the state or region. As appropriate, applicants should reference the pathway to HIE and the five critical domains discussed above.

The Project Narrative must be double-spaced, on 8 ½" x 11" papers with 1" margins on both sides, and a font size of not less than 11. Smaller font sizes may be used to fill in the Standard Forms and Sample Formats. The suggested length for the Project Narrative is 25 to 40 pages; 40 pages is the maximum length allowed. ONC will not accept applications with a Project Narrative that exceeds 40 pages. The State Plans (Strategic and Operational Plans), Governor's Designation Letter, Project Abstract, Letters of Commitment, and Resumes of Key Personnel are not counted as part of the Project Narrative for purposes of the 40-page limit, but all of the other sections noted below are included in the limit.

The components of the Project Narrative counted as part of the 40 page limit include:

- Current State
- Proposed Project Strategy
- Required Performance Measures
- Project Management
- Evaluation
- Organizational Capability Statement

The Project Narrative is a critical part of the application as it will be used as the primary basis to determine whether or not the application meets the minimum requirements for funding under the HITECH Act. The Project Narrative should provide a clear and concise description of the project. ONC recommends that the project narrative include the following components:

### **a) Current State**

In this section applicants shall:

- Discuss and determine the current status of the state's progress in achieving statewide HIE among healthcare providers, including:
  - Electronic eligibility and claims transactions
  - Electronic prescribing and refill requests
  - Electronic clinical laboratory ordering and results delivery
  - Electronic public health reporting (immunizations, notifiable laboratory results)
  - Quality reporting capabilities
  - Prescription fill status and/or medication fill history
  - Clinical summary exchange for care coordination and patient engagement.
- Describe the progress and status of the state in its project planning and implementation as described in Section I.E.1., Self-Assessment of the State's Current Status.

***b) Proposed Project Summary***

This section should provide a clear and concise description of activities funded by the cooperative agreement to develop, finalize and maintain Strategic and Operational plans to increase the extent of electronic information exchange for the HIE program objectives. It is not expected to be a summary of a state's existing state plans. Applicants must articulate the rationale for the overall approach to the project. Also note any major barriers anticipated to be encountered and how the project will be able to overcome those barriers. The project summary should include all portions required but applicants may frame their answers according to their current status (whether the state has an existing plan or intends to develop or finalize one using federal funds). It is expected that those applicants with plans will have more fully developed and final responses while those without applications may address intended approaches to be used. The proposed summary shall include:

- For states without existing state plans at the time of application, a description of the approach the applicant proposes to develop and finalize such a plan.
- For states with existing state plans at time of application, a description of the approach the applicant proposes to implement the plan including the mechanisms to overcome obstacles and a realistic and achievable high-level project plan and timeline.
- A discussion of approach to be employed to ensure compliance with the Privacy and Security requirements for Health IT as outlined in Section I.F.2., Privacy and Security.
- A description of the proposed communications strategy with key stakeholders and the health community.
- A description of how the applicant plans to involve community-based organizations in a meaningful way in the planning and implementation of the proposal project. This section should also describe how the proposed intervention will target medically underserved populations, and the needs of special populations including newborns, children, youth, including those in foster care, the elderly, persons with disabilities, Limited English Proficiency (LEP) persons, persons with mental and substance use disorders, and those in long term care.
- A discussion of how the interests of the stakeholders below will be considered and incorporated into planning and implementation activities.
  - Health care providers, including providers that provide services to low income and underserved populations
  - Health plans
  - Patient or consumer organizations that represent the population to be served
  - Health information technology vendors
  - Health care purchasers and employers
  - Public health agencies
  - Health professions schools, universities and colleges
  - Clinical researchers
  - Other users of health information technology such as the support and clerical staff of providers and others involved in the care coordination of patients
- Additionally, for those submitting collaborative applications (multi-state/territory), a discussion that:
  - Demonstrates that the application represents the best interest of each state or territory involved in the consortium.
  - Documents how financial accountability will be assured, so that risks and challenges faced by one member of the collaborative do not impede the progress of another member and develop a reporting mechanism that tracks expenditures and activities by state.

- Describes how governance standards will be met, to include governance structures at the state/territory level that is represented within a collaborative governance structure.
- Documents how financial accountability will be assured, so that risks and challenges faced by one member of the collaborative do not impede the progress of another member.
- Ensures that sufficient funds will be available to each state/territory for planning at the state level.

**c) *Required Performance Measures and Reporting***

Reporting and Performance Measures are required for applicants requesting funding for planning or implementation activities. Reporting Requirements must be submitted by applicants requesting funding for planning and/or implementation activities. Once a recipient has entered into implementation activities, the Performance Measures become ongoing requirements.

The applicant shall provide detailed information in the application about the methodologies, tools, and strategies they intend to use to collect all data, including the reporting requirements and performance measures, for the project to satisfy the reporting requirements of this program and the Government Performance Reporting Act of 2003. Other performance measures specific to ARRA reporting are required and provided in Appendix G. ARRA reporting requirements will also be included in the Notice of Award. The performance measures will be used as part of the state and/or national program evaluation. As the program evolves, additional requirements may be provided through program guidance.

Specific reporting requirements, performance and evaluation measures and methods to collect data and evaluate project performance will be provided at a later date in program guidance and through technical assistance, prior to award of cooperative agreements. These measures will include those related to the following domains: governance, finance, technical infrastructure, business and technical operations, and legal/policy. The core set of reporting requirements and performance measures enables states to monitor their own progress, and when aggregated across recipients, provides ONC with a national view of progress across the program. The core set of reporting requirements and performance measures includes but are not limited to:

***Reporting Requirements***

*(Required for those requesting funding for planning and/or implementation activities)*

- **Governance**
  - What proportion of the governing organization is represented by public stakeholders?
  - What proportion of the governing organization is represented by private sector stakeholders?
  - Does the governing organization represent government, public health, hospitals, employers, providers, payers and consumers?
  - Does the state Medicaid agency have a designated governance role in the organization?
  - Has the governing organization adopted a strategic plan for statewide HIT?
  - Has the governing organization approved and started implementation of an operational plan for statewide HIT?
  - Are governing organization meetings posted and open to the public?
  - Do regional HIE initiatives have a designated governance role in the organization?
- **Finance**
  - Has the organization developed and implemented financial policies and procedures consistent with state and federal requirements?

- Does organization receive revenue from both public and private organizations?
- What proportion of the sources of funding to advance statewide HIE are obtained from federal assistance, state assistance, other charitable contributions, and revenue from HIE services?
- Of other charitable contributions listed above, what proportion of funding comes from health care providers, employers, health plans, and others (please specify)?
- Has the organization developed a business plan that includes a financial sustainability plan?
- Does the governance organization review the budget with the oversight board on a quarterly basis?
- Does the recipient comply with the Single Audit requirements of OMB?
- Is there a secure revenue stream to support sustainable business operations throughout and beyond the performance period?
- **Technical Infrastructure**
  - Is the statewide technical architecture for HIE developed and ready for implementation according to HIE model(s) chosen by the governance organization?
  - Does statewide technical infrastructure integrate state-specific Medicaid management information systems?
  - Does statewide technical infrastructure integrate regional HIE?
  - What proportion of healthcare providers in the state are able to send electronic health information using components of the statewide HIE Technical infrastructure?
  - What proportion of healthcare providers in the state are able to receive electronic health information using components of the statewide HIE Technical infrastructure?
- **Business and Technical Operations**
  - Is technical assistance available to those developing HIE services?
  - Is the statewide governance organization monitoring and planning for remediation of HIE as necessary throughout the state?
  - What percent of health care providers have access to broadband?
  - What statewide shared services or other statewide technical resources are developed and implemented to address business and technical operations?
- **Legal/Policy**
  - Has the governance organization developed and implemented privacy policies and procedures consistent with state and federal requirements?
  - How many trust agreements have been signed?
  - Do privacy policies, procedures and trust agreements incorporate provisions allowing for public health data use?

### *Performance Measures*

The following measures are applicable to the implementation phase of the cooperative agreement. They are an initial set of measures intended to give a state specific and national perspective on the degree of provider participation in HIE enabled state level technical services and the degree to which pharmacies and clinical laboratories are active trading partners in HIE. E-prescribing and laboratory results reporting are two of the most common types of HIE within and across states.

- Percent of providers participating in HIE services enabled by statewide directories or shared services.<sup>12</sup>

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<sup>12</sup> *ONC will negotiate with each state to determine best way to further specify this measure based on the statewide directories and shared services pursued within each state under this program.*

- Percent of pharmacies serving people within the state that are actively supporting electronic prescribing and refill requests.
- Percent of clinical laboratories serving people within the state that are actively supporting electronic ordering and results reporting.

***Recipients will also be required to report on additional measures that will indicate the degree of provider participation in different types of HIE particularly those required for meaningful use.***

Future areas for performance measures that will be specified in program guidance will include but **are** not limited to: providers' use of electronic prescribing, exchange of clinical summaries among treating providers, immunization, quality and other public health reporting and eligibility checking.

#### ***d) Project Management***

This section should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes. It should specify who would have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, preparation of reports, and communications with other partners and ONC. It should also describe the approach that will be used to monitor and track progress on the project's tasks and objectives.

#### ***e) Evaluation***

This section should describe the method(s), techniques and tools that will be used to track and maintain project information expected to be required for the state to conduct a self-evaluation of the project and to inform a national program-level evaluation.

#### ***f) Organizational Capability Statement***

Each application shall include an organizational capability statement. The organizational capability statement should describe how the applicant agency (or the particular division of a larger agency that will have responsibility for this project) is organized, the nature and scope of its work and/or the capabilities it possesses. It should also include the organization's capability to sustain some or all project activities after federal financial assistance has ended. It must define who is considered key staff and the applicant must provide resumes for each key staff member in the attachments to the application, which are not included in the page limitation.

This description should cover capabilities of the applicant agency, such as any current or previous relevant experience and/or the record of the project team in preparing cogent and useful reports, publications, and other products. If appropriate, include in the attachments an organization chart showing the relationship of the project to the current organization, which will not count toward the page will limit. Also include information about any contractual organization(s) that will have a significant role(s) in implementing project and achieving project goals.

## **6. Required Plans**

If, at the time of application, the applicant has a state plan (Strategic or Operational) that is either consistent or not consistent with planning guidance in this document, it should be included with this application.

Applicants that have plans that are not consistent with the planning guidance may take the time during application period to revise their Strategic and Operational Plans to be consistent with planning guidance, if they choose. The applicant should indicate if the State Plan submitted with this application is submitted for official approval by the National Coordinator.

## **7. Collaborations and Letters of Commitment from Key Participating Organizations and Agencies**

The applicant shall fully describe the current relationships established to meet the State's HIE goals. If there are relationships that have yet to be formalized, provide a plan for engaging these groups. The applicant must also include, in an attachment to the application, a copy of the interagency agreement (or similar document) that outlines the parameters of such relationships. At a minimum this section must explain the demonstrated commitment on the part of the state government and how the state and project coordinate with critical stakeholders.

Include confirmation of the financial or in-kind commitments to the project (should it be funded) made by key collaborating organizations and agencies in this part of the application. Any organization that is specifically named to have a significant role in carrying out the project should be considered an key collaborating organization and a letter of support should be included for each. For applications submitted electronically via grants.gov, signed letters of commitment should be scanned and included as attachments. These letters should not be considered as part of the 25 page limit. A template for these letters can be found in Appendix E.

## **8. Budget Narrative/Justification**

All applicants are required to outline proposed costs that support all project activities in the Budget Narrative/Justification. The application must include the allowable activities that will take place during the funding period and outline the estimated costs that will be used specifically in support of the program. Costs are not allowed to be expended until the start date listed in the Notice of Grant Award. All costs must be allowable, allocable, reasonable and necessary under the applicable OMB Cost Circular: [www.whitehouse.gov/omb/circulars](http://www.whitehouse.gov/omb/circulars) (Circular A-87 for States and Circular A-122 for SDEs) and based on the programmatic requirements for administering the program as outlined in ARRA.

Prior to the application due date, and after submission of the required letter of intent, eligible applicants will be provided an allocation amount for the proposed project period. This figure will be determined as described in Section G.2 – Other Funding Information, below. This amount plus required match should be the total of all allowable project costs for the four year project period. Applicants are required to submit a one year budget for each of the four years of the project period.

Applicants are suggested to use the format included as Appendix K of this Funding Opportunity Announcement. Applicants are also encouraged to pay particular attention to Appendix J, which provides an example of the level of detail sought. A combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required. Instructions are also included in Appendix I as they pertain to completing the SF 424.

## **D. Submission Dates and Times**

Letters of Intent to Apply must be submitted electronically or by mail, no later than 5:00 p.m. Eastern Standard Time on August 31, 2009. For those applicants who are not a state agency, a Governor's Designation letter on official letterhead must be attached to the Letter of Intent. Formats for both documents are included in Appendices D and C, respectively. Information on where to submit the Letter of Intent can be found at Section IV.C.1.

Applications must be submitted via grants.gov no later than 5:00 p.m. EST on October 16, 2009.

Applications that fail to meet the application due date will not be reviewed and will receive no further consideration.

Grants.gov will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in grants.gov. After the Office of Grants Management retrieves the application form from grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by grants.gov.

## **E. Intergovernmental Review**

This program is excluded from Executive Order 12372.

## **F. Funding Restrictions**

Applicants responding to this announcement may request funding for a project period of up to four years.

ONC will negotiate with applicants regarding allowable activities consistent with the yet-to-be developed Medicare/Medicaid “meaningful use” definition. ONC reserves the right to not award a cooperative agreement to any applicant that proposes activities that are not aligned with the goals and vision of enabling standards-based HIE in support of meaningful use and a high performance health care system.

Funds under this announcement cannot be used for the following purposes:

- To supplant or replace current public or private funding.
- To supplant on-going or usual activities of any organization involved in the project.
- To purchase or improve land, or to purchase, construct, or make permanent improvements to any building except for minor remodeling.
- To reimburse pre-award costs.

Funds are to be used in a manner consistent with program policies developed by ONC and within allowable budget categories outlined in Appendix I and J. Allowable administrative functions/costs include:

- Usual and recognized overhead, including indirect rates for all consortium organizations that have an approved indirect cost rate by a federal cognizant agency.
- 2% of total project costs must be included in the budget for project evaluation.

## **G. Other Funding Information**

### **1. Project Period**

The four-year project period is intended to allow recipients time to complete the goals of the program. However, applicants are strongly encouraged to plan projects and budgets that accomplish most of the project goals and milestones within the first two years of the project period to best enable HIE capacity.

Funding decisions will be made based on a combination of formulaic allocations and needs-based assessment. More specific information will be forthcoming, but a general description of the process is below.

### **2. Funding Formula**

**Base Allocation:** Each state, the District of Columbia, and the Commonwealth of Puerto Rico will be given an equal base amount of \$4,000,000. American Samoa, Guam, the Northern

Mariana Islands, and the Virgin Islands will each receive a base amount adjusted to reflect their population. Given the complexity, urgency, and importance of the work associated with achieving HIE services to reach all health care providers in the territories, we strongly encourage each of the territories to team with a state for the purposes of this cooperative agreement. For those that apply using a multi-state approach, the base amount will be adjusted to reflect the efficiencies of shared services.

**Equity Adjustments:** For states and the District of Columbia: Additional funds will be added to this base amount to account for differences in existing health care delivery environment. These additional funds will be determined by formula using the following equity factors – number of primary care physicians, number of short-term (acute) care hospitals, state population, and indicators of rural and underserved areas.

Following are the sources of information to be used for these equity adjustments along with the associated weights for each:

- PCP Populations –The Robert Graham Center, as an extract of the American Medical Association’s master data file. Primary care physicians, for the purpose of this funding formula include MD/DO family physicians, general internists, and pediatricians. (40% of total allocation).
- Short-Term (Acute) Care Hospital –The CMS Point of Service file, identifying the number of acute care and pediatric facilities in each state. (30% of total allocation).
- Medically Underserved and Rural Providers –The CMS Point of Service file, identifying the Federally Qualified Health Center, and Rural Health Clinics in each state. (25% of total allocation).
- State Population – 2000 Census estimates for 2008, used to determine the population for each state. (5% of the total allocation).

**Needs-Based Adjustments:** ONC will allocate 10% of the total funds available using information provided by the applicant regarding their historic investment in HIE as required in the Letter of Intent (see Appendix C, Required Format for Letter of Intent to Apply). States, the District of Columbia, and territories will be ranked on a scale of 1-3 based on historic investment, with a lower level of investment indicating a higher need for HIE grant funding.

**Base Allocation + Equity Adjustments + Needs-Based Adjustments = Full Cooperative Agreement Award Amount**

Unobligated funds at the end of the budget/project period are restricted and remain in the account for future disposition. Unobligated funds are those reported on the final Financial Status Report (SF-269), which is required to be submitted after the end of the budget/project period.

### **3. Performance-Based Funding**

The performance and other reports submitted by award recipients will help to determine the project’s progress. Special conditions will be placed on each cooperative agreement that divides total funding among major milestones and meeting specific metrics for the program. For example, those recipients who do not have State Plans may drawdown funds for planning purposes; when the plan is complete and approved, the recipient will be able to drawdown additional funds related for implementation. Other milestones may include the initiation and completion and/or certain implementation activities of HIE Stages. Specific measures may include the HIE services that are available to providers.

#### **4. Indirect Costs**

Applicants should reference their approved indirect costs rates for any management and administrative needs while budgeting. ONC will not reimburse indirect costs unless the recipient has an approved indirect cost rate covering the applicable activities and period. Applicants are encouraged to consider budgeting for lower indirect cost rates in an effort to direct more resources toward project goals.

#### **H. Other Submission Requirements**

Applicants are required to attend the State HIE Leadership Training and the State HIE Forum, supported by ONC. The submitted budget must reflect funds allocated for travel for two people to attend each event for two days each year of the project period. One will be held in Washington, D.C. and one will be in Chicago, Illinois. Applicant's attendance is an annual requirement.

#### **I. Summary of Required Attachments**

- Copy of Letter of Intent, as previously submitted (Appendix C).
- Letter designating the component of state government that will apply or a private entity as the SDE (Appendix D).
- Letters of Support from critical stakeholders (Appendix E).
- Not-for-profit certification or pending application (for State Designated Entities).
- State Plan (if available).

### **V. Application Review Information**

#### **A. Criteria**

A panel that may include both expert peer reviewers and federal staff will review each application that meets the responsiveness and screening criteria in Section III.C, 1 and 2. The purpose of this review is to determine if the approach, strategy, and any provided state plans are aligned with program requirements, not as a competitive means of comparing applications. The detailed results of this review will be shared with the applicant upon request. Additionally, the review results will form the basis for development of the programmatic terms and conditions of the cooperative agreement. These terms and conditions will outline the necessary milestones that must be met to continue receiving funds. Lastly, the review results will assist Project Officers in their collaborative discussions with the applicant regarding needed changes and for continued collaboration with recipients.

Each of the following items within each section will be assessed on a three point scale. A score of one means that the application has not met the requirements; a score of two means that the application has met requirements; a score of three means that the application has exceeded requirements. If an applicant fails to address the item, a score of zero will be given.

Applications will be reviewed for the following items:

#### **Current State and Gap Analysis**

- Determination of current status of the state's level of maturity as currently described in Section I.D.1.a, The Stages of HIE.
- Determination of the progress and status of the state in its project planning and implementation as described in Section I.E.1., Self - Assessment of the State's Current Status.
-

### **Proposed Strategy**

- For states without existing State Plans at time of application, an assessment of the strategy the applicant proposes to develop and finalize such a plan.
- For states with existing State Plans at time of application, an assessment of the strategy the applicant proposes to implement the plan including:
  - The approaches to overcome obstacles described.
  - Whether the proposed project plan and timelines are realistic and achievable.
- A determination of the alignment of the application's description of the Privacy and Security requirements for Health IT as required by Section I.F.2., Privacy and Security.
- An assessment of the proposed communications strategy with key stakeholders and the health community.
- An assessment of the strategy to incorporate special target populations and organizations, as described in Project Narrative section.
- An assessment of whether the application demonstrates how the interests of the stakeholders below will be considered and incorporated into planning and implementation activities.
  - Health care providers, including providers that provide services to low income and Underserved populations
  - Health plans
  - Patient or consumer organizations that represent the population to be served
  - Health information technology vendors
  - Health care purchasers and employers
  - Public health agencies
  - Health professions schools, universities and colleges
  - Clinical researchers
  - Other users of health information technology such as the support and clerical staff of providers and others involved in the care coordination of patients
- For those submitting collaborative applications (multi-state/territory), an assessment of whether the applicant organization:
  - Demonstrates that the application represents the best interest of each state or territory involved in the consortium.
  - Documents how financial accountability will be assured, so that risks and challenges faced by one member of the collaborative do not impede the progress of another member and develop a reporting mechanism that tracks expenditures and activities by state.
  - Describes how governance standards will be met, to include governance structures at the state/territory level that is represented within a collaborative governance structure.
  - Documents how financial accountability will be assured, so that risks and challenges faced by one member of the collaborative do not impede the progress of another member.
  - Ensures that sufficient funds will be available to each state/territory for planning at the state level.

### **Project Management**

- An assessment of whether the proposed staffing of the project is adequate to achieve the stated goals and to develop and/or implement State Plans.
- An assessment of whether the proposed strategy for project management is adequate to ensure progress and the ability to meet the stated goals and/or implement State Plans in a timely and effective manner.

### **Evaluation and Performance Measures**

- An assessment of the quality and thoughtfulness of the techniques to be employed by the applicant to track and maintain project information and metrics.

### **Organizational Capability Statement**

- An assessment of the organizational capability and background to carry out the goals and requirements of the program.
- An assessment of the organization's ability to sustain the project after federal assistance ends.

### **Budget Narrative/Justification**

- An assessment of the proposed costs for allocability, reasonableness and allowability of costs.
- An assessment of the proposed costs' alignment with ONC program and proposed project goals.

## **B. Review and Selection Process**

An independent review panel of at least three individuals will evaluate applications that pass the screening and meet the responsiveness criteria, if applicable. These reviewers will be experts in their field, and will be drawn from academic institutions, non-profit organizations, state and local government, and federal government agencies. Based on the Application Review Criteria as outlined under Section V.A, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Final award decisions will be made by The National Coordinator for Health Information Technology. In making these decisions, The National Coordinator for Health Information Technology will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; and the likelihood that the proposed project will result in the benefits expected.

Applicants have the option of omitting from the application specific salary rates or Social Security Numbers for individuals specified in the application budget.

## **VI. Award Administration Information**

### **A. Award Notices**

Each applicant will receive notification of the outcome of the review process outlined in Section V.A, including whether the application was selected for funding. The authorized representative of the state or SDE selected for funding will be required to accept the terms and conditions placed on their application before funding can proceed. Letters of notification acknowledge that an award was funded, but do not provide authorization for the applicant to begin performance and expend funds associated with the award until the start date of the award as indicated in the notice. Applicants may request a summary of the expert committee's assessment of the application's merits and weaknesses.

The Notice of Grant Award (NGA) contains details on the amount of funds awarded, the terms and conditions of the cooperative agreement, the effective date of the award, the budget period for which support will be given, the required match to be provided, and the total project period timeframe. This NGA is then signed by the ONC Grants Management Officer, sent to the applicant agency's Authorized Representative, and will be considered the official authorizing

document for this award. It will be sent to applicants prior to the start date of this program January 15, 2010.

Successful applicants will receive an electronic NGA from ASPR. This is the authorizing document notifying the applicant of the award from the U.S. Assistant Secretary for Preparedness and Response authorizing official, Officer of Grants Management, and the ASPR Office of Budget and Finance. Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail.

## **B. Administrative and National Policy Requirements**

The award is subject to HHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement located at <http://www.hhs.gov/grantsnet/adminis/gpd/index.htm>.

### **1. HHS Grants Policy Statement**

ONC awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable to the grant/cooperative agreement based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award, as well as any requirements of Part IV. The HHS GPS is available at <http://www.hhs.gov/grantsnet/adminis/gpd/>. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

#### ***a) Records Retention***

Recipients generally must retain financial and programmatic records, supporting documents, statistical records, and all other records that are required by the terms of a grant, or may reasonably be considered pertinent to a grant, for a period of three years from the date the annual FSR is submitted. For awards where the FSR is submitted at the end of the competitive segment, the three-year retention period will be calculated from the date the FSR for the entire competitive segment is submitted. Those recipients must retain the records pertinent to the entire competitive segment for three years from the date the FSR is submitted. See 45 CFR 74.53 and 92.42 for exceptions and qualifications to the three-year retention requirement (e.g., if any litigation, claim, financial management review, or audit is started before the expiration of the three-year period, the records must be retained until all litigation, claims, or audit findings involving the records have been resolved and final action taken). Those sections also specify the retention period for other types of grant-related records, including indirect cost proposals and property records. See 45 CFR 74.48 and 92.36 for record retention and access requirements for contracts under grants.

## **C. Reporting**

All reporting requirements will be provided to successful applicants, adherence to which is a required condition of any award. In general, the successful applicant under this guidance must comply with the following reporting and review activities:

### **1. Audit Requirements**

The recipient shall comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at [www.whitehouse.gov/omb/circulars](http://www.whitehouse.gov/omb/circulars).

### **2. Financial Status Reports**

The recipient shall submit an annual Financial Status Report. An SF-269 financial status report is required within 90 days of the end of each budget and project period. The report is an accounting

of expenditures under the project that year. More specific information on this reporting requirement will be included in the Notice of Grant Award.

### **3. Progress Reports**

Progress Reports will be evaluated by ONC and are required on a semi-annual basis. ONC will provide required additional reporting instructions after awards are made.

As component of regular reporting, recipients will be required to detail expenditure information that reflect spending on developing a statewide governance and policy framework and developing HIE capacity with the state. Exceptions to this reporting requirement include activities related to the development of the state's Strategic Plan and statewide shared services and directories that meet HHS adopted standards. Format and guidance for this requirement will be included in future program guidance.

### **4. ARRA-Specific Reporting**

Quarterly Financial and Programmatic Reporting: Consistent with the Recovery Act emphasis on accountability and transparency, reporting requirements under Recovery Act programs will differ from and expand upon HHS's standard reporting requirements for grants. In particular, section 1512(c) of the Recovery Act sets out detailed requirements for quarterly reports that must be submitted within 10 days of the end of each calendar quarter. Receipt of funds will be contingent on meeting the Recovery Act reporting requirements.

The information from recipient reports will be posted on a public website. To the extent that funds are available to pay a recipient's administrative expenses, those funds may be used to assist the recipient in meeting the accelerated time-frame and extensive reporting requirements of the Recovery Act.

ONC may post information on the public website that identifies recipients that are delinquent in their reporting requirements. Additionally, recipients who do not submit required reports by the due date will not be permitted to drawdown funds thereafter, during the pendency of the delinquency, and may be subject to other appropriate actions by ONC, including, but not limited to, restrictions on eligibility for future ONC awards, restrictions on draw-down on other HHS awards, and suspension or termination of the Recovery Act award.

ONC may provide a standard form or reporting mechanism that recipients would be required to use. Additional instructions and guidance regarding required reporting will be provided as they become available. For planning purposes, however, all applicants shall be aware that the Recovery Act section 1512(c) provides as follows:

**Recipient Reports:** Not later than 10 days after the end of each calendar quarter, each recipient that received recovery funds from a federal agency shall submit a report to that agency that contains—

- (1) The total amount of recovery funds received from that agency;
- (2) The amount of recovery funds received that were expended or obligated to projects or activities; and
- (3) A detailed list of all projects or activities for which recovery funds were expended or obligated, including--
  - (A) The name of the project or activity;
  - (B) A description of the project or activity;
  - (C) An evaluation of the completion status of the project or activity;

(D) An estimate of the number of jobs created and the number of jobs retained by the project or activity; and

(E) For infrastructure investments made by State and local governments, the purpose, total cost, and rationale of the agency for funding the infrastructure investment with funds made available under this Act, and name of the person to contact at the agency if there are concerns with the infrastructure investment.

(4) Detailed information on any subcontracts or subgrants awarded by the recipient to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 (Public Law 109-282), allowing aggregate reporting on awards below \$25,000 or to individuals, as prescribed by the Director of the Office of Management and Budget. OMB guidance for implementing and reporting ARRA activities can be found at [http://www.whitehouse.gov/omb/recovery\\_default/](http://www.whitehouse.gov/omb/recovery_default/).

## **D. Cooperative Agreement Terms and Conditions of Award**

The following special terms of award are in addition to, and not in lieu of, otherwise applicable OMB administrative guidelines, HHS grant administration regulations at 45 CFR Parts 74 and 92 (Part 92 is applicable when State and local Governments are eligible to apply), and other HHS, PHS, and ONC grant administration policies.

The administrative and funding instrument used for this program will be the cooperative agreement, an "assistance" mechanism, in which substantial ONC programmatic involvement with the recipients is anticipated during the performance of the activities. Under the cooperative agreement, the ONC purpose is to support and stimulate the recipients' activities by involvement in and otherwise working jointly with the award recipients in a partnership role; it is not to assume direction, prime responsibility, or a dominant role in the activities. Consistent with this concept, the dominant role and prime responsibility resides with the recipients for the project as a whole, although specific tasks and activities may be shared among the recipients and the ONC as defined below. To facilitate appropriate involvement, during the period of this cooperative agreement, ONC and the recipient will be in contact monthly and more frequently when appropriate. Requests to modify or amend the cooperative agreement may be made by ONC or the recipient at any time. Modifications and/or amendments to the cooperative agreement shall be effective upon the mutual agreement of both parties, except where ONC is authorized under the Terms and Conditions of award, 45 CFR Part 74 or 92, or other applicable regulation or statute to make unilateral amendments.

### **1. Cooperative Agreement Roles and Responsibilities**

#### **Office of the National Coordinator for Health Information Technology**

ONC will have substantial involvement in program awards, as outlined below:

- Technical Assistance – This includes federal guidance on the evolution of HIE in accordance with meaningful use criteria to be established by the Secretary through the rulemaking process.
- Over time ONC will also assist states in meeting the strategic goals of the state and overall program on a national level through ongoing support made available through the NHIN and other ONC funded programs.
- Collaboration – To facilitate compliance with the terms of the cooperative agreement and to more effectively support recipients, ONC will actively coordinate with critical stakeholders, such as:
  - Medicaid and Medicare Administrators
  - State Designated Entities
  - State Government HIT Leads

- Relevant Federal Agencies
- Program Evaluation – As required by section 3013 of the HITECH Act, ONC will conduct a national level program evaluation and work with recipients to implement lessons learned to continuously improve this program and the nation-wide implementation of HIE.
- Project Officers – ONC will assign specific Project Officers to each cooperative agreement award to support and monitor recipients throughout the period of performance.
- Conference and Training Opportunities – ONC will host a minimum of two opportunities for training and/or networking, including, but not limited to, the State HIE Forum and Leadership Training.
- Release of Funds Approval – ONC Project Officers will be responsible for requesting authorization for the release of funds for their assigned projects.
- Monitoring – ONC Project Officers will monitor, on a regular basis, progress of each recipient. This monitoring may be by phone, document review, on-site visit, other meeting and by other appropriate means, such as reviewing program progress reports and Financial Status Reports (SF269). This monitoring will be to determine compliance with programmatic and financial requirements.

### **Recipients**

Recipients and assigned points of contact retain the primary responsibility and dominant role for planning, directing and executing the proposed project as outlined in the terms and conditions of the cooperative agreement and with substantial ONC involvement. Responsibilities include:

- Requirements – Recipients shall comply with all current and future requirements of the project, including those in their approved State Plans, guidance on the implementation of meaningful use, certification criteria and standards (including privacy and security) specified and approved by the Secretary of HHS
- Participation in the State HIE Forum and Leadership Training.
- Recipients are required to collaborate with the critical stakeholders listed in this Funding Opportunity Announcement and the ONC team, including the assigned Project Officer.
- Recipients are required to collaborate with their Medicaid Directors to assist with monitoring and compliance of eligible meaningful use incentive recipients, to be established by the Secretary through the rulemaking process.
- Recipients are required to collaborate with the Regional Centers to ensure that the provider connectivity supported by the Regional Centers is consistent with the State’s Plan for HIE.
- Reporting – Recipients are required to comply with all reporting requirements outlined in this Funding Opportunity Announcement and the terms and conditions of the cooperative agreement to ensure the timely release of funds.
- Program Evaluation – Recipients are required to cooperate with the ONC directed national program evaluation.

### **Dispute Resolution**

Both ONC and the recipient are expected to work in a collegial fashion to minimize misunderstandings and disagreements. ONC will resolve disputes by using alternative dispute resolution (ADR) techniques. ADR often is effective in reducing the cost, delay, and contentiousness involved in appeals and other traditional ways of handling disputes. ONC will determine the specific technique to be employed on a case by case basis. ADR techniques include mediation, neutral evaluation, and other consensual methods. The National Coordinator for Health IT will make final determinations pertaining to cooperative agreements based on the output of these resolution methods.

## **2. Other Terms**

These special terms and conditions of the award are in addition to and not in lieu of otherwise applicable OMB administrative guidelines, HHS grant administration regulations in 45 CFR, and other HHS and ONC policy statements.

Cooperative agreements are for a period of up to four years.

As meaningful use criteria to be established by the Secretary through the rulemaking process and other relevant guidance evolve, ONC will update ongoing program guidance. By accepting an award, recipients are required to abide by this guidance.

Drawdown of funding for this grant serves as official acceptance of this cooperative agreement. If you do not plan to accept the award, please send a letter of declination to the ONC Project Officer within 30 days of receipt of the Notice of Award.

Requests to modify or amend this cooperative agreement may be made at any time by ONC or the recipient, which shall be effective upon mutual agreement of both parties and if not agreed to will be subject to the dispute resolution practice below.

Recipients must comply with reporting requirements of the cooperative agreement.

Recipients must comply with the requirements of and cooperate with ONC in completing its responsibility to conduct a national evaluation.

Special conditions may be placed on cooperative agreements, based on the outcomes of negotiations with the applicants. These are binding on recipients. Among these conditions will be specific performance milestones with ties to funding availability. Available federal funds will be broken down into funding phases according to these milestones. During the course of the project period, recipients may drawdown funds as needed using the funds available to them for the phase they are in. At the achievement of the next milestone, such as the State Plan being approved by the National Coordinator, additional funding will become available for drawdown.

## **E. American Recovery and Reinvestment Act of 2009**

### **1. HHS Standard Terms and Conditions**

HHS award recipients must comply with all terms and conditions outlined in their award, including policy terms and conditions contained in applicable Department of Health and Human Services (HHS) Grant Policy Statements, and requirements imposed by program statutes and regulations and HHS grant administration regulations, as applicable, unless they conflict or are superseded by the following terms and conditions implementing the American Recovery and Reinvestment Act of 2009 (ARRA) requirements below. In addition to the standard terms and conditions of award, recipients receiving funds under Division A of ARRA must abide by the terms and conditions set out below. The terms and conditions below concerning civil rights obligations and disclosure of fraud and misconduct are reminders rather than new requirements, but the other requirements are new and are specifically imposed for awards funded under ARRA. Recipients are responsible for contacting their HHS grant/program managers/project officers for any needed clarifications.

Awards issued under this guidance are also subject to the requirements outlined in the HITECH Act, Section 3013 of ARRA.

## **2. Preference for Quick Start Activities**

In using funds for this award for infrastructure investment, recipients shall give preference to activities that can be started and completed expeditiously, including a goal of using at least 50 percent of the funds for activities that can be initiated not later than 120 days after the date of the enactment of ARRA. Recipients shall also use funds in a manner that maximizes job creation and economic benefit. (ARRA Sec. 1602).

## **3. Limit on Funds**

None of the funds appropriated or otherwise made available in ARRA may be used by any State or local government, or any private entity, for any casino or other gambling establishment, aquarium, zoo, golf course, or swimming pool. (ARRA Sec. 1604).

## **4. ARRA: One-Time Funding**

Unless otherwise specified, ARRA funding to existent or new awardees should be considered one-time funding.

