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Preparing Your Practice for the Implementation of Health Information Technology

Regional Osteopathic Medical Education Conference

August 18, 2011

Legislative & Regulatory History of Health Information Technology

- 2004 Bush Administration Executive Order
  - Created Office of the National Coordinator of Health Information Technology
  - Set goal of interoperable health care system
  - Required Federal health care agencies to lead on HIT
- Deficit Reduction Act of 2007 and Medicare Improvements for Patients and Providers Act of 2008
  - Electronic Prescribing
- American Recovery & Reinvestment Act of 2009 (Stimulus)

American Recovery & Reinvestment Act of 2009

- February 13, 2009
  - Approved by the House of Representatives 246-183
    - All Republicans and 7 Democrats voted no
  - Approved by the United States Senate 60-38
    - 3 Republicans voted yes (Collins, Snowe, Specter)
- February 17, 2009
  - President Barrack Obama signs bill into law (Public Law 111-5)
- January 13, 2010
  - Electronic Health Record (EHR) Incentive Notice of Proposed Rulemaking (NPRM) published
  - Comment period closed March 15, 2010
  - AOA submitted extensive comments

ARRA Funding and Requirements

- The "American Recovery and Reinvestment Act of 2009" (ARRA) provides $19 billion over a specified five-year period to assist physicians in purchasing and implementing health information technology systems.
  - $17 billion in provider incentives
  - $2 billion to fund the Office of the National Coordinator for Health Information Technology (ONCHIT)
- Development of uniform electronic standards that allow various HIT systems to communicate with each other.
  - Secretary of the Department of Health and Human Services (HHS) required to develop such standards by December 31, 2009.

Health Information Technology

- Defined as hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use of healthcare entities or patients for electronic creation, maintenance, access, or exchange of health information.

