



February 17th, 2009 - LATE EDITION

STIMULUS
PACKAGE
APPROVED

The Stimulus Package Impacts on Healthcare

CSC Emerging Practices

June 2009

American Recovery and Reinvestment Act of
Congress enacted by the
Congress and signed



Overview of Major Healthcare Provisions

- **The legislation includes roughly \$36 billion in spending on Medicare and Medicaid incentives for the “Meaningful Use” of certified electronic health records (EHRs)**
 - The provisions are designed to create a use incentive, not a purchase incentive
 - The \$36 billion estimate relies on two aggressive assumptions:
 - 90 percent of physicians and 70 percent of hospitals will be “Meaningful Users” by 2019
 - Increased adoption of health IT (HIT) will save the government \$15-\$16 billion
- **The Office of the National Coordinator (ONC) has received elevated status and budget (\$2 billion)**
 - The timelines for developing and approving standards are aggressive
 - New programs provide both financial assistance and implementation guidance/expertise
- **\$1.1 billion to study comparative effectiveness**
 - Research funds go to the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), and the U.S. Department of Health and Human Services (HHS)
- **Health Insurance Assistance for the Unemployed**
 - COBRA premium assistance for unemployed workers
 - Expanded matching funds for state Medicaid programs
 - 6.2 percentage point increase in Medicaid FMAP amounts
 - Intended to help states handle expected beneficiary increases due to rising unemployment rate

Advice to clients is to get started on EHR implementation now.

Incentives Overview

The HITECH act includes incentives for the “Meaningful Use” of certified systems; it is not a purchase incentive

1. Medicare EHR incentives

- Individual physicians are eligible for incentive payments of 75 percent of their Medicare charges up to a total of \$44,000 over five years
- Medicare EHR incentive payments to hospitals are based on discharge volume and the hospital’s percentage of Medicare patients
- First payment year is 2011; penalties for non-use start in 2015

2. Medicaid EHR incentives

- Requires that individual provider or hospital have a minimum Medicaid patient volume
- Individual providers receiving Medicaid EHR incentives waive any right to Medicare EHR incentive payments; hospitals are eligible for both
- Incentives for individual providers are based on costs for EHR software, implementation and maintenance
- Medicaid EHR incentives for hospitals are calculated in a similar fashion to Medicare incentives, but are based on a hospital’s percentage of Medicaid patients
- No penalties for non-use

Incentives Overview

The terms “Certified System” and “Meaningful Use” were not fully defined in the Act

- **Meaningful Use**

- The draft requirements for meaningful use were presented to the ONC policy Committee on June 16
- Next update on July 16 – likely requirements will become more aggressive
- Requirements are staged – 2011 is the starting point, more requirements added in 2013, 2015
- To get the payments in any year, you must meet requirements for that year.
- The biggest leap for most organizations will be meeting the 2011 requirements, that are proposed to include:
 - CPOE for all orders
 - Maintaining up-to-date problem, medication, and allergy lists
 - Medication reconciliation
 - HIPAA compliance (new requirements)
 - Data exchange of core clinical information across settings
 - Reporting quality measures from the EHR
 - e-Rx and visit documentation in ambulatory care

For more information on the latest requirements for meaningful use go to:

http://www.csc.com/health_services/insights/28577-update_on_meaningful_use

Incentives Overview

The terms “Certified System” and “Meaningful Use” were not fully defined in the Act

Certified System

- **The first recommendations to the ONC Policy committee are due on July 16**
- **The original requirements state that certified EHRs must:**
 - Include patient demographic and clinical health information, such as medical history
 - Have the “capacity” to:
 - Provide clinical decision support
 - Support computerized physician order entry (CPOE)
 - Capture and query information relevant to healthcare quality
 - Exchange electronic health information with, and integrate such information from, other sources.
 - The ONC Operating Plan indicates that draft certification requirements will be released by August 26
 - Certification must include requirements to achieve meaningful use

Incentives for Hospitals

Hospitals are eligible for both Medicare and Medicaid EHR incentives; penalties for non-use begin in 2015

- **Medicare EHR incentive payments are paid over four years**
 - The base Medicare EHR incentive, an amount that varies based on discharge volume and the hospital's percentage of Medicare patients, is paid in full the first payment year
 - A decreasing fraction of the base incentive is paid in years two, three, and four
 - Medicare EHR incentives phase out starting in 2014
- **Hospitals with greater than 10 percent Medicaid patient volume (as well as children's hospitals with any Medicaid volume) are also eligible for Medicaid incentive payments**
 - Calculated similarly to Medicare hospital EHR incentives, but based on the hospital's percentage of Medicaid patients
 - Unlike Medicare EHR incentives, "Meaningful Use" does not have to be demonstrated until second payment year
 - HHS Secretary shall establish the overall hospital EHR amounts for each Medicaid provider
- **Hospitals that do not demonstrate meaningful EHR use prior to 2015 will be subject to Medicare market basket reductions**

