
Frequently Asked Questions/Answers (FAQs)

The responses below represent our understanding to-date of selected HIT provisions of the American Recovery and Reinvestment Act (ARRA) in the absence of regulatory guidance and do not constitute legal advice. The FAQs are based on the CHIME-NAHIT-AHA webinar, *What You Need to Know and Can Do Today*, held on February 25, 2009.

Funding

Q 1- If you have already implemented a hospital and physician-based EHR and are a meaningful user now, how soon can you obtain funding?

A - 2011

Q 2: I assume early adopters get payments in first year?

A: Yes, as long as you meet the eligibility criteria.

Q 3 - Do we know where the definition of "meaningful use" will ultimately come from? Is CCHIT certification required for the application(s) in use?

A - *The Secretary will determine these requirements. Certification is required, but the legislation does not state CCHIT explicitly.*

Q 4 – Is Physician Order Entry necessary for an EMR to be valid for hospitals?

A- *There is no language at this time that requires CPOE. Meaningful use does include reporting of quality measures and at some point meaningful use could involve the use of CPOE to collect such quality measures.*

Q 5- Some hospitals implement CPOE in a gradual form. For instance first Cardiology, second Orthopedics, Third internal Medicine..... How will the "meaningful use" be determined if you only have 55% of your physicians using CPOE?

A - *There is no language at this time that **requires** CPOE.*

Q 6: Is the discharge-based incentive based on Medicare discharges?

A – *No, it is based on all discharges but the Medicare Share (the money to paid by Medicare not Medicaid) is determined based on a formula taking the hospital's Medicare and Charity volumes into account.*

Q 7: Will a hospital's legacy EHR investments count towards their organization's requirement on any matching grants?

A – *The grants to be made available and the criteria for obtaining them have not yet been defined. Since the law states that the organizations seeking grants should be willing to put up similar dollars, it is doubtful that money already spent will be counted. For the incentive, however, payment is available for qualifying legacy systems.*

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Q 8 - I have purchased an EMR and we are implementing it in a pilot site. I need more funding to roll out to the entire practice of 60 physicians. Does this meet the requirement to receive the funds to continue the implementation?

A – The final rule will spell out more clearly how group practices will be handled; for now it is likely that it will be paid based on Medicare provider number. The incentive payment will not be for implementation costs, but rather a set rate based on Medicare volume and the meaningful use of an EMR by that provider. Grant funding may be a source of money for implementations but the details on the grants have not yet been determined.

Q 9: Are there funds available if you are already 50% completed in an EMR?

A - See response to previous question.

Q 10- Does the cost of the solution affect the amount of the payment received, or will the stimulus payment be unaffected by the cost of the solution?

A - Payment under Medicare for hospitals is based on discharges, the base amount, and the proportion of Medicare bed days. The cost of the HIT system does not figure into the calculation. The incentive payment for the Medicaid Share does take into account how much was or is spent during a particular year, creating a cap on the Medicaid incentive.

Q 11 - If an organization has not yet purchased an EHR, should it hold off on decision making until ONC reveals whether they will provide an ONC-Sponsored-EHR offering? Or until final specifications are made for certification/standards?

A – The selection of system certified by CCHIT should not be a risk at this time. The risk in not installing a system soon is that an organization may miss out on the 2011 funding, which is the highest. The other factor is whether or not you are in a rural or underserved area specifically mentioned in the language about possible grants; in that case, there might be some other sources of funding.

Q 12- Will health systems or physicians who have already implemented EHR and HIT systems be reimbursed under ARRA?

A- If the system is "certified" and meets the minimum requirements for meaningful use (to be determined in detail by HHS), yes, starting in 2011.

Q 13- We operate in a very heterogeneous environment. Do you have any insight about the impact of the mix of certified and uncertified products?

A – Nothing in the ARRA addresses home grown system certification, so there is an assumption you would need CCHIT certification or move to a certified vendor, if you want to be eligible for incentive funds.

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Q 14- We are in that small minority of health systems that have an in-house developed EHR. Does ARRA make any accommodations for this? Do we need to move toward a vendor-provided solution or should we investigate certification of our EHR by CCHIT?

A- Basically the same response as noted to the previous question.

Q 15- We have just completed a successful pilot project demonstrating HIE for a region. What portion of this bill applies to expansion opportunities?

A - The grant and State funds would probably be your best opportunity.

Physicians

Q 16- How does the legislation define "meaningful use" for physicians?

A - Meaningful use is defined as having a system that is connected in such a manner that can exchange information electronically to improve the quality of healthcare, the provider is electronically prescribing and is able to submit reports on clinical quality measures.

Q 17- Are hospitals eligible to receive physician EMR funding for hospital-owned physician practices?

