The ACA Gives Most Women Free Preventive Benefits; 90% of All Insurance Plans Expected to Comply by 2014

Health care law offers free preventive services to 47 million women.

Forty-seven million women are getting greater control over their health care and access to eight new prevention-related health care services without paying more out of their own pocket beginning Aug. 1, 2012, Health and Human Services (HHS) Secretary Kathleen Sebelius recently announced.

Previously some insurance companies did not cover these preventive services for women at all under their health plans, while some women had to pay deductibles or co-pays for the care they needed to stay healthy. The new rules in the health care law requiring coverage of these services take effect at the next renewal date – on or after Aug. 1, 2012–for **most health insurance plans**. For the first time ever, women will have access to even more life-saving preventive care free of charge.

According to a new HHS report also released today, approximately 47 million women are in health plans that must cover these new preventive services at no charge. Women, not insurance companies, can now make health decisions that will keep them healthy, catch potentially serious conditions at an

earlier state, and protect them and their families from crushing medical bills.

> ***"President Obama is moving our country forward by giving women control over their health care," Secretary Sebelius said. "This law puts women and their doctors, not insurance companies or the government, in charge of health care decisions."***

What services are now covered?

The eight new prevention-related services are:

- Well-woman visits.
- Gestational diabetes screening that helps protect pregnant women from one of the most serious pregnancy-related diseases.
- Domestic and interpersonal violence screening and counseling.
- FDA-approved contraceptive methods, and contraceptive education and counseling.
- Breastfeeding support, supplies, and counseling.
- HPV DNA testing, for women 30 or older.
- Sexually transmitted infections counseling for sexually-active women.
- HIV screening and counseling for sexually-active women.

For women who are pregnant or nursing, the new preventive services include gestational diabetes screening as well as breast-feeding support, counseling and supplies. Health services already provided under the health care law include folic acid supplements for women who may become pregnant, Hepatitis B screening for pregnant women, and anemia screening for pregnant women.

These services are based on recommendations from the Institute

of Medicine, which relied on independent physicians, nurses, scientists, and other experts as well as evidence-based research to develop its recommendations. **These preventive services will be offered without cost sharing beginning August 1, 2012 in all new health plans.**

Who does not have to offer these benefits?

Group health plans and issuers that have maintained grandfathered status are not required to cover these services. In addition, certain nonprofit religious organizations, such as churches and schools, are not required to cover these services. The Obama administration will continue to work with all employers to give them the flexibility and resources they need to implement the health care law in a way that protects women's health while making common-sense accommodations for values like religious liberty.

What is "grandfathered status"?

> *Health plans that existed before the health care reform law have been "grandfathered" in, meaning that they do not need to comply with the ACA coverage requirements until significant changes (e.g. benefit cuts, cost sharing increases, etc. are made to the plan. Grandfathered plans don't have to follow the new preventive services cost sharing rules. All non-grandfathered private health plans have to comply with the new preventive health services coverage and cost-sharing rules.*
>
> ***A recent survey found that 90% of all large U.S. companies expect that their health plans will lose grandfathered status by 2014. – Stephen Miller, Society for Human Resources***

Management, Nine of 10 Big Companies Expect to Lose Grandfathered Status (Aug. 20, 2010),

Eventually all plans will lose their grandfathered status and distinctions between the two types of plans will disappear. At that point, all plans will cover these important preventive health services without cost sharing.

Do religious organizations have to comply with the contraceptive coverage requirements of the ACA?

The Department of Health and Human Services has proposed a rule that would exempt a small segment of religious employers, such as churches, from this contraceptive coverage requirement. This decision is not yet final and in its current form, it would not apply to most religiously-affiliated employers such as religious hospitals, church-affiliated schools and universities, and religiously-affiliated charities. Therefore, most religiously-affiliated employers will have to comply with this law. (Courtesy of the **National Women's Law Center** FAQ on Contraceptive Coverage in the New Health Care Law: Frequently Asked Questions)

The Week of March 5, 2012 in Healthcare: CMS National Provider Call on MU Stage 2, 5010 Issue Update, the Blunt Amendment and More

(5010) Important Update Regarding HIPAA Version 5010/D.0 Implementation (jump to story)