## **5. Civil Rights Obligations**

While ARRA has not modified awardees' civil rights obligations, which are referenced in the HHS' Grants Policy Statement, these obligations remain a requirement of federal law. Recipients and sub-recipients of ARRA funds or other federal financial assistance must comply with Title VI of the Civil Rights Act of 1964 (prohibiting race, color, and national origin discrimination), Section 504 of the Rehabilitation Act of 1973 (prohibiting disability discrimination), Title IX of the Education Amendments of 1972 (prohibiting sex discrimination in education and training programs), and the Age Discrimination Act of 1975 (prohibiting age discrimination in the provision of services). For further information and technical assistance, please contact the HHS Office for Civil Rights at (202) 619-0403, OCRmail@hhs.gov, or <http://www.hhs.gov/ocr/civilrights/>.

## **6. Disclosure of Fraud or Misconduct**

Each recipient or sub-recipient awarded funds made available under the ARRA shall promptly refer to the HHS Office of Inspector General any credible evidence that a principal, employee, agent, contractor, sub-recipient, subcontractor, or other person has submitted a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving those funds. The HHS Office of Inspector General can be reached at <http://www.oig.hhs.gov/fraud/hotline/>.

## **7. Responsibilities for Informing Sub-recipients**

Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the federal award number, any special CFDA number assigned for ARRA purposes, and amount of ARRA funds.

### ***Recovery Act Transactions listed in Schedule of Expenditures of Federal Awards and Recipient Responsibilities for Informing Sub-recipients***

(a) To maximize the transparency and accountability of funds authorized under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) (ARRA) as required by Congress and in accordance with 45 CFR 74.21 and 92.20 "Uniform Administrative Requirements for Grants and Agreements", as applicable, and OMB A-102 Common Rules provisions, recipients agree to maintain records that identify adequately the source and application of ARRA funds.

(b) For recipients covered by the Single Audit Act Amendments of 1996 and OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations," recipients agree to separately identify the expenditures for federal awards under ARRA on the Schedule of

Expenditures of Federal Awards (SEFA) and the Data Collection Form (SF-SAC) required by OMB Circular A-133. This shall be accomplished by identifying expenditures for federal awards made under ARRA separately on the SEFA, and as separate rows under Item 9 of Part III on the SF-SAC by CFDA number, and inclusion of the prefix "ARRA-" in identifying the name of the federal program on the SEFA and as the first characters in Item 9d of Part III on the SF-SAC.

(c) Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the federal award number, CFDA number, and amount of ARRA funds. When a recipient awards ARRA funds for an existing program, the information furnished to sub-recipients shall distinguish the sub-awards of incremental ARRA funds from regular sub-awards under the existing program.

(d) Recipients agree to require their sub-recipients to include on their SEFA information to specifically identify ARRA funding similar to the requirements for the recipient SEFA described above. This information is needed to allow the recipient to properly monitor sub-recipient expenditure of ARRA funds as well as oversight by the federal awarding agencies, Offices of Inspector General and the Government Accountability Office.

### Recipient Reporting

#### **Reporting and Registration Requirements under Section 1512 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5**

(a) This award requires the recipient to complete projects or activities which are funded under the American Recovery and Reinvestment Act of 2009 ("ARRA") and to report on use of ARRA funds provided through this award. Information from these reports will be made available to the public.

(b) The reports are due no later than ten calendar days after each calendar quarter in which the recipient receives the assistance award funded in whole or in part by ARRA.

(c) Recipients and their first-tier recipients must maintain current registrations in the Central Contractor Registration ([www.ccr.gov](http://www.ccr.gov)) at all times during which they have active federal awards funded with ARRA funds. A Dun and Bradstreet Data Universal Numbering System (DUNS) Number ([www.dnb.com](http://www.dnb.com)) is one of the requirements for registration in the Central Contractor Registration.

(d) The recipient shall report the information described in section 1512(c) using the reporting instructions and data elements that will be provided online at [www.FederalReporting.gov](http://www.FederalReporting.gov) and ensure that any information that is pre-filled is corrected or updated as needed.

## **VII. Agency Contacts**

### **Program Contact:**

Chris Muir  
Senior Program Analyst  
Office of the National Coordinator  
for Health Information Technology  
Department of Health and Human Services  
200 Independence Avenue, S.W., Suite  
729D  
Washington, DC 20201  
Tel: (202) 205-0470  
[Christopher.Muir@hhs.gov](mailto:Christopher.Muir@hhs.gov)

### **Grant Management Contact:**

Alexis Lynady  
Grant Management Specialist  
Assistant Secretary for Preparedness  
And Response  
Department of Health and Human  
Services  
395 E Street, SW, Room 1075.42  
Washington, D.C. 20201  
Tel: (202)245-0976  
[Alexis.Lynady@hhs.gov](mailto:Alexis.Lynady@hhs.gov)

This funding announcement is subject to restrictions on oral conversations during the period of time commencing with the submission of a formal application<sup>13</sup> by an individual or entity and ending with the award of the competitive funds. Federal officials may not participate in oral communications initiated by any person or entity concerning a pending application for a Recovery Act competitive grant or other competitive form of Federal financial assistance, whether or not the initiating party is a federally registered lobbyist. This restriction applies unless:

- (i) the communication is purely logistical;
- (ii) the communication is made at a widely attended gathering;
- (iii) the communication is to or from a Federal agency official and another Federal Government employee;
- (iv) the communication is to or from a Federal agency official and an elected chief executive of a state, local or tribal government, or to or from a Federal agency official and the Presiding Officer or Majority Leader in each chamber of a state legislature; or
- (v) the communication is initiated by the Federal agency official.

For additional information see [http://www.whitehouse.gov/omb/assets/memoranda\\_fy2009/m09-24.pdf](http://www.whitehouse.gov/omb/assets/memoranda_fy2009/m09-24.pdf).

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<sup>13</sup> *Formal Application includes the preliminary application and letter of intent phases of the program.*

## VIII. Appendices

- A. State Grants to Promote Health Information Technology, authorized by Section 3013 of the PHSA as added by ARRA
- B. Detailed Guidance for Strategic and Operational Plans
- C. Required Content for Letter of Intent to Apply
- D. Suggested Format for Letter from State Designating Official (Governor or Equivalent, for Territories)
- E. Suggested Format for Letter of Support from Critical Stakeholders
- F. Privacy and Security Resources
- G. ARRA-Required Performance Measures
- H. Public and Private Sector Models for Governance and Accountability
- I. Instructions for completing the SF 424, Budget (SF 424A), Budget Narrative/Justification, and Other Required Forms
- J. Budget Narrative/Justification, Page 1 – Sample Format with EXAMPLES
- K. Budget Narrative/Justification — Sample Template
- L. Instructions for Completing the Project Summary/Abstract
- M. Survey instructions on Ensuring Equal Opportunity for Applicants
- N. Glossary of Terms

## A. State Grants to Promote Health Information Technology, authorized by Section 3013 of the PHS Act as added by ARRA

### “SEC. 3013. STATE GRANTS TO PROMOTE HEALTH INFORMATION TECHNOLOGY.

“(a) IN GENERAL.—The Secretary, acting through the National Coordinator, shall establish a program in accordance with this section to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards.

“(b) PLANNING GRANTS.—The Secretary may award a grant to a State or qualified State-designated entity (as described in subsection (f)) that submits an application to the Secretary at such time, in such manner, and containing such information as the Secretary may specify, for the purpose of planning activities described in subsection (d).

“(c) IMPLEMENTATION GRANTS.—The Secretary may award a grant to a State or qualified State designated entity that—

“(1) has submitted, and the Secretary has approved, a plan described in subsection (e) (regardless of whether such plan was prepared using amounts awarded under subsection (b)); and

“(2) submits an application at such time, in such manner, and containing such information as the Secretary may specify.

“(d) USE OF FUNDS.—Amounts received under a grant under subsection (c) shall be used to conduct activities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards through activities that include—

“(1) enhancing broad and varied participation in the authorized and secure nationwide electronic use and exchange of health information;

“(2) identifying State or local resources available towards a nationwide effort to promote health information technology;

“(3) complementing other Federal grants, programs, and efforts towards the promotion of health information technology;

“(4) providing technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information;

“(5) promoting effective strategies to adopt and utilize health information technology in medically underserved communities;

“(6) assisting patients in utilizing health information technology;

“(7) encouraging clinicians to work with Health Information Technology Regional Extension Centers as described in section 3012, to the extent they are available and valuable;

“(8) supporting public health agencies’ authorized use of and access to electronic health information;

“(9) promoting the use of electronic health records for quality improvement including through quality measures reporting; and

“(10) such other activities as the Secretary may specify.

“(e) PLAN.—

“(1) IN GENERAL.—A plan described in this subsection is a plan that describes the activities to be carried out by a State or by the qualified State-designated entity within such State to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications.

- “(2) REQUIRED ELEMENTS.—A plan described in paragraph (1) shall—
- “(A) be pursued in the public interest;
  - “(B) be consistent with the strategic plan developed by the National Coordinator, (and, as available) under section 3001;
  - “(C) include a description of the ways the State or qualified State-designated entity will carry out the activities described in subsection (b); and
  - “(D) contain such elements as the Secretary may require.

“(f) QUALIFIED STATE-DESIGNATED ENTITY.—For purposes of this section, to be a qualified State-designated entity, with respect to a State, an entity shall—

- “(1) be designated by the State as eligible to receive awards under this section;
- “(2) be a not-for-profit entity with broad stakeholder representation on its governing board;
- “(3) demonstrate that one of its principal goals is to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information;
- “(4) adopt nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders; and
- “(5) conform to such other requirements as the Secretary may establish.

“(g) REQUIRED CONSULTATION.—In carrying out activities described in subsections (b) and (c), a State or qualified State designated entity shall consult with and consider the recommendations of—

- “(1) health care providers (including providers that provide services to low income and underserved populations);
- “(2) health plans;
- “(3) patient or consumer organizations that represent the population to be served;
- “(4) health information technology vendors;
- “(5) health care purchasers and employers;
- “(6) public health agencies;
- “(7) health professions schools, universities and colleges;
- “(8) clinical researchers;
- “(9) other users of health information technology such as the support and clerical staff of providers and others involved in the care and care coordination of patients; and
- “(10) such other entities, as may be determined appropriate by the Secretary.

“(h) CONTINUOUS IMPROVEMENT.—The Secretary shall annually evaluate the activities conducted under this section and shall, in awarding grants under this section, implement the lessons learned from such evaluation in a manner so that awards made subsequent to each such evaluation are made in a manner that, in the determination of the Secretary, will lead towards the greatest improvement in quality of care, decrease in costs, and the most effective authorized and secure electronic exchange of health information.

“(i) REQUIRED MATCH.—

- “(1) IN GENERAL.—For a fiscal year (beginning with fiscal year 2011), the Secretary may not make a grant under this section to a State unless the State agrees to make available non-Federal contributions (which may include in-kind contributions) toward the costs of a grant awarded under subsection (c) in an amount equal to—
  - “(A) for fiscal year 2011, not less than \$1 for each \$10 of Federal funds provided under the grant;
  - “(B) for fiscal year 2012, not less than \$1 for each \$7 of Federal funds provided under the grant; and
  - “(C) for fiscal year 2013 and each subsequent fiscal year, not less than \$1 for each \$3 of Federal funds provided under the grant.

“(2) AUTHORITY TO REQUIRE STATE MATCH FOR FISCAL YEARS BEFORE FISCAL YEAR 2011.—For any fiscal year during the grant program under this section before fiscal year 2011, the Secretary may determine the extent to which there shall be required a non-Federal contribution from a State receiving a grant under this section.”

## B. Detailed Guidance for Strategic and Operational Plans

### 1. Detailed Guidance for the Strategic Plan

The strategic planning process includes the development of the initial Strategic Plan and ongoing updates. There are distinct and/or concurrent planning activities for each domain that need to be coordinated and planned. The Strategic Plan may address the evolution of capabilities supporting HIE, as well as progress in the five domains of HIE activity, the role of partners and stakeholders, and high-level project descriptions for planning, implementation, and evaluation.

The following criteria in General Topic Guidance and Domain Requirements must be included in the Strategic and Operational plans unless noted as otherwise.

#### a) *General Topic Guidance*

- **Environmental Scan** – The Strategic Plan must include an environmental scan of HIE readiness which may include broad adoption of HIT but must include HIE adoption across health care providers within the state and potentially external to the state, as relevant. The environmental scan must include an assessment of current HIE capacities that could be expanded or leveraged, HIT resources that could be used, the relevant collaborative opportunities that already exist, the human capital that is available and other information that indicates the readiness of HIE implementation statewide.
- **HIE Development and Adoption** – The Strategic plan must address vision, goals, objectives and strategies associated with HIE capacity development and use among all health care providers in the state, to include meeting HIE meaningful use criteria to be established by the Secretary **Error! Hyperlink reference not valid.** through the rulemaking process. The Strategic Plan must also address continuous improvement in realizing appropriate and secure HIE across health care providers for care coordination and improvements to quality and efficiency of health care. Strategic Plans should also address HIE between health care providers, public health, and those offering services for patient engagement and data access.
- **HIT Adoption** (*encouraged but not required*)–
  - HIT adoption may also be included in the Strategic Plan. Although it is beyond the scope of this program to fund HIT adoption initiatives described in a State Strategic Plan, it does not preclude other HITECH ACT programs or state funded initiatives to advance HIT adoption in a state.
  - While many states have already addressed HIT adoption in their existing Health IT State Plans, it is not a requirement. However, the inclusion of Health IT adoption in the Strategic Plan is valuable and provides for a more comprehensive approach for planning how to achieve connectivity across the state.
- **Medicaid Coordination** – The Strategic Plan must describe the interdependencies and integration of efforts between the state’s Medicaid HIT Plan and the statewide HIE development efforts. The description should include the state’s HIE related requirements for meaningful use to be established by the Secretary through the rulemaking process and the mechanisms in which the state will measure provider participation in HIE.
- **Coordination of Medicare and Federally Funded, State Based Programs** – Strategic Plan shall describe the coordination activities with Medicare and relevant federally-funded, state programs (see program guidance). These programs include:
  - Epidemiology and Laboratory Capacity Cooperative Agreement Program (CDC)
  - Assistance for Integrating the Long-Term Care Population into State Grants to Promote Health IT
  - Implementation (CMS/ASPE)

- HIV Care Grant Program Part B States/Territories Formula and Supplemental Awards/AIDS Drug Assistance Program Formula and Supplemental Awards (HRSA)
- Maternal and Child Health State Systems Development Initiative programs (HRSA)
- State Offices of Rural Health Policy (HRSA)
- State Offices of Primary Care (HRSA)
- State Mental Health Data Infrastructure Grants for Quality Improvement (SAMHSA)
- State Medicaid/CHIP Programs
- IHS and tribal activity
- Emergency Medical Services for Children Program (HRSA)
- **Participation with federal care delivery organizations** (*encouraged but not required*)– When applicable, the Strategic Plan should include a description of the extent to which the various federal care delivery organizations, including but not limited to the VA, DoD, and IHS, will be participating in state activities related to HIE.
- **Coordination of Other ARRA Programs** – Because other ARRA funding will be available to the state that can help advance HIE, the Strategic Plan must describe, when applicable, coordination mechanisms with other relevant ARRA programs including Regional Centers, workforce development initiatives, and broadband mapping and access. As these programs are developed, ONC will provide program guidance to facilitate state specific coordination across Regional Centers, workforce development and broadband programs. For planning purposes, applicants should specify how entities or collaboratives planning to be Regional Centers will provide technical assistance to health care providers in their states, how trained professionals from workforce development programs will be utilized to support statewide HIE, and how plans to expand access to broadband will inform State Strategic and Operational Plans overtime. This program coordination will be the subject of future guidance, and plans may need to be modified as other programs are clarified.

#### **b) Domain Requirements**

- **Governance**
  - **Collaborative Governance Model** – The Strategic Plan must describe the multi-disciplinary, multi-stakeholder governance entity including a description of the membership, decision-making authority, and governance model. States are encouraged to consider how their state governance models will align with emerging nationwide HIE governance.
  - **State Government HIT Coordinator** – The Strategic Plan shall identify the state Government HIT Coordinator. The plan shall also describe how the state coordinator will interact with the federally funded state health programs and also the HIE activities within the state.
  - **Accountability and Transparency** – To ensure that HIE is pursued in the public’s interest, the Strategic Plan shall address how the state is going to address HIE accountability and transparency.
- **Finance**
  - **Sustainability** – In order to ensure the financial sustainability of the project beyond the ARRA funding, the Strategic Plan shall include a business plan that enables for the financial sustainability, by the end of the project period of HIE governance and operations.
- **Technical Infrastructure**

- **Interoperability** - The plan must indicate whether the HIE services will include participation in the NHIN. The plan shall include the appropriate HHS adopted standards and certifications for health information exchange, especially planning and accounting for meaningful use criteria to be established by the Secretary through the rulemaking process .
- **Technical Architecture/Approach** (*encouraged but not required*)– Because the state or SDE may or may not implement HIE, the Strategic Plan may include an outline of the data and technical architectures and describe the approach to be used, including the HIE services to be offered as appropriate for the state’s HIE capacity development.
- **Business and Technical Operations**
  - **Implementation** – To address how the state plans will develop HIE capacity, the Strategic Plan must include a strategy that specifies how the state intends to meet meaningful use HIE requirements established by the Secretary, leverage existing state and regional HIE capacity and leverage statewide shared services and directories. The implementation strategy described in the Strategic Plan shall describe the incremental approach for HIE services to reach all geographies and providers across the state. The implementation strategy shall identify if and when the state HIE infrastructure will participate in the NHIN.
- **Legal/policy**
  - **Privacy and Security**– The Strategic Plan shall address privacy and security issues related to health information exchange within the state, and between states. The plan shall give special attention to federal and state laws and regulations and adherence to the privacy principles articulated in the HHS Privacy and Security Framework, and any related guidance.
  - **State Laws** – The Strategic Plan shall address any plans to analyze and/or modify state laws, as well as communications and negotiations with other states to enable exchange.
  - **Policies and Procedures** – The Strategic Plan shall also address the development of policies and procedures necessary to enable and foster information exchange within the state and interstate.
  - **Trust Agreements** –The Strategic Plan shall discuss the use of existing or the development of new trust agreements among parties to the information exchange that enable the secure flow of information. Trust agreements include but are not limited to data sharing agreements, data use agreements and reciprocal support agreements.
  - **Oversight of Information Exchange and Enforcement** - The Strategic Plan shall address how the state will address issues of noncompliance with federal and state laws and policies applicable to HIE.

## **2. Detailed Guidance for the Operational Plan**

Prior to entering into funded implementation activities, a state must submit and receive approval of the Operational Plan. The Operational Plan shall include details on how the Strategic Plan will be carried forward and executed to enable statewide HIE. It must also include a project schedule describing the tasks and sub-tasks that need to be completed in order to enable the statewide HIE. The implementation description shall identify issues, risks, and interdependencies within the overall project. In addition, the Operational Plan must include the following general topics and domains. The requirements for the initial Operational Plan are outlined below.

**a) *General Topic Requirements***

**Coordinate with ARRA Programs** – The Operational Plan must describe specific points of coordination and interdependencies with other relevant ARRA programs including Regional Centers, workforce development initiatives, and broadband mapping and access. As these programs are developed, ONC will provide program guidance to facilitate state specific coordination across Regional Centers, workforce development and broadband programs. For planning purposes, applicants concurrently applying as HIE recipients and Regional Center recipients should specify how they will provide technical assistance to health care providers in their states with estimates of geographic and provider coverage. In addition, project resource planning should take into account how and when trained professionals from workforce development programs will be utilized to support statewide HIE, and how and when broadband will be available to health care providers across the state according to the availability of up to date broadband maps and funded efforts to expand access.

**Coordinate with Other States** – In order to share lessons learned and encourage scalable solutions between states, the Operational Plan shall describe multi-state coordination activities including the sharing of plans between states.

**b) *Domain Requirements***

• **Governance**

- **Governance and Policy Structures** – The Operational Plan must describe the ongoing development of the governance and policy structures.

• **Finance**

- **Cost Estimates and Staffing Plans** – The Operational Plan must provide a detailed cost estimate for the implementation of the Strategic Plan for the time period covered by the Operational Plan. It must also include a detailed schedule describing the tasks and sub-tasks that need to be completed in order to enable statewide HIE along with resources, dependencies, and specific timeframes. The implementation description shall specify proposed resolution and mitigation methods for identified issues and risks within the overall project. Additionally, recipients shall provide staffing plans including project managers and other key roles required to ensure the project's success.
- **Controls and Reporting** – The Operational Plan must describe activities to implement financial policies, procedures and controls to maintain compliance with generally accepted accounting principles (GAAP) and all relevant OMB circulars. The organization will serve as a single point of contact to submit progress and spending reports periodically to ONC.

• **Technical Infrastructure**

- **Standards and Certifications** –The Operational Plan shall describe efforts to become consistent with HHS adopted interoperability standards and any certification requirements, for projects that are just starting; demonstrated compliance, or plans toward becoming consistent with HHS adopted interoperability standards and certifications if applicable, for those projects that are already implemented or under implementation.
- **Technical Architecture** – The Operational Plan must describe how the technical architecture will accommodate the requirements to ensure statewide availability of HIE among healthcare providers, public health and those offering service for patient engagement and data access. The technical architecture must include plans for the protection of health data. This needs to reflect the business and clinical requirements determined via the multi-stakeholder planning process. If a state plans to exchange

information with federal health care providers including but not limited to VA, DoD, IHS, their plans must specify how the architecture will align with NHIN core services and specifications.

- **Technology Deployment** – The Operational Plan must describe the technical solutions that will be used to develop HIE capacity within the state and particularly the solutions that will enable meaningful use criteria established by the Secretary for 2011, and indicate efforts for nationwide health information exchange. If a state plans to participate in the Nationwide Health Information Network (NHIN), their plans must specify how they will be compliant with HHS adopted standards and implementation specifications. (For up-to-date publicly available information on meaningful use, see: <http://healthit.hhs.gov/meaningfuluse>).
- **Business and Technical operations**
  - **Current HIE Capacities** – The Operational Plan must describe how the state will leverage current HIE capacities, if applicable, such as current operational health information organizations (HIOs), including those providing services to areas in multiple states.
  - **State-Level Shared Services and Repositories** – The Operational Plan must address whether the state will leverage state-level shared services and repositories including how HIOs and other data exchange mechanisms can leverage existing services and data repositories, both public or private. Shared services for states to consider include (but are not limited to): Security Service, Patient Locator Service, Data/Document Locator Service, and Terminology Service. These technical services may be developed over time and according to standards and certification criteria adopted by HHS in effort to develop capacity for nationwide HIE.
  - **Standard operating procedures for HIE** (*encouraged but not required*)– The Operational Plan should include an explanation of how standard operating procedures and processes for HIE services will be developed and implemented.
- **Legal/policy**
  - **Establish Requirements** – The Operational Plan shall describe how statewide health information exchange will comply with all applicable federal and state legal and policy requirements. This plan needs to include developing, evolving, and implementing the policy requirements to enable appropriate and secure health information exchange through the mechanisms of exchange consistent with the state Strategic Plan. The Operational Plan should specify the interdependence with the governance and oversight mechanisms to ensure compliance with these policies.
  - **Privacy and Security Harmonization** – The Operational Plan must describe plans for privacy and security harmonization and compliance statewide and also coordination activities to establish consistency on an interstate basis.
  - **Federal Requirements** – To the extent that states anticipate exchanging health information with federal care delivery organizations, such as the VA, DoD, Indian Health Service, etc. the Operational Plan must consider the various federal requirements for the utilization and protection of health data will be accomplished.

### C. Required Content for Letter of Intent to Apply

Prospective applicants must submit a Letter of Intent that includes the following information. *(For multi-state applications, only one letter of intent should be submitted. This letter should be submitted by the state or SDE that will act as the applicant on behalf of all states involved in the proposed project.):*

- Descriptive title of proposed project.
- Indication of whether a State Plan already exists or will be developed during the life of this cooperative agreement.
- Will the application submitted be for more than one state/territory? If so, which states/territories will be included?
- Name, address, and telephone number of the primary Point of Contact.
- Names of other key personnel.
- Participating stakeholders.
- Does the applicant for this program intend to apply to be a Regional Center as well?
- Number and title of this funding opportunity.
- The total amount of expenditures to develop HIE capacity based on funded activities in the following domains:
  - **Legal and policy HIE capacity:** Types of activities include but are not limited to expenses incurred to create: data use agreements, business associate agreements, vendor contracts, privacy policies and procedures, governance documents, employee policies and procedures, and legal opinions.
  - **Governance capacity:** Types of activities include but are not limited to expenses incurred to: convene health care stakeholders, create plans for statewide coverage of HIE services; provide oversight and accountability of health information exchange activities.
  - **Business and Technical Operations capacity:** Types of activities include but are not limited to expenses incurred to: develop and operate the technical services needed for health information exchange on a national, state and regional level, support activities including procurement, functionality development, project management, help desk, systems maintenance, change control, program evaluation, reporting and other related activities, legal and policy documents that support HIE enabled meaningful use criteria to be established by the Secretary through the rulemaking process.
  - **Technical infrastructure capacity:** Types of activities include but are not limited to expenses incurred to: developed the architecture, hardware, software, applications, network configurations and other technological aspects that physically enable health information exchange in a secure and appropriate manner that also meets overarching goals for a high performance health care system.
  - **Finance capacity:** Types of activities include but are not limited to expenses incurred to: develop and manage finance policies procedure and controls, sustainability plans, pricing strategies, market research, public and private financing strategies, financial reporting, business planning, and audits.
- A brief description of your state's progress in each of the areas above, as well as, a brief description of the state's intentions to leverage existing regional efforts to advance health information exchange.
- Explanation of how the proposed project will be in the public interest.

A letter of intent is not binding, and does not enter into the review of a subsequent application, the information that it contains allows ONC staff members to estimate the potential review workload and plan the review.

The letter of intent should be no longer than 5 pages and can be sent by the date listed in the Important Dates table above (Opportunity Overview).

The letter of intent shall be sent to at the following address:

David Blumenthal MD, MPP  
National Coordinator for Health Information Technology  
Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201  
Tel: (202) 690-7151  
**StateHIEgrants@<mailto:hhs.gov>**

## **D. Suggested Format for Letter from State Designating Official (Governor or Equivalent, for Territories)**

*Designating Official is the Governor. For territories and the District of Columbia, it is the Equivalent Official (i.e. Mayor). For multi-state applications, a letter from the Governor (or equivalent) designating the partnering state or SDE must be received on behalf of each state participating in the proposed project.*

David Blumenthal MD, MPP  
National Coordinator for Health Information Technology  
Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

Date

Dear Dr. Blumenthal,

The official (State Agency/State Designated Entity) for the State Grants to Promote Health Information Technology Program, for the State/Commonwealth/Territory of \_\_\_\_\_ is:

Name  
Title  
Agency  
Division (if applicable)  
State  
Address

Phone  
Fax Number  
Email

Governor's (or equivalent) Signature

## E. Suggested Format for Letter of Support from Critical Stakeholders

David Blumenthal MD, MPP  
National Coordinator for Health Information Technology  
Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

Date

Dear Dr. Blumenthal,

(Name of organization/group submitting the letter) is very interested in addressing (insert the issue being addressed by the grant application.) and (State why the issue is of concern.)

(State knowledge of proposal, knowledge of agency submitting proposal, and encouragement of funding entity to provide resources to address issue identified above.)

(State that the need to address the issue is significant and how other resources to address the need are insufficient to address or impact the need.)

(Specifically state how your organization will support this project – through assistance with meeting matching requirements, board/commission participation, advocacy)

(State that the proposing organization would coordinate with appropriate partners to ensure efficient and effective use of grant funds.)

(Conclude with general statement of confidence in and support for the organization seeking assistance, based on past experience with the applicant entity, reputation for effectiveness)

(Provide the following information for the point of contact in the supporting organization.)

Name  
Title  
Agency  
Division (if applicable)  
State  
Address

Phone  
Fax Number  
Email

## **F. Privacy and Security Resources**

### **American Reinvestment and ARRA References**

ARRA Section D – Privacy describes improved privacy provisions and security provisions related to:

- Sec. 13402 - notification in the case of breach
- Sec. 13404 – application of privacy provisions and penalties to business associates of covered entities
- Sec. 13405 – restrictions on certain disclosures and sales of health information; accounting of certain protected health information disclosures; access to certain information in electronic format
- Sec. 13406 – conditions on certain contacts as part of health care operations
- Sec. 13407 – temporary breach notification requirement for vendors of personal health records and other non-HIPAA covered entities
- Sec. 13408 – business associate contracts required for certain entities

This list is provided to highlight examples of the ARRA privacy and security requirements. It is not intended to be comprehensive, nor definitive program guidance to recipients regarding the ARRA requirements for privacy and security. To read a full version of ARRA, [click here](#).

### **Privacy Act of 1974**

- 45.C.F.R. Part 5b A link to the full Privacy Act can be found at:  
<http://www.hhs.gov/foia/privacy/index.html>

### **HIPAA Security Rule**

- 45 CFR Parts 160, 162, and 164.

A link to the HIPAA Security Rule can be found

<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpleregtext.pdf>.

### **HIPAA Privacy Rule**

- 45 CFR Part 160 and Subparts A and E of Part 164. For more details:  
<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/adminsimpleregtext.pdf>

### **Federal Information Security Management Act, 2002**

- 45 CFR Parts 160, 162, and 164. A link to the full Act can be found at:

<http://aspe.hhs.gov/datacncl/Privacy/titleV.pdf>

### **Confidentiality of Alcohol and Drug Abuse Patient Records**

- 45 CFR Part 2
- For more details: <http://www.hipaa.samhsa.gov>

### **The HHS Privacy and Security Framework Principles**

- Individual Access - Individuals should be provided with a simple and timely means to access and obtain their individually identifiable health information in a readable form and format.

- Correction- Individuals should be provided with a timely means to dispute the accuracy or integrity of their individually identifiable health information, and to have erroneous information corrected or to have a dispute documented if their requests are denied.
- Openness and Transparency - There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their individually identifiable health information.
- Individual Choice - Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their individually identifiable health information.
- Collection, Use and Disclosure Limitation - Individually identifiable health information should be collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately.
- Data Quality and Integrity - Persons and entities should take reasonable steps to ensure that individually identifiable health information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner.
- Safeguards - Individually identifiable health information should be protected with reasonable administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure.
- Accountability - These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

For more information, please visit [healthit.hhs.gov](http://healthit.hhs.gov) and click on the Privacy and Security link for the Framework and its Principles, or [click here](#).

## G. ARRA-Required Performance Measures

To assist in fulfilling the accountability objectives of the Recovery Act, as well as the Department's responsibilities under the Government Performance and Results Act of 1993 (GPRA), Public Law 103-62, applicants who receive funding under this program must provide data that measure the results of their work. Additionally, applicants must discuss their data collection methods in the application. The following are required measures for awards made under the Recovery Act:

Objective	Performance Measures	Data the recipient provides for 3-month reporting period	Description (Plain language explanation of what exactly is being provided)
Recovery Act: Preserving jobs	Number of jobs saved (by type) due to Recovery Act funding.	a) How many jobs were prevented from being eliminated with the Recovery Act funding during this reporting period? b) How many jobs that were eliminated within the last 12 months were reinstated with Recovery Act funding?	An unduplicated number of jobs that would have been eliminated if not for the Recovery Act funding during the three-month quarter. Report this data for each position only once during the project period. A job can include full time, part time, contractual, or other employment relationship.
Recovery Act: Creating jobs	Number of jobs created (by type) due to Recovery Act funding.	How many jobs were created with Recovery Act funding this reporting period?	An unduplicated number of jobs created due to Recovery Act funding during the three month quarter. Report this data for each position only once during the award. A job can include full time, part time, contractual, or other employment relationship.

## H. Public and Private Sector Models for Governance and Accountability

According to the National Governors Association (NGA) report on Public Governance Models for a Sustainable Health Information Exchange Industry, there are three types of legal structures that are utilized in a public sector model including the public authority model, the non-profit government controlled model, or the state agency model. The public authority model is part of the state government and subject to requirements of due process, open meetings, and public records. The government controlled non-profit corporation model is typically created by statute and includes a majority interest of state government board members on a separate non-profit board. Lastly, with the state agency model the HIE planning and implementation becomes the responsibility of an existing state agency. As for accountability, public sector controlled models typically leverage contract mechanisms to provide public accountability for privacy, security, fiscal integrity, system interoperability, and auditing of system access. Additional governmental accountability is provided through legislative reporting processes.

The private non-profit corporations usually utilize a governance structure whereby directors and officers are responsible for working with management to set strategy and adopt policies for HIE operation. The bylaws of any private non-profit corporation spell out the details of board composition, voting rights, board member terms and subcommittee composition. For accountability, private non-profit boards execute non-discrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory board activities. In addition, to ensure trust and buy-in, organization activities are usually open to the public and described in an annual activities report.

## I. Instructions for completing the SF 424, Budget (SF 424A), Budget Narrative/Justification, and Other Required Forms

This section provides step-by-step instructions for completing the four (4) standard federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. Standard Forms 424 and 424A are used for a wide variety of federal grant programs, and federal agencies have the discretion to require some or all of the information on these forms. Accordingly, please use the instructions below in lieu of the standard instructions attached to SF 424 and 424A to complete these forms.

### a. Standard Form 424

**1. Type of Submission:** (Required): Select one type of submission in accordance with agency instructions.

• Preapplication • Application • Changed/Corrected Application – If requested, check if this submission is to change or correct a previously submitted application.

**2. Type of Application:** (Required) Select one type of application in accordance with agency instructions.

• New . • Continuation • Revision

**3. Date Received:** Leave this field blank.

**4. Applicant Identifier:** Leave this field blank.

**5a Federal Entity Identifier:** Leave this field blank.

**5b. Federal Award Identifier:** For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned federal award (grant) number.

**6. Date Received by State:** Leave this field blank.

**7. State Application Identifier:** Leave this field blank.

**8. Applicant Information:** Enter the following in accordance with agency instructions:

**a. Legal Name:** (Required): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website.

**b. Employer/Taxpayer Number (EIN/TIN):** (Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

**c. Organizational DUNS:** (Required) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website.

**d. Address:** (Required) Enter the complete address including the county.

**e. Organizational Unit:** Enter the name of the primary organizational unit (and department or division, if applicable) that will undertake the project.

**f. Name and contact information of person to be contacted on matters involving this application:**

Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on matters related to this application.

**9. Type of Applicant:** (Required) Select the applicant organization “type” from the following drop down list.

A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K. Indian/Native American Tribally Designated Organization L. Public/Indian Housing Authority M. Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education) N. Nonprofit without 501C3 IRS Status (Other than Institution of Higher Education) O. Private Institution of Higher Education P. Individual Q. For-Profit Organization (Other than Small Business) R. Small Business S. Hispanic-serving Institution T. Historically Black Colleges and Universities (HBCUs) U. Tribally Controlled Colleges and Universities (TCCUs) V. Alaska Native and Native Hawaiian Serving Institutions W. Non-domestic (non-US) Entity X. Other (specify)

**10. Name Of Federal Agency:** (Required) Enter U.S. Assistant Secretary for Preparedness and Response

**11. Catalog Of Federal Domestic Assistance Number/Title:** The CFDA number can be found on page one of the Program Announcement.

**12. Funding Opportunity Number/Title:** (Required) The Funding Opportunity Number and title of the opportunity can be found on page one of the Program Announcement.

**13. Competition Identification Number/Title:** Leave this field blank.

**14. Areas Affected By Project:** List the largest political entity affected (cities, counties, state).

**15. Descriptive Title of Applicant’s Project:** (Required) Enter a brief descriptive title of the project.

**16. Congressional Districts Of:** (Required) 16a. Enter the applicant’s Congressional District, and 16b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12th district, NC-103 for North Carolina’s 103rd district. • If all congressional districts in a state are affected, enter “all” for the district number, e.g., MD-all for all congressional districts in Maryland. • If nationwide, i.e. all districts within all states are affected, enter US-all.

**17. Proposed Project Start and End Dates:** (Required) Enter the proposed start date and final end date of the project. Therefore, if you are applying for a multi-year grant, such as a 3 year grant project, the final project end date will be 3 years after the proposed start date.

**18. Estimated Funding:** (Required) Enter the amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines, as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses.

**NOTE:** Applicants should review matching principles contained in Subpart C of 45 CFR Part 74 or 45 CFR Part 92 before completing Item 18 and the Budget Information Sections A, B and C noted below.

