



Physicians, EHR Stimulus and Healthcare Reform

The Physicians Foundation is proud to present this webinar on the evolving world of EHRs and office practice as part of its mission to improve the care, quality and viability of the practice of medicine.

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Physicians, EHR Stimulus and Healthcare Reform:

**Opportunity and Mine Field —
What's in it for me? What should I
do? When should I do it?**

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Presenters



William Bernstein

Chair, Health Division, Manatt, Phelps & Phillips, LLC

Contact: wbernstein@manatt.com; 212-830-7282



William Connelly

Attorney, Manatt, Phelps & Phillips, LLC

Contact: wconnelly@manatt.com; 202-585-6552



Meaningful Use Overview Regulatory Definition

To be a “meaningful user,” EPs must use a certified EHR to satisfy all Criteria and all Measures.

In HITECH, Congress specified three types of requirements for meaningful use:

1. Use of certified EHR technology in a meaningful manner (e.g. Electronic Prescribing);
2. That the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and
3. That, in using certified EHR technology, the provider submits to the Secretary information on clinical quality measures and such other measures selected by the Secretary.



Meaningful Use Overview Policy Vision & Goals*

Vision

Enable significant and measurable improvements in population health through a transformed health care delivery system.

Goals

Improve quality, safety, and efficiency

Engage patients and their families

Improve care coordination

Improve population and public health

Ensure privacy and security protections

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*Source: Health IT Policy Committee Meaningful Use Workgroup's June 23, 2009 presentation



Meaningful Use Overview Three CMS & ONC Regulations

CMS Notice of Proposed Rule Making (NPRM) for EHR Incentive Program

Defines the provisions for incentive payments to eligible professionals and hospitals participating in Medicare and Medicaid programs that adopt and meaningfully use certified EHRs.

ONC Interim Final Rule with Comments (IFC) on Standards and Certification Criteria

Proposes initial set of standards, implementation specifications, and certification criteria to "enhance the interoperability, functionality, utility, and security of health IT and to support its meaningful use."

ONC Rule on Certification Process

Outlines the process by which an organization becomes an official certification entity.

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CMS EHR Incentive Program NPRM Brief Overview

The NPRM specifies...

- Eligibility requirements for professionals and hospitals
- Criteria for Stage 1 Meaningful Use
- Reporting methodology and timeframes
- Payment periods
- Payment calculations/procedures for Medicare & Medicaid
- Medicare penalties for failing to meaningfully use certified EHRs
- Medicaid Agencies' implementation of incentives



CMS EHR Incentive Program NPRM Key Terms

Certified EHR: The item of technology that an Eligible Professional (EP) or Eligible Hospital (EH) must meaningfully use in order to qualify for financial incentives (*and avoid payment penalties*).

Stages 1- 2 - 3: Three graduated stages for implementing “meaningful use” and EHR certification requirements.



CMS Vision for Stages Requirements Scaling Up Over Time

Stage 1	Stage 2	Stage 3
<ol style="list-style-type: none"> 1. Capturing health information in a coded format 2. Using the information to track key clinical conditions 3. Communicating captured information for care coordination purposes 4. Reporting of clinical quality measures and public health information 	<ol style="list-style-type: none"> 1. Disease management, clinical decision support 2. Medication management 3. Support for patient access to their health information 4. Transitions in care 5. Quality measurement 6. Research 7. Bi-directional communication with public health agencies 	<ol style="list-style-type: none"> 1. Achieving improvements in quality, safety and efficiency 2. Focusing on decision support for national high priority conditions 3. Patient access to self-management tools 4. Access to comprehensive patient data 5. Improving population health outcomes

For Stage 2, CMS may also consider applying the criteria more broadly to both the inpatient and outpatient hospital settings. CMS expects to propose Stage 2 criteria by the end of 2011.

CMS expects to propose Stage 3 criteria by the end of 2013.

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Meaningful Use Overview NPRM Definitions

To implement these core requirements, CMS proposes several fundamental definitions:

Meaningful EHR User. An Eligible Professional (EP) who, for an EHR reporting period for a Payment Year, demonstrates meaningful use of a certified EHR technology in the form and manner consistent with CMS standards.

Payment Year. For EPs any calendar year beginning with January 2011. The "first Payment Year" would mean the first calendar year for EP in which they receive an incentive payment.

