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**New Credit Risks in
The Era of ARRA**



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***What You Need to Know Now about the
Meaningful Use Proposed Rule,
Standards and Implementation
Specifications, and Interim Final Rule
Certification Criteria***

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Meaningful Use – Medicare and
Medicaid EHR Incentive Programs

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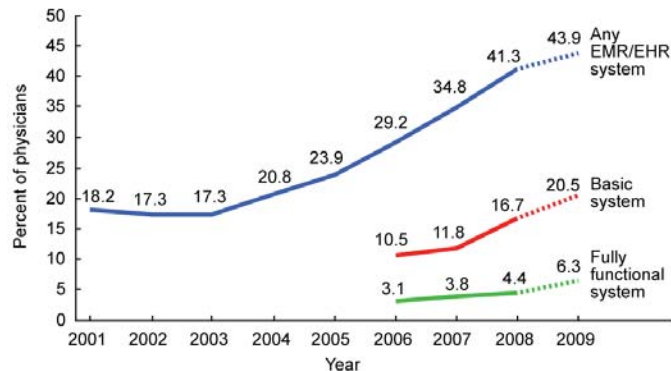
Adoption Rates

Setting	2006	2007	2008	2009*
Physicians offices (basic**)	11%	13%	17%	21%
Physicians offices (full**)	3%	4%	4%	6%
Hospitals (basic**)	N/A	N/A	8%	N/A
Hospitals (full**)	N/A	N/A	2%	N/A

*2009 statistics are preliminary.

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Figure. Percentage of office-based physicians using electronic medical records/electronic health records (EMRs/EHRs): United States, 2001–2008 and preliminary 2009



NOTES: Any EMR/EHR is a medical or health record system that is either all or partially electronic (excluding systems solely for billing). The 2009 data are preliminary estimates (as shown on dashed lines), based only on the mail survey. Estimates of basic and fully functional systems prior to 2006 could not be computed because some items were not collected in the survey. Starting in 2007, the skip pattern after the all or partial EMR/EHR systems question was removed. Includes nonfederal, office-based physicians. Excludes radiologists, anesthesiologists, and pathologists.
SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey.

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Five Broad Healthcare Goals for “Meaningful Use”

- Improve quality, safety, efficiency, and reduce health disparities
- Engage Patients and Families
- Improve Care Coordination
- Ensure adequate privacy and security protections for Personal Health Info
- Improve Population and Public Health

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Incentive Programs

- Medicare FFS EHR Incentive Program
 - Incentive payments made under the original Medicare Program
- Medicaid EHR Incentive
 - Incentive payments made under Medicaid
- MA EHR Incentive
 - Incentive payments made to qualifying MA organizations
- Medicare EHR Incentive Program
 - Includes both the Medicare FFS EHR and the MA EHR incentive programs

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- Incentive Programs are for Meaningful Use of Certified Technology
 - Eligible Professionals
 - Can not participate in both simultaneously
 - May change program participation once
 - Hospitals
 - Medicare and Medicaid

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Meaningful Use Defined

- An EP and an eligible hospital shall be considered a meaningful EHR user for an EHR reporting period for a payment year if they meet the following three requirements:
 - Use certified EHR in a meaningful manner (ex. E-Prescribing)
 - Utilize certified EHR technology that is connected in a manner that provides for the electronic exchange of health information to improve the quality of healthcare such as promoting care coordination
 - Submit information on clinical quality measures and other measures in a form and manner specified by the Secretary

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Key Definitions – Qualified EHR

- “An electronic record of health-related information on an individual that:
 - (A) includes patient demographic and clinical health information, such as medical history and problem lists; and
 - (B) has the capacity to:
 - (i) provide clinical decision support;
 - (ii) support physician order entry;
 - (iii) capture and query information relevant to health care quality; and
 - (iv) exchange electronic health information with, and integrate such information from other sources.”

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Key Definitions – Certified EHR Technology

- A Complete EHR or a combination of EHR Modules, each of which:
 - 1) meets the requirements included in the definition of a Qualified EHR; and
 - 2) has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary.

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Key Definitions - Eligibility

- **Eligible Professional**
 - **Medicare:** Doctor of Medicine, Doctor of Osteopathy, Dental surgeon, Doctor of Dental Medicine, Podiatrist, Optometrist, Chiropractor
 - **Medicaid:** Physicians, Pediatricians, Dentists, Certified Nurse Midwives, Nurse Practitioners, Physicians Assistants operating at an FQHC/RHC led by a Physician Assistant
- **Eligible Hospital**
 - **Medicare:** Subsection (d) hospitals that are paid under the hospital inpatient prospective payment system, Critical Access Hospitals; must reside in 50 the states or District of Columbia
 - **Medicaid:** Acute Care Hospitals, Childrens' Hospitals

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Medicare and Medicaid EHR Incentive Programs

- **Design -- Three-stage effort** (pages 40-43 of the **NPRM**):
- **Stage I** – Electronic capture of health information in a coded format; tracking key clinical conditions and communicating outcomes for care coordinating; implementing clinical decision support tools to facilitate disease and medication management; and reporting outcomes for public health purposes.
- **Stage II** – Expands on stage I. Encourages the use of health IT to enhance computerized provider order entry; transitions in care; electronic transmission of diagnostic test results; and, research.
- **Stage III** – Expands on stage II. Promotes improvements to quality and safety; focuses on clinical decision support at a national level by encouraging patient access and involvement; and, improved population health data.

