Why Would a Healthcare Organization Join an Exchange?

Joe Brisson

HIT Associates

The Importance of Healthcare Information Exchange

- The nature of healthcare is evolving due to advances in technology which allow health records to be electronically exchanged between providers. This electronic exchange of information has the potential to improve the quality of healthcare. Health records can be transmitted between patients, doctors, hospitals, and other providers at the time of service. With accurate and complete records at the time of care, it is anticipated that providers will be able to make better medical decisions.*

*NCHICA Consumer Advisory Council on Health Information

Establishing a Common Vocabulary*

Health Information Exchange (HIE)	Health Information Organization (HIO)	Regional Health Information Exchange (RHIO)
The electronic movement of health-related information among organizations according to nationally recognized standards.	An organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards.	A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

*The National Alliance for Health Information Technology Report to the Office of the National Coordinator for Health Information Technology On Defining Key Health Information Technology Terms April 28, 2008

Reasons Not to Join an Exchange

#5 Future Penalties from Medicare

#4 HIPAA Privacy

#3 Loss of Revenue from Duplicate Services

#2 Loss of Business from Competing Providers

#1 My Patients will sue me because:

A. I didn't use their community record

B. I used their community record


BEFORE WE BEGIN, MS BLATT WILL RETRIEVE YOUR
BILLING RECORDS FROM THE ARCHIVES.

Reasons Not to Join an Exchange

#5 Future Penalties from Medicare

- Beginning in FY 15 for hospitals and Calendar 15 for physicians
- The “adjustments” start at 1% of the physician’s Medicare fee schedule and are set to begin in 2015, after four years of available incentives for adoption. The penalties are set to increase each subsequent year to a maximum of 5%.

