



HIT Perspectives

Perspectives and Updates on Health Information Technology

PUBLISHED BY POINT-OF-CARE PARTNERS ([WWW.POCP.COM](http://www.pocp.com))

MAY 21, 2009

HIT Legislation

How Meaningful Are the Stimuli?

by *Tony Schueth, Editor-in-Chief* and *Michael Solomon, Executive Editor*

Over the years, there has been a great deal of hype surrounding health information technology (HIT), by whatever name it's being called at the time. To our clients, we have always been a moderating voice and, frankly, have always been right. This has won us significant points, respect and credibility.

The American Reinvestment and Recovery Act of 2009 (ARRA) is the latest to exude hype as the boldest attempt yet to coerce physicians into doing something they do not want to – convert their practice to the electronic era. (Let's be honest, folks, most physicians just want to practice medicine, and the gargantuan effort required to convert from paper to electronic orders and records understandably causes pain.)

We have recently conducted an unscientific, small-sample, qualitative survey among physicians and have found that few know about either electronic health record (EHR) or electronic prescribing (ePrescribing) incentives or "carrots." The message about these financial benefits is just not penetrating physicians who are already on overload. According to an article in the *Journal of the American Board of Family Practice*, "If physicians would read two articles per day out of the 6 million medical articles published annually, in one year they would fall 82 centuries behind in their reading."

What is interesting about ARRA and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) are the "sticks" that follow. For MIPPA, physicians will begin having their pay docked in 2012 if they're not ePrescribing. For ARRA, they will begin to be penalized in 2015 if not "meaningfully using" a certified EHR.

In 2005, we conducted a survey of current HIT leaders. A key question was, "How many years do you think it will take for there to be 50% of providers prescribing electronically?" Seventy-three percent (73%) said within five years. While we're not there yet, Surescripts just came out with its *National Progress Report on ePrescribing* and in 2008, we were at 12% and on a pace to double that this year. The fact that the experts were a little optimistic is irrelevant. At the time, people "in the know" told us that if they didn't see progress, the federal government would mandate ePrescribing. Let's be honest, penalties are nothing more than politically correct mandates.

Whereas the positive information about incentives haven't penetrated, we think that negative messages around penalties will. Furthermore, once 2012 rolls around and pay reductions begin, physicians – through their lobbyists – will turn to their representatives, who won't offer much sympathy because of the money they have let slip away.

Will this work to encourage adoption? We are debating this right now. To be sure, the debate isn't "Will it?" but "How much will it?" Most of us want to be

conservative, while others are wondering if we've finally put together the package that will force behavior change.

For our clients, we have laid out the factors that could accelerate and decelerate adoption. While not all are equal, the fact that there are more potential decelerators is telling. Space does not permit us to get into each of these (and we get paid for this kind of insight, anyway), but we would point out that several factors are still to be determined from the ARRA legislation, as we have less issues with MIPPA.

On the MIPPA (ePrescribing) side, as we've noted, there is the notion of both "carrots" and "sticks." While the "carrots" aren't plentiful, we think there are enough to offset the costs of the technology should a physician choose a stand-alone ePrescribing solution or upgrade to a version of an EMR that is MIPPA compliant. Furthermore, we like the fact that physicians need to contract directly with the vendor. By having "skin in the game," they appreciate what they're purchasing.

The MIPPA incentives probably don't provide enough to cover substantial value from training, implementation and interfaces, representing an opportunity for health plans or coalitions should they recognize it. (A number of value assessments have come out within the past six months, the most compelling of which may be from the Southeastern Michigan ePrescribing Initiative, where the savings from ePrescribing was nearly \$5 per prescription on the aggregate. It doesn't take a math wiz to figure out the benefit derived from high-value prescribers.)

What we don't like is the fact that ePrescribing is defined narrowly and that incentives only exist for electronic transmission of a prescription, which benefits just a small number of stakeholders. We also don't like that compliance is self-reported (what the government calls, "attestation"), at least in the near-term. As we've written in the past, we'll be in a better place when we can track whether a prescription was received electronically in the claim.

Turning back to ARRA, the potential impact of the HIT funding in this legislation can be put into perspective with numbers. The \$5 billion per year, on average, that will flow from ARRA for HIT during the seven-year period is comparable to the entire amount spent in 2007 by providers for clinical information systems! And the \$1 billion to \$2 billion distributed by the Department of Health and Human Services during the first two years dwarfs the roughly \$200 million doled out recently in a typical year by federal and state governments for EHR-type projects.

