Health Information Technology

HITECH Act, EHR Adoption, Meaningful Use Criteria, ARRA Grants, and Adoption Alternatives

May 2010

The MARYLAND
HEALTH CARE COMMISSION

HITECH

HITECH – Introduction and Overview

- On February 17, 2009, President Barack Obama signed the American Recovery and Reinvestment Act of 2009
- Title XIII of Division A comprises the provisions of HITECH, the Health Information Technology for Economic and Clinical Health Act

HITECH – Introduction and Overview

- HITECH enacts five major components of a new national health information technology (HIT) strategy
  - A restructured role for the federal government as the coordinator of federal HIT policy
  - An expanded role for the federal government in HIT testing and research
  - A federally subsidized role for states, nonprofits, and educational organizations in promoting and implementing HIT
  - Revisions to current privacy and security rules
  - Incentive payments for adoption of electronic health records (EHR)

HITECH – Introduction and Overview

- Prior federal role defined by executive order to create
  - Office of National Coordinator for Health Information Technology (ONC)
  - Healthcare Information Technology Standards Panel
  - Certification Commission for Health Information Technology
- HITECH creates expanded federal role
  - Authorizes ONC
  - Establishes a HIT Policy Committee and HIT Standards Committee
  - Identifies $17.5 Billion in incentive payments for adoption of EHRs
  - Authorizes the National Institute for Standards and Technology (NIST) to test and certify HIT, including EHRs

HITECH – Introduction and Overview

- Promotion of EHRs is HITECH's most dramatic difference from prior approaches
- Before HITECH, federal government relied upon efforts such as small demonstration awards for physicians, federal agency purchasing initiatives, and prototypical subsidies to promote e-prescribing
- HITECH now provides strong financial incentives for the adoption of EHRs by "meaningful users"

HITECH – Why Now?

- HITECH intends for HIT to play a transformative role in health care
  - EHRs can reduce adverse events
  - HIT can generate savings by eliminating errors and duplication
  - EHRs can accelerate and expand the pool of useful data by which to:
    - Conduct comparative effectiveness research
    - Identify provider variations and inefficiencies

Federal Policy – ONC

- Office of the National Coordinator for Health Information Technology
  - Develops nationwide HIT infrastructure for electronic use and exchange of information
  - Coordinates Health and Human Services' (HHS) HIT policy and programs
  - Recommends HHS standards, implementation specifications, and certification criteria for electronic exchange and use of health information

Federal Policy – ONC

- ONC advised by new ONC Federal Advisory Committees
  - HIT Policy Committee
    - Recommends policy for development and adoption of a nationwide HIT infrastructure permitting the electronic exchange and use of health information
    - Recommends order of priority for development, harmonization and recognition of standards, specifications, and certification criteria
  - HIT Standards Committee
    - Recognizes and recommends standards, implementation specifications, and certification criteria
    - Provides for standards and technology testing with NIST
    - Ensures consistency with HIPAA standards

Financial Incentives for EHRs

- Overview
  - Incentives require “meaningful use” of “certified EHRs”
  - Reports on “clinical quality” also required
  - Certified EHRs will demonstrate “meaningful use” to the satisfaction of the HHS Secretary
    - Details to follow regarding how “meaningful use” is demonstrated (e.g., attestation requirement, actual demonstration)
- EHRs must connect in a manner that provides for electronic exchange of health information to improve the quality of health care (e.g., promoting care coordination)
- Physicians – must use e-prescribing

Financial Incentives for EHRs

- Certified EHRs
  - Certified EHR technology is defined as a qualified electronic health record that is certified as meeting standards applicable to the type of record involved
  - ONC will consult with NIST to develop a program for certification of compliance with HITECH criteria
    - HIT Standards Committee recommends standards, implementation specifications, and certification criteria
    - HIT Policy Committee makes policy recommendations regarding these issues
    - December 31, 2009 deadline for initial standards, implementation specifications, and certification criteria

Financial Incentives for EHRs

- Qualified EHR
  - Defined as an electronic record of an individual's health-related information that contains demographic and clinical health information, and has the capacity to:
    - Provide clinical decision support;
    - Support physician order entry;
    - Capture and query information relevant to health care quality; and
    - Exchange electronic health information and integrate such information with other sources.