Reasons Not to Join an Exchange

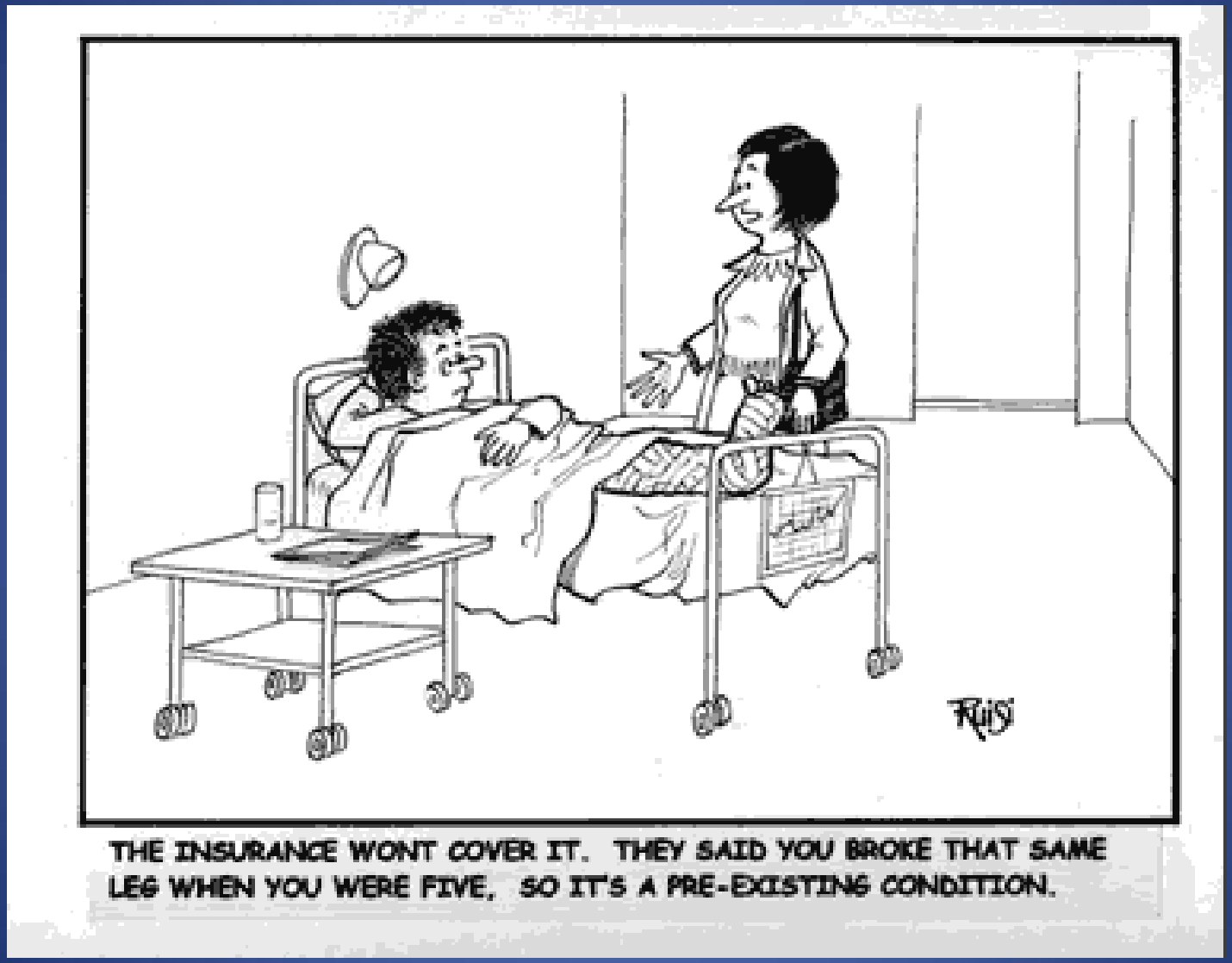
#4 HIPAA Privacy

- Sharing Patient Data for Treatment Purposes is Allowable
- Other Patient Data uses Should be Examined

Reasons Not to Join an Exchange

#3 Loss of Revenue from Duplicate Services

- True
- Increased Patient Satisfaction


THE INSURANCE WONT COVER IT. THEY SAID YOU BROKE THAT SAME LEG WHEN YOU WERE FIVE, SO IT'S A PRE-EXISTING CONDITION.

Reasons Not to Join an Exchange

#2 Loss of Business from Competing Providers

- Possible – do we need More Business?
- Improved Patient Care – Longitudinal Record

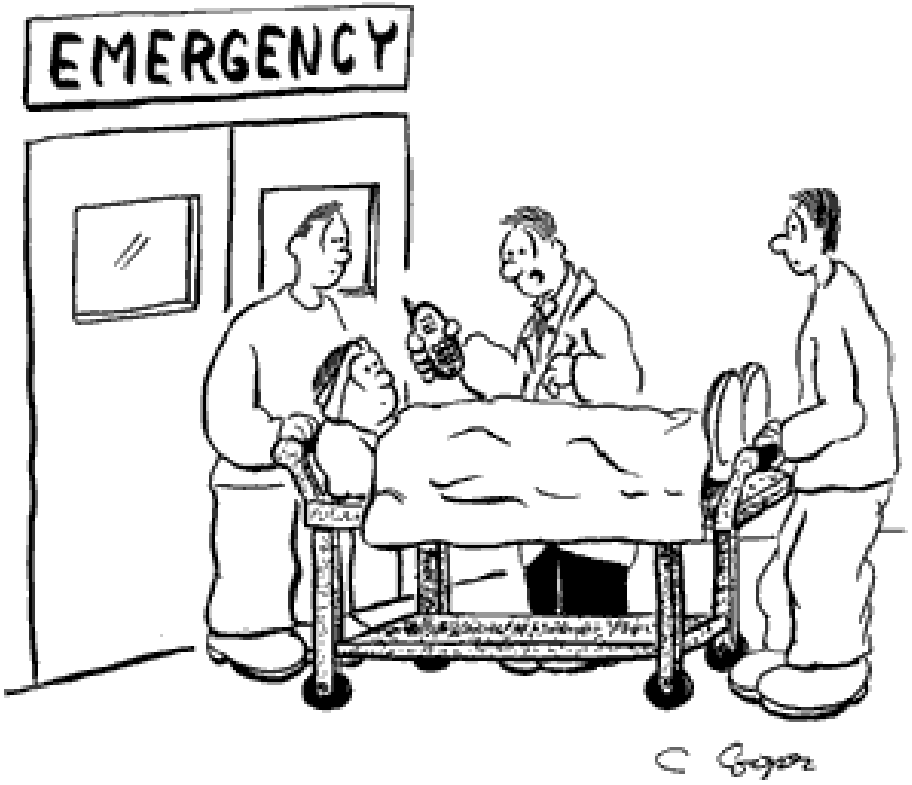
Reasons Not to Join an Exchange

#1 My Patients will Sue me because:

A. I didn't use their community record

B. I used their community record

- Limited or No Case Law to Support this Fear
- Perhaps they'll Sue less because you knew:
  - Their current Medications
  - Their current Allergies
  - Other Health History



"It's your mother. She wants to know if you were wearing clean underwear."

