Red Flags Rules (RFR) Delayed for the Fifth Time – This Time Until December 31, 2010

From the Federal Trade Commission:

“At the request of several Members of Congress, the Federal Trade Commission is further delaying enforcement of the "Red Flags" Rule through December 31, 2010, while Congress considers legislation that would affect the scope of entities covered by the Rule. Today’s announcement and the release of an Enforcement Policy Statement do not affect other federal agencies’ enforcement of the original November 1, 2008 deadline for institutions subject to their oversight to be in compliance.”

Read more here.

My post and resources on Red Flags Rule here and in the Manage My Practice Library.

Congress Expected to Further Delay SGR Cut to Medicare Physician Fee Schedule

UPDATE: On June 24, 2010 the House and Senate passed legislation to further delay the Medicare cuts until November 30, 2010. More here.
Congress has yet to pass a bill delaying the June 1, 2010 21.2% reduction in physician reimbursement, but most believe it will happen and be effective retroactively.

CMS has said it is anticipating a further delay in Medicare fee schedule cuts, so they have “instructed contractors to hold claims containing services paid under the MPFS for the first 10 business days of June.”

More information on my post [here](#).

Stay tuned!

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**ARRA Eligible Providers: Who Is Eligible to Receive Stimulus Money and How Much is Available Per Provider?**

Note: read my latest post on getting the EHR Incentives [here](#).

**Medicare Definition of Eligible Provider (EP)**

For Medicare, physicians and some hospitals are eligible providers. “Physicians” includes doctors of medicine (MD) or osteopathy (DO), dentists or dental surgeons (DDS or DMD), podiatric medicine (DPM), and optometry (OD) and chiropractors (DC).

For providers, their annual payment will be equal to 75 percent of Medicare allowable charges for covered services in
a year, not to exceed the incentives in the table below. Payments will be made as additions to claims payments.

Hospitals include quick-care hospitals (subsection-d) and critical access hospitals and only includes hospitals in the 50 States or the District of Columbia.

Medicaid Definition of Eligible Provider (EP)

Medicaid takes the Medicare definition of eligible providers (physicians) and adds nurse practitioners, certified nurse midwives and physician assistants, however, physician assistants are only eligible when they are employed at a federally qualified health center (FQHC) or rural health clinic (RHC) that is led by a Physician Assistant. Eligible hospitals include quick care hospitals and children’s hospitals.

At minimum, 30 percent of an EP’s patient encounters must be attributable to Medicaid over any continuous 90-day period within the most recent calendar year. For pediatricians, however, this threshold is lowered to 20 percent.

The first year of payment the Medicaid provider must demonstrate that he is engaged in efforts to adopt, implement, or upgrade certified EHR technology. For years of payment after year 1, the Medicaid provider must demonstrate meaningful use of certified EHR technology.

Change 1:

The definition of “hospital-based physician” was recently clarified to include physicians working in hospital outpatient clinics (employed physicians) as opposed to the inpatient units, surgery suites or emergency departments. This still
excludes pathologists, anesthesiologists, ER physicians, hospitalists and others who see most of their patients in the ER as outpatients or as hospital inpatients.

Possible Change 2:

The Health Information Technology Extension for Behavioral Health Services Act of 2010 (HR 5040) is a bill in the US Congress originating in the House of Representatives that would amend the Public Health Service Act and the Social Security Act to extend health information technology assistance eligibility to behavioral health, mental health, and substance abuse professionals and facilities, and for other purposes. You can track the bill [here](#).

For more information on stimulus money for meaningful use of an EMR, read my post [here](#).

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**My Notes from the CMS Open Door Forum on May 19, 2010: PECOS, DMEPOS and Blue Ink on Paper Forms**

CMS held a two-hour Open Door Forum today and there was so much good information shared that I thought I’d pass my notes from the call along to you.

**New EFT Form**

The revised EFT (Electronic Funds Transfer) authorization form 588 is available [here](#) (pdf.) The old form will still work for a few months longer before it becomes invalid.
Changes to the Medicare Program Integrity Manual

The Program Integrity Manual (publication 100-08) will have revisions related to the changes in provider enrollment. The online-only manual [here](#) will have content moved from Chapter 10 to Chapter 15 and the provider enrollment information will be easier to understand.

The Question on Everyone’s Lips

How do I know if I’m listed in PECOS (Provider Enrollment and Chain/Ownership System) and how do I know if others are listed in PECOS? A new downloadable file is now available [here](#) (12,000 pages!) and everyone listed in this Ordering/Referring file has approved enrollment status. Anyone not appearing on this list is not in approved status, or has opted completely out of the Medicare program.

Advanced Diagnostic Imaging

Beginning in January 2012, all diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET) must be performed in a facility accredited by the American College of Radiology (ACR), The Joint Commission (TJC) or the Intersocietal Accreditation Commission (IAC) for the technical component of the test to be reimbursed by Medicare. This rule does not apply to x-rays, ultrasound, fluoroscopy, mammography or DEXA scans and does not apply to any professional component.

