

# Michigan Health Information Network Update



John Hazewinkel, JD  
Project Manager, MiHIN  
Resource Center

---

---

---

---

---

---

---

---

## Background

Federal, state, and local policymakers have promoted the use of information technology in the health care industry to increase efficiency, reduce cost, and improve quality. Studies have estimated that a fully functioning system could yield over \$77 billion in net benefits per year. [1]



[1] See Jan Walker et al., "The Value of Health Care Information Exchange and Interoperability," *Health Affairs*, 19 January 2005, w5-18 and RAND Corporation, "Health Information Technology: Can HIT Reduce Costs and Improve Quality?", 2005, last accessed at [http://www.rand.org/pubs/research\\_briefs/RB9136/index1.html](http://www.rand.org/pubs/research_briefs/RB9136/index1.html)



---

---

---

---

---

---

---

---

## Background

Health care relies on the exchange and storage of paper-based records to a greater extent than other industries. Clinical information is frequently maintained in separate silos and infrequently made accessible at the point of care. Much information is stored in paper files, even if it originated in electronic form.



---

---

---

---

---

---

---

---

## Background

Since health information flows and records are scattered, comprehensive patient information is seldom consolidated in one place. Duplication of services and treatment without complete information are some of the consequences.



---

---

---

---

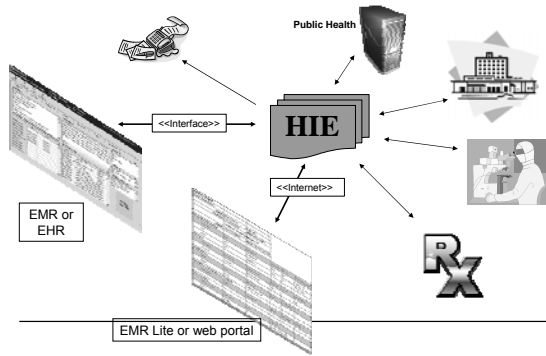
---

---

---

---

## Health Information Exchange



---

---

---

---

---

---

---

---

## State of Michigan

Governor Jennifer M. Granholm charged the Michigan Department of Community Health and the Michigan Department of Information Technology with convening Michigan's health care stakeholders to develop a vision and roadmap for the future of health information technology and exchange in Michigan.



Governor Jennifer M. Granholm

*"We will help our help care industry stop depending on your memory and their paper records as databanks. We are going to use technology to vastly improve the system."*

- Governor Jennifer M. Granholm, 2006 State of the State Address



---

---

---

---

---

---

---

---

## State of Michigan

A multi-stakeholder effort in 2006 resulted in the Michigan Health Information Network (MiHIN) *Conduit to Care* report, a roadmap to improve the quality, safety and efficiency of health care delivery in Michigan by accelerating adoption and use of HIT and health information exchange (HIE) using a regional approach.



---

---

---

---

---

---

---

---

## Michigan HIE Initiatives



---

---

---

---

---

---

---

---

## Michigan's HIE Backbone

- March 2009 the Michigan HIT Commission voted to reaffirm the objectives of the MiHIN project but modify the approach
  - Centralize certain elements of HIE technology and administration in order to attain the optimal economy of scale and the most efficient use of available resources
  - Allows for earlier adopters to populate the record locator service
  - Unifies privacy and consent management policies, governance and data sharing agreements
  - Allows Michigan's earlier adopters of HIE/interoperability to connect with each other and state applications (i.e., MCIR)
  - Aligns with the American Reinvestment and Recovery Act HIE infrastructure requirement for State funding



---

---

---

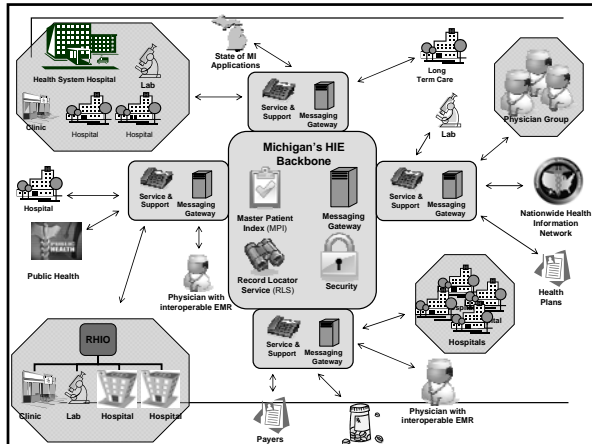
---

---

---

---

---




---

---

---

---

---

---


---

---

---

---

### ARRA Incentive Funding



- February 17, 2009 President Obama signed the American Recovery and Reinvestment Act (ARRA)
  - 33 billion dedicated to Medicare and Medicaid incentives for physicians and hospitals who purchase and use Electronic Health Records (EHRs).
  - Bonus payments will only be made to "meaningful users" of qualified EHRs. To take maximum advantage of them, physicians will need to be ready by calendar year 2011 and hospitals will need to be ready by FY 2011 (beginning October 1, 2010).

