

Health Reform, ACOs & Health Information Technology

Virginia Bar Association Seventh Annual
Health Care Practitioner's Roundtable

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November 4, 2011

- ➔ **These materials and associated remarks are intended as a general discussion of the subject matter addressed. They are not intended to be comprehensive or as legal advice, and they should not be relied upon as such. Attorneys will need to draw their own conclusions relative to any particular case and take into account all applicable laws when formulating advice**

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The “Triple Aim” of Health Reform

- ➔ **CMS Administrator Berwick’s vision:**
 - ➔ **Better care for individuals**
 - ➔ **Better health for populations**
 - ➔ **Reduced per capita costs**
- ➔ **PPACA is replete with projects, pilots and programs that address these goals**
- ➔ **Clinical pathways/evidence based medicine**
- ➔ **What is the common thread?**

DATA

**Health Reform 1.0: The Health
Information Technology for
Economic and Clinical Health Act
(The “HITECH Act”)**

- **Part of the American Recovery and Reinvestment Act of 2009**
- **Goal: nationwide HIT infrastructure that allows for the electronic use and exchange of information and that**
 - ⇒ **Reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care and incomplete information and**
 - ⇒ **Improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information**

(among other things)

- ➔ **HIT Policy & Standards/ONCHIT**
 - ➔ **HHS Implementation Plan:**
www.hhs.gov/recovery/reports/plans/onc_hit.pdf
- ➔ **Encourages EHR Adoption & Use Through Incentives & Disincentives**
- ➔ **Breach Notification**
- ➔ **Security, Privacy & Business Associates**
- ➔ **Penalties & Enforcement**

EHR Incentives & Disincentives

- ➔ **Available incentives include:**
 - ➔ **Medicare Incentives for Eligible Professionals (HITECH § 4101)**
 - ➔ **Medicare Incentives for Hospitals (HITECH § 4102)**
 - ➔ **Medicaid Provider Payments (HITECH § 4201)**

- ➔ Incentive payments are available for “eligible professionals” (EPs) who are “meaningful EHR users”
 - ➔ Eligible Professional = “physician” under Medicare
 - ↳ MD, DO, DDS, DPM, OD, Chiropractors
 - ➔ No incentive payments available for hospital based physicians (they use hospital EHR systems)

- ➔ To be a “meaningful EHR user,” the following requirements must be met:
 - ➔ Demonstrate use of certified EHR technology in a meaningful manner
 - ➔ Demonstrate that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve quality (e.g. care coordination)

- **Meaningful EHR User (cont.)**
 - **Submit specified information on clinical quality measures and other measures using the certified EHR technology**
- **Stage I Requirements (effective now):**
 - **Satisfy 15 “core criteria”**
 - **Satisfy at least 5 of 10 “menu set criteria”**
 - **Examples:**
 - **Computerized Provider Order Entry for medication orders**
 - **Drug-drug and drug-allergy interaction checks**
 - **Active medication list**
 - **Submission of e-data to immunization registries**

- ➔ **Stage 2 (expected in 2013) and Stage 3 (expected in 2015) build on Stage 1 requirements**
- ➔ **Payments available from 2011 to 2016**
- ➔ **Annual Payments: \$18,000 to \$2,000**
 - ⇒ **Maximum = \$44,000 over 5 years**
 - ⇒ **10% kicker for EP in HPSA**

Medicare EHR Disincentives - Professionals

- ➔ **Beginning in 2015, eligible professionals who are not meaningful EHR users will have MFS payments reduced**
 - ➔ **1% in 2015**
 - ➔ **2% in 2016**
 - ➔ **3% in 2017**
 - ➔ **3% in 2018 (4% if use rate <75%)**
 - ➔ **3% in 2019 (4%-5% if use rate <75%)**
- ➔ **“Significant Hardship” exception available (up to 5 years)**

- ➔ Incentive payments also are available for “eligible hospitals” that are “meaningful EHR users”
- ➔ “Eligible Hospital” = subsection (d) hospital = hospital in the United States other than
 - ➔ psychiatric, rehabilitation, and children’s hospitals;
 - ➔ certain cancer hospitals; and
 - ➔ hospitals with ALOS > 25 days
- ➔ “Meaningful Use” defined separately in the statute, but similar to meaningful use by EPs

⇒ **Stage 1 requirements:**

- ⇒ **Satisfy 14 core criteria**
- ⇒ **Satisfy 5 of 10 menu criteria**

⇒ **Examples:**

- ⇒ **Computerized Provider Order Entry for medication orders**
- ⇒ **Drug-drug and drug-allergy interaction checks**
- ⇒ **Active medication list**
- ⇒ **Report hospital clinical quality measures to CMS or the State (if Medicaid eligible)**

⇒ **Amount of Incentive Payment =**
Initial Amount x Medicare Share x Transition Factor

where

⇒ **Initial Amount = Base Amount + Discharge
Related Amount**

↳ **Base Amount = \$2 million**

↳ **Discharge Related Amount = \$200 per
discharge for discharges 1,150 – 23,000
(max = \$4,370,000)**

➔ Amount of Incentive Payment (cont.)