Hospital Revalidations

Hospitals not enrolled in PECOS or not receiving EFT (Electronic Funds Transfer) will be contacted by CMS in an attempt to get all hospitals revalidated.

PECOS (pronounced “pay-cose”)

CMS recommends that anyone with questions or just getting
started in PECOS read the “Getting Started Guide”, of which there are two versions, both available here in pdf form. One is for providers and one is for suppliers of DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.) You need to know your corporate structure before getting started because the business must enroll before the providers can assign benefits to the business. The 855I is for individual/solos providers and the 855B is for non-individuals (multiple owners) billing Medicare Part B and assigning benefits to a legal entity/corporation. Dentists and pediatricians who order or refer services for Medicare patients are required to have an enrollment record in the PECOS. Residents and interns are exempt from the enrollment requirement, but an attending physician needs to be identified on the claim when a service is ordered or referred. The main page for enrollment is

https://www.cms.gov/MedicareProviderSupEnroll/

Two Ways to Get Into PECOS

One is to complete the paper form in BLUE INK (and if time is of the essence CMS suggests that you use the paper form) and let the MAC enter it into PECOS for you. The other is to use the internet-PECOS system directly, and sign, date and mail the certification statement to complete the process. Submit the participation form or EFT form if required. The certification form for the paper process is NOT the same as the certification from for the internet-PECOS process.

What is the 30-day rule?

The 30-day rule states that you can bill for services provided to Medicare patients up to 30 days prior to your filing date. The filing date is the date your enrollment is accepted, not the date you mailed it. Online it will say “Status Approved”, and you will receive an email, and then a letter confirming it. You will appear on the Ordering/Referring file on the CMS website.
What happens to payments for patients that were referred by a provider not enrolled on PECOS?

Even though you are enrolled, if the referring physician is not enrolled, you will not be paid for that patient’s services. However, if that referrer becomes enrolled, you can resubmit the claim and it will be paid.

What happens on July 6, 2010? When does this happen?

July 6, 2010 The compliance date for Part A providers (hospitals, skilled nursing homes and home health agencies) and Part B providers (physicians, ambulance) must be enrolled in PECOS as ordering/referring physicians for payments to be made has been delayed indefinitely!

What happens on July 13, 2010?

DMEPOS (pronounced “demmy-pos”) providers must be enrolled in PECOS to receive Medicare payments.

What should be done if a provider leaves a group?

The provider or his Authorized Official (CEO, CFO, Manager) should file a 855R or make the change in PECOS as soon as possible.

Why do provider offices still request UPINs from our office?

Unclear. UPINs were no longer required as of May 23, 2008. The NPI is the only number accepted on Medicare claims.

Should the information submitted on a 855 be the same information in PECOS?

Yes, if it isn’t, contact the Help Desk. Their toll-free number is 1-866-484-8049 and their e-mail address is eussupport@cgi.com.

For more information on the nuts and bolts of PECOS, see my post here.
ARRA Changes Rules for HIPAA – Did You Miss These Three February Deadlines?

With so much going on in healthcare, it would not surprise me if a lot of practices missed the February 2010 deadline for three expanded HIPAA rules. This expansion was dictated by the Health Information Technology for Economic and Clinical Health (HITECH) Act passed by Congress in February 2009.

If you haven’t already, get started now with the new requirements.

1. **New obligations for business associates (BA) – February 17, 2010** Remember that a BA is a person or organization outside of your entity with whom you share protected health information (PHI) so they may provide services to you. Good examples are your billing service, collection agency, attorney, consultant, computer vendors, attorneys and providers of documentation abstracting or coding services. Under HITECH, BA have the same responsibilities for breaches as the healthcare entity does, but it is the healthcare organization’s responsibility to have an updated, signed BA agreement in place that describes this new responsibility. [Here](#) is an excellent example of a BA agreement (first link under Publications) that you can download and tweak for your practice.

2. **New disclosure agreement provision – February 18, 2010** This is a big one! Patients now may waive their right to have you file their medical insurance, pay for your services themselves and request that their medical
information NOT be disclosed to their insurance plan or any other entity. In other words, patients may elect to become “self-insured”. **I recommend that you create a new financial class for these patients** so they neither fall into the standard self-pay/financial assistance class or into their actual insurance class. These patients, if you have any, will need to be identified according to their wishes, which could mean that they want you to file insurance for some services and not for others. This means their record must be tagged for what records can be released and what records cannot. There could be an argument made either way for whether or not these patients should receive self-pay discounts that you have in place for your non-insured patients. I would be interested to know how different groups have decided to handle this. There are sample forms for PHI disclosure accounting and for patients to request an accounting of PHI disclosures in the Manage My Practice Library under Operations.

