HIT Perspectives

Perspectives and Updates on Health Information Technology

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HIMSS11

HIMSS11: A Retrospective Boots-on-the-Ground Analysis

By Tony Schueth, Editor-in-Chief

The Point-of-Care Partners (POCP) team, along with the rest of the world it seems, recently returned from the Healthcare Information and Management Systems Society (HIMSS) meeting in Orlando. We are exhausted but energized from attending the biggest and best HIMSS meeting to date. And big it was: a record-breaking 31,225 attendees came to hear hundreds of symposia, more than 400 educational sessions and numerous workshops. The exhibit hall really was a mile long –with more than 1,000 exhibitors – and we have the blisters and sore feet to prove it.

Despite its size, the meeting was a well-oiled machine. The weather was perfect. The record-breaking crowds of attendees, presenters and vendors offered new insights on health information technology (HIT) policies and legislation, market innovations, and technology solutions. These included presentations by our own Mihir Patel, PharmD, who provided an update on ePrescribing of controlled substances and meaningful use, and Michael Solomon, PhD, who summarized his work on engaging patients in their health care through the use of an interactive patient portal.

But HIMSS is always more than just presenting…

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Electronic Health Records

Surviving the HIT Buffet: Helping Physicians Make Healthy Choices

By Ed Daniels, Contributor

Physicians looking to make an electronic health record (EHR) purchasing decision are challenged with many options, each having a wide variety of pros and cons. To help, the government has established a new certification process, but the choices are still daunting. One thing that complicates decisionmaking is confusion between modular EHRs and complete EHRs. Complete EHRs are those that meet all of the government’s requirements for a “qualified EHR" and have been tested and certified by one of the federally approved certification bodies. This means that by installing one system from one vendor, a physician can obtain federal incentive payments and avoid late-adoption payment penalties, provided he or she is using the system “meaningfully.”

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ePrescribing

Can CMS Align Its Dueling Incentive Programs and Eliminate Provider Confusion?

By Kurt Andrews, Contributor

The General Accountability Office (GAO), the heavy-duty federal watchdog agency, recently issued a report spotlighting a problem that has been causing a lot of confusion for physicians and health information technology (HIT) vendors[1]: the misalignment of ePrescribing incentives and penalties within two federal programs administered by the Centers for Medicare and Medicaid Services (CMS).

The two programs were created under separate pieces of legislation. The first is the Medicare Improvements for Patients and Providers Act (MIPAA). It was enacted before the American Recovery and Reinvestment Act of 2009 (ARRA), which created the meaningful use (MU) requirements. Both incentive programs encourage ePrescribing adoption and use. MIPAA addresses ePrescribing outright, while ePrescribing is included in the criteria for the certified electronic health records that must be used in order to qualify for the MU incentives.

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But HIMSS is always more than just presenting, attending sessions and passing out business cards. The POCP team also uses the opportunity to gather intelligence on trends we can use to help our clients position themselves for success in the coming year. At the 5,000-foot level, the meeting take-aways can be distilled into the following themes.

- **It's all about meaningful use.** Meaningful use (MU) was everywhere, seemingly in every presentation and exhibit. Surrounding this overarching principle was an air of cautious conservatism in how it will be translated into practice by vendors and practitioners. Nobody appears to want to do more than the federally required minimum. This makes some sense, as MU is an evolving target, and getting too far out in front may be risky at this nascent stage. On the other hand, we wonder if innovation isn't being stifled somewhat due to the uncertainties and complexities surrounding where MU is headed and how it will get there. Because there are so many unknowns and so much is at stake, nobody is willing to think too far outside the box. How that plays out in terms of vendor offerings remains to be seen.

- **Mebbe thar's gold in them thar ACOs.** Even though regulations have yet to be published, there's a "land office business" by provider groups, insurers and others positioning themselves for the "gold rush" associated with accountable care organizations (ACOs). As part of that positioning for perceived big payoffs once ACOs are up and running, payers and big health systems are talking about the huge impact HIT will have on successfully creating and sustaining ACOs, as we have discussed in previous issues of *HIT Perspectives*. The head start goes to the big, already integrated systems. They are better positioned to have ACO startup capital and fund the HIT that will be required, as well as more easily adapt to whatever regulatory environment emerges.