Health Information Exchange Types

1. Birds of a Feather (BoF) – IDN/IDS, MSO, Medical Societies, other
2. Community or Regional Health Information Network – most common
3. Statewide or State-level Health Information Exchange – emerging every state and territory
4. National – SureScripts, Google Health, Kaiser Permanente, others – usually private
5. Federal – SSA, DoD, VA, IHS, CDC, others

Meaningful Use*

- Clinicians and hospitals must acquire and implement certified EHRs in a way that fully integrates these tools into the care delivery process;
- Technical, legal, and financial supports are needed to enable information to flow securely to wherever it is needed to support health care and population health; and,
- A skilled workforce needs to support the adoption of EHRs, information exchange across health care providers and public health authorities, and the redesign of work-flows within health care settings to gain the quality and efficiency benefits of EHRs, while maintaining individual privacy and security.

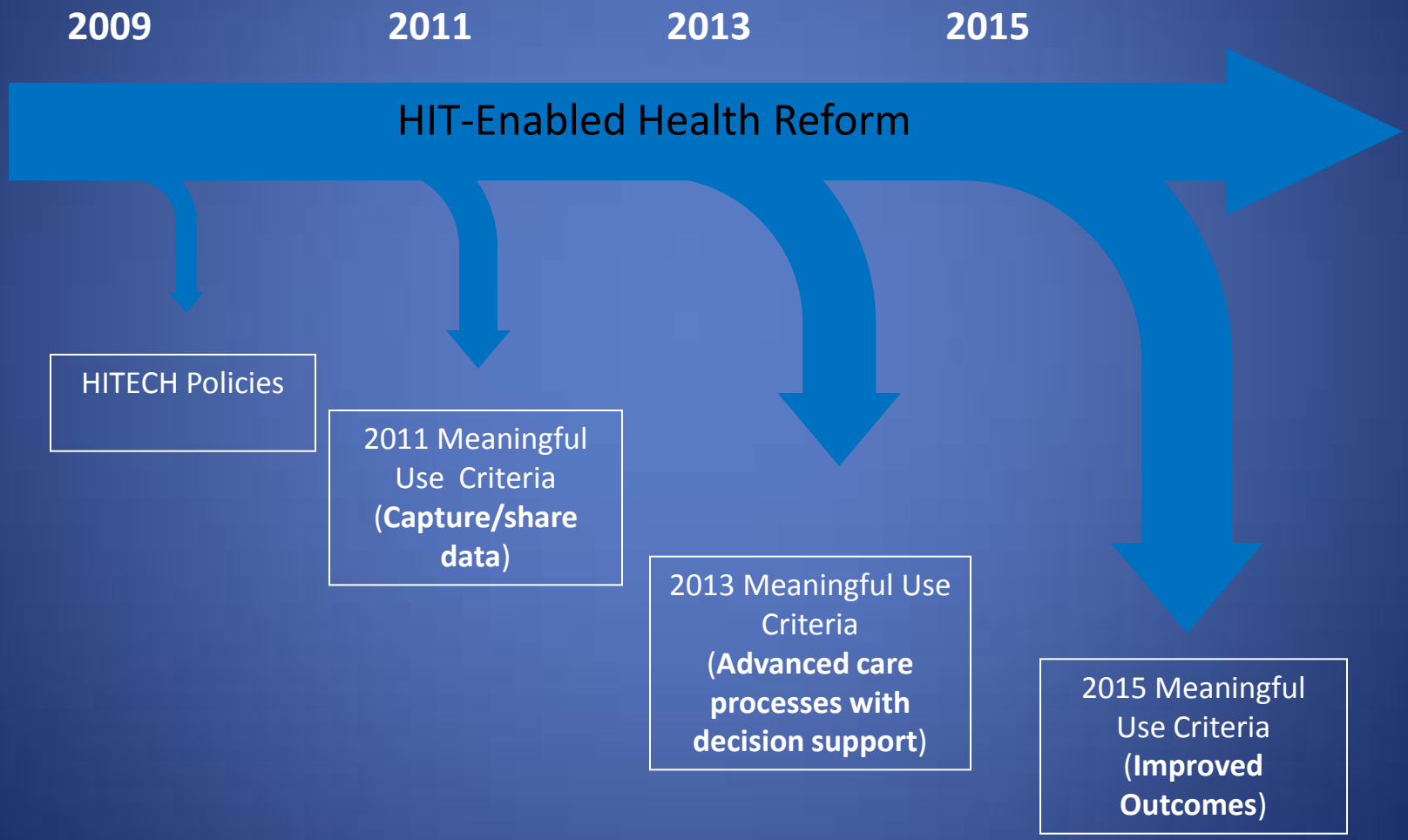
**State Health Information Exchange Cooperative Agreement Program*
Office of the National Coordinator for Health Information Technology - 2009

