The American Recovery and Reinvestment Act of 2009 (ARRA) allocated more than $180 billion to healthcare, with $22.8 billion appropriated to the adoption of health information technology (HIT). In the next five years, the Congressional Budget Office (CBO) projects that ARRA will drive 85% of physicians and 55% of hospitals to adopt HIT by 2015; and by 2019, these numbers are expected to reach 90% and 75%, respectively.\(^1\) The goal of driving HIT adoption is to proactively reduce inefficiencies and federal costs because currently 21% or nearly $592 billion of the federal budget was spent on healthcare.\(^2\)

AT&T concurs that HIT will play a transformational role in eliminating redundancies, improving quality of care, increasing collaboration, and reducing the number of medical errors. The ARRA incentive money will act as a catalyst to achieve the objective for all Americans have an electronic health record (EHR) by 2014.\(^3\) To receive any ARRA incentive money, healthcare providers must make “meaningful use” of HIT via a “qualified or certified EHR”. This paper explores who the stakeholders are, how funds will be allocated, what certification might look like, and where AT&T can assist in this revolutionary shift on healthcare delivery.
Stakeholders
Given the size and scope of ARRA’s HIT provisions, there are a number of entities tasked with coordinating policy, developing standards, and allocating funds. In conjunction with the HHS, the Office of the National Coordinator for Health Information Technology (ONC) has been named the primary governing body for HIT policy. The ONC is directly responsible for:

- Defining HIT standards
- Coordinating programs and initiatives with other HIT entities, including other governmental agencies
- Developing the long-term HIT adoption strategy
- Identifying a certification method
- Establishing a mechanism for allocating funds

To assist the ONC in this undertaking, the HIT Policy Committee and the HIT Standards Committee were established. The HIT Policy Committee will focus on setting the priority for HIT standards and recommending a policy framework for the development and implementation of a nationwide infrastructure that will promote the “meaningful use” of EHRs. In the interim, the HIT Standards Committee will define the HIT standards and institute both the certification methods as well as the reporting criteria needed to qualify for incentive funds. The HIT Standards Committee is required to announce these standards by 2010 and update the Federal Health IT Strategy Plan. In conjunction with the ONC and HIT Committees there are several other organizations – in conjunction with the ONC and HIT Committees – that will directly and indirectly influence ARRA initiatives. These include:

- Centers for Medicare and Medicaid Services (CMS), will allocate much of the Medicare and Medicaid incentive dollars
- Certification Commission for Healthcare Information Technology (CCHIT), may be the authority in certifying EHR systems
- National Committee on Vital and Health Statistics (NCVHS), will advise the HIT Committees
- National eHealth Collaborative, may be recognized by the Secretary as the HIT Policy Committee or the HIT Standards Committee
- National Institute of Standards and Technology (NIST)
- American National Standards Institute (ANSI)
- Healthcare Information Technology Standards Panel (HITSP), which has previously advised ANSI and ONC on data and technical standards

Allocation of Funding
In recent memory, the federal and state governments have made numerous legislative attempts to change and/or modify the U.S. healthcare system. One of the key differences with the stimulus legislation of 2009 is the unprecedented amount of money allocated for the widespread adoption of EHRs. Under ARRA, almost every healthcare professional is incentivized to purchase and use HIT. The below provides an overview of qualification and potential funding amounts to be received.

UNL Grants and Loans
The ARRA has allocated $2 billion to the ONC to establish and reinforce the nation’s HIT infrastructure. This money will be allocated to healthcare providers, public health agencies, and other interested parties in an effort to prepare for the adoption and “meaningful use” of HIT. Designated as “jump-start” funds, these initiatives are designed to support HIT architecture providers not eligible for other incentives, training, telemedicine, interoperability, best practice development, as well as a research center. Other initiatives include competitive grants for states and Indian tribes to develop EHR loan programs, integrating certified HIT into clinical education and formal academia, as well as an additional $300 million for investments in regional health information exchanges (HIEs).

Medicare and Medicaid Incentives
Starting in 2011 and going through 2018, Congress has allocated between $30 and $45 billion in payments to physicians, hospitals, and certain other qualified providers, who demonstrate that they are meaningful users of certified, qualified, EHRs. The most prevalent of these payment initiatives is the Medicare and Medicaid incentive programs administered by CMS. It should be noted that those healthcare providers who qualify for both incentives will need to choose either the Medicare or Medicaid reimbursement. Outlined below are the details of the programs.

Incentives for Physicians and Healthcare Professionals
For all qualified healthcare professionals, the Medicare incentive is calculated as 75% of allowable Medicare Part B charges for the payment year. These payments will be disbursed over a five-year period. The maximum incentive payments are as follows:

- Year 1 – $18,000 – if Year 1 starts in 2011 or 2012, otherwise $15,000
- Year 2 – $12,000
- Year 3 – $8,000
- Year 4 – $4,000
- Year 5 – $2,000
In 2016, those healthcare professionals who have not adopted an EHR and qualified for “meaningful use” will be penalized by a reduction in the incentive fee schedule as follows:

- 2015 – will receive 99% of billed and allowed Medicare fees
- 2016 – 98%
- 2017 and each subsequent year – 97%

Healthcare professionals in “health professional shortage areas” will receive a 10% increase in the incentive payment. The ARRA excludes hospital-based professionals from participating in these incentives.