3. **Information breach notification – February 22, 2010**

We’ve heard a lot about this one as the media (along with HHS) must now be notified if a PHI breach involves 500 people or more. Breaches are being reported weekly as non-encrypted laptops are stolen or repurposed, and as copier hard drives (story here) go unnoticed as a security risk. If a breach involves 500 people or less, each individual must receive written notice with details of the breach, the information disclosed, and the steps being taken by the practice or entity to avoid any future breaches, as well as explaining the rights of the patient(s) in protecting their private healthcare information. Several of my employees have received notification letters from health plans and they have been horrified that this could happen. Note that entities that secure health information through encryption or destruction don’t have to provide notification in the event of a breach!
Enforcement is also beefed up. Criminal penalties will apply to covered entities that violate privacy rules AND to those organizations’ individual employees (can you track who accesses whose records when?) Civil penalties have been increased and harmed individuals may share in the booty. Probably most importantly, HITECH gives state attorneys general the power to enforce HIPAA rules.

Other resources:

HHS FAQ on HIPAA Privacy
AMA HIPAA Resources
Healthcare Blog Listing

Forget January 3, 2011! PECOS Date Moved 6 Months Closer for Referring & Supplying Providers New Date is July 6, 2010

NOTE: The date has been changed to July 5, 2011. delayed indefinitely.

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Physicians and “eligible” providers received a jolt today in the May 5, 2010 Federal Register as the date for enrollment in PECOS was moved up (pending the comment period and any changes
resulting from the comment period) six months for providers that order or supply durable medical equipment (DME) for Medicare patients. Instead of the January 3, 2011 date previously announced by CMS, the Patient Protection and Affordable Care Act (Affordable Care Act or PPACA) has provisions to move the go-date to July 6, 2010, just 60 days away.

What does this mean to you? Unless something changes based on public comments, beginning July 6, 2010:

1. Providers with a National Provider Identifier (NPI) must include it on their Medicare and Medicaid enrollment applications and claims.

2. Providers of medical items/other items/services and suppliers that qualify for a National Provider Identifier (NPI) must include their NPI on all applications to enroll in the Medicare and Medicaid programs AND on all claims for payment submitted under the Medicare and Medicaid programs.

3. The ordering/referring supplier must be a physician or an eligible professional with an approved enrollment record in the Provider Enrollment Chain and Ownership System (PECOS) thus changing the previously reported January 3, 2011 date given by CMS.

4. Claims that do not meet these requirements will be rejected by Medicare contractors.

You can read the rule in its entirety here.

Want to read the comments on this interim final rule when they are published? Go here.
UPDATE: On June 24, 2010 the House and Senate passed legislation to further delay the Medicare cuts until November 30, 2010. More here.

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Close on the heels of an affirmative Senate vote, the House of Representatives approved HR 4851 (Continuing Extension Act of 2010) which once more delays, albeit temporarily, the mandated 21.2% physician fee cuts tied to the SGR. The bill now goes to the President to be signed.

What is the SGR? The Sustainable Growth Rate is a general marker of inflation. In 1998, due to concerns of rapidly escalating healthcare costs, Medicare payments for physicians were permanently tied to the SGR. As healthcare inflation has outstripped general inflation since 2002, the cost of physician services has exceeded the predicted SGR. Every year since then, a predicted cut in Medicare physician fees has been bitterly fought, a temporary fix has been passed and the cumulative effect grows.

Many physician organizations are lobbying for the permanent repeal of tying Medicare rates to the SGR, but there are varying opinions on what would take its place and what it would cost to make the change.

Here is the recent history of the Medicare physician fees by year, the proposed cuts and the actual change in physician fees:

2002 -5.4% cut proposed — None made
2003 -4.4% cut proposed – 1.6% increase given  
2004 -4.5% cut proposed – 1.5% increase given  
2005 -3.3% cut proposed – 1.5% increase given  
2006 -4.4% cut proposed – Freeze at 2005 level  
2007 -5% cut proposed - Freeze at 2005 level  
2008 -10.1% cut proposed – 0.5% increase given  
2009 -15% cut proposed – 1.1% increase given  
2010 -21% cut – ??????

Hopefully, no Medicare claims have actually been paid at the 2010 level, although it was reported that the system with new rates in place was being thoroughly “tested” today. If no checks went out with 2010 reimbursement and no “makeup” checks are generated, I suspect more than just a few of the taxpayers’ dollars will have been saved.

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**The Healthcare Bill, Rage, Concierge Practices, Cuts, Claims and Don Berwick (Yes!)**

- **HEALTHCARE BILL IMPACT ON INDIVIDUALS AND RAGE**

A number of people asked me about the impact of health reform on them as individuals. Here is a great story from the Atlanta Journal-Constitution that takes specific examples of individuals and families and speculates on how the new bill(s) will impact them.

For 2010, the changes are minimal:

- Dependent children may be covered by their parents’ health insurance policies until age 26.
A high-risk insurance pool will open for people with pre-existing conditions who have been uninsured for six months.

In 2011 Medicare will pay for an annual checkup, and deductibles and co-payments for many preventive services and screenings will be eliminated. The Medicare prescription drug doughnut hole will gradually narrow every year until it is eliminated in 2020. People in the “doughnut hole” could receive a $250 rebate this year.

I have to say that I’ve been dumbfounded by the fury raised over the passage of the new healthcare legislation. I realize that the bills separate people into winners (uninsured, providers with uncompensated charity care, patients with pre-existing conditions, Medicare patients, providers who see Medicaid patients, families with adult children, etc.) and losers (companies who have to pony up more money for their retired employees, insurance companies, illegal immigrants, high wage earners, etc.), but this story placed the fury into a different perspective for me. It’s a good read.

