

Rock and a Hard Place

An analysis of the \$36 billion impact from
Health IT stimulus funding

Highlights

1. The stimulus funding for health IT is a small carrot compared to the amount of resources it will take to deploy this technology over the next five years. Also, providers will feel a big stick of financial penalties if they fail to use government-certified electronic health records (EHRs) in a certified manner beginning in 2015.
2. Health IT is moving from a voluntary initiative over the past decade to a highly regulated one with new rule-making government committees, stricter privacy laws and more onerous fines.
3. With billions in new funding and government regulations, the health IT market will balloon far beyond the provider segment, providing new opportunities for health plans, pharma companies and other vendors.
4. The Office of the National Coordinator will have broad new powers and \$2 billion in funding. Nearly all of the funds will flow to those that are already using systems in a strategic and government-certified way.

The American Recovery and Reinvestment Act (ARRA) of 2009 has a number of goals, one of which is to reduce long-term costs by modernizing healthcare through the use of information technology. To drive adoption of electronic health records by 2015, the federal government will invest \$36 billion in Medicare and Medicaid providers and through government agencies between 2010 and 2017.

Capital-constrained healthcare organizations may struggle to find the necessary funding to purchase EHR systems or ensure that theirs are interoperable with other organizations. Those with systems already in place are more likely to receive the most funding because they're likely to be closer to interoperability standards.

Of the stimulus funding, \$36 billion will flow to hospitals and physicians with early adopters receiving the biggest payments.

The funding will go to providers that use government-certified systems and show that they achieve “meaningful use.” The definition of “meaningful use” will be released later in 2009. The amount expected to be paid in incentives between 2011 and 2015 is nearly \$36 billion, according to the Congressional Budget Office. The overall budget impact from the incentive program is \$20 billion because of expected savings of \$15 billion between 2016 and 2019. For example, the government hopes to increase adoption from the meager 17%¹ of physicians today to 90% by 2015.

Speed of adoption could hinge on the current economy. A number of large integrated delivery networks (IDNs), technology firms, and a large national retailer are already in the market with significantly decreased pricing, and new pricing models (monthly subscription fee) have the potential to break down the cost barriers, especially the up-front capital requirements. Although it is unlikely that the Office of the National Coordinator for Health IT (ONCHIT) will support a government-sponsored certified EHR (e.g., EHR default), widespread adoption could drive down system costs, which will help physician practices achieve automation and preclude financial penalties.

The national coordinator has broad new powers in quality, security, and standards, and \$2 billion to spend.

The Office of the National Coordinator for Health IT (ONCHIT) will receive \$2 billion to fund initiatives that grow out of a plan to be issued later in 2009. This is an enormous funding boost over a budget of \$8 million in 2006 and a flat \$61 million in 2007 and 2008. Some of this funding will be appropriated to fund the new federal standards-setting bodies, and it’s possible that some might be used to fund a national infrastructure.

Of the total, \$300 million will be granted to states or “qualified” state-designated non-profit, multi-stakeholder partnerships to conduct and expand the electronic movement and use of health information. However, ONCHIT has the authority to apply other funds. Matching grants (1:5 hospital/government matching) can be used for EHR loan programs at the state level after standards are outlined as follows:

- Purchase or enhance certified technology
- Train personnel
- Improve the secure exchange of health information
- Agree to submit reports on quality measures, improve the quality of health care, and provide a plan for sustainable EHR

The funding for ONCHIT’s new Federal Advisory Committee Act (FACA) will change health IT standardization from a voluntary effort that was done through the Healthcare Information Technology Standards Panel (HITSP), Certification Commission for Health Information Technology (CCHIT), and the American Health Information Community (AHIC) to one in which standards are mandated. In addition, significant changes to existing unfunded HIPAA mandates will include much steeper penalties for non-compliance, stringent rules about reselling data, and costly changes to business associate agreements, data segmentation, and audit requirements. Many organizations have barely met HIPAA standards in the past, and will find the new interpretations put them well out of compliance.

The national coordinator will lead the establishment and operations of a Health IT Policy Committee and the Health IT Standards Committee and will serve as a liaison between those two committees and the federal government. In addition, the national coordinator will take a lead role in the operations of the committees, which must be established by early 2010. The standards committee will recommend implementation specifications, pilots, harmonization of and certification criteria for the electronic exchange and use of health information.

