

JHD GROUP

HEALTHCARE KNOWLEDGE. APPLIED.

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United States of America

American Recovery and
Reinvestment Act
of 2009



Stark Safe Harbor meets the Stimulus Bill

An assessment of the impact the American
Recovery and Reinvestment Act should have on
the adoption of Electronic Health Records –
and how to deal with it

About the Author



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“The Stark Safe Harbor Meets the Stimulus Bill”

The Synopsis

The passing of the American Recovery and Reinvestment Act of 2009 (ARRA) has given “legs” to accelerate physician electronic health record (EHR) adoption via Stark Safe Harbor compliant programs for hospitals. The nature of these combined incentives creates a window between now and 2014 where completing an ambulatory EHR implementation and getting providers up to a measurable level of use on the system provides a one-time opportunity for both hospitals and physicians such that:

- Hospitals are able to significantly strengthen their Medical Staff Model by “gluing” community physicians more tightly to the hospital through a common EHR which will improve market position and the ability to coordinate care.
- Physicians, both hospital owned and community, will have a one-time bonus of up to \$44,000, paid over five years, which should more than offset the acquisition and implementation cost of an EHR.

Transitioning to an EHR, however, is not a trivial process. It is a significant initiative that will transform the way ambulatory care delivery is managed. In this regard, the adoption of an ambulatory EHR should be viewed by hospitals and hospital systems at the CEO level and as a fundamental change in how the Medical Staff Model will support the hospital/hospital system going forward through profound changes in coordination-of-care and the availability of data.

In assessing the changed environment, timing is critical. Those who act earlier will have market, medical staff model, and bonus advantages. Those who do not, will be facing increased implementation/adoption risk, clinical disaggregation pressure, and/or Medicare payment penalties.

However, while there is a need to act with deliberate urgency if the window of opportunity is to be seized, the approach should be pragmatic, phased, and undertaken as a disciplined, fully resourced project. In this context, there needs to be recognition that the EHR is not an information technology project, but rather a transformation of clinical practice and work flow that is enabled by an EHR system.

Lastly, we all need to recognize that having an EHR on every physician’s desktop is only the starting point for physicians, hospitals, and communities to effectively manage clinical quality, medical costs, and the needs of consumers and their communities.

Introduction

As long as there have been hospitals, the goals of demonstrating superior clinical quality, improving the cost effectiveness of care delivery, competing on patient service, and improving hospital-physician relationships have been achieved unevenly at best. Now the Federal Government has thrown the tools and “Incentive Challenge” on the table that could make a significant difference if hospitals act with a sense of deliberate urgency.

In October 2006, the federal government enacted a “Safe Harbor” policy related to the Stark Regulations, allowing hospitals to donate Electronic Health Record (EHR) related hardware, software, Internet connectivity, implementation and training, and support services to physicians. In February 2009, the same government enacted the American Recovery and Reinvestment Act (ARRA) which provides incentives for moving forward with a physician EHR, including potential bonuses in the range of \$44,000 per physician.

The nature of these combined incentives creates a window between now and 2014 where acting on an EHR implementation provides a one-time opportunity for both hospitals and physicians.

Given these events, this Whitepaper addresses four key questions:

1. Does it make sense to expedite an ambulatory EHR?
2. Are there alternative approaches?
3. What are the “key considerations” in developing a Stark Safe Harbor Program?
4. What are the immediate next steps?

The New Framework of Rules

The Stark Safe Harbor and ARRA are creating a framework of rules and incentives that are intended to urge hospitals to equip their clinical staff model with EHRs, and to do it soon.

The American Recovery and Reinvestment Act

The ARRA has allotted \$17.2 billion to reward Medicare and Medicaid providers who can prove they are using certified healthcare IT "in a meaningful way." With the ARRA, independent physicians and hospitals with owned physicians, can earn \$44,000 per physician, and in some case additional payments, over a five-year period. If the first year of "meaningful use" is 2011 or 2012 the initial payment is \$18,000 per physician, with the subsequent payments ramping down to \$12,000 for the second year, \$8,000 for the third year, \$4,000 for the fourth year, and \$2,000 for the fifth year. If the first payment year is after 2013, the initial payment is \$15,000.

