HITECH Payment Models for Hospitals and Physicians

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Basic HITECH Incentive Payment Requirements

A. Available to Eligible Professionals or Eligible Hospitals
B. Must –
   1. "Meaningfully Use"
   2. Certified Electronic Health Record ("EHR") Technology

Eligible Hospitals

A. Under Medicare
   1. Acute care hospitals subject to PPS
   2. Critical access hospital

B. Under Medicaid
   1. Acute care hospitals
   2. Children's hospitals
   3. At least 10% Medicaid volume, except Children's hospitals

Eligible Hospital Issues Under Medicare

A. What is an eligible hospital?
   1. Subject to IPPS, acute only,
   2. NIH Cancer Centers and Children's excluded,
   3. Critical Access Hospitals included, but subject to different payment rules.

Eligible Hospital Issues Under Medicare, cont'd

B. What is an IPPS acute care hospital under the Proposed HITECH Rules?
   1. CMS proposes only to use provider number in commentary;
   2. Limits multi-campus hospitals to 1 base payment and the 23,000 discharge limit per year;
   3. Providers argue CMS should separately count any hospital with one of the following:
      a) Provider number,
      b) License, or
      c) Emergency room

Eligible Hospital Issues Under Medicaid

More expansive than Medicare:
   1. Includes children's, and
   2. Acute hospital with
      a) ALOS <= 25 days
      b) 10% Medicaid
      c) Medicare CCN last four digits 0001-0879
         1) Includes NIH Cancer Center
         2) Does not include CAHs) CCNs 1300-1399;

Eligible Professionals

A. Under Medicare –
   1. Payment made under Physician Fee Schedule;
   2. Drs. of medicine, osteopathy, dental surgery, podiatry, optometry or chiropractor; and
   3. Not hospital based.

B. Under Medicaid –
   1. Physician – see above;
   2. Dentist, certified nurse-midwife, nurse practitioner or physician assistant practicing in a PA lead RHC or FQHC;
   3. Not hospital-based and 20% Medicaid for pediatrician and 30% everyone else

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Issues With Eligible Professional Limitations

Excludes Hospital Based Professional when substantially all services in a hospital setting:
1. CMS proposes at least 90%;
2. More than Half of the House and Senate have requested CMS to liberalize this exclusion;
3. Differences between inpatient and ambulatory EHR;
4. Physicians incentivized to purchase ambulatory EHR;
5. Outpatient or clinic services should be excluded;
6. CPT code place of service is problematic and e-prescribing denomination should be exluded

Meaningful Use Issues

A. Three stages and all or nothing in each stage
   1. Stage 1 2011-2012 Payment Years
   2. Stage 2 2013-2014 Payment Years
   3. Stage 3 2015-2016 Payment Years

B. 23 Criteria in Stage 1 – Significant opposition
   1. House and Senate oppose approach
   2. Some suggest focus on 10 core elements
   3. Use 80% threshold
   4. Exclude non-clinical functions (e-claims submission, eligibility checks) not currently certified EHR based

Meaningful Use Issues, cont'd

C. Road Map for Next Stages
   1. Announce complete vision soon,
   2. Allows hospitals to plan technology upgrade cycles and contract limitations
   3. Current approach could create barrier to progress,
   4. Consider 4th stage into 2017.

Meaningful Use Issues, cont'd

D. Attestation of Meaningful Use
   1. Should not be absolute,
   2. Should be premise on good faith knowledge and belief of individual executing attestation, and
   3. Concern is FCA liability and whistleblowers.

Meaningful User Stage 1 Objectives and Measures

A. Objective -Implement drug-drug, drug-allergy, drug-formulary checks. Measure - The EP, eligible hospital or CAH has enabled this functionality;

B. Objective - Maintain an up-to-date problem list of current and active diagnoses. Measure - At least 80 percent of unique patients seen by the EP or admitted to an eligible hospital or CAH have at least one entry or an indication of none recorded as structured data;

C. Objective - Maintain active medication list. Measure - At least 80 percent of unique patients seen by the EP or admitted by the eligible hospital or CAH have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.

Cont'd

D. Objective - Maintain active medication allergy list. Measure - At least 80 percent of all unique patients;
E. Objective - Record the specified demographics. Measure - At least 80 percent of all unique patients;
F. Objective. Record and chart changes in the following vital signs: Height, weight, blood pressure, body mass index (BMI) 2 years+, growth charts 2 to 20 years + BMI. Measure - 80 percent of all unique patients;
G. Objective – Smoking status of 13 yrs and older. Measure - 80 percent of all unique patients;
H. Objective - Incorporate clinical lab-test results into EHR as structured data. Measure - At least 50 percent of all clinical lab tests results ordered are incorporated in certified EHR technology as structured data.

