



Tomorrow's Doctors, Tomorrow's Cures

# ARRA & HIT: What Do They Mean to You?

## An Update on the EHR Incentives

**July 14, 2009**

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# Today's Goals

- Discuss the timeline for future rulemaking and other activities
- Explain the ARRA Medicare and Medicaid incentives for EHR adoption for hospitals and physicians
- Discuss what we know about meaningful use
- Take questions; try to provide some answers

# From David Blumenthal

- The incentives are not just about the placement of machines, they are “a down payment on health system improvement”
- EHRs are part of a larger health care reform agenda that has as its goals outcome and performance improvement
- Between the enactment of the legislation and the publication of final rules there will be a “period of uncertainty”
- July 9, 2009; discussion with the AAMC’s Advisory Panel on Health Care

# A Few Key Terms:

- **EHR (Electronic Health Record)**
  - **vs. EMR (Electronic Medical Record)**
    - **vs. PHR (Personal Health Record)**
- **CPOE (Computerized Physician Order Entry)**
- **“Decision Support”**

# A Few Key Organizations:

- **ONC** (Office of the National Coordinator of Health Information Technology; formerly known as ONCHIT)
  - **David Blumenthal** (National Coordinator)
  - **HIT Policy Committee & HIT Standards Committee**
- **NCVHS** (National Committee on Vital and Health Statistics)
- **CCHIT** (Certification Commission for Healthcare Information Technology)

# What is the Regulatory Timeline?

July 16 & August 14: Next HIT Policy Committee Meetings

July 21 & August 20: Next HIT Standards Committee Meetings

December 31: Deadline for HHS to publish rule (likely interim final) adopting an initial set of standards, implementation specifications, and certification criteria

# Regulatory Timeline (con't)

**“Late 2009”**: CMS planning to publish proposed rule with 60-day comment period regarding Medicare/Medicaid incentive payments

**“Sometime in 2010”**: CMS planning to publish final rule regarding incentive payments

# Regulatory Timeline (con't)

**October 2010**: Earliest CMS will start paying Medicare incentives to hospitals

**January 2011**: Earliest CMS will start paying Medicaid incentives to hospitals and Medicare and Medicaid incentives to physicians

**2015**: Medicare penalties begin for hospitals and “eligible professionals” failing to meet definition of “meaningful use”

# Some Things We Still Don't Know About the Rulemaking Process:

ONC vs. CMS – which details decided by whom?

When will CMS issue a proposed rule? ... a final rule?

# Where Are We with EHR Use Right Now?

## Hospitals:

- < 2% have fully implemented comprehensive EHRs in all units
- < 8% have basic EHRs
- <17% have CPOE fully implemented
- 75% have electronic lab/image reports

*(Source: Blumenthal, NEJM, April 16, 2009)*

# Where Are We with EHR Use Right Now?

## Ambulatory Settings:

- 4% of physicians have fully-functional EHR
- 13% have basic EHRs
- 16% purchased but not implemented
- 26% plan to purchase within 2 years

*(Source: Blumenthal, NEJM, June 18, 2008)*

# \$20 Billion in Incentives

## Physicians

- Medicare or Medicaid or E-prescribing
- Incentives for max of 5 years
- CBO estimates 2009-2019:
  - Bonuses: \$15.2 b
  - Penalties: \$1.3 b

## Hospitals

- Medicare and Medicaid
- Incentives for max of 4 years
- CBO estimates 2009-2019:
  - Bonuses: \$8.7 b
  - Penalties: \$2.6 b

# Where's the money? (EPs)

- Medicare maximum (for early adopters; 2011-2012): \$44,000
  - \$18,000; \$12,000; \$8,000; \$4,000; \$2,000
  - 10% increase if in health professional shortage area
- Amount is a cap--75% of allowed charges for all covered services furnished by the EP during the year

# Where's the money? (EPs, con't)

- Medicaid maximum: \$63,750
- E-prescribing bonus (MIPAA, not ARRA):
  - 2010: 2% Part B allowable charges
  - 2011: 1% Part B allowable charges
  - 2012: 0.5% Part B allowable charges

# What's a physician to do?

If receiving an EHR incentive is the goal, become an eligible professional who is a meaningful user

If that is not the goal, be aware that penalties for not being a meaningful user begin in 2015

# Who's an eligible professional?

## Medicare

- A physician (medicine or osteopathy)
- Dentist
- Podiatrist
- Optometrist
- Chiropractor

## Medicaid

- Physician
- Dentist
- Certified nurse mid-wife
- Nurse practitioner
- Physician assistant in rural health clinic or FQHC

# Meaningful User; EPs/Medicare

- The floor:
  - Using EHR technology in a meaningful manner, including e-prescribing
  - Exchanging health information electronically to improve quality of care
  - Reporting on clinical quality measures
- Measures of meaningful use are to be more stringent over time

# Group Practices

- ARRA provides alternative for group practices to be meaningful users
- First step may be defining a group practice
  - PFS '10 proposed definition:
    - Defined by Tax Identification Number (TIN)
    - 200 or more eligible professionals who have reassigned their billing rights to the TIN
- More to come