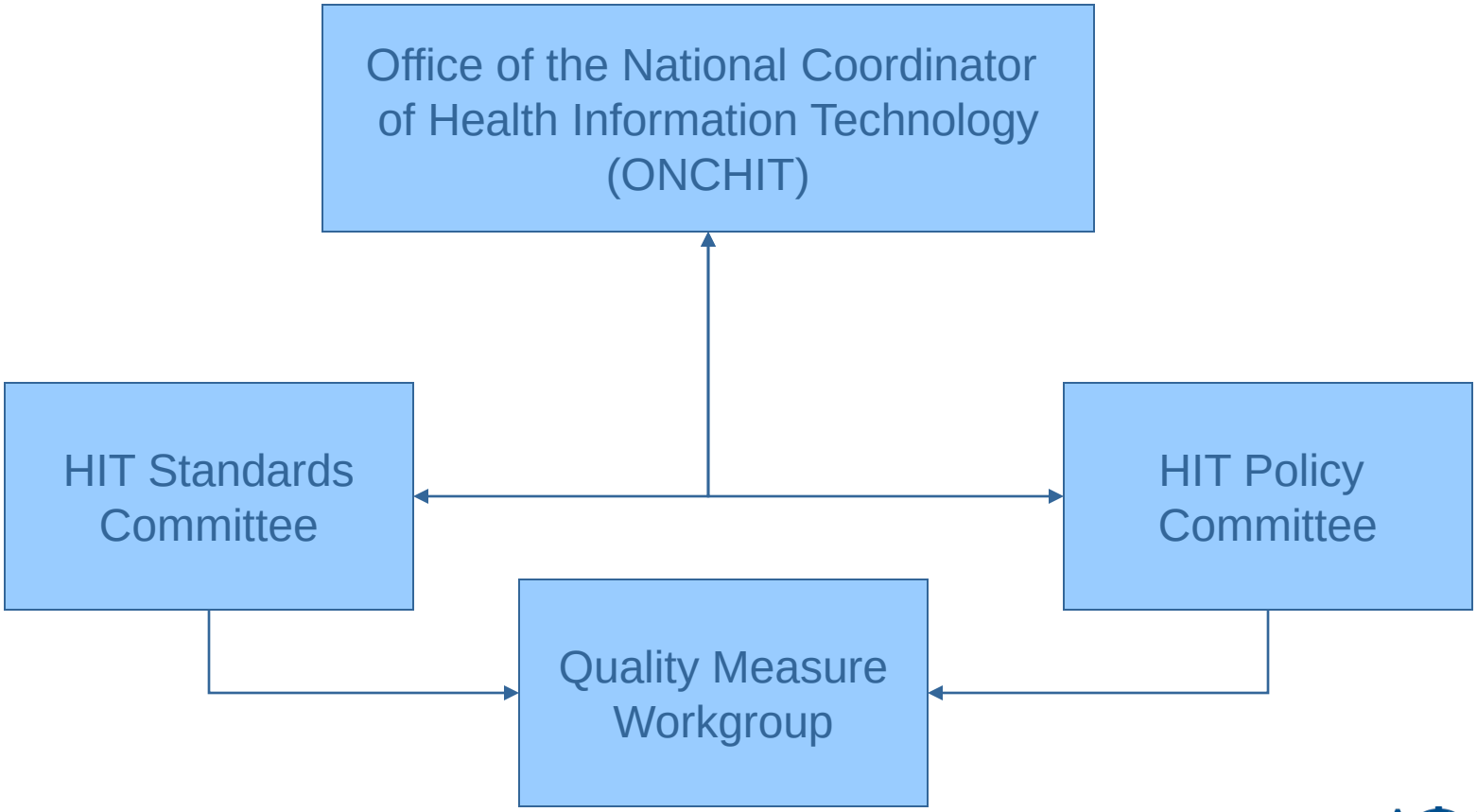
Certified EHR Technology

- A qualified electronic health record meeting standards adopted under section 3004 of ARRA that are applicable to the type of record involved (ambulatory electronic health record for office-based physicians or an inpatient electronic health record for hospitals.

Qualified Electronic Health Record

- An electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists.
- A qualified EHR must have the capacity to:
  - To provide clinical decision support
  - To support physician order entry
  - To capture and query information relevant to healthcare quality
  - To exchange electronic health information with and integrate such information from other sources.

Regulatory Structure Established by ARRA



Regulatory Structure

- Office of the National Coordinator of Health Information Technology (ONCHIT)
  - Created by Executive Order in 2004
- Chief Privacy Officer Of The National Coordinator
- HIT Standards Committee
- HIT Policy Committee
- HIT Quality Measures Committee

Office of the National Coordinator of Health Information Technology

- ARRA statutorily authorizes the Office of the National Coordinator for Health IT (ONCHIT) and defines the purpose of the office with regard to the development of a national health information technology infrastructure that allows electronic exchange and use of information.

Mission of ONCHIT

- Ensure that each patient's health information is secure and protected, in accordance with applicable law
- Improve healthcare quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care
- Reduce healthcare costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information
- Provide appropriate information to help guide medical decisions at the time and place of care
- Ensure the inclusion of meaningful public input in such development of such infrastructure
- Improve the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of healthcare information
- Improve public health activities and facilitates the early identification and rapid response to public health threats and emergencies, including bioterror events and infectious disease outbreaks
- Facilitate health and clinical research and healthcare quality
- Promote early detection, prevention, and management of chronic diseases.
- Improve efforts to improve health disparities

HIT Standards Committee

- Secretary of HHS required to establish interoperability standards by December 31, 2009
- Chaired by the National Coordinator
- Members represent providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies and individuals with technical expertise on healthcare quality, privacy and security, and on the electronic exchange of health information.
- Ensure involvement of outside experts and advisors

EHR Certification

- Certification Commission for Healthcare Information Technology, CCHIT, is one certification body. CCHIT certification requirements include EHR suitability, quality, interoperability and data portability, and security.