Cont'd

I. Objective - Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research and outreach. Measure - Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition;
J. Objective - Implement five clinical decision support rules relevant to specialty or high clinical priority and track compliance with those rules. Measure - Implement five clinical decision support rules relevant to the clinical quality metrics reported under this subpart;
K. Objective - Check insurance eligibility electronically from public and private payers. Measure - Insurance eligibility is checked electronically for at least 80 percent of all unique patients;
L. Objective - Submit claims electronically to public and private payers. Measure - At least 80 percent of all claims filed electronically by the EP or the eligible hospital or CAH;

Cont'd

M. Objective - Perform medication reconciliation at relevant encounters and each transition of care. Measure - Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care;

N. Objective - Provide summary care record for each transition of care and referral. Measure - Provide summary of care record for at least 80 percent of transitions of care and referrals;

O. Objective - Capability to submit electronic data to immunization registries and actual submission where required and accepted. Measure - Performed at least one test of certified EHR technology's capability to submit electronic data to immunization registries;

P. Objective - Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission. Measure – Perform one unless agency incapable;

Cont'd

Q. Objective. Protect electronic health information created or maintained by certified EHR technology through the implementation of appropriate technical capabilities. Measure - Conduct or review a security risk analysis and implement security updates as necessary;

Additonal Stage 1 Criteria for EPs

A. Objective - Use computerized provider order entry (CPOE). Measure - At least 80 percent of all orders;
B. Objective - Generate and transmit permissible prescriptions electronically (eRx). Measure. At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology;
C. Objective - Report ambulatory quality measures to CMS or, in the case of Medicaid EPs, the States. Measure - Successfully report to CMS (or, in the case of Medicaid EPs, the States) clinical quality measures in the form and manner specified by CMS;
D. Objective - Send reminders to patients per patient preference for preventive/follow-up care. Measure - Reminder sent to at least 50 percent of all unique patients seen by the EP that are 50 years of age and over;

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Cont'd

E. Objective - Provide patients with copy of EHR upon request. Measure - At least 80 percent are provided it within 48 hours;
F. Objective - Provide patients with electronic access within 96 hours of the information being available to the EP. Measure - At least 10 percent provided timely electronic access to their health information;
G. Objective - Provide clinical summaries to patients for each office visit. Measure – At least 80 percent of all office visits;
H. Objective- Capability to exchange key clinical information among providers of care and patient authorized entities electronically. Measure - Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

Additional Stage 1 Criteria for Hospitals or CAHS

A. Objective - Use computerized provider order entry (CPOE) for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP). Measure - CPOE is used for at least 10 percent of all orders;
B. Objective - Report hospital quality measures to CMS or, in the case of Medicaid eligible hospitals, the States. Measure - Successfully report to CMS (or, in the case of Medicaid eligible hospitals, the States) clinical quality measures in the form and manner specified by CMS;
C. Objective - Provide patients with electronic copy of record upon request. Measure -At least 80 percent within 48 hours;
D. Objective - Provide patients with an electronic copy of discharge Instructions upon request. Measure - At least 80 percent.

Cont'd

E. Objective - Capability to exchange key clinical information among providers of care and patient-authorized entities electronically. Measure - Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information;
F. Objective - Capability to provide electronic submission of reportable lab results (as required by State or local law) to public health agencies and actual submission where it can be received. Measure - Performed at least one test unless none of the public health agencies to which the eligible hospital submits such information have the capacity to receive the information electronically).

Demonstration of Meaningful Use

A. For Eligible Professional
   1. 2011 –
      a) Attest EHR use during and identify product;
      b) Attest objectives and measures;
      c) For Medicaid, attest additional criteria approved by CMS;
      d) Exception for Medicaid – If adopted, implemented or upgraded EHR demonstrates meaningful use in year 2
   2. 2012
      a) Same as above, plus,
      b) Report ambulatory quality measures.

Cont'd

B. For Eligible Hospitals and CAHs
   1. For 2011
      a) Same as for EPs
   2. For 2012 and after
      a) Same as above, plus
      b) Report clinical quality measures
   3. CMS may audit
   4. Maintain documentation of demonstration for 10 years.

Hospital Payment Incentives and Disincentives Under Medicare and Medicaid

A. Medicare

1. IPPS Hospitals (acute care, excluding Children's) are eligible for payment incentives if they meet the following three requirements:
   a) meaningful use of certified EHR technology;
   b) electronic exchange of health information;
      1) Regional Health Information Exchange (RHIO), gov't, payers and foundations
      2) Health Information Exchange (HEI), hospitals, IDN's etc.

Medicare Hospitals, cont'd

   c) reporting on measures using certified EHR technology (provided the Secretary has the capacity to receive such information electronically).
      1) HHS may select the measures, including clinical quality measures, that hospitals must provide to CMS;
      2) Likely clinical measures will include those selected for RHQDAPU program under section 1886(b)(3)(B)(viii).

2 Incentive Payments for "meaningful use."
   a) Beginning in 2011 (only 90 consecutive days in payment year 1 and potentially available for 4 years);
   b) Subject to a Medicare share percentage and decreasing payment factor, the payment calculation begins with:
      1) A base payment of $2,000,000; and
      2) $200 per discharge for the 1150th through 23,000th

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Medicare Hospitals, cont'd

c) A hospital with over 23,000 discharges and a 100% Medicare share would receive $6,370,400 in year one, and would loose 25% in each of the next 3 years;

d) Medicare share is a complex fraction, as follows:

$$\frac{(\text{Number of Part A inpatient bed days}) + (\text{Number of Part C inpatient bed days})}{\text{Inpatient bed days} \times \frac{(\text{Total charges}) - (\text{Charity care related charges})}{\text{Total Charges}}}$$

1) The Medicare share will be established from a designated base year.

e) The transition factor for a hospital that qualifies for incentives beginning in 2011 is 100% in 2011, and then 75%, 50% and 25% in each of 2012 through 2014.