The HIT Policy Committee will make policy recommendations to the national coordinator about implementing a nationwide health information technology infrastructure. This committee will also recommend an order of priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria among the areas so recommended. Recommendations from HIT Policy Committee will include technologies that protect the privacy of health information to reduce the reluctance of patients to seek care because of privacy concerns. They also will work towards utilization of a certified electronic health record for every American by 2014. In addition, the committee will review how EHRs can improve the quality and coordination of care and reduce errors.

PwC analysis shows an average 500-bed hospital would receive an average of \$6.1 million in incentives.

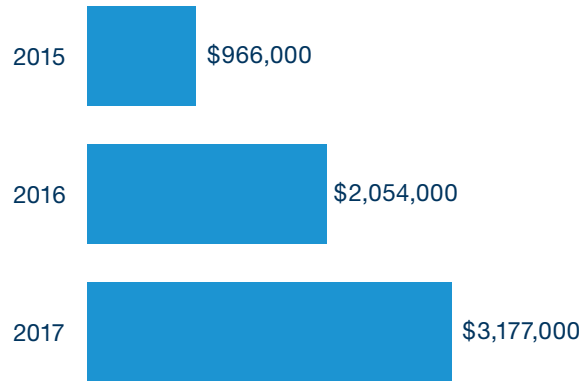
For modeling purposes, PwC analyzed the impact on an average 500-bed hospital, using assumptions for average discharges, inpatient days, charges and charity care. For example, the model assumed the hospital provided 2.5% of its average \$1.2 billion in charges in charity care, that it had an average of 26,000 annual discharges, and 62,500 Medicare inpatient days (this includes both Medicare fee for service and Medicare Advantage days). Assuming the hospital has shown “meaningful use” of its EHR by 2011, it would receive \$2.4 million the first year. In total, it could receive \$6.1 million in incentive payments.² See Figure 1.

The amount an individual hospital will receive in health IT stimulus funding has nothing to do with how much it spends on the technology. The funding hinges on its Medicare, Medicaid, and charity care volumes, which can differ radically from hospital to hospital. Hospitals would receive the full incentive the first year, if they achieve “meaningful usage” in 2011, 2012 or 2013. Hospitals that achieve that would receive four years of incentives, with the amount dropping 25% each of the next three years.

PricewaterhouseCoopers’ analysis shows that the stimulus incentives to comply with the new requirements for purchasing, deploying, and maintaining interoperable EHRs do not come near to compensating the overall costs. However, when considering future penalties from reduced Medicare reimbursement, the implementation becomes more fiscally compelling. Hospitals that fail to implement a government-certified system would start to see a reduction in Medicare reimbursements in 2015. The reduction is in the form of a smaller inflationary adjustment, known as the market basket update. By the time the penalties are fully phased in 2017, the average 500-bed hospital could lose as much as \$3.2 million

annually in Medicare funding.³ See Figure 2. However, the amount could be much greater for hospitals with high Medicare volumes.

Figure 2: Loss in Medicare reimbursement for 500-bed hospital that fails to implement a government-certified EHR



Although hospitals may realize some return on their EHR investment, the primary return on investment is expected to accrue directly to private and public payers. The federal government estimates that the conversion to digital records will save \$12 billion in healthcare spending over 10 years, which presumably would be seen in lower Medicare and Medicaid outlays. Since hospitals are the biggest beneficiary of government health spending, they are most likely to experience the biggest reduction. Some of the hardest work to be done in healthcare is still left undone, that of an overall alignment of financial incentives from acute care and disease to wellness and prevention. Technology may enable the capture, analytics and transparency required to move closer to this objective.

Figure 1: PwC modeling of incentive payments for a 500-bed hospital if it achieves meaningful usage in 2011, 2012 or 2013

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Year 4</u>	<u>Total incentive</u>
Transition factor	100%	75%	50%	25%	
Base incentive	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	
Variable incentive based on Medicare volume and charity care ratio	\$1,665,800	\$1,665,800	\$1,665,800	\$1,665,800	
Total incentive per year when multiplied by Medicare share and transition factors	\$2,428,000	\$1,821,000	\$1,214,000	\$607,000	\$6,070,000

Source: PricewaterhouseCoopers’ analysis, 2009

Half of hospital CIOs surveyed said federal funding is “crucial” to their ability to implement EHRs, according to a March 2009 survey of 100 CIOs by PricewaterhouseCoopers and the College of Health Information Management Executives. To capitalize on their share of incentives, hospital executives may want to consider the following:

Inpatient Medicare volume. Hospitals with a higher percentage of inpatient Medicare volume will receive higher incentive payments. Hospitals will be eligible for more stimulus money if they reduce their inpatient days from private payers while maintaining or increasing their Medicare inpatient volume.