Physicians

Financial Incentives for EHRs

- Medicare incentives are available for Eligible Professionals (EPs)
  - An EP is defined as a physician
  - EPs will not receive incentives if they provide services in a hospital inpatient or emergency department setting
    - Recent Jobs Bill, HR 4213 includes a provision designed to make it easier for certain hospital-based physicians to receive incentives
    - Focus is on site of service, not identity of employer or billing arrangement
  - Excludes most pathologists, anesthesiologists, and emergency room physicians

Financial Incentives for EHRs

- The EP must be a “meaningful user” of EHRs
  - Must demonstrate to the satisfaction of HHS
  - Physicians must include the use of e-prescribing
  - EHR must connect in a manner that provides for the electronic exchange of health information to improve the quality of care
  - EHR must be able to report on clinical quality and other measures as determined by HHS

Financial Incentives for EHRs

- Details to follow regarding:
  - How much and what type of use is “meaningful”
  - What type of electronic exchange is sufficient
  - What clinical information must be provided
  - How much eRx will be required
- Standards for “meaningful use” will evolve as HHS will require more stringent measures of meaningful use over time

The Carrot – Calculation of Financial Incentives

- Medicare incentives for EPs are 75 percent of estimated allowed charges for a payment year, subject to caps
- Earliest payment year is calendar year 2011
- If the first year of meaningful use is 2013 or after, incentive payments “phase down”
- No incentives if the first payment year is after 2014
- No incentives paid after 2016

The Carrot – Calculation of Financial Incentives

Stimulus Medicare Incentives, per Physician							
	Pay-Out Year						
Starting Year	2011	2012	2013	2014	2015	2016	Totals
2011	$18,000	$12,000	$8,000	$4,000	$2,000	$0	$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					$0	$0	$0

The Stick – Decreases in Fee Schedule

- If an EP is not a “meaningful user” of EHR by 2015 or thereafter, the Medicare fee schedule amount for that EP will be cut as follows:
  - 1 percent for 2015
  - 2 percent for 2016
  - 3 percent for 2017 and thereafter
- HHS may establish hardship exceptions

Medicaid Incentives

- Alternative incentive system is included for professionals with specific percentages of patients receiving medical assistance or meeting a definition of “needy”
  - Receiving Medicaid assistance, CHIP assistance, uncompensated care, or charging for care on a sliding scale based on ability to pay
- Incentives may not exceed 85 percent of net allowable costs (as determined by HHS) for certified EHR technology, support, and training, subject to caps:
  - $25,000 in the first year
  - $10,000 for the second and subsequent years
  - No payments for more than five years or after 2021 (later than Medicare incentive program)
  - Pediatricians limited to 2/3 of these amounts

Medicaid Incentives

- Types of professionals eligible are broader than under Medicare incentive program and include:
  - Physicians
  - Dentists
  - Certified nurse midwives
  - Physician assistants leading rural health clinics or federally qualified health centers
- Professionals seeking Medicaid incentives must waive their right to receive the Medicare incentives

Medicaid Incentives

- To qualify, the professional must have the following patient volumes:
  - Professionals (not hospital based) – at least 30 percent of patients receiving medical assistance
  - Pediatricians (not hospital based) – at least 20 percent of patients receiving medical assistance
  - Professionals in rural health clinics/federally qualified health centers – at least 30 percent of patients are “needy”

Medicaid Incentives

- Professional must demonstrate “meaningful use” of certified EHR technology by the second and in later years of incentives
  - Demonstrate by means acceptable to HHS and to the State
- First year of costs must occur by 2016 (later than for Medicare incentive program)

Hospitals

Financial Incentives for Eligible Hospitals

- An eligible hospital (EH) excludes rehab hospitals, cancer and children's hospitals or hospitals with average stays of 25 or more days
- Separate incentives are available for critical access hospitals

