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Winter 2009

American Recovery and Reinvestment Act and the HITECH Act of 2009

To help our physicians navigate all the information around HITECH please take a look at the frequently asked questions below.

On February 17, 2009 the Economic Stimulus Bill also known as the American Recovery and Reinvestment Act 2009 (ARRA - commonly referred to as the Stimulus) was finalized and signed by President Obama. The health IT component of the Bill is the Health Information Technology for Economic and Clinical Health Act (HITECH Act) to encourage healthcare organizations to adopt and effectively utilize Electronic Health Records (EHR) and establish health information exchange networks at a regional level, all while ensuring that the systems deployed protect and safeguard the critical patient data at the core of the system.

Basics of Bill

igcirc: I've seen lots of numbers out there about the health IT parts of the Stimulus -\$19 billion, \$23 billion, \$36 billion and \$38 billion. What do they mean and

Originally, it was estimated that \$19.2 billion in health IT was included in the ARRA. This was based on \$2 billion for the Office of the National Coordinator for Health IT (ONCHIT or ONC) and \$31 billion for incentives through Medicare and Medicaid; once savings of \$12 billion were subtracted out, the net was \$19.2 billion.

However, the Center for Medicare & Medicaid Services (CMS) now estimates higher projections for incentive bonus payments made to eligible providers that demonstrate a meaningful use of certified EHR technology at \$46 billion, as well as greater savings for the government based on improved efficiencies, tax revenue and reduced fee schedule payments due to penalties for non-adoption. When you subtract the anticipated savings of \$28.5 billion achieved through efficiencies, there is now an estimate of a new net cost of \$19.5 billion.

igcirc: What are the different incentive options related to Electronic Medical Records?

There are two incentive payment programs outlined under the HITECH Act – one through Medicare and another from Medicaid. Providers can only submit for payment of an incentive bonus from one of the programs so will need to analyze their organization's public payer mix to determine where they stand to benefit most. Both require that a provider prove "meaningful use" of an EHR product to qualify for the incentives, as well.

Comparison of Medicare vs. Medicaid Incentive Programs

Medicare

\$44,000

Physicians are not required to see a minimum # of Medicare Patients

Mid-Levels do not qualify to receive incentive

Calculation of the amount of incentive received is 75% of submitted allowable charges by physician, up to cap for the year.

Penalties for non-compliance – Medicare fee schedule reduced beginning in 2015

All external funds (i.e. subsidy from IPA or hospital) are okay

Medicare: Physicians who accept Medicare can receive up to \$44,000 over the five years. Those delivering care entirely in a hospital environment, such as anesthesiologists, pathologists and ED physicians, are ineligible.

Medicaid

\$64,000

Physicians must see least 30% of their patients paying with Medicaid [20% for Pediatricians]

Nurse Practitioners, Nurse Mid-wives do qualify; Physician Assistants only if they are the lead provider in a rural health clinic

No calculation based on fees. It is a flat payment intended to offset the purchase of the EHR and maintenance costs

No penalties defined - yet

If physician receives Federal Grants or subsidy under Stark Exemption – the Medicaid incentive payment will be lowery

Medicaid: Physicians who see more than 30 percent of patients paying with Medicaid (20 percent for pediatricians) are eligible for payments of up to \$64,000 over five years. The incentives will be calculated through a formula that factors in the exact Medicaid mix seen by the provider as well as amounts ranging from \$25,000 in the first year to \$10,000 in subsequent years.

(continued on next page)



Kaizen - Pavilion **Outpatient Services**

IMAGINE HAVING TO SET ASIDE OVER AN HOUR for a simple lab procedure that actually takes less than 10 minutes to perform. Or spending up to two hours for a pre-op visit – with 60 minutes wait time. Our patients at the new patient registration/pre-op testing office in the Pavilion were not happy about this and they let us know. On October 26, Six Sigma black belts executed a Kaizen project to help improve the cycle time of Pavilion pre-op registration and laboratory services from arrival to patient discharge. A Kaizen is a session that focuses on process improvement with the goal of eliminating workplace wasted time and duplication. Kai means change and Zen means good. We were looking for a good change!

Prior to the project, the average cycle time in pre-operative services was 111 minutes, with 60 minutes being nothing but wait time. The average lab only cycle time was 50 minutes, with an average of 31 minutes of waiting. All this waiting resulted in a low patient satisfaction rating. The goal set by Bernadette Merlino, the executive sponsor, was to reduce overall cycle time for both types of patients by 10 percent. This would equate to a total cycle time of 38 minutes for laboratory procedures and total cycle time of 90 minutes for pre-op services patients.

One of the new processes implemented through the Kaizen was "advanced signaling." Advanced signaling creates an overlap from one step to the next, resulting in a shorter

wait time and better communication. This is accomplished by having each employee involved, alert the next employee when the patient is on the way to them. During the week of the Kaizen, "advanced signaling" reduced the average overall patient flow in pre-op by 43 percent, down to 64 minutes. Similarly, the lab procedure cycle wait time was also reduced by 43 percent, to a new average of only 11 minutes!

A "workload balancing" concept was also introduced to help create standard operating procedures and a consistent process. Phlebotomists' assignments are now divided into two primary responsibilities: lab-only patients or pre-op only patients. Prior to the Kaizen, the patient assignment was not divided by type. This process improvement has resulted in a reduction of lab throughput by 40 percent, or 35 minutes.