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Incentive Programs Stage I Requirements

- Certified EHR technology that includes 25 measures; 17 metrics require attestation by the provider; eight require information submitted by the provider.
- Requires Computerized Provider Order Entry (CPOE) for 10% of all hospital orders and 80% of all eligible providers' orders
- Delineates robust clinical quality measures for eligible professionals (EPs) and eligible hospitals.
- Requires patients be provided with an electronic copy of test results, problem lists, medication lists, and discharge summary upon request.

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Stage of Meaningful Use Criteria by Payment Year

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015 +**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015+*					Stage 3

* Avoids payment adjustments only for EPs in the Medicare EHR Incentive Program.

** Stage 3 criteria of meaningful use or a subsequent update to the criteria if one is established through rulemaking.

Table 1 on Page 46 of the Medicare and Medicaid Programs; EHR Incentive Program (CMS-0033-P) December 2009

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Maximum Total Amount of EHR Incentive Payments for a Medicare EP who does not Predominantly Furnish Services in a HPSA

Calendar Year	First CY in which the EP Receives an Incentive Payment				2015 - subsequent years
	2011	2012	2013	2014	
2011	\$18,000	-----	-----	-----	-----
2012	\$12,000	\$18,000	-----	-----	-----
2013	\$8,000	\$12,000	\$15,000	-----	-----
2014	\$4,000	\$8,000	\$12,000	\$12,000	-----
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016	-----	\$2,000	\$4,000	\$4,000	\$0
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0

Table 22 on Page 194 of the Medicare and Medicaid Programs; EHR Incentive Program (CMS-0033-P) December 2009

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Medicare-FFS Incentive Program

Incentive Payment Calculation

- Incentive Payment Amount = [Initial Amount] x [Medicare Share] x [Transition Factor]
 - Initial amount = \$2,000,000 + [\$200 per discharge for the 1,150th - 23,000th discharge]
 - Medicare Share = Medicare / (Total x Charges)
 - Medicare = # of inpatient bed days for Part A + # of inpatient bed days for MA beneficiaries
 - Total = number of Total Inpatient Bed Days
 - Charges = Total charges minus charges for charity care divided by total charges

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Medicare-FFS Incentive Program

- Transition Factor

TABLE 25: Transition Factor for Medicare FFS Eligible Hospitals

Fiscal Year	Fiscal Year that Eligible Hospital First Receives the Incentive Payment				
	2011	2012	2013	2014	2015
2011	1.00	-----	-----	-----	-----
2012	0.75	1.00	-----	-----	-----
2013	0.50	0.75	1.00	-----	-----
2014	0.25	0.50	0.75	0.75	-----
2015	-----	0.25	0.50	0.50	0.50
2016	-----	-----	0.25	0.25	0.25

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Medicare-FFS Incentive Program

The chart below indicates how market basket payment reduction would work if a hospital is not a meaningful user and/or does not report quality data by FY 2015 and beyond.

Year	Report Data	MU EHR	Update
2015	X	X	2%
2015		X	1.50%
2015	X		1.50%
2015			1%
2016	X	X	2%
2016		X	1.50%
2016	X		1%
2016			0.50%
2017	X	X	2%
2017		X	1.50%
2017	X		0.50%
2017			0%

2018 and beyond incurs the same payment update = 0%

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Medicare-FFS Incentive Program

Critical Access Hospitals

- Incentive Payment Calculation
 - May receive incentive payments for the reasonable costs incurred for the purchase of depreciable assets like computers and associated hardware/software (excludes any depreciation and interest)
 - Incentive payment = product of reasonable costs incurred for the purchase of certified EHR technology x Medicare share percentage
 - Medicare share percentage cannot exceed 100 percent
 - 100 percent
 - Sum of Medicare share fraction and 20% points

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Medicaid EHR Incentive

TABLE 27: Maximum Incentive Payment Amount for Medicaid Professionals

Cap on Net Average Allowable Costs, per the HITECH Act	85 percent Allowed for Eligible Professionals	Maximum Cumulative Incentive over 6-year Period
\$25,000 in Year 1 for most professionals	\$21,250	
\$10,000 in Years 2-6 for most professionals	\$8,500	\$63,750
\$16,667 in Year 1 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$14,167	
\$6,667 in Years 2-6 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$5,667	\$42,500

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Medicaid EHR Incentive

TABLE 28: Payment Scenarios For Medicaid EPs Who Begin Adoption in the First

Year

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

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Medicaid EHR Incentive

Medicaid Share =

Medicaid inpatient bed days + Medicaid
managed care inpatient bed day

Total inpatient days x estimated total charges
minus charity care

estimated total charges

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Medicaid EHR Incentive

TABLE 31: Hospital Incentives

States will monitor compliance of hospitals coming onto the program with different requirements depending on the year. Incentive determination will also be based on Y1 versus subsequent years. This chart is an example, noting that hospitals may collect the incentive over 3-6 years.