Financial Incentives for Eligible Hospitals

- Calculation of the incentive for an EH is the product of three elements for the payment year in question:
  - The Initial Amount, multiplied by
  - The Medicare Share, multiplied by
  - The Transition Factor

Financial Incentives for Eligible Hospitals

- The Initial Amount is the sum of:
  - The Base Amount ($2,000,000), plus
  - The Discharge Related Amount
    - Zero for the first 1,149 total (not just Medicare) discharges;
    - $200 per discharge for discharges between 1,150 and 23,000;
    - Zero for discharges in excess of 23,000; and
    - Provides more incentive money for larger hospitals

Financial Incentives for Eligible Hospitals

- The Medicare Share for a period is a fraction
  - Intended to calculate the percentage of inpatient bed days that are Medicare bed days
- The Transition Factor is:
  - 1.0 for payment year one
  - 0.75 for payment year two
  - 0.50 for payment year three
  - 0.25 for payment year four
  - Zero thereafter
- The earliest payment year is fiscal 2011 and the transition factor will be reduced if the first payment year is after 2013
- The transition factor will be zero if the first payment year is after 2015 (resulting in no incentive payments)

Financial Incentives for Eligible Hospitals

- Example: Assume an EH with 15,000 discharges and 50 percent Medicare bed days
  - Initial Amount = $5,000,000 ($2,000,000 (base amount) plus $3,000,000 ($200 x 15,000 discharges))
  - Medicare Share = 50 percent, resulting in $2,500,000 ($5,000,000 x 0.50)
  - If the payment year is payment year one and occurs in fiscal year 2011, 2012 or 2013, then transition factor is 1.0 and the incentive for that year is $2,500,000

Financial Incentives for Eligible Hospitals

- “Meaningful Use” requirement
  - Requires demonstration of meaningful use of EHR to the satisfaction of HHS
  - Substantially similar requirements and issues as applicable to EPs
  - However, no requirement for eRx
  - As with EPs, standards for “meaningful use” will change as HHS requires more stringent measures of meaningful use over time

The Stick for Eligible Hospitals

- If an EH is not a meaningful user of EHR by 2015, then 3/4ths of the applicable fee schedule percentage increase otherwise due will be reduced as follows for the fiscal year in question:
  - 33 1/3 percent for FY 2015
  - 66 2/3 percent for FY 2016; and
  - 100 percent for FY 2017

Medicaid Incentives

- Incentives available for hospitals
  - Acute care hospitals with at least 10 percent of patient volume receiving medical assistance
  - Children’s hospitals regardless of volume
- Hospitals must adopt an EHR by 2016
- Payments limited to six years (longer than Medicare incentive)

Meaningful Use Criteria
Stage 1

(Proposed Rule)

Health Outcomes Policy Priority	Care Goals	Objectives	Measures
Improving quality, safety, efficiency, and reducing health disparities	Provide access to Comprehensive patient health data for patient's health care team Use evidence-based order sets and CPOE Apply clinical decision support at the point of care Generate lists of patients who need care and use them to reach out to patients Report information for quality improvement and public reporting	Use CPOE	CPOE is used for at least 80% of all orders
		Implement drug-drug, drug-allergy, drug-formulary checks	The EPI has enabled this functionality
		Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	At least 80% of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data
		Generate and transmit Permissible prescriptions electronically (eRx)	At least 75% of all Permissible prescriptions written by the EP are Transmitted electronically using certified EHR Technology
		Maintain active medication list	At least 80% of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data
		Maintain active medication allergy list	At least 80% of all unique patients seen, by the EP have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data
		Record demographics o preferred language o insurance type o gender o race o ethnicity o date of birth	At least 80% of all unique patients seen by the EP have demographics recorded as structured data
		Record and chart changes in vital signs: o height o weight	For at least 80% of all unique patients age 2 and over seen by the EP record blood pressure and BMI;

