

AMC/NOMA Article -- Stimulus Package Promotes Health IT Adoption
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The Obama Administration clearly expects every American to have an electronic medical record by 2014. The American Recovery and Reinvestment Act of 2009 (ARRA) stimulus package will drive substantial funding for health information technology (HIT) adoption over the next seven years. ARRA appropriates billions for HIT infrastructure and provides significant incentives for health care providers to adopt electronic health records (EHR).

ARRA also includes the Health Information Technology for Economic and Clinical Health Act, also known as HITECH. HITECH sets forth a broad HIT agenda with concrete goals and objectives, significant changes to the HIPAA medical privacy and security rules, and criteria for how providers adopting EHR become eligible for bonus payments beginning in 2011. HITECH provides an enormous opportunity for those providers seriously interested in HIT adoption. At the same time, approaching EHR projects with the requisite planning and implementation tools these projects deserve is important.

HIT Promotion

President Obama's HIT agenda envisions HIT as a tool to drive efficiency and quality gains in the American health care system. In his inaugural address, President Obama promised that every physician office and hospital would have "cutting-edge technology and electronic medical records to cut red tape, prevent medical mistakes and help save billions of dollars each year." Congress responded within weeks by passing this historic legislation.

Section 3001 of HITECH codifies the U.S. Health and Human Services (HHS) Office of National Coordinator for Health Information Technology (ONC), which was established by executive order under the Bush administration. ONC has been given an extensive mission to develop a nationwide HIT infrastructure that:

- ensures health information is secure and protected
- improves health care quality, reduces medical errors and health disparities, and advances patient-centered medical care
- reduces health care costs from inefficiencies, medical errors, inappropriate care, duplicative care, and incomplete information
- provides appropriate information to help guide medical decisions at the point of service
- ensures the inclusion of meaningful public input in infrastructure development
- improves care coordination and health information sharing among physician offices, hospitals, labs, and others through an effective infrastructure for the secure and authorized exchange of health information
- improves public health and early identification and rapid response to public health threats and emergencies (e.g., bioterror events and infectious disease outbreaks)
- facilitates health and clinical research and health care quality
- promotes early detection, prevention, and management of chronic diseases

- promotes a more effective marketplace, greater competition, increased consumer choice, and improved outcomes in health care services
- improves efforts to reduce health disparities

HITECH affords the ONC a great deal of flexibility in implementing the HIT agenda. President Obama appointed Dr. David Blumenthal, a primary care physician and Harvard Medical School professor, as the new National Coordinator for HIT. Dr. Blumenthal is expected to bring significant health policy considerations to the position as the Obama administration links HIT adoption with health reform efforts. He will be advised by members of the new HIT Policy Committee, many of whom bring broad health policy experience to update the federal Health IT Strategic Plan. A HIT Standards Committee of HIT experts is also being appointed to recommend uniform standards, technical specification and certification criteria for HIT technologies.

Federal and State Stimulus Funding

HITECH includes substantial stimulus funding to encourage HIT adoption. Federal funding will be available to invest in the infrastructure needed for the nationwide health information network, assist with provider education and medical informatics programs, fund HIT/EHR research and development programs, provide grants to states to facilitate HIT acquisition, and fund extension programs and regional HIT centers to assist providers with implementing, operating and maintaining HIT. ONC will control a significant portion of the stimulus funds by awarding federal planning and implementation grants to states and state-designated entities (with broad stakeholder representation) to jump start HIT/EHR adoption. States are required to match at least 10% of any federal grants received from ONC. For example, by investing as much as \$15M in state funds for HIT implementation, Ohio may be eligible for as much as \$150M in matching federal funds. Rex Plouck, Governor Strickland's point person for HIT, hopes to create a state-designated entity for Ohio to help fund EHR software for physician practices and regional HIT extension centers for training and implementation assistance. Plouck has pointed to health information exchange efforts as a forum for best practices to reduce duplicate tests, adverse drug interactions, and redundancies. Plouck envisions connecting physicians to results reporting for labs, medications, and imaging. The statewide organization could also serve as Ohio's central contact for a nationwide electronic health information network.

Incentive Payments to Providers

Additional funding will be available directly to providers to encourage HIT/EHR adoption. Much of this funding will be made available to providers in the form of incentive payments through Medicare and Medicaid reimbursement. Medicare incentive payments for hospitals and physicians will begin in 2011 for those who can establish "meaningful use" of certified EHR technology. Incentive payments will be made over 5 years and are weighted with higher payments for early adopters.

Medicare incentive payments can reach \$44,000 for eligible physicians and up to \$11 million for hospitals. For example, physicians demonstrating meaningful use by 2011 or 2012 will receive \$18,000 in the first year, and \$12,000, \$8,000, \$4,000, \$2,000 respectively over the following

four years. Physicians practicing in a health professional shortage area (HPSA) can receive an additional amount of 10% in incentive payments. Hospital-based physicians (e.g., pathologists, anesthesiologists, or emergency physicians) would not be eligible for any incentive payments.

On the other hand, physicians choosing not to adopt HIT/EHR and engage in meaningful use by 2015 face reductions in their Medicare fee schedule -- 1% in 2015, 2% in 2016, and 3% in 2017 (see attached schedule).