EHR Reporting Period. For the first Payment Year only, CMS proposes to define "EHR Reporting Period" to mean any continuous 90-day period within a Payment Year in which an EP successfully demonstrates meaningful use of certified EHR technology.

For the second Payment Year and all subsequent Payment Years, the EHR reporting period would be the entire Payment Year.

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Eligibility Framework for EPs EPs must choose Medicare or Medicaid

	Medicare	Medicaid
Eligibility	Doctor of Medicine or Osteopathy and, for certain limited purposes a Doctor of Dental Surgery or Dental Medicine, a Doctor of Podiatric Medicine, a Doctor of Optometry, or a Chiropractor.	Physicians and Osteopaths, Dentists, Certified Nurse Midwives, Nurse Practitioners, Physicians Assistants (in a rural health clinic or FQHC that is led by a physician assistant).
	Available to physicians paid under the Physician Fee Schedule (PFS). Must meet Meaningful Use in first adoption year.	30% Medicaid volume required for most EPs to qualify. Payment based on a percentage of technology cost. Adopt/Implement/Upgrade option for first adoption year.
	Total possible funding available per EP: \$44,000	Total possible funding available per EP: \$63,750



Eligibility Framework for EPs EPs must choose Medicare or Medicaid

	Medicare	Medicaid
Payment Timeframe	Funds available Calendar Year 2011-2016	Funds available Calendar Years 2011 - 2021
	Must adopt by 2014 to receive payments	EPs may demonstrate meaningful use as late as 2016 and still qualify for the maximum total incentive but may collect partial incentives thereafter.
	Lower aggregate payment if adopt in 2013 or later years	Aggregate payments not reduced for late adopters
	Penalties for non-compliant EPs begin in 2015 to receive payments. Reduction in fee schedule: 2015=1%; 2016=2%; 2017 and beyond = 3%	No payment penalties proposed by CMS.
	Up to 5 years of payment	Up to 6 years of payment



CMS EHR Incentive Program NPRM Medicare Incentives for Eligible Professionals

Adoption Year	Maximum Payment							PFS Penalty
	2011	2012	2013	2014	2015	2016	Total	
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	1%
2016							\$0	2%
2017+							\$0	3%

For each year under the incentive program, an EP will receive 75 percent of the EP's total "allowed charges" (that is, the amounts Medicare pays under the PFS) during the Payment Year, subject to a cap.

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CMS EHR Incentive Program NPRM Medicaid Incentives for Eligible Professionals

Eligible Professional	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Total
Physician – 30%	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$63,750
Certified Nurse Mid-Wife – 30%	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$63,750
Dentist – 30%	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$63,750
RN Practitioner-30%	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$63,750
Physician Assistant	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$63,750
Pediatrician (at 20% Medicaid)	\$14,167	\$5,667	\$5,667	\$5,667	\$5,667	\$5,667	\$42,502

•EPs can receive a total of six years of payments totaling \$63,750; the first incentive payment year at \$21,250, plus five years at \$8,500.

•EPs can start collecting incentives in January 2011. Medicaid incentives run through 2021. EPs may demonstrate meaningful use as late as FY 2016 and still qualify for the maximum total incentive.

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Eligibility Framework for EPs Reporting

In order to draw down incentive payments, EPs will need to attest to meeting meaningful use requirements:

25 Objectives and Measures for EPs for Stage 1 Meaningful Use

- 8 measures will require 'Yes' or 'No' as structured data
- 17 measures will require a Numerator and Denominator



Meaningful Use Measures

Measures are grouped into two categories:

Health IT Functionality Measures

Clinical Quality Measures



Meaningful Use Measures

Related to Medication

Objective	Measure
Generate and transmit permissible prescriptions electronically (eRx)	75% of all permissible prescriptions
Implement drug-drug, drug-allergy, drug-formulary checks	Functionality Enabled
Maintain active medication list	80%
Maintain active medication allergy list	80%
Record demographics	80%



Meaningful Use Measures

Related to Documentation & Orders

Objective	Measure
Use CPOE – Computerized Provider Order Entry	80%
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT	80%
Record smoking status for patients 13 years or older	80%
Record demographics	80%
Vital signs	80%
Incorporate clinical lab test results into EHR as structured data	50%



