

ARRA and the Timing of Your EMR Deployment

SEVEN CRUCIAL CONSIDERATIONS FOR
COMMUNITY AND CRITICAL ACCESS HOSPITALS

An Executive Decision Guide

Table of Contents

Executive Summary	2
Crucial considerations	3-7
#1: Final word on meaningful use and other criteria.....	3
#2: Required timeframe to demonstrate meaningful use	3
#3: Factoring in time for deployment and user adoption	4
#4: EHR vendor scheduling and capacity	4
#5: Incentive payments stood to be gained — or lost.....	5-6
#6: Penalties for delayed meaningful use.....	6
#7: Benefits beyond revenue implications	7
Conclusion	7

Executive Summary

In 2004 the federal government launched a campaign to institute electronic health records (EHRs) for all Americans within a decade. The Obama administration gave teeth to this effort by signing the American Recovery and Reinvestment Act of 2009 (ARRA). In a nutshell, the ARRA contains both financial incentives and reimbursement penalties to push healthcare providers toward the adoption of electronic medical record (EMR) systems.

But not everyone is ready to jump on the opportunity.

Critical access hospitals and small community hospitals across the country are facing the same quandary: “Do we proceed with our EMR initiative now? Or wait until the federal government provides 100% clarity concerning the qualification criteria for ARRA incentives and the precise amount of revenue to be gained?” For many hospitals, the easy answer has been “Let’s wait.”

The focus of this executive decision guide is to help you understand that waiting comes with costs — and that it may actually be better for your organization to act sooner rather than later. This executive decision guide will examine crucial considerations pertaining to:

- Definitions of “meaningful use” and other ARRA qualification criteria yet to be finalized by the Office of the National Coordinator for Health Information Technology (ONC)
- The likely timeframe required to demonstrate meaningful use of EHR technology
- How much additional time you should factor in for deployment and user adoption
- Vendor scheduling and capacity, especially during periods of peak demand
- How delays in EMR implementation could reduce incentive payments and put you at risk for penalties

Finally, we’ll review key reasons beyond ARRA incentives to begin (or continue) the journey toward an EMR implementation. While incentive payments may be a primary motivator to act now, EHR adoption holds the very real potential to positively transform the delivery of healthcare in your hospital and community.

Crucial consideration #1: **FINAL WORD ON MEANINGFUL USE AND OTHER CRITERIA**

For an EMR system to qualify for ARRA incentives, we know it will need to satisfy specific requirements related to certification, meaningful use, and other criteria starting in 2011. The big question is, what are the requirements? We learned more from the December 30th Proposed Final Rule, but we are still waiting the ONC to issue a final definition of meaningful use; expected in late spring 2010.

So, is it necessary to wait for the ONC's final word on these criteria?

No. The American Hospital Association states: "Since the process for determining 'meaningful use' is still unknown, having a currently certified EHR product in place is probably the best way to prepare. If you are already using HIT (health information technology), ensure that the system is certified or be prepared to upgrade to a certified version prior to FY 2011."¹

What is meant by "certified?" While the ONC has not provided a final definition, it has identified Certification Commission for Health Information Technology (CCHIT®) as one of the certification bodies that will be recognized under the ARRA.²

In other words, choosing a CCHIT-certified EHR solution provides a significant degree of assurance that your hospital's EMR installation will pass muster in 2011 and beyond.

Crucial consideration #2: **REQUIRED TIMEFRAME TO DEMONSTRATE MEANINGFUL USE**

In its recommended Proposed Final Rule, the ONC's HIT Policy Committee specifies minimum standards (objectives and measures) for meaningful use in Stage 1, Stage 2 and Stage 3. Once these standards are finalized, hospitals will need to prove they measure up in each of the categories. For example, 10% percentage of physician orders must be entered through a computerized physician order entry (CPOE) system for Stage 1.

The HIT Policy Committee indicated in the Proposed Final Rule a period of 90 days of continuous meaningful use during the first incentive year and a period of 12 months of continuous meaningful use during each subsequent incentive year over which these standards must be demonstrated. The committee further indicated that all measures must be tracked and reported using EHR technology.

Consequently, hospitals should give themselves adequate time before a demonstration to make certain they can achieve and report the standards.

Keep in mind, also, that the meaningful use standards become more stringent in Stage 2 and Stage 3. By satisfying the less rigorous Stage 1 requirements early on, you'll take an important first step toward meeting the tougher standards in subsequent years.

