

Analysis of the HITECH Act's Incentives to Facilitate Adoption of Health Information Technology

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The "Health Information Technology for Economic and Clinical Health Act" or the "HITECH Act" (as contained within the American Recovery and Reinvestment Act of 2009 [the "Stimulus"]) will expand the use of **health information technology** (HIT) and appropriates \$250 million for this Fiscal Year for implementing the new HITECH provisions.¹ Politicians are now convinced that health care expenditures can be tamed using HIT: Health care expenditures currently make up 16% of the U.S. gross domestic product and are projected to become about 20% of the gross domestic product by 2015.² The HITECH Act thus offers significant financial incentives to providers for implementing HIT, in particular, electronic health records (EHR). However EBG advises a cautious and coordinated approach when adopting an EHR some key issues to watch for include:

- Vendor lock-in may make abandoning a poor EHR system very expensive;
- When and if EHR adoption will reach a critical mass of market penetration to yield real benefits;
- Scope creep may dramatically increase implementation costs;
- Lack of clarity with respect to establishing meaningful use and interoperability under the new Federal standards required to receive financial incentives;

¹ The \$787 billion Stimulus was signed into law on February 17, 2009 by President Obama.

² Christine Borger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal and M. Kent Clemens. Health Spending Projections Through 2015: Changes On The Horizon. Health Affairs, 25, no. 2 (2006): w61-w73 (Published online 22 February 2006)(available at <http://content.healthaffairs.org/cgi/content/full/25/2/w61>)

- The desire to begin implementing an EHR system without following prudent project management controls including benchmarks is a serious risk given the large amount of money at-stake; and
- Aligning your successful implementation of an EHR with your vendor's compensation.

THE GOALS OF THE HITECH ACT

The HITECH Act is intended to encourage more effective and efficient health care through the use of technology, thereby reducing the total cost of health care for all Americans and then using these savings to enable all Americans to have access to the health care system. Savings are expected to come from efficiency gains and improved clinical guidelines, allowing treatments to be standardized for various medical conditions.³

Promotion of Health Information Technology

The United States is set to invest significant resources into health information technology over the next seven years, with the expectation that every citizen will have an electronic medical record by the year 2014. To accomplish this herculean effort, the HITECH Act implements a new administrative structure within HHS to manage the implementation of HIT technology at a national level. The **National Coordinator** is responsible for coordinating HIT policies and programs, developing a voluntary HIT certification program, and setting milestones for utilization of EHRs for each person in the United States by 2014. Along with the creation of a new national HIT administrative structure to facilitate adoption of Health Information Technology, the HITECH Act also provides incentives to promote use of EHRs, telemedicine, and clinical data repositories. These incentives are discussed below. In many instances, previous government attempts to encourage EHR have been less than satisfactory. Unlike earlier initiatives, the new program offers both a carrot and stick approach.

The Incentives – Medicare and Medicaid Health Information Technology

The HITECH Act provides incentives under either Medicare or Medicaid for providers who have adopted EHR systems determined to meet the Secretary's relevant guidance and statutory requirements for meaningful use: those providers can receive bonus payments starting in 2011. "Meaningful use" of an EHR includes three key components:

- The EHR must be certified and include ePrescribing capabilities;
- The technology must provide for the electronic exchange of personal health information with other systems (interoperability); and
- The system must produce reports utilizing various (yet to be defined) clinical and quality metrics.⁴

The HITECH Act, has set aside \$17 billion for incentive payments to providers who implement a qualifying EHR under either Medicare or Medicaid. Providers may only seek incentive payments under either Medicare or Medicaid but not both. Individual providers who are

³ Giroi, F., Melti R., and Scoville, R., Extrapolating Evidence of Health Information Technology Savings and Costs (© 2005 Rand Corporation)(available at http://www.rand.org/pubs/monographs/2005/RAND_MD410.pdf).

⁴ Section 4101(a)(o)(2) of the HITECH Act.

“hospital-based” are not eligible for the incentive payments. The Act defines “hospital-based professionals” to include pathologists, anesthesiologists, and emergency physicians who furnish substantially all of her/his services in a hospital setting (either inpatient or outpatient). The thought is that these physicians would use the hospital’s EHR. Hospitals are entitled to a separate set of incentive payments under the law. Whether an eligible professional is hospital-based is determined by the billing or employment arrangements between the provider and the hospital.

Certified EHR technology is defined to include EHRs which have been deemed qualified in accordance with the necessary standards and implementation specifications as established under the Act. The National Coordinator is tasked with the development of qualified electronic health record technology (i.e. a certification system) for EHRs. The criteria for certification are to be developed under Section 3001(c)(3) of the Act.

