Meaningful Use and Physician Integration Strategies

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Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs

Presented By:

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Overview

- Final Rule implements provisions of the American Recovery and Reinvestment Act of 2009 (ARRA)
- ARRA provides for nearly $38 Billion in incentive payments for adopting, implementing, upgrading, or demonstrating Meaningful Use of certified EHR technology
- Three programs: Medicare, Medicare Advantage, and Medicaid

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Eligible Providers

- Eligible Professionals (EPs)
  - "Hospital-based" EPs are <u>not</u> eligible for incentive payments
- Eligible Hospitals
- Critical Access Hospitals (CAHs)

Timing

- The Medicare program is now operational as of January 3, 2011
- Participation is not mandatory in 2011 in order to receive maximum incentives
- Eleven State Medicaid programs have been approved, and are operational
- EPs and eligible hospitals have already received incentive payments

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What is Meaningful Use?

- The programs require Meaningful Use of "Certified EHR Technology"
- Three main components
  1. Clinical Use
  2. Exchange of Information
  3. Quality Reporting
- Physician integration

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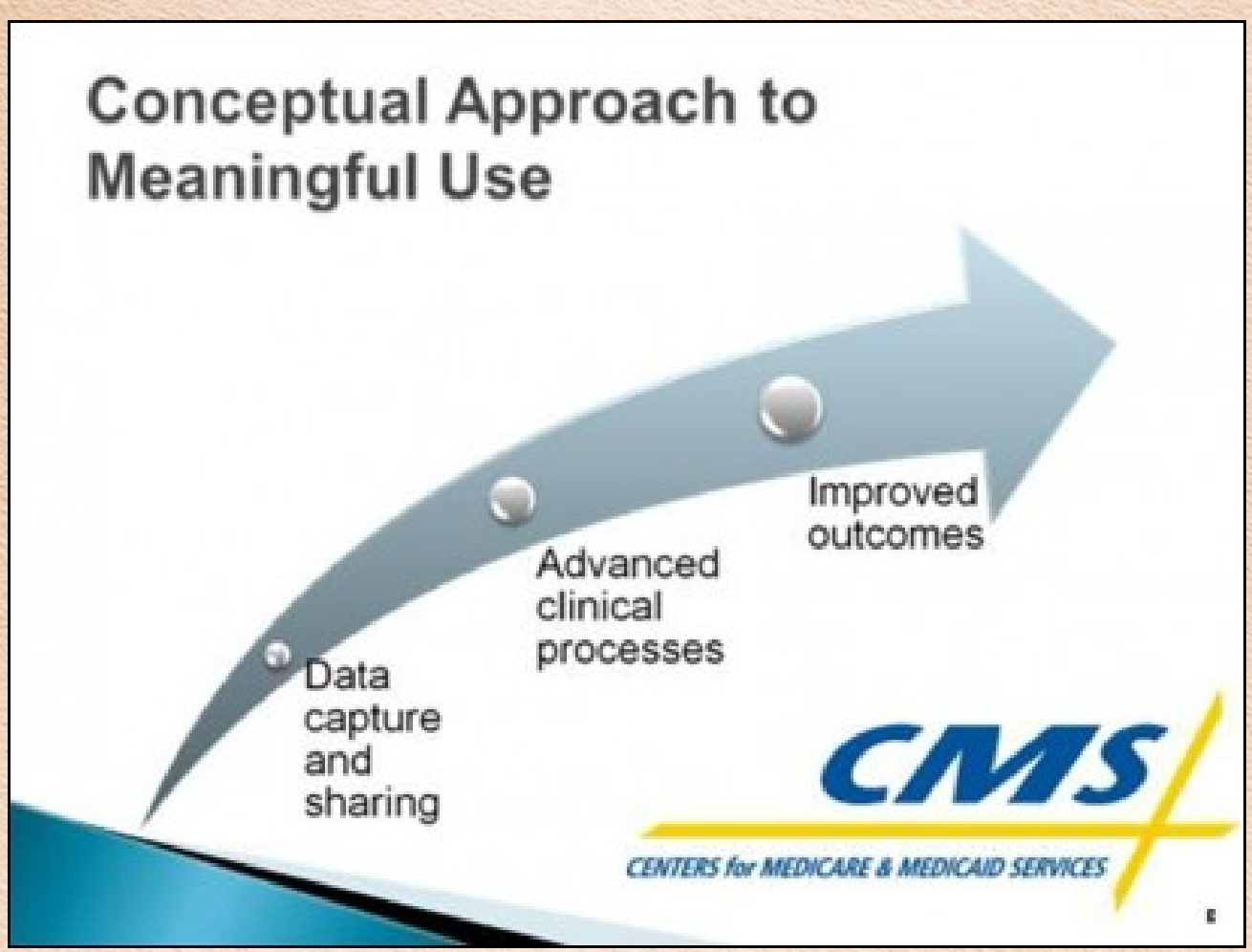
Staged Criteria



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Staged Criteria

TABLE 1: 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	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD

Table found at 75 Federal Register 44323

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Stage 1 Requirements

- EPs: 25 objectives
  - 15 required core objectives
  - 10 menu set objectives
  - 20/25 must be met
- Eligible hospitals: 24 objectives
  - 14 required core objectives
  - 10 menu set objectives
  - 19/24 must be met

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Clinical Quality Measures (CQMs)

- EPs: 6 CQMs (3 core, and 3 additional)

TABLE 7: Measure Group: Core for All EPs, Medicare and Medicaid

NQF Measure Number & PQRI Implementation Number	Clinical Quality Measure Title
NQF 0013	**Title:** Hypertension: Blood Pressure Measurement
NQF 0028	**Title:** Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention
NQF 0421 PQRI 128	**Title:** Adult Weight Screening and Follow-up
	Alternate Core Measures
NQF 0024	**Title:** Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	**Title:** Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
NQF 0038	**Title:** Childhood Immunization Status

Table found at 75 Federal Register 44410

- Eligible hospitals (15 required core)