Meaningful Use Measures

Related to Clinical Decision Support

Objective	Measure
Implement five clinical decision support rules relevant to specialty or high clinical priority along with the ability to track compliance	5 rules
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	1 list

Related to Administrative Transactions

Objective	Measure
Check insurance eligibility electronically from public and private payers	80%
Submit claims electronically to public and private payers	80%



Meaningful Use Measures

Related to Patient & Family Engagement

Objective	Measure
Send reminders to patients, per patient preference, for preventive/follow-up care	50% of all patients aged 50 or over
Provide patients with an <u>electronic copy</u> of their health information (including diagnostic test results, problem list, medication lists, allergies), <u>upon request</u>	80% of requests - within 48 hours
Provide patients with timely electronic <u>access</u> to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP	10% of all unique patients seen
Provide clinical summaries for patients for each office visit	80%



Meaningful Use Measures

Related to Care Coordination

Objective	Measure
Provide summary-of-care record for each transition of care and referral	80%
Perform medication reconciliation at relevant encounters and each transition of care	80%
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	1 test



Meaningful Use Measures

Related to Public Health & Data Security

Objective	Measure
Capability to submit electronic data to immunization registries and actual submission where required and accepted	1 test
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	1 test
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct risk assessment & fix problems as required



Clinical Quality Measures

- EPs are required to submit clinical data on 2 measure groups.
- Example: A primary care physician would submit information on core measures, and on measures in the set for "primary care."
- Once an EP selects a specialty-specific measure group for 2011, cannot alter choice for 2012.

Report Core Measures

Report on At Least One Group of Specialty Measures

Core Measures to be reported by all EPs

PQRI 114 NQF 0028	Preventive Care & Screening: Inquiry Regarding Tobacco Use
NQF 0013	Blood pressure measurement
NQF 0022	Drugs to be avoided in the elderly

Measure Group for 15 specialties

•Cardiology	•OB/GYN
•Pulmonology	•Neurology
•Endocrinology	•Psychiatry
•Oncology	•Ophthalmology
•Proceduralist/ Surgery	•Podiatry
•Primary Care	•Radiology
•Pediatrics	•Gastroenterology
	•Nephrology

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Examples: Clinical Quality Measures

Preventative Care & Screening: Inquiry Regarding Tobacco Use

Description:

Percentage of patients aged 13 years or older who were queried about tobacco use one or more times within 24 months

Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)

Description:

Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy

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How Are Clinical Quality Measures Reported?

- 2011: Self-attestation methodology will be utilized
- 2012 & beyond: Intent to receive electronic information via
 - a web portal
 - local HIE
 - specialty registries



What Happens Next?

- **Public comment period closed March 15, 2010**
- **CMS is reviewing all public comments (3,000+) and will issue the final rule**
- **Final rule is expected around June 2010**
- **CMS is concurrently reviewing and approving individual state plans around distribution of Medicaid funds**
- **Incentives come on line for EPs January 2011**



Physicians, EHR Stimulus and Healthcare Reform:

Skating to the Puck: Thinking ahead before installing Information Technology in your Practice

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Presenter



Rushika Fernandopulle, MD MPP, FACP
Renaissance Health
Contact: rf@renhealth.net

Rushika Fernandopulle is a physician who has spent much of the last ten years involved in efforts to improve the quality of healthcare delivered to patients. He was the first Executive Director of the Harvard Interfaculty Program for Health Systems Improvement, an effort to leverage top faculty from across Harvard University and senior leaders in health care organizations to tackle the largest, most difficult problems facing the health system. As part of this role he was involved in research on many aspects of the U.S. health care system including racial disparities in care, clinical information systems, pay for performance, and the uninsured

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Thinking Ahead

Payment Redesign

- Bundled payments
- Significant P4P
- Risk/gain sharing

Patient Expectations

- Electronic communication
- Self service
- Transparency

Practice redesign

- Staffing
- Processes
- IT tools

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A Variety of Tools

- Practice management (scheduling, billing)
- Electronic Documentation
- Connectivity (labs, hospital, pharmacy)
- Patient transactions (email, payment, scheduling, record/results access)
- Decision support
- Population management- identify gaps, document performance