- List of CCHIT certified EHR products:

  - CCHIT Certified 08 Ambulatory EHR
    http://www.cchit.org/choose/ambulatory/08/index.asp

  - CCHIT Certified Inpatient EHR 2007
    http://www.cchit.org/choose/inpatient/2007/index.asp

- CCHIT certified EHR technology has not been named the official certification body for EHRs. Other EHR certification organizations may be involved

HIT Policy Committee

- HHS Secretary required to establish definition of "meaningful use" by December 31, 2009
- Electronic Health Record (EHR) Incentive Program Notice of Proposed Rulemaking (NPRM) published January 13, 2010
  - Comment period closed March 15, 2010
  - AOA submitted extensive comments on the proposed rule

The Cost of EHR Implementation

- In May 2008 the Congressional Budget Office cited studies that the total costs for office-based EMRs range from $25,000 to $45,000 per physician, with annual operating costs ranging from $3,000 to $9,000 per physician a year. Indirect costs may result from reduction of productivity while the system is established and staff members are trained.
- The installation process may take up to a year to get all the features fully functioning and to adapt workflow
- EMRs may or may not be interoperable
- Most studies indicate a positive ROI from the use of EMRs over time

Source: "Evidence on the Cost and Benefits of Health Information Technology" Congressional Budget Office (May 2008)

Incentives for Physician Adoption of Health Information Technology

- Physicians (non-hospital based) are eligible for Medicare incentive payments based on an amount equal to 75% of the allowed Medicare Part B charges, up to a maximum of $18,000 for early adopters whose first payment year is 2011 or 2012.
- The Secretary of HHS will define the reporting period(s) with respect to a payment year.
- Incentive payments would be reduced in subsequent payment years, eventually phasing out in 2016. Physicians who do not adopt/use an EHR system before 2015 will face a reduction in their Medicare fee schedule beginning in 2015.
- The Secretary of HHS has the authority to make exceptions to this reduction on a case-by-case basis for physicians who demonstrate significant hardship

Incentives for Physicians

- If adoption begins in 2011 or 2012 the physician is eligible for $44,000 maximum incentive
- If adoption begins after 2013 the physician is eligible for a maximum of $39,000
- Eligible professionals in a designated health professional shortage area will receive a 10% increase in the bonus.
- No incentive payment for hospital-based eligible physicians.
  - Hospital-based eligible physicians include pathologists, anesthesiologists, or emergency physicians, who furnish substantially all of such services in a hospital setting.

Who Is Eligible for Medicare Bonus Payments

- Medicare Fee-For-Service
  - Eligible Professionals
  - Eligible Hospitals
  - Eligible Critical Access Hospitals
- Medicare Advantage
  - Medicare Advantage Eligible Professionals
  - Medicare Advantage Affiliated Eligible Hospitals
- Medicaid
  - Eligible Professionals
  - Eligible Hospitals

Medicare Eligible Provider

- Doctor of Medicine
- Doctor of Osteopathic Medicine
- Doctor of Dental Surgery
- Doctor of Dental Medicine
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Chiropractor
- Acute Care Hospitals
- Critical Access Hospitals

Medicare Advantage Eligible Provider

- Medicare Advantage Eligible Professional
  - Must furnish, on average, at least 20 hours per week of patient-care services and be employed by the qualifying Medicare Advantage organization
  - Or
  - Must be employed by, or be a partner of, an entity that through contract with the qualifying Medicare Advantage organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of the qualifying Medicare Advantage organization
- Medicare Advantage Affiliated Eligible Hospitals
  - Will be paid under the Medicare Fee-for-Service incentive program

Hospital Based Eligible Professionals

- Any Eligible Professional that furnishes 90% or more of their services in a hospital setting
  - Inpatient, Outpatient, Emergency Room
- Hospital based Eligible Professionals do not qualify for Medicare incentive payments
- Most hospital based Eligible Professionals will not qualify for Medicaid incentive payments

HIT Financial Incentives for Physicians - Medicare

Year	Incentives	Penalties for Non-Compliance
2011	$18,000, $12,000, $8,000, $4,000, $2,000	$0
2012	$18,000, $12,000, $8,000, $4,000, $2,000	$0
2013	$15,000, $12,000, $8,000, $4,000	$0
2014	$12,000, $8,000, $4,000	$0
2015	$0	-1% in Medicare Fee Schedule
2016	$0	-2% in Medicare Fee Schedule
2017 & beyond	$0	-3% in Medicare Fee Schedule

