



Overview of Meaningful Use Regulations and Implementation Issues

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Agenda

- Welcome
- About HIT Now
- Overview of Rules
 - IFR Standards, Implementation Specifications and Certification
 - Medicare
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- Conclusion



HIT Now Coalition

- Founded in Spring of 2007.
- Central goal is advancing the adoption and use of health information technology to improve quality and outcomes and to lower costs.
- 55 Diverse Organizations representing patients, providers, payers, brokers and unions.
- 501(c)(4).

www.healthitnow.org



HIT Now Members

- Aetna
- Alliance for Plasma Therapies
- American Academy of Nursing
- American Cancer Society
- American Diabetes Association
- American Health Care Association
- American Heart Association
- American Homeowners Grassroots Alliance
- American Telemedicine Association
- AmeriSource Bergen
- The Boeing Company
- Bronx Regional Health Information Organization
- Business Roundtable
- CIGNA
- Consumers for Competitive Choice
- The Dow Chemical Company
- FasterCures
- Genetic Alliance
- Health Tech Strategies
- Intel
- International Brotherhood of Electrical Workers
- Latino Coalition
- Marshfield Clinic
- Mercy Medical Center
- Montefiore Medical Center
- National Alliance for Caregiving
- National Alliance on Mental Illness
- National Association of Health Underwriters
- National Association of Manufacturers
- National Center for Assisted Living
- National Disease Clusters Alliance
- National Medical Association
- National MS Society
- National Patient Advocate Foundation
- National Retail Federation
- New York Presbyterian Hospital
- Nortel
- Parkinson's Action Network
- Pharmaceutical Care Management Association
- Research!America
- RetireSafe
- Seniors Coalition
- Society for Human Resource Management
- United Health Group
- US Chamber of Commerce
- US Oncology
- Vanderbilt Center for Better Health
- Verizon
- WebMD Health Corp
- Whitman-Walker Clinic
- Women Work!
- World Institute on Disability
- Xerox Corporation



Meaningful Use Overview

Two Rules were posted on January 13, 2010 to implement ARRA incentives for health information technology:

1. What is an EHR? Interim Final Rule on EHR Standards, Specifications and Criteria.

<http://edocket.access.gpo.gov/2010/pdf/E9-31216.pdf>

2. What must people do to access billions in Medicare and Medicaid incentives? Proposed Rule on Medicare and Medicaid incentives.

<http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf>



IFR Overview

- Criteria
 - Stage 1 – 2011
 - Stage 2 – 2013 (defined in later rule)
 - Stage 3 – 2015 (defined in later rule)
 - Standards
 - Implementation Specifications
 - Certification
- 



IFR Overview

- The rule sets out standards, implementation specifications and certification criteria for EHRs.
- 24 criteria categories for eligible providers (EPs) and 22 criteria categories for hospitals.
- In addition, certified EHRs must include
 - patient demographic information
 - provide clinical decision support;
 - support physician order entry;
 - capture and query quality information; and
 - electronically exchange health information.



Stages

- *Stage 1 (2011)*. Focus on electronically capturing health information in a coded format, and using it to track clinical conditions and for care coordination purposes.
- *Stage 2 (2013)*. Expand on Stage 1 to include continuous quality improvement at the point of care. Stage 2 will be defined in a subsequent rule.
- *Stage 3 (2015)*. Expand on Stage 2 to promote decision support for high priority conditions, patient access to self management tools, access to comprehensive patient data and improving public health. Stage 3 will be defined in a subsequent rule.



IFR Criteria

Requirement	Example
Functional	<ul style="list-style-type: none">•E-Prescribing•Computerized Provider Order Entry (CPOE)•Reporting quality measures to CMS or States•Implementing clinical decision support rules
Administrative	<ul style="list-style-type: none">•Check insurance eligibility•Electronically submit claims
Privacy	<ul style="list-style-type: none">•Encryption•Audit trails•Verification information is not altered in transit•Create a record of disclosures
Patient Access	<ul style="list-style-type: none">•Electronic copy of their health information upon request•Access to lab results within 96 hours•Electronic copy of their discharge instructions



IFR Standards

- There are primary standards and some fall back alternative standards and vocabulary governing information exchange.
- HHS recognizes the need for a standard vocabulary to promote interoperability.
- HHS views the standards process as iterative, with new standards to be adopted as needed.
- HHS states that standards will be increasingly more demanding over time and certified EHR technology will need to include more capabilities.



IFR IS and Certification

Implementation Specifications

- Implementation specifications are the instructions or requirements to implement a standard.
- HHS adopted IS for health plan eligibility, claims transactions, and quality reporting.

Certification

- The rule requires all products must gain new certification and meet all the criteria to qualify as EHR technology for meaningful use incentives.
- HHS will publish a separate rule to recognize a certification program or programs to replace the current certification process.
- HHS has indicated the new certification rule will be released “shortly”.



Medicare and Medicaid Proposed Rule

- Provider adoption of an EHR is voluntary, but adoption and use generates incentive payments.
- Over time, those that don't adopt and use will face Medicare payment reductions.
- Payments depend on adoption year.
 - Year one adopters must use a certified EHR for 90 continuous days to qualify for payments. In subsequent years, the use must be demonstrated for the full year.
 - Year one Medicaid adopters can receive payments for adoption, implementation or upgrading EHRs. This includes staffing, maintenance and training.



Proposed Rule

- Medicare: EP and Hospital eligible for payments if:
 - Demonstrates use in a meaningful manner.
 - Demonstrates the technology provides for electronic exchange.
 - Submits reports on quality measures to HHS.
- Medicaid: EP and Hospital eligible for payments if:
 - Engaged in efforts to adopt, implement or upgrade certified EHR technology.
 - Demonstrates MU as defined by a State and approved by the Secretary.
 - States may add additional objectives to the definition of meaningful use, but HHS will reject any additions to EHR functionality.
- Switch: EPs can switch programs once prior to 2015.
- Hospitals can access both incentive programs.



