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Electronic Health Records: What Risk Managers Need to Know

Ivy Baer, J.D., M.P.H.
Director & Regulatory Counsel
ibaer@aamc.org
202-828-0499

Association of American Medical Colleges

Why focus on electronic health records?

- For hospitals and physicians, there's lots of money to be had
- Starting in 2015, there will be financial penalties for Medicare providers and hospitals that do not use EHRs and achieve "meaningful use"

ARRA ("Stimulus Bill")

For "Meaningful Use" for EPs, hospitals, CAHs, and MAs:

- Using EHR technology in a meaningful manner, including e-prescribing
- Exchanging health information electronically to improve quality of care
- Reporting on clinical quality measures

- Meaningful use measures to become more stringent over time

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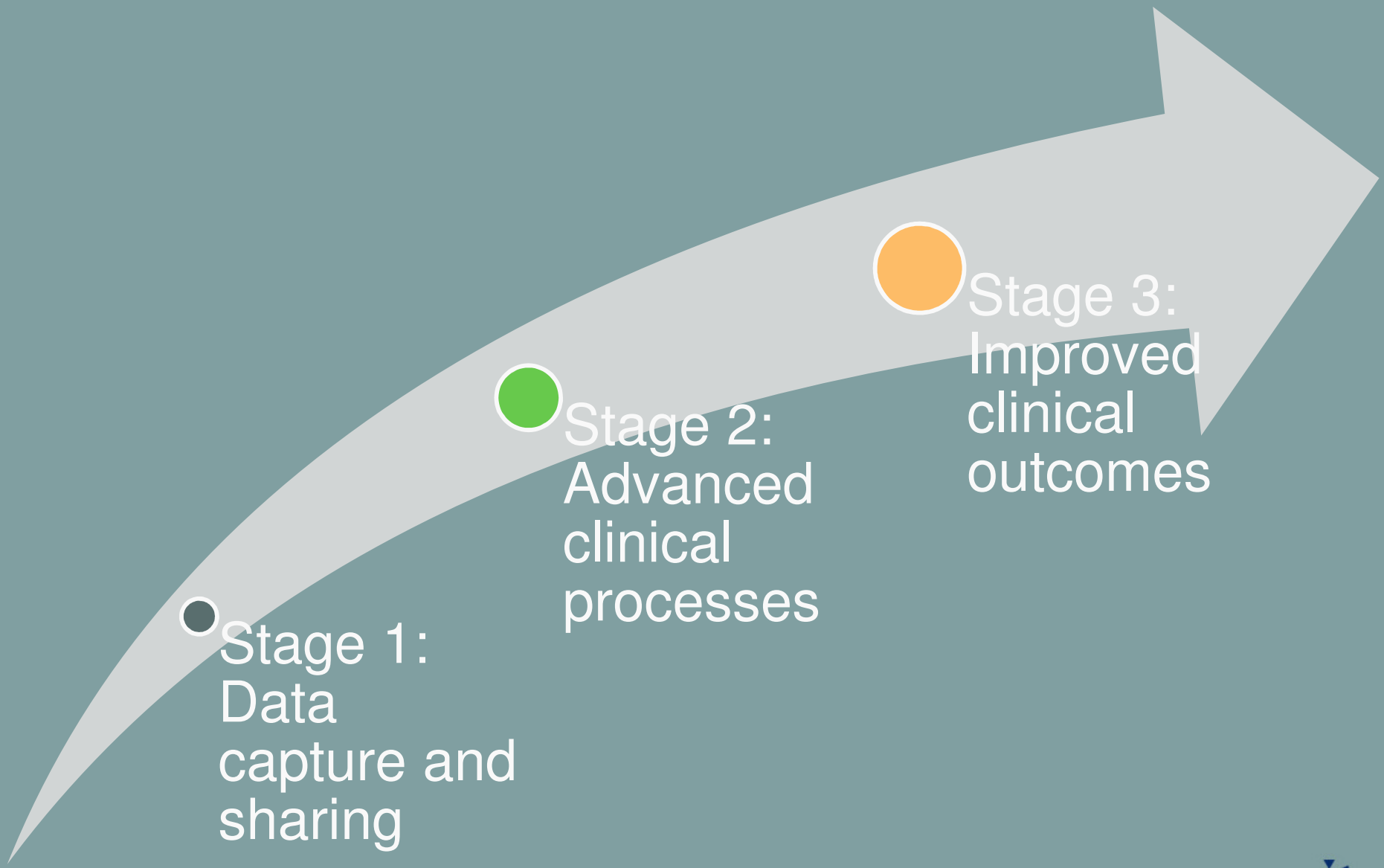
The MU Trajectory



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Stage 2 Decision Tree: Medicare

INCENTIVE! (CMS)!