- **Quality reporting is growing.** We have said more than once that we're at the end of the beginning of HIT. Say what? Simply put, we have entered a new phase of health care delivery, monitoring and payment that is being enabled through the next generation of HIT and related reporting requirements by public and private payers. The result: quality reporting is becoming more mainstream. To be sure, quality reporting and payment have been linked for years but hampered by mediocre-quality data, lack of measurable metrics and the inability to share data within and across platforms. Now we have the technology that can do the job and also can be coupled with new models of care, such as the patient-centered medical home. This will propel quality reporting into an even more prominent and commonplace requirement in the payment and delivery of health care.

- **What's a sustainable HIE?** While health information exchanges (HIEs) are recognized as integral parts of data exchange within and across states and regions, the value proposition of of the state and regional HIEs has been — and continues to be – elusive. In fact, we heard one pundit postulate that long-term success of HIEs is inversely proportional to the level of grant funding. Why? Because the HIEs that depend heavily on grant funds — as many state and regional HIEs do – really won't have to be competitive and will not be forced to deliver value; they will only have to deliver functionality to move data from one electronic health record (EHR) to another. In another words, they're not apt to make the hard decisions. State and regional HIEs soon will reach a sustainability juncture: they're going to have to start producing or will go under.

- **eMedication Management is starting to come into its own.** Until recently, HIMSS focused only on ePrescribing. Then the world changed, with ePrescribing taking a backseat to MU and the related push to EHRs. In addition, there are the added requirements of

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- medication reconciliation and a growing interest in improving medication compliance — both of which are HIT enabled. In thinking about this transformative process, we at POCP have coined the phrase “eMedication management,” which embraces traditional models for treatment and dispensing of medications in patient care but expands them by leveraging the power, functionalities and interoperabilities of EHRs, personal health records, ePrescribing systems, and other Internet-based systems, such as mobile health applications and Web portals. eMedication management allows payers, pharmacists, physicians and patients to use the Internet and ehealth applications to participate in the continuum of care involving prescription drugs, from the moment the patient is diagnosed, through obtaining medications and monitoring medication therapy outcomes. The time is right for this concept. Stay tuned – you will be hearing more about it in the future.

- **MIAs.** Yes, there were some obvious entities that were hard to find at HIMSS11. The first was regional extension centers, which we believe lack the money to attend HIMSS or don’t fully understand the importance of being there. Mobile health didn’t seem to make the transformational technology list for this meeting. However, we understand that HIMSS is already on the case and will make this a priority moving forward.

In conclusion, HIMSS11 was an informative and worthwhile meeting by any measure. Let us know how the POCP team can help you understand these trends and capitalize on them.

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Alternatively, a physician can assemble several certified EHR modules in a combination that meets all of the “qualified EHR" requirements. For example, a physician could assemble products and services providing ePrescribing, provider-to-provider connectivity, clinical decision support, disease registries and an interactive patient Web portal, creating a qualified EHR without ever acquiring a “complete EHR.” The combinations can be selected online and a *Centers for Medicare and Medicaid Services* (*CMS) EHR Certification ID* can be obtained from the government at http://onc-chpl.force.com/ehrcert/ EHRProductSearch?setting=Ambulatory.

So far, the “modular vs. complete” battle has not really been a fair fight. While the government has clearly defined which modular EHR components must be combined, the wide range of possibilities can leave the nontechnical or unguided physician hopelessly confused.

Adding to the confusion is the fact that some of the products currently certified as modular are intentionally modular, while others are simply modular because certain functions have not yet been certified. Those products are temporarily modular, but are enroute to becoming complete EHRs.

In conversations with representatives of several regional extension centers (RECs), none was presenting a modular choice on its short list. Those RECs are worried about complexity, partially because they are so strongly incented to help each physician make an EHR choice quickly, get it installed and achieve “meaningful use” as soon as possible. The Michigan REC, M-CEITA, is an exception. According to its Web site, it acknowledges and embraces the use of EHR modules – including ePrescribing tools, disease registries, practice management systems, and patient portals – and deals with this diversity through vendor certification.