# Who's ineligible for incentives?

Hospital-based professionals (pathologist, anesthesiologist, emergency physician)

- Generally expected to use EHR system of the hospital
- Not disqualified merely on the basis of some association or business relationship with the hospital

# Hospital-based: Take 2

- Test will be based on the setting
  - Common examples: professional employed by a hospital to work in an ambulatory care clinic
  - Physician submits claims together with hospital or other entities
- The good news: no payment reductions for hospital-based professionals who are not meaningful users
- Want clarity? Look for rulemaking

# Hospital-Based: Take 3

Letter from Reps. Eshoo and Speir to Sec. Sebelius:

“We are concerned that this provision will also exclude physicians who are practicing in ambulatory clinics owned by hospitals. We believe the Conference Report is clear when it states that the legislation does not disqualify otherwise eligible professionals merely on the basis of some association or business relationship with a hospital [such as] professionals who are employed by a hospital to work in an ambulatory care clinic . . . .”

July 7, 2009

# More on MU: Quality Measures

Selection of quality measures:

- Look to proposed PFS '10: preference for measures endorsed by an entity with a contract with the Secretary: NQF

# Proposed PFS 2010

“PQRI could potentially provide invaluable experience and serve as a foundation for establishing the capacity for eligible professionals to send, and for CMS to receive, data on quality measures via EHRs.”

74 *FedReg* 33561, July 13, 2009

# Suppose MU has been achieved

- How is the money paid?
  - Consolidated payment or periodic installments
  - Rules to be promulgated to coordinate incentives for an eligible professional furnishing services in more than one practice; cannot be paid more than the capped amount for any payment year

# How will the government know you've achieved MU?

- Attestation
- Submission of claims with appropriate coding
- Survey response
- Reporting
- Other

# What happens 2015 and after?

- Fee schedule reductions for EPs who do not achieve meaningful use:
  - 2015: 1%
  - 2016: 2%
  - 2017 and after: 3%
  - 2018 and after: if less than 75% of eligible professionals are meaningful users, further reductions possible, but not be less than 95%
    - Significant hardship on case-by-case basis if practice in rural area without sufficient internet access

# Other details

Website posting of individuals and groups receiving incentive payments

# Medicaid Incentives: Eligibility

- Not hospital-based and at least 30% of patient volume attributable to Medicaid beneficiaries
- A pediatrician who is not hospital-based and has at least 20% of patient volume attributable to Medicaid beneficiaries
- Practices predominantly in a FQHC or rural health clinical and has at least 30% patient volume attributable to “needy individuals”

# Medicaid MU

- 1<sup>st</sup> year: demonstrate that are engaged in efforts to adopt, implement, or upgrade certified EHR technology
- Subsequent years: demonstrate meaningful use through a means approved by the state and HHS

# Gaps Identified by NCVHS

- Clarification in definition of what constitutes an “exchange”
- Identifying selected group of functional capabilities that are key to establishing meaningful use
- For clinical decision support: definition of pathway, metrics for reporting and specific goals to be achieved
- Information on hospital capacity and quality reporting using certified EHR technology

# Gaps (con't)

- Information about availability and usability of PHRs for the underserved
- Should there be multiple options for quality reporting or only one; which quality measure are key
- Guidance on how compliance with privacy and security requirements could be measured, especially for HIE
- Specifics on how meaningful use can contribute to public health's responsibility for assuring accountability of the health care system and improving population health

# Medicare Payments to Hospitals

## Key Points:

- Hospitals are eligible for both Medicare and Medicaid incentives (because based on inpatient discharges)
- Must be an “eligible hospital”
- Must use “certified” EHR technology
- Status as “meaningful user” will be posted on internet

# Medicare Payments to Hospitals

What is the payment formula?

$$[(\text{Base amount} + \text{Discharge related amount}) \times \text{Medicare share}] \times \text{Transition factor}$$

# Medicare Payments to Hospitals

## Medicare payments to hospitals *(continued)*

### Base Amount:

\$2 million

### Discharge Related Amount:

\$200 for each hospital discharge between 1,150<sup>th</sup> and 23,000<sup>th</sup> discharge within 12 month period

# Medicare Payments to Hospitals

## Medicare payments to hospitals *(continued)*

### Medicare Share:

- Numerator: total Parts A and C inpatient days
- Dominator: total inpatient days adjusted to exclude any charges attributable to charity care
- Note: if no data available on charity care, uncompensated care will be used as proxy and adjusted downward to eliminate bad debt data.

# Medicare Payments to Hospitals

## Transition Factor

First payment year: 100%

Second payment year: 75%

Third payment year: 50%

Fourth payment year: 25%

Any succeeding payment year: 0

If a hospital adopts an EHR after 2015, the transition factor is 0.

# Medicare Payments to Hospitals

## What are the payment penalties?

75% of inpatient payment update at risk.