All budget information entered under item 18 should cover the upcoming budget period. For sub-item 18a, enter the federal funds being requested. Sub-items 18b-18e is considered matching funds. The dollar amounts entered in sub-items 18b-18f must total at least 1/3rd of the amount of federal funds being requested (the amount in 18a). For a full explanation of ONC's match requirements, see the information in the box below. For sub-item 18f, enter only the amount, if any, which is going to be used as part of the required match.

There are two types of match: 1) non-federal cash and 2) non-federal in-kind. In general, costs borne by the applicant and cash contributions of any and all third parties involved in the project, including sub-grantees, contractors and consultants, are considered matching funds. Generally, most contributions from sub-contractors or sub-grantees (third parties) will be non-federal in-kind matching funds. Volunteered time and use of facilities to hold meetings or conduct project activities may be considered in-kind (third party) donations. Examples of non-federal cash match include budgetary funds provided from the applicant agency's budget for costs associated with the project.

**NOTE: Indirect charges** may only be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency; or (2) the applicant is a state or local government agency. State governments should enter the amount of indirect costs determined in accordance with DHHS requirements. **If indirect costs are to be included in the application, a copy of the approved indirect cost agreement must be included with the application. Further, if any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.**

#### **ONC's Match Requirement**

Under this program, the applicant's match requirement is \$1 for every \$10 Federal dollars for the first year of the program (FY2011) In other words, for every ten (10) dollars received in Federal funding, the applicant must contribute at least one (1) dollar in non-Federal resources toward the project's total cost. This "ten-to-one" ratio is reflected in the following formula which you can use to calculate your minimum required match:

$$\frac{\text{Federal Funds Requested}}{10} = \text{Minimum Match Requirement}$$

For example, if you request \$100,000 in Federal funds, then your minimum match requirement is \$100,000/10 or \$10,000. In this example the **project's total cost** would be \$110,000.

**If the required non-Federal share is not met by a funded project, ONC will disallow any unmatched Federal dollars.**

**19. Is Application Subject to Review by State Under Executive Order 12372 Process?** Check c. Program is not covered by E.O. 12372.

**20. Is the Applicant Delinquent on any Federal Debt?** (Required) This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

**21. Authorized Representative:** (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required) title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain federal agencies may require that this authorization be submitted as part of the application.)

**b. Standard Form 424A**

NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the SF 424A should reflect a one year budget.

**Section A - Budget Summary**

Line 5: Leave columns (c) and (d) blank. Enter TOTAL federal costs in column (e) and total non-federal costs (including third party in-kind contributions and any program income to be used as part of the grantee match) in column (f). Enter the sum of columns (e) and (f) in column (g).

**Section B - Budget Categories**

Column 3: Enter the breakdown of how you plan to use the federal funds being requested by object class category (see instructions for each object class category below).

Column 4: Enter the breakdown of how you plan to use the non-federal share by object class category.

Column 5: Enter the total funds required for the project (sum of Columns 3 and 4) by object class category.

**Separate Budget Narrative/Justification Requirement**

You must submit a separate Budget Narrative/Justification as part of your application. When more than 33% of a project's total budget falls under contractual, detailed Budget Narratives/Justifications must be provided for each sub-contractor or sub-grantee. **Applicants requesting funding for multi-year grant programs are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. A separate Budget Narrative/Justification is also REQUIRED for each potential year of grant funding requested.**

For your use in developing and presenting your Budget Narrative/Justification, a sample format with examples and a blank sample template have been included in these Attachments. In your Budget Narrative/Justification, you should include a breakdown of the budgetary costs for all of the object class categories noted in Section B, across three columns: federal; non-federal cash; and non-federal in-kind. Cost breakdowns, or justifications, are required for any cost of \$1,000 or more. The Budget Narratives/Justifications should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Non-federal cash as well as, sub-contractor or sub-grantee (third party) in-kind contributions designated as match must be clearly identified and explained in the Budget Narrative/Justification. The full Budget Narrative/Justification should be included in the application immediately following the SF 424 forms.

Line 6a: Personnel: Enter total costs of salaries and wages of applicant/grantee staff. Do not include the costs of consultants; consultant costs should be included under 6h - Other. In the Budget Narrative/Justification: Identify the project director, if known. Specify the key staff, their titles, brief summary of project related duties, and the percent of their time commitments to the project in the Budget Narrative/Justification.

Line 6b: Fringe Benefits: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate. In the Justification: Provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement insurance, etc.

Line 6c: Travel: Enter total costs of out-of-town travel (travel requiring per diem) for staff of the project. Do not enter costs for consultant's travel - this should be included in line 6h. In the Justification: Include the total number of trips, destinations, purpose, and length of stay, subsistence allowances and transportation costs (including mileage rates).

Line 6d: Equipment: Enter the total costs of all equipment to be acquired by the project. For all grantees, "equipment" is non-expendable tangible personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit. If the item does not meet the \$5,000 threshold, include it in your budget under Supplies, line 6e. In the Justification: Equipment to be purchased with federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related functions; the equipment, or a reasonable facsimile, must not be otherwise available to the applicant or its sub-grantees. The justification also must contain plans for the use or disposal of the equipment after the project ends.

Line 6e: Supplies: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d. In the Justification: Provide general description of types of items included.

Line 6f: Contractual: Enter the total costs of all contracts, including (1) procurement contracts (except those, which belong on other lines such as equipment, supplies, etc.). Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individuals or consultants on this line. In the Budget Narrative/Justification: Attach a list of contractors indicating the name of the organization, the purpose of the contract, and the estimated dollar amount. If the name of the contractor, scope of work, and estimated costs are not available or have not been negotiated, indicate when this information will be available. **Whenever the applicant/grantee intends to delegate more than 33% of a project's total budget to the contractual line item, the applicant/grantee must provide a completed copy of Section B of the SF 424A Budget Categories for each sub-contractor or sub-grantee, and separate Budget Narrative/Justification for each sub-contractor or sub-grantee for each year of potential grant funding.**

Line 6g: Construction: Leave blank since construction is not an allowable cost under this program.

Line 6h: Other: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (i.e. for project volunteers this is different from personnel fringe benefits); non-contractual fees and travel paid directly to individual consultants; local transportation (all travel which does not require per diem is considered local travel); postage; space and equipment rentals/lease; printing and publication; computer use; training and staff development costs (i.e. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then rest assured this is where it belongs. In the Justification: Provide a reasonable explanation for items in this category. For individual consultants, explain the nature of services provided and the relation to activities in the project. Describe the types of activities for staff development costs.

Line 6i: Total Direct Charges: Show the totals of Lines 6a through 6h.

Line 6j: Indirect Charges: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency; or (2) the applicant is a state or local government agency.

Budget Narrative/Justification: State governments should enter the amount of indirect costs determined in accordance with DHHS requirements. An applicant that will charge indirect costs to the grant **must enclose a copy of the current indirect cost rate agreement.** If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

If the applicant organization is in the process of initially developing or renegotiating a rate, it should immediately upon notification that an award will be made, develop a tentative indirect cost rate proposal based on its most recently completed fiscal year in accordance with the principles set forth in the cognizant agency's guidelines for establishing indirect cost rates, and submit it to the cognizant agency. Applicants awaiting approval of their indirect cost proposals may also request indirect costs. It should be noted that when an indirect cost rate is requested, those costs included in the indirect cost pool should not also be charged as direct costs to the grant. Also, if the applicant is requesting a rate which is less than what is allowed under the program, the authorized representative of the applicant organization must submit a signed acknowledgement that the applicant is accepting a lower rate than allowed.

Line 6k: Total: Enter the total amounts of Lines 6i and 6j.

Line 7: Program Income: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project. Program Income must be used as additional program costs and cannot be used as match (non-federal resource).

### ***Section C - Non-Federal Resources***

Line 12: Enter the amounts of non-federal resources that will be used in carrying out the proposed project, by source (Applicant; State; Other) and enter the total amount in Column (e). Keep in mind that if the match requirement is not met, federal dollars may be reduced.

***Section D - Forecasted Cash Needs*** - Not applicable.

### ***Section E - Budget Estimate of Federal Funds Needed for Balance of the Project***

Line 20: Section E is relevant for multi-year grant applications, where the project period is 24 months or longer. This section does not apply to grant awards where the project period is less than 17 months.

### ***Section F - Other Budget Information***

Line 22: Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final or fixed) to be in effect during the funding period, the base to which the rate is applied, and the total indirect costs. Include a copy of your current Indirect Cost Rate Agreement.

Line 23: Remarks: Provide any other comments deemed necessary.

### **c. Standard Form 424B - Assurances**

This form contains assurances required of applicants under the discretionary funds programs administered by the Assistant Secretary for Preparedness and Response. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

#### **d. Certification Regarding Lobbying**

This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

#### **e. Other Application Components**

##### **Survey on Ensuring Equal Opportunity for Applicants**

The Office of Management and Budget (OMB) has approved an HHS form to collect information on the number of faith-based groups applying for a HHS grant. Non-profit organizations, excluding private universities, are asked to include a completed survey with their grant application packet. Attached you will find the OMB approved HHS "Survey on Ensuring Equal Opportunity for Applicants" form (Attachment F). Your help in this data collection process is greatly appreciated.

##### **Proof of Non-Profit Status**

Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

- A copy of a currently valid IRS tax exemption certificate.
- A statement from a State taxing body, State attorney general, or other appropriate State official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

##### **Indirect Cost Agreement**

Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency. This is optional for applicants that have not included indirect costs in their budgets.

## J. Budget Narrative/Justification, Page 1 – Sample Format with EXAMPLES

Below is an example of how to reflect project costs in the template provided., and are suggested to offer guidelines when applicants are completing their budget justifications. Justifications must include supporting detail and narrative justification for the costs proposed. Sufficient detail should be provided to demonstrate costs as they pertain to the administration of the project. In any case, the applicant should assure that the narrative and justification are legible and clearly provide all required information.

### INSTRUCTIONS:

**The Budget Detail must include the following information:**

- An itemized breakout of proposed costs and sub-total of these costs for each Object Class Category listed in the template below.
- A breakout of proposed costs by whether they are funded through Federal, Non-Federal Cash or Non-Federal In-Kind support.
- A brief description of the expense or service in the Justification column, as they demonstrate costs pertaining to the administration of the project.
- The time period in which the cost will be utilized in the Justification column.
- Any pertinent information that will aid the reviewer in evaluating the proposed cost.

**The Budget Detail must be supported by a narrative justification of why the proposed costs are necessary and reasonable to fulfill the purpose and achieve the milestones of the proposed project, in context of the proposed technical approach. An example of such justification would be:**

Project Administrator Salary Costs – assumes at least a master’s in public health or health administration, or equivalent degree, with at least 6 years’ experience managing health services, programs, or providers. Salary is typical for this level of qualifications and responsibility in the proposed service area. Assumes this position would provide executive-level direction and management oversight

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	\$40,000	\$5,000		\$45,000	Project Administrator (name) = .3FTE @ \$50,000/yr = \$15,000 (\$10,000 = Federal; \$5,000 = Non-Federal) Project Director (name) = 1FTE @ \$30,000 = \$30,000 (Federal) <b>TOTAL: \$45,000</b>
Fringe Benefits	\$12,600	0	0	\$12,600	Fringes on Project Staff @ 28% of salary. (Federal) FICA (7.65%) = \$ 3,442 Health (12%) = \$ 5,400 Dental (5%) = \$ 2,250

					Life (2%) = \$ 900 Workers Comp Insurance (.75%) = \$ 338 Unemployment Insurance (.6%) = \$ 270 <b>TOTAL: \$12,600</b>
<b>Travel</b>	\$4,120	\$1,547		\$5,667	Travel to 2 Annual (Federal) Grantee Meetings: Airfare: 1 RT x 2 = \$3,000 people x \$750/RT x 2 Lodging: 2 nights x 2 = \$ 800 people x \$100/night x 2 Per Diem: 2 days x 2 = \$ 320 people x \$40/day x 2 <b>TOTAL: \$4,120</b>
					Out-of-Town Project Site Visits (Non-Federal cash) Car mileage: 3 trips x 2 people x = \$ 767 350 miles/trip x \$ .365/mile Lodging: 3 trips x 2 people x 1 = \$ 300 night/ trip x \$50/night Per Diem: 3 trips x 2 people x = \$ 480 2days/trip x \$40/day <b>TOTAL: \$1,547</b>
<b>Equipment</b>	0	0	0	0	No equipment requested
<b>Supplies</b>	\$1,340	\$2,160		\$3,500	Laptop computer for = \$1,340 use in client intakes (Federal) Consumable supplies (paper, pens, etc.) \$100/mo x 12 = \$1,200 (Non-Federal cash) Copying \$80/mo x 12 = \$ 960 (Non-Federal cash) <b>TOTAL: \$3,500</b>
<b>Contractual</b>	\$150,000		\$50,000	\$200,000	Contracts to A,B,C direct service providers (name

					providers) contractor A = \$75,000 (Federal) contractor B = \$75,000 (Federal) contractor C = \$50,000 (Non-Federal In-Kind) <b>TOTAL: \$200,000</b>
<b>Other</b>	\$1,250	\$2,000		\$3,250	Local conf registration fee = \$ 200 (Non-Fed cash) (provide conference name) Printing brochures = \$ 1,250 (25,000 @ \$0.05 ea) (Federal) Postage: \$150/mo x = \$ 1,800 12 months (Non-Fed cash) <b>TOTAL: \$4,200</b>
<b>TOTAL</b>	<b>\$209,310</b>	<b>\$10,707</b>	<b>\$50,000</b>	<b>\$270,017</b>	

**K. Budget Narrative/Justification --Template**

<b>Object Class Category</b>	<b>Federal Funds</b>	<b>Non-Federal Cash</b>	<b>Non-Federal In-Kind</b>	<b>TOTAL</b>	<b>Justification</b>
<b>Personnel</b>					
<b>Fringe Benefits</b>					
<b>Travel</b>					
<b>Equipment</b>					
<b>Supplies</b>					
<b>Contractual</b>					
<b>Other</b>					
<b>Indirect Charges</b>					
<b>TOTAL</b>					

## L. Instructions for Completing the Project Summary/Abstract

All applications for grant funding must include a Summary/Abstract that concisely describes the proposed project. It should be written for the general public.

To ensure uniformity, please limit the length to no more than 500 words on a single page with a font size of not less than 11, doubled-spaced.

The abstract must include the project's goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, products, and duration. The following are very simple descriptions of these terms, and a sample Compendium abstract.

- **Goal(s)** – broad, overall purpose, usually in a mission statement, i.e. what you want to do, where you want to be.
- **Objective(s)** – narrow, more specific, identifiable or measurable steps toward a goal. Part of the planning process or sequence (the “how”). Specific performances which will result in the attainment of a goal.
- **Outcomes** - measurable results of a project. Positive benefits or negative changes, or measurable characteristics that occur as a result of an organization's or program's activities. (Outcomes are the end-point).
- **Products** – materials, deliverables.

A model abstract/summary is provided below:

The grantee, Okoboji University, supports this three year Dementia Disease demonstration (DD) project in collaboration with the local Alzheimer's Association and related Dementias groups. The goal of the project is to provide comprehensive, coordinated care to individuals with memory concerns and to their caregivers. The approach is to expand the services and to integrate the bio-psycho-social aspects of care. The objectives are: 1) to provide dementia specific care, i.e., care management fully integrated into the services provided; 2) to train staff, students and volunteers; 3) to establish a system infrastructure to support services to individuals with early stage dementia and to their caregivers; 4) to develop linkages with community agencies; 5) to expand the assessment and intervention services; 6) to evaluate the impact of the added services; 7) to disseminate project information. The expected outcomes of this DD project are: patients will maintain as high a level of mental function and physical functions (thru Yoga) as possible; caregivers will increase ability to cope with changes; and pre and post – project patient evaluation will reflect positive results from expanded and integrated services. The products from this project are: a final report, including evaluation results; a website; articles for publication; data on driver assessment and in-home cognitive retraining; abstracts for national conferences.

## M. Survey instructions on Ensuring Equal Opportunity for Applicants

**Applicant Organization's Name:** \_\_\_\_\_  
**Applicant's DUNS Number:** \_\_\_\_\_  
**Grant Name:** \_\_\_\_\_ **CFDA Number:** \_\_\_\_\_

1. Does the applicant have 501(c)(3) status?

Yes  No

2. How many full-time equivalent employees does the applicant have? (Check only one box).

3 or Fewer  15-50  
 4-5  51-100  
 6-14  over 100

3. What is the size of the applicant's annual budget? (Check only one box.)

Less Than \$150,000  
 \$150,000 - \$299,999  
 \$300,000 - \$499,999  
 \$500,000 - \$999,999  
 \$1,000,000 - \$4,999,999  
 \$5,000,000 or more

4. Is the applicant a faith-based/religious organization?

Yes  No

5. Is the applicant a non-religious community-based organization?

Yes  No

6. Is the applicant an intermediary that will manage the grant on behalf of other organizations?

Yes  No

7. Has the applicant ever received a government grant or contract (federal, State, or local)?

Yes  No

8. Is the applicant a local affiliate of a national organization?

Yes  No

**Provide the applicant's (organization) name and DUNS number and the grant name and CFDA number.**

1. 501(c)(3) status is a legal designation provided on application to the Internal Revenue Service by eligible organizations. Some grant programs may require nonprofit applicants to have 501(c)(3) status. Other grant programs do not.
2. For example, two part-time employees who each work half-time equal one full-time equivalent employee. If the applicant is a local affiliate of a national organization, the responses to survey questions 2 and 3 should reflect the staff and budget size of the local affiliate.
3. Annual budget means the amount of money your organization spends each year on all of its activities.
4. Self-identify.
5. An organization is considered a community-based organization if its headquarters/service location shares the same zip code as the clients you serve.
6. An "intermediary" is an organization that enables a group of small organizations to receive and manage government funds by administering the grant on their behalf.
7. Self-explanatory.
8. Self-explanatory.

**Paperwork Burden Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is 1890-0014. The time required to complete this information collection is estimated to average five (5) minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. **If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to:** U.S. Department of Education, Washington, D.C. 20202-4651.

**If you have comments or concerns regarding the status of your individual submission of this form, write directly to:** Joyce I. Mays, Application Control Center, U.S. Department of Education, 7th and D Streets, SW, ROB-3, Room 3671, Washington, D.C. 20202-4725.

## N. Glossary of Terms

**EHR:** For purposes of this Funding Opportunity Announcement “electronic health record”, “certified EHR” and “certified EHR technology” have been used interchangeably to signify electronic health record certified pursuant to Section 3001(c)(5) of the Public Health Service Act as added by the ARRA.

**Health Information Exchange (HIE):** For purposes of this Funding Opportunity Announcement, “Health Information Technology” or “HIE” is used to mean the electronic movement of health-related information among organizations according to nationally recognized standards.

**Meaningful Use:** Under the HITECH Act, an eligible professional or hospital is considered a "meaningful EHR user" if they use certified EHR technology in a manner consistent with criteria to be established by the Secretary through the rulemaking process, including but not limited to e-prescribing through an EHR, and the electronic exchange of information for the purposes of quality improvement, such as care coordination. In addition, eligible professionals and hospitals must submit clinical quality and other measures to HHS.

Pursuant to Titles 18 and 19 of the Social Security Act as amended by Title IV in Division B of ARRA, the Secretary will propose and finalize a definition for meaningful EHR use through formal notice-and-comment rulemaking by the end of FY 2010.

### Provider Terms

**Primary-Care Physician:** For purposes of this Funding Opportunity Announcement, “Primary-Care Physician” is defined as a licensed doctor of medicine or osteopathy practicing family practice, obstetrics and gynecology, general internal or pediatric medicine regardless of whether the physician is board certified in any of these specialties.

**Individual primary-care physician practice:** For purposes of this Funding Opportunity Announcement, “individual primary-care physician practice” is defined as a practice in which only one primary-care physician furnishes professional services. The practice may include one or more nurse practitioners and/or physician assistants in lieu of or in addition to registered and licensed vocational nurses, medical assistants, and office administrative staff.

**Small-group primary-care physician practice:** For purposes of this Funding Opportunity Announcement, “small-group primary-care physician practice” is defined as a group practice site that includes 10 or fewer licensed doctors of medicine or osteopathy routinely furnish professional services, and where the majority of physicians practicing at least 2 days per week at the site practice family, general internal, or pediatric medicine. The practice may include nurse practitioners and/or physician assistants (regardless of their practice specialties) in addition to registered and licensed vocational nurses, medical assistants, and office administrative staff.

*Note: a practice otherwise meeting the definition of individual or small-group physician practice, above, may participate in shared-services and/or group purchasing agreements, and/or reciprocal agreements for patient coverage, with other physician practices without affecting their status as individual or small-group practices for purposes of the Regional Centers.*

### Selected Definitions Relevant to the Medicare EHR Incentives

**1886 (d) Hospitals:** Section 1886(d) of the Social Security Act (the Act) sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the

inpatient prospective payment system (IPPS). Acute-care hospitals subject to IPPS 1886(d) are often referred to as 1886(d) hospitals.

**Eligible Hospital:** Per Title 18 of the Social Security Act as amended by Title IV in Division B of ARRA, an 1886(d) inpatient acute care hospital paid under the Medicare inpatient prospective payment system (IPPS) or an 1814(l) Critical Access Hospital (CAHs).

**Non-eligible Hospital:** Per Title 18 of the Social Security Act as amended by Title IV in Division B of ARRA, any hospital *other than* an acute-care hospital under 1886(d) or Critical Access Hospital under 1814(l). (Per SSA 1886(d), examples include Long-term Care Hospitals, Inpatient Rehabilitation Hospitals, Inpatient Psychiatric Hospitals, non-IPPS Cancer Centers and Children’s Hospitals.)

**Eligible Professional:** For purposes of the Medicare incentive, an eligible professional is defined in Social Security Act Section 1848(o), as added by ARRA, as a physician as defined in Social Security Act 1861(r). The definition at 1861(r) includes doctors of medicine, doctors of osteopathy, doctors of dental surgery or of dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors.

**Hospital-Based Professional:** SSA 1848(o)(1)(C)(ii), as added by ARRA, defines a ‘hospital-based professional’ for purposes of clause (i) of SSA 1848(o)(1)(C). A hospital-based professional is an otherwise eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of his or her covered professional services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital. The determination of whether an eligible professional is a hospital-based eligible physician shall be made on the basis of the site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the primary care provider and any other provider. SSA 1848(o)(1)(C)(i) that no Medicare incentive payments for meaningful use of certified EHR technology may be made to hospital-based eligible professionals.

### **Selected Definitions Relevant to Medicaid EHR Incentives**

**Eligible professional:** Social Security Act 1903(t)(3)(B), as added by ARRA, defines an eligible professional for Medicaid health IT incentives as a physician, dentist, certified nurse mid-wife, nurse practitioner, or a physician assistant practicing in a rural health clinic or FQHC that is led by a physician assistant, if he/she meets the criteria set forth in SSA 1903(t)(2)(A) as added by ARRA.

**Rural Health Clinic:** For purposes of this Funding Opportunity Announcement, “rural health clinic” is defined as a clinic providing primarily outpatient care certified to receive special Medicare and Medicaid reimbursement. RHCs provide increased access to primary care in underserved rural areas using both physicians and other clinical professionals such as nurse practitioners, physician assistants, and certified nurse midwives to provide services.

**Federally Qualified Health Center (FQHC):** A type of provider defined by the Medicare and Medicaid statutes for organizations that provide care to underserved populations and include Community Health Centers, Migrant Health Centers, Health Care for the Homeless Programs, Public Housing Primary Care Programs and some tribal clinics. FQHC provide services in both medically underserved area and to medically underserved populations.

**Eligible Hospital:** The definition of Medicaid providers for purposes of eligibility for Medicaid HIT incentive payments, provided at Social Security Act 1903(t)(2)(B), as added by ARRA, is a Children's Hospital or an Acute Care Hospital with at least 10 percent patient volume attributable to Medicaid.

**Other Definitions for the purpose of this announcement**

**Note: Unless otherwise noted in the specific definition, the below terms are defined as used in this Funding Opportunity Announcement, for purposes of this announcement.**

**Health IT:** certified EHRs and other technology and connectivity required to meaningfully use and exchange electronic health information

**Priority primary care providers:** Primary-care providers in individual and small group practices (fewer than 10 physicians and/or other health care professionals with prescriptive privileges) primarily focused on primary care; and physicians, physician assistants, or nurse practitioners who provide primary care services in public and critical access hospitals, community health centers, and in other settings that predominantly serve uninsured, underinsured, and medically underserved populations.

**Provider:** All providers included in the definition of “Health Care Provider” in Section 3000(3) of the Public Health Service Act (PHSA) as added by ARRA. This includes, though it is not limited to, hospitals, physicians, priority primary care providers, Federally Qualified Health Centers (and “Look-Alikes”) and Rural Health Centers.

**Primary-care physician:** A licensed doctor of medicine (MD) or osteopathy (DO) who practices family, general internal or pediatric medicine or obstetrics and gynecology.

**Primary-Care Provider:** A primary-care physician or a nurse practitioner, nurse midwife, or physician assistant with prescriptive privileges in the locality where s/he practices and practicing in one of the specialty areas included in the definition of a primary-care physician for purposes of this announcement.

**Shared Directory:** A service that enables the searching and matching of data to facilitate the routing of information to providers, patients and locations.

**Appendix 6 -Excerpted language from H.R. 3200**

## APPENDIX NUMBER SEVEN (7)

111TH CONGRESS

# 1ST SESSION **H. R. 3200**

To provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 14, 2009

Mr. DINGELL (for himself, Mr. RANGEL, Mr. WAXMAN, Mr. GEORGE MILLER of California, Mr. STARK, Mr. PALLONE, and Mr. ANDREWS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, Oversight and Government Reform, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

...

**10 “SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE  
11 TRANSACTIONS.**

12 ‘ ‘(a) STANDARDS FOR FINANCIAL AND ADMINISTRA  
13 TIVE TRANSACTIONS. –

14 ‘ ‘(1) IN GENERAL. –The Secretary shall adopt  
15 and regularly update standards consistent with the  
16 goals described in paragraph (2).

17 ‘ ‘(2) GOALS FOR FINANCIAL AND ADMINISTRA

18 TIVE TRANSACTIONS. –The goals for standards  
19 under paragraph (1) are that such standards shall–

20 ‘ ‘(A) be unique with no conflicting or re  
21 dundant standards;

22 ‘ ‘(B) be authoritative, permitting no addi  
23 tions or constraints for electronic transactions,  
24 including companion guides;

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□HR 3200 IH

1 ‘ ‘(C) be comprehensive, efficient and ro  
2 bust, requiring minimal augmentation by paper

3 transactions or clarification by further commu  
4 nications;

5 ‘ ‘(D) enable the real-time (or near real  
6 time) determination of an individual’s financial  
7 responsibility at the point of service and, to the  
8 extent possible, prior to service, including  
9 whether the individual is eligible for a specific  
10 service with a specific physician at a specific fa  
11 cility, which may include utilization of a ma  
12 chine-readable health plan beneficiary identi  
13 fication card;

14 ‘ ‘(E) enable, where feasible, near real-time  
15 adjudication of claims;

16 ‘ ‘(F) provide for timely acknowledgment,  
17 response, and status reporting applicable to any  
18 electronic transaction deemed appropriate by  
19 the Secretary;

20 ‘ ‘(G) describe all data elements (such as  
21 reason and remark codes) in unambiguous  
22 terms, not permit optional fields, require that  
23 data elements be either required or conditioned  
24 upon set values in other fields, and prohibit ad  
25 ditional conditions; and

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□HR 3200 IH

1 ‘ ‘(H) harmonize all common data elements  
2 across administrative and clinical transaction  
3 standards.

4 ‘ ‘(3) TIME FOR ADOPTION.—Not later than 2  
5 years after the date of implementation of the X12  
6 Version 5010 transaction standards implemented  
7 under this part, the Secretary shall adopt standards  
8 under this section.

9 ‘ ‘(4) REQUIREMENTS FOR SPECIFIC STAND  
10 ARDS.—The standards under this section shall be

11 developed, adopted and enforced so as to-  
12 ‘ ‘(A) clarify, refine, complete, and expand,  
13 as needed, the standards required under section  
14 1173;

15 ‘ ‘(B) require paper versions of standard  
16 ized transactions to comply with the same  
17 standards as to data content such that a fully  
18 compliant, equivalent electronic transaction can  
19 be populated from the data from a paper  
20 version;

21 ‘ ‘(C) enable electronic funds transfers, in  
22 order to allow automated reconciliation with the  
23 related health care payment and remittance ad  
24 vice;

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**HR 3200 IH**

1 ‘ ‘(D) require timely and transparent claim  
2 and denial management processes, including  
3 tracking, adjudication, and appeal processing;

4 ‘ ‘(E) require the use of a standard elec  
5 tronic transaction with which health care pro  
6 viders may quickly and efficiently enroll with a  
7 health plan to conduct the other electronic  
8 transactions provided for in this part; and

9 ‘ ‘(F) provide for other requirements relat  
10 ing to administrative simplification as identified  
11 by the Secretary, in consultation with stake  
12 holders.

13 ‘ ‘(5) BUILDING ON EXISTING STANDARDS. -In  
14 developing the standards under this section, the Sec  
15 retary shall build upon existing and planned stand  
16 ards.

17 ‘ ‘(6) IMPLEMENTATION AND ENFORCEMENT. -

18 Not later than 6 months after the date of the enact  
19 ment of this section, the Secretary shall submit to

20 the appropriate committees of Congress a plan for  
21 the implementation and enforcement, by not later  
22 than 5 years after such date of enactment, of the  
23 standards under this section. Such plan shall in  
24 clude-

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□HR 3200 IH

1 ‘ ‘(A) a process and timeframe with mile  
2 stones for developing the complete set of stand  
3 ards;

4 ‘ ‘(B) an expedited upgrade program for  
5 continually developing and approving additions  
6 and modifications to the standards as often as  
7 annually to improve their quality and extend  
8 their functionality to meet evolving require  
9 ments in health care;

10 ‘ ‘(C) programs to provide incentives for,  
11 and ease the burden of, implementation for cer  
12 tain health care providers, with special consid  
13 eration given to such providers serving rural or  
14 underserved areas and ensure coordination with  
15 standards, implementation specifications, and  
16 certification criteria being adopted under the  
17 HITECH Act;

18 ‘ ‘(D) programs to provide incentives for,  
19 and ease the burden of, health care providers  
20 who volunteer to participate in the process of  
21 setting standards for electronic transactions;

22 ‘ ‘(E) an estimate of total funds needed to  
23 ensure timely completion of the implementation  
24 plan; and

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□HR 3200 IH

1 ‘ ‘(F) an enforcement process that includes  
2 timely investigation of complaints, random au

3 dits to ensure compliance, civil monetary and  
4 programmatic penalties for non-compliance con  
5 sistent with existing laws and regulations, and  
6 a fair and reasonable appeals process building  
7 off of enforcement provisions under this part.

8 ‘ ‘(b) LIMITATIONS ON USE OF DATA.—Nothing in  
9 this section shall be construed to permit the use of infor  
10 mation collected under this section in a manner that would  
11 adversely affect any individual.

12 ‘ ‘(c) PROTECTION OF DATA.—The Secretary shall en  
13 sure (through the promulgation of regulations or other  
14 wise) that all data collected pursuant to subsection (a)  
15 are—

16 ‘ ‘(1) used and disclosed in a manner that meets  
17 the HIPAA privacy and security law (as defined in  
18 section 3009(a)(2) of the Public Health Service  
19 Act), including any privacy or security standard  
20 adopted under section 3004 of such Act; and

21 ‘ ‘(2) protected from all inappropriate internal  
22 use by any entity that collects, stores, or receives the  
23 data, including use of such data in determinations of  
24 eligibility (or continued eligibility) in health plans,

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■HR 3200 IH

1 and from other inappropriate uses, as defined by the  
2 Secretary.’ ’ .

3 (2) DEFINITIONS.—Section 1171 of such Act  
4 (42 U.S.C. 1320d) is amended—

5 (A) in paragraph (7), by striking ‘ ‘with  
6 reference to’ ’ and all that follows and inserting  
7 ‘ ‘with reference to a transaction or data ele  
8 ment of health information in section 1173  
9 means implementation specifications, certify  
10 cation criteria, operating rules, messaging for  
11 mats, codes, and code sets adopted or estab

12 lished by the Secretary for the electronic ex  
13 change and use of information’ ’ ; and  
14 (B) by adding at the end the following new  
15 paragraph:

16 ‘ ‘(9) OPERATING RULES.—The term ‘operating  
17 rules’ means business rules for using and processing  
18 transactions. Operating rules should address the fol  
19 lowing:

20 ‘ ‘(A) Requirements for data content using  
21 available and established national standards.

22 ‘ ‘(B) Infrastructure requirements that es  
23 tablish best practices for streamlining data flow  
24 to yield timely execution of transactions.

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□HR 3200 IH

1 ‘ ‘(C) Policies defining the transaction re  
2 lated rights and responsibilities for entities that  
3 are transmitting or receiving data.’ ’ .

4 (3) CONFORMING AMENDMENT.—Section

5 1179(a) of such Act (42 U.S.C. 1320d-8(a)) is  
6 amended, in the matter before paragraph (1)–

7 (A) by inserting ‘ ‘on behalf of an indi  
8 vidual’ ’ after ‘ ‘1978)’ ’ ; and

9 (B) by inserting ‘ ‘on behalf of an indi  
10 vidual’ ’ after ‘ ‘for a financial institution.’ ’

11 (b) STANDARDS FOR CLAIMS ATTACHMENTS AND

12 COORDINATION OF BENEFITS .—

13 (1) STANDARD FOR HEALTH CLAIMS ATTACH

14 MENTS.—Not later than 1 year after the date of the  
15 enactment of this Act, the Secretary of Health and  
16 Human Services shall promulgate a final rule to es  
17 tablish a standard for health claims attachment  
18 transaction described in section 1173(a) (2) (B) of the  
19 Social Security Act (42 U.S.C. 1320d-2(a) (2) (B))  
20 and coordination of benefits.

21 (2) REVISION IN PROCESSING PAYMENT TRANS

22 ACTIONS BY FINANCIAL INSTITUTIONS. —

23 (A) IN GENERAL.—Section 1179 of the So  
24 cial Security Act (42 U.S.C. 1320d-8) is  
25 amended, in the matter before paragraph (1)—

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□HR 3200 IH

1 (i) by striking ‘ ‘or is engaged’ ’ and in  
2 serting ‘ ‘and is engaged’ ’ ; and

3 (ii) by inserting ‘ ‘(other than as a  
4 business associate for a covered entity)’ ’  
5 after ‘ ‘for a financial institution’ ’ .

6 (B) EFFECTIVE DATE.—The amendments  
7 made by paragraph (1) shall apply to trans  
8 actions occurring on or after such date (not  
9 later than 6 months after the date of the enact  
10 ment of this Act) as the Secretary of Health  
11 and Human Services shall specify.