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Incentive Programs

- Medicare
  - EPs
  - Eligible hospitals
- Medicaid
  - EPs
  - Eligible hospitals

Medicare Incentive Program Basics

- Incentive payments to EPs, eligible hospitals, and CAHs that demonstrate Meaningful Use of certified EHR technology
- Can begin in 2011; 2016 is last year for payment
- Payment years must be consecutive—no gaps permitted
- For 2015 and later, EPs, eligible hospitals, and CAHs that fail to successfully demonstrate Meaningful Use will have a payment adjustment in Medicare reimbursement

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Medicare Incentive Program Eligibility

- EPs
  - Doctor of medicine or osteopathy
  - Doctor of dental surgery or dental medicine
  - Doctor of podiatry
  - Doctor of optometry
  - Chiropractor
- Eligible Hospitals
  - Subsection (d) hospitals in the 50 states or D.C.
  - CAHs

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Medicare Program Incentive Payments for EPs

- Up to $44,000 over five years
- No incentive payment made after 2016

Table 1: Maximum Incentive Payments Based on the First CY in Which an EP Participates in the Program

Calendar Year	*Maximum Incentive Payments Based on the First CY in Which an EP Participates in the Program*			
	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
2016		$2,000	$4,000	$4,000
Total	$44,000	$44,000	$39,000	$24,000

Table found at CMS Tip Sheet: Medicare EHR Incentive Payments for Eligible Professionals, pg. 3

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Medicare Program Incentive Payments for Eligible Hospitals and CAHs

- Up to four years of incentive payments
- Must begin by 2015, and 2016 is last year of payment—regardless of when payment began
- Payment is calculated as the product of three items:
  1. Initial amount
  2. Medicare share
  3. Transition factor

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Medicaid Incentive Program Basics

- Incentive payments to EPs, eligible hospitals, and CAHs as they "adopt, implement, upgrade," **or** demonstrate Meaningful Use of certified EHR technology in their first year of participation, and demonstrate Meaningful Use for up to five remaining years
- Voluntarily offered by individual states and territories beginning as early as 2011
- Final year of payment is 2021
- Payment years need not be consecutive
- No penalties, but no HPSA bonuses

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Medicaid Incentive Program Eligibility

- EPs
  - Physicians (as defined by each state)
  - Nurse practitioners
  - Certified nurse-midwives
  - Dentists
  - Physician assistants who furnish services in a FQHC or RHC that is led by a physician assistant
- Eligible Hospitals
  - Acute care hospitals
  - Children's hospitals

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Medicaid Incentive Program Patient Volume Threshold

TABLE 15: Qualifying Patient Volume Threshold for Medicaid EHR Incentive Program

Entity	Minimum 90-day Medicaid Patient Volume Threshold	
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 led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	N/A
Children's hospital	N/A	N/A

Table found at 75 Federal Register 44487

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"Adopt, Implement, or Upgrade"

- Adopt—acquire and install certified EHR technology
  - E.g., demonstrate evidence of installation
- Implement—begin using certified EHR technology
  - E.g., staff training or data entry of patient demographic information into EHR
- Upgrade—expand existing technology to meet certification requirements
  - E.g., upgrade to certified EHR technology or add new functionality to meet the definition of certified EHR technology

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Medicaid Program Incentive Payments for EPs

- Up to $63,750 over six years
- Must begin receiving incentive payments no later than 2016
- Pediatrician incentive payments are 2/3 the maximum if they meet a 20% Medicaid patient volume threshold, but fall short of the 30% mark
- Incentives are the same whether adopting, implementing, or upgrading in year 1, **or** demonstrating Meaningful Use in year 1

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TABLE 17: 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

TABLE 18: Maximum Incentive Payments for Medicaid EPs Who Are Meaningful Users in the First Payment Year

Calendar Year	Medicaid EPs who begin meaningful use of certified EHR technology 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

Tables found at 75 Federal Register 44496-97

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Medicaid Program Incentive Payments for Eligible Hospitals and CAHs

- Payment made for no more than six years
- No payment made after 2016, unless a payment was made in the previous year
- Incentive payment amount is the product of two factors:
  1. Overall EHR amount
     - (Initial amount) x (Medicare share) x (transition factor)
  2. Medicaid Share

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Eligible for Both Programs?

- EPs must choose one when they register
- Hospitals eligible for both should select "Both Medicare and Medicaid" at registration
- EPs may switch only once after the first incentive payment and before 2015

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Nuts and Bolts

- Registration and Attestation
  - https://ehrincentives.cms.gov/hitech/login.action
- Payment
- Oversight

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Important Dates

- 10/1/10 – Reporting year begins for eligible hospitals and CAHs.
- 1/1/11 – Reporting year begins for EPs.
- 1/3/11 – Registration for the Medicare Program begins.
- 1/3/11 – For Medicaid providers, states may launch their programs if they so choose.
- April 2011 – Attestation for the Medicare Program begins.
- May 2011 –Incentive Payments expected to begin.
- 7/32011 – Last day for eligible hospitals to begin their 90-day reporting period to demonstrate Meaningful Use for the Medicare Program.
- 9/30/11 –End of reporting year for eligible hospitals and CAHs.
- 10/1/11 – Last day for EPs to begin their 90-day reporting period for calendar year 2011 for the Medicare Program.
- 11/30/11 – Last day for eligible hospitals and critical access hospitals to register and attest to receive an Incentive Payment for FY 2011.
- 12/31/11 – Reporting year ends for EPs.
- 2/29/12 – Last day for EPs to register and attest to receive an Incentive Payment for CY 2011.