Medicare Incentives for Physicians

Unlike the Medicaid incentives, bonus payments under the HITECH Act for physicians seeking Medicare incentives are all the same flat amount based on the year in which the provider places in service a qualifying EHR. No incentive payments will be provided before 2011 and after 2016.⁵

Table 1 - Physician Incentives under Medicare⁶

Year	2011	2012	2013	2014	2015	2016	Max Bonus Payment
2011	\$18,000.00	\$12,000.00	\$8,000.00	\$4,000.00	\$2,000.00	\$-	\$44,000.00
2012	\$-	\$18,000.00	\$12,000.00	\$8,000.00	\$4,000.00	\$2,000.00	\$44,000.00
2013	\$-	\$-	\$15,000.00	\$12,000.00	\$8,000.00	\$4,000.00	\$39,000.00
2014	\$-	\$-	\$-	\$12,000.00	\$8,000.00	\$4,000.00	\$24,000.00
2015	\$-	\$-	\$-	\$-	\$-	\$-	\$-

Incentive payments will be increased by 10% if the provider predominantly serves beneficiaries in any area designated as a Health Professional Shortage Area (“HPSA”).

If an eligible professional was not a meaningful user, then the fee schedule amount for such services furnished by the professional during the year shall be equal to the applicable percent of the fee schedule amount as follows. The discount amounts are as follows: for 2015, 99%; for 2016, 98%; and for 2017 and each subsequent year, 97%. The percentages can be decreased on and after 2018 based upon the proportion of eligible professionals who are meaningful users.

Medicare Incentives for Hospitals

Beginning in 2011, incentives payments are available for "eligible hospitals" that are making meaningful use of an EHR and that submit quality metrics based on criteria identified by HHS.⁷ Hospital payments are based on a \$2 million **base amount**. Added to the base amount is an additional **discharge-related payment**. The sum of the **base amount and the discharge related payment** are multiplied by the **hospital’s Medicare share** and a **Transition Factor**.

⁵ Section 4101(a)(o)(2)(A)(ii) of the HITECH Act.

⁶ Title IV, Subtitle A, Section 4101(a) of Health Information Technology for Economic and Clinical Health Act” or the “HITECH Act.”

⁷ Section 4102(n)(2)(G), Section 4102(n)(3).

Incentive amounts are phased out beginning in 2015 for hospitals that have not implemented a meaningful EHR. In addition, incentive payments are not available for hospitals that are not “meaningful EHR users.”

1. **Calculating the Discharge Amount:** The discharge amount is calculated by summing the total discharges beginning with the 1,150th discharge through the 23,000th discharge. The sum of discharges above 1,150 but below 23,001 for the hospital is then multiplied by \$200.⁸

2. **Calculating the Medicare Share:** The **Medicare share** is calculated by summing the number of inpatient-bed-days attributable to individuals for whom payment is made under Medicare part A and under a Medicare Advantage plan. (In the absence of Medicare specific inpatient data this amount is assumed to be zero.) This sum is then divided by the product of:

- The total number of inpatient-bed-days for the hospital during the 12-month period; and
- The total amount of eligible hospital charges during the period (excluding charges that are attributable to charity care) divided by total amount of the hospital’s charges during the same period. (In the absence of data for charges for Medicare patients this amount is assumed to be one.)⁹

Starting in 2015, any "eligible hospitals" failing to turn in the required quality data will also be subject to a reduction in their annual reimbursement rate updates.

Medicaid Incentives

Prior to the HITECH Act the Social Security Act (SSA) authorized a 90% match for expenditures attributable to the design, development or installation of mechanized claims processing and information retrieval systems referred to as Medicaid Management Information Systems (MMISs)¹⁰ and a 75% match for the operation of MMISs that are approved by the Secretary.¹¹ The HITECH Act amends the SSA to authorize a 100% federal match for a portion of payments to encourage the adoption of EHRs (including support services and maintenance) to certain Medicaid providers who meet certain requirements.¹² The state must prove to the Secretary that allowable costs are paid directly to the healthcare provider without any deduction or rebate, that the provider is responsible for payment of the EHR technology costs, that the user certifies “meaningful use,” and that the technology is compatible with federal administrative management systems.¹³

A health care provider is eligible for incentives where the provider waives any right to Medicare EHR incentive payments. Physicians who seek bonus payment under the Medicaid incentive program can potentially receive the funds under Medicaid if the provider:

⁸ Section 4102(n)(2)(C))

⁹ Section 4102(n)(2)(D).

¹⁰ Section 1903(a)(3) of the Social Security Act and defined in regulation at 42 CFR 433.111. (http://www.cms.hhs.gov/MMIS/01_Overview.asp#TopOfPage visited March 15, 2009).