Health Outcomes Policy Priority	Care Goals	Objectives	Measures
		o blood pressure o Calculate and display: BMI o Plot and display growth charts for children 2-20 years, including BMI.	additionally plot growth chart for children age 2-20
		Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP have "smoking status" recorded
		Incorporate clinical lab-test results into EHR as structured Data	At least 50% of all clinical lab tests ordered whose results are in a positive/ negative or numerical format are incorporated in certified HER technology as structured data
		Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP with a specific condition
		Report ambulatory quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule; For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule
		Send reminders to patients per patient preference for preventive/ follow up care	Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over
		Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP is responsible for as described further in section II(A)(3).
		Check insurance eligibility electronically from public	Insurance eligibility checked electronically for at least 80%

Health Outcomes Policy Priority	Care Goals	Objectives	Measures
		and private payers Submit claims electronically to public and private payers.	of all unique patients seen by the EP At least 80% of all claims filed electronically by the EP
Engage patients and families in their health care	Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP Provide clinical summaries for patients for each office visit	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information Clinical summaries are provided for at least 80% of all office visits
Improve care coordination	Exchange meaningful clinical information among professional health care team	Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically Perform medication reconciliation at relevant encounters and each transition of care Provide summary care record for each transition of care and referral	Performed at least one test of certified EHR technology's capacity to Electronically exchange key clinical information Perform medication reconciliation for at least 80% of relevant encounters and transitions of care Provide summary of care record for at least 80% of transitions of care and referrals
Improve population and public health	Communicate with public health agencies	Capability to submit electronic data to immunization registries and actual submission where required and	Performed at least one test of certified EHR technology's capacity to submit electronic data to Immunization registries

Health Outcomes Policy Priority	Care Goals	Objectives	Measures
		accepted Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)
Ensure adequate privacy and security protections for personal health information	Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law. Provide transparency of data sharing to patient.	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary

ARRA Grant Opportunities

State HIE Exchange Cooperative Agreement Grant Program

- In August, the Department of Health and Human Services (HHS) released a Funding Opportunity Announcement (FOA) to provide grants for planning and implementation projects that advance appropriate and secure HIE across health care systems
- The application and *Health Information Technology State Plan* was submitted by October 16, 2009
  - The MHCC was notified in March that it received $9.3M

HIT Extension Program: Regional Centers Cooperative Agreement Program

- In August 2009, HHS released an FOA for establishment of Regional Centers to plan and implement the outreach, education, and technical assistance for providers to become “meaningful users” of EHRs
- The *Chesapeake Regional Information System for our Patients (CRISP)* is the lead applicant with support from the MHCC submitted the response by November 3, 2009
  - CRISP was notified in April that it received $5.5M

Beacon Community Cooperative Agreement Program

- In December 2009, HHS released a FOA to award approximately 15 communities in building and strengthening their health IT infrastructure
- Communities must have advanced rates of EHR adoption and the readiness to incorporate HIT to advance community-level care coordination and quality monitoring and feedback
  - Application due date – February 1st
  - Average award is $15M
  - Howard County consortium application was not funded

Development of a State Medicaid HIT Plan

- CMS will fund the development of an *HIT Planning Advanced Planning Document (HIT P-APD)* to obtain prior approval and secure 90 percent Federal Financial Participation for the planning activities that lead to the development of the *State Medicaid HIT Plan*
  - States have flexibility in the completion date of the HIT P-APD
  - Average award is $1.5M
  - Award determination made within 60-90 days from the submission of the HIT P-APD

Adoption Alternatives

EHR Product Portfolio – A Purchasing Guide

- The EHR product portfolio includes 26 vendors that meet the latest CCHIT certification requirements
- The web-based document includes a vendor contact list, privacy and security policies, product overview, pricing, and a user reference report
- The EHR product portfolio is updated semi-annually and all CCHIT vendors are invited to participate

