

eClinicalWorks

FROM LEGISLATION TO IMPLEMENTATION:

Healthcare Reform - the American Recovery and Reinvestment Act ,
the HITECH Act, and EMR Adoption



March 2009

How does the \$19 billion that's allocated to Health IT break down in the Stimulus Bill?

There is \$2.1 billion that will be available to the Secretary of Health & Human Services for distribution through the Office of the National Coordinator for Health IT (ONCHIT). These funds will be spent on projects related to standards evaluation and development, infrastructure for health information exchange (HIE), grants to states for the purpose of furthering EHR adoption, improvements in telemedicine delivery, and the establishment of Regional Health IT Resource Centers.

There is an additional \$17 billion to be applied to longer term utilization incentive bonuses for providers meeting certain criteria.

What are the different incentive options?

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 each practice 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.

How does the bill define adequate EMR 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 PHI
- Complies with submission of reports on clinical quality measures

All further details about what type of reporting will need to be submitted, what level of connectivity will be required and the final criteria for standards will be determined by the Secretary of Health & Human Services before the utilization incentives begin.

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

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

Medicare Bonus Payments							
Year of first filing	2011	2012	2013	2014	2015	2016	TOTAL
2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$44,000
2012	\$0	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$44,000
2013	\$0	\$0	\$15,000	\$12,000	\$8,000	\$4,000	\$39,000
2014	\$0	\$0	\$0	\$12,000	\$8,000	\$4,000	\$24,000
2015 or Later	\$0	\$0	\$0	\$0	\$0	\$0	\$0

Two notes:

- 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 and ED physicians, are ineligible.

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

Beginning in 2015, physicians not demonstrating meaningful use will have their Medicare fee schedule reduced.

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 EHR beginning in 2018, the Secretary can further reduce the fee schedule to 96% and then 95% in subsequent years but not further.

How is the incentive program structured? Is it based on payment of a flat dollar amount or is it a percentage of Medicare allowables like it is for PQRI?

The utilization bonus payments identified as incentives for physician utilization in the Bill are flat payments that will be the same for all providers who meet the criteria.

Are groups that do Medicare Advantage also eligible for the stimulus dollars?

Yes, there are provisions of the Bill related to groups accepting Medicare Advantage. Those organizations and their providers are eligible for the incentives as long as the provider delivers a minimum of twenty hours a week of patient care services and the organization furnishes at least 80 percent of the services of the individual professional to clients of their organization.

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

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

- is not hospital-based and has at least 30 percent of the professional's patient volume coming from Medicaid patients;
- who is a pediatrician, who is not hospital-based, and who has at least 20 percent of the patient volume coming from Medicaid patients;
- practices predominantly in a FQHC or rural health clinic and has at least 30 percent of the professional's patient volume coming from Medicaid patients;
- is a children's hospital, or an acute-care hospital that is not described in clause (i) and that has at least 10 percent of the hospital's patient volume coming from Medicaid patients.

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.

The highest potential for Medicaid payments is \$64,000.

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.

Are all physicians in the U.S. eligible for incentive bonus payments from Medicare and Medicaid?

While the majority of physicians stand to earn incentive payments if they meet the meaningful use threshold, there are some that will not qualify - those not accepting Medicare, or those that do not have a patient base that is comprised of more than 30% Medicaid patients. Additionally, physicians delivering all care in a hospital, such as anesthesiologists, pathologists or emergency physicians, do not qualify.

Note that while most providers must demonstrate that 30% of their patients are using Medicaid in order to qualify for that portion of the program, pediatricians need only prove 20%. This is an effort to facilitate the participation of more pediatricians in the program who would not normally accept Medicare and very well might not have a sufficient Medicaid volume to qualify.

How are Pediatricians and Family Physicians going to be able to participate?

If a physician does not meet the Medicaid payer mix threshold and does not accept Medicare, they will be able to apply for grants and/or loans to offset the upfront costs of the purchase of an EHR but will not be eligible for incentives as currently delineated.

Additionally, the Secretary of HHS will be assessing utilization levels beginning in 2011, and if he or she believes that there is a need to offer other incentives to prompt adoption among those populations of providers, that will be addressed then.