CONCIERGE PRACTICES

What does healthcare reform mean for the physician practice? Many are predicting the rise of concierge practices (also called boutique medicine, retainer practices, VIP medicine and cash practices) as physicians find they cannot survive if their patient population is predominantly Medicare, Medicaid and uninsured patients. Concierge practices fall into two categories:

• The first operates on an insurance+ model, which means that the practice accepts and files the insurance for the patient, but also requires an additional out-of-pocket fee of anywhere from $1500 to $1800 per year to be a patient of the practice. The fee is to cover services that Medicare and commercial insurance do not,
such as physicals, phone consultations, wellness counseling and patient education.

- The second operates on a strictly cash basis and the practice does not accept or file any insurance for the patient. The patient pays a flat fee per year for care (usually in the $5,000 to $15,000 range) and all primary care is provided for that amount. The patient still needs to carry insurance for prescriptions, hospital services and sub-specialist services. Imagine being a manager in this type of practice – no pre-authorizations, no insurance department, no eligibility checking, no refunds...

Concierge medicine has not been around that long, but it is growing in popularity by leaps and bounds. The first acknowledged concierge practice was formed in 1996 in the Pacific Northwest. In 2002, CMS (Centers for Medicare and Medicaid) published a memo stating that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any Medicare requirements. In 2003, the Department of Health and Human Services ruled that concierge medical practices are not illegal. Today, there are approximately 5,000 physicians using the concierge model in the United States today.

**MEDICARE CUTS, MEDICARE CLAIMS AND DON BERWICK**

Shortly after all the shouting and voting on healthcare reform was over, Congress recessed for two weeks leaving the controversy over the 21.5% cuts required by the SGR formula still unsettled. CMS has advised the MACs to again hold claims for services provided from April 1 to April 10 to give Congress a chance to get back to work and back to voting for an additional delay (or not) for the cuts. If the cuts are allowed to stand, many physicians will start making their own cuts by minimizing the number of Medicare and Medicaid patients they will see.
Amidst this craziness, a voice of sanity is heard and it is Donald Berwick, MD, current President of the Institute for Healthcare Improvement (IHI) and probable Obama pick for the head of CMS. If you don’t know Don Berwick or the IHI, click here to read an interview with him about the IHI’s “100,000 Lives Campaign” or watch the video below of him speaking about the dimensions of quality. Good stuff!

Historic Votes on H.R. 3590 and H.R. 4872 Usher In Healthcare Reform

As I write this Sunday night I am listening to the US House of Representatives’ discussion/posturing prior to a ‘yes” or “no” vote for the Senate’s healthcare reform bill H. R. 3590. I don’t usually listen to CNN Live, but I want to remember this moment as I think it is the beginning of significant change in healthcare.

I’m not sure what this change will be, but many things that have been status quo for healthcare during my career might change almost beyond recognition by the time I retire. This, I think, is a good thing. I don’t think the current system is bad, but I sure think it could be better. As with any change, there will be good things, bad things, and unintended good and bad things. It should be fascinating.

Discussion has now timed out and the representatives are voting; 216 votes are needed to pass. The vote has just been announced (10:45 p.m.) and it is 219 Yeas to 210 Nays and the bill is passed! The next step is for it to be signed into law.
by President Obama, which might happen tonight or tomorrow.

Now the representatives are voting on H.R. 4872 – “The Health Care and Education Affordability Reconciliation Act of 2010” which contains fixes to H.R. 3590 that have been negotiated between the two chambers. The bill has just passed (11:37 p.m.) with 220 Yeas and 211 Nays! 4872 will now go to the Senate for a vote which some are predicting will pass as early as Tuesday.

President Obama spoke from the White House after the votes and said “Tonight we answered the call of history.” The passage of these bills has been compared to the passage of Medicare in 1965 and the passage of Social Security in 1935.

Here are details of both bills.

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**Details on H.R. 3590 ”˜”˜Patient Protection and Affordable Care Act’’**

**Cost:** $940 billion over ten years.

**Deficit:** Would reduce the deficit by $143 billion over the first ten years. Would reduce the deficit by $1.2 trillion dollars in the second ten years.

**Coverage:** Would expand coverage to 32 million Americans who are currently uninsured.

**Health Insurance Exchanges:**

- The uninsured and self-employed would be able to purchase insurance through state-based exchanges with subsidies available to individuals and families with income between the 133 percent and 400 percent of poverty level.
- Separate exchanges would be created for small businesses to purchase coverage – effective 2014.
Funding available to states to establish exchanges within one year of enactment and until January 1, 2015.

**Subsidies:** Individuals and families who make between 100 percent – 400 percent of the Federal Poverty Level (FPL) and want to purchase their own health insurance on an exchange are eligible for subsidies. They cannot be eligible for Medicare, Medicaid and cannot be covered by an employer. Eligible buyers receive premium credits and there is a cap for how much they have to contribute to their premiums on a sliding scale. Federal Poverty Level for family of four is $22,050.