¹American Hospital Association. American Recovery and Reinvestment Act: Health IT Provisions, FAQs, Timeline and Medicaid Incentive Calculator. Retrieved from www.aha.org on May 7, 2009.

²Healthland inpatient and ambulatory EMR applications are CCHIT-certified through 2011, and Healthland will recertify with CCHIT under the new ARRA standards for 2011, 2013 and 2015.

Crucial consideration #3: **FACTORING IN TIME FOR DEPLOYMENT AND USER ADOPTION**

The preceding discussion on meaningful use does not take into account the timeframe involved with the typical EMR deployment. From vendor selection through user training and organization-wide adoption, the process can require several months, if not years, especially with a phased implementation.

In a joint letter to the ONC Meaningful Use Committee, Mark Leavitt, MD, CCHIT chair, and Alisa Ray, CCHIT executive director, stated:

“The lag between a decision to invest in EHR technology and its full, meaningful use in a provider organization is one to two years at best, and more typically, three to five years. For this reason, we believe most of the measures proposed for 2011 would be difficult to achieve by providers who have not already begun EHR implementations.”³

The Association of Medical Directors of Information Systems (AMDIS) has also weighed in on the issue, advocating a “crawl-walk-jog-run” progression to EHR adoption. “These cycles cannot be skipped or condensed...without risking failure to ‘go the distance’ in the marathon that is HIT-powered healthcare transformation,” says the AMDIS.⁴

Looking at this big picture, the journey to demonstrating meaningful use clearly represents years of advance work.

Crucial consideration #4: **EHR VENDOR SCHEDULING AND CAPACITY**

Like other service and product providers, EMR vendors possess a finite set of resources to meet customer demand. As we move closer to the incentive payment period, the demand for EMR solutions is expected to grow rapidly.

By taking a wait-and-see stance, hospitals are likely to encounter increasingly significant delays in the scheduling and completion of their EMR implementations. This, in turn, could reduce their ARRA incentive payments and bring them perilously close to incurring penalties for noncompliance. Conversely, early adopters stand to enjoy the benefits of greater EMR vendor capacity, particularly related to project scheduling and the resulting ability to capture all incentive payments and avoid penalties.

Remember, it’s not just about the actual EMR deployment. Many vendors can accomplish an implementation in as little as six to 12 months. More critical is the time required to achieve organization-wide adoption and meaningful use. Expect this process to take 12 to 18 months.

³ CCHIT letter dated June 26, 2009. Retrieved from www.cchit.org.

⁴ Industry Pushes Back on EHR ‘Meaningful Use’ Definition,” a Health Care BNET Blog, by Ken Terry. July 2, 2009.

Crucial consideration #5: INCENTIVE PAYMENTS STOOD TO BE GAINED — OR LOST

First, let's dispel a common myth in the healthcare industry: that the federal government might renege on its \$19.2 billion commitment to HIT projects. The incentive payments specified in the ARRA are federal law and would require an act of Congress to overturn. In other words, if your hospital satisfies the qualification criteria, you will receive the incentive payments in full.

Secondly, many hospital executives have questioned how the incentives will be calculated and, therefore, are reluctant to commit to an EMR system until they're certain about the return on their investment.

Healthland's analysis, which has been corroborated by an independent legal advisor, shows that Prospective Payment System (PPS) and critical access hospitals can realize substantial Medicare and Medicaid incentive payments by deploying EMR systems and by demonstrating meaningful use. The incentive formula clearly favors hospitals that act sooner rather than later.

The following examples show potential incentive payouts for PPS and critical access hospitals.⁵

Medicare incentive for PPS hospitals

For PPS hospitals, the ARRA Medicare incentive will be calculated as follows:

Multiply initial amount by Medicare share by transition factor amount

Using this calculation and assuming the following:

- 1,500 total annual inpatient discharges
- 2,500 bed days attributed to Medicare Part A
- 250 bed days attributed to Medicare Part C
- 4,500 total inpatient days
- \$40 million total annual charges
- \$1.5 million total annual charity care charges

...the total incentive payments are shown in the grid below:

First year of meaningful use	FY 2011, 2012, or 2013	FY 2014	FY 2015	FY 2016
Total 4-year incentive	\$3,286,032	\$1,971,619	\$985,810	\$0

⁵ The incentive payment examples shown here are based on Healthland's understanding and interpretation of the American Recovery and Reinvestment Act of 2009 and may vary from the actual amounts paid. For a detailed look at how we arrived at these incentive amounts and to calculate the estimated incentive for your hospital, visit www.healthland.com/stimulus.