Hospital base incentive (Medicare) =
\$2,000,000 + \$200 per discharge for discharges 1,150 to 23,000
 X
 the hospital's **percentage of Medicare patients** (with an adjustment for charity)

Medicare EHR Payment Year	Actual Payment Amount to Hospital
Year 1	100% of base incentive
Year 2	75% of base incentive
Year 3	50% of base incentive
Year 4	25% of base incentive

Year	Reduction in Market Basket for Hospitals Without an EHR ¹
2015	33.3%
2016	66.6%
2017	100%
2018	100%

¹Reduction in market basket applies to ¾ of the amount the hospital would otherwise be eligible for.

Incentives for Hospitals

The example hospital below would be eligible for up to \$4,265,270 in Medicare incentive payments if meaningful EHR use was demonstrated prior to 2014

Example Hospital

- Beds: 276
- Total discharges: 19,453
- Medicare patient volume: 29%
- Medicaid patient volume: 12%
- Percent of total charges for charity care: 3.6%

First Year of Meaningful EHR Use	Medicare Incentive Payment/Adjustment to Market Basket Update									
	2011	2012	2013	2014	2015	2016	2017	2018	2019	TOTALS
2011	\$1,706,108	\$1,279,581	\$853,054	\$426,527	\$0	\$0	\$0	\$0	\$0	\$4,265,270
2012	\$0	\$1,706,108	\$1,279,581	\$853,054	\$426,527	\$0	\$0	\$0	\$0	\$4,265,270
2013	\$0	\$0	\$1,706,108	\$1,279,581	\$853,054	\$426,527	\$0	\$0	\$0	\$4,265,270
2014	\$0	\$0	\$0	\$1,279,581	\$853,054	\$426,527	\$0	\$0	\$0	\$2,559,162
2015	\$0	\$0	\$0	\$0	\$853,054	\$426,527	\$0	\$0	\$0	\$1,279,581
2016	\$0	\$0	\$0	\$0	-33%	\$0	\$0	\$0	\$0	\$0
2017	\$0	\$0	\$0	\$0	-33%	-66%	\$0	\$0	\$0	\$0
2018	\$0	\$0	\$0	\$0	-33%	-66%	-100%	\$0	\$0	\$0
2019	\$0	\$0	\$0	\$0	-33%	-66%	-100%	-100%	\$0	\$0

Incentives for Hospitals

State-awarded Medicaid incentives for the example hospital would total \$1,787,622

Example Hospital

- Beds: 276
- Total discharges: 19,453
- Medicare patient volume: 29%
- Medicaid patient volume: 12%
- Percent of total charges for charity care: 3.6%

First Year of Meaningful EHR Use	Maximum Medicaid Incentive Payment Available from State									
	2011	2012	2013	2014	2015	2016	2017	2018	2019	TOTALS
2011	\$893,811	\$715,049	\$178,762	\$0	\$0	\$0	\$0	\$0	\$0	\$1,787,622
2012	\$893,811	\$715,049	\$178,762	\$0	\$0	\$0	\$0	\$0	\$0	\$1,787,622
2013	\$0	\$893,811	\$715,049	\$178,762	\$0	\$0	\$0	\$0	\$0	\$1,787,622
2014	\$0	\$0	\$893,811	\$715,049	\$178,762	\$0	\$0	\$0	\$0	\$1,787,622
2015	\$0	\$0	\$0	\$893,811	\$715,049	\$178,762	\$0	\$0	\$0	\$1,787,622
2016	\$0	\$0	\$0	\$0	\$893,811	\$715,049	\$178,762	\$0	\$0	\$1,787,622
2017	\$0	\$0	\$0	\$0	\$0	\$893,811	\$715,049	\$178,762	\$0	\$1,787,622
2018	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

Assumes fastest possible payout of Medicaid incentive by state (50% in first year, 40% in second year, 10% in third year)

Note: To receive Medicaid EHR incentive payments, "Meaningful Use" does not need to be demonstrated until payment year 2. A qualified provider must only demonstrate that "it is engaged in efforts to adopt, implement, or upgrade certified EHR technology" during the first payment year.

