The Federal Landscape Relative to Critical Access Hospitals and Health Information Technology

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Presentation Overview

- Review of ARRA
- Medicare Provisions
- Meaningful User
- Medicaid Provisions
- HIT in ARRA

The Office of Rural Health Policy and CAHs

- The Voice within HHS
  - Regulation review; policy development
- A Resource for CAHs
  - Flex Program
  - Small Hospital Improvement Program
  - Research on CAHs
  - Technical Assistance for CAHs

Office of Rural Health Policy

- FLEX Critical Access Hospitals Health Information Technology Network
- State Offices of Rural Health
- Rural Hospital Flexibility
- Rural Health Outreach
- Network Development
- Network Development Planning
- Small Rural Hospital Improvement
- Small Health Care Provider Quality Improvement

HRSA/Office of Health Information Technology

- Division of HIT State and Community Assistance offers the following grant opportunities in FY 2009
  - EHR Implementation for Health Center Controlled Networks Grant
  - HIT Implementation for Health Center Controlled Networks Grant
- Office for the Advancement of Telehealth grant opportunities in FY 2009
  - Telehealth Network Grant Program
  - Licensure Portability Grant Program
  - Telehealth Resource Center Grant Program

What is Rural?

"This method uses RUCAs 4-10 to identify small towns and rural areas within large metropolitan counties. In addition, census tracts within metropolitan areas with RUCA codes 2 and 3 that are larger than 400 square miles and have population density of less than 30 people per square mile are also considered rural."

http://www.rupri.org/Forms/RuralDefinitionsBrief.pdf

What Funds Are Out There?

- Funds available from a number of Agencies
  - HRSA, AHRQ, CMS, NTIA, FCC, NIST
- ARRA has provided for funds to be distributed through above agencies and ONC
- Nothing is static

Summary of ARRA HIT Funding

- Total $19.2 Billion for HIT
  - $2 Billion for ONC
  - $17.2 Billion for incentives through Medicare and Medicaid Reimbursement systems
- Codifies ONC, HIT Standards Committee, HIT Policy
- Provides grant and loan programs to assist providers and consumers in adopting HIT
- Privacy and Security provisions in HIPAA for electronic health info

Summary of ARRA HIT Funding (CONT)

- $4.7 Billion for Broadband Technology (NTIA)
- $2.5 Billion for USDA Distance Learning, Telemedicine, Broadband Program
- $500 million to SSA
- $85 million for IHS
- $50 million for VA

The American Reinvestment and Recovery Act (ARRA)

- Title VI- BROADBAND TECHNOLOGYOPPORTUNITIES PROGRAM
- TITLE IV—MEDICARE AND MEDICAIDHEALTH INFORMATION TECHNOLOGY;MISCELLANEOUS MEDICAREPROVISIONS
- TITLE XIII—HEALTH INFORMATION TECHNOLOGY

Title VI- BROADBAND TECHNOLOGYOPPORTUNITIES PROGRAM

- $4.7 Billion for Broadband Technology Opportunities Program: grants to States and other entities for acquiring equipment and other technologies related to providing broadband service infrastructure
- $2.5 Billion for broadband loans and loan guarantees. Recipients of these funds may not receive funds under the other program described above

Title VI- BROADBAND TECHNOLOGYOPPORTUNITIES PROGRAM

The purposes of the program are to—

(1) provide access to broadband service to consumers residing in unserved areas of the United States;

(2) provide improved access to broadband service to consumers residing in underserved areas of the United States;

(3) provide broadband education, awareness, training, access, equipment, and support to schools, libraries, medical and healthcare providers, community colleges and other institutions of higher education, and other community support organizations

- Facilitate Underserved Population Use
- Job Creation

(4) improve access to, and use of, broadband service by public safety agencies

Title VI- BROADBAND TECHNOLOGYOPPORTUNITIES PROGRAM

- Ensure that all funds are awarded by FY 2010
- Projects are to be completed within 2 years of award
- Eligible entities:
  - States (or political subdivision)
  - Nonprofits
  - Any other entity ruled by the Assistant Secretary of Commerce as acting in the public interest (broadband providers or infrastructure providers included)

2009 RURAL UTILITIES SERVICE BROADBAND INVESTMENT PROGRAM

- ARRA requires that funds be obligated by September 30, 2010
- RUS will offer grants, direct loans and loan/grant combo.
- Funds will be awarded on a competitive basis
- Fund projects that will support rural economic development and job creation beyond the immediate construction and operations of the broadband facilities
- 75% of the investment serves rural areas
- Implement in concert with NTIA and FCC
- http://www.usda.gov/RUS/TELECOM

Why is this relevant?

TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY PROVISIONS

- Medicare Incentives both Provider and Hospital Based
- Medicaid Incentives to Providers, RHCs, FQHCs, and Hospitals
- Based on "Meaningful HIT Adoption"
- The Law established maximum annual incentive amounts and include Medicare penalties for failing to me meaningfully adopt EHRs
- Three broad criteria:1) Meaningful use of EHR, 2) Information Exchange, and 3) reporting on measures using EHR

Medicare Incentives- Physicians

- Definition of Eligible Professional means a physician as defined in Section 1861 (r) of the Social Security Act:
  - Doctor of Medicine or Osteopathy
  - Doctor of Dental Surgery or of Dental Medicine
  - Doctor of Podiatric Medicine
  - Doctor of Optometry
  - Chiropractor
- Incentive value to be 75% of allowed Medicare charges for professional services for a payment year with yearly maximums

Medicare Incentives- Physicians

- 75% of allowed Medicare Charges for professional services a payment year
  - e.g. 2011 = $18K, 2012 = $12K, 2013 = $8K, 2014 = $4K, 2015 = $2k… for 5 years
  - Maximum incentive of $44K
  - only applicable for 2011-12, and is reduced starting 2013, all payments end in 2016
  - Incentive to adopt incurs a 1% reduction starting in 2015, and reduces 1% each year until 2018
  - In 2018 if its determined that less than 75% of eligible professionals are Meaningful Users, a reduction of no more than 5% can be assessed by the Secretary
  - If providing service in a HPSA, incentive can be bumped 10%

Medicare Incentives- Physicians

- Paid as a lump sum or in periodic payments determinant on the Secretary's Decision
- Hospital based providers are not eligible
- Secretary to establish rules for payments for professionals working in more than one practice as payments will not be duplicative

Medicare Incentives- PPS Hospitals

- Those that are meaningful users by 2013 are eligible for full 4 years of incentive payments
- Penalties for non-users starting in 2015
- Early adopters rewarded, since $s are paid whether you implemented 5 years ago or any time prior to 2013

Medicare Incentives- PPS Hospitals

Incentive payment per PPS Hospital for EHR Meaningful Use Adoption:

$2M Base + Discharge Payment

x

Medicare Share

Medicare Incentives- PPS Hospitals

Discharge Payment

- 1st – 1,149th discharge = $0/discharge
- 1,150th – 23,000th discharge = $200/discharge
- 23,001st discharge or more = $0/discharge

Medicare Share

Estimated # of inpatient-bed days with payment under Part A **+** Estimated # of inpatient-bed days for those enrolled with Medicare Advantage Part C

÷

Estimated total # inpatient days **x** Percentage of an eligible hospital's total charges that are not charity care

Medicare Incentives- PPS Hospitals

What does the formula mean?

- Year 1 of adoption = 1 x (formula)
- Year 2 of adoption = ¾ x (formula)
- Year 3 of adoption = ½ x (formula)
- Year 4 of adoption = ¼ x (formula)
- Year 5 of adoption = 0 x (formula) = no more incentive

- Starting in 2014 the transition factor is reduced and if Meaningful Use Occurs after 2015 then the incentive is lost

Medicare Incentives- CAHs

- CAHs that are meaningful users by 2011 are eligible for 4 years of enhanced Medicare payments (20% over Medicare Share with charity adjustment) with immediate full depreciation of certified EHR costs, including undepreciated costs from previous years.
- Penalties for non-users starting in 2015 (2015 .33% reduction in Medicare reimbursement increases to 1% reduction in 2017)
- Early adopters are not rewarded, since most of their investments have already been made and may be fully depreciated

Medicare Incentives- CAHs

- CAH enhanced Medicare payment formula ("formula"):

Total EHR Costs
X
(Medicare Share + 20%)