¹¹ 42 CFR §433.15(b).

¹² Section 4201(a).

¹³ Section 4201(a)(3)), Section 4201(a)(9)(meaningful use).

- Is not hospital-based and his/her practice consists of at least 30% Medicaid patients by volume;
- Is not hospital-based, is a pediatrician and his/her practice consists of at least 20% Medicaid patients by volume; or
- A provider practices predominantly in a federally qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume (as estimated in accordance with a methodology established by the Secretary) attributable to needy individuals.¹⁴

Providers are eligible for reimbursement of 85 percent of allowable EHR costs, not to exceed a maximum (per provider) of \$65,000 over five years. The Medicare program will begin to cut payments to doctors and hospitals lacking a qualifying electronic records system in 2015; however under the Medicaid program there are no such punitive incentives. Incentives are calculated through a formula that factors in the exact Medicaid mix seen by the provider. Doctors can get as much as \$25,000 in the first year from Medicaid incentive payments to defray some of the cost of acquiring the technology, and earn up to \$10,000 annually for four additional years to support "meaningful use" of EHRs.¹⁵

Hospitals with at least 10 percent Medicaid patient volume are eligible for an incentive payment based on a formula similar to the calculation for incentive payments provided for under the Medicare economic incentive¹⁶, except that the numerator amount that is equal to the number of inpatient-bed-days includes days attributable to individuals who are receiving medical assistance.¹⁷ Hospitals must have a qualifying EHR in place by 2016 to receive any Medicaid incentive funding. Hospitals can recoup up to 100% of "allowable" costs for an EHR via Medicaid incentives. Reimbursement is capped at 50% of actual costs for the first year and 90% for the first two years combined. Allowable costs are adjusted to reflect the Medicaid load for the provider.¹⁸

EBG ADVISES AN INFORMED AND CAUTIOUS APPROACH IN ADOPTING EHR

Because of the possibility of financial benefit, for small and large providers alike, the implementation of an EHR likely will be a top priority over the next two years; however, financial benefits will not be realized without navigating a bureaucratic obstacle course and until a critical mass of providers have adopted interoperable EHRs.

Recent studies highlight the need for a critical mass of provider adoption before benefits can be realized from EHRs. Some studies primarily done in smaller provider settings show that implemented EHR systems have serious issues.¹⁹ Some clinical studies that have looked at

¹⁴ Section 4201(a)(2)(A)(i)-(iii).

¹⁵ Section 4201(a)(4)(A).

¹⁶ Section 4201(a)(2)(C).

¹⁷ Section 4201(a)(5)(B).

¹⁸ Section 4201(a)(5)(C).

¹⁹ <http://www.ischool.drexel.edu/faculty/ssilverstein/failurecases/?loc=home>. Concerns of providers that have implemented EHRs include:

whether EHRs increase the quality of care for patients (within non-integrated providers) have raised concerns about the effectiveness of EHRs to create new efficiencies and increase the quality of care. These studies have found that confusing navigation, inaccurate documentation and overly complicated features²⁰ distract physicians from providing quality care.

- A Harvard/Stanford EHR study reported that "EHRs were not associated with better quality ambulatory care."²¹
- Another study of the relationship between EHR usage and diabetes care quality published in 2007 found that "the use of an EMR in primary care practices is insufficient for ensuring high-quality diabetes care. Efforts to expand EMR use should focus not only on improving technology but also on developing methods for implementing and integrating this technology into practice reality."²²

However, research done with larger integrated service providers found evidence of increased efficiency and quality of care:

- Properly implemented and widely adopted, Health Information Technology would save money and significantly improve healthcare quality;

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1. The cost of EHR technology, the lack of consistent pricing, and the inability to recoup costs hinder implementation of HIT. (It is not clear whether financial incentives under the HITECH act will be sufficient to offset the costs of implementing an EHR for a typical physician practice);
 2. CCHIT requires features that add significantly to cost while raising privacy and data security concerns of physicians;
 3. EHRs lack interoperability, and the cost associated with trying to connect to other computer systems is significant, usually requiring custom development to allow for interoperability;
 4. Loss of productivity when converting from a paper-based to an electronic practice is significant; and
 5. Comparative effectiveness research may undermine individual-specific care when comparative effectiveness data are used as the basis for "standards" by all payors (including Medicare). Ultimately could these new Federal standards provide the basis for determining medical necessity?

²⁰ CCHIT certification has hundreds of specific criteria defining how an EHR must work. Every implementation specification is required for certification, causing a CCHIT-certified EHR to become blotted by all the required "features". Some examples of their onerous requirements include: criteria #71a, which mandates the EHR be capable of recording comments by the patient or patient's representative regarding the veracity of information in the patient record; and criteria #238 which requires an EHR to be able to display medical eligibility obtained from a patient's insurance carrier.