Medicare Physician EHR Incentives

	2011	2012	2013	2014	2015	2016	2017	TOTAL
Adopt 2011	$18,000	$12,000	$8,000	$4,000	$2,000	$0	$0	*$44,000*
Adopt 2012	----------	$18,000	$12,000	$8,000	$4,000	$2,000	$0	*$44,000*
Adopt 2013	----------	----------	$15,000	$12,000	$8,000	$4,000	$0	*$39,000*
Adopt 2014	----------	----------	----------	$12,000	$8,000	$4,000	$0	*$24,000*
Adopt 2015 +	----------	----------	----------	----------	$0	$0	$0	*$0*

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Additional Medicare Incentives for Physicians Practicing in HPSAs

	2011	2012	2013	2014	2015	2016	TOTAL
Adopt 2011	$1,800	$1,200	$800	$400	$200		*$4,400*
Adopt 2012		$1,800	$1,200	$800	$400	$200	*$4,400*
Adopt 2013			$1,500	$1,200	$800	$400	*$3,900*
Adopt 2014				$1,200	$800	$400	*$2,400*

Medicaid Financial Incentives

- Incentives will start in 2011
  - Up to $63,750
- No Medicaid payment reductions if a provider does not adopt certified EHR technology
- To be eligible for Medicaid providers are required to waive Medicare EHR incentive payments
- Incentives for up to 85% of costs for EHR
  - Caps: 1st year payment at $21,250
  - Caps: following years at $8,500/year
    - 1st yr cost no later than 2016
    - No payments made after 2021 or more than 5 years

Medicaid Eligible Provider

- Doctors of Medicine & Doctors of Osteopathic Medicine
  - Pediatricians have special eligibility and payment rules
- Nurse Practitioners
- Certified Nurse Midwives
- Dentists
- Physician Assistants
  - Must lead a Federally Qualified Health Center or Rural Health Clinic
- Eligible Hospitals
  - Acute Care
  - Children's Hospital

Medicaid Eligibility – Patient Volume

Eligible Professional	Minimum Medicaid Patient Volume
Physicians	30%
Pediatricians	20%
Dentists	30%
Nurse Practitioners	30%
Certified Nurse Midwives	30%
Physician Assistants	30%
Acute Care Hospitals	10%
Children's Hospital	No requirement

HIT Financial Incentives for Physicians - Medicaid

Year	Incentives	Penalties for Non-Compliance
2011	$21, 250, $8,500, $8,500, $8,500, $8,500, $8,500	$0
2012	$21, 250, $8,500, $8,500, $8,500, $8,500, $8,500	$0
2013	$21, 250, $8,500, $8,500, $8,500, $8,500, $8,500	$0
2014	$21, 250, $8,500, $8,500, $8,500, $8,500, $8,500	$0
2015	$21, 250, $8,500, $8,500, $8,500, $8,500, $8,500	$0
2016	$21, 250, $8,500, $8,500, $8,500, $8,500, $8,500	$0
2017 & beyond	$0	$0

Medicaid Physician EHR Incentives

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	TOTAL
Adopt 2011	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0					*$63,750*
Adopt 2012		$21,250	$8,500	$8,500	$8,500	$8,500	$8,500					*$63,750*
Adopt 2013			$21,250	$8,500	$8,500	$8,500	$8,500	$8,500				*$63,750*
Adopt 2014				$21,250	$8,500	$8,500	$8,500	$8,500	$8,500			*$63,750*
Adopt 2015					$21,250	$8,500	$8,500	$8,500	$8,500	$8,500		*$63,750*
Adopt 2016						$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	*$63,750*

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Differences Between Medicare and Medicaid EHR Incentive Programs