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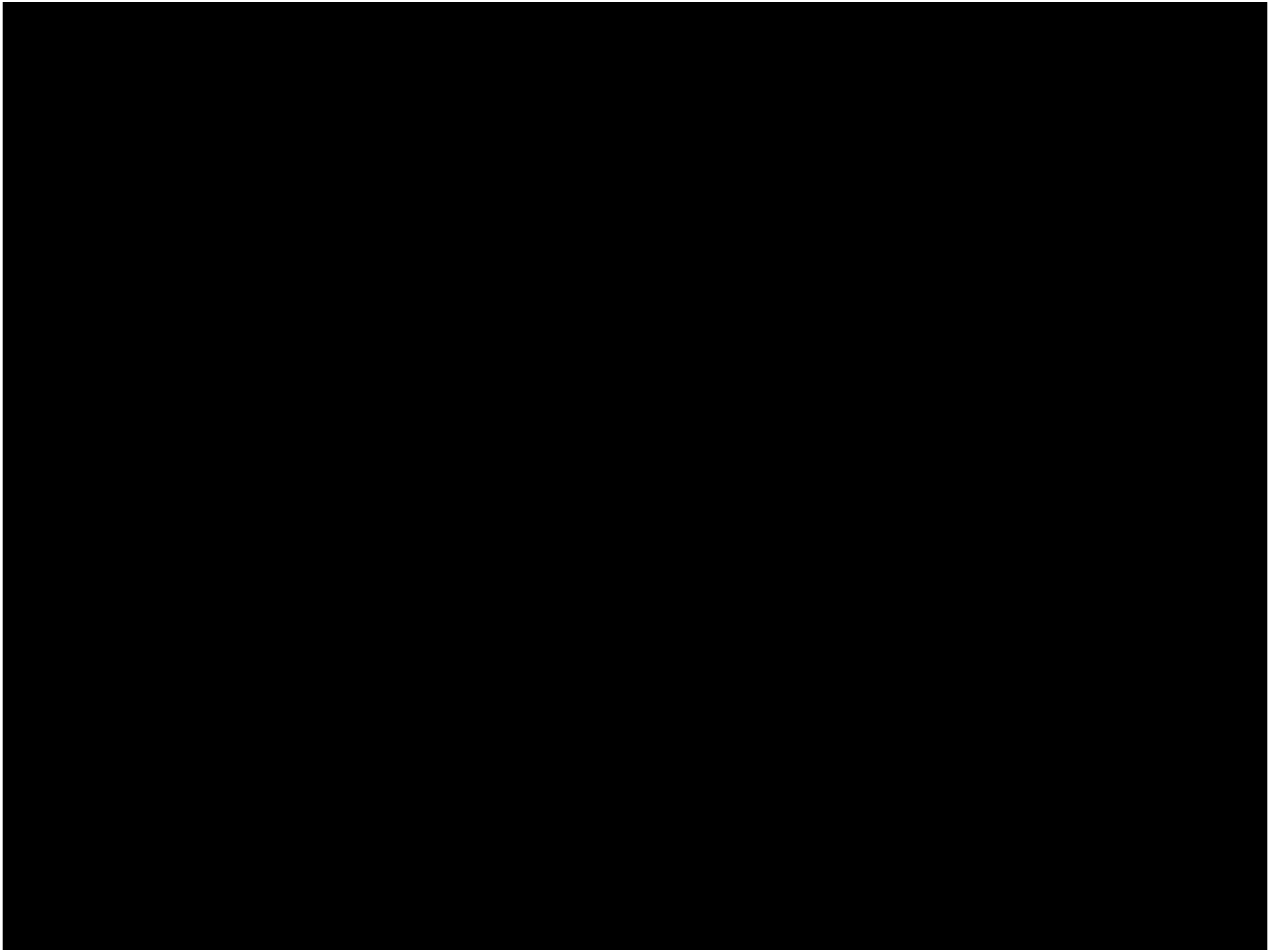

Physician Integration Strategies

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Benefits of Integration

- Revenue enhancement
- Increased efficiency
- Reduced costs
- Improved patient care
- Competitive pressure to expand EHR adoption

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Modes of Achieving Integration

- Successful efforts to date have included one or more of the following:
  - Physician employment
  - Granting subsidies for implementation
  - Purchasing and amortization of software licensing
  - Implementing of management services agreements with monthly fee arrangements
  - Working with third-party payers to negotiate financial incentives for use of EHRs
  - Creating an independent entity to facilitate systems management
  - Utilizing beta-testing agreements
  - Physician education
  - Phasing in physicians based on specialty or role within the hospital's mission
  - Providing a choice between appropriate EHR services
  - Granting physicians a role in hospital governance
  - Imposing mandates on affiliated physicians

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Stark Exception/Anti-Kickback Safe Harbor for EHR

- Interoperable when provided
- Donor does not limit interoperability with other EHR or e-prescribing systems
- Physician pays 15% of the donor's cost of items/services before their receipt
- Receipt of items is not a condition of doing business with donor
- Arrangement does not take into account the volume or value of referrals
- Terms of donation are set forth in a written agreement
- Donor is not aware that the recipient already has an equivalent form of the items to be donated
- No restrictions regarding recipient's ability to use EHR for any patient, regardless of payer status
- Items/services do not include staffing or uses not related to the medical practice
- EHR contains e-prescribing component when provided
- Transfer of items/services is complete by December 31, 2013