To qualify for these incentives, providers must be using certified electronic health record technology. At the moment, the Certification Commission for Healthcare Information Technology (CCHIT) (www.cchit.org) is the only government sponsored certifier. The provider must be able to certify that they are "meaningful EHR users" which at this time is defined as:

- Providing for the electronic exchange of health information with other sources to improve the quality and coordination of health care
- Providing for electronic prescribing (ePrescribing)
- Having the ability to report on clinical quality measures

For those failing to use certified healthcare IT by 2014, there will be no incentive payment. If a physician is not using an EHR by 2015, Medicare payments will be reduced to 99 percent in 2015, 98 percent in 2016, and 97 percent thereafter.

The ARRA has yet to be defined through the regulatory process, and there are a number of definitions and interpretations that will be forthcoming over time.

The Stark Safe Harbor

The Stark Safe Harbor legislation provides hospitals an exception to the restrictions of the Stark and Anti-Kickback laws. This exception allows hospitals to donate "*Items & services necessary and used predominantly to create, maintain, transmit, or receive EMRs*" to community or affiliated physicians. Hospitals can provide the EHR items and services to physicians, as long as the selection criteria do not take into account the volume or value of referrals, or other business between the parties. The Stark Safe Harbor requires that ePrescribing be included and prohibits a hospital from donating physician office equipment or replacing an existing EHR.

The receiving providers must contribute 15% of the donor's cost for the items and services provided, but at the hospitals discretion may be required to contribute a larger amount. The safe harbor exception ends December 31, 2013.

What the Combination Means

The combined Stark Safe Harbor and ARRA makes a clear case to move quickly with an EHR initiative. Hospitals, hospital systems, and community physicians will lose the combined benefits of the acts in the 2013 – 2014 window. This “window of benefits” includes:

- The ability to reinvent the Medical Staff Model to more effectively include community and affiliated physicians through the “glue” provided by a common EHR
- The ability to differentiate the hospital/hospital system and its physicians in the market based on greater patient service
- Realizing the bonus incentives provided through the ARRA

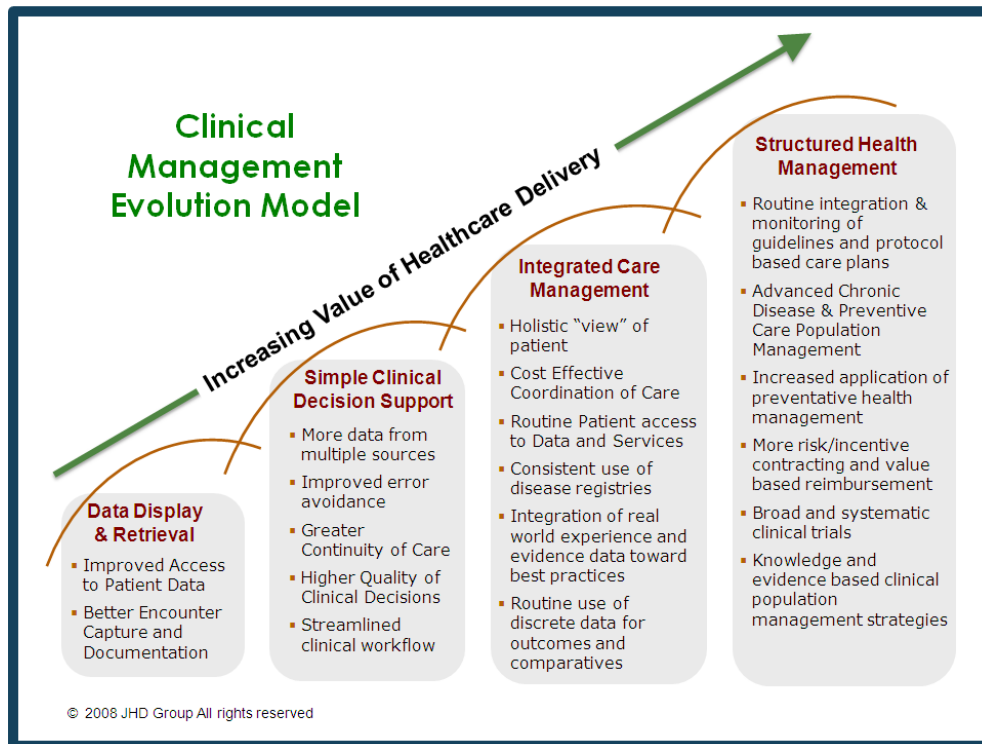
The combination of government incentives also means that there is likely to be a substantial increase in demand for qualified resources able to plan, implement, and support the number of potential adoptions in such a short time.