**Paying for the Plan:**

- Medicare Payroll tax on investment income – Starting in 2012, the Medicare Payroll Tax will be expanded to include unearned income. That will be a 3.8 percent tax on investment income for families making more than $250,000 per year ($200,000 for individuals).
- Excise Tax – Beginning in 2018, insurance companies will pay a 40 percent excise tax on so-called “Cadillac” high-end insurance plans worth over $27,500 for families ($10,200 for individuals). Dental and vision plans are exempt and will not be counted in the total cost of a family’s plan.
- Tanning Tax – 10 percent excise tax on indoor tanning services.

**Medicare:**

- Closes the Medicare prescription drug “donut hole” by 2020. Seniors who hit the donut hole by 2010 will receive a $250 rebate.
- Beginning in 2011, seniors in the gap will receive a 50 percent discount on brand name drugs. The bill also includes $500 billion in Medicare cuts over the next decade.

**Medicaid:** Expands Medicaid to include 133 percent of federal
poverty level which is $29,327 for a family of four.

- Requires states to expand Medicaid to include childless adults starting in 2014.
- Federal Government pays 100 percent of costs for covering newly eligible individuals through 2016.
- Illegal immigrants are not eligible for Medicaid.

**Insurance Reforms:**

- Six months after enactment, insurance companies can no longer deny children coverage based on a preexisting condition.
- Starting in 2014, insurance companies cannot deny coverage to anyone with preexisting conditions.
- Insurance companies must allow children to stay on their parent’s insurance plans through age 26.

**Abortion:**

- The bill segregates private insurance premium funds from taxpayer funds. Individuals would have to pay for abortion coverage by making two separate payments, private funds would have to be kept in a separate account from federal and taxpayer funds.
- No health care plan would be required to offer abortion coverage. States could pass legislation choosing to opt out of offering abortion coverage through the exchange.

***Separately, anti-abortion Democrats worked out language with the White House on an executive order that would state that no federal funds can be used to pay for abortions except in the case of rape, incest or health of the mother. [Read more here]***

**Individual Mandate:** In 2014, everyone must purchase health insurance or face a $695 annual fine. There are some exceptions for low-income people.

**Employer Mandate:** Technically, there is no employer mandate. Employers with more than 50 employees must provide health
insurance or pay a fine of $2000 per worker each year if any worker receives federal subsidies to purchase health insurance. Fines applied to entire number of employees minus some allowances.

**Immigration:** Illegal immigrants will not be allowed to buy health insurance in the exchanges – even if they pay completely with their own money.

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**Details on H.R. 4872 – “The Health Care and Education Affordability Reconciliation Act of 2010” (fixes to 3590)**

**COST:** $940 billion over 10 years, according to the Congressional Budget Office.

**HOW MANY COVERED:** 32 million uninsured. Major coverage expansion begins in 2014. When fully phased in, 95 percent of eligible Americans would have coverage, compared with 83 percent today.

**INSURANCE MANDATE:** Almost everyone is required to be insured or else pay a fine. There is an exemption for low-income people. Mandate takes effect in 2014.

**INSURANCE MARKET REFORMS:** Major consumer safeguards take effect in 2014. Insurers prohibited from denying coverage to people with medical problems or charging them more. Higher premiums for women would be banned. Starting this year, insurers would be forbidden from placing lifetime dollar limits on policies, and from denying coverage to children because of pre-existing medical problems. Parents would be able to keep older kids on their policies up to age 26. A new high-risk pool would offer coverage to uninsured people with medical problems until 2014, when the coverage expansion goes into high gear.

**MEDICAID:** Expands the federal-state Medicaid insurance program
for the poor to cover people with incomes up to 133 percent of the federal poverty level, $29,327 a year for a family of four. Childless adults would be covered for the first time, starting in 2014. The federal government would pay 100 percent of the tab for covering newly eligible individuals through 2016. A special deal that would have given Nebraska 100 percent federal financing for newly eligible Medicaid recipients in perpetuity is eliminated. A different, one-time deal negotiated by Democratic Sen. Mary Landrieu for her state, Louisiana, worth as much as $300 million, remains.

**TAXES:** Dramatically scales back a Senate-passed tax on high-cost insurance plans that was opposed by House Democrats and labor unions. The tax would be delayed until 2018, and the thresholds at which it is imposed would be $10,200 for individuals and $27,500 for families. To make up for the lost revenue, the bill applies an increased Medicare payroll tax to investment income as well as wages for individuals making more than $200,000, or married couples above $250,000. The tax on investment income would be 3.8 percent.

**PRESCRIPTION DRUGS:** Gradually closes the “doughnut hole” coverage gap in the Medicare prescription drug benefit that seniors fall into once they have spent $2,830. Seniors who hit the gap this year will receive a $250 rebate. Beginning in 2011, seniors in the gap receive a discount on brand name drugs, initially 50 percent off. When the gap is completely eliminated in 2020, seniors will still be responsible for 25 percent of the cost of their medications until Medicare’s catastrophic coverage kicks in.