MEDIOCRITY

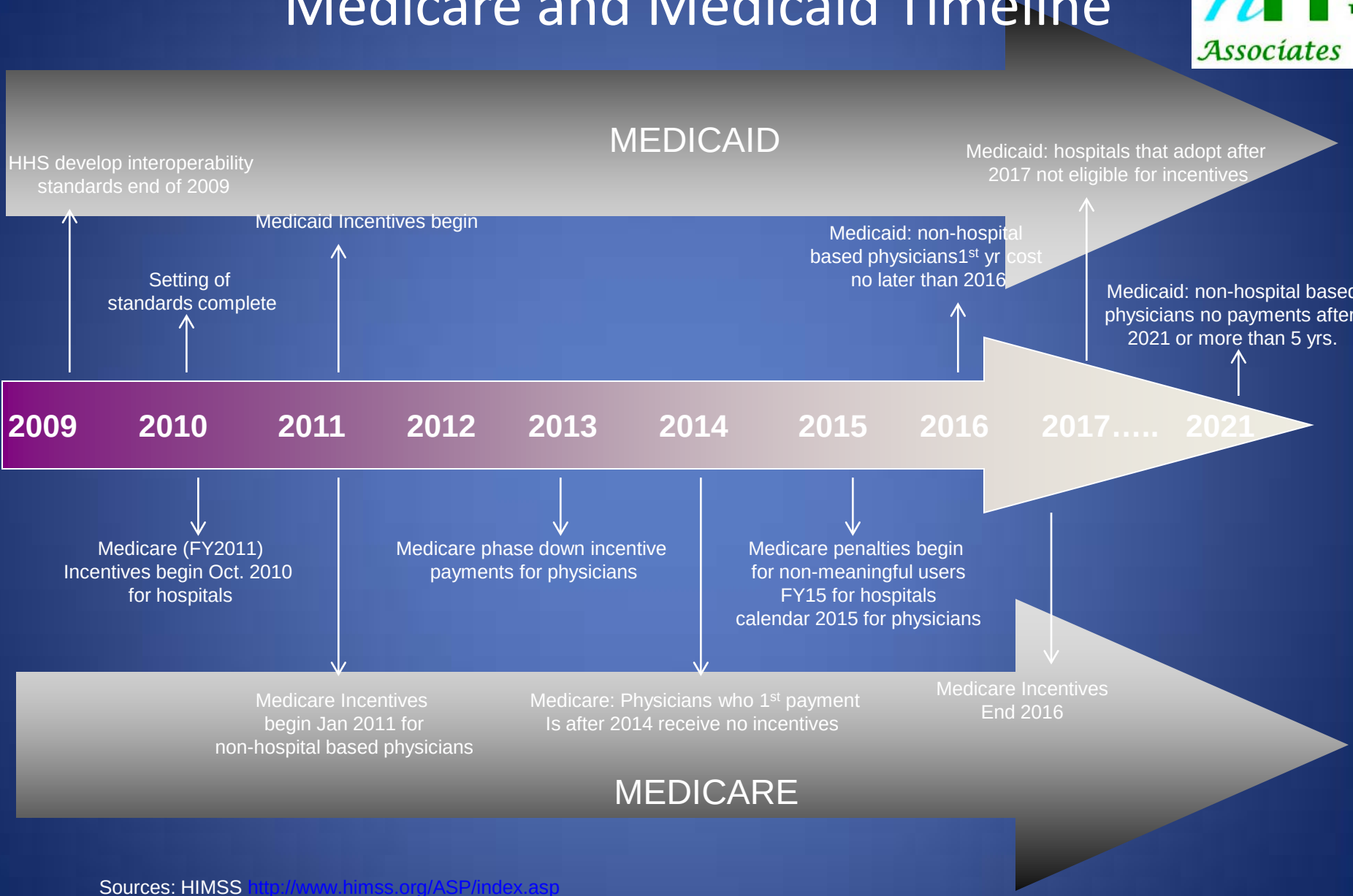
It Takes a Lot Less Time
and Most People Won't Notice the Difference
Until It's Too Late.