Recognizing that deploying an EHR “at scale” is challenging and requires thoughtful and diligent preparation, achieving the “window of benefits” will require most organizations to start acting now.

The Case To Act

Given that acting on an ambulatory EHR is a “When” and not “If” situation, there are a number of clinical, operational, and financial benefits linked to adopting an EHR. These benefits will apply to several constituencies including:

- The Patient
 - Improving the patient experience through increased continuity-of-care
 - Improving patient satisfaction with timely test results, access to physician, appointment scheduling, and involving patients in self management of their diseases
 - Increasing the sophistication of patient services to include personal health records and the information needed to support emerging “consumerism”
- The Physician
 - Increasing the availability and timeliness of patient clinical information to improve the quality for diagnosis and care planning
 - Reducing cost through more efficient test order and results tracking, patient flow and communication, and chart access; less cost for transcription and the elimination of manual billing interventions
 - Restructuring clinical roles so that each clinical professional can work at the “Top-of-Licensure” thereby more effectively leveraging the physician
 - Realizing potential incremental revenues from risk-adjusted coding, pay-for-performance, government incentives, and the like
- The Hospital/Hospital System
 - Increasing the bond between the community physicians and the hospital through coordination-of-care, seamless communication in the patient’s interest across multiple provider entities (both physician and hospital), improved clinical quality and patient safety, and the effectiveness of clinical offerings
 - Achieving a more cohesive and integrated medical staff model composed of “owned” and credentialed community physicians with benefits such as improving referral management and tracking leakage outside the system
 - Positioning to move up the “Clinical Care Management Evolution Curve” (See diagram) moving from simple display of clinical data to integrated care and disease management with evidence based tools and the aggregation of clinical information at the patient level rather than the encounter level, enabling cost effective disease management, enhanced proactive health maintenance and error avoidance, and supports measures of quality outcomes and reporting.



- Realizing a Return on Investment up to 25% - 60% annually once the systems are fully implemented (approximately 18 - 24 months from start date) through lower costs and new or incremental revenues.

In addition to the above benefits, the ARRA provides for direct incentives which are paid based on the number of "meaningful EHR users". For larger organizations, these bonuses can be substantial as indicated in the hypothetical 200 physician group example below which will earn over \$8 million in bonuses if all the physicians are operational by 2013.

Example Physician Ramp-up and ARRA Bonus Schedule

Payment Year	Number of Physicians Effectively Using			
	2011	2012	2013	Total
	80	80	40	200
2011	\$1,440,000			\$1,440,000
2012	\$ 960,000	\$1,440,000		\$2,400,000
2013	\$ 640,000	\$ 960,000	\$ 600,000	\$2,200,000
2014	\$ 320,000	\$ 640,000	\$ 480,000	\$1,440,000
2015	\$ 160,000	\$ 320,000	\$ 320,000	\$ 800,000
2016		\$ 160,000	\$ 160,000	\$ 320,000
	\$3,520,000	\$3,520,000	\$1,560,000	\$8,600,000

While these benefits should be sufficient to act on an ambulatory EHR, the actual decision needs to be considered in the context of the specific hospital/market situation. In this regard, there are five key considerations and one or more may apply to any market situation.

- 1) Highly competitive markets: In highly competitive markets, the “first mover” to provide EHRs to the community physicians is most likely to secure the loyalty of those physicians. Accordingly, late movers are at risk of losing referrals from physicians who join a competing hospital’s Stark program.
- 2) Hospital – Physician Integration: A Stark EHR program needs to integrate within the larger fabric intended to “Glue” community physicians to the hospital. This larger program can include facility joint ventures, MSO services, payor contracting, and the like, which the EHR will only serve to strengthen.
- 3) Commitment to Quality: The hospital is committed to tangibly improving the quality of care in its community, and recognizes that supporting a hospital – community physician EHR initiative will directly improve continuity-of-care, patient safety, and the patient experience.
- 4) Position for the Future: The hospital recognizes that the ability to collect and report on clinical data across the community will effectively support negotiating “Value Based Reimbursement” (i.e. P4P, acuity coding, etc.) contracts, providing “Report Cards” on performance, and responding to “Episodes of Care” payments if and when they are initiated.
- 5) Avoiding a “Mess”: With the new ARRA now in place, community physicians will be incented to move forward with an EHR in order to realize the available bonuses. Without hospital leadership, there is the risk of too many EHR products being poorly implemented which will compromise the hospitals’ ability to realize a number of advantages.