**EMPLOYER RESPONSIBILITY:** As in the Senate bill, businesses are not required to offer coverage. Instead, employers are hit with a fee if the government subsidizes their workers’ coverage. The $2,000-per-employee fee would be assessed on the company’s entire workforce, minus an allowance. Companies with 50 or fewer workers are exempt from the requirement. Part-time workers are included in the calculations, counting two part-
timers as one full-time worker.

**SUBSIDIES:** The proposal provides more generous tax credits for purchasing insurance than the original Senate bill did. The aid is available on a sliding scale for households making up to four times the federal poverty level, $88,200 for a family of four. Premiums for a family of four making $44,000 would be capped at around 6 percent of income.

**HOW YOU CHOOSE YOUR HEALTH INSURANCE:** Small businesses, the self-employed and the uninsured could pick a plan offered through new state-based purchasing pools called exchanges, opening for business in 2014. The exchanges would offer the same kind of purchasing power that employees of big companies benefit from. People working for medium-to-large firms would not see major changes. But if they lose their jobs or strike out on their own, they may be eligible for subsidized coverage through the exchange.

**GOVERNMENT-RUN PLAN:** No government-run insurance plan. People purchasing coverage through the new insurance exchanges would have the option of signing up for national plans overseen by the federal office that manages the health plans available to members of Congress. Those plans would be private, but one would have to be nonprofit.

**ABORTION:** The proposal keeps the abortion provision in the Senate bill. Abortion opponents disagree on whether restrictions on taxpayer funding go far enough. The bill tries to maintain a strict separation between taxpayer dollars and private premiums that would pay for abortion coverage. No health plan would be required to cover abortion. In plans that do cover abortion, policyholders would have to pay for it separately, and that money would have to be kept in a separate account from taxpayer money. States could ban abortion coverage in plans offered through the exchange. Exceptions would be made for cases of rape, incest and danger to the life of the mother.
STUDENT LOAN OVERHAUL: Requires the government to originate student loans, closing out a role for banks and other private lenders who charge a fee. The savings "projected to be more than $60 billion over a decade" are plowed into higher Pell Grants for needy college students and increased support for historically black colleges.

MEDICARE: Extends Medicare’s solvency by at least nine years and reduces the rate of its growth by 1.4 percent, while closing the doughnut hole for seniors, meaning there will no longer be a gap in coverage of medication.

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FAQ on HITECH, Meaningful Use, Eligible Providers, and the Stimulus Money

NOTE: Read my latest post on how to register and attest for the EHR Incentive Programs here.

Where Did the Idea of Meaningful Use of Electronic Medical Records Come From?

The American Recovery and Reinvestment Act of 2009 was signed by President Obama on February 17, 2009. The Law includes the Health Information Technology for Economic and Clinical Health Act or the HITECH Act. The HITECH Act establishes programs under Medicare and Medicaid to provide incentive payments for the Meaningful Use of Certified Electronic Health Records technology.

The goal of the HITECH legislation is to improve healthcare outcomes, to facilitate access to care and to simplify care.
It is believed that the installation of electronic health records in medical practices is only the beginning. The goals of HITECH will be met when the EHR is used in a meaningful way.

**What is Meaningful Use (MU)?**

There are three identified components of Stage I Meaningful Use. They are:

1. Use of a certified EHR in a meaningful manner such as e-prescribing.
2. Use of Certified EHR Technology for the exchange of health information (exchange data with other providers of care or business partners such labs or pharmacies)
3. Use of Certified EHR Technology to submit clinical quality and other measures.

The first stage of Meaningful Use is capturing and sharing the data. Meaningful Use Stage II is advanced clinical processes and Stage III is starting to look Meaningful Use of an EHR in the context of improved healthcare outcomes.

There are 25 specific criteria for MU Stage I listed in this article in [Healthcare IT News](https://www.healthcareitnews.com):

[1] Objective: Use CPOE (Computerized Physician Order Entry)  
Measure: CPOE is used for at least 80 percent of all orders

Measure: The EP (Eligible Provider) has enabled this functionality

[3] Objective: Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®  
Measure: At least 80 percent of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data.
[4] Objective: Generate and transmit permissible prescriptions electronically (eRx).
Measure: At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

Measure: At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient is not currently prescribed any medication) recorded as structured data.

Measure: At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient has no medication allergies) recorded as structured data.

Measure: At least 80 percent of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data.

[8] Objective: Record and chart changes in vital signs.
Measure: For at least 80 percent of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20.

[9] Objective: Record smoking status for patients 13 years old or older
Measure: At least 80 percent of all unique patients 13 years old or older seen by the EP “smoking status” recorded.

[10] Objective: Incorporate clinical lab-test results into EHR as structured data.
Measure: At least 50 percent of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital during the EHR reporting period whose results are in either in a positive/negative or numerical format are
incorporated in certified EHR technology as structured data.

[11] Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.
Measure: Generate at least one report listing patients of the EP with a specific condition.

Measure: For 2011, an EP would provide the aggregate numerator and denominator through attestation as discussed in section II.A.3 of this proposed rule. For 2012, an EP would electronically submit the measures are discussed in section II.A.3. of this proposed rule.

