

American Recovery and Reinvestment Act of 2009 (ARRA)

January 21, 2010



American Recovery & Reinvestment Act of 2009

- Enacted February 17, 2009
- \$787 billion to “jumpstart” economy
- Significant focus/dollars on Health Information Technology (HITECH)

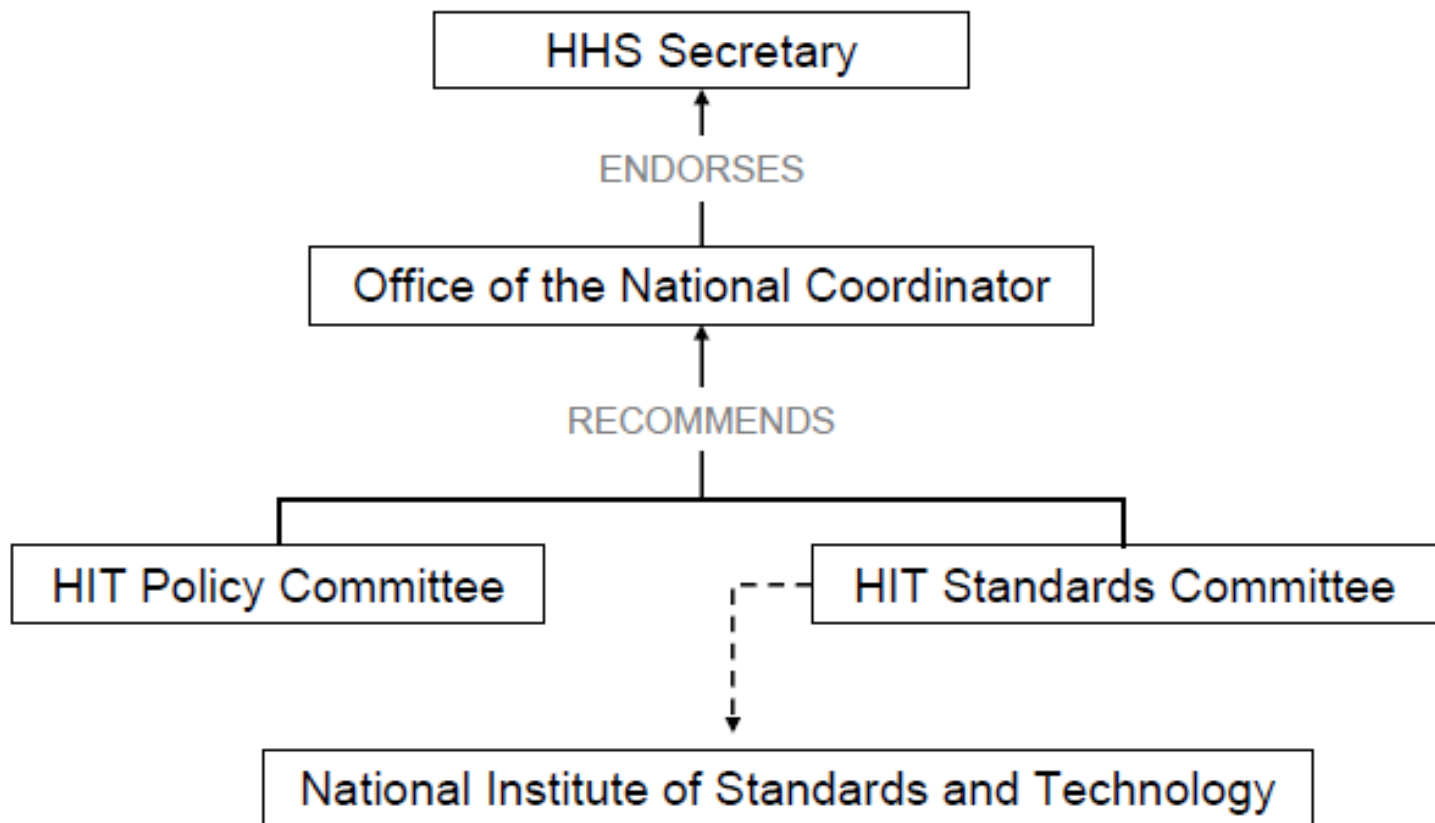
HITECH Act Goals:

- Improve care coordination, efficiency, quality through IT
- Patient-centric focus
- Create secure, interoperable nationwide health information network
- Information follows patient without artificial barriers
- Create secure information exchange across boundaries
- Funding opportunities support these goals

HITECH Creates:

- **Office of the National Coordinator (ONC)** for HIT
- **HIT Policy Committee** – charged with making recommendations to National Coordinator on policy framework for IT development, adoption of nationwide health information exchange; standards for exchange of patient info; multiple workgroups established
- **HIT Standards Committee** – charged with making recommendations on to ONC on standards, implementation specifics, certification; multiple workgroups established

Policy Development Under HITECH



Significant Funding Opportunities:

- Hospital/Eligible Professional Incentive Payments
- HIT Regional Extension Center
- Beacon Community Cooperative Agreements
- State Level Health Information Exchange Cooperative Agreement

HIT Incentive Payments:

- Available to hospitals/eligible professionals
- Medicare and Medicaid
- Health care providers must be “meaningful users” of “certified” electronic health records in order to receive incentive payments/not receive penalties.
- Incentives available 2011-2017

HIT Regional Extension Centers:

- Wisconsin's Grant Application is WHITEC – *Wisconsin Regional Extension Center*
(<http://www.metastar.com/web/HealthCareSolutions/WHITEC/tabid/386/Default.aspx>)
- Lead applicant is MetaStar; Grant a collaboration between MetaStar, WMS, WHA, RWHC, WPHA, DHS
- Goal of RECs are to help providers reach “meaningful use”
- RECs to focus on primary health care providers practicing in setting of less than 10 providers
- \$600 million available; ave. award \$10 million over 2 years

Beacon Community Cooperative Agreements

- Milwaukee Health Care Partnership's application
 - Wisconsin Beacon Application
 - Collaborative grant with WHA, DHS, WHIE, WCHQ...
 - Leverage ED Care Coordination initiative
 - Partnership's letter of intent submitted Jan. 8
 - Final application due Feb. 1
- Beacon funds designed
 - build/strengthen existing HIT in communities
 - goal of demonstrating meaningful use of health IT
 - measurable improvements in quality, efficiency, safety, population health in community
- \$220 million available; roughly 15 grants awarded; floor of \$10 million, ceiling of \$20 million over 4 years

State-Level HIE:

- WIRED for Health is Wisconsin State-Level HIE
- All 50 state governments were awarded share of \$564 million to plan and/or implement Health Information Exchange (HIE) in the state.
- Wisconsin's share is \$9.4m
- Four-year cooperative agreement begins Jan. 2010.

State-Level Health Information Exchange

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Planning for State-Level HIE

- \$9.44 million planning & implementation grant
- Creation of “State Designated Entity” (SDE) to address governance, finance, policy, infrastructure, business operations.
- Proposed temporary board would have significant overlap with WHIO board (multistakeholder, public-private). (WHIO board meets today.)
- If Governor approves, bodes well for WHIO Board becoming the official board in 6 months.

WHA Engagement

- Represented on eHealth Board; likely to be part of temporary and permanent WIRED for Health Board.
- Principles:
 - Participation/funding to be voluntary (if it SLHIE delivers value, no mandate needed).
 - SLHIE should facilitate exchange of information, not create new barriers (unwieldy privacy requirements could reduce overall value).
 - Enabling legislation, if any, should be minimum necessary to move forward. Other details left to governance structure with robust private-sector representation.