The last consideration regarding the “Case To Act” is that time is running out. Unless the law changes, the Stark Act sunsets at the end of 2013 and there will no longer be an opportunity for the hospital to directly impact its community physicians using this tool. Additionally, to earn the maximum ARRA bonus, a physician must be meaningfully using the EHR by the end of 2011, and all bonus payments stop after 2016.

Alternative Approaches

While there are compelling reasons to move forward with an ambulatory EHR program, it is a complex challenge requiring a measured and pragmatic approach. Jumping in without a strategy, a plan, sufficient capital, and EHR trained resources can result in organizations failing to achieve their targets, and an unsuccessful effort will be very costly.

The approach should be phased, and undertaken as a disciplined, fully resourced project with a deliberate sense of urgency and managed to a date-specific timeline. In this context, there needs to be recognition that the EHR is not simply an information technology project, but rather a clinical practice and work flow transformation that is enabled by an EHR system

The most essential step is to first develop a plan. Each hospital/system needs to assess how the ambulatory EHR fits into its market strategy and its ability to successfully execute. Key considerations to be addressed during a planning process, among many, include:

- **Target Physician Participation:** It rarely makes sense to provide a “Blanket” Stark Safe Harbor Program, and the hospital will need to determine how many physicians should be invited to participate and the basis (not referral volume).
- **Stark Subsidy Strategy:** The subsidy can be close to zero or as high as 85% for allowable items. Each hospital needs to determine what subsidy strategy makes sense in its particular situation and build a program around criteria such as:
 - Differentiating the subsidy level based on specialty, location, “first in”, etc.
 - Linking the nature of the subsidy to the hospital’s core strategy
 - Decreasing the subsidy over time
 - Front loading the costs to the physicians or using an ASP model
- **The ROI Plan:** Have a clear plan for realizing a tangible ROI (see sample table). There is increasing evidence that when EHRs are effectively utilized they will deliver positive ROI.
- **Process Integration:** Linking the introduction of the EHR with other processes such as “patient intake”, hospitalist liaison, system interoperability, etc.
- **“Loose or Tight”:** Does the hospital want to have a “loose” arrangement with the physicians where there are no cross platform standards or policies, or a “tight” framework of standards and policies which will enable greater use of data and more effective Health Information Exchange.
- **On-going Support:** Does the hospital want to assist in providing on-going support related to Help Desk, Network Management, Template Development, etc.
- **Vendor Partnerships:** Does the hospital wish to support a single vendor or a multiple vendor solution.

Sample Return On Investment Schedule

Category	Factoring Level	Estimated Range
Revenue Increases		
-Coding Enhancement	Increasing coding levels	\$1million - \$2 million
-P4P	1.5% Medicare Revenue	\$300,000 - \$450,000
-ePrescribing Incentive	2% Medicare Revenue	\$500,000 - \$600,000
- HCC Coding	1.5 - 3% Medicare Revenue	\$350,000 - \$900,000
-PQRI Reporting	1 - 2% Medicare Revenue	\$300,000 - \$600,000
	Subtotal	\$2.45 - 4.55 million
Cost Reduction		
-Medical Records	Reduction of 2/3 to 3/4 cost	\$500,000 - \$750,000
-Transcription	Reduction of 1/2 cost	\$220,000 - \$300,000
-Billing and Posting	Reduction of staff	\$250,000 - \$400,000
	Subtotal	\$970,000 - \$1.45 million
Operating Cost Increases		
-New Department Staff	New salaries	\$450,000 - \$575,000
-Annual Maintenance	Annual fees	\$240,000 - \$320,000
-Continued Growth	Assumed 15% growth/year	\$300,000 - \$400,000
	Subtotal	\$990,000 - \$1.95 million
Net Improvements		\$2.43 - \$4.05 million
One Time Investments		\$5.7 million
Return On Investment		42% - 71 %

- Capital Sources: Funding the implementation of an ambulatory EHR is costly, particularly if it is to be done right, and front-end loaded.
- Timeframe: What is pragmatic in terms of a deployment schedule?