(Affordable Care Act) Statement by HHS Secretary Kathleen Sebelius on the Blunt Amendment (jump to story)

(PECOS) Were You Sent a Request to Revalidate Your Medicare Enrollment? (jump to story)

(MU Stage 2) National Provider Call: Overview and Listening Session: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs (jump to story)

(Resources) MLN Fact Sheets on ESRD, ZPICS and Mass Immunizers/Roster Billing (jump to story)

(FAQs on MU) CMS Has New FAQS on Meaningful Use and Attestation (jump to story)

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Important Update – "HIPAA Version 5010/D.0 Implementation" Document has been Updated

Updates have been made to the recently-posted document titled "Important Update Regarding *HIPAA* Version 5010/D.0

Implementation" – specifically, CMS has modified information related to the Diagnosis Related Group (DRG) code. The document can be found at the top of the *HIPAA* Versions 5010 & D.0 Overview webpage, at http://www.CMS.gov/-versions5010andd0/01_overview.asp.

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Statement by HHS Secretary Kathleen Sebelius on the Blunt Amendment

Earlier this month, the Department of Health and Human Services reported that over 20 million American women in private health insurance plans have already gained access to at least one free preventive service because of the health care law. Without financial barriers like co-pays and deductibles, women are better able to access potentially life-saving services, and cancers are caught earlier, chronic diseases are managed and hospitalizations are prevented.

A proposal being considered in the Senate this week would allow employers that have no religious affiliation to exclude coverage of any health service, no matter how important, in the health plan they offer to their workers. This proposal isn't limited to contraception nor is it limited to any preventive service. Any employer could restrict access to any service they say they object to. This is dangerous and wrong.

The Obama administration believes that decisions about medical care should be made by a woman and her doctor, not a woman and her boss. We encourage the Senate to reject this cynical attempt to roll back decades of progress in women's health.

NOTE: On Thursday, March 1, 2012, the dangerous Blunt Amendment failed to pass the U.S. Senate. The amendment, which would have enabled employers to pick and choose what services

they would cover under insurance on moral grounds, was defeated.

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Were You Sent a Request to Revalidate Your Medicare Enrollment?

Lists of providers sent notices to revalidate their Medicare enrollment may be found on the CMS website at http://www.CMS.gov/MedicareProviderSupEnroll/11_-Revalidations.asp and in the links below. Information on revalidation letters sent in February will be posted in late March.

- Revalidations Mailed September through October 2011
- Revalidations Mailed November through December 2011

CMS is working to make this information available in Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) in mid April.

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National Provider Call: Overview and Listening Session: Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs

Mon Mar 12; 12:30-2pm ET

More than $3.2 billion in Medicare and Medicaid electronic health record (EHR) incentive payments have been made since the program began last year; more than 191,000 eligible

professionals, eligible hospitals, and critical access hospitals are actively registered. On Thu Feb 23, CMS announced a proposed rule for Stage 2 requirements and other changes to the program, which will be published on Wed Mar 7.

This National Provider Call will provide an overview of the proposed rule, so you can learn what you need to know to receive EHR incentive payments. (CMS plans to hold another National Provider Call on program basics for Eligible Professionals on Tue Mar 27; more information about this call will be available soon.)

The CMS proposed rule can be found at http://www.OFR.gov/OFRUpload/OFRData/2012-04443_PI.pdf. For more information on the EHR Incentive Programs, visit http://www.CMS.gov/EHRIncentivePrograms.

Target Audience: Hospitals, Critical Access Hospitals (CAHs), and professionals eligible for the Medicare and/or Medicaid EHR Incentive Programs. For more details:

Eligibility Requirements for Professionals

Eligibility Requirements for Hospitals

Agenda:

- Extension of Stage 1
- Changes to Stage 1 Criteria for Meaningful Use
- Proposed Medicaid policies
- Stage 2 Meaningful Use Overview
- Stage 2 Clinical Quality Measures
- Medicare Payment Adjustments and Exceptions
- Question and Answers about the incentive programs (note that we cannot answer questions on the rule beyond what is proposed)

Registration Information: Registration for this call will be available soon at http://www.eventsvc.com/blhtechnologies.