**Medicare Incentives for Hospitals**

To qualify for incentive payments a hospital must implement an EHR and demonstrate “meaningful use” of the system. Incentives will commence in 2011 with a maximum payment of $11 million over a five-year period. The annual payment calculation is as follows:

- $2M Base + Discharge Amount x Medicare Share x Transition Factor = Payment Amount
- Discharge Amount: calculated as $200 for each of the 1,150th – 23,000th discharge regardless of payer
- Medicare Share – calculated as a fraction:
  - Numerator – Medicare inpatient bed days under part A + Medicare Advantage inpatient days under part C
  - Denominator – Total number of inpatient bed days* (charges – charges for charity care)/Total Charges
- Transition Factor – calculated as:
  - For the first payment year for such hospital, 1
  - For the second payment year for such hospital, ¾
  - For the third payment year for such hospital, ½
  - For the fourth payment year for such hospital, ¼
  - For any succeeding payment year for such hospital, 0

In fiscal year 2015, those hospitals that have not adopted an EHR and qualified for “meaningful use” will be penalized. This penalty will be administered by reducing three quarters of the applicable Market Basket Adjustment percentage increase otherwise applicable for such fiscal year by:

- 2015 – 33.33%
- 2016 – 66.66%
- 2017 and each subsequent year – 100%

There are two factors to note for hospitals that are designated as a critical access hospital. The first is that the 20 percentage points should be added to the Medicare Share calculation, with the result not to exceed 100 percent. The second concerns the penalties associated with not reaching EHR compliance by 2015. For a critical access hospital this penalty will be administered by reducing three quarters of the applicable Market Basket Adjustment percentage increase otherwise applicable for such fiscal year by:

- 2015 – 100.66%
- 2016 – 100.33%
- 2017 and each subsequent year – 100%

**Medicaid Incentives**

The ARRA has authorized state governments to make payments to Medicaid providers totaling no more than 85% of the net average allowable costs for EHR adoption. These costs may include: implementation, support services, maintenance, training, and the operation of EHR technology. Medicaid providers eligible for funding are defined as:

- Non-hospital-based professional with at least 30 percent of the professional’s patient volume attributable to individuals who are receiving medical assistance under this title
- A non-hospital-based pediatrician with at least 20 percent of his/her patient volume attributable to individuals who are receiving medical assistance under this title
- An eligible professional who practices predominately in a federally qualified health center or rural health clinic, and has at least 30 percent of the professional’s patient volume attributable to needy individuals
- Children’s hospitals or an acute care hospital – that is not a children’s hospital – that have at least 10 percent of the hospital's patient volume attributable to individuals who are receiving medical assistance under this title
The legislation’s net allowable costs for the initial implementation of EHR technology cannot exceed $25,000 or include costs over a five-year period. Annual allowable costs outside of the initial implementation may not exceed $10,000 per year over a five-year period. And the maximum allowable reimbursement may not exceed $63,750 or $75,000 prior to the 85% adjustment.

**EHR Qualification**

How do you qualify for the stimulus money? At this point, the stakeholders are still debating how to certify EHR systems, measure use of those systems, and qualify healthcare professionals for incentive funds. Although the HIT standards and the certification method are both currently unknown, there are a number of policies under discussion. At the forefront of these discussions is the CCHIT, which proposes three types of certification:

- **EHR-S** – Simplified, low cost certification of EHR technologies in use at a specific site, for providers who self-develop or assemble EHRs from non-certified source.

- **EHR-M** – Flexible certification of Federal standards compliance for EHR, Health Information Exchange (HIE), ePrescribing (eRx), personal health record (PHR), Registry and other EHR-related technologies, for providers who prefer to integrate technologies from multiple certified sources.

- **EHR-C** – Rigorous certification of comprehensive EHR systems that significantly exceeds the minimum federal standards and requirements, for providers who seek maximal assurances of EHR compliance and capabilities.

The general expectation is that any certification method must account for a basic set of functionality. This functionality may include eRx, EMRs, clinical support tools, physician-to-physician communication, physician-to-patient communication, lab results, quality measurement tools, disease management, immunization tracking, and the secure exchange of clinical and administrative information. The previously mentioned disparate features must be integrated to qualify for the interoperability clause under the ARRA. Likewise, all of these features must be accessed in such a manner that qualifies as “meaningful use.” Whereas this may seem an expensive and daunting proposal – AT&T must be accessed in such a manner that qualifies as “meaningful use.”