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Advice from the Trenches

- Don't jump to buy just because of stimulus money, but use it as an opportunity
- Spend the time to choose wisely, and think ahead
- Consider cloud computing, modular systems
- Make sure you can interface with labs, Rx, hospital
- Try before you buy, and visit others using it
- Support is critical in the long term
- Read the contracts and push back
- Overinvest in training, but in two phases
- Make sure you have at least 2 superusers
- Assume lower productivity (or late nights) for months
- Once you have these systems, document benefits and get in front of payment opportunities

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Physicians, EHR Stimulus and Healthcare Reform:

How to Harvest the Incentives Without Risking the Practice

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Presenter



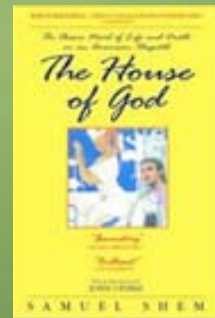
John Haughton MD, MS
Chair, Chief Medical Officer, DocSite, LLC
Contact: jhaughton@docsite.com; (919) 256-9510

Dr. Haughton has over twenty years of experience in patient care, health services research and clinical informatics, focusing his work and research initiatives on applications involving care management, evidence-based clinical measures, population analytics, and pay for performance. Dr. Haughton is an authority on risk adjustment methodologies, pay for performance, predictive modeling, disease and care management, evidence based measure development, physician profiling, and healthcare clinical information systems for the payer, provider, patient and community. After starting his clinical career in geriatric rehabilitation, he has worked across the spectrum of healthcare with the Institute for Healthcare Improvement, Federal and State Governments, Private Industry, Major Healthplans, Provider Networks and Individual Physicians in designing effective care management and risk identification programs and software tools. An expert in quality payment programs and evolving web and modular electronic health technology, Dr. Haughton will discuss how to harvest the incentives without risking your practice



Modified Fat Man's rule # 3 – [With EHRs & Meaningful Use] “Take Your Own Pulse First”

- Cost vs. Benefit
 - Where are you starting
 - Cost of change / next steps...
 - Spending vs Productivity
 - What's happening in the Market
- Timing of Office Actions
 - Actions Now
 - Actions Soon (2nd half 2010)
 - Actions in 2011
- Flow of Money





You're Not alone

- If you already have an EHR system
- If you're thinking about getting one
- If you're thinking about changing systems
- If you're waiting for the dust to settle...

EMR/EHR Systems are changing from island of patient level documentation, and billing to collections of clinical information across place and time for various business and clinical purposes at the patient and population level

Interoperability and Web are gaining momentum. Pricing in the market is changing (subscription / sponsored / modules)

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Federal Incentives – that pay **NOW**

- 2009 – Pays fall 2010
 - PQRI – comprehensive, 30 patients
 - 2% Medicare, 2, 180, 365 days.
 - PQRI – Rx – comprehensive process
 - 2% Medicare, 180 or 365 days
- 2010 – Pays fall 2011
 - PQRI – comprehensive, 30 patients
 - 2% Medicare, 2, 180, 365 days.
 - PQRI – Rx – comprehensive, 30 patients
 - 2% Medicare, 2, 180, 365
- 2010-2011 – RECs “Extension Centers” - \$5,000 worth of consulting effort



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Meaningful use Timing – Stage 1

90 days of use in 2011 – Payment follows Use for Medicare

- Criteria of **WHAT you** need to do will be available in June or so.
 - Until then, **NO ONE** knows what you will need and what you will have to do to earn your incentive \$
- There are hints
 - It's OK to get started now, if it makes sense (EHR, Prescribing, PHR, Quality Reporting...)
 - It's OK to wait – the rules will become clear, the market will respond **QUICKLY**
- OK to Think now, Act in a few months,
 - Implement and Show Use in 2011 for 90 days

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Evolving Needs

- **Stage 2 meaningful use** = better process
 - eg for diabetics – the A1c or LDL test occurs more reliably
- **Stage 3 meaningful use** = better outcomes
 - eg for diabetics – the A1c value or the LDL value is in the desired range more often or for more of the population
- **Other considerations** - ICD-10, Accountable Care Organizations, Gain Share...

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Whatever You Do...

- Protect the integrity of your practice
 - \$ and Time
- Harvest those pieces in reach
- It's OK to take your time

Prices will change for systems. To date they have not been going up... *Past may well predict future in this space...*

GOOD LUCK!

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QUESTIONS?

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