Medicare Incentives- CAHs

Medicare Share

(Estimated # of inpatient-bed days with payment under Part A **+** Estimated # of inpatient-bed days for those enrolled with Medicare Advantage Part C)

÷

(Estimated total # inpatient days **x** Percentage of an eligible hospital's total charges that are not charity care)

Medicare Incentives- CAHs

- Medicare formula above is valid through 2014
- If Meaningful EHR User status is attained after 2014 then no incentives are paid
- In addition to loss of incentives, starting in 2015 a .33% reduction in Medicare Reimbursement occurs, then .66% in 2016, topping out at 1% in 2017

Medicare Incentives Applied- CAHs

	Item	Value
I.	Est. Avg. Total "Eligible Certified EHR" Capital Cost per "Meaningful" CAH	$1,500,000
II.	Est. of Undepreciated Costs When CAH becomes "Meaningful" (80% of Line I)	$1,200,000
III.	Est. Avg. Medicare "Incentive" Share (Inpatient & Charity Stimulus Formula)	65%
IV.	Estimated Accelerated Depreciation II x III	$780,000
V.	Incentive Add-on	20%
VI.	Value of 20% Add-on (II x V)	$240,000
VII.	Est. Accelerated Depreciation + 20% Add-on (Total IV+V)	$1,020,000
VIII.	Est. Medicare Share Based on Traditional Allocation Cost Report	45%
IX.	Est. Traditional Medicare Cost Reimbursement Would Have Received (II x VIII)	$540,000
X.	**Est. Net Incentive Typical Eligible Hospital (VII-IX)**	**$480,000**

- This would be done through Interim Payments

What is Meaningful EHR User?

Hospitals

- 10% of all orders (any type) directly entered by authorizing provider (e.g., MD, DO, RN, PA, NP) through CPOE
  - Electronic interfaces to receiving entities are not required in 2011
- The HIT Policy Committee recommends that incentives be paid according to an "adoption year" timeframe rather than a calendar year timeframe
  - Qualifying for the first-year incentive payment would be assessed using the "2011 Measures.
- Use of CCHIT certified vendors (though language says certified)
- Participation in Information Exchange
- Quality reporting participation

Improve Quality, Safety, Efficiency, and Reduce Health Disparities (Hospitals)--2011

- 10% of all orders (any type) directly entered by authorizing provider (e.g., MD, DO, RN, PA, NP) through CPOE
- Implement drug-drug, drug-allergy, drug-formulary checks
- Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED
- Maintain active medication list
- Maintain active medication allergy list
- Record demographics:
- Record advance directives
- Record vital signs:
- Calculate and display:
- Record smoking status
- Incorporate lab-test results into EHR as structured data
- Generate lists of patients by specific conditions
- Report hospital quality measures to CMS
- Implement one clinical decision rule related to a high priority hospital condition
- Check insurance eligibility electronically from public and private payers, where possible
- Submit claims electronically to public and private payers.

Engage patients and families and Improvement of Care Coordination/HIPAA (Hospitals)-2011

Patients

- Provide patients with an electronic copy of their health information (including lab results, problem list, medication lists, allergies, discharge summary, procedures)[upon request]
- Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request
- Provide access to patient-specific education resources

Care Coordination

- Capability to exchange key clinical information (e.g., discharge summary, procedures, problem list, medication list, allergies, test results), among providers of care and patient authorized entities electronically
- Perform medication reconciliation at relevant encounters and each transition of care
- Capability to submit electronic data to immunization registries and actual submission where required and accepted.
- Capability to provide electronic submission of reportable lab results to public health agencies and actual submission where it can be received.
- Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice
- Compliance with HIPAA Privacy and Security Rule
- Compliance with fair data sharing practices set forth in the Nationwide Privacy and Security Framework

What is Meaningful EHR User?