Incentives for Individual Physicians

Individual physicians are eligible for as much as \$44,000 in Medicare EHR use incentive payments, but the timeline is aggressive

- **Incentives are based on 75 percent of the physician's allowable charges to Medicare Part B in a given payment year, up to the amounts detailed in the table below**
 - Individual physicians that demonstrate meaningful EHR use in 2011 or 2012 are eligible for up to \$44,000 in total incentive payments; this drops down to \$39,000 for EHR adoption in 2013 and \$24,000 for adoption in 2014
 - Note: For physicians in designated health professional shortage areas, the incentive payment is 10 percent higher
- **Incentives phase out fairly quickly**
 - No incentive payments will be made after 2016
 - Individual physicians who do not demonstrate meaningful EHR use until 2014 will only be eligible for payment years 2, 3, and 4
- **Individual physicians who have not demonstrated "Meaningful Use" of an EHR by 2015 will subject to Medicare pay reductions**
 - If EHR adoption is less than 75 percent in 2018 or 2019, the penalty increases one percentage point from the previous year, but the overall penalty cannot exceed 5 percent

Payment Year	Maximum Payment
1	\$18,000/\$15,000 ¹
2	\$12,000
3	\$8,000
4	\$4,000

Year	Medicare Penalty
2015	1%
2016	2%
2017	3%
2018	3 – 4%*
2019	3 – 5%*

¹ \$18,000 is for meaningful EHR use in 2011 or 2012; \$15,000 if first payment year is 2013.

Incentives for Individual Physicians

The chart below shows the maximum Medicare EHR incentive payments for "Meaningful Use" available to an individual physician

- Actual amounts will depend on amount of services furnished under Medicare Part B
- Physicians in designated health professional shortage areas are eligible to receive an additional 10 percent of the amounts below

First Year of Meaningful EHR Use	Maximum Medicare Incentive Payment/Percent Reduction in Medicare Pay									
	2011	2012	2013	2014	2015	2016	2017	2018	2019	TOTALS
2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$0	\$0	\$0	\$44,000
2012	\$0	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$0	\$0	\$44,000
2013	\$0	\$0	\$15,000	\$12,000	\$8,000	\$4,000	\$0	\$0	\$0	\$39,000
2014	\$0	\$0	\$0	\$12,000	\$8,000	\$4,000	\$0	\$0	\$0	\$24,000
2015	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2016	\$0	\$0	\$0	\$0	-1%	\$0	\$0	\$0	\$0	\$0
2017	\$0	\$0	\$0	\$0	-1%	-2%	\$0	\$0	\$0	\$0
2018	\$0	\$0	\$0	\$0	-1%	-2%	-3%	\$0	\$0	\$0
2019	\$0	\$0	\$0	\$0	-1%	-2%	-3%	-3-4%	\$0	\$0
2020	\$0	\$0	\$0	\$0	-1%	-2%	-3%	-3-4%	-3-5%	\$0

Incentives for Individual Physicians

Individual providers with high Medicaid patient volumes can choose to receive Medicaid EHR incentive payments instead, but they cannot “double dip”

- **The provider must have Medicaid patient volume of greater than 30 percent in order to qualify for individual Medicaid incentive payments**
 - Applies to non-hospital-based physicians, nurse practitioners, and certified nurse midwives are also eligible for Medicaid EHR incentives
 - Non-hospital-based pediatricians with Medicaid patient volume between 20 and 30 percent are eligible for two-thirds of incentive payment amount
- **Participating providers are eligible for a payment equal to 85 percent of their net “allowable costs” for an EHR**
- **To be eligible for the first Medicaid EHR incentive payment year, a qualified provider must only demonstrate that “it is engaged in efforts to adopt, implement, or upgrade certified EHR technology”**
 - "Meaningful Use" must be demonstrated to receive incentives in subsequent years

“Allowable Costs”

- Total costs for purchase and implementation of EHR (including hardware, software and services) **cannot exceed \$25,000 or include costs over a period of 5 years**
- Annual allowable costs not associated with the initial EHR purchase/implementation (such as maintenance) **cannot exceed \$10,000 per year or exceed a period of greater than 5 years**
- Maximum aggregate allowable amount is **\$75,000 per provider** (\$25,000 up front + \$10,000 annually over five years) - or **\$63,750 with 85 percent adjustment**

Incentive Calculations for Integrated Delivery Networks (IDNs)

An IDN would calculate its total incentive payment based on the amount available to each individual hospital and each eligible ambulatory provider

- **Only “Subsection (d) hospitals” are eligible for Medicare EHR incentives**
 - Link to hospital definition: (http://www.ssa.gov/OP_Home/ssact/title18/1886.htm#act-1886-d-1)
 - The Subsection (d) definition excludes psychiatric, children’s, rehabilitation, and long-term care hospitals, as well as certain cancer centers
- **The legislation is not clear on whether hospital-based physicians who provide routine ambulatory care are eligible for individual incentive payments**
 - The legislation states only that the provider cannot be “hospital-based”
 - Hospital-based providers are those who furnish “substantially all” of their “services in a hospital setting (whether inpatient or outpatient) and through the use of facilities and equipment, including qualified electronic health records, of the hospital”
 - The determination of who is a hospital-based eligible professional “shall be made on the basis of the site of service (as defined by the HHS Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider“