---

---

---

---

---

---

---

---

---

---

### Electronic Health Records

- NAHIT defines an EHR as "An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization."

Source: 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 26, 2008), p. 6. Currently available at: [http://www.nahit.org/images/pdfs/HITTermsFinalReport\\_051508.pdf](http://www.nahit.org/images/pdfs/HITTermsFinalReport_051508.pdf)

---

---

---

---

---

---

---

---

---

---

### “Qualified & Certified EHRs”

This distinction influenced the ARRA’s definition of a “qualified electronic health record” which is “an electronic record of health-related information on an individual that-

(A) includes patient demographic and clinical health information, such as medical history and problem lists; and

(B) has the capacity--

- (i) to provide clinical decision support;
- (ii) to support physician order entry;
- (iii) to capture and query information relevant to health care quality; and
- (iv) to exchange electronic health information with, and integrate such information from other sources.”

---

---

---

---

---

---

---

---

### EHR Certification

- Certified EHR Technology: Qualified EHR that is also certified by meeting standards determined by type of record involved
- Certification Commission for Healthcare Information Technology, CCHIT, is one certification body. CCHIT certification requirements include EHR suitability, quality, interoperability and data portability, and security.
- List of CCHIT certified EHR products on CCHIT.org:
  - [CCHIT Certified 08 Ambulatory EHR](#)
  - [CCHIT Certified Inpatient EHR 2007](#)
- CCHIT certified EHR technology has not been named the official certification body for EHRs. Other EHR certification organizations may be involved .
- Commentators on the ARRA have said that as the demand for EHRs rises across the country in responses to the incentives, certified vendors will be increasingly challenged to keep up the supply and long delays can be anticipated.



---

---

---

---

---

---

---

---

### EHR Incentives

- To be eligible for incentive payments physicians must be “meaningful EHR users”
  - Criteria:
    - Demonstrate to HHS that they are using EHR in meaningful manner
    - Participate in E-prescribing
    - Technology provides electronic exchange of health information to improve quality of health care
    - Submit information to HHS for quality measures

---

---

---

---

---

---

---

---

### Medicare Physician Incentives

- Incentives most likely will start in calendar year 2011
- Physicians may receive payments up to \$44,000 over five years
  - Payment based on 75% of Medicare claims, subject to caps (see next slide).
- Health care providers in "provider shortage areas" are eligible for 10% increase
- Incentive payments end in **2015**
- In 2015, reduction in Medicare reimbursements start if physicians do not become "meaningful users"

---

---

---

---

---

---

---

---

---

---

---

### Medicare Physician EHR Incentives

|              | 2011     | 2012     | 2013     | 2014     | 2015    | 2016    | 2017 | TOTAL           |
|--------------|----------|----------|----------|----------|---------|---------|------|-----------------|
| Adopt 2011   | \$18,000 | \$12,000 | \$8,000  | \$4,000  | \$2,000 | \$0     | \$0  | <b>\$44,000</b> |
| Adopt 2012   | -----    | \$18,000 | \$12,000 | \$8,000  | \$4,000 | \$2,000 | \$0  | <b>\$44,000</b> |
| Adopt 2013   | -----    | -----    | \$15,000 | \$12,000 | \$8,000 | \$4,000 | \$0  | <b>\$39,000</b> |
| Adopt 2014   | -----    | -----    | -----    | \$12,000 | \$8,000 | \$4,000 | \$0  | <b>\$24,000</b> |
| Adopt 2015 + | -----    | -----    | -----    | -----    | \$0     | \$0     | \$0  | <b>\$0</b>      |

Maximum payments based on 75% of Medicare claims (Must bill at least \$24,000 to claim maximum \$18,000 bonus, for example.)  
 Hospital-based professionals are not eligible for Medicare incentives.

Sources: HIMSS <http://www.himss.org/ASPI/index.asp>  
 and AHIMA <http://www.ahima.org>

---

---

---

---

---

---

---

---

---

---

---

### Medicare Physician Penalties

- In 2015, reduction in Medicare reimbursements for physicians who are **not** meaningful EHR users  
 (exceptions for significant hardship cases)

| First Payment Year  | Reduction in Medicare Fee Schedule for non-adoption |
|---------------------|---|
| 2011                | \$0   |
| 2012                | \$0   |
| 2013                | \$0   |
| 2014                | \$0   |
| 2015                | -1%   |
| 2016                | -2%   |
| 2017 and thereafter | -3%...  |

Source: American Medical Association, AMA  
<http://www.ama-assn.org/ama/1/pub/upload/mm/399/ama-hit-provisions.pdf>

---

---

---

---

---

---

---

---

---

---

---

## EHR Usage in Michigan

- 36% of active fully licensed physicians surveyed in 2007 by MDCH reported that someone in their medical practice used an EHR.\*
- A article in the New England Journal of Medicine (NEJM) found that 13% of the physician respondents reported having a basic electronic records system. Only 4% reported a fully-function system as defined by the authors.\*\*
- Although adoption rates in Michigan may be higher than the national average, the higher figure cited by the MDCH survey likely reflects physician use of EHRs for practice management purposes and not necessarily clinical purposes.

