Background Paper
Incentives for HIT Adoption
NHII 2004 Meeting

I. Goals:
Last year, Molly Joel Coye made the following point about financing the National Health Information Infrastructure: "We can't get there from here." The argument was put forth that the healthcare marketplace, as it was currently structured, was unlikely to attract ample capital investments from independent healthcare IT companies in order to build the information technology infrastructure. In addition, Healthcare Information Technology as a solution to improving the quality of care and reducing cost has seen a very slow adoption rate by providers and approval rate among purchasers, as well as undistinguished support in the stock market. This has shown that Healthcare IT has a long way to go in gaining acceptance. However there is a great deal of consensus that investment in IT infrastructure is necessary if we are to achieve quantum leaps in quality improvement and efficiencies in healthcare delivery as demonstrated by:

1. The Institute of Medicine reports
2. The President's Information Technology Advisory Committee report
3. The National Committee on Vital Health Statistics reports and recommendations
4. LeapFrog Initiatives
5. Veteran's Administration implementation
6. Selected regional initiatives
    A. CareScience Santa Barbara County Care Data Exchange Pilot
    B. New England Healthcare EDI Network (NEHEN)
    C. Indianapolis Network for Patient Care

The momentum created by these early initiatives has contributed to significant changes in better aligning incentives between payers and providers in the market. However, much work has yet to be done to achieve the goals stated by President Bush in his April 26 Executive Order of having 50% of the physicians in the country using fully interoperable electronic health records within ten years.

II. 03 Consensus recommendations from NHII 03
The current state of funding versus the desired state is one of much debate. The current state is that everybody wants change, but nobody wants to fund it. As well, in the current state anything that gets funded benefits the funders' competitors. The desired state implies that a broad national coalition will convince Congress that we need global funding, in the sense that shared efforts lead to shared gains for all community- based development of NHII. The desired amount would be 10 million dollars to start.

1) Stable Source of Federal Funds (Short term). A short-term recommendation is that the government should provide a stable source of funding for the development, implementation and maintenance of health information standards. This could be accomplished though an expansion of the Consolidated Health Informatics Initiative or development of a new public/private partnership entity for:

A. Tracking use of standards

B. Coordination with states and private sector on standards development;
C. Defining "voluntary" strategies to support adoption of standards;
D. Providing education with respect to HIPAA on ability to share information;
E. Defining and developing strategies to remove barriers to adoption of standards and functional models.

2) Safe Harbor (Short term). Immediate federal action to create a safe harbor protecting and supporting investments in healthcare information technology should be provided. This will protect against adverse scrutiny under fraud and abuse, as well as anti-kickback statutes and regulations.

3) Education (Short term). Increased Federal and state support for education and training programs relating to health informatics, including public health in the health professions should be provided. The purchasers of healthcare should educate consumers in order to increase demand for health information technology.

4) Lead in Healthcare IT (Short term). The Federal Government should lead in the development of a national strategy for the investment in Healthcare IT. There should be rapid progress with public and private support for projects that allow communities to invest in Local Health Information Infrastructure (LHII) initiatives to establish regional data sharing. All projects should be evaluated with respect to their impact on quality and safety, as well as, with respect to their financial impact on all stakeholders. Importantly, all projects should be consistent with national standards.

5) Payment Incentives (Short term). There should be an adoption of a coordinated set of payment incentives, led by CMS in its role as the major nationwide payer, and adopted voluntarily by private payers. The payment incentives should evolve over time, as well as encourage investment in the use of IT. The payment incentives should also support process improvements and improvements in-patient care outcomes.

6) Public- Private cooperation (Medium term). A medium term recommendation would be for Congress to enact legislation, creating a public- private partnership-financing vehicle, which supports the nation's public health goals and the administration of the Medicare, Medicaid and other federal programs. The last medium term recommendation is to create regional health information technology corporations (HITC's), which are not-for-profit public-private entities.

III. Achievements during the past year have included making some of the NHII '03 recommendations a reality:

- Increased number of pay-for-performance programs in the private sector, including but not limited to:
    - Bridges To Excellence – www.bridgestoexcellence.org -- rewards physician practices for adopting health information technology tools, especially EHRs

  - Integrated Healthcare Association – www.iha.org -- rewards physician groups for using HIT to improve quality and safety
  - Taconic IPA & MVP Health Plan – rewards physicians for adopting and using health information technology
  - Empire BCBS – rewards hospitals, on behalf of five large self-insured purchasers, for adopting CPOE systems
- Introduction of demonstration programs and other provisions specified in the 2003 Medicare Improvement and Modernization Act:
  - Electronic prescribing: The MMA stipulates that the new drug benefit should be applied in a delivery system that has broadly adopted e-prescribing. To that end, HHS is authorized to give up to 50% matching grants for physicians that adopt certain tools for e-prescribing. A total of $50MM in grants are available for fiscal 2007 and other sums as needed to be defined later for 2008 and 2009
  - Section 649 – Care Management Program: This demonstration program will pay a financial reward to physicians that have adopted certain health information technologies, including electronic registries, e-prescribing, EHRs, and can show that they used these tools in delivering better outcomes for patients with chronic conditions.
  - Section 721 – Chronic Care Improvement: This demonstration program encourages the better management of patients in Medicare FFS that have a chronic condition. The program encourages the use of health information technology in better tracking patient care.
- Introduction and expansion of AHRQ grants for the creation and development of local and regional programs that will contribute to building the NHII, and for demonstrating the value of health information technology.
- Launch of the HRSA-funded Connecting Communities For Better Health grant program to encourage the development and sustainability of programs that will contribute to building the NHII
- Publication of a report by the eHealth Initiative on the importance of and business case for widespread adoption of e-prescribing http://www.ehealthinitiative.org/news/eRXReportpressrelease.mspx
- Publication of a report by the eHealth Initiative on the impact of incentives and rewards for adoption of health information technology http://ccbh.ehealthinitiative.org/highlights.aspx?Document=261
- Issuance of preliminary regulations for the potential exemption of the Stark Law to facilitate the funding of health information technology in communities across hospitals and physicians.
- Issuance of a Presidential Executive Order that asks HHS and OPM to find new ways to create incentives for physicians to adopt health information technology, including EHRs. It also asks DOD and the VA to make their health information systems a viable low cost option for rural and underserved communities.