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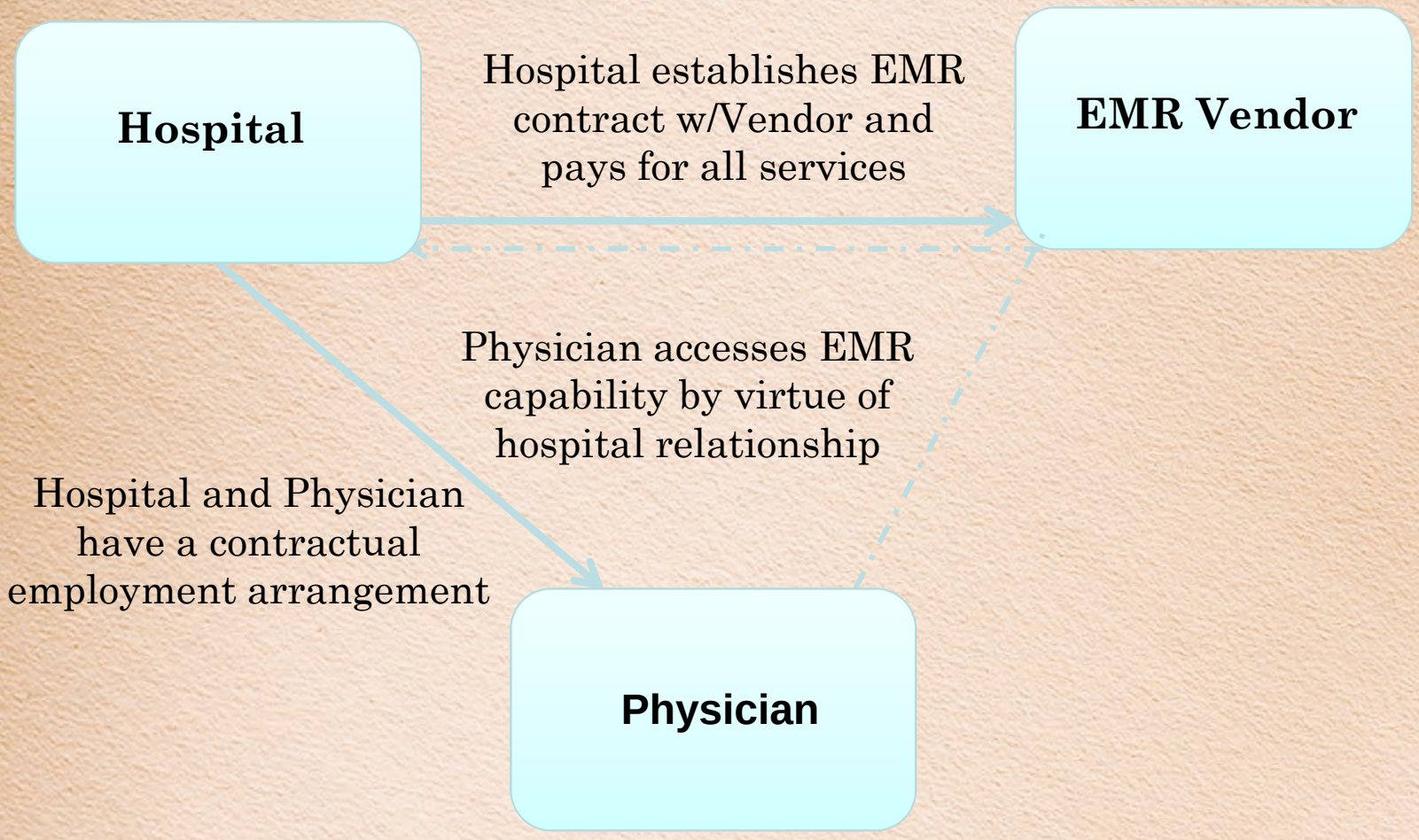
Increase Physician Employment



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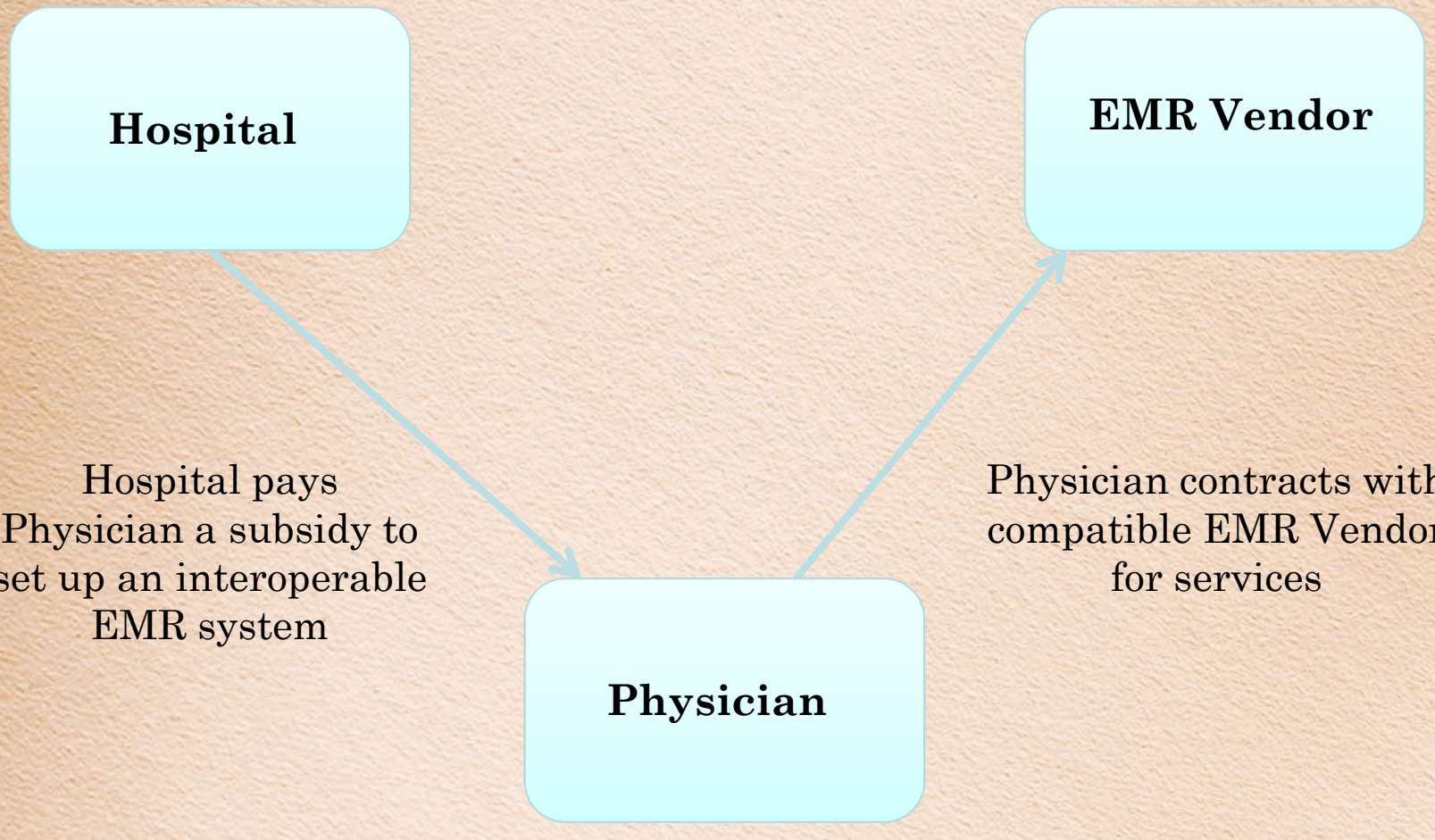
Increase Physician Employment (cont'd)