In many cases, it makes sense to survey the owned and community physicians to ensure a complete understanding of the current status of existing installed systems, their “appetite” for an EHR (which with the ARRA will be increasing), their readiness to adopt an EHR, and the price point they are willing to pay.

Once a basic plan has been developed (which should take less than 120 days), the alternative approaches to execution can be assessed. There are several including:

- Hospital Sponsored and Managed: With this approach, the hospital directly performs the market feasibility assessment, manages the deployment, and provides the post implementation support.
- Hospital Sponsored – 3rd Party Managed: There are cases where either the hospital does not want to commit its Information Technology resources to a ambulatory and/or Stark program, or there is concern that the community physicians will be reluctant to let the hospital have access to their data. In these situations, an independent entity can be used that the hospital and physicians fund (the hospital through Stark grants and the physicians through monthly payments). The major advantages of this approach include:
 - Community Physician Adoption Rate: Community physicians will often more quickly sign-on to a Stark Safe Harbor program when they know their financial data will not be readily accessible by the hospital, with the data protected by an independent entity.
 - Availability of Resources: Information technology people resources are limited, particularly those with physician Practice Management/EHR experience.
 - Controlling the Cost: All of the cost of the program will be highly visible and not “hidden” in embedded salaries.
 - Delegating the “Hassle”: The necessary activities of physician Stark Contracting, fee collection, daily technical support, and community physician communication can be delegated to the outsourced service firm thereby insulating the provider organization.
- Community Sponsored: In situations where the physicians do not have, and/or are not likely to develop single hospital loyalty, it may make sense for more than one hospital to collaborate in a Stark initiative, probably through a new independent entity.

A Note of Caution

Implementing physician EHRs under the best of conditions is challenging. It is a labor intensive, “high touch” transformational undertaking. The clinical needs and computer experience of each individual physician should be considered and accommodated. A successful result requires a structured roll-out that integrates clear change management with extensive work flow redesign, specific checks and verifications, and training, training, and training. It cannot be emphasized enough that deploying an EHR is in no way a mere software implementation.

An EHR project also requires EHR specialized, trained resources that are not “learning-on-the-job”. These resources are scarce and will be more so as the market moves to complete the EHR transition within the Stark/ARRA window. As recently noted by Dave Garets, president and CEO of HIMSS Analytics:

“94 percent of hospitals currently don't have enough healthcare IT in place to meet the stipulations required to receive (ARRA) bonuses. It's not as simple as hiring a software technician to make the transition. There is a need for qualified people who know how to help with workflow adaptation and how to implement software packages so they work for the organization.”

Absent a rigorous methodology and sufficient resource commitment, it is a costly “redo”.

The End Game - Not

The Stark – ARRA combination places great incentives on the table to achieve widespread EHR adoption in the next five years. The winners will approach this challenge with a sense of pragmatic urgency, improving their market position, their ability to manage the clinical process, and their ability to take advantage of reimbursement trends. The losers will either be at increasing risk for clinical “disaggregation” and/or have a very costly experience because they waited too long and/or were not sufficiently deliberate.

Given all the benefits of an EHR on every physician’s desktop, it is not the end game. It is the starting point for physicians, hospitals, and communities to effectively manage clinical quality, medical costs, and the needs of consumers and their communities.

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For more information

To read the actual stimulus bill online, go to the government printing office version at <http://fdsys.gpo.gov/fdsys/pkg/BILLS-111hr1ENR/pdf/BILLS-111hr1ENR.pdf>.

To read the Stark regulations and the Center for Medicare and Medicaid Services analysis online go to www.cms.hhs.gov/PhysicianSelfReferral/.



Hospital – Physician Alignment
Physician Operations Improvement
Clinical Integration
Practice Management

The JHD Group is a leader in assisting physician organizations to meet the challenges of care delivery, managed care, technology, compliance and patient services. We focus on driving the operational excellence and financial results that our clients seek through our expert comprehensive clinical integration, management consulting and practice management services.

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