Incentive Calculations for Critical Access Hospitals

Critical Access Hospitals that demonstrate meaningful use are eligible to receive enhanced Medicare reimbursement for the hospital's reasonable EHR costs

- **Medicare incentives for Critical Access Hospitals start in 2011**
 - Payments are based on the existing cost-based reimbursement model for critical access hospitals (101 percent of Medicare costs), but with an enhanced Medicare share.
$$101 \text{ percent} \times [(\text{Reasonable EHR costs}) \times (\text{Medicare share}^1 + 20 \text{ percentage points})^2]$$
 - Critical Access Hospitals that demonstrate meaningful use are eligible to receive this enhanced Medicare reimbursement for reasonable EHR costs until 2015 (up to four consecutive years)
 - There is nothing in the legislation that prohibits Critical Access Hospitals from capturing Medicaid incentives in the same way as other acute care facilities
- **The Secretary will compute reasonable EHR costs by expensing costs in a single payment year**
 - Costs are not depreciated over multiple years
- **There are payment penalties for not achieving meaningful use by 2015. The normal 101 percent reimbursement is reduced in accordance with the following schedule:**
 - 100.66% in 2015
 - 100.33% in 2016
 - 100.00% in 2017 and beyond
 - The Secretary may exempt a hospital from the meaningful use requirement if achieving meaningful use would result in significant financial hardship (instances will be reviewed on a case-by-case basis)

¹Medicare share for EHR incentives is calculated the same way for CAHs as it is for IPPS facilities

²Not to exceed 100 percent

Security and Privacy

The HITECH act includes new privacy requirements for covered entities and expands accountability for data breaches

- **Covered entities must notify individuals of privacy breaches within 60 days**
 - Organizations can notify affected individuals by mail or e-mail
 - Organizations must notify HHS and media outlets for breaches that affect more than 500 individuals
 - Further guidance will be as part of the annual update process (by February 18 2010)
- **Individuals have a right to an accounting of all protected health information (PHI) disclosures from the past three years**
 - This includes disclosures related to payments, treatments and operations
 - Current EHR users have until 2014 to comply; others must comply by 2011 or upon implementation
- **The Health Information Portability and Accountability Act (HIPAA) privacy provisions and breach requirements now also apply to business associates of covered entities**
 - New requirements also apply to personal health record (PHR) vendors, service providers, Regional Health Information Organizations (RHIOs), and Health Information Exchanges (HIEs)
 - Interim final regulations will be published by August 18, 2009
- **Allows criminal and civil penalties to apply to individuals**
 - New criminal penalties take effect in 24 months (final regulations will be issued by February 18 2010)
 - New civil monetary penalties take effect immediately

Office of the National Coordinator for Health IT

The purpose of ONC is to promote the development of a nationwide electronic health IT infrastructure

- **Organization**

- ONC is now an HHS office (previously it was a temporary executive order)
- Dr. David Blumenthal (Institute for Health Policy) has been appointed National Coordinator
- The Secretary will appoint a Chief Privacy Officer under ONC within 12 months

- **Allocation of funds**

- ONC has received \$2 billion in total (not \$2 billion for each of its new activities)
 - Privacy and Security: \$24 million
 - National Institute of Standards and Technology (NIST): \$20 million
 - Regional HIT Exchange: \$300 million
 - The remainder is still unspecified: \$1.65 billion

- **Two new committees have been created: Policy and Standards**

- HIT Policy Committee (HITPC) will recommend areas in which standards are needed
- HIT Standards Committee (HITSC) will review and recommend specific standards
- Both committees are established as Federal Advisory Committees (FACs)
 - All administrative procedures and hearings are to be public knowledge
- HITPC and HITSC appointments have been made, and meetings have commenced
 - HITPC members were named by the GAO, top congressional leaders, and the HHS Secretary; the committee is chaired by ONC David Blumenthal
 - HITSC contains a mix of industry stakeholders and is chaired by Jonathan Perlin (Healthcare Corporation of America) and co-chaired by John Halamka (CareGroup Health System)

ONC *(cont'd)*

The duties of the National Coordinator include reviewing and endorsing the standards specified by the Standards Committee

ONC Areas of Responsibility

Endorse Standards	Endorse the standards recommended by the HIT Standards Committee
Coordinate HIT Policy	Coordinate HHS work on HIT to avoid duplication of efforts
Update the Strategic Plan	Update the Federal Health IT Strategic Plan ¹ with respect to goals and metrics
Provide Transparency	Maintain a website to publicly show schedules, reports and recommendations
Develop Certification	Work with the National Institute of Standards and Technology (NIST) to develop a voluntary HIT certification program
Publish Results	Report within one year on funding needs, lessons learned and HIT costs/benefits
Financial Assistance	Provide financial assistance to nonprofit groups that work to defray HIT costs
Establish Governance	Establish a governance structure for the National Health Information Network (NHIN)

¹ The Federal HIT Strategic Plan developed by ONC seeks to facilitate the development of a nationwide infrastructure, improving patient-focused care and population health. The strategy focuses on privacy and security, interoperability, adoption, and collaborative governance to achieve this goal.