- Physician practices
  - Implement CCHIT certified physician practice EMR (though language says certified)
  - Participation in Information Exchange
  - Use CPOE for all orders
    - Electronic interfaces to receiving entities are not required in 2011
  - Quality reporting participation
  - E-prescribing

HIMSS EMR Adoption Model

Stage	Cumulative Capabilities
0	Laboratory, Radiology & Pharmacy Not Installed
1	Laboratory, Radiology & Pharmacy All Installed
2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support System (CDSS), may have Document Imaging
3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology
4	Computerized Physician Order Entry, CDSS (clinical protocols)
5	Closed loop medication administration
6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS
7	Medical record fully electronic; ability to contribute Continuity of Care Document as byproduct of EMR; Data warehousing in use

EMR Adoption Model[SM]

		Urban	Rural
Stage 7	Medical record fully electronic; HCO able to contribute CCD as byproduct of EMR; Data warehousing in use	0.4%	0.0%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	1.1%	0.0%
Stage 5	Closed loop medication administration	4.4%	1.1%
Stage 4	CPOE, CDSS (clinical protocols)	3.5%	0.8%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	43.7%	17.1%
Stage 2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support, may have Document Imaging	31.3%	34.2%
Stage 1	Ancillaries – Lab, Rad, Pharmacy – All Installed	7.8%	12.6%
Stage 0	All Three Ancillaries Not Installed	7.9%	34.2%

Data from HIMSS Analytics[TM] Database N = 3,867 / 1,303

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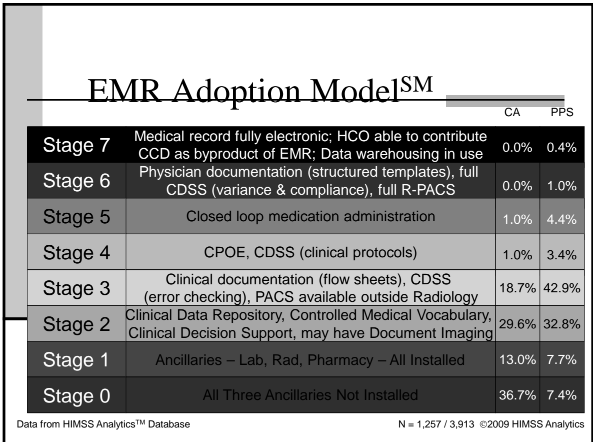

EMR Adoption Model[SM]

		CA	PPS
Stage 7	Medical record fully electronic; HCO able to contribute CCD as byproduct of EMR; Data warehousing in use	0.0%	0.4%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	0.0%	1.0%
Stage 5	Closed loop medication administration	1.0%	4.4%
Stage 4	CPOE, CDSS (clinical protocols)	1.0%	3.4%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	18.7%	42.9%
Stage 2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support, may have Document Imaging	29.6%	32.8%
Stage 1	Ancillaries – Lab, Rad, Pharmacy – All Installed	13.0%	7.7%
Stage 0	All Three Ancillaries Not Installed	36.7%	7.4%

Data from HIMSS Analytics[TM] Database N = 1,257 / 3,913

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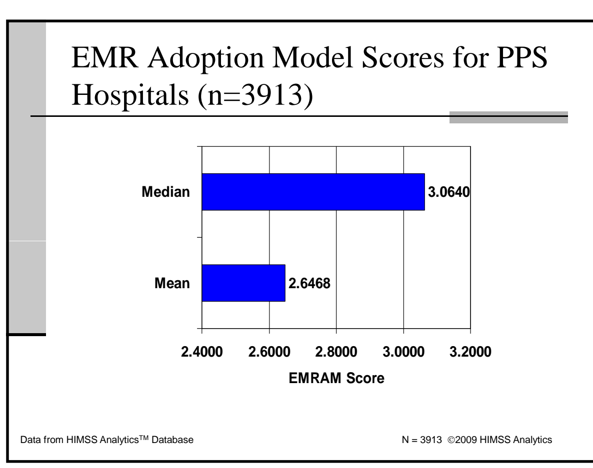
EMR Adoption Model Scores for PPS Hospitals (n=3913)



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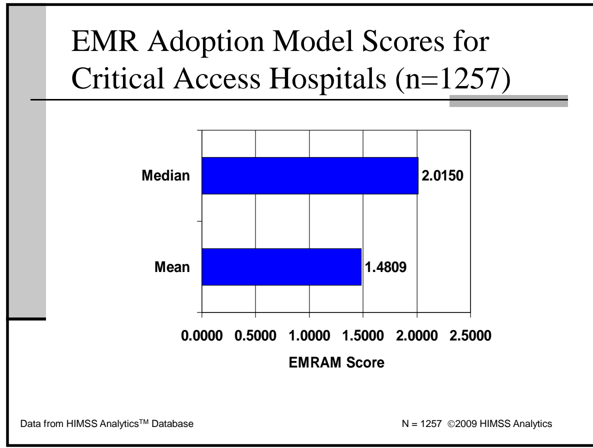
EMR Adoption Model Scores for Critical Access Hospitals (n=1257)



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How Does This Relate To CAHs?