**Appendix 7 -Workgroup Meeting Minutes July 8, 2009**

# HIT Payment Reform- VT Meeting Minutes & Action Items

JULY 8, 2009

8:00-10:30AM

133 STATE STREET , 5<sup>TH</sup> FLOOR  
CONFERENCE ROOM

<b>MEETING CALLED BY</b>	Sen. Bill Carris, Co- Chair and Rep. Anne O'Brien, Co- Chair; Hunt Blair, Deputy Director for Health Care Reform, OVHA
<b>TYPE OF MEETING</b>	Legislative Summer work group on Health information Technology for Payment Reform
<b>FACILITATOR</b>	Anne O'Brien, Co- Chair
<b>NOTE TAKERS</b>	Hunt Blair and Anne O'Brien
<b>ATTENDEES</b>	Tom Murray, Commissioner, Dept. of Information and Innovation; David Gruppo, IBM; Rob Willey, IBM Govt Relations; Joshua Slen, Interim CEO VITL, Jim Hester, Vermont Healthcare Reform Commission Director; John Grubmuller, VP Health and Human Services, First Data; Jean Landsverk, Gov't and Education, First Data; Nolan Langweil, Joint Fiscal Office; Craig Jones, M.D. Vt Blueprint for Health; Kevin Goddard, VP for External Affairs, Blue Cross and Blue Shield, Hunt Blair, Senator Bill Carris, Representative Anne O'Brien

## REVIEW CHARGE IN H 441

ANNE O'BRIEN

<b>DISCUSSION</b>	Handed out and reviewed the H. 441 pages 123, 124 Sec. E 102.1 Health Information Technology for Payment Reform Work Group membership and charge.	
	<ol style="list-style-type: none"> <li>1) Explore opportunity for using HIT to achieve health care payment reform including smart card technology and mechanisms to enable real time eligibility determinations and claims preparation and adjudication.</li> <li>2) Identify potential sources of funding including grants and other federal funds.</li> <li>3) Develop one or more proposals for appropriate funds including those under ARRA( American Reinvestment and Recovery Act)</li> <li>4) Create a working plan for implementation of HIT payment reform initiatives for further action by the work group by August 31, 2009.</li> </ol>	
<b>CONCLUSIONS</b>	Need to get very clear as to the scope of this for this timeframe with August 31, 2009 deadline for initial report and recommendations. Need to identify the current status and the future vision and gaps which will clarify next steps and action items in the proposal. Need to align with the State HIT plan. Need to meet HIPAA and HIT Federal Standards and VITL privacy and security standards.	
	<p>The goal of the work group is a statewide initiative that would ultimately provide for comprehensive electronic adjudication of health care claims. An immediate step to inform the group's understanding will be to review the current state of such (primarily batch) transactions to see what is required to achieve the vision of a real time (or close to real time) transactional system. The model that was offered was the type of system some dentists and dental insurers have in place, where the dentist and insured patient can see what is and isn't covered by their insurance, and thus, what a consumer would owe. Concept overview by Dave Gruppo: This payment reform project has three key elements 1) Providers 2) Hub for Transactions 3) Payers.</p> <p>Potential benefits: Decrease transactional Costs, estimated that administration costs can be decreased up to 15%. Increase efficiency by decreasing timeframe for payment.</p>	
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Draft a "current status" flow or diagram of health payment process in Vermont.	WHO?	
Draft a vision of the desired outcome which will include technology . Get specific information presented from First Data on the current use of smart card. Get specific information from IBM on the proposed hub function between the providers and the payors.	Jean Landsverk and John Grubmuller, First Data Diane Hawkins to schedule WebEx meeting	Prior to July 22 meeting

## STAKEHOLDERS: DO WE HAVE THE RIGHT PEOPLE HERE?

<b>DISCUSSION</b>	Question by Jim Hester, Health Care Reform Commission , Director
Stakeholders in payment reform- who needs to be here? What about Vermont Medical Society, VAHHS, UVM Researchers? Is there anyone else?	

MVP and CIGNA were invited and not represented at this meeting and it is important to include them. Would be useful to find a practice management group to include in our planning process. Discussed Central Vermont since it is close by.		
<b>CONCLUSIONS</b>	We need to include provider and payer perspectives from the front end.	
Paul Harrington, Bea Grause and Melody Burkins should be included in the future meetings.		
New VITL Director David Cochran will be here for the next meeting. Need to meet with him to get his perspective on this.		
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Call Paul Harrington, VMS and invite to next meeting Call Bea Grause, VAHHS and invite to next meeting Call Melody Burkins, UVM Research and Development and invite to next meeting	Hunt Blair/ Anne O'Brien	July 22 meeting
Set up meeting with new VITL CEO prior to July 22 meeting	Diane Hawkins	Set for July 17 at 1:30 PM in Williston OVHA office.

## SCOPE OF THE WORK

ALL

<b>DISCUSSION</b>	Hans K stated that at this time focus should be on ambulatory care and physician practices and not include hospital billing systems. Focus should not be on " smart card" rather on increasing efficiency and decreasing duplication in the billing process.	
Discussion on the scope including the need for a statewide plan verses a "pilot". Conclusion was that state wide would strengthen the proposal for Washington. Some concern about scope creep and whether we should include any clinical aspects in this proposal. Need to identify the current number of physician practices in Vermont to determine scope.		
Discussion about the idea of understanding the smart card technology as a "key" like the key to a car. It is a functional and important item to make the system work.		
<b>CONCLUSIONS</b>	No conclusions, some variation in understandings and will need to conclude next meeting once we have a better understanding of the proposal requirements.	
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Continue discussion next meeting- put on agenda	Anne O'Brien	ongoing
Gather data on practice numbers from VMS or collect it by calling.	Hunt Blair	

## FUNDING

HUNT BLAIR

<b>DISCUSSION</b>	What funding sources have been identified? ARRA money? What are the requirements?	
Hunt identified the money sources that are potential for this project.		
Comparative Effectiveness Research funding potential... Dave Gruppo suggested working with UVM Researcher, Melody Burkins to include this aspect.		
<b>CONCLUSIONS</b>	Sect 3013 state money, CMS 90/10 money, VT eligible for discretionary funds?, private funding and the project itself being a revenue generating stream with a transaction fee.	
Challenge which exists is that the ARRA funding requirements are not written and likely will not be completed prior to the deadline of August 31.		
Because of the vagaries of ARRA related funding the work group will not be able to develop an actual grant proposal in this time frame, but its recommendations will constitute one of the chapters of the updated State HIT Plan and the work group plans to create a road map for how to move ahead in this area.		
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Ongoing review of funding requirements availability from ARRA	Hunt Blair	ongoing
Set up meeting with UVM Research Division Director -Melody Burkins Ph.D.	Anne O'Brien	August 10

**RESOURCES FOR PROJECT SUPPORT/WRITING PROPOSAL**

<b>DISCUSSION</b>		
Hans –Questioned funding for staff to write the proposal?		
There was originally funding included for staff however it was not funded in the final budget from the legislature. State does not have extra staff for this per Hunt Blair. No one around the table had resources to write and produce the proposal.		
<b>CONCLUSIONS</b>		
Anne O'Brien offered to be the central coordinator of the content for proposal.		
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Template for outline of paper to start the proposal writing	Dave Gruppo, IBM	Email prior to next meeting

<b>OBSERVERS</b>	
<b>RESOURCE PERSONS</b>	Hans Kastensmith, Health Care Reform Consultant
<b>SPECIAL NOTES</b>	Meeting length was expanded by 30 minutes and all agreed that next meeting we will plan to meet July 22, 2009 from 10:30 AM – 12:30 PM. Following the meeting Hans and Alex indicated that they received approval from Peter Shumlin for \$15,000 to fund a staff person for this project.

**Appendix 8 - Workgroup Meeting Minutes July 22, 2009**

# Vermont HIT Payment Reform Workgroup

## Meeting Minutes & Action Items

JULY 22, 2009

10:30 – 12:30

133 STATE STREET , 5<sup>TH</sup> FLOOR  
CONFERENCE ROOM

<b>MEETING CALLED BY</b>	Sen. Bill Carris, Co- Chair and Rep. Anne O'Brien, Co- Chair; Hunt Blair, Deputy Director for Health Care Reform, OVHA
<b>TYPE OF MEETING</b>	Legislative Summer work group on Health information Technology for Payment Reform
<b>FACILITATOR</b>	Anne O'Brien, Co- Chair
<b>NOTE TAKERS</b>	Beth Waldman and Joshua Slen, Bailit Health Purchasing
<b>ATTENDEES</b>	Tom Murray, Commissioner, Dept. of Information and Innovation; David Gruppo, IBM; Wendi Monahan, IBM; Jim Hester, Vermont Healthcare Reform Commission Director; John Grubmuller, VP Health and Human Services, First Data; Jean Landsverk, Gov't and Education, First Data; Don George, President and CEO, Blue Cross and Blue Shield; Hunt Blair; Senator Bill Carris; Representative Anne O'Brien; Neil Sarkar, University of Vermont, Dawn Bennett, BISHCA; Paul Forlenza, VITL; David Cochran, CEO, VITL; Alex MacLean, Senator S. Staff; Kathy Merchant (interested party); George Eisenberg, IBM; Hans Kastensmith, Capital Health Associates; Rob Willey; Carla Colenzar

### INTRODUCTIONS AND REVIEW AND APPROVAL OF MINUTES

ANNE O'BRIEN

<b>DISCUSSION</b>		
<p>Representative O'Brien introduced Beth and Joshua and explained that they would be providing facilitation and report drafting assistance to the workgroup in order to meet the aggressive deadline of August 31, 2009 for the final production of the workgroup's report.</p> <p>Representative O'Brien asked for any discussion of the minutes from the July 8<sup>th</sup> meeting. It was noted that the efforts this committee and the Vermont Claims Administrative Collaborative (VCAC) need to be reviewed in order to identify if there is alignment.</p>		
<b>CONCLUSIONS</b>		
The minutes were approved.		
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
NONE		

### STATEMENT OF CHARGE

BETH WALDMAN

<b>DISCUSSION</b>		
<p>Beth presented the overall vision and called for discussion.</p> <p>Representative O'Brien asked everyone to consider the importance of a "wow" factor. In other words, what is in</p>		

this for different stakeholder groups. She asked for a brainstorming session around both the positive and the potential negatives surrounding this issue. The following points were made by various parties:

1. Providers: saves time and money (potentially reduces bad debt)
2. Patients: a card is something that everyone is used to, there is a potentially huge improvement to the patient in the experience, there may be a barrier to care erected by consumers knowing their financial exposure at the front end.
3. Carriers: only a small float exists (8-10 days of current float) this is a small price to pay; not something that should be a barrier from the Carrier perspective.
4. Potential Funding Sources: this will be the first state-wide point-of-service adjudication of eligibility and claims.

After a thorough discussion of the forgoing points the following vision statement was developed:

**The overall vision of the work group is the implementation of a statewide initiative that will reduce administrative costs through the provision of a comprehensive point-of-service eligibility and electronic adjudication of health care claims using a token based system and starting in physician offices/ambulatory care centers.**

Beth presented the draft workgroup goal to be achieved by the end of August and called for discussion. There was general agreement around the following statement of the workgroup goal by the end of August.

**The goal of the work group is to deliver a report by the end of August that describes that overall vision and details the specific opportunities and potential barriers to implementing it. The report will outline next steps for the development of an implementation plan over the next twelve to eighteen months.**

During the discussion, attendees noted a number of opportunities and potential barriers to implementation. In addition to the “wow” factors described above, opportunities include: giving all parts of the health system more time to focus on medical issues rather than administrative billing issues; providing the potential to give patients greater choice and opportunity for shared decision making in their treatment. Identified barriers to implementation included the fact that many providers will not have the capability to implement such a system either because of the fact that they rely on paper records or because their practice management systems cannot accept the financial information in an integrated fashion. There was a long discussion of the use of a smart card, as the legislation requires consideration of a smart card, as compared to other potential solutions.

Beth presented a framework for the work between now and the next full workgroup meeting (August 26, 2009) and called for discussion.

There was general agreement in the following framework:

**The work group will produce recommendations regarding what should be included in the detailed implementation plan including the estimated resources necessary to produce a detailed plan for implementing a state-wide real-time (point-of-service) claims adjudication system in physician**

**offices/ambulatory care settings with all major public and private payers.**

The workgroup discussed utilizing use cases as part of the report to showcase the “as is” scenario for eligibility confirmation and claims adjudication and the “to be” scenario based on implementation of the workgroup’s vision. A significant piece of the implementation plan will include this assessment of the system and the steps required to move from the “as is” to the “to be” scenario. In addition, the workgroup discussed that the implementation plan would need to include a staged approach (either by provider type, carrier, region or product readiness). The implementation plan should also include milestones, meaningful measurement and evaluation of the solution. It should also include a communication plan.

There was a discussion regarding who else should be included in the process:

It was suggested that one or more practice managers could be included. Jim Hester suggested that we contact Sandy Bechtel with MBA health group and Donna Izor from CVMC is potential resources. He also suggested Paul Harrington of the Vermont Medical Society who is active with the Physician Foundation in California, whose mission is to preserve small physician practices.

It was suggested that the group come up with real use cases - - identifying other places/entities that have done what we are attempting to do. David Gruppo from IBM suggested that IBM could provide some use cases to the group.

Representative Anne O’Brien suggested that a meeting with BISHCA regarding the Vermont Claims Administrative Collaborative (VCAC) could provide a good baseline for the group as VCAC has been meeting for almost a year with the goal of simplifying the existing system. Jim Hester, Health Care Reform Commission, suggested that this workgroup obtain the claims administration executive summary and perhaps the full report as a point of reference. Don George, BCBS suggested that a difference between the VCAC group and this group could be stated this way; The VCAC is built on improving the existing process. This group is talking about replacing the existing process.

Senator Carris requested that we provide a link to the BISHCA report that includes the baseline data around the number of covered lives by Carrier (Payer) in the minutes. The link to the most recent BISHCA report is provided here:

[http://www.bishca.state.vt.us/HcaDiv/Data\\_Reports/healthinsurmarket/VHHIS\\_Initial\\_Findings2008\\_01\\_15\\_09.pdf](http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/VHHIS_Initial_Findings2008_01_15_09.pdf)

There was a discussion surrounding the creation of subgroups to describe and diagram the “As Is” and “To Be” states.

It was decided that we complete “As Is” use cases for Medicare, Medicaid, and a Private Payer. It was determined that a Workers Compensation use case was beyond the capacity of this workgroup given the time constraints.

Representative O’Brien called for volunteers for the “As Is” subgroup and the following individuals either requested to be part of the subgroups or were suggested by a workgroup member as a potential resource; Sandy Bechtel (suggested by Jim Hester as a resource), Don George indicated that BCBS would participate, Paul

Forlenza, John (from First Data), Senator Carris, Representative O'Brien, a BISHCA representative, Representative O'Brien called for volunteers for the "To Be" subgroup and the following individuals or organizations volunteered; Don George, Neil Sarkar, David Gruppo, and John Grubmiller.

Jim Hester reminded the group that we would need to identify potential funding sources and two were suggested by the group; 1) ARRA, and 2) self-funding mechanisms.

Representative O'Brien indicated that the final report needed to include a communication plan.

It was suggested that the AAFP - American Association of Family Practitioners - might be helpful to the group.

Similarly it was suggested that The Physician Foundation, CA - could be a possible resource for finding out what is important to small practices.

ACTION ITEMS	PERSON RESPONSIBLE	DEADLINE
Schedule a webex meeting for the entire workgroup to receive a presentation from IBM regarding the system architecture solution that IBM has available.	Joshua and Beth/Diane Hawkins	August 7, 2009
Schedule two meetings of the "As Is" subgroup to produce a diagram and written explanation of the current system.	Joshua and Beth/Diane Hawkins	Scheduled by July 31, 2009 Second meeting complete by August 21, 2009
Produce a compilation of current data and metrics that exist and which will assist the subgroups in defining the current state of the system in Vermont.	Joshua and Beth with assistance from each of the parties at the table.	Prior to the first subgroup meeting.
Schedule two meetings of the "To Be" workgroup to produce a diagram and written description of the new system as it is envisioned.	Joshua and Beth/Diane Hawkins	Scheduled by July 31, 2009 Second meeting complete by August 21, 2009

**Appendix 9 - "as is" Subgroup Meeting Minutes August 10, 2009**

# HIT Payment Reform- VT "As Is" Subgroup Meeting Minutes & Action Items

AUGUST 10, 2009, 10:00 – 12:00

OVHA, 312 HURRICANE LANE,  
WILLISTON, VT

MEETING CALLED BY	Sen. Bill Carris, Co- Chair and Rep. Anne O'Brien, Co- Chair; Hunt Blair, Deputy Director for Health Care Reform, OVHA
TYPE OF MEETING	Legislative Summer work group on Health information Technology for Payment Reform; Sub group on "As Is" state of eligibility and claims adjudication
FACILITATOR	Beth Waldman, Bailit Health Purchasing
NOTE TAKERS	Beth Waldman
ATTENDEES	Ajay Asthana, IBM; David Gruppo, IBM; Rob Willey, IBM; John Grubmuller, First Data; Nolan Langweil, Joint Fiscal Office; Sandy Bechtel, MBA Health Group; Sue Keenoy, BCBSVT; Don George, BCBSVT; Lauren Parker, MBA Health Group; Paul Forlenza, VITL; Christine Oliver, BISCHA; Lori Collins, OVHA; Hunt Blair, Senator Bill Carris, Representative Anne O'Brien

## REVIEW OF "AS IS" ELIGIBILITY VERIFICATION PROCESS

DISCUSSION OF AS IS ELIGIBILITY VERIFICATION PROCESS	Discussion of current eligibility verification process in VT, based mainly on experiences of practices that are managed through MBA Health Group.
<p>Key Facts:</p> <ol style="list-style-type: none"> <li>Many practices do not have capability today to check eligibility electronically. Those practices without access to an eligibility verification system, check a patient's eligibility for insurance either by calling the carriers (and speaking to a person or confirming through an IVR process) or by a website check. Typically practices will do a web site check first and if that is not available, will confirm via a phone call. Depending on the number of patients seen in a practice per day, this function takes office staff approximately 2-4 hours per day.</li> <li>Eligibility verification checks can happen at various times – including when a patient calls for an appointment, 1-2 days prior to an appointment, at the time a patient presents for an appointment or retrospectively through submission of a claim.</li> <li>When offices check for eligibility prior to a patient presenting for an appointment, the office can check back with the patient to alert to an eligibility problem. This gives the patient time to try to fix any error prior to the appointment or to decide whether will pay for the visit out of pocket.</li> <li>Medicaid eligibility checks include ability for provider to check if the specific service that is being provided is covered and whether it needs prior authorization. Commercial carriers publish a prior authorization manual that provides information as to when need a PA. General consensus in the room was that PA is not as big of a problem today as it was 3-4 years ago.</li> <li>Carriers have individualized systems for verifying eligibility. The process is not consistent across carriers.</li> <li>A small number of practices are beginning to contract with a service that checks eligibility for patients. The MBA Health Group practices with this capacity use I-Verify which can check for eligibility with major VT carriers and Medicaid.</li> <li>A small number of practices use a provider portal that allows patients to fill out forms on line prior to their arrival at the physician's office. Other offices may mail patients forms to complete and return prior to the appointment (though many just bring the form to the appointment).</li> <li>Despite the work that providers do to confirm insurance eligibility prior to or at the time of an appointment, providers still see denied claims based on lack of eligibility. This is due to fact that not all providers check up front; providers may get bad information from a patient, or the carrier still denies claim despite initial confirmation of eligibility. If a claim is denied for lack of eligibility, a provider may attempt to resubmit the claim or work with carrier to determine the issue that resulted in non-payment.</li> <li>Some denials may be because employers do not always provide carriers with timely updates of changes in employment or insurance status for their employees. This may result in retroactive disenrollment from a plan. BCBSVT noted that it has developed an employer portal that will allow employers to make changes to covered lives on-line.</li> <li>Medicare is the easiest carrier to check in terms of eligibility, because an individual's Medicare coverage is stable over time. Commercial carriers have some churn in membership based on changes in employment, but overall is a typically stable coverage. Medicaid eligibility can change on a daily basis and providers need to make sure to check this often.</li> <li>A limited number of providers have the Medicaid swipe box option which allows for a member to swipe the card and a provider to confirm Medicaid eligibility. This option is not widely used as office staff typically use the state's website or help desk option to confirm Medicaid eligibility.</li> <li>VITL estimates that there are approximately 1500 FTE physicians in the state, including primary care physicians and specialists. Of the estimated 639 primary care doctors in 2008, VITL estimates that there are 228 practices. Of the estimated 916 specialists based on 2006 information, VITL estimates that there are approximately 4 specialists per practice for a resulting 229 practices.</li> <li>Medicare is requiring proof of identification at the time of an appointment (to limit/prevent cardholder fraud).</li> </ol>	

<b>ADDITIONAL INFO THAT WOULD BE HELPFUL</b>	To the extent this information can be gathered in the next couple of weeks, should be included within report to the Legislature. To extent requires further research, should be included as an action step for the anticipated more detailed planning phase of the project.	
<ol style="list-style-type: none"> <li>1. Percentage of patients where practices see an eligibility problem, or cannot confirm eligibility.</li> <li>2. Time studies of eligibility verification work in practices that use I-Verify (or other electronic service) vs. practices that check manually (phone or internet).</li> <li>3. Percent of claims denied for lack of eligibility for coverage (as opposed to eligibility for a particular service).</li> <li>4. Survey of practices to understand how do eligibility verification today and how burdensome it is to the practice.</li> <li>5. Difference in eligibility verification for specialists (based on coverage policies, prior authorization for services)</li> </ol>		
<b>DISCUSSION ITEMS FOR SESSION ON FRIDAY, AUGUST 14, 2009</b>	<b>PERSON RESPONSIBLE</b>	
Review of "As Is" Eligibility Verification Flow	Ajay Asthana	

## REVIEW OF "AS IS" CLAIMS ADJUDICATION PROCESS

<b>DISCUSSION</b>	Discussion of current claims adjudication process in VT, based mainly on experiences of practices that are managed through MBA Health Group.	
<ol style="list-style-type: none"> <li>1. Providers utilize an electronic or paper routing form for patients, depending on whether or not have an EMR</li> <li>2. The routing form follows that patient throughout the office – beginning with the patient’s check-in at the front desk. The form takes information from the provider’s patient management system and adds specific information based on the patient’s visit – specifically, information about the patient’s diagnosis, services and recommended treatment.</li> <li>3. Prior to submitting a claim for adjudication, an individual manually confirms that the diagnosis code matches the procedure code on the routing form. If it doesn’t match, office staff will flag for physician and attempt to fix with a matching code.</li> <li>4. Approximately 80% of claims are submitted electronically in VT. Many offices use clearinghouses to submit claims to the appropriate carrier. The clearinghouse serves to help clean the claim form for the practice and simplify the billing process for providers. Providers typically pay a monthly fee to clearinghouse for the processing of the claims. Depending on the arrangement, the practice may also pay per claims submitted. Clearinghouses typically have add on fees for a number of services such as providing remittance advices and if a claim needs to be “dumped” to paper.</li> <li>5. Some claims must be submitted on paper based on the need for an attachment. This happens in Medicaid where there is multiple coverage and Medicaid is the payer of last resort. Medicaid must receive a hard copy of the EOB from the other insurer. Medicaid is moving towards allowing to submit electronically for some claims, but not every practice has the ability to carry through the other carrier’s denial code onto its claim submission to Medicaid. Medicaid does have an automatic cross-over payment with Medicare for dually eligible members.</li> <li>6. While in some states, insurers provide some of the funding for clearinghouses, that is not the case in Vermont.</li> <li>7. While not including workers comp in this phase, it was noted that this is big burden to providers and should be explored in the next planning phase.</li> <li>8. Noted pain points – denials (most claims are paid in the end; some deny finally for failure to meet timely filing requirements); unpaid claims (this includes both denials and those that have been processed and say that are paid but didn’t really run or process – these claims need to be reprocessed) and patient calls re: balances due.</li> <li>9. To resolve an unpaid claim need to follow carriers process – get info on why denied through a call, IVR, or website. Sometimes get inconsistent reasons from carriers for denials. Noted that Medicare is right only 4% of the time when give information out.</li> <li>10. In some cases, claims are denied b/c of upcoding – that is bill for a higher level of services than looks should have been provided. If first time, carrier may “pay and educate” upon appeal.</li> <li>11. It was noted that physicians often feel like should be paid for services provided, whether an allowable service or not.</li> </ol>		
<b>FOR FRIDAY 8/14 MEETING</b>	These topics were not fully discussed at the 8/10 meeting and need to be concluded on Friday.	
1. Description from BCBSVT of how claims processing/adjudication works from the carrier’s perspective.		
2. Discussion of patient payment. Noted that its often biggest part of the accounts receivable of a practice.		
<b>ACTION ITEMS</b>	<b>PERSON RESPONSIBLE</b>	<b>DEADLINE</b>
Review of "As Is" Claims Adjudication Flow	Ajay Asthana	

**Appendix 10 - "to be" Subgroup Meeting Minutes August 10, 2009**

# HIT Payment Reform- VT "To Be" Subgroup Meeting Minutes & Action Items

AUGUST 10, 2009, 1:00 – 3:00

OVHA, 312 HURRICANE LANE,  
WILLISTON, VT

<b>MEETING CALLED BY</b>	Sen. Bill Carris, Co- Chair and Rep. Anne O'Brien, Co- Chair; Hunt Blair, Deputy Director for Health Care Reform, OVHA
<b>TYPE OF MEETING</b>	Legislative Summer work group on Health information Technology for Payment Reform; Sub group on "To Be" vision of eligibility and claims adjudication
<b>FACILITATOR</b>	Beth Waldman, Bailit Health Purchasing
<b>NOTE TAKERS</b>	Beth Waldman
<b>ATTENDEES</b>	Neil Sakar, UVM; Ajay Asthana, IBM; David Gruppo, IBM; Rob Willey, IBM; John Grubmuller, First Data; Nolan Langweil, Joint Fiscal Office; Sandy Bechtel, MBA Health Group; Lauren Parker, MBA Health Group; Paul Forlenza, VITL; Hunt Blair, Senator Bill Carris, Representative Anne O'Brien

## VISION OF "TO BE" PROCESS

<b>DISCUSSION OF TO BE ELIGIBILITY VERIFICATION AND CLAIMS ADJUDICATION PROCESS</b>	Discussion of the vision for the "to be" state, based on the pain points identified during the "as is" session.
<p>The conversation of the "to be" process was fluid. These notes reflect the major points of the conversation:</p> <ol style="list-style-type: none"> <li>1. The group re-asserted the goals of the process to develop an on-line, real time, point of service eligibility verification and claims adjudication process. There was some confusion in the group as to whether the system – based on this vision – needed to be designed to be used only at the point of service, or whether the system could begin prior to a patient being at the point of service.</li> <li>2. While IBM has a proposed HTS solution that utilizes a smart card; the consensus of the group was that it was important to talk about the solution in a neutral manner and consider solutions beyond the use of a smart card. For lack of a better word, the group focused on the use of a "token" which may or may not be a physical item.</li> <li>3. It should be a priority to address where there are failures in the system today – determining eligibility (real time); ability to auto-populate the record/routing information; coding errors; ability to determine a patient's responsibility for payment prior to the patient leaving the provider's office (including feed back deductible balance in real-time)</li> <li>4. In order to be able to adjudicate a claim real time, the following information will be needed: patient eligibility information (including deductible/co-pay/co-insurance responsibility of payment); diagnosis code and treatment code; charge for payment; contracted payment amount and remaining patient responsibility. Patient should be able to review an EOB and pay there full patient payment amount before they leave the physician's office.</li> <li>5. The vision includes an HIE that, instead of clinical information, is focused on financial information. It is possible that this could be linked with a clinical HIE.</li> <li>6. The claims adjudication may still go through a clearinghouse as it often does today.</li> <li>7. In detailing the vision, the group made an assumption that all providers have EMR with minimal decision support services.</li> <li>8. It was noted that BCBS of SC does do eligibility verification and real-time adjudication currently; and have mandated it to be done nationally.</li> <li>9. First Data did a pilot program where it concluded that the technology was good; but there was a chicken/egg situation where payers and providers wouldn't commit unless the other agreed first. Lesson learned: important to have a central authority to make it happen. Also, in the pilot there was not integration between the practice management system and the eligibility/claims adjudication process. Lesson learned: to be successful, providers need to be able to do as part of a seamless process, practices do not want to be required to take a two step process.</li> <li>10. Discussion of potential of leveraging the work of VITL for this process. Paul F. noted that the process was parallel to VITL's process and not inconsistent (whether or not this was something that VITL may be interested in taking on in the future as an additional responsibility. Should be able to interface with the enterprise management provider index (EMPI).</li> </ol>	
<b>ISSUES TO BE ADDRESSED</b>	To the extent this information can be gathered in the next couple of weeks, should be included within report to the Legislature. To extent requires further research, should be included as an action step for the anticipated more detailed planning phase of the project.
<ol style="list-style-type: none"> <li>1. Will the system be able to identify the patient responsibility – either based on remaining deductible or co-insurance amount?</li> <li>2. How will the system handle exceptions – that is anything that falls outside of a simple claim (such as coordination of benefits, prior authorization)</li> <li>3. Will it remain necessary to have a personal intervention/manual review of whether the diagnosis code matches the treatment code or will that be able to be done in an automated manner?</li> <li>4. Important to monitor national reform – including definition of meaningful use (which includes checking of eliqibility); health reform bills</li> </ol>	

contain language requiring real time adjudication of claims by date certain

5. How will the HIE collect and store information from third party payers? Is it critical to have all payers as part of the process or is it going to be sufficient to have the major players (BCBSVT, MVP, CIGNA, MEDICAID) in the mix? What happens if Medicare is not involved? Other insurers with smaller segments of the market?
6. If most of the eligibility issues are based on Medicaid, will automating the system solve the issues or are the issues based in Medicaid policy? Are there potential ways to modify the eligibility requirements for Medicaid to allow for easier verification and reduced burden for providers?
7. How will this new system interact with the practice management systems of providers? It is important for there to be integrated systems.
8. Is it possible for the eligibility verification to be rechecked/updated between original review and time of appointment? Can the eligibility verification be linked in some way to the provider's scheduling system?
9. Commercial market data on eligibility must also be up to date
10. What will report include? Should include proposed comprehensive planning process leading to implementation; should discuss a proposal for funding and recommendation for this to be included as part of VT's overall HIT plan and request for federal dollars.

Next Steps: For meeting on Friday, 8/14/09 should review the "to be" flow and ensure the design hits on the pain points of the current process. Additionally, should address how will meet complex needs of the eligibility/claims adjudication process which are not simple, and changes to each process to fit within this structure.

**Appendix 11 - "as is" Subgroup Meeting Minutes August 14, 2009  
(including attachments)**

# HIT Payment Reform- VT "As Is" Subgroup Meeting Minutes & Action Items

AUGUST 14, 2009, 10:00 – 12:00

OVHA, 312 HURRICANE LANE,  
WILLISTON, VT

MEETING CALLED BY	Sen. Bill Carris, Co- Chair and Rep. Anne O'Brien, Co- Chair; Hunt Blair, Deputy Director for Health Care Reform, OVHA
TYPE OF MEETING	Legislative Summer work group on Health information Technology for Payment Reform; Sub group on "As Is" state of eligibility and claims adjudication
FACILITATOR	Joshua Slen, Bailit Health Purchasing
NOTE TAKERS	Beth Waldman (by phone); Joshua Slen
ATTENDEES	Ajay Asthana, IBM (by phone); David Gruppo, IBM; Rob Willey, IBM (by phone); John Grubmuller, First Data; Wendy Monihan, IBM – by phone; Sandy Bechtel, MBA Health Group; Sue Keenoy, BCBSVT; Don George, BCBSVT; Lauren Parker, MBA Health Group; Paul Forlenza, VITL; Debbie Austin, OVHA; Hunt Blair, Senator Bill Carris, Representative Anne O'Brien;

## REVIEW OF "AS IS" ELIGIBILITY VERIFICATION PROCESS

CONTINUED DISCUSSION OF AS IS ELIGIBILITY VERIFICATION PROCESS	Discussion of current eligibility verification process in VT, based mainly on experiences of practices that are managed through MBA Health Group.
<ol style="list-style-type: none"> <li>1. Sue Keenoy walked through the BCBS VT Eligibility Flow.</li> <li>2. More Medicare Advantage plans in the state; so Medicare eligibility becomes more of an issue (in that need to check a number of more places)</li> <li>3. Lauren Parker – third party site like I-verify is currently available in limited office practice systems. The I-Verify system interfaces with carriers and delivers an eligibility result electronically into the practice management system. So the eligibility issue has a solution today:             <ol style="list-style-type: none"> <li>a. Barriers to doing it today – didn't work with provider management systems; cost – small set up fee &amp; per transaction fee (for each 270/271)(for MBA HealthCare Group charge 15 cents per transaction);</li> <li>b. Could reside on a "VT HIE"; could be on multiple platforms – use I-Verify (All-Scripts), not sure if there are other products out there that do the same thing. AthenaHealth has own program that they've written.</li> <li>c. It was noted that Providers see a transaction based fee structure as a barrier; don't have a charge today if go individually for each transaction (but are paying for the staff time).</li> <li>d. Important to know what the co-pay is; b/c patients often don't know what their co-pay is.</li> <li>e. In order to have clinical transformation also need to have "business process redesign"</li> <li>f. Anne asked Lauren whether MBA has an ROI analysis – there is currently no ROI analysis available. One example was given where a single large practice setting had 1.5 FTEs checking eligibility prior to the I-Verify (preliminary data cut from approximately 12 hours per day of staff time to 2 hours per day. They have only been doing it for three months.)</li> </ol> </li> </ol>	

## REVIEW OF "AS IS" CLAIMS ADJUDICATION PROCESS

CONTINUED DISCUSSION	Continued Discussion of current claims adjudication process in VT, based on process at BCBSVT process.
<ol style="list-style-type: none"> <li>1. MBA passed out a hard copy handout the represented a number of different current claims adjudication issues.</li> <li>2. Claims trending info document from BCBS VT (two documents - didn't get electronically) Within 14 days more than 90% have been processed;</li> <li>3. High level claims flow from BCBS VT – 94% first pass rate (means claims adjudicate – can be pay or deny or need more information).</li> <li>4. Technology as connected through overall health care system reform --- will still need to have medical review in the system (about 5% kick out and have standards for how fast are reviewed).</li> <li>5. Small number go beyond 45 days - if do, need to pay interest under VT regulation/law.</li> <li>6. Denials as low as possible is better for everyone. Sandy B. tracks all claims for clients and tries to teach/educate about why claims are not paying and how can fix. A number of problems are based on manual errors at provider office. MBA distributed a handout (hard copy only) to the group.</li> <li>7. Ongoing goal to make clear why claims are not paying. What does "suspense" period mean – clients don't know what to be; today carriers don't show what it is. In everyone's interest to understand why things are in suspense.</li> <li>8. If have denied claims, can't just resubmit them – need to file an appeal which takes more time. (e.g. – forget a modifier);</li> <li>9. Does effective EHR bring higher payment? Lauren believes that without EHR practices are down coding b/c so worried about upcoding. The EHR helps to make consistent policies across the system – but EHRs need to be able to take words and capture into</li> </ol>	

claims. EHRs also, even though they are used, not all of them are used.

10. Carriers do monitor practices to see if big errors, and do try to help educate
11. Providers really want carriers to use same rules.
12. MBA noted that Patient Accounts Receivable are currently at an average of 23% (based on a survey of their clients) – they report that this number is higher this year than last and is going up; surgical patient specialties have higher dollars.
13. Important to Connect to broader health reform --- cost of care – employers encouraging more review of care (prior authorizations).

**PREVIEW OF TO BE FLOW**

This reflects a brief description and questions regarding the “to be” flow (further discussion occurred during the “to be” session in the afternoon.

Ajay provided a quick overview of the “To Be” Flow

- a. Including numbers in --- how comfortable does group feel with that? Or do we just want to recognize that need detail in next several months.
  - i. Will need to look at more groups, see this at good start – will definitely need to have a range.
  - ii. Don George:
    1. No business process management – no good measures of time
    2. ROI also dependent on the cultural issues – will actually take the cost out of the system
    3. Industry wide ability to do this?
  - iii. Anne O’Brien – short term; patient perspective; put it into human context into the first report. Capture as is as best we can; build a case of why need to be;
  - iv. Sandy Bechtel: Carriers and billing is where the “job” is – physicians feel like billing shouldn’t be as complicated as it is today anyway.

Next Steps:

The As Is workflow is to be finalized and shared with the group towards the end of next week.

#### Common reasons for denials –

- Inclusive to another procedure (top denial reason code)
- Duplicate claim (even when resubmitted with appropriate modifier)
- Pt cannot be identified as our insured (eligibility)
- No prior auth or referral on file
- Bill primary insurance first (eligibility)
- Questionnaire was not returned by patient or provider

#### Common denials via payer –

##### Cigna

- Inclusive
- Pre-existing condition questionnaire
- All multiple services (defined in the claim with a modifier) now must have a paper claim and a copy of the notes. (Office visit and a minor office procedure)
- Policy terminated

##### MVP

- Inclusive
- Pre-existing condition questionnaire (MVP will pend the claim, but they also send the questionnaire to several different physicians, not just ours. They will not reprocess the claim until all of the questionnaires are returned. This is very frustrating since even though our physician has returned the questionnaire, our claims are still pending awaiting the other physicians response to it)
- Policy terminated
- Duplicate claim (corrected claim hitting up against original claim – need special form to correct)

##### Medicaid

- Inclusive
- Bill primary first – practice was not aware of other insurance
- Layers of edits – if a claim denies for 1 reason, you submit it corrected, then it will deny for another reason.