Total discharges. The formula puts a cap of 23,000 discharges annually. Hospitals below that level may want to evaluate their growth strategies as a primary clinical/business strategy but if timed correctly, a byproduct would be to increase their incentive amounts.

Charity care. Charity care is figured on the basis of percentage of overall charges. This is likely to encourage hospitals to identify more charity care patients on the front end, rather than writing off their bills later as bad debt. Bad debt has no effect on the incentives. PwC research has shown that most hospitals classify at least part of their charity care as bad debt.⁴

Timing. Incentives are front loaded for hospitals that achieve compliance in 2011 through 2013; on or after 2017, hospitals will receive no more incentive. The annual outlay is still unknown so each system will want to be poised to apply for the funding as it becomes available. Funding will flow in the current calendar year for planning and solidification of standards. After that, some funds will be available in a methodically laid out plan (such as in the case of Medicaid and

Medicare reimbursement and bonuses), but other money will just be available until the funds are spent (e.g., matching grants, loan programs, and telemedicine programs). Once the incentives are gone, operational and on-going capital budgets will have to sustain the implemented solutions or risk non-compliance with the “meaningful use” portion of the new law. For example, many large-scale health IT programs have been shut down over the years because of the lack of operational funding.

The formula for incentives applies to hospitals in Medicare’s prospective payment system. However, there are incentives for those outside the PPS system. For example, the nearly 1,300 critical access hospitals that are under cost-based reimbursement can receive 120% of Medicare’s portion of the cost of EHR for up to four years.

Physicians can receive up to a total of \$44,000 each for adopting certified EHR systems, but their overall costs will exceed these incentives.

For some physician practices, the purchase, deployment, and operations of an EHR may still be unaffordable because of the current cost of these systems and the lag between incentives and the time of initial capital outlay. However, like hospitals, the penalties may be severe enough to motivate compliance with government-certified systems. Physician offices would be prudent to calculate the ongoing maintenance and upgrades beyond the five-year planned funding to assure that they can sustain the EHR indefinitely. See Figure 3. All physicians who contract with Medicare are eligible, with the exception of hospital-based physicians. Those ineligible would include radiologists, emergency physicians, anesthesiologists, hospitalists, and intensivists who are employed by or under contract with hospitals.

Figure 3: Cost of implementing EHR system for three-physician practice

<u>Component</u>	<u>Volume</u>	<u>Range of cost per unit</u>	<u>Total cost range</u>
EHR Software (including implementation and training)	3 Physicians	\$33,000-\$60,000	\$99,000-\$180,000
HL7 Interface	4	\$10,000-\$14,000	\$40,000-\$56,000
Advanced reporting configuration	1	\$10,000-\$15,000	\$10,000-\$15,000
Software maintenance over 2 years	25% of upfront capital	\$8,250-\$15,000	\$24,750-\$45,000
Total cost range		\$61,250-\$104,000	\$173,750-\$296,000

Source: PricewaterhouseCoopers’ analysis, 2009

That said, there could be exceptions to this based on where the majority of their services are provided independent of any employment or billing arrangement between the eligible professional and any hospital.

As shown in Figure 3, a three-physician office can be expected to invest nearly \$330,000 over two years to purchase and maintain an EHR system.⁵ Incentive payments go to individual physicians, not to practices, which may be a disappointment to independent physician associations (IPAs) that have invested in information systems. Some groups are engaging in discussions about how to apportion the costs when a group practice or IPA is making the investment. However, IPAs and large hospital systems who provide systems to physicians should have stand alone sustainable business models that have nothing to do with temporary incentive programs.

Physicians who “meaningfully use” a certified EHR beginning in 2010 are eligible to receive 75% of their Medicare allowed charges as a health IT incentive, up to the maximum incentive payment for that year. Early adopters could receive as much as an \$18,000 bonus the first year of adoption if their allowed charges total \$24,000 or more. See Figure 4.