Are you an eligible professional (EP)?

NO: $0; no penalty

YES

Are you a non-hospital based EP?

NO

YES

Are you using certified EHR technology?

NO

YES

Have you attested to core & menu measures of meaningful use ?

NO

YES

Have you attested to EP quality measures ?

NO

YES

2015: Unless are hospital-based or meet an exception, penalty begins

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Stages of Meaningful Use By Payment Year

First Payment Year	Payment Year						
	2011	2012	2013	2014	2015	2016	2017
2011	Stage 1	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 2	Stage 3	Stage 3
2013			Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2014				Stage 1	Stage 1	Stage 2	Stage 2

Source: Federal Register, Table 2 (March 7, 2012 p. 13703)

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Show me the money: EPs

1st year EP attests to meaningful use	Total for Medicare (assumes attestation in consecutive years)	Total for Medicaid
2011	$44,000	$63,750
2012	$44,000	$63,750
2013	$39,000	$63,750
2014	$24,000	$63,750
2015	$0	$63,750
2016	$0	$63,750

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A core measure of MU

For EPs, hospitals, and CAHs:

Conduct or review a security risk analysis . . . including addressing the encryption/security of data at rest . . . and implement security updates as necessary and correct identified security deficiencies **as part of the provider's risk management process**.

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EHR Incentives to Hospitals

Hospital payment formula:

[(Base amount + Discharge related amount) x Medicare share or Medicaid Share] x Transition factor

Base amount = $2 million

Discharge related amount = $200/discharge for 1,150th – 23,000th discharge in a 12 month period

Medicare share = A+C Inpatient Days / (Total Inpatient Days Minus Charity Care)

Transition factor = 100% in 1st payment year; 75% in 2nd payment year; 50% in 3rd payment year; 25% in 4th payment year; 0% thereafter

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Hospital Example

Assume:

- 5,000 Total Discharges
- 11,000 Medicare Inpatient A+C Days
- 3,000 Medicaid Inpatient (including managed care) Days
- 55% Medicare share (will be adjusted by charity care %)
- 15% Medicaid share (will be adjusted by charity care %)

Payments Would be Approximately:

- First Year: Medicare = $1,523,610; Medicaid = $415,530
- Second Year: Medicare = $1,142,703; Medicaid = $311,648
- Third Year: Medicare = $761,805; Medicaid = $207,765
- Fourth Year: Medicare = $380,903; Medicaid = $103,883
- **TOTAL: Medicare = $3,809,025; Medicaid = $1,038,825**

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Hospital Penalties

No payment if first year of MU is 2015 or later

Penalites beginning 2015

- 75% of inpatient payment update at risk.
  - 2015: 25% of update
  - 2016: 50% of update
  - 2017 on: 75% of update
- E.g., if 2015 IPPS update = 2%, hospital that did not meet MU would only get a 1.5% increase

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What happens 2015 and after?

- Fee schedule reductions for EPs who do not achieve meaningful use:
  - 2015: 1%
  - 2016: 2%
  - 2017 and after: 3%
  - 2018 and after: if less than 75% of eligible professionals are meaningful users, further reductions possible, but cannot be more than 95%

HHS OIG FY 2012 Workplan

1. Will assess inappropriate payment for E/M services; identify electronic health records (EHR) documentation practices associated with potentially improper payments.
2. Will review Medicare/Medicaid incentive payment data from 2011 to identify payments to providers that should not have received incentive payments; will also assess CMS's plans to oversee incentive payments for the duration of the program and actions taken to remedy erroneous incentive payments.

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Federal False Claims Act

- For knowingly submitting or causing to be submitted a false or fraudulent claim to the United States may be subject to triple damages and a penalty of $5500-$11,000 per claim.
- Exclusion from Medicare also a possibility

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Fraud and Abuse and EHRs

- Correct documentation in an EHR shows who did what, when, where and why

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Quality and Fraudulent Claims

Quality problems can lead to charges of a false claim submission

An FCA settlement that resolves allegations of fraud that impact the quality of patient care, may lead to a "quality-of-care" Corporate Integrity Agreement (CIA).

- Requires retention of an independent quality monitor to address the specific issues underlying the allegations and look at the delivery of care and evaluate the provider's ability to prevent, detect, and respond to patient care problems.

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