Presentation: The presentation for this call will be posted at least one day before the call at http://www.CMS.gov/NPC/-Calls.

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MLN Fact Sheets on ESRD, ZPICS and Mass Immunizers/Roster Billing

From the MLN: "Mass Immunizers and Roster Billing" Fact Sheet Available in Hardcopy – The "Mass Immunizers and Roster Billing" fact sheet (ICN 907664) is now available in hardcopy. This fact sheet is designed to provide education on mass immunizers and roster billing, and includes information on simplified billing procedures for the influenza and pneumococcal vaccinations. To place your order for any of Medicare Learning Network® products available in print, visit http://www.CMS.gov/MLNProducts and click on 'MLN Product Ordering Page' under 'Related Links Inside CMS' at the bottom of the webpage.

From the MLN: February 2012 Version of Medicare Learning Network Products Catalog Now Available – The February 2012 version of the MLN Products Catalog is now available. The MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on "Formats Available." The catalog can be found at http://www.CMS.gov/MLNProducts/downloads/-MLNCatalog.pdf.

From the MLN: "Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders" MLN Matters Article Released – MLN Matters Special

Edition Article #SE1210, "Recovery Auditors Findings Resulting from Medical Necessity Reviews of Renal and Urinary Tract Disorders," has been released and is available in downloadable format. This article is designed to provide education on Recovery Audit review findings related to renal and urinary tract disorders, and includes a description of the problems found and guidance on how providers can avoid them in the future.

From the MLN: "The Role of the Zone Program Integrity Contractors, Formerly the Program Safeguard Contractors" MLN Matters Article Revised – MLN Matters Special Edition Article #SE1204, "The Role of the Zone Program Integrity Contractors (ZPICs), Formerly the Program Safeguard Contractors (PSCs)," has been revised is now available in downloadable format. This article is designed to provide education on the roles and responsibilities of Zone Program Integrity Contractors (ZPICs), and includes an overview of the various program integrity functions that ZPICs perform and each of their seven designated zones. The article was revised to change information cited in the table on page 2; all other information remains the same.

From the MLN: "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention" Fact Sheet Available in Hardcopy –

The revised "Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT)" fact sheet (ICN 904084) is designed to provide education on Substance (Other Than Tobacco) Abuse Structured Assessment and Brief Intervention (SBIRT), and includes an early intervention approach that targets those with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment. To order hardcopies of this fact sheet, visit http://www.CMS.gov/MLNProducts and click on the 'MLN Product Ordering Page' under 'Related Links Inside CMS' at the bottom

of the webpage.

From the MLN: "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" Fact Sheet Revised – The "Composite Rate Portion of the End-Stage Renal Disease Prospective Payment System" fact sheet (ICN 006469) has been revised and is now available in downloadable format. It includes information about the End-Stage Renal Disease Prospective Payment System (ESRD PPS) transition, the basic case-mix adjusted composite rate, separately billable items and services, and the ESRD Quality Incentive Program.

From the MLN: "End-Stage Renal Disease Prospective Payment System" Fact Sheet Revised – The "End-Stage Renal Disease Prospective Payment System" fact sheet (ICN 905143) has been revised and is now available in downloadable format. It includes background information, as well as information on transition period, payment rates for adult and pediatric patients, outlier adjustments, transition budget neutrality factor, home dialysis, laboratory services and drugs, beneficiary deductible and coinsurance, and the ESRD Quality Incentive Program.

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CMS Has New FAQS on Meaningful Use and Attestation

CMS has recently added five new FAQs on meaningful use and attestation. Take a minute and review them below:

1. For meaningful use objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that require a provider to test the transfer of data, such as "capability to exchange key clinical information" and testing submission of data to public

health agencies, can the eligible professional (EP), eligible hospital or critical access hospital (CAH) conduct the test from a test environment or test domain of its certified EHR technology in order to satisfy the measures of these objectives? Read the answer.