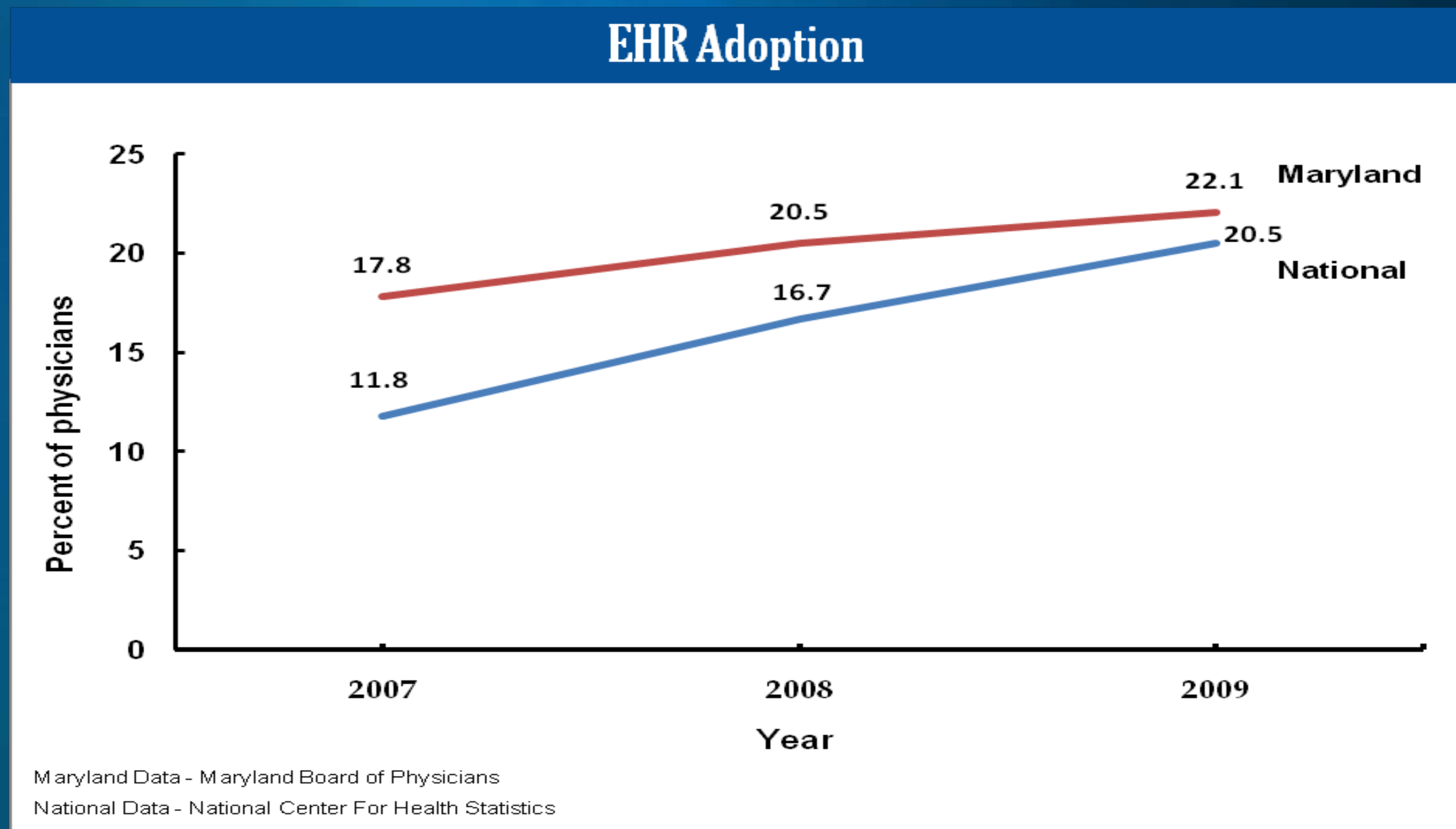
Hosted EHRs

- Existing law (HB 706) requires the MHCC to designate one or more management service organizations (MSOs) to offer services in the state by October 1, 2012 which:
  - Use an application service provider model to host one or more EHR systems through the Internet
  - Well positioned to leverage buying power and manage the technical aspects of EHRs
  - Will likely compete for market share based on their EHR solutions and other administrative practice support services
- An Advisory Board has been convened to identify criteria for MSOs that seek state designation
- The MHCC expects to begin designating MSO(s) during the third quarter of 2010