##### Medicare

- Inclusive
- Patient has another health insurance plan that is primary – office was not aware of other insurance
- Cumbersome and time consuming paper “appeal” process
- Layers of edits – if a claim denies for 1 reason, you submit it corrected, then it will deny for another reason.
- Medicare HMO’s – patients are not aware that they no longer have Medicare and don’t report the change to the provider. Patients think the HMO is the secondary to Medicare.
- Incorrect diagnosis due to LMRP (Local Medicare Regulations by region)

##### BC/BS

- Inclusive
- Eligibility – patient can’t be verified in their system but can be verified on BCBS website with the same ID that was submitted
- No prior auth – new issue effective January 2009 and opposite of other carriers regarding prior authorization requirements
- Questionnaire not returned from patient
- Duplicate claim (corrected claim hitting up against original claim – need to complete appeal form to correct)
- Claim reps are often not able to give you the denial reason, therefore you must submit the request on a form. This is due to a system “upgrade” which does not allow the customer service reps to view data that would define

what the denied claim is inclusive to. An appeal form must be completed, even though this is not an appeal. A few reps have access to both systems and can give the information necessary but most can not.

- Provider is now (effective January 2009) held liable for prior authorization – formerly the patient was responsible to be sure of the coverage. Offices who have walk in services that require a PA (mental health services) are being penalized for the patient not knowing the coverage of their own policy.

Most common reason for an unpaid claim:

- No claim on file – even with proof of being filed electronically and received by the carrier
- Medicare secondary claims not going through to the secondary payer – most likely due to technical problem on either Medicare or Medicaid side

Biggest headaches:

- Cumbersome appeals process for all the carriers. If a claim denies inclusive and a modifier is added, it should be able to be rebilled electronically. Instead, we are having to submit appeals on paper, at times with notes attached.
- Cigna sending out several different remits with the same date (often times we receive 10+ remits, each with only 1 patient on them and they all have the same process date).
- Waiting on questionnaire to be returned from the patient or provider
- NPI was supposed to be the answer to all the convoluted billing issues but this has not been the case. Now Medicare requires at least 3 different numbers (NPI, PTAN and TIN) before they will take requests about claims. Medicaid requires Medicaid number, sometimes the taxonomy number and NPI. MVP requires taxonomy number in addition to NPI. Taxonomy identifies the specialty of the provider (which should have been in their credentialing). Cigna does not use NPI – they use Tax Identification Number.
- The greatest solution to the financial problems facing physicians would be to require universal rules for offices to follow. Every carrier has own rules and the rules change when the carrier (including Medicare) choose to change them.

Patient AR – In surveying our practice data, patient balances are a higher proportion of the total AR than they were last year. The range of patient responsible balances is from 13%-31% with the average being 23%. Last year the range was from 3%-28% with the average being 16%. Across the board surgical specialties had a higher patient balance due percentage of the AR. It is not clear if this is due to loss of insurance or to higher deductible plans.

**Appendix 12 - "to be" Subgroup Meeting Minutes August 14, 2009  
(including attachments)**

# HIT Payment Reform- VT "To Be" Subgroup Meeting Minutes & Action Items

AUGUST 14, 2009, 2:00 – 4:00

OVHA, 312 HURRICANE LANE,  
WILLISTON, VT

MEETING CALLED BY	Sen. Bill Carris, Co- Chair and Rep. Anne O'Brien, Co- Chair; Hunt Blair, Deputy Director for Health Care Reform, OVHA
TYPE OF MEETING	Legislative Summer work group on Health information Technology for Payment Reform; Sub group on "As Is" state of eligibility and claims adjudication
FACILITATOR	Joshua Slon, Bailit Health Purchasing
NOTE TAKERS	Beth Waldman (by phone); Joshua Slon
ATTENDEES	Ajay Asthana, IBM (by phone); David Gruppo, IBM; John Grubmuller, First Data; Sandy Bechtel, MBA Health Group; Paul Forlenza, VITL; Hunt Blair, Senator Bill Carris, Representative Anne O'Brien; Hans Katsensmith; Neil Sakar; UVM; Steve Kappel, Joint Fiscal Office; Debbie Austin, OVHA

## DISCUSSION OF "TO BE"

	<ol style="list-style-type: none"> <li>1. It was indicated that it will be important to link to national reform.</li> <li>2. System that would exchange through a "logical construct" – one interface for the provider (check eligibility or claim through same system) – all functions of all carriers in "black hole" – don't care how do it if you are a provider. Provider wants to be able to do instant checking through their provider management system.</li> <li>3. There was a question about the ability of existing clearinghouses to automate the eligibility and claims adjudication processes.</li> <li>4. EHR standard --- what need vs. what would like? Key things that are precursors – must have interfaces and certain level of standards; may need some of the physical interfaces.</li> <li>5. A clear distinction was made between the Health Information Exchange being developed by VITL for the exchange of clinical information and this process to produce Real Time Eligibility and Claims Adjudication. While the concept of a central hub and standards based exchange are common the processes and the information flows differ in a number of ways.</li> <li>6. The importance of having all the carriers at the meeting and participating in the planning process was noted.</li> <li>7. BCBS Association and AHIP both supportive of move to this system (according to conversations with these entities and IBM).</li> <li>8. One member indicated that for the report we should recommend a total redesign of the system; should have an overarching picture – not just current process in electronic form. Important to be careful here - don't just want to do bad things faster – that is, essentially take current system and make electronic.</li> <li>9. A question was raised regarding what assumptions can/should be made regarding the ability to change state law/policy as part of this process.</li> <li>10. Insurers are mostly in a batch world; not a consumer driven single transaction process.</li> <li>11. Economic incentives – BCBS of NC doing now; only one payor though. The group would like to see the system currently in use in NC by BCBS.</li> <li>12. Discussion of credit card analogy – VT has opportunity to break prisoners dilemma – put an exchange in place; transaction hub provides connections in and out to carriers systems and provider management systems to allow for HIPAA transactions to go through.</li> <li>13. What does it need to look like to be done on a statewide payer system?</li> <li>14. There is not agreement among the group on the need for a specific device – therefore the group has agreed on the use of the descriptor "token" to indicate the need for some process to prove identity and obtain eligibility information.</li> <li>15. If we had a central system of eligibility and attached to it the balance of payment due --- then getting eligibility correct would be a large improvement over the current system, in and of itself.</li> <li>16. Discussion about potential of I-Verify – a system that is offered through AllScripts Practice Management System which electronically interfaces the practice management system with the insurers eligibility information and delivers information back to the provider.</li> <li>17. Important to take time to determine what the necessary structure is and where it sits.</li> <li>18. There are liability issues about moving data from point A to point B; big pushback from providers – don't want folks to know financial data. Should exchange be only open to provider/payer? Closed with specific exceptions – but recognize that protected data. Would need to work through privacy and standards. Is it an exchange or data repository? Claims data? Access to clinical data and financial data tied together would be important from public health.</li> <li>19. Real time adjudication – large percentage get paid on first and second pass through – 25-40% don't get paid in first pass; 85-90% of paid claims by second pass --- last percentage that don't solve with this --- that will hang up with % of the claim. Allows for payment by patient before leave the office. Want to get to "total" claims – certain percentage won't process right away.</li> <li>20. Important for the exercise to go deeper than the denied/unpaid claims --- if just go to one level, not doing too much. If going to be meaningful, will need to define how to "clean up the system" – could do a process/model to see everything else needs to be fixed ---</li> <li>21. Patient expectation of when needs to pay and how. Patient now doesn't know what have to pay; and doesn't know what need to pay. Magically through a patient portal securely what they owe on line (can pay online now, but can't find out how much they owe).</li> </ol>

22. Discussion of whether and how should make a link to the VCAC group for the second planning phase
23. At the end of the meeting a few key agreements were recognized:
  - a. The need for a central exchange to facilitate real time eligibility verification and claims adjudication was agreed upon in concept.
  - b. The general As Is and To Be workflows as presented in diagrammatic form were unanimously agreed to represent accurately the current and desired future states (with the caveat that everyone would like a chance to review the final workflows as they will be inserted into the final report).
  - c. The exchange of eligibility and claims information should be through a closed system with limited exceptions that must be developed through a transparent privacy and security standards process. This process should be based on the VITL process and might use as its foundation the VITL Privacy and Security Standards for secondary use. However, there would be no primary release under this system as it is primarily envisioned as a point-to-point transactional system.
  - d. The importance of connecting this effort to overall health care reform in Vermont and to any state level submission/request for ARRA/Stimulus monies.

# Percentages of processing time for Claims

By LOB and Time Ranges

Paid Time Period: August 2008 - July 2009

Rolling 12 Month Report

LOB	Time Range	Number of Claims	Percent of total LOB
Indemnity	0 - 7 days	416,726	54.43%
Indemnity	8 - 14 days	306,787	40.07%
Indemnity	15 - 21 days	20,750	2.71%
Indemnity	22 - 45 days	14,884	1.94%
Indemnity	46 + days	6,429	0.84%
	<b>Indemnity Total:</b>	<b>765,576</b>	<b>100.00%</b>
VHP	0 - 7 days	361,348	70.64%
VHP	8 - 14 days	133,068	26.01%
VHP	15 - 21 days	8,354	1.63%
VHP	22 - 45 days	7,216	1.41%
VHP	46 + days	1,537	0.30%
	<b>VHP Total:</b>	<b>511,523</b>	<b>100.00%</b>
TVHP	0 - 7 days	222,364	59.04%
TVHP	8 - 14 days	140,331	37.26%
TVHP	15 - 21 days	7,539	2.00%
TVHP	22 - 45 days	5,125	1.36%
TVHP	46 + days	1,257	0.33%
	<b>TVHP Total:</b>	<b>376,616</b>	<b>100.00%</b>
Safety Net or Non Group	0 - 7 days	32,498	63.34%
Safety Net or Non Group	8 - 14 days	16,187	31.55%
Safety Net or Non Group	15 - 21 days	1,330	2.59%
Safety Net or Non Group	22 - 45 days	988	1.93%
Safety Net or Non Group	46 + days	307	0.60%
	<b>SN or NG Total:</b>	<b>51,310</b>	<b>100.00%</b>
Catamount	0 - 7 days	55,292	62.00%
Catamount	8 - 14 days	29,521	33.10%
Catamount	15 - 21 days	2,228	2.50%
Catamount	22 - 45 days	1,843	2.07%
Catamount	46 + days	291	0.33%
	<b>Catamount Total:</b>	<b>89,175</b>	<b>100.00%</b>
VT Blue 65	0 - 7 days	131,338	48.05%
VT Blue 65	8 - 14 days	122,481	44.81%
VT Blue 65	15 - 21 days	9,540	3.49%
VT Blue 65	22 - 45 days	6,674	2.44%
VT Blue 65	46 + days	3,279	1.20%
	<b>VT Blue 65 Total:</b>	<b>273,312</b>	<b>100.00%</b>
<b>Total of all Claims</b>	0 - 7 days	1,219,566	58.99%
<b>Total of all Claims</b>	8 - 14 days	748,375	36.20%
<b>Total of all Claims</b>	15 - 21 days	49,741	2.41%
<b>Total of all Claims</b>	22 - 45 days	36,730	1.78%
<b>Total of all Claims</b>	46 + days	13,100	0.63%
	<b>GRAND TOTAL:</b>	<b>2,067,512</b>	<b>100.00%</b>

# Average Processing Time for Claims

By LOB and Paid Month

Paid Time Period: August 2008 - July 2009

Rolling 12 Month Report

8
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Average Processing Time for All Claims (days):

LOB	Paid Month	Number of Claims	Number of Days	Average Number of Days to Pay
Indemnity	200808	62,977	540,046	9
Indemnity	200809	65,819	576,835	9
Indemnity	200810	70,451	571,818	8
Indemnity	200811	59,016	493,728	8
Indemnity	200812	72,601	616,526	8
Indemnity	200901	65,965	669,844	10
Indemnity	200902	59,386	497,468	8
Indemnity	200903	65,917	544,645	8
Indemnity	200904	63,088	599,007	9
Indemnity	200905	58,232	452,682	8
Indemnity	200906	63,625	508,723	8
Indemnity	200907	58,499	442,556	8
<b>AVERAGE FOR ALL INDEMNITY:</b>		<b>765,576</b>	<b>6,513,878</b>	<b>9</b>
VHP	200808	41,846	283,455	7
VHP	200809	40,684	274,368	7
VHP	200810	45,258	307,437	7
VHP	200811	38,304	264,395	7
VHP	200812	45,396	323,357	7
VHP	200901	41,477	309,003	7
VHP	200902	40,903	269,291	7
VHP	200903	45,369	300,451	7
VHP	200904	44,116	313,975	7
VHP	200905	40,422	270,462	7
VHP	200906	44,656	297,580	7
VHP	200907	43,092	286,843	7
<b>AVERAGE FOR ALL VHP:</b>		<b>511,523</b>	<b>3,500,617</b>	<b>7</b>
TVHP	200808	27,883	214,776	8
TVHP	200809	30,069	223,021	7
TVHP	200810	31,631	244,052	8
TVHP	200811	26,167	195,438	7
TVHP	200812	31,598	241,419	8
TVHP	200901	32,552	350,513	11
TVHP	200902	31,440	236,538	8

200903	35,098	265,359	8
200904	35,138	273,992	8
200905	31,101	229,548	7
200906	33,643	247,333	7
200907	30,296	192,534	6
<b>AVERAGE FOR ALL TVHP:</b>	<b>376,616</b>	<b>2,914,523</b>	<b>8</b>

Safety Net or Non Group	4,383	42,386	10
Safety Net or Non Group	4,525	35,537	8
Safety Net or Non Group	5,085	38,296	8
Safety Net or Non Group	4,237	31,802	8
Safety Net or Non Group	4,701	36,302	8
Safety Net or Non Group	4,248	36,614	9
Safety Net or Non Group	3,917	29,475	8
Safety Net or Non Group	4,201	32,281	8
Safety Net or Non Group	4,136	33,427	8
Safety Net or Non Group	3,758	28,111	7
Safety Net or Non Group	4,333	31,892	7
Safety Net or Non Group	3,786	26,665	7
<b>AVERAGE FOR ALL SN OR NG:</b>	<b>51,310</b>	<b>402,788</b>	<b>8</b>

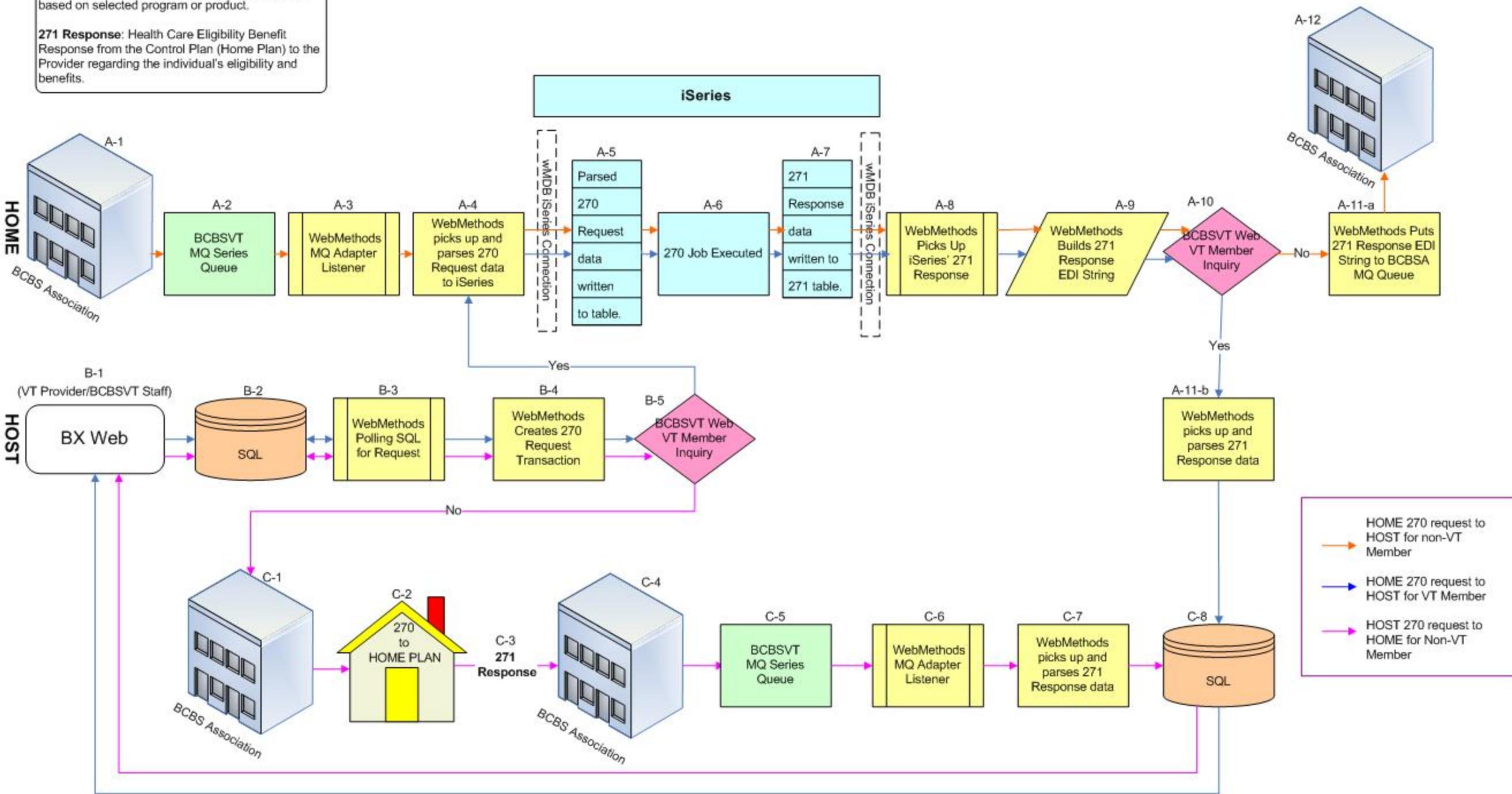
Catamount	5,029	37,719	8
Catamount	5,777	40,758	7
Catamount	6,542	51,597	8
Catamount	6,133	46,170	8
Catamount	6,758	53,910	8
Catamount	7,161	56,100	8
Catamount	6,792	54,944	8
Catamount	8,473	68,852	8
Catamount	9,490	82,024	9
Catamount	8,265	56,749	7
Catamount	9,708	66,585	7
Catamount	9,047	63,149	7
<b>AVERAGE FOR ALL CATAMOUNT:</b>	<b>89,175</b>	<b>678,557</b>	<b>8</b>

VT Blue 65	22,610	215,436	10
VT Blue 65	23,579	256,748	11
VT Blue 65	24,287	197,554	8
VT Blue 65	20,294	162,368	8
VT Blue 65	25,948	211,152	8
VT Blue 65	23,542	197,434	8
VT Blue 65	20,172	181,283	9
VT Blue 65	24,570	222,193	9
VT Blue 65	22,974	331,105	14
VT Blue 65	20,224	179,179	9
VT Blue 65	23,631	208,258	9
VT Blue 65	21,481	166,988	8
<b>AVERAGE FOR ALL VT BLUE 65:</b>	<b>273,312</b>	<b>2,528,698</b>	<b>9</b>

# BX WebMethods 270/271 Transaction Data Flow

**270 Request:** Health Care Eligibility Benefit Inquiry from a Local Provider. It is used to verify an individual's eligibility and level of medical benefits based on selected program or product.

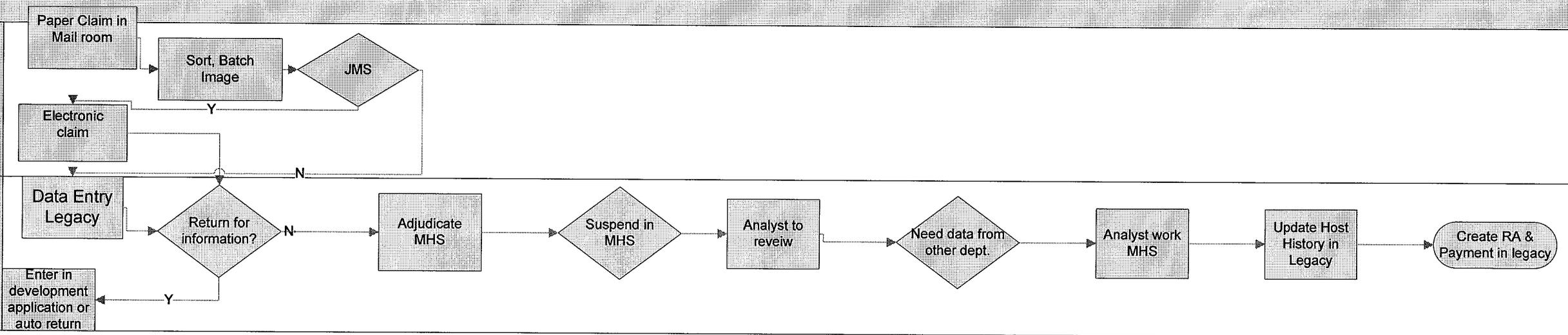
**271 Response:** Health Care Eligibility Benefit Response from the Control Plan (Home Plan) to the Provider regarding the individual's eligibility and benefits.



Claim process

External Process

Internal Systems



**Appendix 13 -Workgroup Meeting Minutes August 26, 2009**

# VT HIT Payment Reform Meeting Minutes & Action Items

AUGUST 26, 2009  
10:30 AM – 12:00 PM

133 STATE STREET, 5<sup>TH</sup> FLOOR  
CONFERENCE ROOM  
MONTPELIER, VT

MEETING CALLED BY	Sen. Bill Carris, Co- Chair and Rep. Anne O'Brien, Co- Chair; Hunt Blair, Deputy Director for Health Care Reform, OVHA
TYPE OF MEETING	Legislative Summer work group on Health information Technology for Payment Reform
FACILITATOR	Joshua Slen, Bailit Health Purchasing
NOTE TAKERS	Beth Waldman, Bailit Health Purchasing
ATTENDEES	Ajay Asthana, IBM (by phone); David Gruppo, IBM; Rob Willey, IBM; George Eisenberg, IBM (by phone); John Grubmuller, First Data; Jean Landsverk, First Data; Nolan Langweil, Joint Fiscal Office; Steve Kapple, Joint Fiscal Office; Don George, BCBSVT; Lauren Parker, MBA Healthgroup; David Cochran, VITL; Dawn Bennett, BISCHA;; Bob Hines, Department of Information and Innovation; Hans Kastensmith, Capital Health Associates; Paul Harrington, Vermont Medical Society; Craig Jones, VT Blueprint for Health; Jim Hester, Vermont Healthcare Reform Commission; Hunt Blair, Senator Bill Carris, Representative Anne O'Brien

## REVIEW AND DISCUSSION OF DRAFT REPORT

DISCUSSION	For final meeting of workgroup, discussion focused on a review of the draft Report
I.	Representative O'Brien welcomed attendees to the meeting and having the group do introductions.
II.	Beth Waldman and Joshua Slen gave a brief overview of the "As Is" and "To Be" subgroup meetings. Ajay Asthana from IBM noted that he is working on a simulation process that compares the "as is" and "to be" flows he has created and notes the potential difference in effort an efficiency based on those differences. The group noted that if it is included within the final report will need to be specific that the flows and time estimates need further discussion and confirmation and that by including it the group is not endorsing the findings. Further work on this can be done in the implementation planning process.
III.	The remainder of the meeting was spent discussing the draft report. The discussion hit on the following aspects of the report: <ul style="list-style-type: none"> <li>➤ Highlighting need to align with federal funding within the executive summary</li> <li>➤ Placing finding on increasing health care cost, including administrative spending, at the top of list of findings</li> <li>➤ Change phrasing of pilot from "Stage One" to "first stage"</li> <li>➤ Lengthy discussion of whether including pilot was good idea; in end, pilot remains in as "first stage" with language that defers final decision for if and how a pilot would be included in the planning process to the successor Workgroup</li> <li>➤ Add explicitly that "to be" process must meet federal and state privacy and security standards</li> <li>➤ Caveat that responsibility for implementation planning phase sits with OVHA/Health Care Reform, to the extent that funding is attached; and that OVHA/Health Care Reform will work in collaboration with VITL</li> <li>➤ Implementation planning process should include an RFI</li> </ul>
IV.	In wrapping up, the group noted that it was a big accomplishment to get as far as we did in the time we had, that we had made significant progress in coming up with a clear vision.
Next Steps: Comments on report to Joshua and Beth by COB on Thursday, August 27 <sup>th</sup> ; Ability to comment on final draft report before final submission on Monday, August 31, 2009.	

**Appendix 14 -IBM webinar July 29, 2009**



IBM SWG Industry Solutions for Health Care

# Healthcare Transaction System

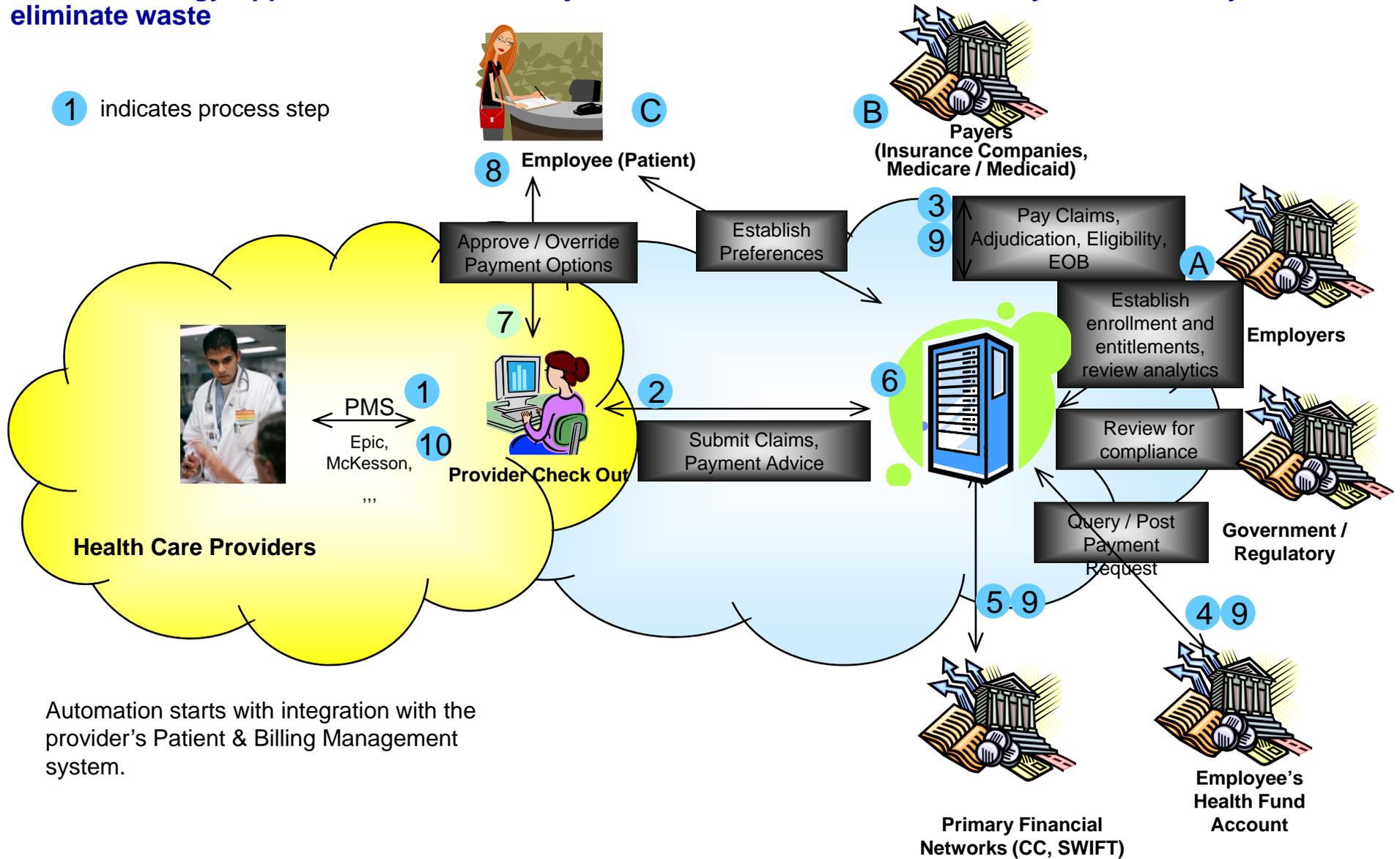
**George Eisenberger**  
**IBM Distinguished Engineer**  
**Senior Certified IT Architect**  
**Manager Industry Solutions – Health Care**  
**CPHIT, CPEHR**

# Transformation Drivers

- ❑ The Healthcare ecosystem is well entrenched in its legacy, but feeling the pressure for change
  - Individual transformation efforts are typically burdened by the bias of the payer
  - No one payer is yet dominating the transformation for Real Time Eligibility, Adjudication, Payment Summary Presentment
  
- ❑ Payer issues
  - Legacy payer plan management systems are batch and not easily transformed to perform real time adjudication (RTA) request
  - Transformation of plan management systems for RTA will require stepwise improvement –or– replacement
  - Payers recognize the need to shift the to RTA of claims and many have projects planned or underway to make the transformation
  - Early adopters of RTA are our target partners for HTS
  
- ❑ Provider issues
  - Providers are Doctors first, Businessmen second, Technologist last; thus very resistant to change office procedures & technology
  - Transformation will require technical integration of office Practice Management Systems (PMS)
  
- ❑ The hardest part of making this successful:
  - Short Term: Providers are looking for proof points & concerned about disruption to their office procedures & IT plans
  - Long Term: Scaling the deployment with 250 leading PMS systems and to 250,000 Provider offices
  
- ❑ Business value is strong
  - “RTA & patient portion collection at time of service is the ‘ holy grail ’ ”
  - Employer Groups (IBM, Ford, etc) are strong advocates of change

# HTS Technology Approach is Real-Time adjudication & settlement of "Claim Payment Summary" to eliminate waste

1 indicates process step



Automation starts with integration with the provider's Patient & Billing Management system.

## HTS Patients Check-Out Kiosk – Sample Screen

### McNeil PCP, M.D

Time: 10:14 am, Date: 06/26/2009, Friday  
Please touch this screen to make your selections.

Patient Name: Pete Roberts  
Email: Pete\_Roberts@hotmail.com  
Physician: Dr. McNeil

Change email address

Procedures	Description	Negotiated Amount	Paid Under Plan by Acme Insurance	Paid by HSA
12345	Yearly Adult Physical	\$100.00	\$95.00	\$5.00
23456	Tick Extraction	\$20.00	\$18.00	\$2.00
34567	Attitude Adjustment	\$50.00	\$0.00	\$0.00
	Totals	\$170.00	\$113.00	\$7.00
	Total Covered	-\$120.00		
	Patient Responsibility Billed to Visa (...1879)	-\$50.00		
	Balance Due	\$00.00		

Change Method of Payment

You have paid \$450 toward your \$500 yearly detectable.

Your claim has been approved and processed. Please note that your financial institution (HSA, FSA, checking, savings account, credit card, etc.) may not reflect this payment for 3 days.

You can review this claim & payment information at [www.aetna.com/hts](http://www.aetna.com/hts)

Approve

Print this bill now

I need the Clerk to help me

Close this window

# HTS Delayed Real-Time Check-Out Screen via Secure Web Login – Sample Screen

IBM HTS  
Welcome Mr. icmadmin | 10.19.2006 20:18:16

*Garcia and Daughters, M.D., Ph.D.*  
Time: 9:25 am,  
Date: 06/26/2009, Friday

Patient Name: **Pete Roberts**  
Email: Pete\_Roberts@hotmail.com  
Physician: Anne Garcia

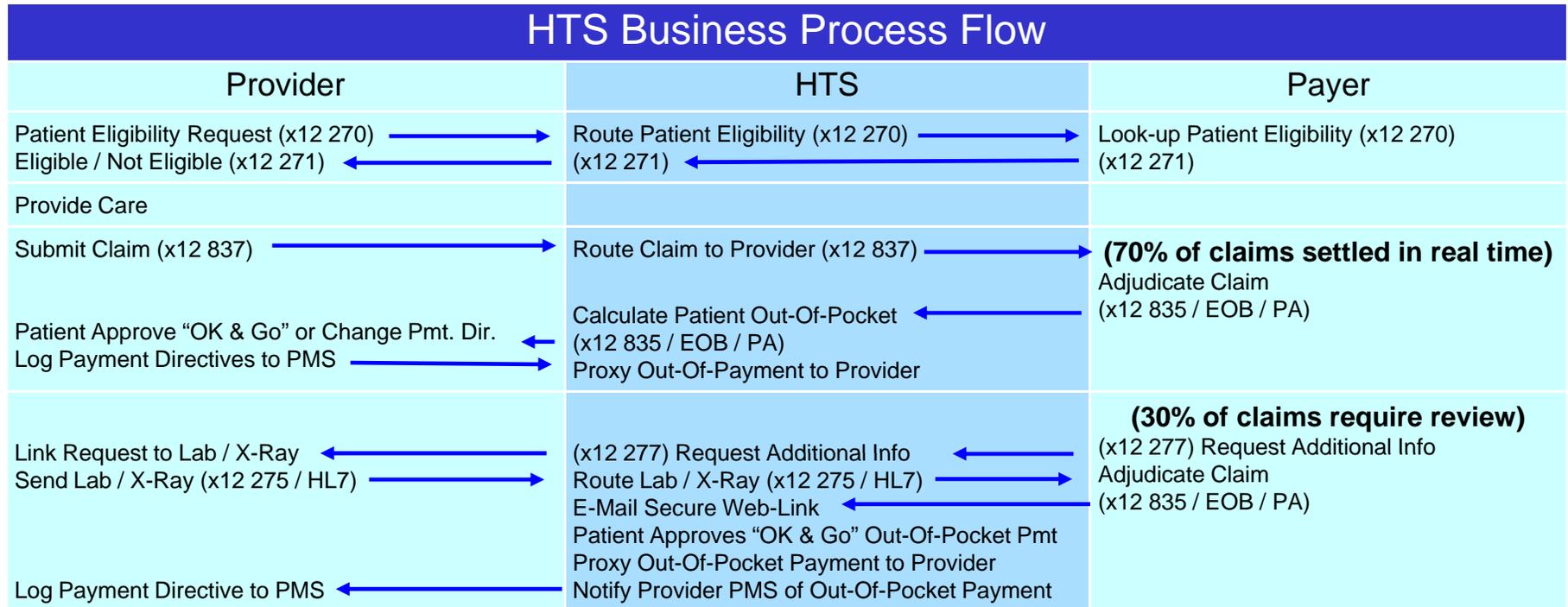
Procedures	Description	Negotiated Amount	Paid Under Plan by Acme Insurance	Paid by HSA
12345	Yearly Adult Physical	\$100.00	\$95.00	\$5.00
23456	Tick Extraction	\$20.00	\$18.00	\$2.00
34567	Attitude Adjustment	\$300.00	\$0.00	\$0.00
Totals		\$420.00	\$113.00	\$7.00
Total Covered		\$300.00		
Patient Responsibility Billed to Visa (...1879)		-\$120.00		
Balance Due		\$00.00		

Change Payment...