Expansion of Coverage

Provisions in the HITECH act and recently signed state Children's Health Insurance Program (CHIP) Bill expand coverage for low-income and unemployed residents

- **65 percent subsidy of COBRA premiums for unemployed individuals and their families for up to nine months**
- **Medicaid Federal Medical Assistance Percentage (FMAP) will also be increased by 6.2 percentage points for each state**
 - FMAP increase applies to all states and DC, and funds are already being distributed
 - FMAP increase is effective retroactively October 1, 2008 and ends December 31, 2010
 - States will be evaluated quarterly for additional unemployment-related FMAP increase (would equal a percentage reduction in the state share)
 - It is estimated that 35 percent of the \$87 billion FMAP increase will be set aside for unemployment-related uses
 - It is up to states to decide what to do with any available funds
 - States must maintain existing eligibility requirements in order to receive FMAP
- **A 4.5 year, \$32.3 billion CHIP expansion bill was signed in January**
 - CHIP expansion is expected to provide coverage to 11 million low-income children

Other

A portion of ONC's \$2 billion will go to grants and loans to accelerate the planning and implementation of health IT

- **ONC will create two new programs to provide financial assistance to healthcare providers**

- **Both programs require states to provide matching funds**
 - State grants for the planning and implementation of HIT systems
 - States must submit a plan that is in the public interest and which is consistent with the ONC Strategic Plan
 - No matching funds are required in 2009 and 2010
 - Starting in 2011, states must match 9 percent of the grant amount
 - For 2012, states must match 12.5 percent of the grant amount
 - For 2013 and beyond, states must match 25 percent of the grant amount
 - Competitive grants to states for the adoption of certified EHRs
 - States may apply for grants to establish a Loan Fund for the adoption of certified EHRs
 - Recipients can use the funds to purchase a certified EHR, train personnel, or invest in HIE
 - Providers that receive the loans from the Loan Fund must provide matching funds of 20 percent
 - Program starts after January 1, 2010

Other *(cont'd)*

Another portion of ONC's \$2 billion will be used to set up centers to study HIT adoption and disseminate information to providers

- **HHS and ONC will administer programs to give financial and technical assistance to providers as they implement health information technology, including EHRs**
- **Health Information Technology Research Center**
 - Provides technical assistance and develop/recognize best practices to accelerate EHR adoption
 - The HIT Research Center will disseminate knowledge and experiences through a forum
- **Health Information Technology Regional Extension Centers**
 - ONC will seek qualified applicants (must be non-profit entities) to serve as technology extension centers through a solicitation of proposals
 - Preference will be given to applicants who can identify a viable source of matching funds
 - The centers will provide technical assistance to providers adopting EHRs, and as part of their contracts will receive an average of \$1-2 million apiece, with a maximum of \$10 million
- **HITECH Act also provides for other technical resources for disseminating best practices**

Other *(cont'd)*

- **Health and Human Services**
 - Demonstration program to develop curricula to use EHRs in clinical education
 - Grants are for schools and institutions with graduate programs in medicine, nursing, pharmacy, etc.
 - Recipients must fund at least 50 percent of the program (unless overridden by the Secretary)
 - Amounts and dates not yet set
- **HHS and National Science Foundation (NSF)**
 - Funds to establish medical health informatics education programs
 - Grants can be used for developing curricula, recruiting students, purchasing equipment, and IT
 - Recipients must fund at least 50 percent of the program (unless overridden by the Secretary)
 - Amounts and dates not yet set
- **Other HHS Spending**
 - NIH will receive \$10 billion in total (current annual budget is \$29.5 billion)
 - Applications for NIH Challenge Grants were due April 27 (anticipated start date is September 30 2009)
 - HHS will spend \$1 billion on a Prevention and Wellness Fund
 - \$650 million of this amount will be used to carry out evidence-based clinical and community prevention strategies that address chronic diseases
 - The Health Resources and Services Administration (HRSA) will receive \$500 million to address health professions workforce shortages
 - \$75 million of this amount will go to the National Health Service Corps