Next Steps

- Possible legislation before session ends
- “What is it?” Initial planning and implementation recommendations expected in June 2010
- Transition to permanent board

Questions



Implementation of the ARRA HIT Incentive Program:

Meaningful Use Proposed Rule
and
EHR Certification Interim Final Rule

January 21, 2010

HITECH Act:

Health care providers must be "meaningful users" of "certified" electronic health records in order to receive HIT incentive payments/not receive penalties.

Rules are required to define "meaningful use" and "certified EHR."

Process to Develop Incentive Payment Rules

- Step 1: HIT Policy Committee and HIT Standards Committee provide recommendations to the National Coordinator for Health Information. (August 2009)
- Step 2: National Coordinator provides recommendations to HHS Secretary for rulemaking. (Late 2009)
- Step 3: Publication of meaningful use proposed rule and definition of EHR certification interim final rule with 60 day comment period. (Released Dec. 30, 2009; officially published Jan. 13, 2010)

Process to Develop Incentive Payment Rules

- Step 4: Publication of rule setting the process for EHR certification with 60 day comment period. (expected late January 2010)
- Step 5: Comment period on meaningful use and definition of EHR certification ends. (March 15, 2010)
- Step 6: Publication of meaningful use final rules. (expected April 2010)
- Step 7: First date that EHRs may be certified. (expected late summer 2010)

Process to Develop Incentive Payment Rules

- Step 8: First day that hospitals may begin to show meaningful use of a certified EHR to receive 2011 HIT incentives (October 1, 2010)
- Step 9: Last day that hospitals may begin to show meaningful use of a certified EHR to receive 2011 HIT incentives (~July 1, 2011)
- Ongoing steps: Development and publication of additional meaningful use standards for later stage HIT incentive payments between 2013 and 2017 and penalties after 2015. (expected in 2011/2012)

Meaningful Use Proposed Rule

- Notice of Proposed Rulemaking released on December 30, 2009. Published on January 13, 2010.
- It contains:
 - Proposed regulatory language defining “meaningful use.”
 - Proposed regulatory language that implements the Medicare and Medicaid EHR incentive programs (payment amounts, eligibility for payments, etc.).
 - CMS’s detailed summaries of the proposed regulatory language.

EHR Certification Interim Final Rule

- Notice of Proposed Rulemaking released on December 30, 2009. Published on January 13, 2010.
- It contains:
 - Interim final regulatory language defining the standards for a “certified” EHR.
 - ONC’s detailed summaries of the regulatory language.

Highlights of the Rules

- Incentive payment methodology and eligibility
- Staged requirements
- Reporting period
- All or nothing achievement of MU
- CPOE is a required MU objective
- Medicaid meaningful use
- Quality measure submission
- Health information exchange (HIE)
- New measurement burdens
- Limited incentives for CAHs
- Hospital-based physicians ineligible
- Multi-campus hospitals
- No grandfathering of CCHIT certification

Payment Methodology and Eligibility

Medicare Incentive Payments for PPS Hospitals

- Up to four years of Medicare incentive payments.
- First possible payment would be FFY 2011, which begins on October 1, 2010.
- Last possible year a hospital may qualify for payment is FFY 2015, which begins on October 1, 2014.

Medicare Incentive Payments for PPS Hospitals

INCENTIVE PAYMENT = [\$2m + (\$200 X # of discharges between 1,150 & 23,000)] X **MEDICARE SHARE** X **TRANSITION FACTOR**

MEDICARE SHARE = Medicare Inpatient Bed Days ÷ {Total Inpatient Bed Days X [(Total Charges – Charity Care Charges) ÷ Total Charges]}

TRANSITION FACTOR:

	First Qualifying Year				
Payment Year	2011	2012	2013	2014	2015
2011	100%	-	-	-	-
2012	75%	100%	-	-	-
2013	50%	75%	100%	-	-
2014	25%	50%	75%	75%	-
2015	-	25%	50%	50%	50%
2016	-	-	25%	25%	25%