\* Michigan Department of Community Health Survey of Physicians, 2007.

\*\* This article was published at [www.nejm.org](http://www.nejm.org) on June 18, 2008. N Engl J Med 2008;359:50-60.

## EHR Implementation: Physicians

- In May 2008 the Congressional Budget Office cited studies that the total costs for office-based EMRs range from \$25,000 to \$45,000 per physician, with annual operating costs ranging from \$3,000 to \$9,000 per physician a year. Indirect costs may result from reduction of productivity while the system is established and staff members are trained.
- The installation process may take up to a year to get all the features fully functioning and to adapt workflow
- EMRs may or may not be interoperable
- Most studies indicate a positive ROI from the use of EMRs over time
- Alternative Solution to EHR Implementation
  - Physicians participating in an Health Information Exchange (HIE) with an EMR Lite

Source: "Evidence on the Cost and Benefits of Health Information Technology"  
Congressional Budget Office (May 2008) <http://www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf>

## Medicare Hospital Incentives

- Incentives start in FY 2011
- **Hospital compensation formula** starts at \$2 million and then derives from the number of patient discharges in the hospital, Medicare Share, and a transition factor
- **Critical Access Hospitals** use the same formula, but after the Medicare Share is determined, 20% is added. The Medicare Share cannot exceed 100%, however.
- **FY2013:** Phase down for hospitals adopting
- **FY2015:** Adjustments made for those hospitals who are not meaningful EHR users

## Medicare Hospital Penalties

Starting in FY 2015, if an eligible hospital is not a meaningful EHR user than the applicable Market Basket Adjustment percentage shall be reduced

| First Payment Year  | Reduction in Medicare Fee Schedule for non-adoption |
|---------------------|---|
| FY 2011             | 0   |
| FY 2012             | 0   |
| FY 2013             | 0   |
| FY 2014             | 0   |
| FY 2015             | -33.33%   |
| FY 2016             | -66.66%   |
| 2017 and thereafter | -100%   |

Source: HIMMS The American Recovery and Reinvestment Act of 2009  
<http://www.himms.org/ASP/index.asp>

---

---

---

---

---

---

---

---

---

---

## Critical Access Hospitals

Starting in FY 2015, if CAH is not a meaningful EHR user than the applicable Market Basket Adjustment percentage shall be reduced

| First Payment Year  | Reduction in Medicare Fee Schedule for non-adoption |
|---------------------|---|
| FY 2011             | 0   |
| FY 2012             | 0   |
| FY 2013             | 0   |
| FY 2014             | 0   |
| FY 2015             | -0.33%  |
| FY 2016             | -0.66%  |
| 2017 and thereafter | -1%   |

Source: HIMMS The American Recovery and Reinvestment Act of 2009  
<http://www.himms.org/ASP/index.asp>

---

---

---

---

---

---

---

---

---

---

## Medicare Hospital Incentives

- To be eligible for incentives hospitals must be "meaningful EHR users"
  - Criteria:
    - Demonstrate to HHS that they are using EHR in meaningful manner
    - Technology provides electronic exchange of health information to improve quality of health care
    - Submit information to HHS for quality measures

---

---

---

---

---

---

---

---

---

---

## Medicare Hospital Incentives

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       |
| <b>Total</b>   |                    | 6,370,000     | 3,227,500    | 2,185,000    | 1,092,500    | 12,925,000       |

Source: Health Industry Insights, 2009

---

---

---

---

---

---

---

---

---

---

---

---

## Medicare Hospital Incentives

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        |
| <b>Total</b>   |                    | 2,563,400     | 422,550      | 281,700      | 140,850      | 3,408,500        |

Source: Health Industry Insights, 2009

---

---

---

---

---

---

---

---

---

---

---

---

## Medicare Hospital Incentive Examples

- Incentive Payments for Non-Critical Access Hospitals  
Payments are based on: acute discharges, total in-patient days, total in-patient days covered under Medicare Part A and Medicare Part B, Base Sum of \$2,000,000, estimated total hospital charges, and estimated total charges attributable to charity
- 75-bed community hospital
  - Demonstrating "meaningful use" in FY2011
    - Total Incentive Payments = **\$3,539,578**
  - Demonstrating "meaningful use" in FY2014
    - Total Incentive Payments = **\$2,126,569**
- 250-bed hospital
  - Demonstrating "meaningful use" in FY2011
    - Total Incentive Payments = **\$4,629,045**