EHR Adoption

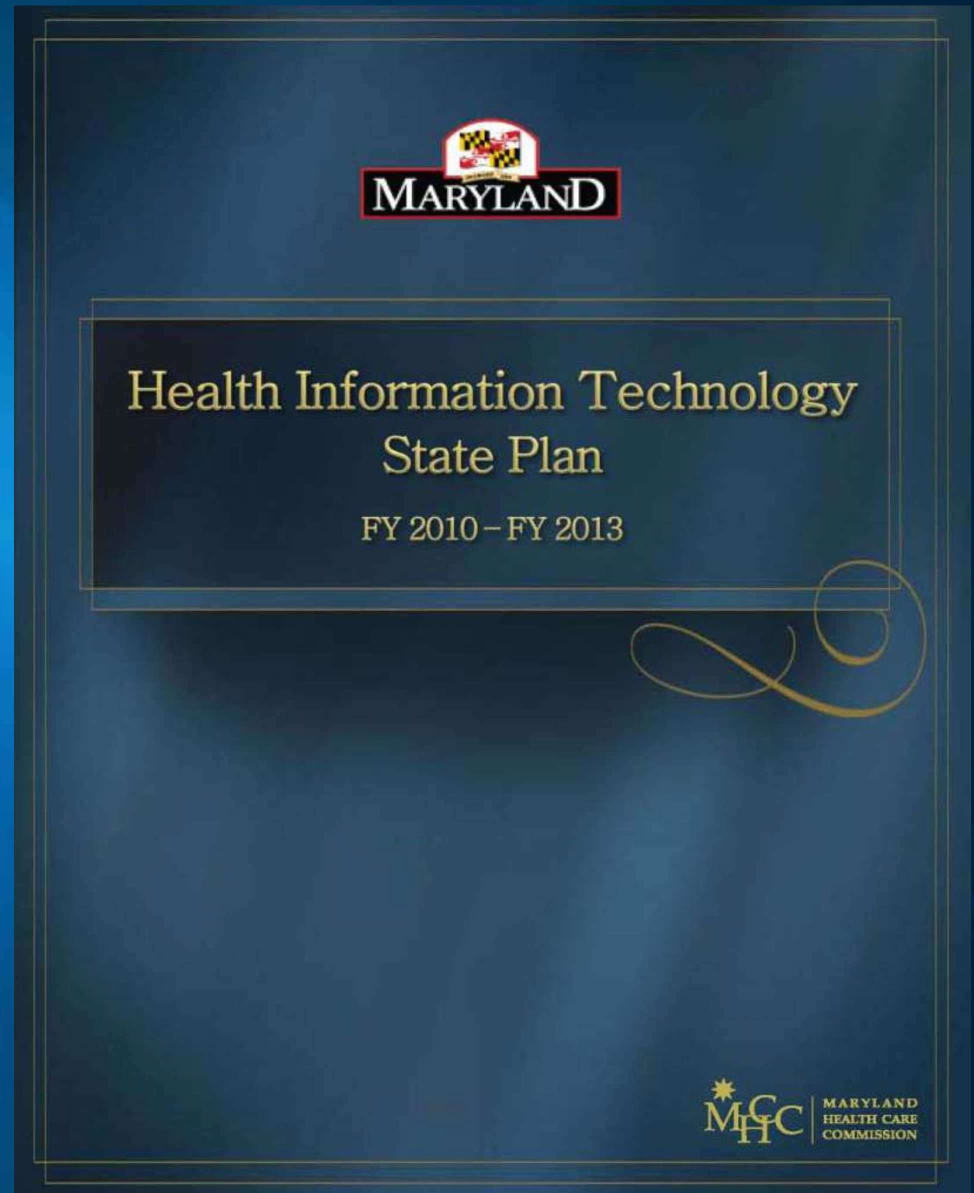
- Physician adoption reported nationally and locally

Hospital adoption ~77 percent *(MHCC Hospital Survey April 2009)*



A Comprehensive Health IT Plan

- A strategic and operational plan for health IT in Maryland
- Approved by the Office of the National Coordinator for Health Information Technology



Questions?

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