First Pmt. Yr.	Incentive Payment per Payment Year						Non-Adoption Penalty
	1	2	3	4	5	Total	
2011	\$ 18,000	\$ 12,000	\$ 8,000	\$ 4,000	\$ 2,000	\$ 44,000	\$ -
2012	\$ 18,000	\$ 12,000	\$ 8,000	\$ 4,000	\$ 2,000	\$ 44,000	\$ -
2013	\$ 15,000	\$ 12,000	\$ 8,000	\$ 4,000	\$ -	\$ 39,000	\$ -
2014	\$ 12,000	\$ 8,000	\$ 4,000	\$ -	\$ -	\$ 24,000	\$ -
2015	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-1% of Medicare fee
2016	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-2% of Medicare fee
2017	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-3% of Medicare fee

* Courtesy of Dr. Brian Keaton

For hospitals, a formula for Medicare incentive payments begins in FY 2011 and similarly phases down over time. The base amount available is \$2M per year for eligible hospitals with add on payments to the DRG payment over a 4-year period based upon the quantity of annual discharges, Medicare payor mix, and a transition factor.

For providers with a high volume of Medicaid patients, Medicaid program incentive payments may be available for meaningful use of certified EHR technology. Providers eligible for Medicaid program incentive payments include pediatricians, federally qualified health clinics (FQHCs), rural health clinics (RHCs), and physician assistants in physician assistant-led RHCs. Medicaid program incentive payments are an alternative to Medicare incentive payments, so eligible professionals must choose which incentive program carries the best benefits. Eligible Medicaid professionals could receive up to \$63,750 in federal contributions towards the adoption, implementation, upgrade, maintenance, and operation of certified EHR technology. Subject to a cap on average allowable costs, up to 85% of \$25,000, or \$21,250, will be provided to eligible Medicaid professionals for certified EHR adoption, implementation, or upgrading and up to 85% of \$10,000, or \$8,500, to eligible Medicaid professionals to operate and maintain certified EHR systems for up to 5 years.

High volume Medicaid hospitals and children's hospitals with little Medicare revenue have alternative Medicaid program incentive payments as well.

What Constitutes Meaningful Use?

The concept that provider incentives are not tied to tangible investments in HIT is a fascinating aspect of HITECH. Rather, the incentives are intended to flow to those providers that can demonstrate meaningful use of certified EHR technology.

Demonstrating that a provider is a meaningful user of certified EHR technology is difficult, at least for now. The demonstration should become easier when HHS develops a regulatory definition of meaningful use. HITECH requires that HHS base its definition of meaningful use on 3 core concepts: (1) the provider must demonstrate that it is using certified EHR technology in a meaningful manner, which shall include the use of appropriate e-prescribing; (2) the provider must demonstrate that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination; and (3) the provider must submit information, in a form and manner specified by HHS, on such clinical quality measures and such other measures as selected by HHS. The core concepts for hospitals are similar without the e-prescribing component. Many industry associations have already begun preparing comments as to the appropriate definition even in advance of HHS rule making.

A key component of meaningful use is the requirement that the provider use certified EHR technology. Under HITECH, certified EHR technology is qualified EHR technology that has been certified as meeting HHS standards for the type of record involved (e.g., ambulatory EHR for office-based physicians or inpatient hospital EHR for hospitals). Qualified EHR technology consists of electronic records of health-related information on an individual that include demographic and clinical information (e.g., medical history and problem lists) with functionality for clinical decision support, physician order entry, and quality information reporting. The technology also needs to exchange and integrate electronic health information with and from other sources.

HHS has not provided any indication as to the certification standards that it will use to certify qualified EHR technology. Nevertheless, some industry stakeholders believe that HHS will look towards CCHIT certification as the standard. A detailed explanation of the CCHIT certification standards and process, along with a comprehensive list of all CCHIT certified EHR technology is available at the CCHIT website (<http://cchit.org>) and CCHIT's EHR blog (<http://ehrdecisions.com>).

Now what?

Nationally, only 15-20% of physicians and 20-25% of hospitals have implemented HIT systems,¹ although this adoption rate is thought to be higher in the metropolitan areas of Northeast Ohio. For these physicians and hospitals with significant investment in HIT, paying close attention to the HHS rulemaking efforts to ensure that their particular technology is certified for purpose of demonstrating "meaningful use" is a priority.

Most importantly, providers who have been considering the adoption of EHR technology will likely do so sooner now that the tipping point has been reached. The Medicare and Medicaid payment incentives are designed to do just that. The hope is that these incentives will ultimately off-set the start-up cost investment of a provider in HIT. This investment can be significant considering an initial license for an EHR system often ranges from \$25-45,000 per physician

¹ "Accelerating Progress: Using Health Information Technology and Electronic Health Information Exchange to Improve Care," in First Annual Report and Recommendations from the State Alliance for e-Health (2008).

together with ongoing maintenance and licensing fees ranging from \$3,000 to \$9,000 per physician annually.²

Healthcare providers who have not yet thought about EHR technology should not run out and buy the first package without first considering their own requirements and incentive eligibility. In addition, hospitals, state and regional health information exchanges, IT vendors and financial institutions will likely be developing packages to assist those physicians who may not have the internal resources to evaluate and/or fund EHR technology solutions.

Since physicians have until January 2012 to establish “meaningful use” and receive full payments under the stimulus plan, prudence dictates that these decisions be made consistent with project management for the desired result with an eye toward incentive eligibility.³ Most often, this begins with a requirements definition for the successful implementation of a solution. Whatever pathway chosen, it is clear that the investment and alignment of EHR technologies within the nationwide health information highway has now begun with full force. Stay tuned to *Northern Ohio Physician* as the robust HHS regulatory agenda and state level initiatives roll out.

² Id. These amounts may be lower for ASP model licenses not requiring significant investment in hardware or operating systems and higher for robust EHR systems with sophisticated decision support.

³ Physicians who wait until 2013 to establish meaningful use of a certified EHR technology are limited to \$27,000 over 3 years.