Nonetheless, the operative word is potential. We are tracking a set of key "signals" that serve as leading indicators of how effective the regulations and funding stemming from ARRA are in building the national health information network (NHIN) grid and driving EHR adoption – the two overarching goals of the legislation. Foremost is the fact that the barriers to adoption of EHRs by smaller physician practices and community hospitals – the bulk of health care providers in this country – remain. In this capital-starved economic environment, providers still need to fund upfront a technology initiative that will cost far more than the financial incentives available. Just last week, we learned of a community hospital that attempted to obtain a loan for its EHR initiative, expecting the ARRA incentives would strengthen its application. The hospital was turned down. Disruption to the business and funding a technology for which other stakeholders derive a large portion of the benefit

are just a couple of other barriers that persist in the post-ARRA era of EHR adoption. Will the National HIT Technology Research Center and regional extensions provide the expertise and support to effectively aid in eradicating these barriers? We'll be watching closely.

The second signal is the interrelated efforts of defining "meaningful use" and putting into place certification mechanisms. Will the regulations uphold the intent of the legislation to ensure vendors develop standards-based, interoperable products with robust applications to measure and report key indicators of quality? Or will the bar for meaningful use be set so low that practically every vendor presently certified by the Certification Commission for Health Information Technology (CCHIT) and newcomers will make certification so diluted as to become meaningless? Already, a great deal of confusion regarding meaningful use exists, and providers remain skeptical of the quality of many EHR products, particularly those targeting physicians. The value of EHRs increases significantly when health information exchange (HIE) is integral to the application and providers can track the same quality measures to which they are being held accountable by payers.

Lastly, a subtle but very important aspect of ARRA is the \$2 billion being distributed by HHS is near term while the EHR incentives are longer term. Will the \$2 billion be spent wisely during the next 24 months to build the NHIN so that as the EHR footprint grows, data can truly be shared among providers to facilitate coordination and continuity of care? Or will a large portion of this money end up in the form of aborted business plans and demonstration projects led by poorly organized HIE organizations? We've had enough "demonstrations." Hopefully, those entities that show they can deliver on HIE services will receive a significant amount of these funds. We encourage you to track these signals along with us and let us know your assessment.

ePrescribing

If I Receive MIPPA Incentives, Can I Still Get ARRA Dollars?

by Tony Schueth, Editor-in-Chief

There is some confusion in the marketplace right now regarding ePrescribing incentives, and we'd like to clarify.

In 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) passed, providing physicians a 2% boost in pay for 2009 if 50% of their prescriptions are transmitted electronically. That number would decrease over time and penalties would begin in 2012.

The American Reinvestment and Recovery Act of 2009 (ARRA) helps offset the cost of acquiring a certified electronic health record (EHR) as long as the physician is "meaningfully using" the clinical system. "Meaningful use" is still being defined, but we know it includes ePrescribing and the ability to exchange information and provide quality data. The ARRA incentives are broken down into multiple "buckets," the largest of which are Medicare and Medicaid.

We also know that a provider can't receive both MIPPA and ARRA Medicare dollars in the same year. Some experts have interpreted that a provider can never receive MIPPA and ARRA Medicare dollars. We don't believe that to be the case.

Our interpretation is that physicians can receive MIPPA incentives now, and in 2012 start receiving ARRA incentives. They just won't be able to receive both MIPPA and ARRA Medicare in 2011. On the other hand, we believe they can receive MIPPA and ARRA Medicaid, if they qualify. Furthermore, there are dependencies on the more detailed definition of "meaningful use" and "certified EHR.")

What are the implications? If a physician has an ambulatory EHR and isn't prescribing electronically using MIPPA-compliant technology, he or she is leaving money on the table by not upgrading to a version that is MIPPA compliant. If a physician is using a stand-alone ePrescribing system, he or she should be submitting for MIPPA incentives.

If a physician is trying to decide between an EHR and stand-alone ePrescribing system, we don't recommend inertia. Certified EHRs will likely qualify under ARRA. As the chairman of the Certification Commission of Health Information Technology (CCHIT), Mark D. Leavitt, MD, noted, "The major parameters are actually written into the bill. It has to be a certified EHR, it has to include ePrescribing, it has to be able to exchange information and it has to be able to report quality data. I'm not sure if we have to know more than that - if you are a provider - to be able to make a technology investment now," he added.

If you're considering a stand-alone ePrescribing system, we don't recommend waiting because the MIPPA dollars can more than cover your costs and studies have shown that the efficiency savings you'll get from 2009 to 2011 will be substantial. Furthermore, while there is some disruption to the practice, implementing a stand-alone ePrescribing system is not substantially difficult, in our view. That said, you should make sure that your vendor is willing and able to provide your data to an EHR provider or that there is a clear pathway to an EHR.

Also, recognize that they're still working on defining "meaningful use" and "certified EHR." If the bar is set low around the definition of "meaningful use," could a stand-alone ePrescribing system evolve into an "EHR light?" While they don't currently certify "EHR lights," they haven't defined "certified EHR" yet, either.

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