[13] Objective: Send reminders to patients per patient preference for preventive/ follow-up care
Measure: Reminder sent to at least 50 percent of all unique patients seen by the EP that are 50 and over

[14] Objective: Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules
Measure: Implement five clinical decision support rules relevant to the clinical quality metrics the EP is responsible for as described further in section II.A.3.

[15] Objective: Check insurance eligibility electronically from public and private payers
Measure: Insurance eligibility checked electronically for at least 80 percent of all unique patients seen by the EP

[16] Objective: Submit claims electronically to public and private payers.
Measure: At least 80 percent of all claims filed electronically by the EP.
[17] Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request.
Measure: At least 80 percent of all patients who request an electronic copy of their health information are provided it within 48 hours.

[18] Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies).
Measure: At least 10 percent of all unique patients seen by the EP are provided timely electronic access to their health information.

[19] Objective: Provide clinical summaries to patients for each office visit.
Measure: Clinical summaries provided to patients for at least 80 percent of all office visits.

[20] Objective: Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure: Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.

[21] Objective: Perform medication reconciliation at relevant encounters and each transition of care.
Measure: Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care.

[22] Objective: Provide summary care record for each transition of care and referral.
Measure: Provide summary of care record for at least 80 percent of transitions of care and referrals.

[23] Objective: Capability to submit electronic data to immunization registries and actual submission where required.
and accepted.
Measure: Performed at least one test of certified EHR technology’s capacity to submit electronic data to immunization registries.

[24] Objective: Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.
Measure: Performed at least one test of certified EHR technology’s capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically).

[25] Objective: Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities.
Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary.

**Have the Details of MU been finalized?**

The comment period for the NPRM (Notice of Proposed Rule Making) for Meaningful Use is currently open but will close on March 15, 2010. You can read the NPRM [here](#). Many individuals and organizations have expressed concern that the timeline for implementing EHR and meeting MU criteria is too short for the majority of providers. The American Academy of Family Physicians (AAFP) recently sent a 7-page letter to acting CMS Administrator Charlene Frizzerathat included the following concerns:

1. The administrative burden of reporting computerized physician order entry measures “is excessive to the point of being unachievable for most eligible providers.”
2. The rule could require manually entering results from laboratories that don’t have an interoperable interface with the physician’s electronic health record.

3. The term “health information” is used throughout the proposed rule, but is never defined.

4. A requirement that a patient’s health information be shared with that patient within 48 hours doesn’t take into account that physicians or their staff may not be able to process the information if that 48-hour period includes weekend days.

5. There is no incentive for physicians who meet less than 100% of the proposed requirements, so it is an all-or-nothing approach.

The Medical Group Management Association recently surveyed (see Modern Healthcare story here) 445 physician practice administrators in February 2010 with the following feedback:

1. Nearly all are aware of the upcoming incentive programs for meaningful use of electronic health records, but fear the programs will reduce physician productivity.

2. 68% of respondents expect physician productivity will decrease if all 25 proposed meaningful use criteria are implemented.

3. Nearly one-third believe the decrease in productivity will be greater than 10 percent.

4. Almost 25% of practices without an EHR doubt some of their providers will ever attempt to qualify for incentives.

5. Among practices with an EHR, nearly 84 percent believe some of their physicians will attempt to qualify for Medicare or Medicaid incentives by the end of 2011.

How Do I Comment on the MU Standard?

You can submit your comments on the NPRM on MU here.

You can read comments already submitted here.
How Do I Know if My EHR is Certified?

No EHRs have been certified for the CMS Incentive Program and the certifying bodies have not yet been announced. It seems reasonable that CCHIT will be one certifying body, but there are expected to be others. If your vendor tells you that his EHR is certified before the rule has been finalized and the certifying bodies have been announced, ask him “For what?”

What Does it Mean to Be Eligible? (description courtesy of Everything HITECH)

This term encompasses three general types of payers to establish eligibility: 1) Medicare Fee For Services (FFS), 2) Medicare Advantage (MA) and 3) Medicaid.

For hospitals to be eligible, they can be acute care (excluding long term care facilities), critical access hospitals, children’s hospitals.

For providers, these include non-hospital-based physicians who receive reimbursement through Medicare FFS program or a contractual relationship with a qualifying MA organization. The Act defines the term “hospital based” eligible professional to mean an EP such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of his or her Medicare covered professional services during the relevant EHR reporting period in a hospital setting (whether inpatient or outpatient) through the use of the facilities and equipment of the hospital, including the hospital’s qualified EHR’s (Fed Reg p. 1905). The determining factor is the site of service as to whether the service is hospital based or not. If the EP provides at least 90 % of their services in a hospital inpatient, hospital outpatient or hospital emergency room setting (Point of Service codes 21, 22, 23), then they are considered a hospital based EP and not eligible for EHR incentive payments (i.e. providing substantially all of his or her Medicare covered
There is a difference between Medicare and Medicaid when it comes to defining an eligible professional for EHR incentive payment purposes. Medicare defines an eligible professional as (Fed Reg p. 1996):

1. doctor of medicine or doctor of osteopathy
2. doctor of dental surgery or dental medicine
3. doctor of podiatric medicine
4. doctor of optometry
5. chiropractor

Medicaid, on the other hand, defines an eligible professional as (Fed Reg p. 2001):

1. physician
2. dentist
3. certified nurse-midwife
4. nurse practitioner
5. physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic, led by a physician assistant.