1) Hospitals that qualify first in 2014 or 2015 lose the first or first and second year payments, respectively

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Medicare Hospitals, cont'd

3. Disincentives for Failure to Adopt

a) Administration's goal for most hospitals to be meaningful EHR users within the foreseeable future;

b) If a hospital does not become a meaningful EHR user by 2015, the hospital will be penalized via an annual negative market basket adjustment, as follows:

1) 2015, the reduction will be 33 1/3 percent.
2) 2016, the reduction will be 66 2/3 percent.
3) 2017, the reduction will be 100 percent.

4. CAH Hospitals –
   a) Must be meaningful EHR users to qualify;
   b) Payments are based on the 101 percent of Medicare allowable costs schedule.
   c) Starting in 2011, CAHs may fully depreciate certified EHR technology costs in a single year, rather than depreciating the costs over a period of years;
   d) CAHs may calculate their Medicare share using the above formula for qualified meaningful EHR hospital users and adding 20 percent;
   e) No incentive payments after 2015; and
   f) Disincentives after 2015 – will lose .33% of cost per year, down to 1% of cost by 2017, but 5 year hardship available.

B. Medicaid Hospital

B. Medicaid
1. Childrens' Hospitals and Acute Care Hospitals with at least 10% Medicaid qualify;
2. Can receive both Medicare (not Children's) and Medicaid payments;
3. Payments determined on a proportional basis between Medicare and Medicaid shares;
4. Payments may be accelerated under Medicaid and may be paid out over 3 years, with 90% of payments in 2 years;
5. No incentive payments unless compliant by 2016.

Physician Payment Incentives and Disincentives Under Medicare and Medicaid

A. Medicare

1. Physicians must not be "hospital based";
2. "Meaningful" EHR users;
   a) Must e-prescribe;
   b) EHR must be interconnected for electronic exchange;
   c) Report clinical quality measures and other key factors;
   d) Certify compliance with above.
3. Timing and Amount – table on next slide
   a) Lump sum or periodic is up to Secretary
   b) Physicians in health professional shortage areas may receive 10% enhancement

Physician Medicare Incentives

Year of Certified EHR Technology Adoption	2011	2012	2013	2014	2015	2016	Total Payment
2011	$18,000	$12,000	$8,000	$4,000	$2,000	0	$44,000
2012		18,000	12,000	8,000	4,000	0	42,000
2013			15,000	12,000	8,000	0	35,000
2014				12,000	8,000	0	20,000
2015					0	0	0

Physician Medicare Incentives

4. Disincentives for failure to adopt EHR:
   a) 2015: penalized 1% in their fee schedule;
   b) 2016: penalized 2%;
   c) 2017: penalized 3%; and
   d) 2018: The 3% penalty will remain in effect.
5. If less than 75% of eligible professions are not meaningful EHR users, the Secretary has the discretion to reduce the fee schedule by an additional percentage point, not exceeding 5%, for each subsequent year;
6. Significant hardship to avoid penalties.

Physician and Eligible Professional Medicaid Incentives

B. Medicaid

1. Eligible professionals:
   a) Non-hospital based physician, dentist, certified nurse midwife, nurse practitioner, or physician assistant practicing in physician-assistant-led FQHC or RHC;
   b) patient volume of at least 30% Medicaid, or, if practicing primarily in an FQHC or RHC, at least 30% "needy individuals;"
   c) **Special rule for pediatricians:** volume of at least 20-30% Medicaid patients are eligible for up to 2/3 of the amount of payments for other physicians;
   d) Must waive Medicare EHR incentives.

Medicaid Incentives

2. Payments
   a) 85% of net average allowable costs
      1) Year 1 costs associated with purchase and initial implementation or upgrade of certified EHR technology and support services, including training, as necessary for adoption and initial operation;
      2) Costs after Year 1 associated with operation, maintenance, and use of certified EHR technology; and
      3) Excludes any payments to providers directly attributable to payment for certified EHR technology or Year 1 support services, except for HITECH incentive payments or payments from State and local governments;
   b) Payment limits - up to $63,750 over 6 years, starting in 2011, see next table

Medicaid Payments

c) Table

Provider type	Adoption year	Payments in Year 1	Payments in Years 2-6	Total potential payments
• Non-hospital-based practitioners with at least 30% Medicaid volume • FQHC or RHC practitioners with at least 30% "needy individual" volume	Begin adopting by 2016	Up to $21,250	Up to $8,500	**Up to $63,750 over 6 years**
• Non-hospital-based pediatricians with 20-30% Medicaid volume	Begin adopting by 2016	Up to $14,167	Up to $5,667	**Up to $42,500 over 6 years**