MEDICARE	MEDICAID
Implemented by HHS	Voluntary for states – not all states will participate
Fee schedule reductions begin in 2015	No Medicaid fee schedule reductions
Must be a meaningful user in year 1	Adopt, implement, upgrade option for year 1 eligibility
Maximum incentive is $44,000 for Eligible Professionals	Maximum incentive is $63,750 for Eligible Professionals
Meaningful Use definition will be common for Medicare	States can adopt more rigorous definition of Meaningful Use for Eligible Professional
Medicare Advantage Eligible Professionals will have special accommodations	Medicaid managed care must meet regular eligibility requirements
Last year and Eligible Professional may initiate program is 2014 – Last payment in program is 2016	Last year and Eligible Professional may initiate program is 2016 – Last payment in program is 2021
Only physicians, hospitals, and CAHs are eligible	5 eligible classes – 3 classifications of hospitals

Incentives for Hospitals

- If inpatient hospital services are furnished by an eligible hospital and the hospital is an eligible EHR user, they are eligible for incentive payments from the Medicare trust fund.
  - Discharge Related Amount
  - A hospital that has less than 1150 inpatient discharges for a year will receive $2 million
  - A hospital with 1150 – 23,000 inpatient discharges gets a $200 per discharge payment in addition to the base amount
- Hospitals need to implement meaningful EHR before 2015 to avoid penalties
- Meaningful Use for Hospitals is defined as:
  - EHR technology is connected in a manner that provides for the the electronic exchange of health information to improve quality of health care, such as the promotion of care coordination.
  - Reporting on quality measures using EHR

Medicare Hospital Incentives

Incentive Payments for a Typical 500-Bed Hospital with an Average Occupancy Rate of 85% ($)

Payment Component	Incentive per Unit	Year 1 (100%)	Year 2 (75%)	Year 3 (50%)	Year 4 (25%)	Cumulative Total
Base payment, year 1 only	2,000,000	2,000,000				**2,000,000**
Bonus per discharge: from 1,150(minimum to 23,000(maximum) discharges	200	4,370,000	3,227,500	2,185,000	1,092,500	**10,925,000**
Total		6,370,000	3,227,500	2,185,000	1,092,500	**12,925,000**

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Medicare Hospital Penalties

Starting in FY 2015, if an eligible hospital is not a meaningful EHR user than the applicable Market Basket Adjustment percentage shall be reduced

First Payment Year	Reduction in Medicare Fee Schedule for non-adoption
FY 2011	0
FY 2012	0
FY 2013	0
FY 2014	0
FY 2015	-33.33%
FY 2016	-66.66%
2017 and thereafter	-100%

Source: HIMMS The American Recovery and Reinvestment Act of 2009
http://www.himss.org/ASP/index.asp