A – Hospital based physicians are excluded (pathologist, ER, etc), but hospital- owned physician practices seeing patients in an office or clinic setting would be treated like other providers irregardless of ownership if the practice is running an ambulatory EHR and not charting in the acute care system.

Q 18- What does "supports CPOE" mean? Should this be interpreted as CPOE fully implemented to meet "meaningful use" ?

A – Supports CPOE means the product has a CPOE module that meets the certification criteria. There is no language at this time that requires CPOE. Meaningful use does include reporting of clinical quality measures. At some point, the Secretary could require the use of CPOE to collect quality measures.

Q 19- If a physician is in private practice, but using the hospital's EHR through an affiliate arrangement, would the physician be eligible for the provider incentive?

A - Most likely, at least for Medicare Incentives. Medicaid incentives will be capped based upon actual dollars spent by the physician for the EHR system for the year.

Q 20- If a hospital donates money to assist a physician with the purchase of an office EMR, how does that effect the incentive money available for physician offices?

A- See response to previous question.

Q 21- Physicians may receive up to \$18,000 in the first year if they have a "meaningful" system. Similar to the hospital incentive payment, is the physician payment prorated based on the percentage of patients/revenue that is Medicare?

A- Yes

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Medicaid

Q 22: Is Medicaid expected to follow the Medicare plan?

A: The Medicaid incentives will be administered by States using a similar formula that incorporates the Medicaid share instead of Medicare share. There are no penalties in the Medicaid incentive. The first year can support adoption, but all payments will be limited to a formula based on actual dollars spent.

Q 23: Can you further explain how the Medicaid portion works?

A- See previous questions. Note this portion will be administered by the States who have some latitude in the definition of meaningful use.

Privacy

Q 24- Does "sale" of PHI include organizations that collect this as a byproduct without payment to source hospital?

A – With this provision that HIPAA now applies to all Business Associates (BA), BAs are prohibited from selling data they acquired through a contract with a covered entity. What remains unclear is whether de-identifying data, (by the definition to be promulgated in the forth coming rules), removes this restriction since the data is not any longer considered PHI.

Q 25- Is de-identified personal health information considered PHI that needs to have the patient's approval for release?

A – It appears not, but hopefully the final rules will clear this up succinctly.

Q 26- Are these privacy provisions law now or will certain rules be published before CEs are expected to comply?

A –The rules will be published in 90 -180 days, then after a comment period and possible fine tuning, they will be made into law.

Q 27- Regarding privacy, can information be shared within a secured Health System sponsored Health Information Exchange as the default approach, i.e., patients would need to opt out of the exchange?

A – The Office of the National Coordinator has been tasked with examining privacy issues in Health Exchanges and RHIOs, until then clarity is lacking.

Q 28- Are the participants in a RHIO (or health information exchange) considered appropriate "requestors" of PHI and therefore covered under the privacy provisions of the bill?

A - Same response as #27.

Standards

Q 29- Do we anticipate current interoperability standards changing?

A – Yes, over time, just like most other standards as more can be normalized.

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Certification

Q 30- Is there any discussion on Security standards/certification?

A- *There are security provisions in the certification criteria.*

Stark

Q 31- What is the interplay between Stark and these incentives - i.e., can a provider "double-dip" and receive a subsidized EMR from a hospital and be eligible for \$40 - \$64K in Medicare/Medicaid incentives?

A. *Most likely, at least for Medicare Incentives. Medicaid incentives will be capped based upon actual dollars spent by the physician for the EHR system for the year.*

National Leadership

Q 32- Who makes up the National e-Health Collaborative?

A – *The National eHealth Collaborative (formerly AHIC Successor, Inc.) is a public-private partnership founded in 2008 to build on the accomplishments of the American Health Information Community (AHIC), consisting of 20 individual stakeholders representing vendors, providers and HIT experts.*

Q 33- What is the process for ONC dispersal of money to the States?

A – *HHS will issue regulatory guidance spelling out this process.*

National Patient ID

Q 34- Does the ARRA provide for a National Patient ID to assist with the interoperability across the nation to be used regardless of the patient's healthcare provider?

A – *No*

Critical Access Hospitals

Q 35- For CAHs, will reimbursement include all year's expenditures, even future?

A - *Yes*

Skilled Nursing Facility

Q 36– Are hospitals eligible to receive funding for a hospital-based SNF EMR?

A – *The Medicare incentives do not cover SNFs.*

Maryland

Q 37- Given that Maryland is the only remaining Medicare waiver state, is there any information on how these provisions might be applied to Maryland hospitals?

A - *The Maryland Health Care Commission and/or the Health Services Cost Review Commission are likely to play an intermediary role in the provisions of the ARRA. Those roles are yet to be defined.*