CY	Demonstration of Compliance					
	2011	Y1	Y1 participants must demonstrate that they engaged in efforts to adopt, implement, or upgrade to certified EHR technology. However, if users already adopted, they may proceed to Y2 requirements in Y1.			
2012	Y2	Y1	Y1, same as above. Y2 must become a meaningful EHR user. We expect to issue definition of meaningful use on a biannual basis beginning in 2011.			
2013	Y3	Y2	Y1	Y1, same as above. Y2-3 will be the same.		
2014	Y4	Y3	Y2	Y1	Y1, same as above. Y2-4, same as above.	
2015	Y5	Y4	Y3	Y2	Y1	Y1, same as above. Y2-5, same as above.
2016	Y6	Y5	Y4	Y3	Y2	Y1
2017		Y6	Y5	Y4	Y3	Y2
2018			Y6	Y5	Y4	Y3
2019				Y6	Y5	Y4
2020					Y6	Y5
2021						Y6

← Becomes more difficult to establish meaningful use.

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Eligible Professionals

- **Clinical Data Repository** – store, retrieve, and manage medications and laboratory and radiology results.
- **Clinical Documentation** – provide appropriate referrals, problem list, current medication list.
- **Clinical Decision Support** – implement drug-drug, drug-allergy, and drug-formulary checks.
- **CPOE** - in the areas of medications, laboratories, radiology/imaging, and provider referrals.
- **E-Prescribing** - Requires electronic generation and transmission of permissible prescriptions.

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Eligible Professionals

- **Financial Information Systems** – ability to check insurance eligibility and submit claims electronically.
- **Patient Communication** – ability to electronically generate reminders, provide test results, problem lists, and immunizations.

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- Implementation
 - Purchasing an EHR is just the beginning
 - It is not just an electronic chart
 - Workflow issues
 - Loss of productivity

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- ROI
 - Patient safety
 - Quality
 - National quality comparisons
 - Business case of health care

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Riverpoint Pediatrics

- Solo practice founded in 1978
- Currently has 1 PA and 2 MOA, 1 Billing Specialist, 1 Part time receptionist

<u>Cost Element</u>	<u>Initial</u>	<u>Ongoing</u>
EHR Software	\$7000	None
Hardware	\$18,500	\$1500
Installation	\$1300	None
Implementation Support	None other than training	None
Training	4 days training at \$700 per day for total of \$2800	None
Coverage for physicians during training or lost revenue (if any)	10% loss of revenue for two days. The third day I went live with no loss of revenue.	None
Interfaces or EDI connections	PMS Interface-No Charge	None
Annual Support Fees	None	Annual support Fee \$2610

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	1999 (Before EHR)	2003 (After EHR)	% Increase
Revenue	\$301,080	\$534,556	77.5%
Profit	\$120,000	\$229,000	90.8%

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North Fulton Family Medicine

- Two sites; 51,000 encounters annually
- 7 MDs, 9 PAs or NPs
- 38 additional staff

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Cost Element	Initial	Ongoing
EHR Software	\$112,000	\$26,000/year
Hardware	\$18,000	N/A
Installation	Included in "implementation support" line item below	Included in "implementation support" line item below
Implementation Support	\$37,000	N/A
Training	Included in "implementation support" line item below	Included in "implementation support" line item below
Coverage for physicians during training or lost revenue (if any)	N/A	N/A
Interfaces or EDI connections	Included in "EHR software" line item above	Included in "EHR software" line item above
Other	N/A	N/A

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- Value Highlights:
 - Two front office staff processed 100 patients per day in 1998, and now process more than 330 patients per day
 - Recouped transcription costs since implementation total approximately \$775,000
 - Time on administrative functions drastically decreased:
 - Chart handling time per day reduced from 625 minutes to zero
 - Missing chart searches time per day reduced from 330 minutes to zero
 - Transcription processing time per day reduced from 705 minutes to zero
 - Lab result handling time per day reduced from 570 minutes to zero

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- With EMR and LabCalls, the practice has reduced the load on their overtaxed phone system by nearly 32%
- Referral letters are now automatically generated within the EMR, populating the letter template with patient information and specialist's contact information.
- First year results revealed the practice's growth strategy resulted in an estimated savings of \$4,594 per day or \$1,249,568 annually
- Ongoing annual savings of \$275,000 on average

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QUESTIONS?

Thank you!

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