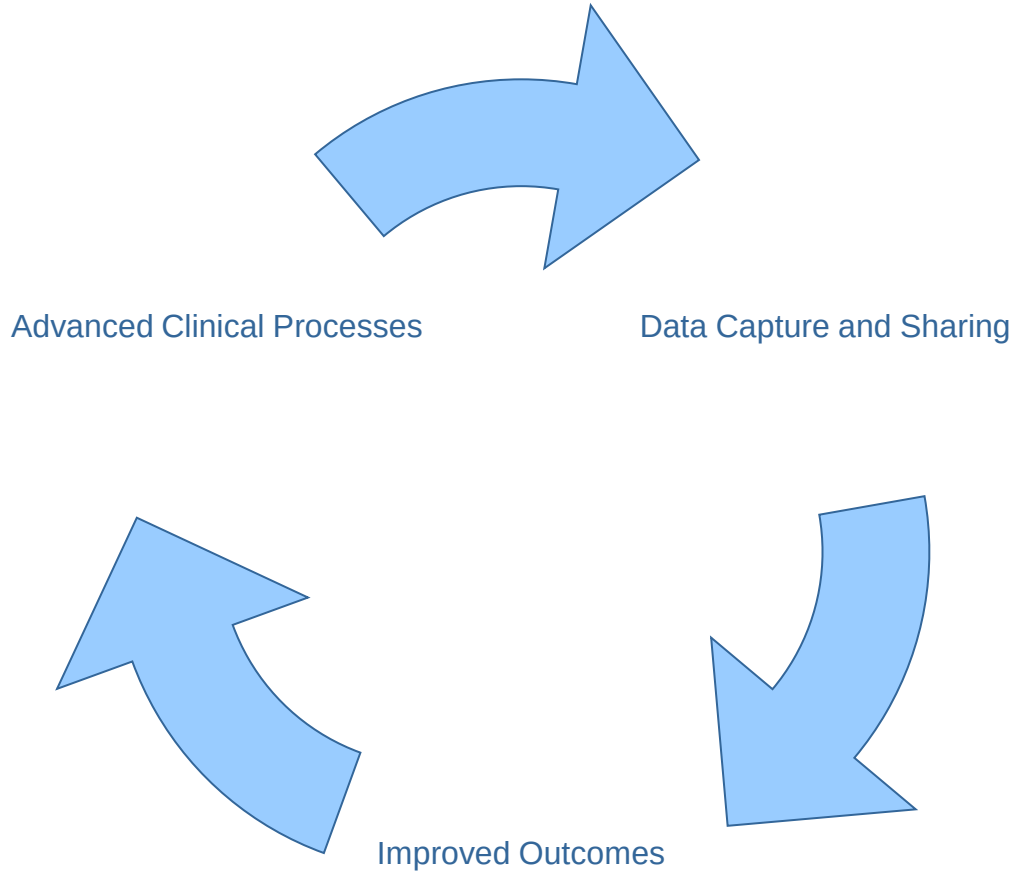
Integration of Health Information Technology into Clinical Education

- The Secretary of HHS is authorized to award grants for the development of academic curricula for the integration of certified EHR technology into clinical education. Awards will be made on a competitive basis.
  - Eligibility requires an application and a submission of a strategic plan to the Secretary
  - Eligible entities will include medical schools, colleges of osteopathic medicine
  - Recipients must collect data on the effectiveness of EHR in improving patient safety, healthcare delivery efficiency

What Is Meaningful Use

- Use of a certified EHR in a meaningful manner
  - Electronic prescribing
  - Patient registry
- Use of a certified EHR for the electronic exchange of health information to improve the quality of health care
- Use of a certified EHR to submit clinical quality and other measures
- 3 Stages of Meaningful Use
  - Stage 1 – Defined in January 2010 NPRM
  - State 2 – Defined in future rulemaking
  - Stage 3 – Defined in future rulemaking

Goals of Meaningful Use



Meaningful Use – Stage 1

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and families in their health care
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

Meaningful Use Criteria

- 25 Health IT Functionality Criteria
  - CPOE
  - Record demographic information
  - Electronic submission of claims
  - E Prescribing
  - Medication Management/Allergy List/Drug Interactions
  - Provide patient with electronic copy of health information
  - Clinical decision support
  - Submit reportable lab results to public health agencies
- Quality Reporting
  - 3 core and 3 to 5 specialty specific quality measures
- Reporting Period
  - 90 days for year 1 and one year subsequently

