



AMERICAN **OSTEOPATHIC** ASSOCIATION

TREATING OUR FAMILY AND YOURS

Preparing Your Practice for the Implementation of Health Information Technology

American College of Osteopathic Internists

October 14, 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.



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

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
 - 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
 - President Barrack Obama signs bill into law (Public Law 111-5)



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



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.



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.

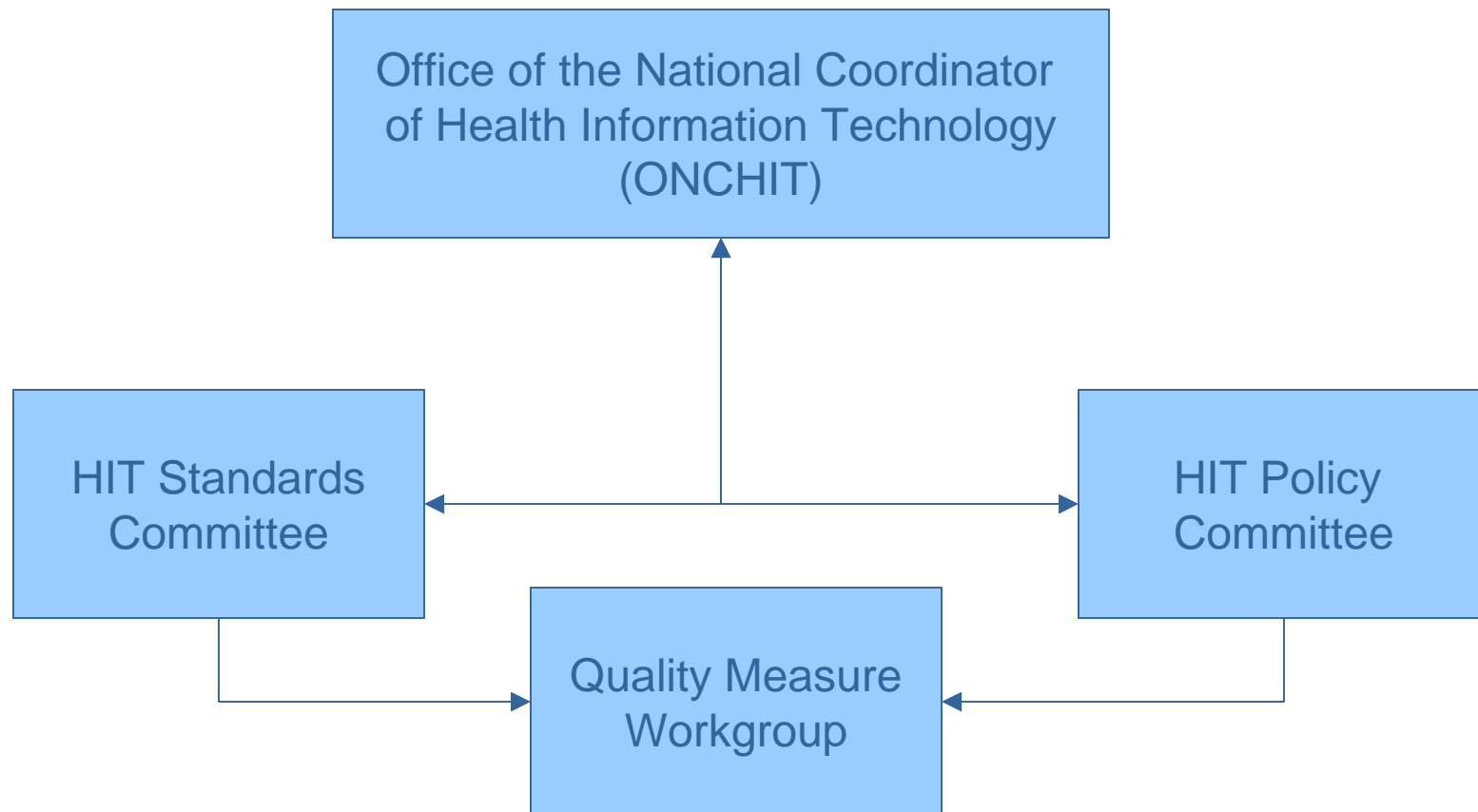


Regulatory Structure

- 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



Regulatory Structure Established by ARRA



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



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

HIT Policy Committee

- HHS Secretary required to establish definition of “meaningful use” by December 31, 2009



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

What Is Meaningful Use?