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

No, all organizations must wait until 2011 to submit for incentive payments. However, you do have an immediate opportunity to earn incentives from CMS for ePrescribing utilization, as well as PQRI bonuses.

How much of the \$19B will be allocated for ambulatory versus in-patient solutions?

The money is not allocated by care setting and is intended to incite as much adoption as possible among healthcare professionals in both delivery environments. Additionally, the funds are not capped in the event that EHR adoption takes off at levels beyond the initial forecast.

What does the connectivity requirement of the meaningful use definition mean?

The Secretary of HHS will be defining this requirement further, but it appears that demonstrating connections and patient data exchange with another provider such as a lab, pharmacy, imaging center, hospital, or other physician will satisfy the requirement. It is possible that as health information exchange initiatives gain traction in more regions across the country that the requirement for connectivity will be adjusted by the Secretary and be interpreted more stringently.

Can hospitals use Stimulus funding for Stark projects?

There is nothing in the Bill that preempts a hospital from moving forward with a program maximizing the relaxation of the Stark and Anti-Kickback laws. Such hospitals may apply for grants and/or loans that become available as the Secretary of HHS allocates the \$2 billion and use that money to further EHR adoption in their larger community.

The incentive payments for meaningful use will not benefit the hospital as those payments go directly to the practicing providers, but it is anticipated that many hospital executives will decide to proceed in an effort to increase physician loyalty and referral dollars.

What does this mean to eClinicalWorks' existing customers?

For those practices who already use the eClinicalWorks unified EMR/PM solution, Congratulations!

Assuming they meet the criteria under Medicare or Medicaid and can demonstrate meaningful use, they will be eligible for the utilization incentives. The HITECH Act will reward customers who use an EMR that meets the criteria, offsetting their purchase costs through the utilization incentives.

eClinicalWorks meets all of the functionality for "meaningful use" as it is defined today.

eClinicalWorks:

- is CCHIT 2008 certified in both ambulatory and child health
- has ePrescribing capability
- The EHR technology is connected for the electronic exchange of PHI
- complies with submission of reports on clinical quality measures

All further details about what type of reporting will need to be submitted, what level of connectivity will be required and the final criteria for standards will be determined by the Secretary of Health & Human Services before the utilization incentives begin.

What does this mean to eClinicalWorks' prospective customers?

For those practices who do not use an EMR but who meet the criteria for incentive payments, this program is motivation to adopt a healthcare IT solution soon, allowing sufficient time to implement and learn how to use the application sufficiently to comply with the "meaningful use" requirement.

Grant dissemination will be prioritized to target organizations that do not currently have an EMR or who have an outdated product that does not meet certification criteria..

WHY eClinicalWorks?



Ambulatory EHR
+ Child Health

eClinicalWorks LLC, a privately held company located in Westborough, Massachusetts, has established itself as the leader in the ambulatory Electronic Medical Records (EMR) and Practice Management (PM) industry. Focused exclusively on the design and deployment of its innovative, reliable, and comprehensive Unified EMR/PM Solution, Patient Portal, and Electronic Health Exchange (eEHX), eCW has been working with large practice groups and community-wide projects as well as medium, small, and solo practices, regardless of specialty or number of locations since its inception in 1999.



eClinicalWorks, a model of carefully managed growth, has over 750 employees working in a stable infrastructure, led by a dedicated management team comprised of the original five company founders. With 2008 revenues of \$84 million, the company enjoys high profitability with a five year compounded growth rate of more than 100% year-to-year. eCW has an established customer base of more than 4,250 customers in all 50 states. eClinicalWorks has additional offices in New York City, NY and Alpharetta, GA.

Corporate Awards & Recognition

eClinicalWorks has received industry recognition and awards, including Best in KLAS and top solution provider by TEPR for four consecutive years. eCW has been included in *Healthcare Informatics* (June 2007) Top 100, ranked by 2006 healthcare IT revenue. eClinicalWorks recently received recognition by *Inc. Magazine* as the 34th fastest growing private company in 2007, further attesting to the quality of the eClinicalWorks EMR/PM Solution.

eCW customers have won the HIMSS Davies award for excellence in IT implementation and utilization.

March 1, 2009

The New York Times

In the world of technology, inventors are hailed as heroes. Yet it is more subtle forms of innovation that typically determine the impact of a technology in the marketplace and on society. Clever engineering, smart business models and favorable economics are the key ingredients of widespread adoption and commercial success.