Medicare Penalties for PPS Hospitals

- Eligible PPS hospitals that do not qualify as meaningful users by FFY 2015 would not receive any incentive payments and would be subject to the following penalties:
 - FFY 2015: Market basket reduced by 25%
 - FFY 2016: Market basket reduced by 50%
 - FFY 2017 and thereafter: Market basket reduced by 75%

Payment Methodology and Eligibility

Medicare Incentive Payments for CAHs

- Up to four years of Medicare incentive payments.
- First possible payment would be FFY 2011, which begins on October 1, 2010.
- Last possible year a hospital may qualify for payment is FFY 2015, which begins on October 1, 2014.

Medicare Incentive Payments for CAHs

INCENTIVE PAYMENT = [reasonable depreciable cost of new EHR purchases or remaining un-depreciated portions of existing EHR assets] X
MEDICARE SHARE

MEDICARE SHARE = .20 + {Medicare Inpatient Bed Days ÷ {Total Inpatient Bed Days X [(Total Charges – Charity Care Charges) ÷ Total Charges]}}

However, the Medicare Share cannot exceed 1.00.

Medicare Penalties for CAHs

- Eligible CAHs that do not qualify as meaningful users by FFY 2015 would not receive any incentive payments and would be subject to reduced cost-based payments as follows:
 - FFY 2015: 100.66% of cost
 - FFY 2016: 100.33% of cost
 - FFY 2017 and thereafter: 100% of cost

Payment Methodology and Eligibility

Medicaid Incentive Payments for PPS Hospitals

- Federal government will provide 90% of the costs of administering a state's Medicaid HIT incentive program and 100% of the cost for incentive payments made to providers.
- The hospital must be:
 - A short term, acute care hospital with 10 percent of its inpatient volume attributable to Medicaid beneficiaries, or
 - A children's hospital.

Medicaid Incentive Payments for PPS Hospitals

- States are given some latitude regarding how many years of payments can be made and how those payments may be divided:
 - Total incentive payments to a qualifying hospital may not exceed a predetermined maximum;
 - The minimum number of years of payments is three and the maximum number is six;
 - The last year for a qualifying hospital to receive any MA incentive payment is 2016;
 - The incentive payment amount for any one year may not exceed 50% of the predetermined maximum;
 - The incentive payment amount for any two-year period may not exceed 90% of the predetermined maximum.

Medicaid Incentive Payments for PPS Hospitals

INCENTIVE PAYMENT = {Sum of 4 years of [\$2m + (\$200 X # of discharges between 1,150 & 23,000)] X TRANSITION FACTOR} X MEDICAID SHARE

MEDICAID SHARE = (Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Bed Days ÷ {Total Inpatient Bed Days X [(Estimated Total Charges – Charity Care Charges) ÷ Estimated Total Charges]})

TRANSITION FACTOR uses

Year 1 = 1

Year 2 = 0.75

Year 3 = 0.5

Year 4 = 0.25

Medicaid Incentive Payments for CAHs

- It appears that CAHs are not eligible for Medicaid incentive payments under the proposed rule.

Medicaid Penalties

- There are no Medicaid penalties for CAHs or PPS hospitals.

Staged Requirements

- CMS proposes making achievement of MU more difficult with time.

<i>First Payment Year:</i>	<i>Payment Year</i>				
	<i>2011</i>	<i>2012</i>	<i>2013</i>	<i>2014</i>	<i>2015</i>
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 1	Stage 3
2014				Stage 1	Stage 3
2015					Stage 3

- The proposed rule only provides MU objectives and measures for “Stage 1” meaningful use.
- Meaningful use for Stage 2 and 3 and years after 2015 are to be promulgated at later dates.