- The Secretary of HHS is required to publish a definition of “meaningful user” on or before December 31, 2009.
 - The ONCHIT Policy Subcommittee submitted its recommendations on September 24.
- A meaningful EHR user will incorporate a certified HIT/EHR system to perform some or all of the following functions:
 - Electronic prescribing
 - Information Exchange
 - Reporting clinical quality measures using the certified EHR technology



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



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)



AMERICAN OSTEOPATHIC ASSOCIATION
TREATING OUR FAMILY AND YOURS

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 after 2013 the physician is eligible for a maximum of \$15,000
- 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.



HIT Financial Incentives for Physicians

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	<i>\$44,000</i>
Adopt 2012	-----	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	<i>\$44,000</i>
Adopt 2013	-----	-----	\$15,000	\$12,000	\$8,000	\$4,000	\$0	<i>\$39,000</i>
Adopt 2014	-----	-----	-----	\$12,000	\$8,000	\$4,000	\$0	<i>\$24,000</i>
Adopt 2015 +	-----	-----	-----	-----	\$0	\$0	\$0	<i>\$0</i>

Medicaid Financial Incentives

- Incentives will start in 2011
 - Up to \$65,000
- 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 \$25,000
 - Caps: following years at \$10,000/year
 - 1st yr cost no later than 2016
 - No payments made after 2021 or more than 5 years



Medicaid Incentives

Who's Eligible?

Providers	Medicaid Patient Volume
Non-hospital based providers	$\geq 30\%$
Non-hospital based pediatrician (eligible for 2/3 of the amount)	$\geq 20\%$
Physician who practices in federally qualified health center or rural health clinic	$\geq 30\%$ attributable to needy individuals
Children's hospitals	No requirement needed
Acute-Care hospitals	$\geq 10\%$



Electronic Prescribing Incentives for Physicians

Year	Incentives	Penalties for Non-Compliance
2009	2% of Medicare allowed charges	\$0
2010	2% of Medicare allowed charges	\$0
2011	1% of Medicare allowed charges	\$0
2012	1% of Medicare allowed charges	-1% in Medicare Fee Schedule
2013	0.5% of Medicare allowed charges	-1.5% in Medicare Fee Schedule
2014	\$0	-2% in Medicare Fee Schedule

As of January 1, 2009, physicians are eligible for a bonus payment under Medicare if they are e-prescribing and report such on at least fifty percent of Medicare patients through submitted claims.



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



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%



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 \$65,000	
Reduction	CY 2015	FY 2015	No penalty	



Medicare and Medicaid Timeline

MEDICAID

HHS develop interoperability standards end of 2009

Medicaid Incentives begin

Medicaid: hospitals that adopt after 2017 not eligible for incentives

Setting of standards complete

Medicaid: non-hospital based physicians 1st yr cost no later than 2016

Medicaid: non-hospital based physicians no payments after 2021 or more than 5 yrs.

2009

2010

2011

2012

2013

2014

2015

2016

2017.....

2021

Medicare (FY2011) Incentives begin Oct. 2010 for hospitals

Medicare phase down incentive payments for physicians

Medicare penalties begin for non-meaningful users FY15 for hospitals calendar 2015 for physicians

Medicare Incentives begin Jan 2011 for non-hospital based physicians

Medicare: Physicians who 1st payment is after 2014 receive no incentives

Medicare Incentives End 2016

MEDICARE



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

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



HIT Resources

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



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS



AMERICAN OSTEOPATHIC ASSOCIATION

TREATING OUR FAMILY AND YOURS

Shawn Martin

**Director of Government Relations
American Osteopathic Association
smartin@osteopathic.org**