History abounds with evidence. For years, much of what was known as “Yankee ingenuity” was, in fact, the American ability to pursue commercial applications of British inventions, from the Bessemer steel process to the jet engine. Even in computing, which we regard as made-in-America technology, the first stored-program computer, simple programming language and reusable code were pioneered in Britain.

But, of course, computer technology and the industry really flowered in the United States. That happened in no small part because the federal government nurtured the market with heavy investment, mainly by the Defense Department, and by choosing standards, like the Cobol programming language.

Today, Washington is about to embark on another ambitious government-guided effort to jump-start a market — in electronic health records. The program provides a textbook look at the economic and engineering challenges of technology adoption.

In its economic recovery package, the Obama administration plans to spend \$19 billion to accelerate the use of computerized medical records in doctors’ offices. Medical experts agree that electronic patient records, when used wisely, can help curb costs and improve care.

The proof is seen in large medical groups, with hundreds or thousands of physicians. They sift, sort and analyze the data from digital records, for example, to better manage the health of patients with costly, chronic conditions like diabetes and heart disease. These larger groups have the scale to invest in information technology, and they are often insurers as well as providers, so they benefit directly from the cost savings.

Yet these large groups are the exceptions in American health care. Three-fourths of the nation’s doctors practice in small offices, with 10 doctors or fewer. For most of them, an investment in digital health records looks like a cost for which they are not reimbursed.

It is scarcely surprising, then, that only about 17 percent of the nation’s physicians are using computerized patient records, according to a government-sponsored survey published last year in *The New England Journal of Medicine*.

“This is really not a technology problem,” observed Erik Brynjolfsson, an economist at the Sloan School of Management at the Massachusetts Institute of Technology. “It’s a matter of incentives and market failure.”

That market failure is a principal target of the Obama administration’s plan. A main feature of the legislation calls for incentive payments of more than \$40,000 spread over a few years for a physician who buys and uses electronic health records. But the technology is just a tool, one that needs to be used properly to improve health care.

So the legislation states that physicians will be paid only for the “meaningful use” of digital records. The government has not yet defined that term precisely. While the long-term goal is better health for patients, that can take years to measure. Consequently, many health experts predict that the meaningful use will be a requirement to collect and report measurements that can be closely correlated with improved health. Examples would be data for blood glucose, cholesterol and blood pressure levels for diabetes patients.

The legislation, health experts say, seems thoughtfully put together, but the obstacles to success will be daunting. “What’s underappreciated is the implementation challenge,” said Dr. Blackford Middleton, chairman of the Center for Information Technology Leadership, a research arm of Partners Healthcare in Boston.

A crucial bridge to success, according to experts, will be how local organizations help doctors in small offices adopt and use electronic records. The new legislation calls for creation of “regional health I.T. extension centers.” In a letter to the White House and Congress last month, Dr. Middleton and 50 other experts emphasized the importance of these centers and pointed to the Primary Care Information Project in New York City as a model.

The New York project’s brief history, beginning two years ago with \$27 million in financing, offers a glimpse of the challenges of wiring small physician practices. The New York team, headed by Dr. Farzad Mostashari, an assistant commissioner in the city’s health department, started by bringing in decision-support experts in medicine to study how doctors work, so the technology would be easier to use. Team members considered writing their own software for simple, Web-based electronic health records, but abandoned that idea once they understood that patient records would have to be tightly linked to billing — a physician’s financial lifeblood.

The project’s 50-member staff provides centralized technical support and education for doctors and others. “There’s no way small practices can effectively implement electronic health records on their own,” Dr. Mostashari said. “This is not the iPhone.”

The staff worked closely with its software supplier, eClinicalWorks, to tweak and tailor the system. They began rolling out the records a little more than a year ago. They are now used by more than 1,000 physicians, mainly in poorer neighborhoods, whose workplaces include two hospital outpatient clinics, 10 community health centers, 150 small group physician practices and one women’s jail, serving a total of one million patients. The rollout is progressing, and the government plan promises to accelerate adoption.

“Our experience here is that it’s just hard,” Dr. Mostashari said. “It’s not impossible.”