2. For meaningful use objectives of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs that require a provider to test the transfer of data, such as “capability to exchange key clinical information” and testing submission of data to public health agencies, if multiple eligible professionals (EPs) are using the same certified EHR technology across several physical locations, can a single test serve to meet the measures of these objectives? Read the answer.
3. For the meaningful use objective of “provide summary care record for each transition of care or referral ” for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, should transitions of care between eligible professionals (EPs) within the same practice who share certified EHR technology be included in the numerator or denominator of the measure? Read the answer.
4. For the “Incorporate clinical lab-test results” menu objective of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, how should a provider attest if the numerator displayed by their certified EHR technology is larger than the denominator? Read the answer.
5. How can I change my attestation information after I have attested and/or received an incentive payment under the Medicare Electronic Health Record (EHR) Incentive Program? Read the answer.

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The CMS Bundled Payment Initiative: Providers Can Apply to Participate in a Mini-ACO Initiative

Last week the U.S. Department of Health and Human Services (HHS) announced a new initiative to help improve care for patients while they are in the hospital and after they are discharged. Doctors, hospitals, and other health care providers can now apply to participate in a new program known as the Bundled Payments for Care Improvement initiative (Bundled Payments initiative). Made possible by the Affordable Care Act, it will align payments for services delivered across an episode of care, such as heart bypass or hip replacement, rather than paying for services separately. Bundled payments will give doctors and hospitals new incentives to coordinate care, improve the quality of care and save money for Medicare.

"Patients don't get care from just one person – it takes a team, and this initiative will help ensure the team is working together," said HHS Secretary Kathleen Sebelius. "The Bundled Payments initiative will encourage doctors, nurses and specialists to coordinate care. It is a key part of our efforts to give patients better health, better care, and lower costs.

Payment bundling is the future

In Medicare currently, hospitals, physicians and other clinicians who provide care for beneficiaries bill and are paid separately for their services. This Centers for Medicare

& Medicaid Services (CMS) initiative will bundle care for a package of services patients receive to treat a specific medical condition during a single hospital stay and/or recovery from that stay – this is known as an **episode of care.** By bundling payment across providers for multiple services, providers will have a greater incentive to coordinate and ensure continuity of care across settings, resulting in better care for patients. **Better coordinated care can reduce unnecessary duplication of services, reduce preventable medical errors, help patients heal without harm, and lower costs.**

The Bundled Payments initiative is being launched by the new Center for Medicare and Medicaid Innovation (Innovation Center), which was created by the Affordable Care Act to carry out the critical task of finding new and better ways to provide and pay for health care to a growing population of Medicare and Medicaid beneficiaries.

Four bundled payment models

Released today, the Innovation Center's Request for Applications (RFA) outlines four broad approaches to bundled payments. Providers will have flexibility to determine which episodes of care and which services will be bundled together. By giving providers the flexibility to determine which model of bundled payments works best for them, it will be easier for providers of different sizes and readiness to participate in this initiative.

Three models involve a retrospective bundled payment arrangement, and one model would pay providers prospectively. Through the Bundled Payments initiative, providers have great flexibility in selecting conditions to bundle, developing the health care delivery structure, and determining how payments will be allocated among participating providers.

"This Bundled Payment initiative responds to the overwhelming

calls from the hospital and physician communities for a flexible approach to patient care improvement," said CMS Administrator Donald Berwick, M.D. "All around the country, many of the leading health care institutions have already implemented these kinds of projects and seen positive results."

Cost savings for Medicare and for patients

The Bundled Payments initiative is based on research and previous demonstration projects that suggest this approach has tremendous potential. For example, a Medicare heart bypass surgery bundled payment demonstration saved the program $42.3 million, or roughly 10 percent of expected costs, and saved patients $7.9 million in coinsurance while improving care and lowering hospital mortality.

"From a patient perspective, bundled payments make sense. You want your doctors to collaborate more closely with your physical therapist, your pharmacist and your family caregivers. But that sort of common sense practice is hard to achieve without a payment system that supports coordination over fragmentation and fosters the kinds of relationships we expect our health care providers to have," said Dr. Berwick.