- Advantages
  - Hospitals: complete control over EHR adoption and no need to find regulatory exception to justify expenditures
  - Physicians: better malpractice premiums, more predictable income and caseload, less administrative hassle/overhead

Increase Physician Employment (cont'd)

- Disadvantages
  - Not a viable strategy for physicians who want to remain independent or for providers lacking capital to employ a large group of physicians
  - For hospitals, large up-front risk and potential for sunk cost

Grant Subsidies to Physician Participants



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Grant Subsidies to Physician Participants (cont'd)

- "Safe Harbor" under the Stark Regulations allows hospitals to donate EHR hardware/software to physicians
  - Recipient physicians must contribute 15% toward donor's cost of any items and services provided

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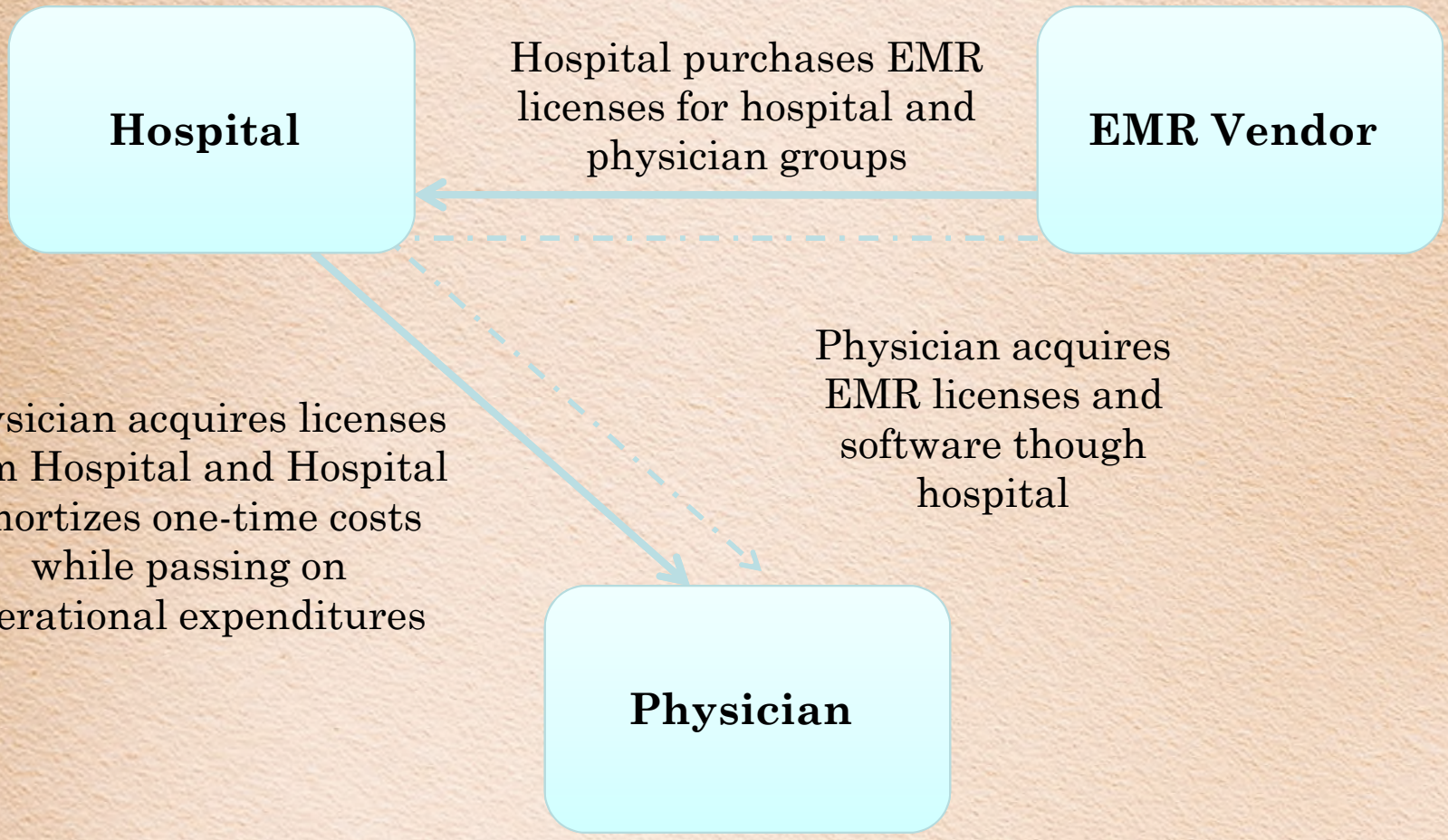
Purchase EHR Licensing



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Purchase EHR Licensing (cont'd)

- Hospitals can purchase the initial set of EHR licenses and amortize them back to physicians over 3 or 5 years
  - Eliminates most up-front costs for physician practices
- Negotiate discounted licenses for physician office modules when setting the price for hospital modules
  - Discount can be passed on to physicians who sign up