Another difficulty for the modular challengers is integration. The certification bodies test the functionality of each module, but do not test the ability of each module to integrate with other modules. Since the government certification process does not test all the possible combinations of EHR modules, the physician will not only need to produce a CMS EHR ID using the Web site listed above, but also make certain the selected set of products will work together.
So, why would anyone want to go the modular route? One reason is because the modular approach allows a practice to select the best vendor for each application area. A modular approach can also be less expensive, help ease practice workflow integration issues and even reduce the need for support. This makes the modular approach appealing to some practices.

Another reason to select a modular approach is because a practice may already be using one modules – e.g. ePrescribing or registry – and not want the disruption of relearning how to use a completely different system or move historical data from one system to another. In the case of patient registries, some practices – even those that will eventually implement a complete EHR – may want to keep the registry in place because its function is superior to that provided by the EHR. In other words, there is no reason to believe that it’s a requirement to throw away the ePrescribing and patient registry even when a implementing a complete EHR.

For physicians wrestling with the modular versus complete approach, the good news is that the “penalty phase” of meaningful use (MU) is still a ways off. Physicians choosing to wait until 2012 can still qualify for full incentive payments under MU and also have the luxury of only reporting on a 90-day period, compared with those who register in 2011 and will report on a full year in 2012. Because the modular path may take a bit more thought, it is important to know there is time to make a considered choice.

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So, how can physicians make healthy choices when eating at the HIT buffet? In today's environment with today's products, Point-of-Care Partners (POCP) advises the smaller physician practice to either go the complete EHR route or to find a trusted entity, such as the American Medical Association or one of its certified modular vendors, to help it assemble a set of complementary and certified products. Having a single trusted point of contact to help with selection, implementation, support and problem solving is critical for the busy practice that decides to go the modular route.

The exception to this approach is the tech-savvy physician who has a strong desire to explore many different products and select his or her favorite combination. Fortunately, the government's Web site makes it easy to vet this set of products and be sure it can be certified. The next challenge for the tech-savvy practice will be to work with its selected team of vendors and make sure their products can communicate among themselves.

POCP anticipates a much more modular future. A modular world will foster innovation. Just as the iPhone and Android application marketplaces have generated an explosion in new ideas and concepts for smartphones, the marketplace for EHR modules will provide an opportunity for innovative clinicians and developers to try out all varieties of new ideas and concepts. In the not-too-distant future, EHR modules will not only be tested and certified, they will also be able to plug into a federal-, regional- or enterprise-level HIE architecture and interoperate reliably. These future HIEs will be designed to support a wide array of best-of-breed applications without requiring excessive due diligence and training from already busy clinicians.[2]

[1] . (Comments on the President's Council of Advisors on Science and Technology Report Entitled: REPORT TO THE PRESIDENT REALIZING THE FULL POTENTIAL OF HEALTH INFORMATION TECHNOLOGY TO IMPROVE HEALTHCARE FOR AMERICANS: THE PATH FORWARD Submitted by The Clinical Groupware Collaborative January 2011).

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There are two real problems: having the "right stuff" technology-wise varies between the two programs, and both programs have established separate reporting requirements related to ePrescribing. Furthermore, unlike MU, MIPAA lacks a software certification entity – this places the burden on the ePrescriber to understand whether or not the software will meet incentive requirements. Unlike MIPAA, MU applies to both Medicare and Medicaid providers.

While both programs initially provide incentives for those meeting requirements and transition to an era when providers will be penalized for not qualifying, their timelines are not aligned. In fact, it is possible that a prescriber could be penalized by MIPAA and incented by Medicare and Medicaid MU in the same year. The mechanics of the two programs' incentives and penalties have been detailed in previous issues of *HIT Perspectives*. A summary of the MIPAA and Medicare MU incentives and payments are summarized below.