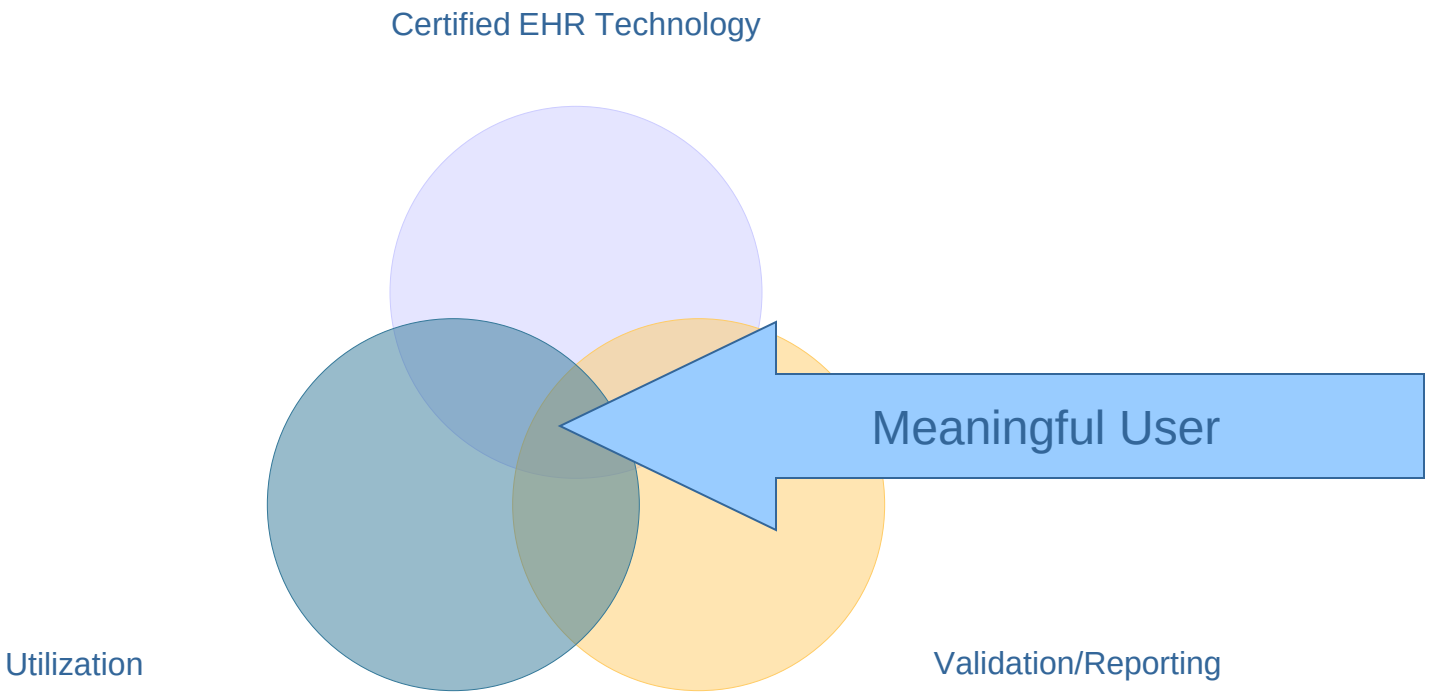
Core Quality Measures

- Preventive care and screening
- Blood pressure management
- Drug Interactions among the elderly

Specialty Quality Measures

- Eligible Professionals will be required to select one of the following specialties
  - Cardiology
  - Pulmonology
  - Endocrinology
  - Oncology
  - Proceduralist/Surgery
  - Primary Care
  - Pediatrics
  - Nephrology
  - Obstetrics/Gynecology
  - Neurology
  - Psychiatry
  - Ophthalmology
  - Podiatry
  - Radiology
  - Gastroenterology

To Achieve Meaningful Use



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Key Dates

	MEDICARE		MEDICAID	
	Physicians	Hospitals	Physicians	Hospitals
Incentive start	Calendar yr 2011	FY 2011	2011	2011
Incentive End	Calendar yr 2016	FY 2015	2016	2021
Incentive Amount	up to $44,000	$2 million base	Up to $63,750	
Reduction	CY 2015	FY 2015	No penalty	