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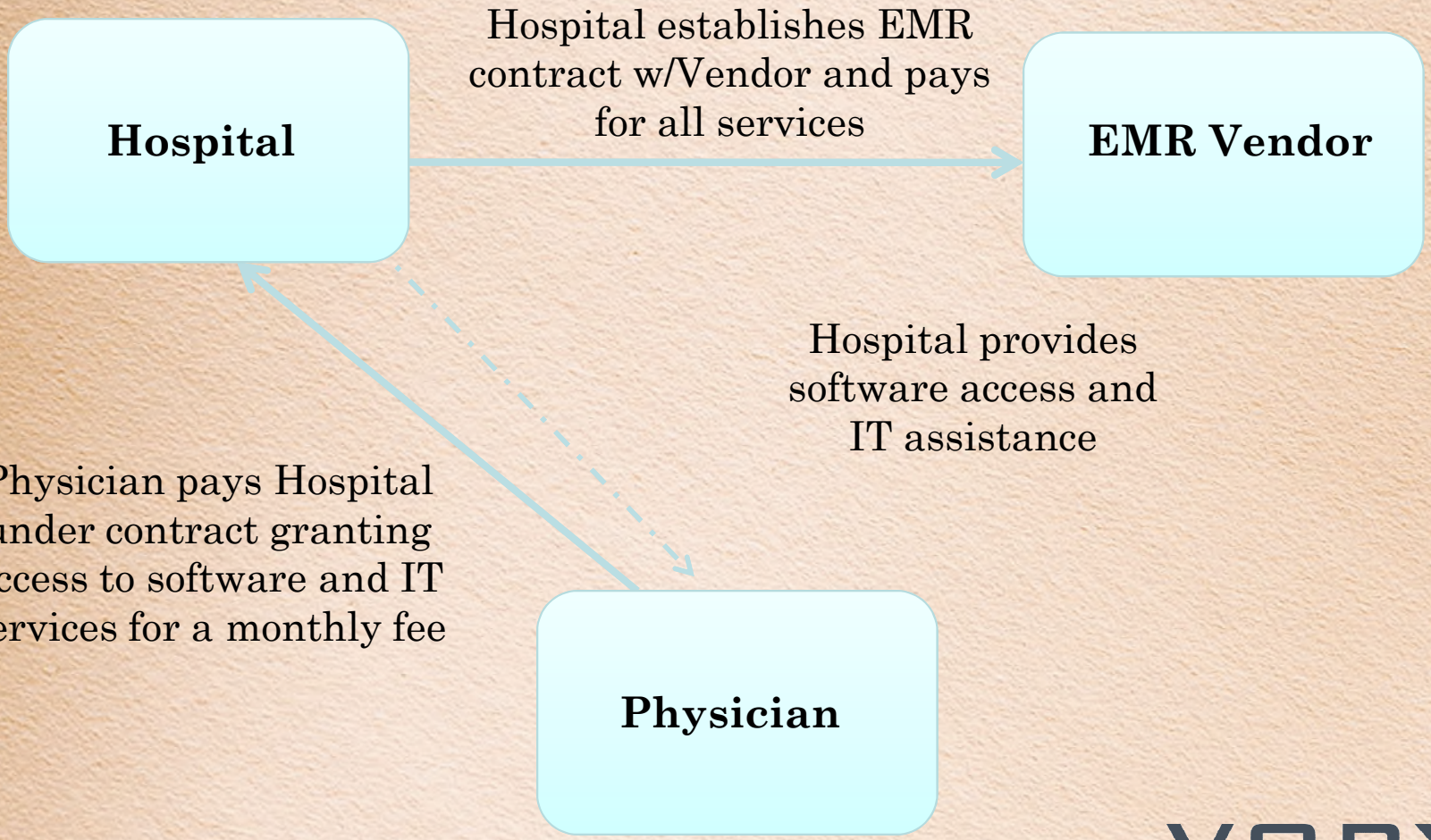
Institute a Management Services Agreement



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Institute a Management Services Agreement (cont'd)

- Hospitals charge physicians a monthly subscription fee to enable physicians to have access to their systems
  - Fee includes:
    - License/maintenance fees
    - Technical support
    - Costs of implementation/upgrades
    - Setup and maintenance of network and interfaces

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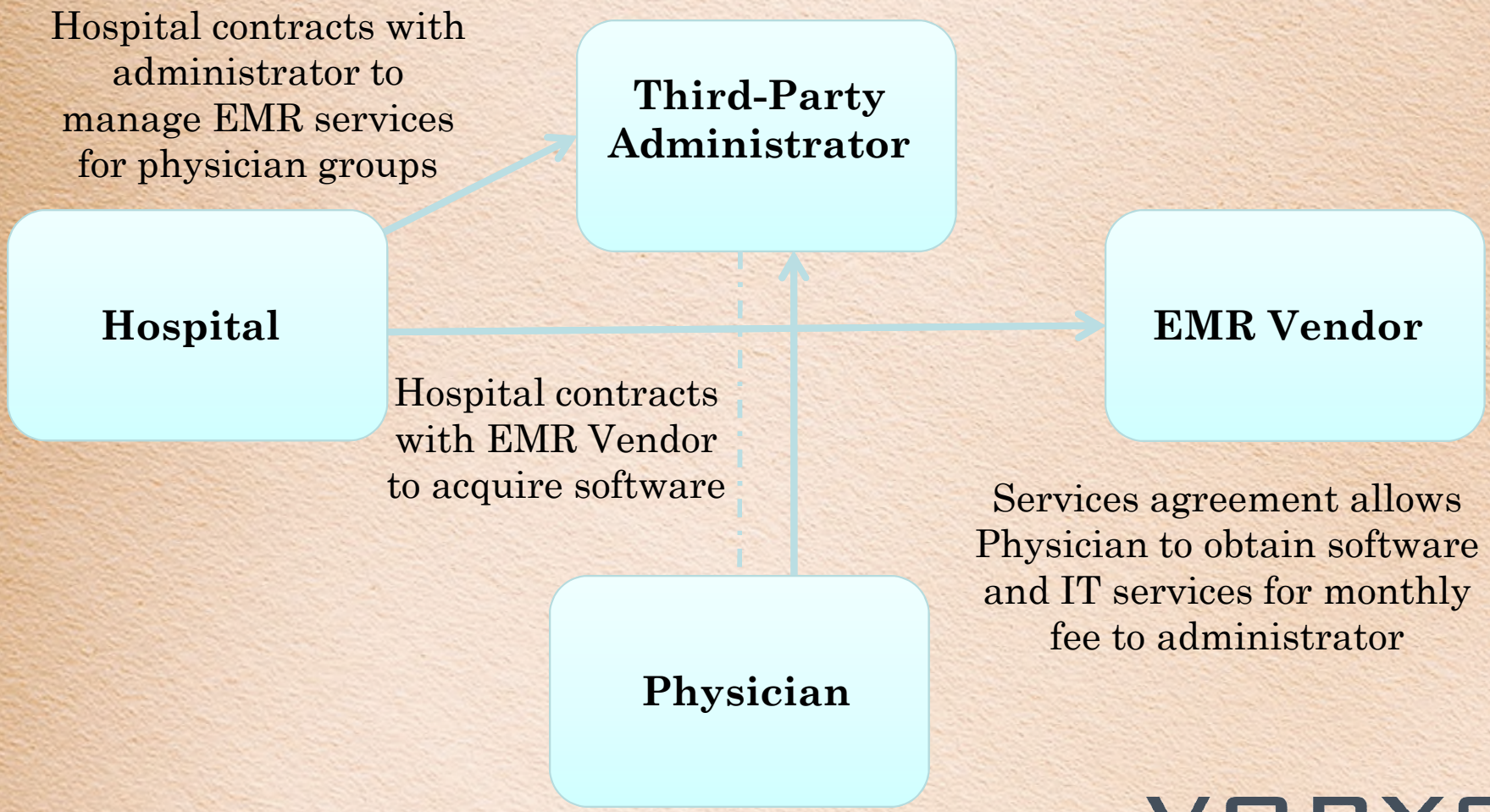
Create an Independent Entity to Implement EHR Support Services