⇒ Medicare Share (for a given payment year) =
(Est. Part A bed days) + (Est. Part C bed days)
 (est. total bed days) x (“charge fraction”)

↳ Charge Fraction =
est. total hospital charges w/o charity care
 est. total hospital charges

⇒ Amount of Incentive Payment (cont.)

⇒ If First Payment Year is 2011, 2012 or 2013,
Transition Factor =

- ↳ 1 for First Payment Year
- ↳ $\frac{3}{4}$ for Second Payment Year
- ↳ $\frac{1}{2}$ for Third Payment Year
- ↳ $\frac{1}{4}$ for Fourth Payment Year
- ↳ 0 for all years thereafter

➔ Amount of Incentive Payment (cont.)

➔ If First Payment Year is 2014 or 2015, Transition Factor for a year is the same as it would have been if 2013 were the First Payment Year. Example if 2014 is FPY:

↳ $\frac{3}{4}$ for 2014

↳ $\frac{1}{2}$ for 2015

↳ $\frac{1}{4}$ 2016

↳ 0 for all years thereafter

➔ If First Payment Year is after 2015, TF = 0

- ➔ **If a hospital is not a meaningful EHR user by 2015, the market basket percentage increase that otherwise would apply will be reduced (subject to certain exceptions):**
 - ➔ **In the case of an eligible hospital that is not a meaningful EHR user for an EHR reporting period for such fiscal year, $\frac{3}{4}$ of the applicable percentage increase otherwise applicable under clause (i) for such fiscal year shall be reduced by 33.3% for fiscal year 2015, 66.67% for FY 2016, and 100% for 2017 and each subsequent year.**

- ➔ **EHR incentive payments (and payment reductions) for certain professionals and hospitals are also available under Medicaid**
- ➔ **Eligibility requirements vary from Medicare**
- ➔ **Payments to professionals are based on “average allowable cost” of EHR acquisition (in year 1) and costs of operation and maintenance (thereafter), which are to be established by HHS after study**

- ➔ **Payments to hospitals are based on available Medicare incentive payments, subject to certain adjustments and limitations**
- ➔ **Payments may not be made over a period of more than 6 years, or for any year beginning after 2016 unless the provider received payment the previous year**

- ➔ Covers nonmonetary remuneration
 - ➔ Consisting of items and services in the form of software or information technology and training services (no hardware) and
 - ➔ Necessary and used predominantly to create, maintain, transmit or receive EHRs
- ➔ Must be provided by an “entity” to a physician
 - ➔ ACO ≠ “entity”
- ➔ Physician must pay 15% of donor’s cost before receipt of the items or services

- ➔ Covers nonmonetary remuneration (like Stark Law exception)
- ➔ Must be provided by
 - ⇒ Individual or entity that provides services covered by FHCP and submits claims or requests for payment to the FHCP; or
 - ⇒ A health plan
 - ↳ An ACO is neither
- ➔ Recipient must pay 15% of donor's cost prior to receipt of the items and services

HIT Implications For Accountable Care Organizations (ACOs)

- ➔ **EHR = ACO table stakes**
- ➔ **Can an ACO facilitate EHR acquisition and use by participants?**
 - ➔ **Who owns the ACO?**
 - ➔ **How is it funded?**
 - ➔ **Stark Law, AKBL implications**
- ➔ **Do the Medicare Shared Savings Program waivers help?**
- ➔ **What if the ACO does not participate?**

- ➔ **What is an ACO for HIPAA purposes?**
 - ➔ **Is it a covered entity?**
 - ➔ **Is it a business associate?**
 - ➔ **Is it an organized health care arrangement?**
- ➔ **Does HIPAA permit PHI to be disclosed to, used by or disclosed by the ACO?**
- ➔ **What are the ACO's HIPAA compliance obligations?**

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QUESTIONS?