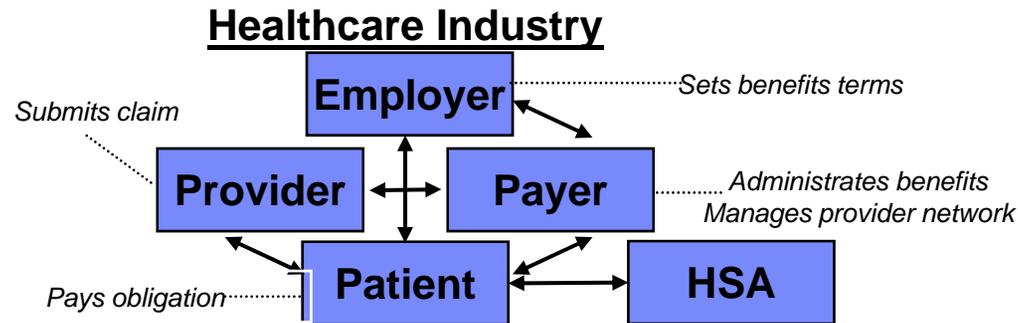
Paid out of pocket: \$450  
Yearly Deductible: \$500

Advanced...    Print this Receipt    Close

# The HTS Message Flow

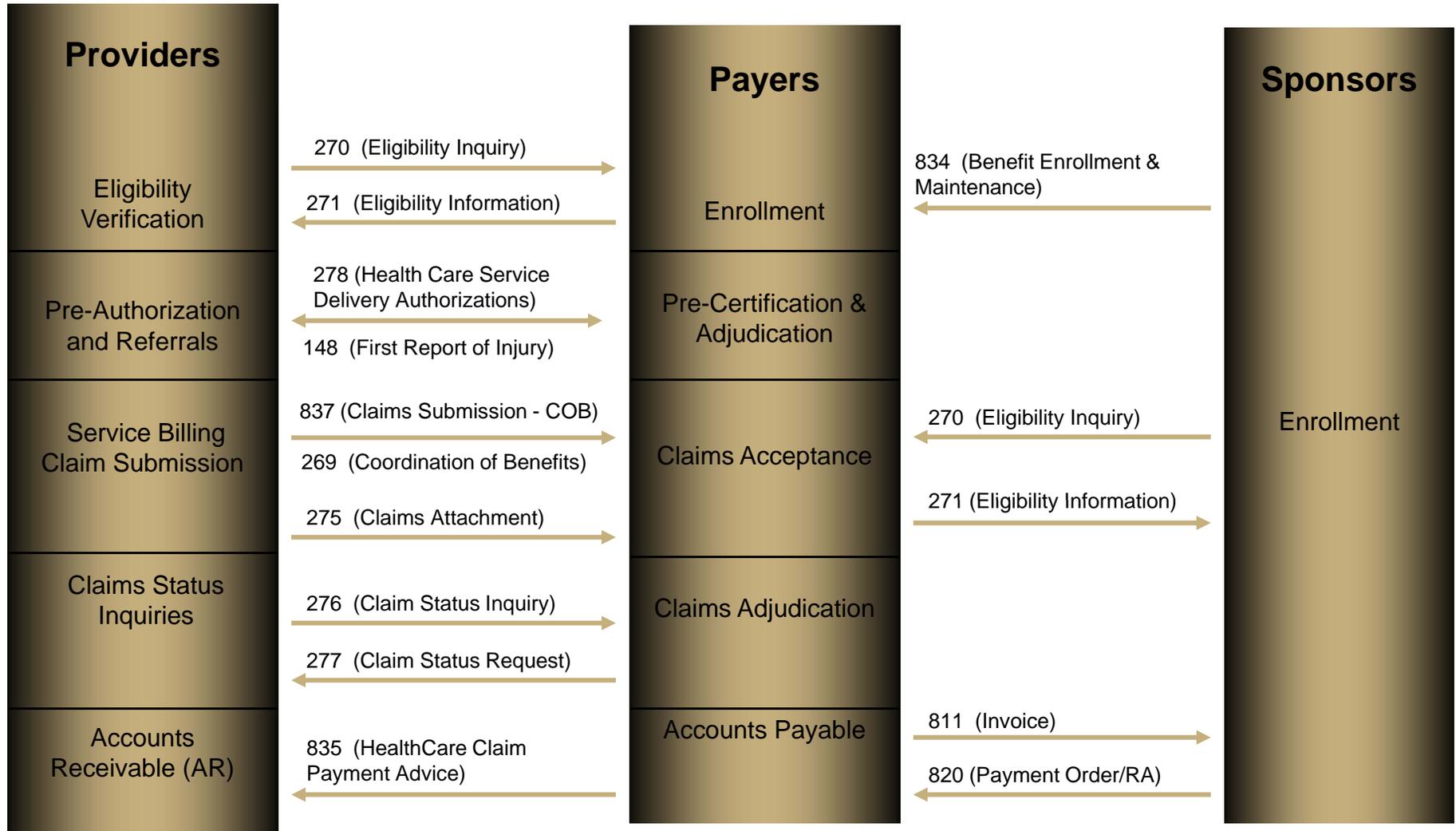


## The HTS opportunity exists because of a structural inefficiency unique to the US healthcare industry

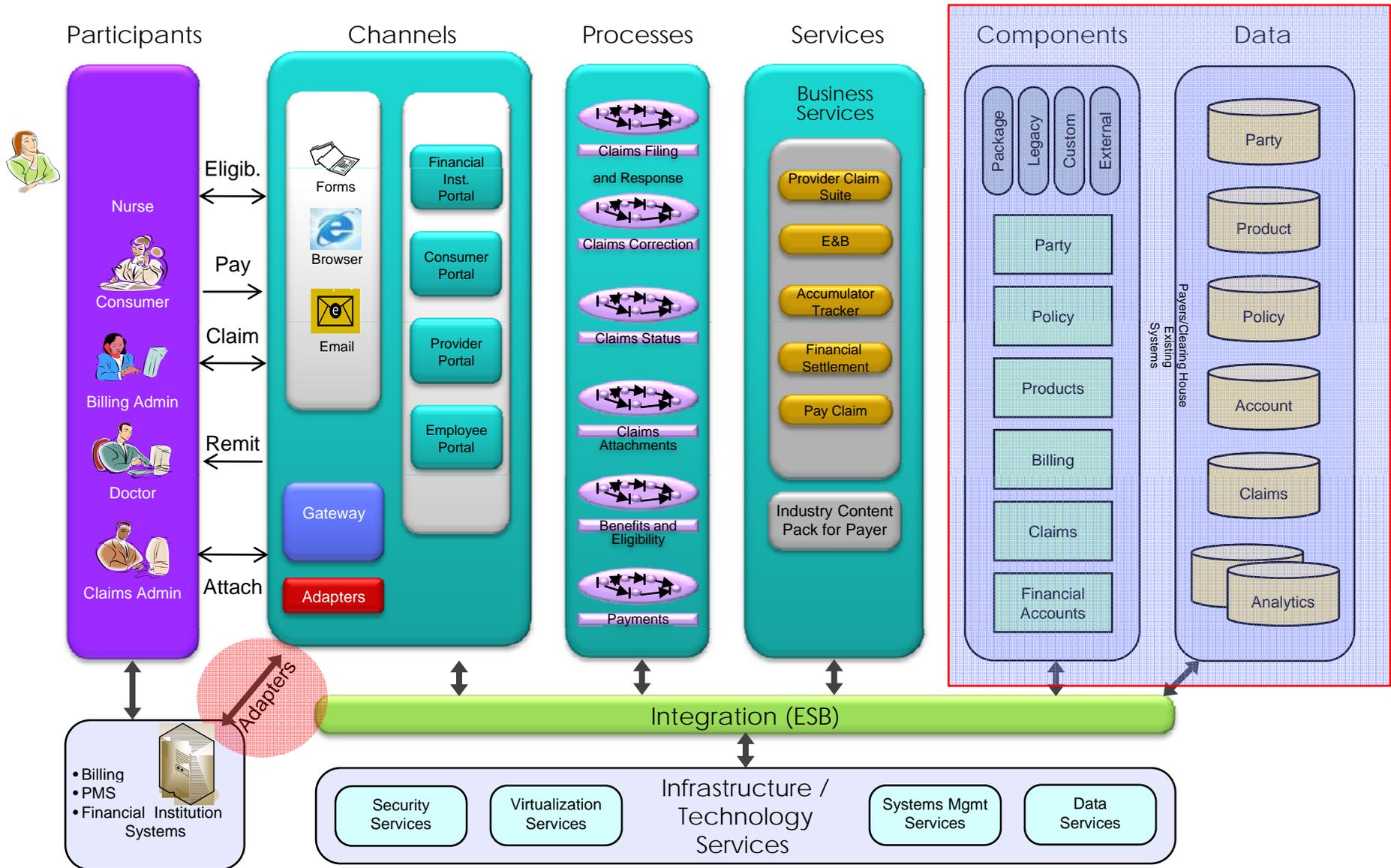


- The healthcare industry's payment and reimbursement system is notoriously complex and inefficient
- Physicians bear the direct cost of this inefficiency, in the form of manual processing, leading to high administrative costs (\$6.2B), bad debt (\$3.0B) and slow payments (\$0.4B)
- Large employers and their employees finance this inefficiency indirectly through the higher cost of medical care.
- Long recognized as a problem, a solution has so far eluded the marketplace primarily because it requires the cooperation of stakeholders with divergent and competing interests
- This inefficiency is also seen in the hospital, imaging, pharmacy and lab services segments

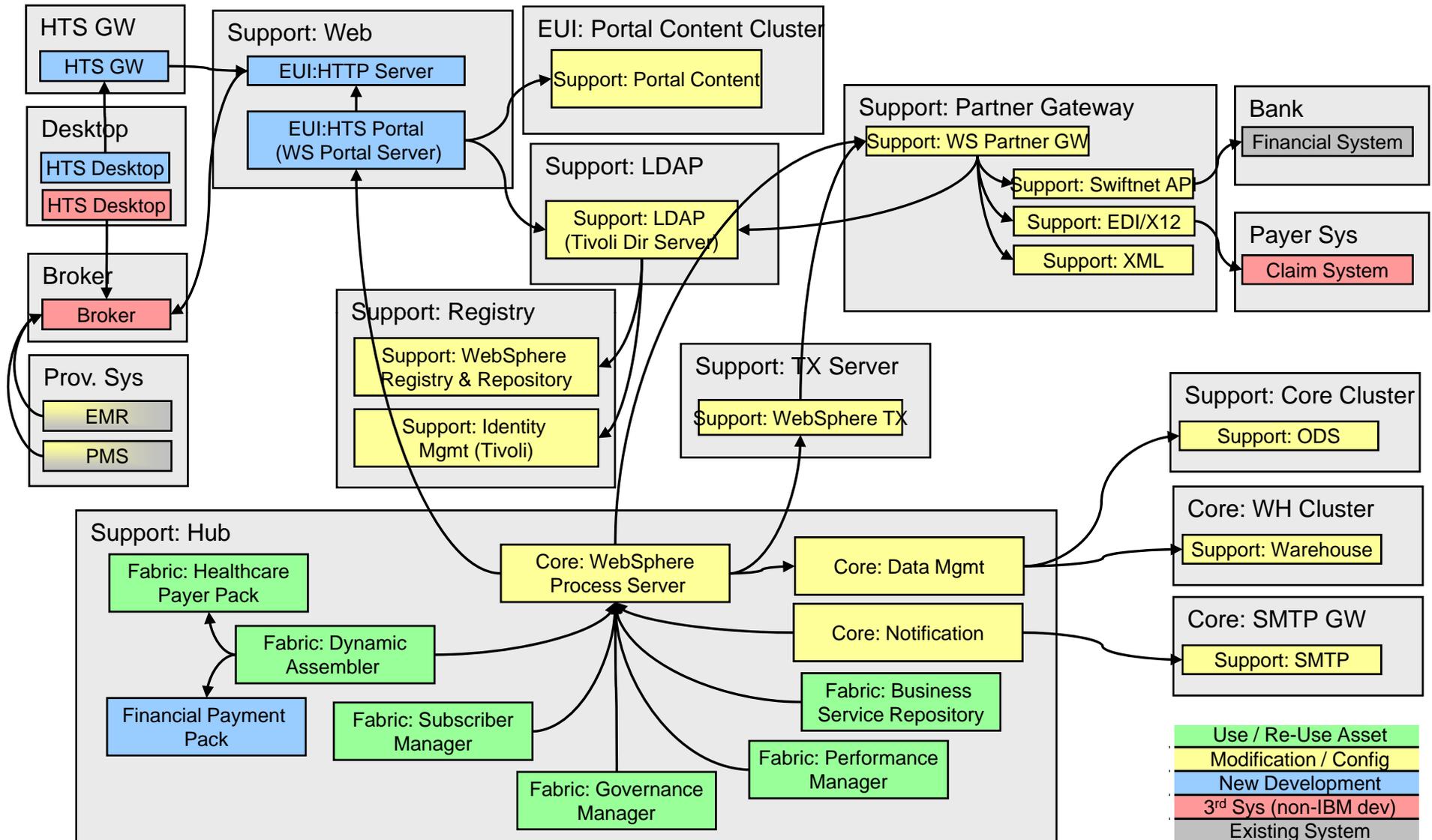
# ASC X12N Standard Transaction Flow



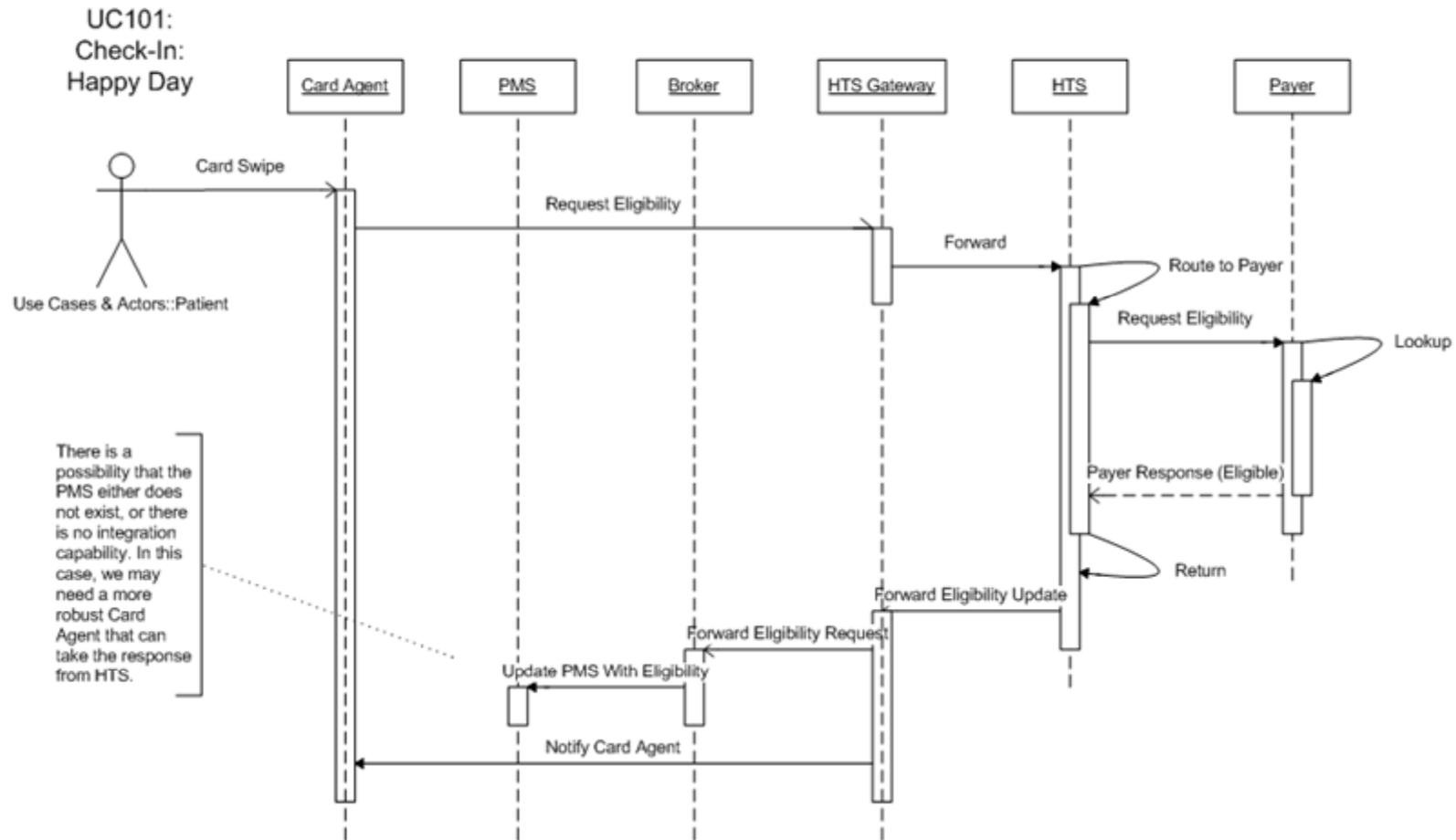
# Architecture Overview



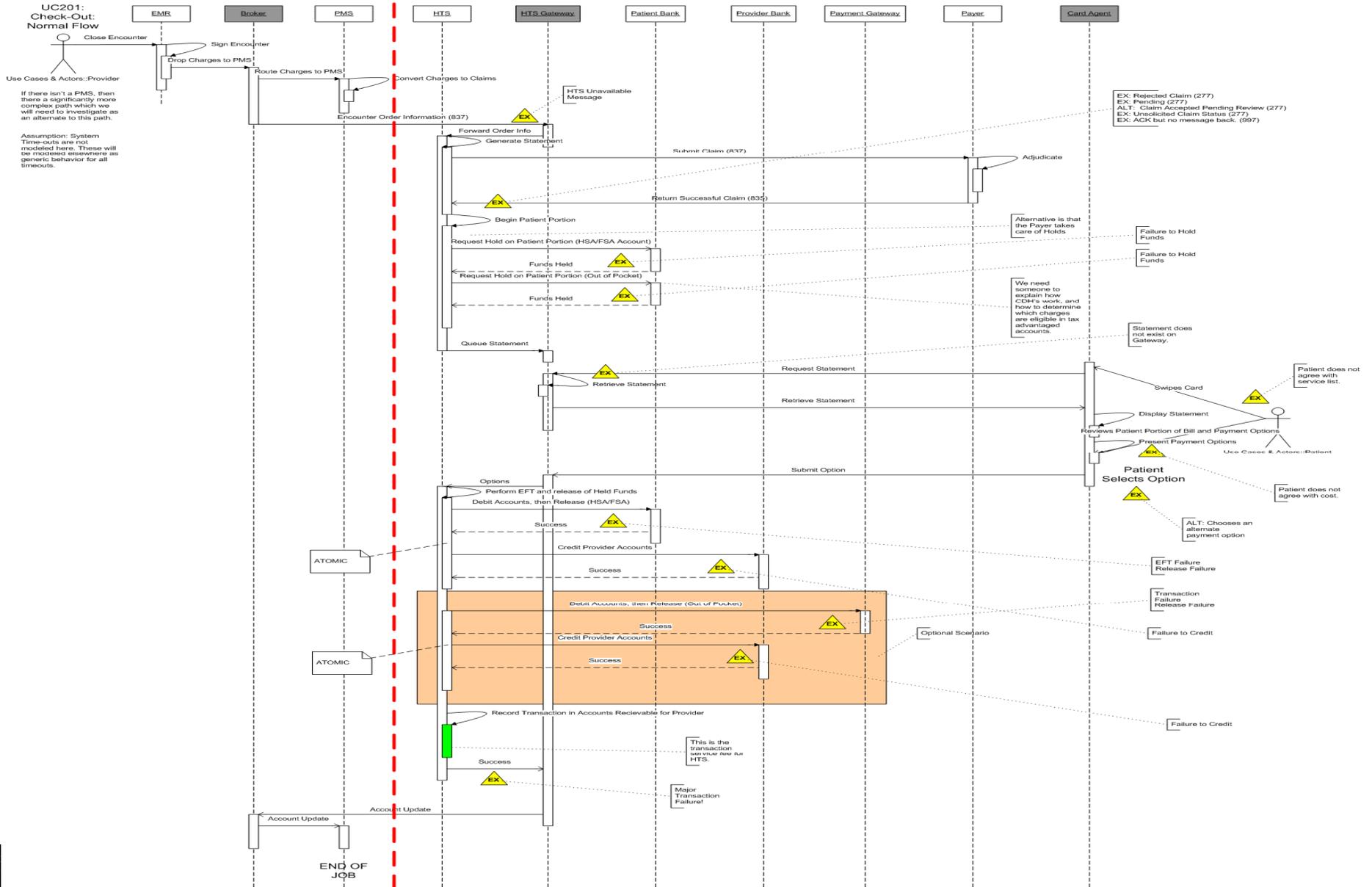
# HTS' Component Model



# Eligibility and Benefits Flow



# Check Out – Normal Flow



धन्यवाद

Hindi

多謝

Traditional Chinese

*Grazie*

Italian

ขอบคุณ

Thai



Спасибо

Russian

Obrigado

Brazilian Portuguese

Merci

French

Gracias

Spanish

شكراً

Arabic

多谢

Simplified Chinese



Danke

German

நன்றி

Tamil

ありがとうございました

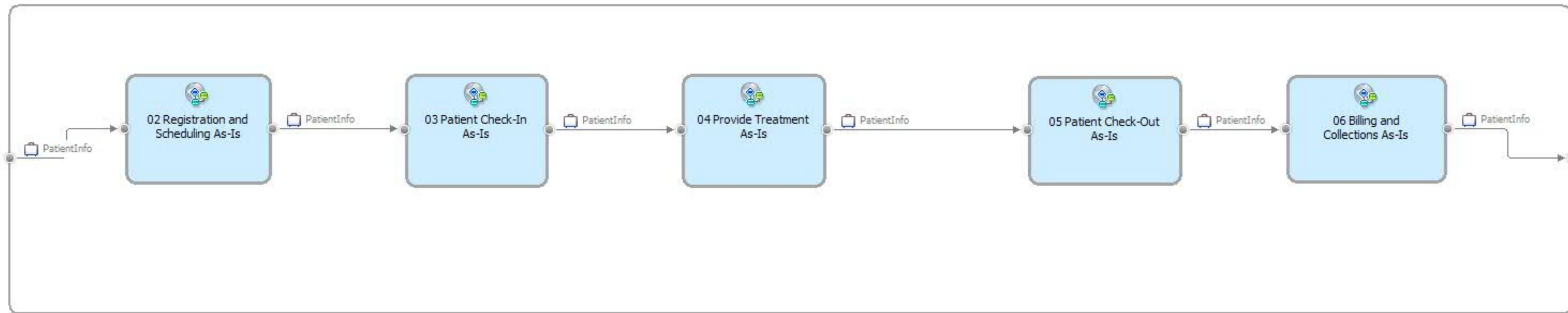
Japanese

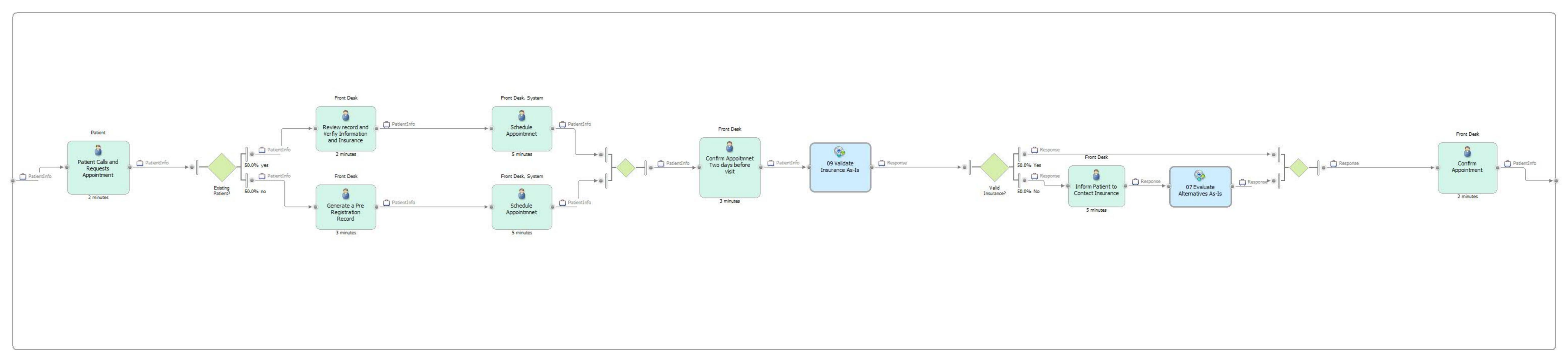
감사합니다

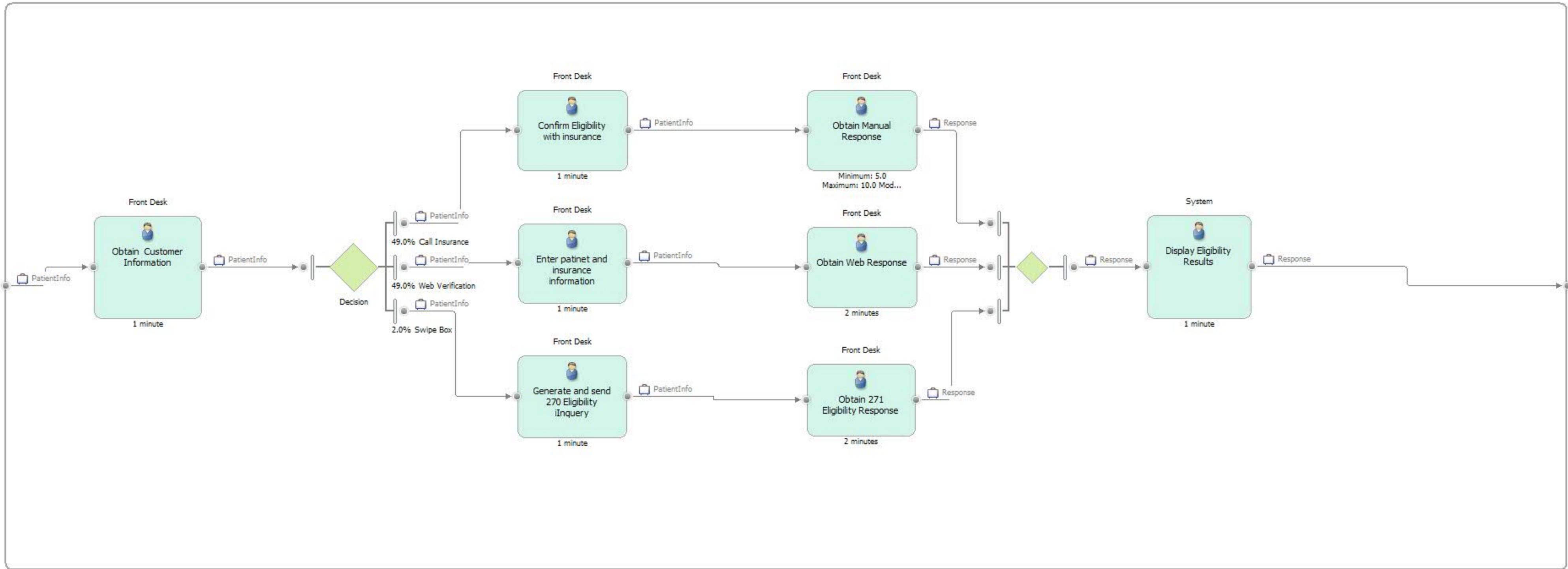
WebSphere software

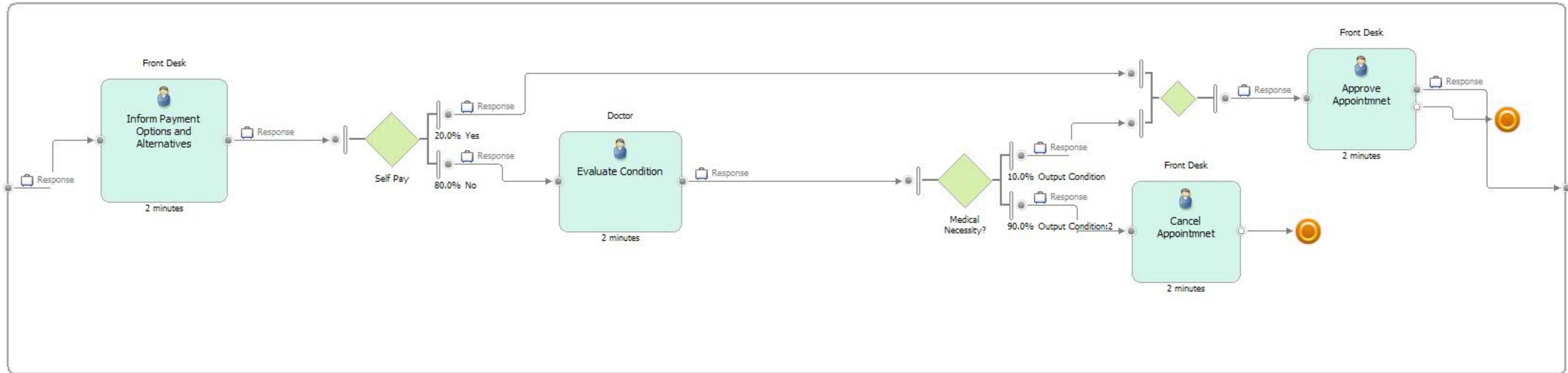
## **Appendix 15 - As is and To Be Process Flows**

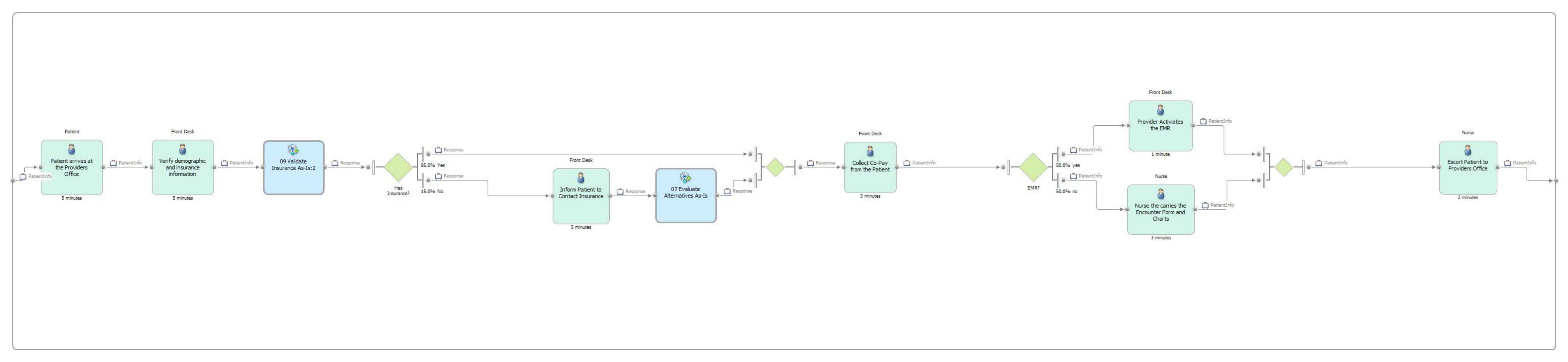
Developed by IBM for Illustration Only  
Time standards have not been verified.