²¹ "For 14 of the 17 quality indicators, there was no significant difference in performance between visits with [versus visits] without EHR use. Categories of these indicators included medical management of common diseases, recommended antibiotic prescribing, preventive counseling, screening tests, and avoiding potentially inappropriate medication prescribing in elderly patients. For 2 quality indicators, visits to medical practices using EHRs had significantly better performance: avoiding benzodiazepine use for patients with depression (91% vs 84%; P = .01) and avoiding routine urinalysis during general medical examinations (94% vs 91%; P = .003). For 1 quality indicator, visits to practices using EHRs had significantly worse quality: statin prescribing to patients with hypercholesterolemia (33% vs 47%; P = .01)." Linder JA, Ma J, Bates DW, Middleton B, Stafford RS. Electronic health record use and the quality of ambulatory care in the United States. Arch Intern Med. 2007 Jul 9;167(13):1400-5.(Summary available at <http://archinte.highwire.org/cgi/content/abstract/167/13/1400>).

²² Jesse C. Crosson, PhD, Pamela A. Ohman-Strickland, PhD, Karissa A. Hahn, MPH3, Barbara DiCicco-Bloom, RN, PhD, Eric Shaw, PhD, A. John Orzano, MD, and Benjamin F. Crabtree, PhD. Electronic Medical Records and Diabetes Quality of Care: Results From a Sample of Family Medicine Practices. Annals of Family Medicine 5:209-215 (2007) (Available at <http://www.annfammed.org/cgi/reprint/5/3/209>).

- Annual savings from efficiency could be \$77 billion or more;
- Health and safety benefits could double the savings while reducing illness and prolonging life; and
- To be effective implementation must be widespread to realize network effect efficiencies.²³

One study of particular note identified four classes of trajectory-changing events. The identification and management of such events was made possible in part by the use of health information technology. Four noted interventions that resulted in both efficiency and quality gains included:

- Computerized Physician Order Entry (CPOE) reduced adverse drug events (ADEs) thereby reducing the length of stays in the hospital;
- The provision of the influenza and pneumococcal vaccinations, as well as screening for breast, cervical, and colorectal cancer. Many hospitalizations can be avoided with proper vaccinations, while more pervasive screening identifies cancers earlier, improving both survival and allowing less costly treatments to be utilized;
- Enrolling people with chronic conditions (including asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes) in disease management programs saves significant resources and improves the patient's quality of care; and
- Monitoring and encouraging patients to control their weight, stop smoking, exercise, and control their blood pressure and cholesterol with medications.²⁴

The estimated effects of HIT on health care utilization are dependent on having a critical mass of providers. At the critical mass point, the value obtained from an EHR is greater than or equal to the cost. The failure to achieve a critical mass likely accounts for the differences between the utility of EHRs within integrated and non-integrated provider settings. Hopefully, the government's incentives will spur a critical mass of providers to adopt EHRs; otherwise the financial incentives will not be sufficient—in and of themselves—to realize the promise of a national HIT infrastructure.

To help our clients adopt EHR systems that do increase efficiency and effectiveness, we advise a cautious approach, one informed by the possible pitfalls of a hasty early adoption. Obtaining a critical mass of participating providers on an interoperable EHR system is essential, although may present other regulatory challenges. The HITECH Act includes a number of significant health care provisions, many of which are broad and include ambiguities that will need to be resolved by HHS in the near term. We will monitor the implementation of these provisions and

²³ Hillestad R, Bigelow J, Bower A, Girosi F, Meili R, Scoville R, and Taylor R, Can Electronic Medical Record Systems Transform Healthcare? An Assessment of Potential Health Benefits, Savings, and Costs, Health Affairs, Vol. 24, No. 5, September 14, 2005; see also Taylor R, Bower A, Girosi F, Bigelow J, Fonkych K, and Hillestad R, Promoting Health Information Technology: Is There a Case for More-Aggressive Government Action? Health Affairs, Vol. 24, No. 5, September 14, 2005.

²⁴ Bigelow JH, Fonkych K, Fung C, and Wang J, Analysis of Healthcare Interventions That Change Patient Trajectories, RAND Corporation, MG-408-HLTH, 2005; available at <http://www.rand.org/publications/MG/MG408/>; see also Girosi F, Meili R, and Scoville R, Extrapolating Evidence of Health Information Technology Savings and Costs, RAND Corporation, MG-410-HLTH, 2005; available at <http://www.rand.org/publ.org>.

provide additional guidance, as appropriate. If you have any questions regarding these or other provisions within the HITECH Act, please contact Robert Hudock, Patricia Wagner, or Mark Lutes.

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