Recommendations for CSC Clients

- **Get started now**
 - Incentives are based on “Meaningful Use” of systems, not just implementation
 - The window for incentives will close rapidly (especially on the inpatient side)
- **If you have an EHR in place, you will likely need to enhance the capabilities**
 - Start with a market definition of “Meaningful Use” and then adjust as the certification and meaningful use requirements become clear
 - Hospitals: CPOE and eMAR with advanced decision support, nursing and MD documentation, quality reporting
 - Physicians: e-Rx, visit documentation and quality reporting
 - Incentives are contingent upon demonstrating "Meaningful Use" during a payment year, and the bar will be raised over time
- **Develop formal processes for privacy and security**
 - Many organizations are still not even aware what types of breaches occur
 - This needs to change, especially now that there are new penalties going into effect

Recommendations for CSC Clients *(cont'd)*

- **Do not wait until the December 2009 standards are released**
 - With an end-of-year deadline, the HIT Policy and Standards Committees will likely borrow heavily from existing criteria
 - Focus on what has been defined to date
- **Watch for further details from ONC on key definitions, timelines, loans, and grants**
 - The ONC Operating plan was released on May 19:
 - Details on security and privacy requirements
 - A draft of standards and certification requirements will be published by August 26
 - Dates and activities for meaningful use are still TBD
 - No details on grants and loan programs
- **Do not count on immediate benefits from broadband expansion programs**
 - The funding goes primarily to service providers; healthcare will have to compete with other industries for attention
- **Figure out what is going on in your state**
 - Get involved in the HIT and EHR efforts in your state
 - Look for opportunities to influence leaders and collaborate with potential partners



February 17th, 2009 - LATE EDITION



Appendix

Impact of the Stimulus Plan



Medicare Advantage

Medicare Advantage organizations are eligible to receive Medicare EHR incentive payments for certain affiliated hospitals

- Eligible hospitals must be under common corporate governance with the Medicare Advantage health maintenance organization (HMO) and serve people enrolled in a Medicare Advantage plan offered by that HMO
- If at least one-third of an MA-affiliated hospital's Medicare discharges are attributable to Part A, incentive payments are calculated in the standard fashion
- For hospitals whose volume of Medicare patients is predominately Part C enrollees, incentive payments are calculated by the HHS Secretary **as if** services were furnished under Part A
- Penalties for non-use are dependent on the organization's hospital expenditures to Medicare and the proportion of hospitals affiliated with the MA organization that are not meaningful EHR users

Medicare Advantage

Medicare Advantage (MA) organizations are eligible to receive Medicare EHR incentives for certain individual ambulatory physicians

- **The same schedule for incentive payments and penalties applies to MA-affiliated ambulatory physicians**
- **For eligible MA-affiliated physicians who do not qualify for the maximum EHR incentive based on charges under Part B, the Secretary may substitute an incentive payment calculated as *if* charges were made under Part B instead of Part C**
- **Qualifying MA organizations must designate one year that will be treated as the first payment year for all eligible professionals**
 - The organization will only receive incentive payments for the ambulatory physicians demonstrating meaningful EHR use in a payment year
 - First payment year cannot be before 2011
- **The reduction in Medicare payment for non-use starting in 2015 is dependent on the fraction of the organization's eligible professionals who are not meaningful EHR users and the proportion of physicians' Medicare expenditures**

Meaningful Use

Very few individual physicians today would meet the likely requirements for “Meaningful EHR Use”

- According to a 2008 national study of 2,785 ambulatory physicians nationwide, 17 percent of physicians have access to at least basic EHR systems in their practices
- Only four percent of physicians had access to a “fully functional” EHR system¹

	Percent of U.S. Physicians w/ Basic EHR	Percent of U.S. Physicians w/ “Fully Functional” EHR
TOTAL	17%	4%
PCP	21%	6%
Non-PCP	15%	4%
1 – 3 MD practice	9%	2%
4 – 5 MD practice	14%	3%
6 – 10 MD practice	23%	6%
11 – 50 MD practice	30%	8%
50+ MD practice	50%	17%

A “**Basic**” EHR includes capabilities to maintain electronic medication and problem lists, as well as the ability to enter orders electronically.

A “**fully functional**” EHR includes basic decision support for medications as well as full e-prescribing (electronic entry of prescription and electronic transmission of prescription to a pharmacy).²

¹ “Electronic Health Records in Ambulatory Care – A National Survey of Physicians”, NEJM July 2008, 359:50-60.

² “Electronic Health Records in Ambulatory Care – A National Survey of Physicians”, NEJM July 2008, 359:50-60. n=2785.