Medicare incentive for critical access hospitals

For critical access hospitals, the ARRA Medicare incentive is based on a factor of non-depreciated EHR costs multiplied by Medicare share plus 20%. Incentives are not to exceed four payment years and no payments will be made after 2015.

Following is an example of a Medicare incentive payment to a critical access hospital:

- \$500,000 total non-depreciated EHR costs
- 600 bed days attributed to Medicare Part A
- 125 bed days attributed to Medicare Part C
- 1,200 total inpatient days
- \$15 million total annual charges
- \$250,000 total annual charity care charges

First year of meaningful use	FY 2011, 2012, 2013, 2014, or 2015	FY 2016 & beyond
Total accelerated depreciation incentive (single payment year)	\$407,203	\$0

Medicaid incentive

For both PPS and critical access hospitals, Medicaid incentives are calculated similar to how Medicare calculates the incentive for PPS hospitals, but without the scale-down of the transition factor and assuming an annualized growth rate.

Crucial consideration #6: PENALTIES FOR DELAYED MEANINGFUL USE

The financial implications of a delayed EMR deployment aren't limited to missed incentive payments. Critical access and PPS hospitals also run the risk of incurring penalties in the form of Medicare payment reductions if they do not demonstrate meaningful use starting in 2015.

For critical access hospitals, which normally receive 101% of Medicare costs, the penalty is a 0.33% annual reduction in the Medicare cost reimbursements. Without meeting meaningful use, a critical access hospital would receive reimbursement at the following reduced levels:

- FY 2015: 100.66%
- FY 2016: 100.33%
- FY 2017 and beyond: 100%

Noncompliant PPS hospitals would forfeit a progressively larger percentage of their "market basket adjustment" increase under ARRA rules. Specifically, three-quarters of the applicable increase would be reduced as follows:

- FY 2015: 33.3% reduction
- FY 2016: 66.67% reduction
- FY 2017 and beyond: 100% reduction

Crucial consideration #7: BENEFITS BEYOND REVENUE IMPLICATIONS

With the opportunities (and risks) that come with ARRA, it may be easy to lose sight of another compelling argument for EMR adoption: It makes sense — for patients, clinicians, your hospital and the community at large.

Using the right EMR system offers a number of well-documented benefits, including:

- Strengthened quality and safety of patient care
- Reduced operational costs
- Enhanced community image
- An advantage in attracting tech-savvy employees and physicians
- Helps ease the transition to regional health information organizations (RHIOs)

Obviously, the sooner your hospital implements an EMR system and achieves meaningful use, the sooner these benefits and return on investment can be realized.

Conclusion

The question is not whether your hospital will deploy EHR technology. For healthcare, it's as inevitable as the personal computer and internet have become in everyday life. The question of "now or later" is proving to be more difficult to answer.

Through extensive analysis and interpretation of ARRA, we've concluded that you actually cannot begin moving soon enough toward EMR adoption — if you want to take full advantage of the 2011 through 2015 incentives. In summary, here are the key reasons why:

1. CCHIT certification already provides a high degree of certainty that your EHR installation will qualify for ARRA incentives.
2. Meaningful use, one of the most important ARRA criteria, requires a substantial period of time to develop and demonstrate.
3. The process of EMR vendor selection through user training and organization-wide adoption can add years to the front end (especially with a phased implementation) and must be considered when setting meaningful use target dates.
4. Every EMR vendor possesses a finite set of resources. By initiating your project before the period of peak demand, you are more likely to avoid delays in implementation and meaningful use.
5. Demonstrating meaningful use by 2013 will enable you to capture the maximum ARRA incentive payments.
6. Failing to demonstrate meaningful use by 2015 exposes you to the risk of penalties in the form of reduced reimbursements.
7. The sooner your organization embraces electronic medical record technology, the sooner you'll begin to realize its many proven benefits, both financial and non-financial.

At Healthland we're glad to assist your hospital with your EMR initiative whenever the decision is made to move forward, whether it's next week, next year or even further down the road. However, we also feel obliged to share information that can help you seize this unprecedented opportunity and maximize the return on your EMR investment.

Since 1980 Healthland, formerly Dairyland, has served the healthcare market, growing into a leading nationwide provider of comprehensive information systems for community and critical access hospitals.

For more information and to request a demonstration of the Healthland software, visit www.healthland.com/stimulus.