IV. Current Recommendations

- **Policy Actions**

- There is realization that imperative policy actions are needed to address the low E H R conversion rate and to provide an infrastructure that will support interoperability. Without a concerted effort to promote the uptake of E H R the ongoing regression and decapitalization of the health care industry will make it increasingly challenging for private, public or regulatory efforts to accomplish the goal of E H R adoption without top down mandates or other potential draconian measures.

- There is a strong case for Federal involvement in enabling the commercial marketplace for E H R and interoperability to grow and be self- sustaining. Rising health care costs in Medicare and the private sector, the emerging public health crisis of medical errors, the productivity loss to other industries from waste in health care all point to a national burden that will harm both living standards and domestic growth in the future. The federal government also has the means to drive change, through Medicare reimbursement, Medicare regulations, Department of Defense, and Veterans Health Administration contracts with private sector organizations and through regulations in nearly every other federal agency. The federal government cannot be neutral and let industry address the E H R challenge alone.

- A comprehensive, bipartisan federal policy strategy for E H R and interoperability adoption is needed. This will require a high degree of coordination across agencies, among federal, state and local governments and between the government and the private sector. Federal policy should articulate a clear vision of E H R's and interoperability, educate the public about quality and the role of E H R's and interoperability in transforming care, and engage private sector leaders in addressing key barriers.

- **Pay For Performance**

- Budget- neutral mechanisms for rewarding benefits of E H R adoption include:
  - Publication of consumer data about E H R use in hospitals and physician groups;
  - Incorporation of E H R use into Medicare eligibility.
  - Inclusion of E H R requirements in contracts to private providers from the Department of Defense and Veterans Health Administration,
  - E H R- only metrics in pay- for- performance programs and protection from frivolous litigation in cases where E H R's are used. Budget- increasing actions include relaxation of restrictions on E H R use in optimizing Medicare billing.
- Incentives must reward E H R adoption and transformational activities of care coordination, information management, etc.

- **Reimbursements**
  - One of the most challenging aspects of E H R adoption is the risk involved in acquiring and installing a new system. Risk is involved in many aspects such as the high expense of the E H R purchase, the complexity of the technology, the wide range of systematic changes that are going to be needed to take place, as well as many other risk factors involved. Budget-increasing policy actions include marginal reimbursement for E H R use at the point of care, encoded as either E&M modifiers or a new set of CPT and HXPX codes, and underwriting of insurance products that can offset the financial risks of E H R implementation failure.

- **Grants/Loans**
  - Many experiments including Pay- for- Performance and direct E H R subsidies- are being considered. There are calls for radical change in the way healthcare is financed, as well as proposals that are highly specific to E H R adoption, for example loan funds, or 'Hill-Burton' type grants. There is no framework that exists for how proposals should fit together into an overall strategy. Creating this framework, evaluating current ideas and filling in gaps are the purpose of this project.
  - Incentives based on direct measures of good care delivery; such as meeting ADA diabetes guidelines or HEDIS measures.
  - Incentives based on the implementation of care programs such as the federally sponsored demonstrations of care management and chronic care management. If you put in organization and processes to deal with care management, you will need IT investments to manage the processes. Hence you incent the formation of programs.
  - Targeted incentives for specific IT initiatives such as e-prescribing or disease registries. Here one doesn't incent the full E H R but incents pieces of it. This can reduce the cost and start the provider moving down a path towards E H R.
  - Organizations that are recipients of federal dollars (i.e. Health plans participating in the FEBHP) might be required to implement IT standards in their data exchanges for that purpose. The eHI employer/purchaser group has come up with some great criteria.
  - Extensions of the DOQ-IT program (post demonstration) to provide regional resources to educate physicians on E H R's and help them get through selection and implementation.

Topic for Discussion:

Although there are many anecdotal cases documenting financial benefits of E H R's to providers, the most commonly cited barrier to implementation of E H R's is the negative short-term economic cost associated with its purchase, implementation and operation. Because of these concerns, the use of E H R's remains low, and forecasts do not show substantial changes in adoption over the next few years. This constitutes a substantial public policy dilemma because avoidable errors and deaths are occurring on an ongoing basis while these technologies remain underused.

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