Adoption of Clinical IT

Adoption of clinical IT in hospitals today is also low

- According to the 2009 KLAS CPOE Digest, 12.5 percent of hospitals are “live with CPOE,” up from 9.6 in 2008, 6.8 in 2007, and 3.5 in 2003¹
- The latest data from HIMSS Analytics suggests that just over 40 percent of hospitals have basic clinical (nursing) documentation but less than 2 percent have physician documentation²

EMR Adoption Model			
Stage	Cumulative Capabilities	2007 Final	2008 Final
Stage 7	Complete EHR with capability for HIE; CCD as byproduct of EHR; data warehousing	0.0%	0.3%
Stage 6	Physician documentation (structured templates), full CDSS, full R-PACS	0.3%	0.5%
Stage 5	Closed-loop medication administration	1.9%	2.5%
Stage 4	CPOE and basic decision support	2.2%	2.5%
Stage 3	Clinical documentation and error checking, PACS available outside Radiology	25.1%	35.7%
Stage 2	Clinical data repository, controlled medical vocabulary, clinical decision support	37.2%	31.4%
Stage 1	Lab, radiology and pharmacy only	14.0%	11.5%
Stage 0	Lab, radiology and pharmacy not complete	19.3%	15.6%

Source: HIMSS Analytics EMR Adoption Model, accessed March 5, 2009. 2007 n = 5073; 2008 n = 5166.

¹ 2009 KLAS CPOE Digest, March 2009.

² HIMSS Analytics, 2009.

Questions, Comments or Follow-Up

For more information contact
Emerging Practices



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Update on Meaningful Use, Certification, and Health Information Exchange (HIE)

On June 16, the ONC Policy Committee had its second meeting. The main content of the meeting was a discussion of the initial draft of definitions for the meaningful use of an electronic health record (EHR) that had been developed by the ONC Meaningful Use Work Group. There were also brief updates from the Work Groups on Certification/Adoption and Information Exchange.

Meaningful Use

This update summarizes information on the **Draft Definition of Meaningful Use** – both the work group’s proposal and the committee’s discussion. The law states that the \$36 billion in incentive payments in HITECH are for **meaningful use** of certified EHR systems. Since certified systems must provide capabilities to achieve meaningful use, meaningful use requirements are key – and, hence, they were first on ONC’s agenda. The requirements for meaningful use are staged (as expected) but also quite aggressive. (Some industry groups had lobbied to make the requirements easy to reach in the early years; this advice is not reflected in the requirements.) This update is focused on the requirements for meaningful use in hospitals. (We are also creating a set of tables that lay out all the details of the proposed requirements and measures for meaningful use in hospitals and physician practices and a point-of-view paper on meaningful use that will be posted to our external Web site.) **Note: A revised set of proposed requirements will be presented at the next ONC Policy Committee meeting in July; then they will be posted for public comment by CMS and final definitions are expected by the end of the year.**

Our position has always been that meaningful use of an EHR system achieves the goals of increased quality and safety, improved efficiency and transparency, and an enhanced ability to provide patient-centered care. The proposed draft requirements are consistent with this philosophy; proposed meaningful use requirements and measures are tied to the national goals of:

- Improving quality, safety, and efficiency;
- Engaging patients in their care;
- Increasing coordination of care;
- Improving the health status of the population; and
- Ensuring privacy and security.

The proposed requirements for quality, safety, efficiency, coordination of care, and privacy and security are very close to those in the POV paper we published in April (and are closely linked to the requirements in the HITECH Act). However, the draft proposal also included requirements related to engaging patients and families and improving the health of the population.

The Requirements

The proposed requirements for inpatient care in 2011 include:

- Use of CPOE for all orders including medications;
- Drug-drug, drug-allergy, and drug-formulary checking;
- Maintaining up-to-date problem, medication, and medication allergy lists;
- Vital signs;
- Lab test results;
- Reminders for follow-up care;
- Medication reconciliation at relevant encounters;
- Providing patients with electronic copies or electronic access to their records;
- Providing patient-specific educational resources;
- Providing the patient with a summary of each encounter;
- Exchanging “key clinical information” among providers;
- Submitting electronic information to immunization registries and public health agencies;
- Compliance with HIPAA and state laws for privacy and security; and
- Data sharing in accordance with the Nationwide Privacy and Security Framework Act.

During the discussion, many committee members recommended moving some additional requirements into 2011 (from 2013). These included:

- Clinical (nursing) documentation;
- Medication administration;
- Evidence-based order sets;
- Decision support at the point of care; and
- Incorporation of patient-supplied information into the EHR.

In 2013 some of the additional requirements that would need to be met for meaningful use (aside from those mentioned above) include:

- Electronic transmission of prescriptions;
- Management of chronic conditions using patient lists and decision support;
- Reporting to external disease registries;
- Bar code for medication administration;
- Documentation of family medical history;
- Medication reconciliation at each transition of care;
- Retrieve and act on prescription fill information; and
- Produce and share an electronic summary care record at every transition in care.