Source: HIMSS <http://www.himss.org/ASP/index.asp>

---

---

---

---

---

---

---

---

---

---

---

---

## EHR Implementation: Hospitals

- The May 2008 CBO report noted the relative lack of good cost data and studies on EHR implementation in hospitals. It cited one study that found implementation costs for computerized order entry (CPOE) system to be approximately \$14,500 per bed plus annual operating costs of \$2700 per bed.
- Another study, from Rand, estimated implementation costs to be \$63,000 per bed and annual costs of \$18,900 per bed per year.

Source: "Evidence on the Cost and Benefits of Health Information Technology"  
Congressional Budget Office (May 2008) <http://www.cbo.gov/ftpdocs/91xx/doc9168/05-20-HealthIT.pdf>

---

---

---

---

---

---

---

---

---

---

## Medicaid Incentives

- Incentives most likely will start in 2011
- No Medicaid payment reductions if a provider does not adopt certified EHR technology
- Providers include:
  - Physicians
  - Dentists
  - Nurse midwives
  - Nurse practitioners
  - Physician assistants (in rural health clinics or federally qualified health centers led by PA)
  - Children's and acute-care hospitals

To be eligible for Medicaid providers are required to Waive Medicare EHR incentive payments.

---

---

---

---

---

---

---

---

---

---

## Medicaid Incentives

### Who's Eligible?

| Providers   | Medicaid Patient Volume                 |
|---|---|
| Non-hospital based providers  | ≥ 30%                                   |
| Non-hospital based pediatrician (eligible for 2/3 of the amount)                    | ≥ 20%                                   |
| Physician who practices in federally qualified health center or rural health clinic | ≥ 30% attributable to needy individuals |
| Children's hospitals  | No requirement needed                   |
| Acute-Care hospitals  | ≥ 10%                                   |

---

---

---

---

---

---

---

---

---

---

### Medicaid Incentives for Non-hospital based providers

- Incentives for up to 85% of costs for EHR
  - Caps: 1<sup>st</sup> year payment at \$25,000
  - Caps: following years at \$10,000/year
    - 1<sup>st</sup> yr cost no later than 2016
    - No payments made after 2021 or more than 5 years
- Costs Include:
  - Purchasing
  - Implementation
  - Upgrades
  - Support & training
  - Engaging in efforts to adopt, implement...
  - Maintenance & use

---

---

---

---

---

---

---

---

---

---

### Medicaid Incentives: Hospitals

- Limitations
  - Adoption of EHR before 2017 to receive incentives
  - Incentives limited to 6 years
  - Incentives = product of overall Hospital EHR amount and Medicaid Share
  - In any year: total amount not more than 50% of Medicaid Incentive
  - In any two year: total amount not more than 90% of Medicaid Incentive

---

---

---

---

---

---

---

---

---

---

### Key Points

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

Sources: HIMSS <http://www.himss.org/ASPI/index.asp>  
and AHIMA <http://www.ahima.org/>

---

---

---

---

---

---

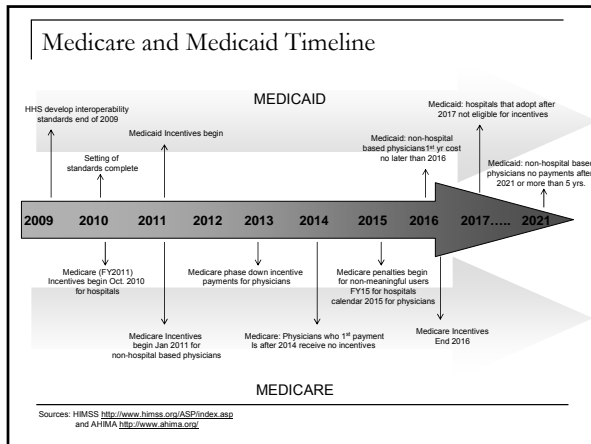
---

---

---

---






---

---

---

---

---

---

---

---

---


---

---

---

### MiHIN Annual Conference


MiHIN Annual Conference (April 29 - May 1 at the Radisson Plaza Hotel, Kalamazoo).



Highlights include:

- Workshops on HL7 and HIE Communications
- General session on CCHIT certification of HIE networks, public health uses of HIE, the Delaware Health Information network, Massachusetts eHealth Collaborative and other topics.
- Concurrent sessions on Behavioral / mental health issues, Integrating the Healthcare Enterprise, the Michiana Health Information Network, and other topics.
- Exhibit Hall

See [www.MiHIN.org](http://www.MiHIN.org) for details




---

---

---

---

---

---

---

---

---

---

---

---