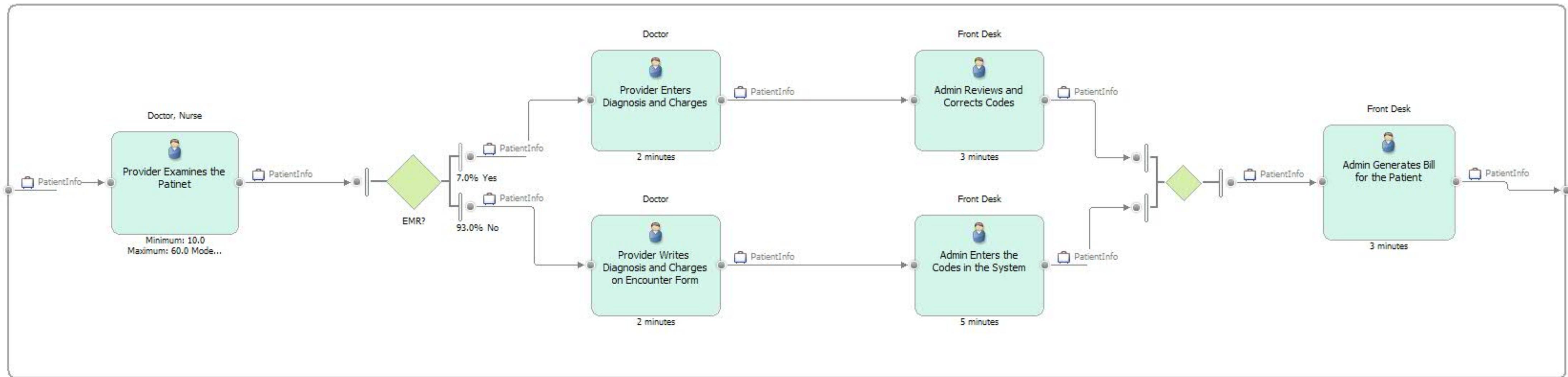


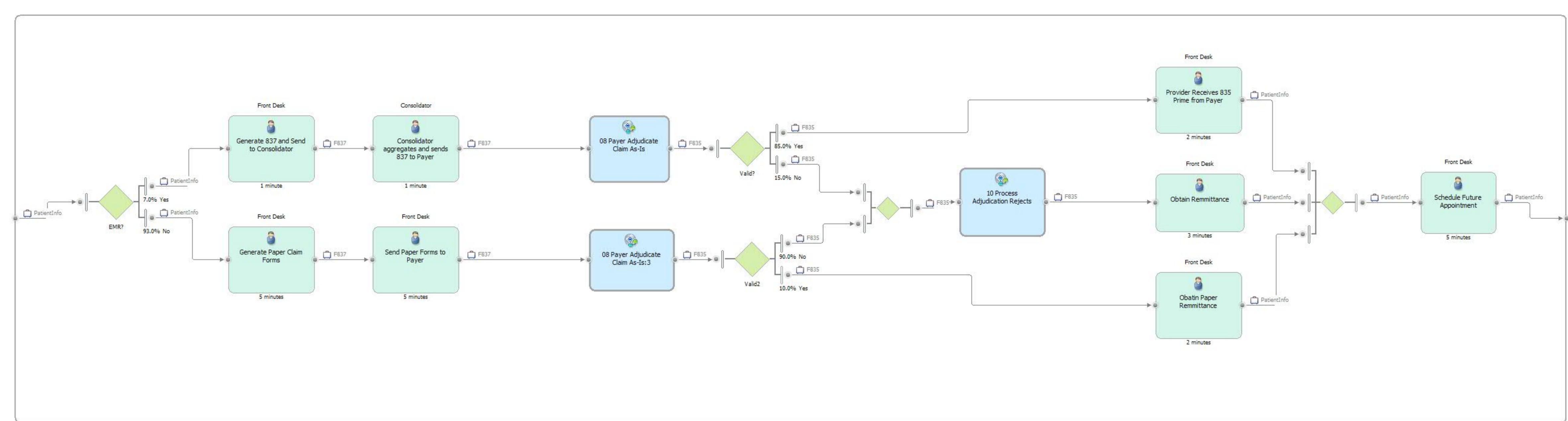


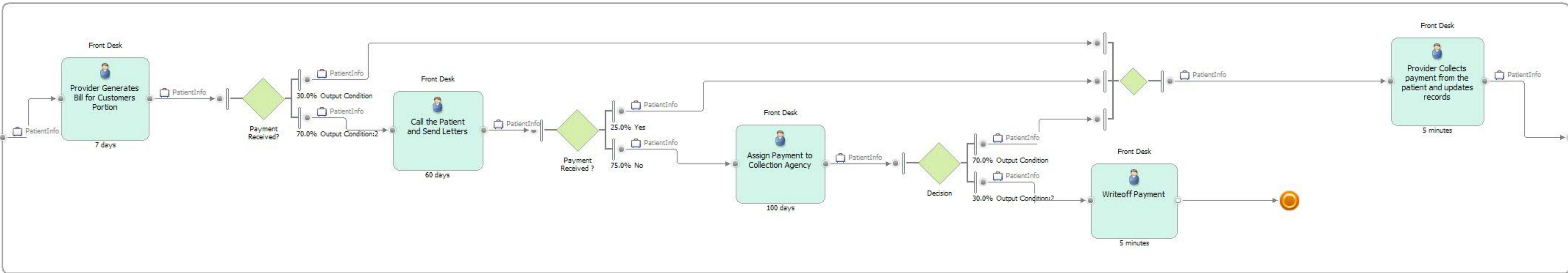


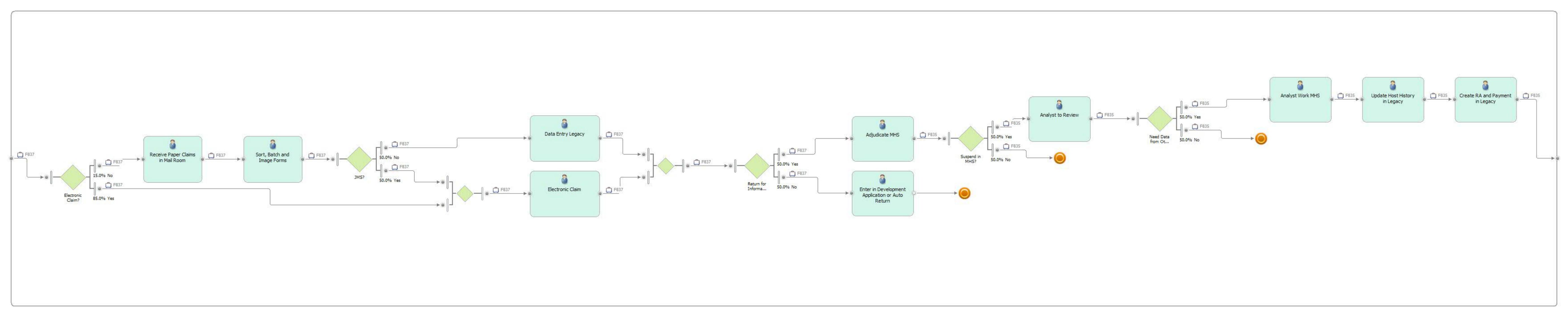


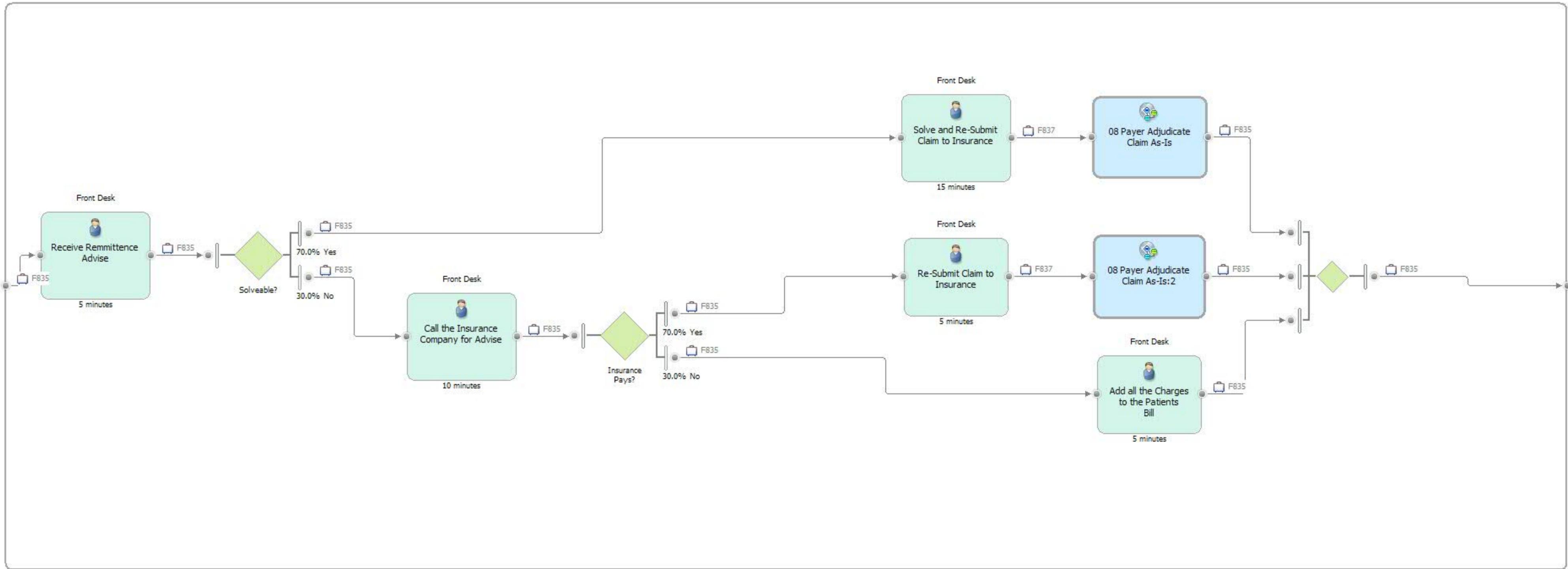


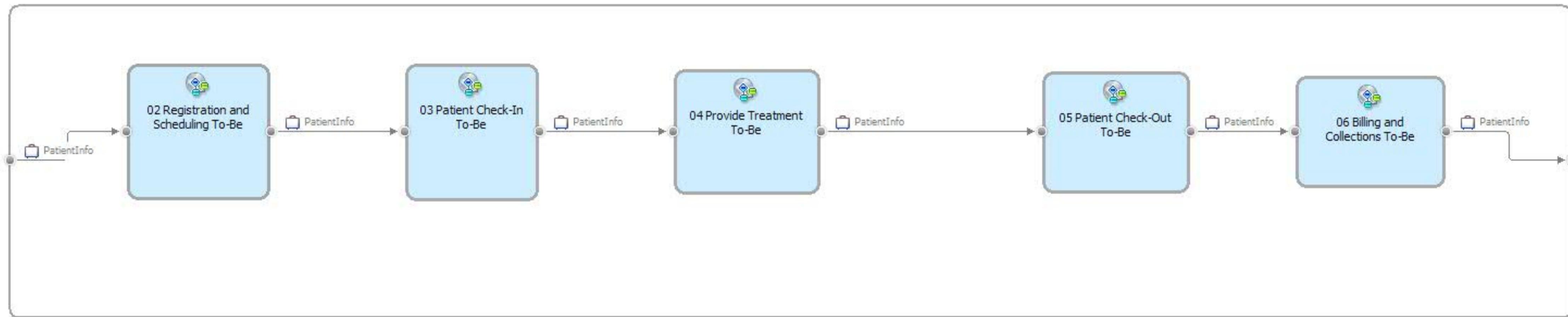


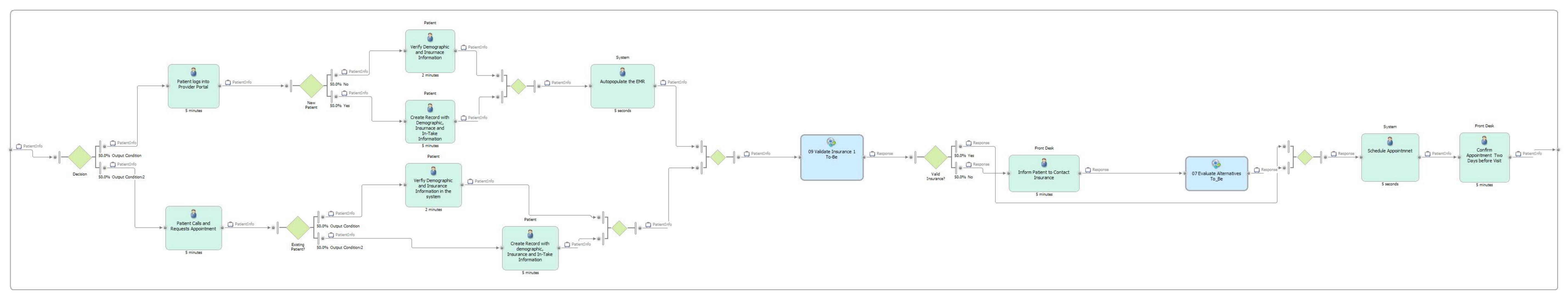


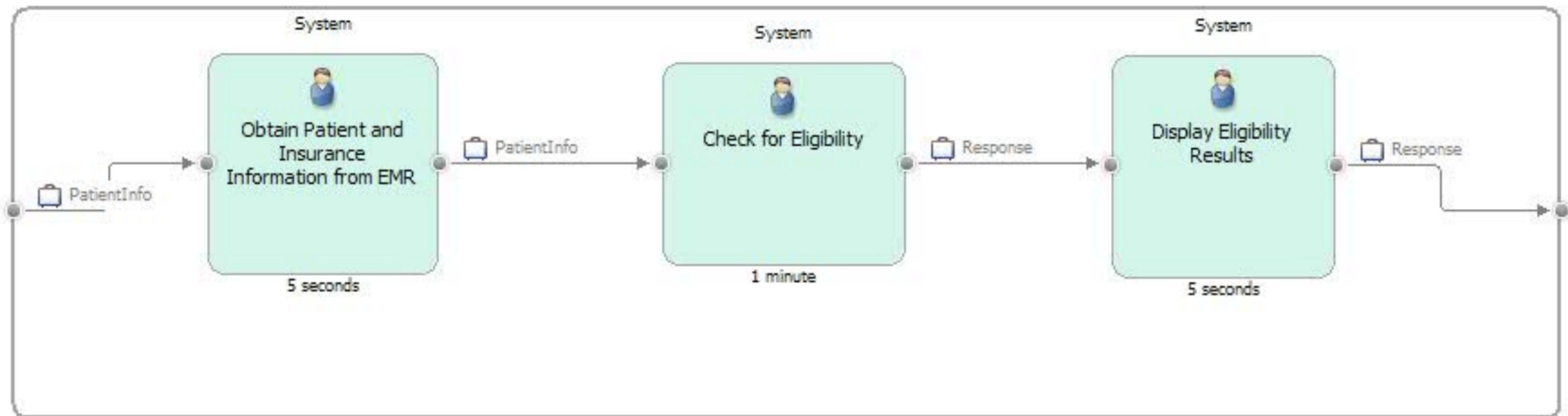


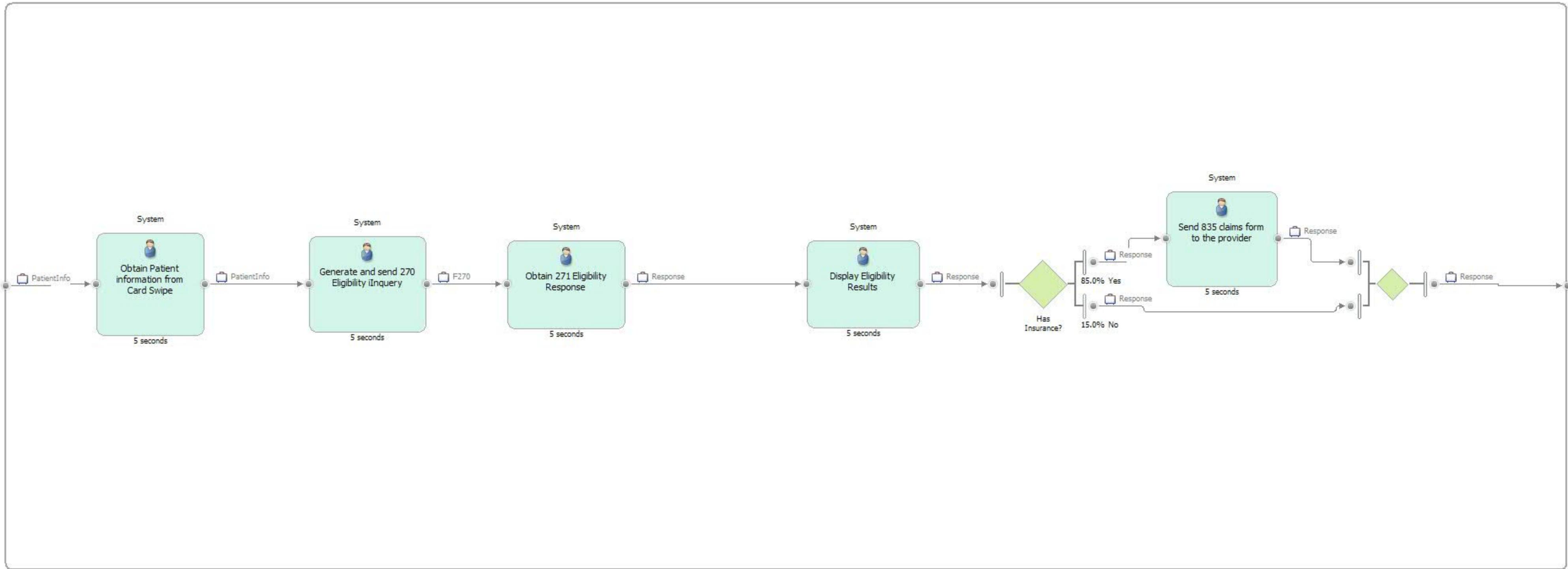


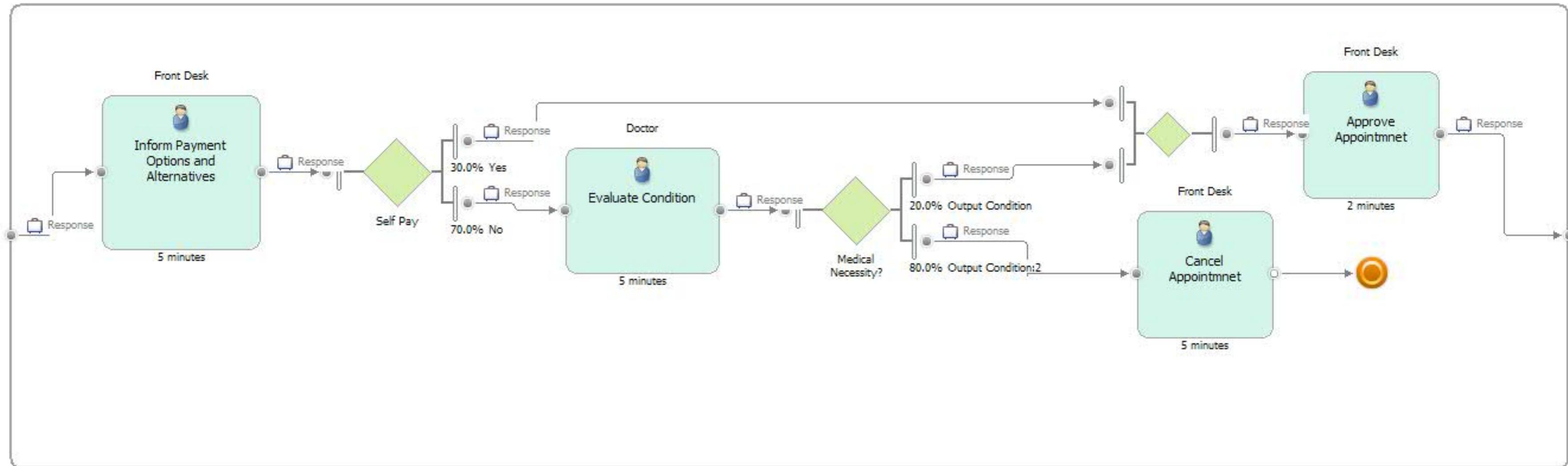


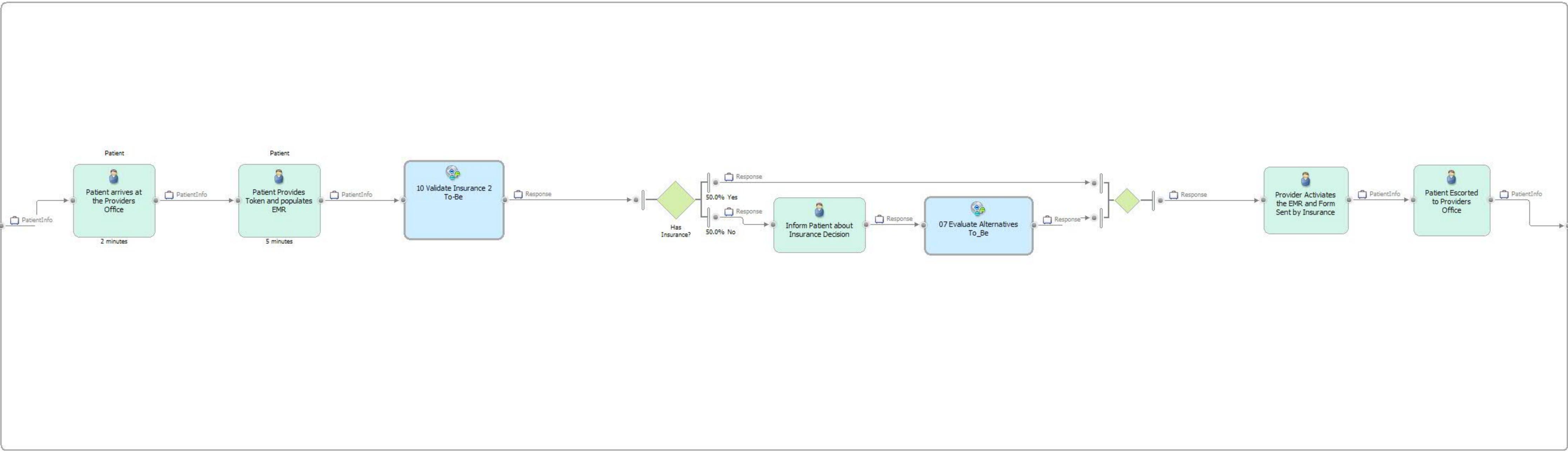


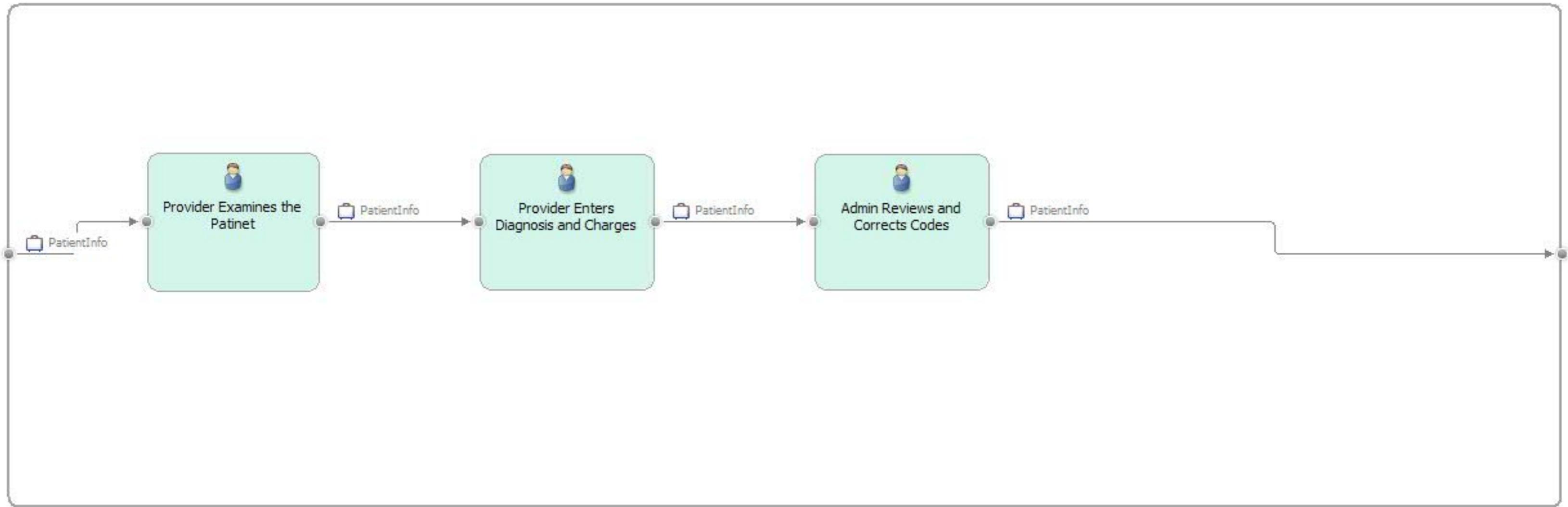












Front Desk

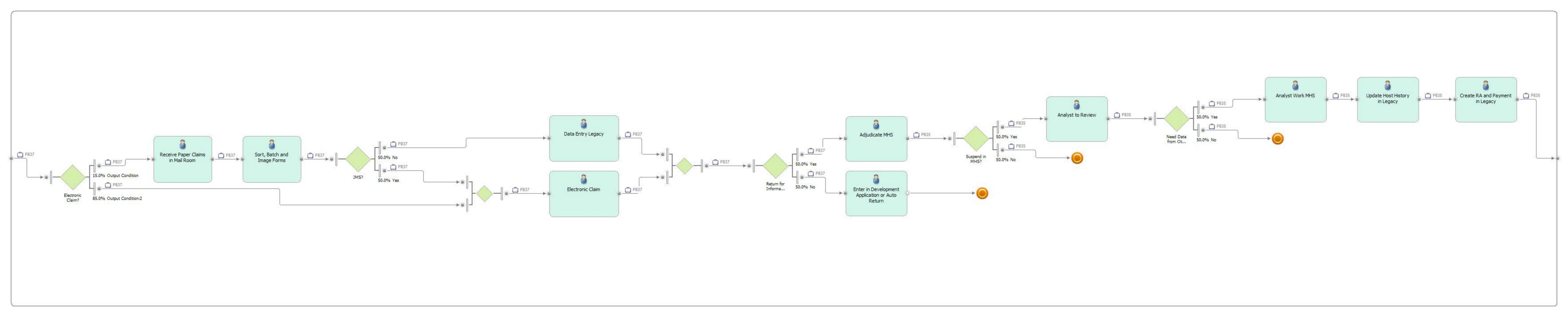
 PatientInfo

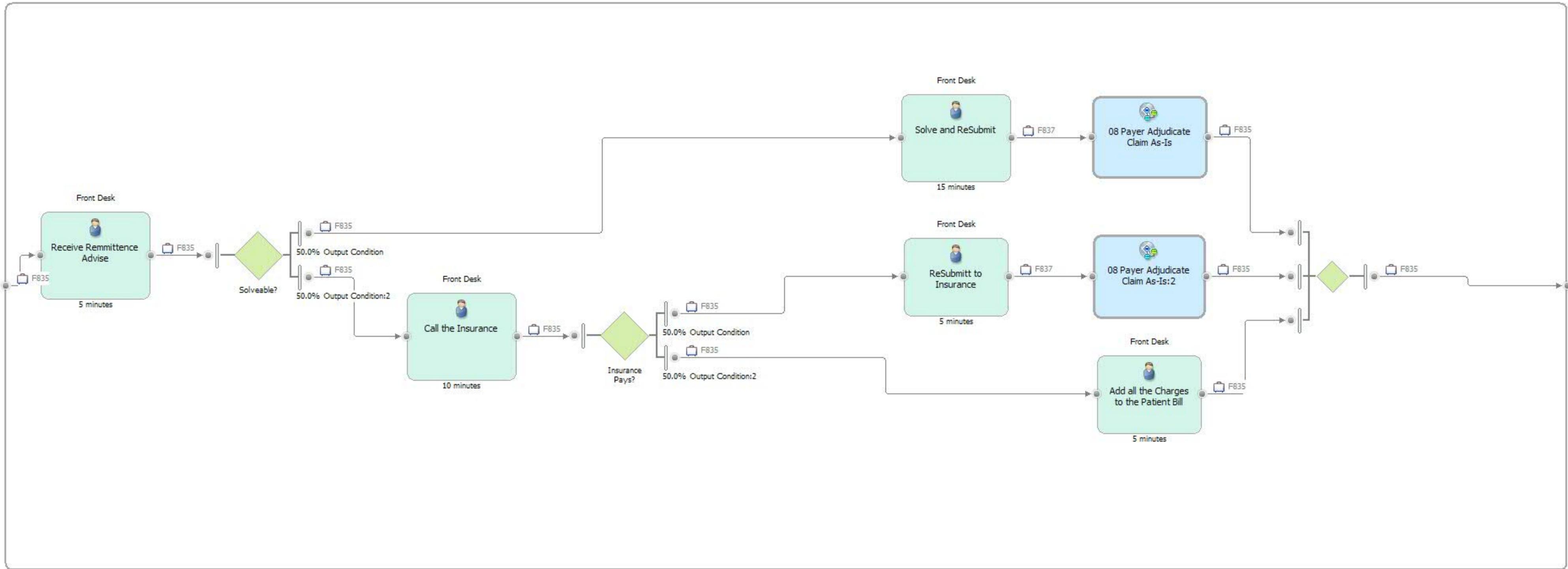
  
Providers collectes  
missed payments

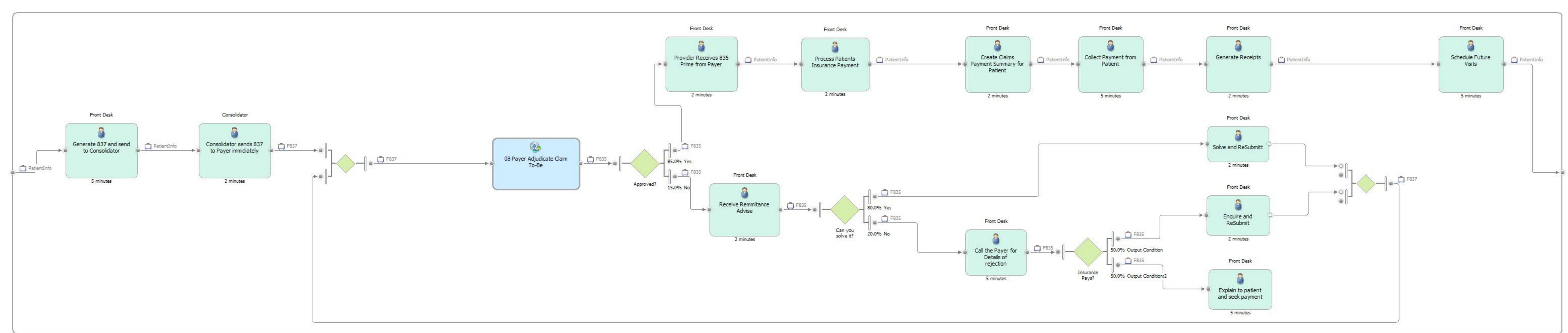
 PatientInfo

10 minutes









**Appendix 16 - First Data webinar July 17, 2009**

# Vermont Healthcare Payment Reform Overview

State and local partners meeting at the crossroads to reform healthcare.



Innovation

Preservation

Jean N Landsverk  
First Data

Mary Dees Griffith  
Preferred Health Technology

David Gruppo  
IBM

Friday, July 17, 2009

# Consumers are Paying the High Price of Inefficiency

## Industry Statistics Indicate the Need for Reform<sup>1</sup>

- \$300 billion annually lost on claims processing, billing and bad debt (\$45 billion)
- 92% of insured patients are able and willing to pay their out-of-pocket expenses
- 50% of patient responsibility bills go unpaid because of patient confusion, lagging invoices and lack of financing options
- Significant increase in number of self-insured
- \$2 trillion in annual healthcare payments

Health Care sector lacks the kind of modern payment systems found in retail.

	US Health Care Sector	US Retail Sector
Total underlying GDP	\$1.9 trillion <sup>1</sup>	~\$9.0 trillion
Number of participants	Many payers, many providers, many plans and many consumers	Many merchants, many consumers
Intermediaries	Few in number, primarily proprietary (eg, payers)	Multiple in number; largely open access (eg, Federal Reserve, major credit/debit networks, NACHA <sup>2</sup> )
Transaction characteristics <sup>3</sup>		
•Exceptions	20-40%	1%
•Manual interaction required	30-40%	Low degree
•Paper processing	80-90%	Low degree
Accounts receivable as % of revenue	15-30%	5%
Processing cost per transaction	15-20%	2%

<sup>1</sup> McKinsey – Overhauling US Healthcare Payments

<sup>2</sup> 2007 Estimate; latest available data from McKinsey – Overhauling US Healthcare Payments

<sup>3</sup> NACHA-the Electronic Payments Association (formerly National Automated Clearing House Association)

<sup>4</sup> Health care transactions include all activities required to process a service rendered by a provider (e.g. eligibility verification, claim adjudication, payment)

# Health Care: An Industry Plagued with Bad Debt

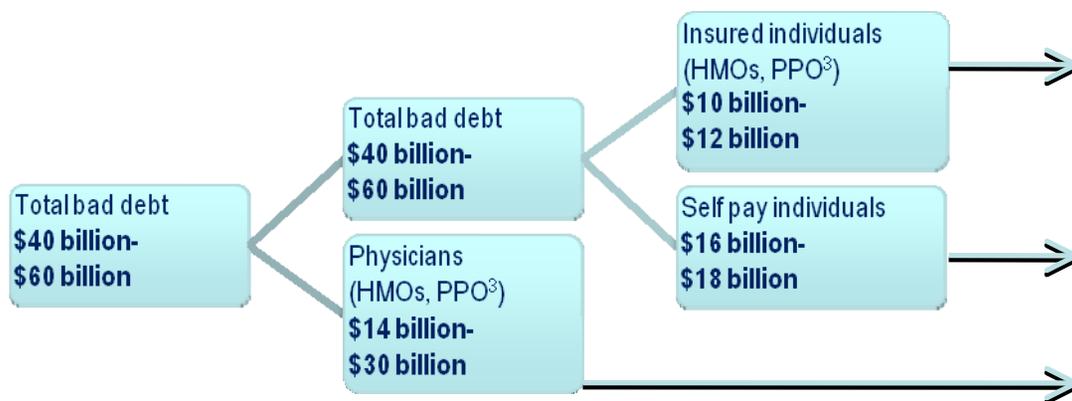
## Alarming statistics from Duke University study:

- Patient liability receivables fall around \$110 million with approximately 35-40% aged in excess of 120 days, driven by ongoing patient interaction and manual account review, active payment plans and bad addresses
- Bad debt as a percent of gross patient revenue approximates 25%; the average write-off ranges from \$850-\$900
- The average patient liability to insurance is about \$520 – an increase of 14% from previous year

Cost and complexity of billing and collections for consumers are onerous.

### McKinsey Quarterly

Overhauling the US health care payment system  
2004<sup>1</sup>



Net revenue <sup>2</sup> \$billion	Bad debt as % of total net revenue	Payment rate for consumer responsibility % collected
235	~4-5	40-50
20	80-90	10-20
440	3-7	40-50

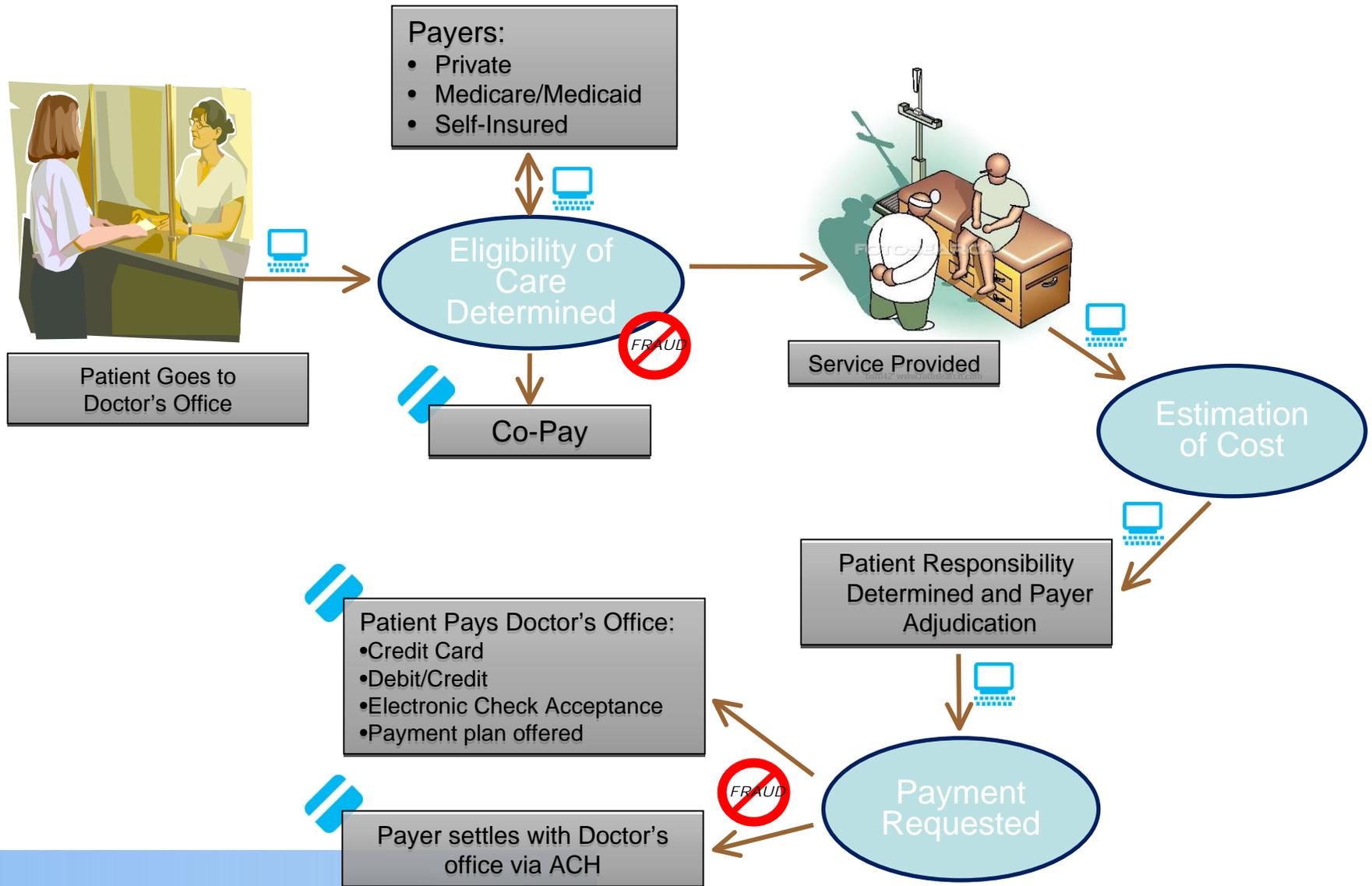
<sup>1</sup>Latest available data

<sup>2</sup>Includes hospitals only; excludes ambulatory surgical centers, laboratories, clinical diagnoses and alternative-care sites (eg. rehab centers, nursing homes)

<sup>3</sup>HMO=health maintenance organization; PPO = preferred-provider organization

<sup>4</sup>Net revenue of \$50 billion adjusted to \$20 billion to reflect actual payments

# Restructuring Vermont's Healthcare Payments



# Today's Product and Systems Provide Solutions

## Payment Products:

- Smart Card
- Electronic eligibility verification
- Real-time claims adjudication
- Payment processing
- Card processing and check conversion
- Automated delayed payment collection
- Automated payment plan administration
- Link to Practice Management Software for settlement

## Delivery Systems:

- Virtual Terminal
  - Integrated web based interface
- IP Terminal
  - Multi application standalone swipe card device

The average bad debt in a provider's office is \$160,000 per year.  
~ US Bank

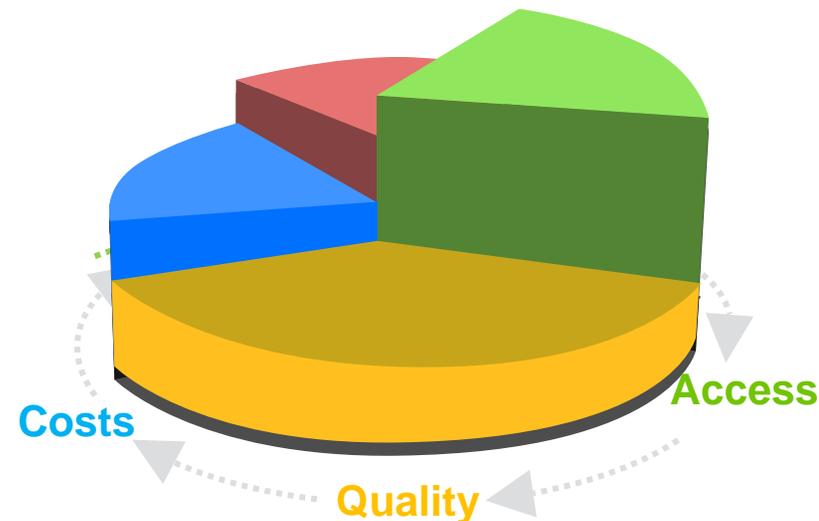


"A 1% increase in bad debt at a typical doctor's office would cut profits by 25%."  
~ McKinsey

# Consumers Benefit from Convenience and Clarity

## Cost Saving Benefits of Payment Reform:

- Identify coverage status
- Eligibility Verification
- Deductibles and copayment amounts determined at time of service
- Service limits/Coverage messages
- Claim Adjudication eliminates paperwork and bills
- Average system wide cost per claim of \$8 could be reduced by at least 60%
- Potential funding of discounts for payment at point of service
- Choice in cost of health care services
- Fraud Protection



"Today there is perhaps no bigger opportunity in the world than the opportunity to transform healthcare and truly make a difference in people's lives. ~ Steve Ballmer, Microsoft

# Ensuring Eligibility

The screenshot shows a Microsoft Internet Explorer browser window displaying the A-Claim web application. The browser's address bar shows the URL: <https://adclaimsys.bcbssc.com/Eligibility.do?action=displayForm>. The application header includes the title "A-Claim™" and a login status: "You are logged in as: GRP528: llazarine (Administrator)".