Letter of Intent to participate due in September

Organizations interested in applying to the Bundled Payments for Care Improvement initiative must submit a Letter of Intent (LOI) no later than September 22, 2011 for Model 1 and November 4, 2011 for Models 2, 3, and 4. For more information about the various models and the initiative itself, please see the Bundled Payments for Care Improvement initiative web site **here.**

Resources

Interested parties may obtain answers to specific questions by e-mailing CMS at **BundledPayments@cms.hhs.gov.**

This initiative is part of a broader effort by the Obama Administration to improve health, improve care, and lower costs. A brief summary of other efforts, including those authorized by the Affordable Care Act, can be found **here.**

For more information about the CMS Innovation Center **click here.**

Additional information:

HHS fact sheet

Federal Register Posting

The Affordable Care Act Leaps Into Social Media With Its Own Facebook Fan Page!

Health and Human Services Secretary Kathleen Sebelius today announced the launch of HealthCare.gov on Facebook: http://www.facebook.com/Healthcare.gov.

“HealthCare.gov on Facebook offers Facebook users a new tool to understand and stay informed about the Affordable Care Act,” said Secretary Kathleen Sebelius. “This new page is another resource that people can use to learn about and discuss health care issues that are important to them, their family, or their small business.”

HealthCare.gov on Facebook provides additional resources that allow consumers to take health care into their own hands.

HealthCare.gov on Facebook allows people to:

- Search for insurance coverage using our “Insurance Finder” tool. The tool asks users to fill out two fields with basic information about themselves and the state they live in. Users are then redirected to a page on HealthCare.gov that continues with the insurance finder process based on the information provided.
- Share thoughts and ideas with other members of the HealthCare.gov network.
- Learn more about what the Affordable Care Act means for individuals, families, or small businesses.
- Stay informed with new blog posts and webchats.

To join HealthCare.gov on Facebook visit http://www.facebook.com/Healthcare.gov, and click the “Like” button at the top of the page.

*Text from today’s press release

Sebelius to AHIP “Zero tolerance for misinformation and unjustified rate increases”

Image via Wikipedia

WASHINGTON, DC ”“ U.S. Department of Health and Human Services Secretary Kathleen Sebelius wrote America’s Health Insurance Plans (AHIP), the national association of health insurers, calling on their members to stop using scare tactics and misinformation to falsely blame premium increases for 2011 on the patient protections in the Affordable Care Act. Sebelius noted that the consumer protections and out-of-pocket savings provided for in the Affordable Care Act should result in a minimal impact on premiums for most Americans. Further, she reminded health plans that states have new resources under the Affordable Care Act to crack down on unjustified premium increases.

The text of Sebelius’ letter is below.

Ms. Karen Ignagni
President and Chief Executive Officer
America’s Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Dear Ms. Ignagni:

It has come to my attention that several health insurer carriers are sending letters to their enrollees falsely blaming premium increases for 2011 on the patient protections in the Affordable Care Act. I urge you to inform your members that there will be zero tolerance for this type of misinformation and unjustified rate increases.

The Affordable Care Act includes a number of provisions to provide Americans with access to health coverage that will be there when they need it. These provisions were fully

supported by AHIP and its member companies. Many of the legislation's key protections take effect for plan or policy years beginning on or after September 23, 2010. All plans must comply with provisions such as no lifetime limits, no rescissions except in cases of fraud or intentional misrepresentation of material fact, and coverage of most adult children up to age 26. New plans must comply with additional provisions, such as coverage of preventive services with no cost sharing, access to OB / GYNs without referrals, restrictions on annual limits on coverage, a prohibition on pre-existing condition exclusions of children (which applies to all group health plans), access to out-of-network emergency room services, and a strengthened appeals process. And health plans that cover early retirees could qualify for reinsurance to sustain that coverage for businesses, workers, and retirees alike.

According to our analysis and those of some industry and academic experts, any potential premium impact from the new consumer protections and increased quality provisions under the Affordable Care Act will be minimal. We estimate that that the effect will be no more than one to two percent. This is consistent with estimates from the Urban Institute (1 to 2 percent) and Mercer consultants (2.3 percent) as well as some insurers' estimates. Pennsylvania's Highmark, for example, estimates the effect of the legislation on premiums from 1.14 to 2 percent. Moreover, the trends in health costs, independent of the legislation, have slowed. Employers' premiums for family coverage increased by only 3 percent in 2010 "" a significant drop from previous years.