What are the Guidelines for Providing Patients With Their Medical Records Electronically?

Under HIPAA, patients currently have the ability to access their medical records. Meaningful Use does not change HIPAA in that regard. You may charge patients for the expense related to providing paper or electronic medical records. Each state has its own schedule for charging for medical records (state-by-state schedule here.)

Do Eligible Providers Have to be Participating With Medicare to Receive the Incentive Money?

No, the eligibility requirements only relate to the benchmarks
for the percentage of Medicaid patients you have, or amount of allowed Medicare charges you have.

**Can Eligible Providers Work at Locations Other Than Hospitals and Private Practices and Receive the Incentive Money?**

The location where the provider works is not the issue. The issue is whether or not the provider meets the requirements, either for Medicare or Medicaid, to be considered eligible for the program.

It doesn’t matter where the provider accesses the certified EHR. If they meet the eligibility criteria, and they are using a certified EHR, they can collect on the stimulus money.

**What Are Health Provider Shortage Areas?**

Physicians practicing in determined “health provider shortage” areas will be eligible for a 10% bonus payment.

**How Does This Incentive Relate to ePrescribing or PQRI?**

If the PQRI Program is extended in its current form, practices can participate in both PQRI and an EHR Incentive Plan.

If the EP chooses to participate in the Medicare EHR Incentive Program, they cannot participate in the Medicare eRx Incentive Program simultaneously. If the EP chooses to participate in the Medicaid EHR Incentive Program, they can participate in the Medicare eRx Incentive Program simultaneously.

Also, e-prescribing penalties sunset after 2014, so that no physician will be subject to penalties for failing to both e-prescribe and use an EHR!

**How Do EPs Get Paid For Meaningful Use of a Certified EHR?**

For the first payment year only, all an EP or hospital has to do is to be a “meaningful user” for a continuous 90-day period
during the payment year. Hospitals’ payment year is October 1 to September 30 and EPs’ payment year is the calendar year. You must start and complete the 90-day period within the payment year with no overlapping.

Also, if you can qualify as a Medicaid Eligible Provider (or Hospital), are in the process of adopting, implementing or upgrading your EHR and your Medicaid patient volume is at least 30% (Pediatricians only need 20% minimum and Hospitals need 10% minimum), you can collect your incentive money without meeting Meaningful Use criteria.

Attestation forms and forms of other types are most likely the way that EPs will provide information to apply for the incentive funds, although the details have not yet been released.

**What Does it Mean to Transition From One Program (Medicaid or Medicare) to Another?**

EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs will be able to participate in only one program, and will have to designate which one they would like to participate in. After their initial designation, EPs are allowed to change their program selection only once during payment years 2012 through 2014.

**To Recap:**

**How Do I Get My EHR Stimulus Money?**

1. Decide whether you are an eligible provider for any of the programs.
2. If you are, buy a certified EMR (once certification has been defined.)
3. Use your EMR in a way that demonstrates your meaningful
use of the product.
4. Pass “GO” and collect your money.

ARRA (Stimulus Bill) Acronyms

"¢ A/I/U "“Adopt, implement or upgrade
"¢ CAH "“Critical Access Hospital
"¢ CCN "“CMS Certification Number
"¢ CDS "“Clinical Decision Support
"¢ CMS "“Centers for Medicare & Medicaid Services
"¢ CY "“Calendar Year
"¢ EHR "“Electronic Health Record
"¢ EP "“Eligible Professional
"¢ eRx "“E-Prescribing
"¢ FFS "“Fee-for-service
"¢ FY "“Federal Fiscal Year
"¢ HHS "“U.S. Department of Health and Human Services
"¢ HIT "“Health Information Technology
"¢ HITECH Act "“Health Information Technology for Electronic and Clinical Health Act
"¢ HITPC "“Health Information Technology Policy Committee
"¢ HIPAA "“Health Insurance Portability and Accountability Act of 1996
"¢ HPSA "“Health Professional Shortage Area
"¢ IFR "“Interim Final Rule
"¢ MA "“Medicare Advantage
"¢ MCMP "“Medicare Care Management Performance Demonstration
"¢ MITA-Medicaid Information Technology Architecture
"¢ MU "“Meaningful Use
"¢ NPI "“National Provider Identifier
"¢ NPRM "“Notice of Proposed Rulemaking
"¢ OMB "“Office of Management and Budget
"¢ ONC "“Office of the National Coordinator of Health Information Technology
"¢ PQRI "“Medicare Physician Quality Reporting Initiative
"¢ Recovery Act "“American Reinvestment & Recovery Act of 2009
"¢ TIN "“Taxpayer Identification Number
For more information who is eligible and for how much, read my post “ARRA Eligible Providers: Who Is Eligible to Receive Stimulus Money and How Much is Available Per Provider?”