- CAHs must have plan to reach "meaningful EHR user" designation before 2015 penalties kick in
- CAHs can enhance bonus incentive value by reaching designation by 2011
- Issue of need for capital financing left unaddressed
- Maximizing incentive bonus will involve strategy to leave as much "Certified EHR" investments undepreciated at time of reaching meaningful user designation
- To earn incentive CAHs will need to move quicker than PPS hospitals, even though they are farther behind
- Definition of "Certified EHR" will ultimately determine the value of the incentive

Certified EHR?

- Current certification programs cover only a fraction of the systems that make up an EHR
- Currently there is only one certifying body (CCHIT) but an opportunity is there for additional certification entities
- PACS, hardware, network infrastructure and many other aspects of EHR do not have certification programs

Now Back to Title IV…Medicaid Incentives

Medicaid Incentives- Providers

- Eligible Professionals are eligible for either Medicare or Medicaid Incentives – NOT BOTH
- Eligible Professional cannot be Hospital based and must have a patient load of 30% Medicaid
  - Payments cover up to 85% of net allowable costs to adopt and operate EHR Technology
  - Allowable costs for the first year are to be the average costs expended for the implementation or upgrade of an EHR system to not exceed $25 K and cannot occur after 2016
  - Subsequent years are to be calculated at 85% 0f 10K to not exceed 2016

Medicaid Incentives- Providers

- If provider is a Pediatrician, then patient volume must be 20% Medicaid and the incentives will be taken at 2/3 the rate
- If eligible provider practices at a FQHC or RHC then patient volume must be 30% “needy” Individuals
  - Medicaid, sliding fee, uncompensated care, or receiving assistance under Title XIX

Medicaid Incentives- Hospitals

Eligible Hospitals

- All Children's Hospitals, Acute Care Hospitals (including CAHs) with at least 10% Medicaid Patient Volume

(EHR Cost + Medicaid Share) x 50% for one year period

or

(EHR Cost + Medicaid Share) x 90% for 2 year period

- Hospital EHR cost defined as the sum of 4 years of payment using:

($2M Base + Discharge Payment x Medicaid Share)

Medicaid Incentives- Hospitals

- Medicaid Share calculated in same methods as Medicare Share but for Medicaid inpatient days and including Medicaid managed care plan
- Payment schedule to use the following transition factor for the 4 years of Hospital EHR cost:
  - Year 1 of adoption = 1 x (EHR cost)
  - Year 2 of adoption = ¾ x (EHR cost)
  - Year 3 of adoption = ½ x (EHR cost)
  - Year 4 of adoption = ¼ x (EHR cost)
- No payments beyond 2016 unless hospital received payment in the previous year
- Payments cannot exceed 6 years

Medicaid Incentives- Hospitals

Example:

- If EHR Cost = $5,000,000 and Medicaid Share = 15%

	Overall Hospital EHR Amount
Year 1 Transition Factor = 1	1 x $5,000,000 = $5,000,000
Year 2 Transition Factor = ¾	¾ x $5,000,000 = $3,750,000
Year 3 Transition Factor = ½	½ x $5,000,000 = $2,500,000
Year 4 Transition Factor = ¼	¼ x $5,000,000 = $1,250,000
Total 4 Year Sum $	**12,500,000**

Aggregated payment maximum = Total 4 Year Sum x Medicaid Share **= $1,875,000**

50% of aggregated payment maximum could be received in one year

Or

90% could be received in a two-year period

- 10% administrative fee for State match, including tracking of meaningful use, conducting oversight, and pursuing initiatives to encourage adoption

TITLE XIII—HEALTH INFORMATION TECHNOLOGY

- ARRA provides $2,000,000,000 to the Office of the National Coordinator to carry out Title XIII until the funds are expended
  - Title XIII – Health Information Technology for Economic and Clinical Health Act (HITECH) – Inserted
- ARRA is required to direct $300,000,000 of the $2,000,000,000 to support regional or sub-national health information exchanges
- Four sections impact how rural will operate: Sections 3011, 3012, 3013, and 3014*