The main content area is titled "Healthcare - Eligibility" and contains the following text: "Swipe Health Card to begin. If Health Card is not present, click 'Manual Entry' to manually key in information. Eligibility data requirements will vary by Payer."

The form is divided into several sections:

- Merchant:** SYSTEM LgName VT329
- Payor:** BlueCross BlueShield of South Carolina
- Member ID:** Type: Number, Member ID: SCZ989400764455
- Provider:** George Beaver
- Date of Service:** 06/11/2008 (MM/DD/YYYY)
- Place of Service:** 11 - OFFICE
- Patient Name:** Fields for First Name, MI, Last Name, and Suffix.
- Relationship to Member:** 18 - Self
- Date of Birth:** (MM/DD/YYYY)
- Gender:** Male
- Service Type:** 30 - Health Benefit Plan Coverage

Buttons for "Swipe/Reswipe", "Manual Entry", "Submit", and "Cancel" are visible. A red asterisk indicates required fields.

Bad debt and fraudulent claims are estimated to be at least 20% of health care expense.  
~ McKinsey

# Eligibility Verification

A-Claim - Microsoft Internet Explorer provided by BCBSSC

File Edit View Favorites Tools Help

Address: <https://adclaimsys.bcbscc.com/Eligibility.do?action=lookUp>

**A-Claim™** You are logged in as: GRP528: llazarine (Administrator) [Log](#)

Connected to: SYSTEM LgName VT329 - CARE329

Healthcare - [Eligibility](#) - Response

Swipe Health Card to begin. If Health Card is not present, click "Manual Entry" to manually key in information. Eligibility data requirements will vary by Payer.

**Transaction Header**

Payer Name: BLUE CROSS BLUE SHIELD OF SC  
File Date: 06/11/2008 15:11

**Eligibility Summary (No Data)**

**Eligibility Contract Information**

Subscriber Name: LEE J LAZARINE  
Subscriber ID: SCZ989400764455  
Subscriber Group: 710029942  
Number:  
Subscriber Address: 12111 SUNLAND ST DALLAS, TX 75218  
Subscriber Birth Date: 01/16/1971  
Subscriber Gender: Male  
Relationship: Self  
Service Date: 06/11/2008  
Enrollment: 02/01/2008  
Eligibility: 02/01/2008-01/01/2009

**Eligibility Services**

Provider Name: SYS OFFNAME VT329  
Provider ID: 1073531935

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc
Active Coverage	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc
Benefit Disclaimer	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)

Message: IF THE MEMBER QUALIFIES FOR COBRA COVERAGE, THE POLICY MAY BE SUBJECT TO RETROACTIVE CANCELLATION OR REINSTATEMENT, BASED ON THE PLAN DESIGN AND THE MEMBER COBRA ELECTION. BENEFITS ARE BASED ON INFORMATION AVAILABLE AT THIS TIME AND ARE SUBJECT TO COVERAGE IN EFFECT ON THE DATE OF SERVICE. THIS IS NOT A GUARANTEE OF PAYMENT, NON-PAYMENT OF PREMIUMS AND OTHER CONTRACTUAL LIMITATIONS MAY RESULT IN DENIAL OF BENEFITS OR REFUNDS.

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc
Pre-existing Condition	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)

Period Start: 12/17/2007  
Period End: 12/17/2008  
Benefit Begin: 12/18/2008

**98-Professional (Physician) Visit - Office**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc	Auth or Cert Ind	In Plan Ind
Active Coverage	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)	Unknown	Yes

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc	Time Period	Amount	Percent	Auth or Cert Ind	In Plan Ind
Deductible	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)	Service Year	\$750.00		Unknown	No
Deductible	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)	Remaining	\$750.00		Unknown	No
Co-Insurance	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)			40.0%	Unknown	No

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc	Time Period	Amount	Percent	Auth or Cert Ind	In Plan Ind
Deductible	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)	Service Year	\$0.00		Unknown	Yes
Deductible	Individual	Preferred Provider Organization	PREFERRED PROVIDER ORGANIZATION	Remaining	\$0.00		Unknown	Yes

Revise Request Print Submit Another Request

Eligibility Print - Microsoft Internet Explorer provided by BCBSSC

803-123-4567

**Transaction Header**

Payer Name: BLUE CROSS BLUE SHIELD OF SC  
File Date: 06/11/2008 15:11

**Eligibility Summary (No Data)**

**Eligibility Contract Information**

Subscriber Name: LEE J LAZARINE  
Subscriber ID: SCZ989400764455  
Subscriber Group: 710029942  
Number:  
Subscriber Address: 12111 SUNLAND ST DALLAS, TX 75218  
Subscriber Birth Date: 01/16/1971  
Subscriber Gender: Male  
Relationship: Self  
Service Date: 06/11/2008  
Enrollment: 02/01/2008  
Eligibility: 02/01/2008-01/01/2009

**Eligibility Services**

Provider Name: SYS OFFNAME VT329  
Provider ID: 1073531935

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc
Active Coverage	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc
Benefit Disclaimer	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)

Message: IF THE MEMBER QUALIFIES FOR COBRA COVERAGE, THE POLICY MAY BE SUBJECT TO RETROACTIVE CANCELLATION OR REINSTATEMENT, BASED ON THE PLAN DESIGN AND THE MEMBER COBRA ELECTION. BENEFITS ARE BASED ON INFORMATION AVAILABLE AT THIS TIME AND ARE SUBJECT TO COVERAGE IN EFFECT ON THE DATE OF SERVICE. THIS IS NOT A GUARANTEE OF PAYMENT, NON-PAYMENT OF PREMIUMS AND OTHER CONTRACTUAL LIMITATIONS MAY RESULT IN DENIAL OF BENEFITS OR REFUNDS.

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc
Pre-existing Condition	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)

Period Start: 12/17/2007  
Period End: 12/17/2008  
Benefit Begin: 12/18/2008

**98-Professional (Physician) Visit - Office**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc	Auth or Cert Ind	In Plan Ind
Active Coverage	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)	Unknown	Yes

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc	Time Period	Amount	Percent	Auth or Cert Ind	In Plan Ind
Deductible	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)	Service Year	\$750.00		Unknown	No
Deductible	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)	Remaining	\$750.00		Unknown	No
Co-Insurance	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)			40.0%	Unknown	No

**30-Health Benefit Plan Coverage**

Benefit Info	Coverage	Ins Type Code	Plan Cov Desc	Time Period	Amount	Percent	Auth or Cert Ind	In Plan Ind
Deductible	Individual	Preferred Provider Organization (PPO)	PREFERRED PROVIDER ORGANIZATION (PPO)	Service Year	\$0.00		Unknown	Yes
Deductible	Individual	Preferred Provider Organization	PREFERRED PROVIDER ORGANIZATION	Remaining	\$0.00		Unknown	Yes

30% of claims submitted to Payer systems are duplicate or fraudulent.

# Real Time Claims Adjudication

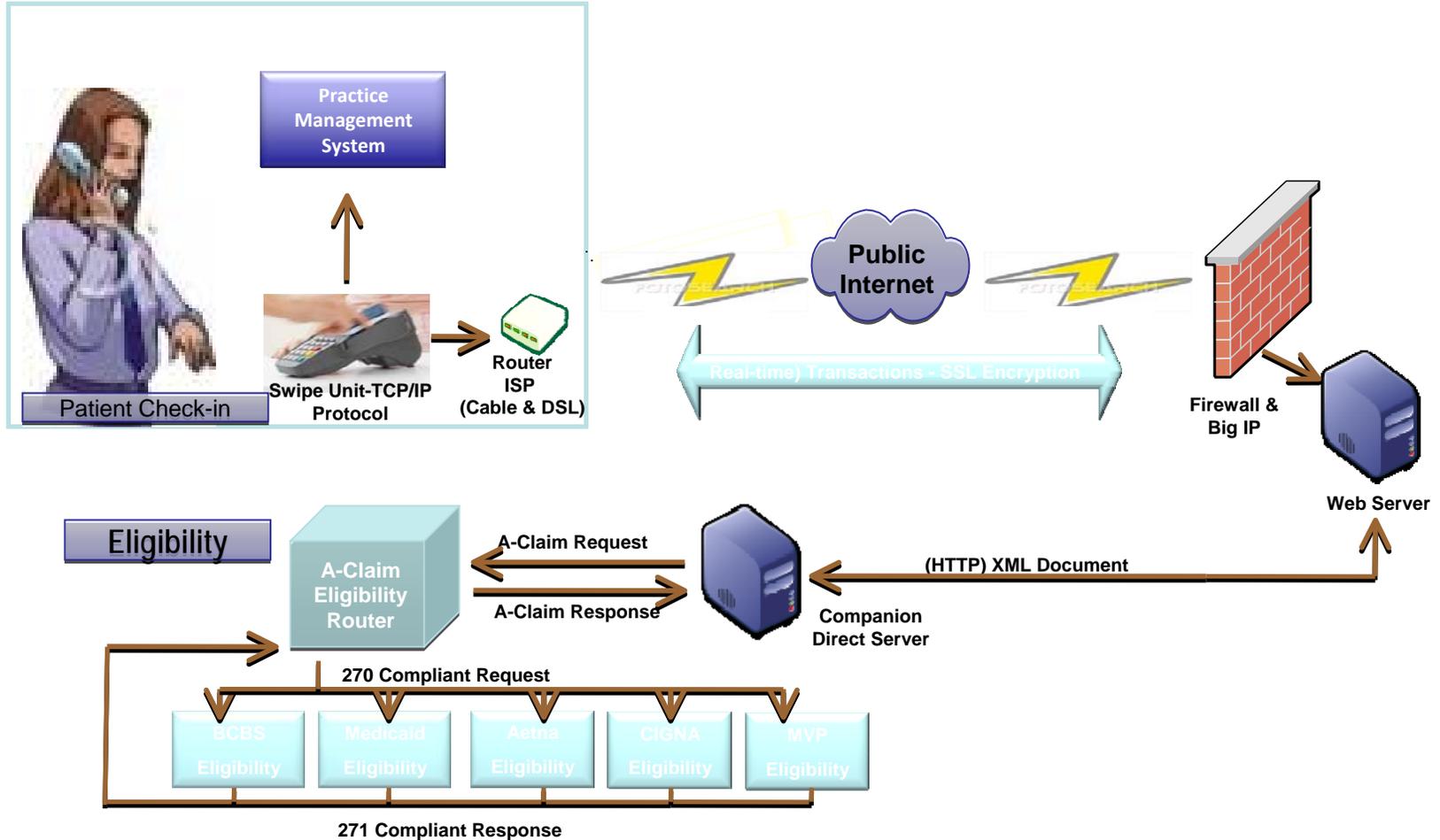
## Lowering the cost of health care in Vermont

- Allows providers to enter and adjudicate patient claims with participating payers in real-time
- Procedure codes are entered into the interface and a real-time transaction is sent to the Payer
- Once the claim is adjudicated, the patient responsibility amount is returned with the claim response
- The platform allows multiple real-time capable payers to deliver this functionality through a uniform interface
- Reduces need for invoices and Payer statements
- ACH Payment is sent from Payer to Provider office
- Links with most Practice Management Systems
- Low cost Electronic Check Clearing and Pin Debit available
- Incentive for immediate patient responsibility payments



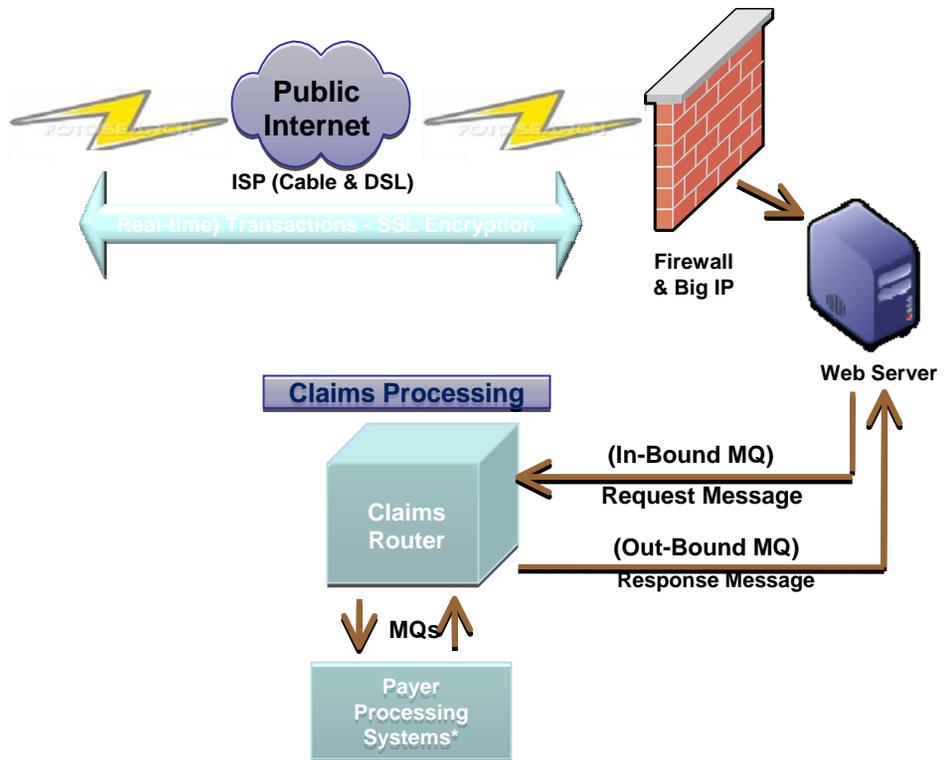
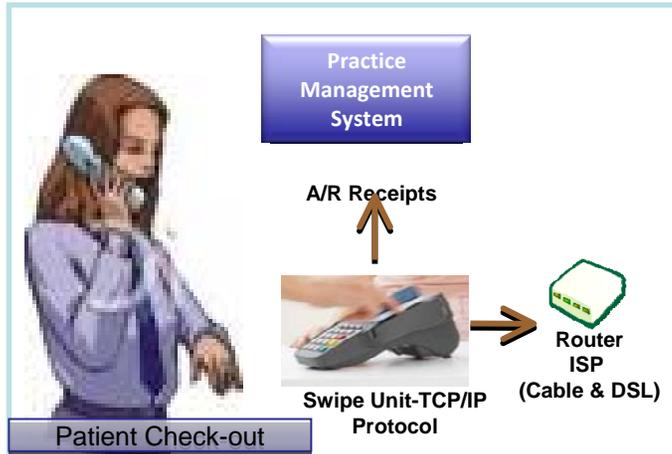
# Real Time Claims Adjudication

## Health Care Providers



# Real Time Claims Adjudication

## Health Care Providers



\* Claims, Benefits, Membership, Provider Systems

# Real Time Claim Adjudication



---

## Insurance Receipt

ACME MEDICAL  
1234 Main Street  
Anytown, SC 29201  
803-555-1212

Status: Processed  
Patient: Tom Jefferson  
Date of Birth: 10/12/1973  
  
Account: ABC123456  
  
Date of Service: 01/01/2007  
Provider: Tom Edison  
Total Charges: \$100.00  
  
Provider Paid: \$60.00  
  
Deductible: \$0.00  
Copayment: \$0.00  
Coinsurance: \$20.00  
  
Patient  
Responsibility: \$20.00  
  
Claim #: 12345678901234567  
Cover: State Health Plan

BY PRESENTING MY MEMBER  
IDENTIFICATION CARD FOR USE IN THIS  
SYSTEM, I AM PERSONALLY SUBMITTING MY  
HEALTHCARE CLAIM FOR BENEFITS TO MY  
HEALTH PLAN AND I AM DIRECTING THAT  
PAYMENT ON MY CLAIM BE MADE TO THE  
PROVIDER LISTED ABOVE.

---

Member/Patient Signature

Office Copy

# Conclusion

- Lowering the cost of care
- Reducing the cost of claim processing
- Reducing complexity of billing and collections
- Reduce bad debt and operating expenses for providers
- Allows Providers to focus on medicine
- Consumers take charge of their healthcare costs



**"We can't solve problems by using the same kind of thinking we used when we created them."  
~ Albert Einstein**

**Appendix 17 – Proposal for the Establishment of a Healthcare  
Information Exchange to Support Real-Time Transaction Services**

**Proposal for the Establishment of a  
Healthcare Information Exchange  
to Support Real-Time Transaction Services ("HTS")**

David M Gruppo  
IBM  
August 2009

**Introduction: Eliminate the 15% Inefficiency Tax**

**Premise.** The U.S. healthcare system imposes a direct 15% inefficiency tax on its doctors, and causes additional economic distortions that add further to the already high cost of healthcare. This waste and inefficiency could be almost entirely eliminated if point-of-sales systems in doctors' offices provided for the real-time submission and adjudication of insurance claims. The technology is within reach and the savings are real.

Government policy and private initiatives have long promoted the adoption of health information exchanges (known as an "HIE") for the sharing of clinical information among patients and providers. The HIE concept must be extended to administrative systems that support the real-time exchange and settlement of claims-related transactions. An HIE for transaction services (or, "HTS") would be akin to the financial transaction networks that facilitate payments and allow consumers to manage their financial resources in real-time.

If payers and providers were able to connect to each other via a transaction hub capable of routing insurance claims for real-time submission and adjudication, the resulting economic benefits would create a powerful incentive for all payers and providers to do so.

Such a system is technically feasible and financially attractive. Moreover, it will drive efficiency across the healthcare industry. An HTS system would benefit all constituents, but without government action it is unrealistic to expect the private sector to invest in a collaborative enterprise that will benefit the community at large. Payers and providers, caught in a classic prisoner's dilemma, remain shackled to a broken system. The funding of the proposed state-wide demonstration project will provide a powerful catalyst to jump-start the private sector towards a rapid adoption of the new payment infrastructure. We now have a unique opportunity to galvanize the industry to productive, collaborative action. By taking the lead to resolve the dilemma, we can set the stage for collaborative behavior, effectuating meaningful healthcare payment reform

**Solution Elements.** The proposed payment infrastructure involves three core elements: (i) a real-time transaction hub providing connectivity across the Internet among all payers and providers ("HTS"); (ii) POS systems at medical offices supporting the real-time eligibility, and preparation and submission of claims; (iii) real-time adjudication of claims by payers. Our proposal is to establish HTS with seed capital provided by the federal government or the private sector, while providing technical support and other necessary assistance to facilitate the adoption of the HTS system by payers, providers, and other participants in the claims process.

**Background.** The U.S. healthcare industry is burdened with inefficient administrative and payment systems that consume up to 30% of the cost of medical services. At least half of this amount is a result of antiquated systems and convoluted, manual processes associated with the preparation, submission, adjudication, and payment of medical claims. By comparison, in almost any other industry the cost of issuing receivables and processing payments represents only a small fraction of revenues.

The current payment systems squeeze all Americans and most of its businesses. As individuals, we suffer the rising cost of healthcare in two ways: aggregate costs increase from year to year and a larger proportion of the growing total is shifted to patients. Wages haven't come close to keeping pace with the burden. Businesses that offer healthcare benefits see a larger portion of their expenses going to cover healthcare, with little ability to manage the increase except through cost-shifting. Not surprisingly, the proportion of businesses offering healthcare benefits has dramatically declined over the last 15 years. Ironically, even health insurers feel its pinch through higher operating expenses associated with an inefficient claims system. It isn't the fault of either insurance companies or doctors because the system itself creates a classic prisoner's dilemma: no single insurance company or doctor can easily justify an investment in changed processes and equipment unless everyone else in the system does so at the same time; the structure of the healthcare industry is in itself a barrier to the adoption of efficient technology.

This situation is akin to the prisoner's dilemma in that each participant would benefit if all were to cooperate, but none can be sure that all others will cooperate so each goes his own way and we are stuck in a sub-optimal market position. It is impractical, at best, for the private sector on its own to organize thousands of payers and nearly a million providers into a collaborative payments system. The government, however, can create the conditions that enable all parties to maximize their own economic interests through collaboration. Once the participants have full information and can count on others to cooperate, each participant will naturally participate in the new system, confident that others will be similarly motivated by the opportunity for gain. Systemic improvement would follow as the economy moves to a position closer to the optimum.

As the cost of healthcare continues its inexorable rise, administrative efficiency will draw increased attention as a potential source of relief. It is time to eliminate the 15% healthcare inefficiency tax

With many contributing factors, one element unique to the healthcare industry stands out as a primary root cause of inefficiency: contractual settlement is almost never achieved at the point-of-sale. A final bill can take weeks to settle, even in the case of a routine office visit. By contrast, a doctor who collects the full amount charged for services before the patient departs enjoys a significant financial advantage relative to standard practices.

. Once a physician agrees to take on the responsibility of collecting first from the insurance company and subsequently from the patient, the cost of doing business rises in two significant ways: (i) the incurrence of high overhead costs associated with the entire claims process; and (ii) by billing the patient only after completing the transaction with the insurance company. The latter, delayed collection of a patient's portion of the financial obligation substantially increases both cost and risk for the physician practice. The direct overhead costs are attributed to the typical patient billing process, payment monitoring and dunning notices for unpaid invoices. The risk is inherent in the current system as it enables a dramatic increase in bad-debt. On average, physicians are unable to collect 50% of patients' obligations. These charges include contractual co-payments, deductibles, and other amounts not covered by the insurance policy and can lead to credit losses as high as 10% of billed revenue. Compounding the problem is the lack of visibility and convoluted processing methods that cause an enormous duplication of effort as doctors and patients attempt to sort out their obligations and benefits: Americas Health Insurance Plans (AHIP) estimates that 30% of all claims submitted are duplicates.

From the point of view of a private physician, the inefficiency tax comprises amounts over-and-above normal administrative costs of invoicing and collecting payment. In an office that accepts no insurance (as has become a common practice in wealthier communities), administrative costs can be half of what their insurance-accepting colleagues incur. The added administrative expense associated with preparing, editing, submitting, correcting, and reconciling claims, represents approximately 50% of the added burden. The remainder covers the expense of invoicing and collecting co-payments, write-offs due to non-payment, and the cost of working capital to finance a large portfolio of long-outstanding receivables. (These amounts, and other figures cited in this paper, are estimates based on industry data and published studies on the magnitude of the "inefficiency tax.")

The most efficient way to eliminate the 15% inefficiency tax, therefore, is through the use of a point-of-sale system supporting the real-time preparation,

submission, and adjudication of insurance claims. This is the same basic technology already in common use across retail industries. The first significant improvement in process efficiency requires real-time claims adjudication at the time of service. Physicians, payers, and large self-insured employers have a significant financial motivation to enable point-of-service payment models; some are beginning to make the investments in enabling technology. Why will insurers give up the benefit of the float? This objection is based on the premise that insurance companies greatly benefit from the float associated with holding onto policyholders' money for as long as possible when, in fact, the benefit is not a significant factor. Insurance companies often act primarily as administrators on behalf of large, self-insured companies that do not transfer money to their insurance administrator until shortly before the administrator must disburse funds to providers and patients. Moreover, any benefit that might accrue to the administrator is factored into the overall price of their services; their corporate clients can and do calculate the value of the float and use that knowledge in contract negotiations. Moreover, payers incur higher costs in the form of customer service support and processing requirements made more difficult by the lack of automation. These costs exceed any earnings that might accrue from the float.

Eliminating unnecessary complexity is, in itself, a private and public good and will put us on track to eliminate the 15% inefficiency tax. Even so, the problem isn't limited to the direct cost of an unnecessarily complex payment process; in fact, the total economic cost is far greater. The current inability of the parties (physician, payer, and patient) to settle their respective obligations at the point-of-sale has the insidious effect of enervating the power of a market-based economy. As soon as a patient is allowed to leave without paying – indeed, without even knowing the final cost of the visit – we've effectively lost the power of a market-based economy to exert pricing discipline. The physician is forced into extending credit of an uncertain amount to a patient of unknown credit-worthiness. The patient is permitted to purchase services at an uncertain cost and on indeterminate payment terms. When you don't know what you're getting charged for something, it is difficult to be a discriminating consumer.

If contractual settlement occurred at the point of sale (as it does with virtually all other business transacted in the U.S. economy): (a) the 15% inefficiency tax will eventually be eliminated; and, (b) we will begin to see the effect of pricing discipline exert downward pressure on the cost of healthcare, providing even greater economic benefits over the long-term.

**Key Benefits.** Payers and providers would be connected across the Internet, via electronic point-of-sale systems and a real-time, claims and payment exchange (i.e., the same methods and technologies we use for almost everything else we buy). This is a simple technology that can be adapted to great effect in the

healthcare industry, would enjoy support across all stakeholder groups, and is complimentary with (if not key to the actual success of) other reform initiatives.

The combination of an electronic health insurance card and a real-time network for electronic claims and payments may be among the single best uses of technology to achieve important healthcare policy objectives. An immediate benefit is that it will reduce the huge inefficiency of administrative systems. It will also facilitate the use and effectiveness of many of clinical systems currently being promoted (e.g., EHRs, PHRs).

Moreover, such a system provides regulators, public health officials, and policy makers, an invaluable source of data, together with a set of tools to influence behavior or promulgate and enforce standards.

Finally, such a system will also address a key weakness of most, if not all, current proposals. Clinical and administrative systems almost never intersect. As such, much of the benefit assumed to flow naturally from more modern clinical systems will never be fully achieved unless there is an easy way of combining data from clinical and administrative (including payment) systems.

Enacting this solution would be legislatively simple and technologically feasible. Consumer adoption is not expected to be a hurdle: using an electronic card to transact business, access databases and on-line accounts, and register with service providers, is already familiar to many Americans. Its promulgation would spur private investment and job creation (akin to what occurred as businesses rushed to meet Y2K compliance). Its implementation would generate direct savings that would begin to flow virtually immediately. Aggregate savings would amount to hundreds of billions of dollars. Finally, by eliminating a key barrier to an efficient market, it would stimulate and facilitate the adoption of other innovative services and key policy objectives.

**A Proposal to  
Extend HIE to Enable Real-Time Administrative Systems  
and  
Eliminate the 15% Inefficiency Tax**

**Proposal Outline**

1. Rationale for Taking Action

- a. The 15% Inefficiency Tax. Paying your doctor shouldn't be much more complicated than paying for groceries. Yet, the health care industry continues to rely on antiquated systems and manual processes that turn a simple transaction into a complicated mess, resulting in significantly higher costs for all of us. Convoluted processes and outmoded technology add at least 15% to the overall cost of health care services. A relatively simple solution is within reach but, without a catalyst for change, we continue to be burdened with an elevated cost of health care, year after year.
- b. Indirect Costs Add to the Burden.
- c. Diagnosis. There is much that ails our healthcare system but a good portion of the illness results directly or indirectly from a single cause: the time-consuming, expensive, complex, multi-party process that patients and doctors must engage in simply to pay for a service already rendered (i.e., transaction settlement).
- d. Cost of Inaction. The process of paying for medical services imposes a direct administrative inefficiency tax of 15% or more on the value of healthcare services and results in additional economic distortions and misallocation of resources that have not been quantified. In an industry of more than \$2 trillion dollars annually, the direct costs of the inefficiency tax are staggering; the indirect and opportunity costs add significantly to the drag on our economy. The elimination of this one cause of disease is technologically simple, quick to deploy and would more than pay for itself. Moreover, the proposed solution would provide the technology foundation and economic base for other cost-saving healthcare industry initiatives.

2. Solution Elements.

- a. ATM Analogy. Healthcare insurance cards would have the transactional efficiency and ubiquity of bankcards. They would enable four real-time electronic transactions: eligibility, claim preparation and submission, auto-adjudication (in a large majority of encounters), and financial reconciliation between claims submitted and paid. An insurance card is often only a plastic record of a policyholder's name and related account information. The cost of issuing and supporting the greater functionality of an ATM-like card would be more expensive than the lowest cost alternatives; many insurers have migrated to magnetic stripe cards and, when issued in large quantities, are inexpensive.
- b. Electronic Enablement of the Claims Process. Insurance carriers would provide each policyholder and beneficiary a machine-readable healthcare payment card which, when tendered, would invoke the carrier's real-time, claims adjudication system and enable transaction settlement at the point-of-service.
- c. Network Connectivity and Transaction Routing. Providers, payers, and other industry participants would send electronic transactions over the Internet and would connect to each other via a central hub (see, HTS, below) which would build and manage the technology infrastructure to route all electronic transactions, securely, and in real-time, in exchange for a fee for services.

3. What's New?

- a. Insurers.
  - i. Must issue ATM-like insurance cards to all policyholders and other beneficiaries.
  - ii. Must support electronic, real-time, confirmation of a patient's eligibility.
  - iii. Must support electronic pre-population of the claim form at patient check-in, facilitating the digital preparation of all claims, minimizing data-entry errors, and making it the insurer's responsibility (rather than the provider's) to ensure all claims conform to the insurer's proprietary rules.
  - iv. Must support electronic submission of claims and real-time electronic adjudication of claims.
  - v. Must provide electronic payments reconciliation reports in connection with each reimbursement payment sent to healthcare providers.
- b. Physicians.
  - i. Must accept ATM-like insurance cards for patient check-in, electronic eligibility requests, claims submission, and as form of tender.

"HTS Proposal Summary: Eliminate the 15% Inefficiency Tax"

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- ii. Must submit all claims electronically or suffer a penalty (in the form of a fee or reduced reimbursement rate). Most private physicians do not prepare an invoice until after the patient leaves the medical office and would, therefore, be required to change existing processes. Under our current system, physicians have little incentive to change the way claims are prepared and submitted because they wouldn't get paid any faster. Under the proposed HTS system, physicians would have ample financial reasons to adopt new procedures; moreover, the simplified claims process described in this approach makes it easier to prepare and submit a clean claim in the first instance.
  - iii. Must accept EFT payments from insurance companies. Most reimbursement payments are made by paper check, which adds to the insurer's cost of doing business. Moving to EFT should save money and simplify the process for all; provided that, electronic payments are accompanied by an electronic reconciliation between claims submitted and paid. Insurers typically bundle reimbursement payments but generally do not have adequate information to match a bundled payment to individual claims, a process physicians are generally required to do manually. Thus, the move to EFT payments must be accompanied by electronic reconciliation.
  - iv. Must submit prescriptions electronically or suffer a penalty (in the form of a fee or reduced reimbursement rate) for the related patient visit.
- c. Healthcare Transaction Services Corp. ("HTS Co.").
- i. HTS Co. is a newly-created, publicly or privately-capitalized company, regulated or subject to government oversight. HTS Co. could be organized as a special, state-chartered institution; however, it might be advantageous for it to exist as a private corporation subject to government regulation and oversight. Private sources of capital could supplement or take the place of federal funding.
  - ii. HTS Co. operates and manages the HTS transaction exchange and provides secure routing over the Internet between physicians and payers.
  - iii. HTS Co. facilitates electronic confirmation of eligibility; preparation, submission, and auto-adjudication of claims; and financial reconciliation of claims submitted and paid.
  - iv. HTS Co. could be remunerated on the basis of transaction routing fees or other metric.
  - v. HTS Co. technology infrastructure will take advantage of open standards and standard computer interfaces to

facilitate multi-party transactions and rapid adoption across all market segments.

4. Government Action is the Needed Catalyst.
  - a. Economic Externalities the Market Can't Address on its Own. All constituency groups suffer under the existing system, some more than others; all constituencies would benefit from the reform we suggest; but, to effectuate a practical, efficient, effective solution requires all constituents must collaborate because no single constituent has the wherewithal or economic motivation to do so on its own.
  - b. Classic Opportunity for Government Catalyst. Because of the multi-party nature of our current payment system, and the high cost of private collaboration among thousands of private actors, government action can help resolve the dilemma more efficiently. If insurance companies implemented the recommended changes but providers didn't do their part, or vice versa, all effort would be wasted and no one takes the first step, therefore. The government can provide merely the catalyst that sparks private initiative. Once each constituent knows that all must participate (or have an economic incentive to participate), the opportunity for private profit (or possibility of loss) will drive the desired behavior. Market forces can then take over, and will likely trigger the necessary investment to build and deploy the HTS solution.
  
5. All Constituents Benefit From the HTS Solution.
  - a. Payers. Payers lose under the current system because the elevated costs of processing claims is much greater than any benefit derived from additional float.
  - b. Providers. Providers will get paid faster with less effort, which will more than compensate for having to adopt new POS systems and slight changes to the claims preparation process.
  - c. Patients. Patients benefit from simplified processes and immediate claims reconciliation, though they may be expected to carry their healthcare insurance cards to doctors' visits.
  - d. Employers. Employers will benefit from the improved service employees should experience; they may benefit directly from the ability to negotiate better rates with insurance companies.
  - e. Banks. Banking institutions will benefit as providers of new, card-related payment services and efficient healthcare savings account interfaces.
  - f. Pharmacies. The HTS solution can be utilized to encourage the quicker adoption of e-prescribing; and, by avoiding the high cost of handling paper prescriptions, pharmacies will enjoy a significant financial benefit.

6. Strategic Enhancements Enabled by HTS

- a. Public Health and Disease Control. As a central routing system for healthcare claims, HTS could easily enable public health officials to have greater and virtually immediate visibility into disease patterns as they develop across the state (with appropriate protection of patient identities).
- b. Electronic Health Records. As a central routing system for healthcare claims, HTS could become a single source for populating patients' electronic health records. The complete electronic record of all claims could be automatically routed to each patient's secure data repository for electronic health records.
- c. Electronic Health Records. HTS could provide the technology infrastructure and economic model for implementing and encouraging the secure electronic storage of digitized patient medical history, medical images, test results and other records.
- d. Monitoring and Influencing the Adoption of Best-Practices. HTS would enable single-point visibility into industry best-practices (e.g., physicians who take advantage of e-prescribing) and the possibility of using a combination of advantageous reimbursement rates or financial penalties to encourage the adoption of such practices. Existing model practice standards promoted by industry associations such as the AAFP could be given greater visibility in the effort to advance the efficiency of medical practices.
- e. E-Prescribing. In spite of the significant economic benefits of e-prescribing, relatively low adoption rates prevail. Today's system provides no mechanism to encourage physicians' use of electronic prescriptions. HTS could provide the technology infrastructure and the economic levers to enable and enforce widespread adoption of e-prescription, increasing the economic return and reducing fraud.
- f. Fraud Detection and Prevention. HTS could significantly enhance rapid detection and prevention of medical fraud – by providers, patients, and payers. Existing, sophisticated analysis systems could be incorporated into the backbone HTS utility.
- g. Enhanced Payment Solutions. Insurance providers could take advantage of the central role of insurance cards by adding valuable technology enhancements. Many insurance providers would be quick to adopt multi-pursuing capabilities, allowing a patient to link multiple payment accounts (e.g., HSAs, FSAs, checking accounts, credit cards) to the healthcare card. Other solutions could help patients plan for and manage healthcare expenses.
- h. Smart Cards and Enhanced Card Capabilities. Insurance providers could easily take advantage of the central role of insurance cards by issuing smart cards, for example, that may contain a patient's

"continuity-of-care" record, an up-to-date electronic version of the patient sign-in sheet, and other enhanced services.

- i. Addresses the Looming Shortage of Family Physicians. The payment and reimbursement nightmare falls especially heavily on generalists and family practice physicians. By eliminating the 15% inefficiency tax, as well as much of the time-sink of dealing with administrative hassles rather than patients, HTS provides much-needed relief in an area of strategic importance to the healthcare of the nation. Most experts agree that as a nation we need to spend more on the prevention of illness. Family physicians and other generalists play an important role, or even the most important role, in prevention but the difficulty of making a good living as a generalist physician is causing a decline in the number of physicians entering the field.

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