**AT&T Methodology and Approach**

The goal of EHR adoption is NOT to create a single system, but to develop communication between systems. AT&T knows that no two healthcare providers are alike across the delivery system. Needs differ by specialty, region, practice, hospital, and individual. In fact, providers have extrapolated on the complexity of the healthcare industry as a primary barrier to HIT adoption. But that should no longer be a deterrent. AT&T Healthcare Community Online (HCO) provides a solution to electronically connect physicians to information and technology across various HIEs and healthcare provider communities. In a cost-effective, minimally-invasive way, the solution is designed to improve the quality, security and efficiency of healthcare by improving access to technology among physicians. HCO provides a single, secure portal where physicians need only to sign-in once to access clinical and administrative applications – that include labs, reporting, e-prescribing, billing systems, patient registries, clinical support tools and revenue cycle management. HCO’s platform enables secure information exchange and collaboration among physicians and physician-to-patient communication.

AT&T wants to empower healthcare providers to choose the applications and features that fit their specific needs, and we have relationships with leading HIT vendors to deliver, customizable, affordable, on-demand solutions to help healthcare providers achieve their goals. The HCO platform brings a variety of vendors into a single location where healthcare providers can evaluate and ultimately purchase the functionality appropriate for their practice at a price point they can afford.

HCO’s core collaboration solution provides a central foundation that functions as the gateway to a complete EHR solution. HCO integrates individual software components and practice management systems (PMS) into a simple user-friendly interface that is delivered to organizations across the healthcare industry. This enhances investments made within the physician office and establishes a foundation for HIT growth and ease-of-use. These organizations have the ability to gain access to their local lab, obtain the clinical support tools they need, use the ePrescribing application they know, and provides access to immunization tracking appropriate for their state. Providers can even reach outside the healthcare profession and integrate video conferencing, administrative, and other tools to create a custom solution that fits their individual preferences. AT&T HCOs technology delivers an EHR solution at an affordable price. This is due to HCO’s unique features:

- **HCO’s Platform-as-a-Service (PaaS) is an on-demand solution that:**
  - Eliminates expensive hardware, implementation and on-going maintenance costs
  - Enables ease of deployment – healthcare initiatives up and running very quickly
  - Provides a “managed service”, lower total-cost-of-ownership (TCO) vs. traditional licensed models
  - Increases scalability and flexibility in adding new healthcare services
  - Available 24x7

With HCO, healthcare professionals can add, remove, or change applications and pay only for what they use. This approach to delivering EHR functionality empowers providers to adopt HIT in an incremental, interchangeable, and modular approach. To maximize HIT adoption, AT&T works alongside organizations that healthcare providers trust and know to provide the training and support they expect. Our solution has been deployed across independent physician associations (IPA), medical and specialty societies, medical associations; integrated delivery networks (IDN) and hospitals, as well as state and local governments. These organizations work with AT&T and the healthcare provider community to deliver a robust and well supported EHR solution.

**Conclusion**

Conceptually, the true definition of “meaningful use” is nebulous and it will be for some time. However, AT&T will continue to collaborate with various vendors so our provider communities will be better able to receive incentives from the stimulus funding as it becomes available. As referenced above the Certification Commission for Healthcare Information Technology (CCHIT) has recently produced (3) areas of possible certification for EHR functionality – that most recently will factor into “meaningful use” definitions. A modular approach is an alternative for providers to easily satisfy “meaningful use”, by accessing a variety of technologies – and AT&T is positioned to help them get there.
The provisions of ARRA dealing with “infrastructure” also are near to AT&T and our initiatives and we work with multiple states in implementing statewide backbones. When working with states AT&T’s “recommended approach” toward implementing a statewide HIE backbone contain a few essential items that AT&T believes must be considered in such a recommendation. There are four key elements that need to be the basis of foundation for states to achieve value in any such approach. At the core, a Master Patient Index (MPI) and Record Locator Service (RLS) are certainly two fundamental pieces; however for an infrastructure to be effective, a plan for the provisioning of access (security) and moving of PHI (messaging) also need to be in place. States will need to vet the credential of the person (provider) requesting access to patient records and then provide the capability to move or aggregate the patient data as needed.

In addition, the most successful state strategies of which AT&T is aware have taken an “application agnostic” approach to the promotion of HIT, e.g., taking the position of not promoting one “ePrescribing” vendor, but promoting “ePrescribing” as a whole. Certain information exchange initiatives within states are at various levels of maturity in their development and technical capability. Any idea of mandating a single application would certainly strand any existing investments made by existing initiatives and be fatal for adoption. Providing interoperability via the four core elements listed above will give states the flexibility necessary to have “all initiatives rising together”.

Finally, the role of a state-based backbone should service both clinical and administrative use cases. This is another key to adoption and a derivative of an application agnostic approach. Too often HIE agendas become lopsided on preserving the interests of only one type of stakeholder (e.g., hospitals vs. health plans) and find themselves with little to no buy-in from their communities. All of the above is consistent with the approach being suggested by the ONC and the new Administration. The majority of the recovery and stimulus funds allocated for healthcare will flow to “shovel ready” infrastructures.

**Notes**

1. Congressional Budget Office Outlook, January 13th, 2010
6. Patient Protection and Affordable Care Act (PL. 11-148)

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For more information contact an AT&T Representative or visit www.att.com/healthcare.