Integration with inpatient medical devices would not be required until 2015. The proposed metrics include the percent of orders entered by physicians using CPOE and traditional quality metrics – similar to those used in quality reporting. The target percentage that would be required in each year is not yet specified. There is a commitment to adopt existing quality measures, rather than even new ones, to minimize the reporting burden. The proposed requirements for meeting physician office incentive payment requirements for meaningful use of an EHR in 2011 are the same as those for inpatient care (with the exception of nursing documentation and eMAR). Additional requirements include:

- E-prescribing,
- Generating lists of patients with specific conditions, and
- Progress notes

The committee suggested moving the requirements for secure patient-provider messaging to 2011 from 2013. In 2013, integration of data from home monitoring devices would be required.

Likely Changes in the Next Version

The committee spent most of its time discussing the requirements (rather than the metrics), and the general theme was that the committee had done a great job. There were a few suggested additions, but most of the comments were related to moving requirements forward from 2013 to 2011. There were also concerns about sequencing of requirements – you cannot share information with patients until it is available; until you build a problem list for each patient, you cannot identify all diabetic patients, etc. There were also concerns about patents on some required capabilities (on-line patient education and device interfaces were mentioned), and some concerns that requiring compliance with HIPAA and state privacy rules would create different requirements in different states. Another concern related to the reporting burden for some of the proposed measures of meaningful use. Our sense was that the next version (to be discussed on July 16) will not be radically different from the initial proposal.

The reporting that “the work group was sent back to the drawing board” really is not the sense that we got from listening to the proceedings. The action was to “table” the recommendations and to prepare a revised version based on the comments that were received. One thing that will not change is the basic payment rules. These are set in the law and cannot be changed. For instance, it is not possible to allow an organization that first qualifies for the incentive in 2013 to qualify under the 2011 requirements – every hospital must qualify under the requirements for that year.

Our Advice to Clients

Based on the information presented on June 16 and the tenor of the committee’s discussion, here is our advice:

- Start today! Seventy percent of the incentive payments are in the first two years of the program. Qualifying in 2011 will provide substantial funding for meeting requirements in 2013 and 2015.
- Develop a short checklist based on the recommendations included in this paper to identify early gaps and begin to close them.
- If you are selecting a vendor make sure they can meet all the requirements through 2013 and have a development plan to meet those required in 2015.
- CPOE will be the biggest challenge in meeting 2011 criteria. If you have not yet implemented CPOE, start now. This is a large-scale change project that has to be done right under strong clinical leadership.
- Independent of the meaningful use requirements, implement CPOE with evidence-based order sets and decision support at the point of care. Order sets greatly reduce the time for ordering and reinforce evidence-based practice. Without decision support the physician will be acting as the transcriber and will not receive any added value from CPOE.
- Actively participate in commenting on the draft requirements. Comments on the initial draft are due June 26. The instructions to submit comments are found here – [Meaningful Use Comment Instructions](#).

Certification

The Certification/Adoption Work Group provided an update on their progress to the Policy Committee. Note that the Certification/Adoption Work Group is charged with making recommendations around processes and policies only; recommendations around specific standards or functionality will be addressed by the HIT Standards Committee.

The group is currently at the information gathering stage – getting input from industry stakeholders on the issue of EHR certification. Those discussions have focused on the following questions:

- Who should conduct certification?
- Should there be more than one certification body?
- What role should CCHIT play?
- How should self-developed systems be certified?
- What are we certifying for?/What is the purpose of certification?
- Should certification simply represent a “seal of approval?”
- How often should a product be certified?
- Should certification be broad-based or specific?
- How should certification apply to privacy?
- Should vendor fitness be certified?
- Should provider readiness be certified?

The co-chairs reported that the group has been making more progress than originally anticipated and now plans to make a recommendation on certification policy by the next HIT Policy Committee meeting (July 16, 2009).

Information Exchange

The Information Exchange Work Group reported that they have held two meetings. At the first meeting, the group discussed various definitions of HIE and proposed that efforts to understand HIE requirements include the activity of formal exchanges as well as the informal data sharing that already takes place. The group recognized that it could be a challenge to grow exchanges that are already at a high functioning level today and that a goal should be to seek to grow new HIEs that do not yet exist or are in the beginning stages.

At its second meeting, the group discussed grants to states. Members reiterated the importance of a national system as the ultimate goal, yet acknowledged that the states and regions are best suited to figuring out what works best for them.

The group recognized that HIE and meaningful use are “fundamentally connected” and that in order to do work on HIE, it needs to see how the definition of meaningful use is digested by the community. The ONC representation for this work group, Kelly Cronin, contended that it is important to set high expectations for HIE over time and that HIE policy goals should proceed in parallel with meaningful use over time.

No details, decisions, or recommendations were given on potential HIE business models, connectivity models, or governance models. There are two views on technology but no consensus: 1) leave technical issues open for vendors to innovate, or 2) pick a technology based on a vision and define a common “technical layer.” The next steps for the committee are to: 1) set priority areas, 2) identify and align interdependencies with other work groups, and 3) develop a plan for timelines, milestones, and deliverables.