So what to do about the confusion? As matters pertain to Medicare MU, the GAO has four recommendations (it didn't even address Medicaid MU). Three are fairly obvious and noncontroversial: 1) encourage physicians and others in the MIPAA program to adopt software that has been certified for MU because MU-certified software will qualify as MIPAA software; 2) expedite efforts to align reporting requirements so that successfully qualifying for incentive payments or avoiding penalties under MU would likewise result in meeting the MIPAA requirements or, in essence, having a single ePrescribing criterion; and 3) have CMS leverage its experience with MIPAA with MU and include consideration of such factors in the integration plan that the agency is required to develop by January 1, 2012. The fourth recommendation — have CMS develop a risk-based strategy to audit a sample of providers who received incentive payments from the electronic prescribing program — is not as simple as it sounds. This would be an unfunded mandate for CMS, which likely would have to set up a whole new auditing program. Even if that could be done, it probably would not be received with open arms by provider groups, which are used to complaint-based enforcement on a case-by-case basis.

See Chart on the next page.

[1] Electronic Prescribing: CMS Should Address Inconsistencies in Two Incentive Programs That Encourage Use of HIT, GAO 11-59

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Incentives and Penalties for Eligible Medicare Providers in the MIPAA and Meaningful Use Programs

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
MIPAA ePrescribing Program										
Incentive										
% of Part B Charges	2%	2%	1%	1%	0.5%					
Penalties *% of Part B Charges*				-1%	-1.5%	-2%				
Meaningful Use Program Incentive										
75% of Part B charges, up to a maximum amount			Up to $18k	Up to $18k	Up to $15k	Up to $12k	Up to $8k	Up to $4k		
Penalties % of Part B charges							-1%	-2%	-3%	-3%

Source: GAO, 2011

What is the impact on eligible prescribers, who are predominantly physicians? The GAO recommendations are good as far as they go, but we believe they won't have much impact on the two programs or physicians. It's a case of too little, too late, even if the recommendations can be implemented fairly quickly. And the GAO's recommendations do not even include Medicaid, which adds yet another set of requirements, timelines and penalties into the confusing mix.

The first problem is the overlapping "carrot and stick" requirements. To avoid the MIPAA payment penalties, CMS will require eligible providers to meet that program's reporting requirement for 2011 even if they participate in the MU program, which also begins this year. We understand the American Medical Association has asked CMS to push back the MIPAA penalty dates.

Next, there are the differences in reporting requirements. CMS potentially would require physicians — the largest and only group of providers eligible to earn incentive payments in both programs — to report to both programs from 2011 through 2014. CMS recognizes this duplication places additional burden on physicians and is in the process of developing a strategy to address this.

Then, there's the money. According to the GAO, CMS paid $148 million in 2009 (the first year that MIPAA incentives were available) to about 8% of the roughly 600,000 eligible Medicare providers.

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That translates to an average payment of about $3,120, and the median payment was around $1,700. Medicare providers qualifying for MU in 2012 could receive up to $18,000.The GAO projects that early adopters could earn a total of $45,200 for the two programs through 2016, while providers who are later adopters could earn $24,600 for the two programs for that time.

According to the GAO, Medicare providers who choose not to participate could lose an average $1,080 over three years for MIPAA and $2,400 over four years under MU, for a combined loss of $3,480 between 2012 and 2018.

While the incentives are hardly chump change, they may not drive adoption for several reasons. For one thing, the incentive payments do not fully cover the costs of adopting a stand-alone ePrescribing system or EHR. Moreover, the penalties are hardly very stiff and may not be enough to encourage a changeover among really hard-core, paper-based practices. And then there is the “hassle factor,” which some physicians simply may want to avoid. For many, giving back $3,480 to Medicare is nothing compared to the potentially onerous costs in revenue and office flow disruption for the implementation and use of an ePrescribing/EMR system. That is not to mention the reports the office must submit to CMS, and even then they still may not qualify for the MIPAA incentives. Lastly, for the reasons previously discussed, there is the possibility that these two programs may drive older physicians to consider phasing out their practices in the next few years. “It’s not worth it” is a phrase we commonly hear in the field from a certain physician demographic.

Point-of-Care Partners is closely monitoring how this all plays out. As leaders in the HIT field with long-standing expertise in ePrescribing, we are well positioned to advise our clients about potential impacts of the two incentive programs and actions the government may take to sync up requirements or adjust penalty dates. Let us know if we can put our expertise to work for you.

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