- 2015: 1/3 reduction (i.e. 25% of update)
- 2016: 2/3 reduction (i.e. 50% of update)
- 2017 on: full reduction (i.e. 75% of update)

(Note: Remaining 25% of update based on successful quality reporting)

# Hospital Incentive Payment and Penalty Timeline

## Payment Year

Year of Adoption	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
2011	100%	75%	50%	25%			
2012		100%	75%	50%	25%		
2013			100%	75%	50%	25%	
2014				75%	50%	25%	
2015					50%	25%	
No adoption by 2015					¾* of percentage increase in market-basket reduced by 33 1/3%	¾* of percentage increase in market-basket reduced by 66 2/3%	¾* of percentage increase in market-basket reduced by 100%

# EXAMPLE (Developed by Andrew Ruskin of Morgan Lewis)

## Assume:

- 21,149 discharges; 50,000 A & C days; 100,000 total days
- Charity care charges as 20% of total charges
- Year 1 of implementation is 2012

**Base amount = \$2 million + ((21,149 – 1,149) x \$200) = \$6 million**

**Medicare Share = 50,000/(100,000 x 80%) = 50,000/80,000 = .625**

**Transition Factor = 1**

**Total = \$6 million x .625 x 1 = \$3.75 million**

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**Now assume** same facts except with charity care charges as 10% of total charges:

**Medicare share = 50,000/(100,000 x 90%) = 50,000/90,000 = .56**

**Total = \$6 million x .56 x 1 = \$3.36 million**

# Medicare Payments to Hospitals

## Note:

- No judicial review of structure, but possible administrative appeal of individual items.
- Special rules apply for CAHs and hospitals affiliated with MA organizations.

# Medicare Payments to Hospitals

## What are the open issues?

- Definition of “meaningful EHR user”
- Definition of “certified EHR technologies”
- Multi-campus providers
- Interaction between meaningful EHR use and quality programs, ICD-10 adoption
- EHR reporting period
- Definition of “charity care”

# Medicaid Payments to Hospitals

- Hospital Medicaid payments are in addition to hospital Medicare payments.
- 10% Medicaid Volume Requirement
  - Except Children's Hospitals, which are eligible regardless of Medicaid volume

# Medicaid Payments to Hospitals

## What is the payment formula?

$[(\text{Base amount} + \text{Discharge related amount}) \times \text{Medicaid share}] \times \text{Transition factor}$

(i.e. same as Medicare formula but with “Medicaid Share”)

# Medicaid Payments to Hospitals

- Numerator: Medicaid inpatient days and Medicaid managed care inpatient days
- Denominator: Total days adjusted for charity care.

# Medicaid Payments to Hospitals

## Limits :

- 6 year limit on payments
- 2016 deadline
- No more than 50% of the total payments may be made in one year or 90% in two consecutive years

# HIT Policy Committee's “Ultimate Goal”

**“The ultimate vision is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities.”**

-HIT Policy Committee, “Meaningful Use: A Definition,”  
Recommendations from the Meaningful Use Workgroup to the  
Health IT Policy Committee, June 16, 2009

# What is the HIT Policy Committee?

- Advisory Committee established by ARRA
- Charged with:
  - Creating a policy framework for development of nationwide HIT infrastructure
  - Identify areas where standards, implementation specifications, and certification criteria are needed (in order of priority)

# HIT Policy Committee (con't)

- Required to make recommendations to National Coordinator in 8 areas, including:
  - Privacy and security
  - Utilization of a certified EHR for everyone in the US by 2014
  - Use of certified EHR to improve quality
- Chair: David Blumenthal
- Vice Chair: Paul Tang

# HIT Policy Committee (con't)

Created 3 Workgroups / Subcommittees

- Meaningful Use
- Certification / Adoption
- Exchange

# HIT Policy Committee (con't)

- Meaningful Use workgroup released first draft of definition of “meaningful use” (the “Meaningful Use Matrix”) at second Committee meeting on June 16
- Comments were due June 26
  - AAMC comment letter is available at <http://aamc.org/members/gir/hit/aamcmeaningfuluse2.pdf>
  - ONC received over 900 comments
- Workgroup to revise draft and release at July 16 Policy Committee meeting

# What is the HIT Standards Committee?

- Advisory Committee established by ARRA
- HIT Policy Committee Sets Standards Committee's Priorities
- Goal: recommend standards, implementation specifications, and certification criteria to National Coordinator
- Initial focus is on policies developed by Policy Committee and recommended to Standards Committee by National Coordinator

# HIT Standards Committee (con't)

- Chair: Jonathan Perlin
- Vice Chair: John Halamka

## Created 3 Workgroups / Subcommittees

- Clinical Operations
- Clinical Quality
- Privacy & Security

# Helpful HIT Web Resources:

- **ONC**: [www.hit.hhs.gov](http://www.hit.hhs.gov)
- **CMS**: [http://www.cms.hhs.gov/Recovery/11\\_HealthIT.asp](http://www.cms.hhs.gov/Recovery/11_HealthIT.asp)
- **AAMC**: <http://aamc.org/members/gir/hit/start.htm>
- (for an HIT laugh) <http://rossmartinmd.com/f/blog.htm>

# The AAMC is:

- Tracking ONC and CMS developments
- Speaking with David Blumenthal
- Attending all Advisory Committee meetings
- Keeping the AAMC HIT webpage current
- Commenting on proposals