We know the process is capable of significantly reduced cycle times. Now the challenge is to sustain that performance as the process is rolled out to all users. Preliminary findings show the staff in pre-op services has maintained the goal of and average cycle time of 90 minutes. Lab only cycle time is at 40 minutes which is an improvement but not at goal. We will continue to work toward further significant improvement.

Next steps to ensure continuous process improvement include the following:

- Continued analysis of trends in delay factors
- Follow-up patient satisfaction survevs
- Work-out session on scheduling/resource and demand
- Work-out session on availability of orders
- Work-out session on

preparation for next day work

Look for an update in future issues of MD Connect.

Frequently Asked Questions

(continued from page 1)

igotimes: How does the bill define adequate EHR utilization? What does "meaningful use" actually mean?

'Meaningful Use" is defined in three ways in the Bill:

- · Use of a certified product complete with ePrescribing
- capability as determined appropriate by the Secretary of HHS • The EHR technology is connected for the electronic exchange
- of Patient Health Information (PHI)
- · Complies with submission of reports on clinical quality measures

However, given the vague terms used in the statutory language, it is clear that Meaningful Use requires further definition. ONC released a set of recommendations related to Meaningful Use in August and passed them to CMS who has responsibility for drafting the official rules by December 2009. There will be an opportunity for public comment in early 2010, and the final rule is expected by mid-Spring 2010.

\bigcirc : Is this incentive done on a per physician basis or on an office basis?

The incentives in the ambulatory (physician) space are paid on a per provider basis.

igotimes: What are the bonus payments that will be available to physicians under Medicare?

Under Medicare, physicians will be eligible for the following incentive bonuses as soon as they can demonstrate "meaningful use" (beginning in January 2011):

Bonus Amount Received (Per provider)

	2011	2012	2013	2014	2015	2016	TOTAL
First File in 2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$44,000
First File in 2012	\$0	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$44,000
First File in 2013	\$0	\$0	\$15,000	\$12,000	\$8,000	\$4,000	\$39,000
First File in 2014	\$0	\$0	\$0	\$15,000	\$12,000	\$8,000	\$35,000
First File in 2015 or later	\$0	\$0	\$0	\$0	\$0	\$0	\$0

- Physicians operating in a "provider shortage area" will be eligible for an incremental increase of 10% in their bonus payments.
 Physicians operating entirely in a hospital environment, such as anesthesiologists, pathologists, hospitalists and ED physicians, are ineligible.

iggr): As a physician, what if I don't demonstrate use of an EHR after the incentives are in place?

A physician who did not demonstrate "meaningful use" in 2014 will have their Medicare fee schedule reduced beginning 2015. Reductions will be:

- For 2015, down to 99 percent of the regular fee schedule
- For 2016, down to 98 percent
- For 2017 and each subsequent year, down to 97 percent

If the Secretary finds that less than 75% of eligible healthcare professionals are utilizing EHRs beginning in 2018, the Secretary can further reduce the fee schedule to 96% and then 95% in subsequent years, but not further.

igotimes : What are the bonus payments that will be available to physicians under Medicaid?

A healthcare provider is eligible for incentive payments from Medicaid who:

- 1) is not hospital-based and has at least 30% of the professional's patient volume coming from Medicaid patients; or
- 2) is a pediatrician, who is not hospital-based, and who has at least 20% of the patient volume coming from Medicaid
- 3) practices predominately in a FQHC or rural health clinic and has at least 30% of the professional's patient volume coming from Medicaid patients; or

Incentive payments will be based on a calculation that factors the physician's Medicaid mix in combination with up to \$25,000 the first year and \$10,000 each subsequent year for five years, all multiplied by 85%. The highest potential for Medicaid payments is \$63,750. Additionally, physicians filing under Medicaid must first demonstrate EHR usage by 2015 and will not be eligible for payments after 2021.

Note: Pediatricians, because they have to meet a lower threshold of only 20% Medicaid patients to qualify for the incentives, are only eligible for 66% of the incentive payments described above.

igotimes: If I already have an EHR, do I qualify to receive incentive payments?

For physicians who already use an EHR product, they will be eligible for the utilization incentives, assuming they are using a certified product and meet the criteria under Medicare or Medicaid and demonstrate "meaningful use."

For those that do not yet use an EHR and meet the criteria for the incentive payments, this program should offer a motivation to adopt so there is sufficient time to implement and learn how to effectively use the software sufficiently enough to comply with the "meaningful use" requirements.

igcolon: If I meet the definition of "meaningful use" now as an EHR user, can I earn incentive payments immediately?

No, by statute, the earliest dates that CMS will be able to pay an incentive under Medicare is January 1, 2011 for eligible professionals (physicians). The statue does not define a date for the Medicaid incentives program. Given the range of regulatory and planning activities that must precede States being able to make provider incentive payments, as well as the importance of coordinating Medicaid and Medicare payments to prevent duplication, CMS does not expect that States will be able to make such payments until 2011

However, you do have an immediate opportunity to earn incentives from CMS under other programs. The current bonus incentives include 2% for e-Prescribing utilization, as well as 2% PQRI, for a total 4% of Medicare allowable.

For further information visit www.healthreform.gov or www.questions.cms.hhs.gov (see Regulations & Guidance > Legislation > Economic Recovery Act).

Contact Rebecca Armato, executive director, Physician and Interoperability Services at (626) 298-1848, or email Rebecca.Armato@HuntingtonHospital.com

As You Requested...

▶ E-Signature of Telephone Orders is coming to Huntington February 1. You must fill out a registration form available at www.Huntingtonhospital.com (Physicians Only section) or stop by physician informatics or medical records. Don't delay and you will be able to sign orders from wherever you have internet access.