To encourage adoption in federally designated health professional shortage areas (HPSAs), additional bonus payments of 10% are available. This is on top of the 10% bonus in Medicare reimbursement already paid to physicians in these shortage areas. For example, a physician in a HPSA who began using HIT in 2011 or 2012 and who received the full \$18,000 incentive payment (as an early adopter) would also receive a bonus of \$1,800, totaling \$19,800.

If adoption of EHRs among physicians nationally does not reach 75% by 2017, the government can begin to reduce Medicare payment rates to non-compliant physicians to 99%, and the rate would continue to drop by 1 percentage point a year until the national adoption threshold is reached. However, the law indicates that the penalty cannot go below 95%. While the penalties for physicians won't be as significant as for hospitals, the revenue implications could still have a major effect.

The Medicaid incentive program has a more complex funding schedule, with payments reaching out until 2021 and a lengthier and more measured adoption rate. Medicaid will contribute 85% of a defined allowable costs cap for HIT adoption and implementation. In the first year, physicians who purchase and implement HIT systems can receive no more than \$21,250 (85% of a \$25,000 maximum) as a Medicaid incentive. During each of the following four years, Medicaid providers cannot receive more than \$8,500 (85% of a \$10,000 maximum) for operation and maintenance. The payment period for purchase, implementation, operation and maintenance of the HIT system cannot exceed five years.

To qualify for the Medicaid incentives, physicians must have a patient population comprised of at least 30% “needy” patients. Outside of OB/GYNs, 10% or less of the overall physician population will be eligible for the Medicaid incentives. The threshold is only 20% for pediatricians to qualify for 2/3 payment; those with 30% qualify for the full amount. “Needy” patients are defined as covered by Medicaid, receiving services under Title XXI, unable to pay, or receiving services on a sliding scale due to inability to pay.

Figure 4: Flow of incentive payments to single physician

	<u>Current EHR users</u>	<u>Meaningful use 2011</u>	<u>Meaningful use 2012</u>	<u>Meaningful use 2013</u>	<u>Meaningful use 2014</u>
2011	\$18,000	\$18,000			
2012	\$12,000	\$12,000	\$18,000		
2013	\$8,000	\$8,000	\$12,000	\$12,000	
2014	\$4,000	\$4,000	\$8,000	\$8,000	\$8,000
2015	\$2,000	\$2,000	\$4,000	\$4,000	\$4,000
2016			\$2,000	\$2,000	\$2,000
Total	\$44,000	\$44,000	\$44,000	\$26,000	\$14,000

PricewaterhouseCoopers' analysis, 2009

Questions and Answers

Q: How must my organization ready itself to capitalize on available funds?

A: Organizations will benefit by:

- Analyzing their potential level of incentives and determining what factors will impact those payments.
- Evaluating and balancing the clinical, capital, and IT resources required to accelerate EHR programs and potentially reducing resources and costs in other areas.
- Monitoring the requirements around showing meaningful use of a certified EHR product.

Q: How do I know if my EHR will be considered certified for the financial incentives?

A: The federal standards, which are likely to be based on the existing CCHIT, HITSP and AHIC standards, are expected to be released by the end of 2009. The ARRA indicates that at a minimum, certified EHRs must be capable of:

- Providing clinical decision support
- Supporting physician order entry
- Capturing and querying information relevant to healthcare quality
- Exchanging electronic health information from other sources.

The Secretary of HHS will likely require changes or enhancements to the existing voluntary standards. CCHIT has certified 56 ambulatory products and 14 inpatient products. If the changes are required, those CCHIT-certified products would likely need re-certification. For example, with the greater emphasis on interoperability, the standards could include integration with regional health information exchanges, state and national health infrastructures, and the new regional centers that do research, training and deployment. Many systems currently certified could have challenges sending and receiving, or they may lack the capability of normalizing foreign source data.

Q: What constitutes “meaningful use”?

A: This will include electronic exchange of information to improve quality and care coordination, including e-prescribing, exchange of health information and reporting on quality measures. However, it is expected that other more detailed criteria may be developed.

Q: If our organization has not yet purchased an EHR, should we hold off until ONCHIT reveals whether it will sponsor an EHR product?