Any premium increases will be moderated by out-of-pocket savings resulting from the law. These savings include a r**eduction in the "hidden tax" on insured Americans** that subsidizes care for the uninsured. By making sure insurance covers people who are most at risk, there will be less uncompensated care, and, as a result, the amount of cost

shifting to those who have coverage today will be reduced by up to $1 billion in 2013. By making sure that high-risk individuals have insurance and emphasizing health care that prevents illnesses from becoming serious, long-term health problems, the law will also reduce the cost of avoidable hospitalizations. Prioritizing prevention without cost sharing could also result in significant savings: from lowering people's out-of-pocket spending to lowering costs due to conditions like obesity, and to increasing worker productivity "" today, increased sickness and lack of coverage security reduce economic output by $260 billion per year.

Given the importance of the new protections and the facts about their impact on costs, I ask for your help in stopping misinformation and scare tactics about the Affordable Care Act. Moreover, I want AHIP's members to be put on notice: the Administration, in partnership with states, will not tolerate unjustified rate hikes in the name of consumer protections.

Already, my Department has provided 46 states with resources to strengthen the review and transparency of proposed premiums. Later this fall, we will issue a regulation that will require state or federal review of all potentially unreasonable rate increases filed by health insurers, with the justification for increases posted publicly for consumers and employers. We will also keep track of insurers with a record of unjustified rate increases: those plans may be excluded from health insurance Exchanges in 2014. Simply stated, we will not stand idly by as insurers blame their premium hikes and increased profits on the requirement that they provide consumers with basic protections.

Americans want affordable and reliable health insurance, and it is our job to make it happen. We worked hard to change the system to help consumers. It is my hope we can work together to stop misinformation and misleading marketing from the start.

Sincerely,

Kathleen Sebelius

And We're Off! Meaningful Use Notes from the CMS & ONC Press Briefing July 13, 2010

I was fortunate enough to be listening by phone to the historic (yes, historic) announcement of the final meaningful use rules by **Kathleen Sebelius**, Secretary HHS; **Don Berwick**, MD, new CMS Administrator; **David Blumenthal**, MD, national coordinator for health information technology at HHS; **Regina Benjamin**, MD, Surgeon General and a surprise speaker, **Regina Holliday**, artist and activist for patient rights.


Image via Wikipedia

The memorable quotes I wrote down were:

Kathleen Sebelius: *"When electronic health records are well-designed and implemented correctly, they can be a powerful force for reducing errors, lowering costs, raising quality of care, and increasing doctor and patient satisfaction."* That is the best one-sentence description of "Why EHR?" I've ever heard.

***Don Berwick**: "If it's (EHR) so good, why doesn't everyone use it? Because it's **HARD**."* There is a little slice of honesty that you won't get from most EHR vendors.

***David Blumenthal**: "We are only as good in treating patients as the information we have."* Wow, an admission that could rock the medical world if we stopped and thought about it.

***Regina Holliday:** "I will not stop until we all have the right see our own information."* Regina's Medical Advocacy Blog is **here.** Her lauded mural **"73 Cents"** refers to how much per page she was told by the hospital medical records department she would have to pay to get a copy of her husband's records while he was still in that hospital.

The Meat: Specifics of Stage 1 Meaningful Use (2011 and 2012)

Meaningful use includes both a core set and a menu set of objectives that are specific for eligible professionals and hospitals.

For Eligible Professionals (**definition here**), there are a total of 25 available meaningful use objectives. 20 of the objectives must be completed to qualify for an incentive payment. 15 are core objectives that are required, and the remaining 5 objectives may be chosen from the list of 10 menu set objectives.

For Hospitals, there are a total of 24 available meaningful use objectives. 14 are core objectives that are required, and the remaining 5 objectives may be chosen from the list of 10 menu set objectives.

Stage 1 (2011 – 2012) sets the baseline for electronic data capture and information sharing.

Stage 2 (est. 2013) and Stage 3 (est. 2015) will continue to

expand on this baseline and be developed through future rule making.

Summary Overview Of Meaningful Use Objectives

(full article from New England Journal of Medicine **here)**

As I am sure you expect, there will be much more information to come.