Medicare Program – Who Gets Paid?

- EPs (physicians, not group practices).
- Hospitals.
- Critical Access Hospitals.
- Medicare Advantage organizations with provider employees or affiliates.
- NOT: SNFs, LTCAHs, Home Health, pharmacy, ESRD



Medicare Program EPs – What They Get Paid

- Is based on adoption year:

Calendar Year	First CY in which the EP receives an incentive payment				
	2011	2012	2013	2014	2015 and subsequent years
2011	\$18,000	N/A	N/A	N/A	N/A
2012	12,000	\$18,000	N/A	N/A	N/A
2013	8,000	12,000	\$15,000	N/A	N/A
2014	4,000	8,000	12,000	\$12,000	N/A
2015	2,000	4,000	8,000	8,000	\$0
2016	N/A	2,000	4,000	4,000	0
Total	\$44,000	\$44,000	\$39,000	\$24,000	\$0

- Additional payments for EPs who predominantly perform in a HPSA.
- Reimbursement cut in 2015 for EPs who do not meaningfully use.



Medicare Hospitals – What They Get Paid

- Payment based on formula:
 - (Base payment of \$2 million + \$200 per discharge for the 1,150th – 23,000th discharge) * Medicare Share * Transition Factor
 - Medicare share takes into account inpatient bed days, total bed days and charity care.
 - Transition Factor declines over time.
- Penalties apply for hospitals that do not meaningfully use in FY2015 and beyond.
- CAHs paid based on reasonable cost times Medicare share plus 20 percent and does not exceed 100 percent. Not available for cost reports after 2016.

Medicaid Program – Who Gets Paid?

- Certain Medicaid providers are eligible for incentive payments if they treat a minimum number of patients who are Medicaid eligible within any 90 day continuous period for a calendar year.

Provider	Minimum 90 Day Medicaid Patient Volume Threshold	Other
Physicians	30	Or the Medicaid EP practices predominantly in an FQHC or RHC – 30% “needy individual” patient volume threshold.
Pediatricians	20	
Dentists	30	
Certified Nurse Midwives	30	
Physician Assistants when practicing at an FQHC/RHC	30	
Nurse Practitioner	30	
Acute Care Hospital	10	
Children’s Hospital	N/A	
<i>“Needy Individual” defined as Medicaid or CHIP eligible, receiving charity care or paying a reduced fee based on income.</i>		



Medicaid EP – What They Get Paid

Statutory Cap on Net Allowable Costs	85 Percent Allowed for EPs	Cumulative Maximum Over 6 Years
\$25,000 in year 1 for most professionals	\$21,250	N/A
\$10,000 in years 2-6 for most professionals	8,500	\$63,750
\$16,667 in year one for pediatricians with Medicaid patient volume more than 20 percent but less than 30 percent	14,167	N/A
\$6,667 in years 2-6 for pediatricians with Medicaid patient volume more than 20 percent but less than 30 percent	5,667	\$42,500

Medicaid EPs – What they Get Paid and When


Calendar Year	Medicaid EPs who begin adoption in:					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	N/A	N/A	N/A	N/A	N/A
2012	8,500	\$21,250	N/A	N/A	N/A	N/A
2013	8,500	8,500	\$21,250	N/A	N/A	N/A
2014	8,500	8,500	8,500	\$21,250	N/A	N/A
2015	8,500	8,500	8,500	8,500	\$21,250	N/A
2016	8,500	8,500	8,500	8,500	8,500	\$21,250
2017	N/A	8,500	8,500	8,500	8,500	8,500
2018	N/A	N/A	8,500	8,500	8,500	8,500
2019	N/A	N/A	N/A	8,500	8,500	8,500
2020	N/A	N/A	N/A	N/A	8,500	8,500
2021	N/A	N/A	N/A	N/A	N/A	8,500
Total	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Payments may be reduced due to payments from sources other than State or local governments or if the EP is a pediatrician with at least 20 percent but not more than 30 percent Medicaid patient volume.



Medicaid Hospitals – What They Get Paid

Payment based on formula:

- $((\text{Base payment of } \$2 \text{ million} + \text{a discharge related amount for each year}) * (\text{yearly transition factor})) * ((\text{Medicaid inpatient bed days} + \text{Medicaid MCO bed days}) / ((\text{total inpatient bed days}) * ((\text{estimated total charges} - \text{charity care charges}) / (\text{estimated total charges}))))$.
 - Confused?
 - Example of Hospital A:
 - 20,000 discharges;
 - 34,000 Medicaid bed days;
 - 100,000 total bed days;
 - \$1 billion in total charges, \$200 million in charity care;
 - Hospital payment = \$6.2 million
- 




So What?

- HITN views the rules as we view other IT issues, namely do they:
 - Promote clinical quality?
 - Improve patient outcomes?
 - Lower costs?
- One example: oncology measures may not be appropriate for oncologists (i.e. screening for mammography). This may promote increased services and costs with little clinical value.



Conclusion

- The rules need to promote tools for physicians that help solve real problems for them.
 - While this challenge shouldn't be underestimated, the solution needn't be overcomplicated.
 - AHA, MGMA, HIMSS, others have already weighed in with initial thoughts.
 - HITN is withholding judgment to reflect on how the rules impact quality, outcomes and costs.
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Questions?

Joel White is the Executive Director of the Health IT Now Coalition, a diverse group of organizations representing patients, health providers, health insurers, agents, and brokers, employers and unions that have come together to help integrate information technology into health care.

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