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Create an Independent Entity to Implement EHR Support Services (cont'd)

- Prevents physicians from being directly dependent on the hospital and gives them more independence
- Sets the stage for the independent system to merge with the hospital's system at a later date

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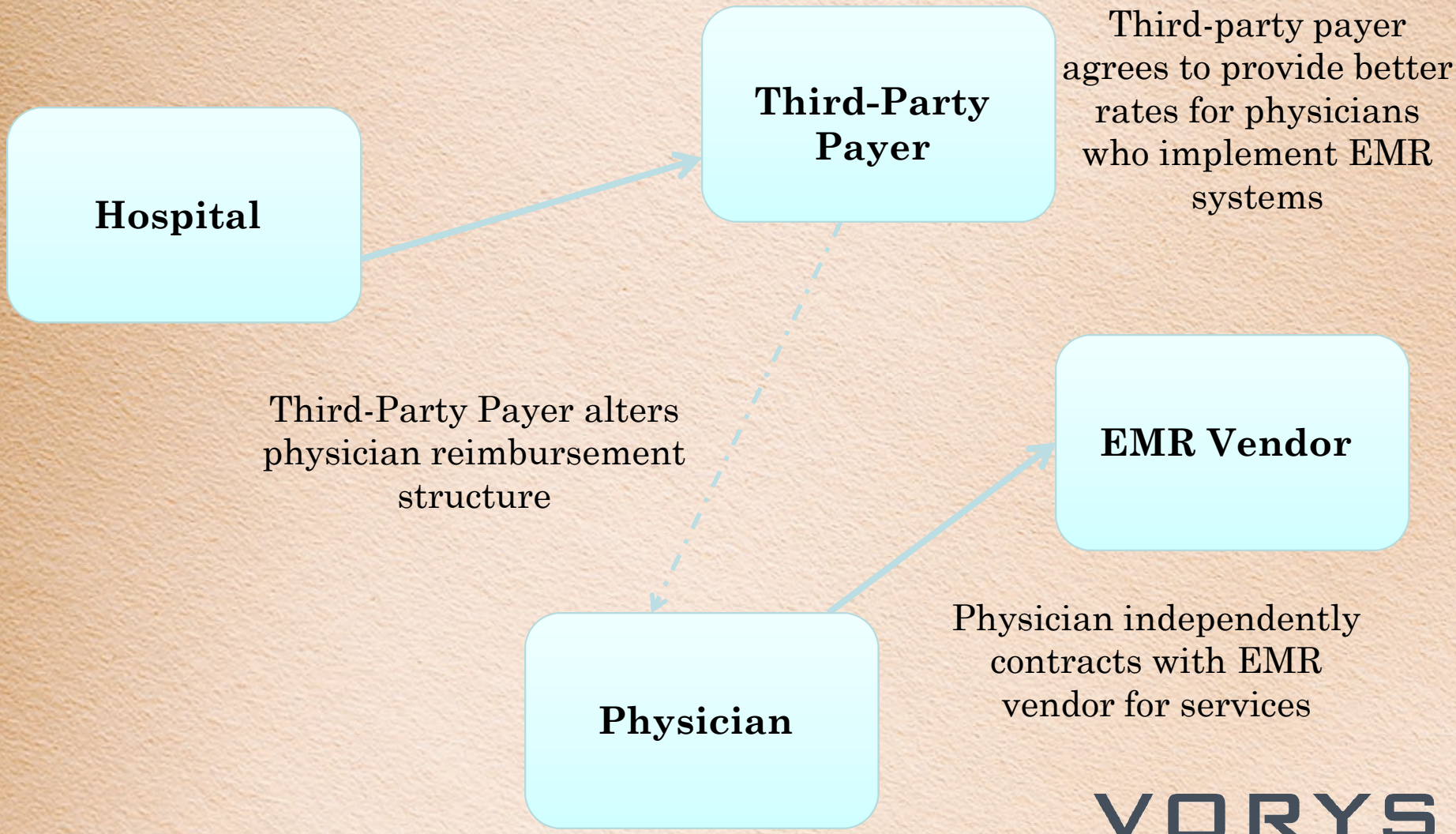
Negotiate Payer Incentives



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Negotiate Payer Incentives (cont'd)