HIT-Enabled Health Reform

Achieving Meaningful Use



Medicare and Medicaid Timeline



Sources: HIMSS http://www.himss.org/ASP/index.asp
and AHIMA http://www.ahima.org/

Incentives Overview

	MEDICARE		MEDICAID	
	Physicians	Hospitals	Physicians	Hospitals
Incentive start	Calendar yr 2011	FY 2011	2011	2011
Incentive End	Calendar yr 2016	FY 2015	2016	2021
Incentive Amount	up to $44,000	$2 million base	Up to $65,000	
Reduction	Calendar yr 2015	FY 2015	No penalty	

Medicare Physicians Incentives

Year they first file	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	$10	$10	$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

Medicare Hospital Incentives

Year of Adoption	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
2011	100%	75%	50%	25%			
2012		100%	75%	50%	25%		
2013			100%	75%	50%	25%	
2014				75%	50%	25%	
2015					50%	25%	

Medicare Hospital – 100 Bed

Incentive Payments for a typical 100-Bed Hospital with an Average Occupancy Rate of 50% ($)

Payment Component	Incentive per Unit	Year 1 (100%)	Year 2 (75%)	Year 3 (50%)	Year 4 (25%)	Cumulative Total
Base payment, year 1 only	2,000,000	2,000,000				**2,000,000**
Bonus per discharge: from 1,150(minimum to 23,000(maximum) discharges	200	563,400	422,550	281,700	140,850	**1,408,500**
Total		2,563,400	422,550	281,700	140,850	**3,408,500**

Medicare Hospital – 500 Bed

Incentive Payments for a typical 500-Bed Hospital with an Average Occupancy Rate of 85% ($)

Payment Component	Incentive per Unit	Year 1 (100%)	Year 2 (75%)	Year 3 (50%)	Year 4 (25%)	Cumulative Total
Base payment, year 1 only	2,000,000	2,000,000				**2,000,000**
Bonus per discharge: from 1,150(minimum to 23,000(maximum) discharges	200	4,370,000	3,227,500	2,185,000	1,092,500	**10,925,000**
Total		6,370,000	3,227,500	2,185,000	1,092,500	**12,925,000**

Medicaid Incentives*

Adoption Year	1	2	3	4	5	6	Total
2011-16	$21,500	$8,500	$8,500	$8,500	$8,500	$8,500	$63,750

*This is a representative perspective on how provider payments may occur, but does not necessarily represent actual payments.

•Incentives most likely will start in 2011

•Eligible professionals must be:

Non-hospital based with at least 30★ percent Medicaid patient volume or
Non-hospital based pediatricians with at least 20★percent Medicaid patient volume (★ still under discussion)

•No Medicaid payment reductions if a provider does not adopt certified EHR technology

Timing is Critical!

- Incentive payments ≠ cost of EHR implementation
- Early Adopters must be able to manage risk
- When to implement EHR
  - Vendor ready with certified product, final guidance on meaningful and certification not available until early 2010
  - Implementation resources severely constrained
  - Can I connect to a health information exchange?
- If cash flow is critical, coordinate implementation with meaningful use incentive payments

PESSIMISM

Every Dark Cloud Has a Silver Lining,
but Lightning Kills Hundreds of People Each Year Who Are Trying to Find It.

Questions?

Joe Brisson
HIT Associates
brissonjoe@hotmail.com
816.809.1314