A: The answer depends on how aggressive you want to be in capturing the available incentives. In the next few months, the new Federal Advisory Committee (FACA) committee may clarify the certification and meaningful use definitions. The existing standards, which are voluntary, should put organizations close to compliance. The majority of work and longevity associated with an EHR implementation is the basic hardware/software design, implementation and roll-out. As long as you are working with a certified software vendor, by the time you get your EHR up and running and work through many of the change management and compliance issues associated with capturing basic data, you should be positioned to configure the software for the outputs required for compliance. However, organizations that are short on capital for upfront implementation may want to wait to see if health IT vendors develop less expensive offerings.

Q: If my organization has already invested in and implemented an EHR would we be eligible for incentive payments?

A: There is nothing that implies that those that have already adopted would be ineligible for the incentives. However, organizations that have implemented older systems may be on uncertified products or versions. You may need to consider changing vendors or upgrading.

Q: When will incentive payments begin?

A: Payments are scheduled to begin in the government’s fiscal year 2011, which begins Oct. 1, 2010. Most providers are on a calendar-based fiscal year, so they may not be ready to submit the necessary data such as cost reports and charity care until much later.

Q: What are the impacts to security and privacy?
How will the new regulations impact my organization?

A: Organizations that were not in full compliance need to strengthen their procedures, especially in light of the following changes:

- Their business associates are now directly subject to the HIPAA Security Rule and the restrictions (not just as it pertains to contracts and contact with covered entities).
- They must contact the media and affected parties for breaches that affect 500 or more residents of a particular state.
- They must segregate data that patients want or do not want communicated to payers (if they pay for the care).
- They'll have to develop more advanced audit trails for disclosure and access.
- The government has expanded the definition of entities and individuals that can be criminally prosecuted for breaches.

Q: Will the creation of the FACA and the elimination of HITSP, CCHIT, and AHIC affect my system selection choices? How, if at all, will it affect my current implementations?

A: It is likely that many if not all of the standards and definitions created by HITSP, CCHIT, and AHIC will be adopted as baseline standards. There is speculation that additional standards will be implemented creating the need for certified products to re-certify.

Q: Can my organization provide input into the Standards and Policy Committee?

A: Yes, each committee is required to allow for public input. Look for routine updates on the DHS ONCHIT website. Also, work closely with your state HIT Czar/CIO and their teams to monitor state requirements.

Q: What other programs are available for HIT funding through the stimulus?

A: Grants will be available to community health centers, rural health centers, and Indian health centers. Some of this money will come from the Office of the Coordinator, but others will come from provisions elsewhere in the stimulus:

- \$4.7 billion for the National Telecommunications and Information Administration's Broadband Technology Opportunities Program.
- \$2.5 billion for the U.S. Department of Agriculture's Distance Learning, Telemedicine, and Broadband Program.
- \$1.5 billion for Federally Qualified Health Centers (FQHCs)
- \$500 million for the Social Security Administration.
- \$85 million for the Indian Health Service.
- \$50 million for the Veterans Benefits Administration.

Q: How should hospitals partner with physicians in their markets on EHRs and the stimulus?

A: Hospitals should consider their overall business strategy and the Stark law. If you have a solid business plan and the quality and clinical business drivers outweigh the costs, then this will move you, your patients, and your community physicians towards a better more interoperable healthcare environment. However, keep in mind that only the individual physicians will receive the physician incentives earmarked within the ARRA and no later than 2015, your systems must meet the federal requirements to avoid penalties to the physician populations who utilize these systems. So the complexity and cost of the undertaking must be carefully balanced with your organizations core hospital EHR requirements.

Endnotes

1 “Electronic Health Records in Ambulatory Care—A National Survey of Physicians,” June 18, 2008, New England Journal of Medicine.

2 PricewaterhouseCoopers’ analysis 2009.

3 Based on total average market basket and calculated in 2007 dollars then applied the inflation rate 3.1%, which is used for forecasting by the Congressional Budget Office. 25% of the market basket update was automatically applied for quality reporting and the penalty was calculated from the remaining market basket.

4 Acts of Charity: Charity care strategies for hospitals in a changing landscape, PricewaterhouseCoopers’ Health Research Institute.

5 PricewaterhouseCoopers’ estimates; 2009.

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