Title XIII (Cont)

Four main focus areas:

- Public Health Information Exchange
- Health Professions
- Health Information Exchange
- Regional Extensions Centers

Section 3011: IMMEDIATE FUNDING TO STRENGTHEN THE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE

(1) Health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges

(2) Development and adoption of appropriate certified electronic health records for categories of health care providers not eligible for support under title XVIII or XIX of the Social Security Act

(3) Training on and dissemination of information on best practices to integrate health information technology

(4) Infrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine

(5) Promotion of the interoperability of clinical data repositories or registries

(6) Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information

(7) Improvement and expansion of the use of health information technology by public health departments

SEC. 3012: HEALTH INFORMATION TECHNOLOGY IMPLEMENTATION ASSISTANCE

1. HEALTH INFORMATION TECHNOLOGY EXTENSION PROGRAM
   - To assist health care providers to adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information
2. HEALTH INFORMATION TECHNOLOGY RESEARCH CENTER
   - To provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize health information technology
3. HEALTH INFORMATION TECHNOLOGY REGIONAL EXTENSION CENTERS
   - creation and support of regional centers to provide technical assistance and disseminate best practices and other information learned from the Center to support and accelerate efforts to adopt, implement, and effectively utilize health information technology

Objectives and Priorities of HIT Regional Extension Center as identified in ARRA

Objective of the regional centers is to enhance and promote the adoption of HIT through:

- Assistance with the implementation, effective use, upgrading, and ongoing maintenance of HIT
- Active dissemination of best practices and research on the implementation, effective use, etc.
- Participation, to the extent practicable, in health information exchanges
- Integration of HIT into the initial and ongoing training of health professionals

Regional centers shall aim to provide assistance to all providers, but shall prioritize direct assistance to the following:

- Public or not-for-profit hospitals or critical access hospitals
- Federally qualified health centers
- Entities in rural areas and other areas that serve uninsured, underinsured, and medically underserved individuals (regardless of whether rural urban)
- Individual or small group practices that are primarily focused on primary care

SEC. 3013: STATE GRANTS TO PROMOTE HEALTH INFORMATION TECHNOLOGY

- Planning Grants- To be awarded to States or State Designated Entities to expand the exchange of electronic health information, technical assistance (public stakeholders), promotion of HIT in Underserved Populations
- Implementation Grants- To be awarded to States or State Designated Entities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications
- There is a required match by States:

Required Matching

Year	State Dollar	Federal Dollar
2011	At least $1	$10
2012	At least $1	$7
2013	At least $1	$3

Why State Level Awards?

State-level HIE governance functions:

- Align HIE policies and practices with the state's legislative and regulatory policy environments
- Serve statewide goals for health care quality, cost-effectiveness and coverage/access
- Address statewide barriers to HIE
- Balance the rights and needs of all state residents
- Bridge issues/needs between nationwide, state and local HIE

SEC. 3014. COMPETITIVE GRANTS FOR THE DEVELOPMENT OF LOAN PROGRAMS TO FACILITATE THE WIDESPREAD ADOPTION OF CERTIFIED EHR TECHNOLOGY***

The National Coordinator may award competitive grants to eligible entities for the establishment of programs for loans to health care providers

(1) facilitate the purchase of certified EHR technology;
(2) enhance the utilization of certified EHR technology (which may include costs associated with upgrading health information technology so that it meets criteria necessary to be a certified EHR technology);
(3) train personnel in the use of such technology; or
(4) improve the secure electronic exchange of health information.

***Currently not part of the ONC plan

So what does Title XIII mean to Rural and CAHs?

- ARRA money is going to States or State Designates
- The money will go towards a unified HIE
- The time to plan is now, not later
- The Secretary of HHS will provide guidance

Other Challenges CAHs Will Face

- Workforce Issues: many CAHs will be challenged by limited HIT expertise
- This is transformative culture change, not simply putting in new systems
- Physician involvement and acceptance can be significant challenge
- Ongoing HIT costs will dramatically increase with EHR implementation

Questions?

THANKS!

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