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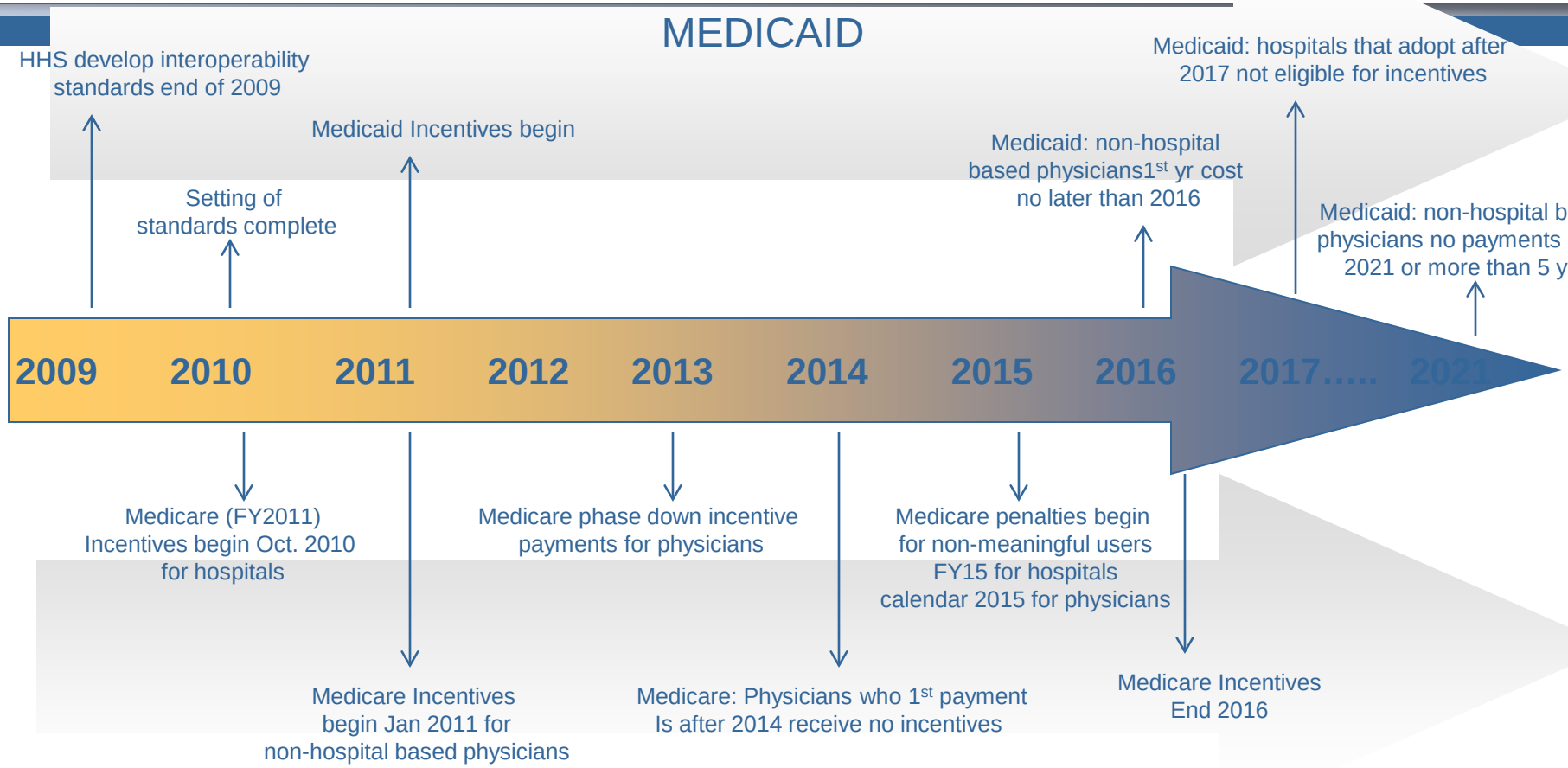
Medicare and Medicaid Timeline



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Participation in HITECH and Other Medicare Incentive Programs

Other Medicare Incentive Program	Eligible for HITECH?
Physician Quality Reporting Initiative	Yes
Medicare Electronic Health Records Demonstration	Yes, if the Eligible Professional is eligible
Medicare Care management Performance Demonstration	Yes, if the practice is eligible. The MCMP ends prior to implementation of the EHR incentives
Electronic Prescribing Incentive Program	If the Eligible Professional chooses to participate in the Medicare EHR incentive program they cannot participate in the Medicare eRx Incentive Program simultaneously. If the Eligible Professional chooses to participate in the Medicaid EHR incentive program they can participate in the Medicare eRx Incentive Program simultaneously.

HIT Resources

- www.cms.gov
- www.do-online.gov
- www.himss.org
- www.ahima.org

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