- Hospital worked with regional payers to ensure EHR implementation factored into pay-for-performance standards
- Once EHRs are in place, providers and payers can negotiate more specific pay-for-performance incentives based on actual use of the systems

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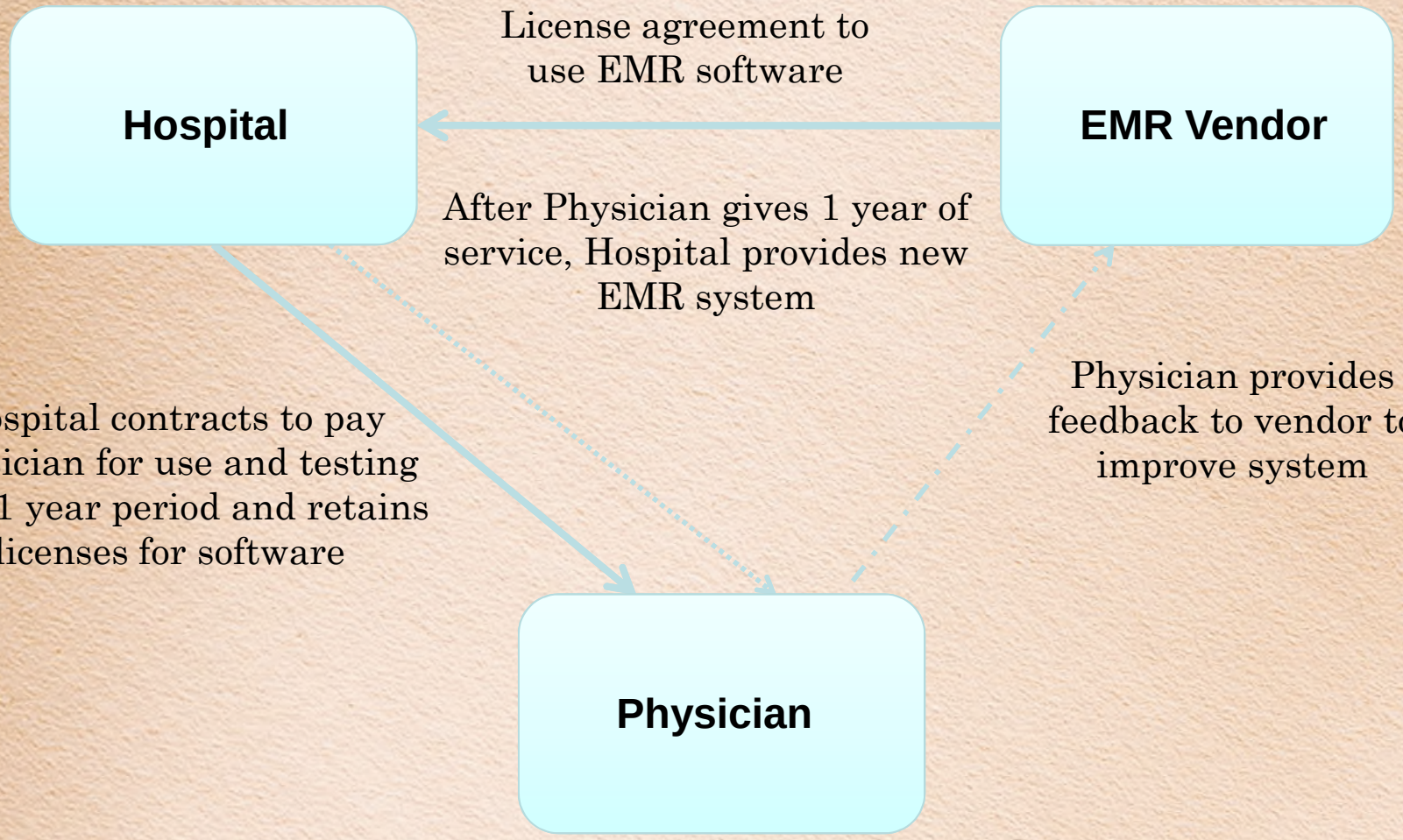
Create a Beta Arrangement



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Providing the EMR Software upon Completion of Beta Testing

- Pay physician $40,000 over 12 months. Leaves $10,000 worth of uncompensated services
  - 3 options for applying $10,000 balloon payment toward physician purchase of the EMR software
    - Pay physician lump sum of $10,000 and physician can opt to pay hospital for EMR system using all or part of those funds
    - Offer physician either $10,000 cash payment or $10,000 applied directly to EMR implementation
    - Set an agreement where physician must put $10,000 toward EMR purchase or lose the $10,000 payment

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Other Strategies and Considerations

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Create Opportunities for Education

- Seminars can:
  - Tout the benefits of EHRs and systems integration
  - Inform doctors about meaningful use requirements and the federal incentive program to ensure they are prepared for the changes ahead
- Hospitals must ensure compliance with Stark Law when orchestrating educational outreach programs

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Develop a Strategy to Integrate Physician Groups

- Set out an integration plan
  - Can be beneficial to focus on primary care physicians first and phase in other specialty areas
  - Some hospitals also choose to focus on physicians that are important to the hospital's mission or long-term strategy
- Any strategy is permissible so long as it's not based on level of referrals

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Offer Some Choice Regarding Appropriate EHR System

- Hire consultants to assess physician practices and help determine which EHR systems work best for a physician's practice type
  - If strong interoperability standards are in place, hospitals can give physicians some choice regarding which EHR system is best for their practice while ensuring the data from that system can be integrated with data from other providers

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Grant Physicians a Role in Governance

- Engaging physicians in co-management agreements or medical directorships
- Creating governance structures that incorporate affiliated physicians in decision-making processes

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Impose Mandates on Affiliated Physicians

- Physicians who don't comply with hospital EHR requirements face loss of significant benefits of being part of provider network
  - Some physicians may choose to leave the network rather than incorporate EHRs into their practice

Use a Template

- Regardless of chosen implementation method, hospitals should consider using a template for all agreements with physicians regarding EMR
  - Ensures consistency and uniformity between contracts
  - Eases operational burden of deciphering different agreements and timelines

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