Staged Requirements

- Stage 1 focuses on:
 - Electronically capturing health information in a coded format,
 - Using that information to track key clinical outcomes,
 - Communicating that information for care coordination purposes,
 - Implementing some clinical decision support tools, and
 - Initiating the reporting of quality measures and public health information.
- For Stages 2 and 3, CMS proposes to require steep increases in the scope and complexity of EHR objectives.
- By 2015, all hospitals would need to meet the Stage 3 criteria to avoid Medicare payment penalties. Late adopters would face a steeper implementation curve than earlier adopters.

Reporting Period

- To receive incentive payments, eligible hospitals must show meaningful use of a certified EHR during a “reporting period.”
- In the first payment year, the reporting period is 90-days.
 - Thus, a hospital could earn the “Stage 1” payment by showing meaningful use as late as approximately July 1 of the payment year.
- In subsequent payment years, the reporting period is the full year.

All or Nothing Requirement

- All 23 distinct MU objectives and measures must be met to achieve meaningful use. (See Attachment 5)
- AHA:
 - Many hospitals meet most of the requirements, though very few meet all.
 - Based on a 2008 survey, less than 1% of the nation's hospitals would meet all 23 MU requirements.
 - Concerned that very few hospitals can meet all 23 in 2011, but most will not be able to comply until 2013.
- Are Wisconsin hospitals in a better or worse position than hospitals nationally?

CPOE is a Requirement for MU

Proposed Stage 1 Meaningful Use Criteria

Hospital Objective	Hospital Measure
18. Use computerized provider order entry (CPOE) for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP).	CPOE is used for at least 10 percent of all orders.
Eligible Professional Objective	EP Measure
Use computerized provider order entry (CPOE).	CPOE is used for at least 80 percent of all orders.

CPOE is a Requirement for MU

- Wisconsin hospitals' CIO concerns in June:
 - CPOE is a technology that all would like to implement in the future, it is a technology that relies on other EMR systems and is not at a maturity level that enables easy implementation and efficient use.
 - CPOE products have not yet been standardized, which leads to difficulties in implementation and use.
 - CPOE should be a long-term goal for 2015 or beyond.
- While Wisconsin hospitals are leaders in EMR implementation, (41% of Wisconsin hospitals surveyed have fully or partially implemented an EMR) only 7% of Wisconsin hospitals surveyed have fully implemented CPOE.

Medicaid Meaningful Use

- Some hospitals are also eligible for Medicaid incentive payments:
 - Children's hospitals
 - Short-term, inpatient acute care hospitals with at least 10 percent of its inpatient volume attributable to Medicaid beneficiaries.
- The Medicare MU standards are the minimum MU standards for the Medicaid incentive program. However, states may add additional objectives or modify existing objectives if the changes would further promote the use of EHRs and health care quality.
- In first year, eligible professionals and hospitals may receive the Medicaid incentive payment by attesting to having adopted, implement, or upgraded their certified EHR technology.

Quality Measures

Proposed Stage 1 Meaningful Use Criteria

Hospital Objective	Hospital Measure
19. Report hospital quality measures to CMS or, in the case of Medicaid eligible hospitals, the States.	Successfully report to CMS (or, in the case of Medicaid eligible hospitals, the States) clinical quality measures in the form and manner specified by CMS.

- Total of 35 hospital quality measures (see Attachment 5)
- Hospitals currently only report 9 of the measures to CMS
- Only 25 of the measures are endorsed by the NQF.
- Readmission rates are included.
- Yet to be determined measurement methodologies.

Quality Measures

- CMS is not currently able to electronically receive the quality data.
- For 2011 and 2012, providers to use an attestation process to submit summarized data, generated using certified EHR technology, on the required quality measures.
- Beginning in 2013, providers would be required to submit patient-level data, using an the EHR, for calculation of quality measures.

Health Information Exchange

Proposed Stage 1 Meaningful Use Criteria

Objective	Measure
22. Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, and diagnostic test results) among providers of care and patient-authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

- Thin record model?
- No requirement to actually exchange information for Stage 1 MU.

New Measurement Burdens

- AHA: Many of the MU measures require a denominator that is not currently or easily calculated for many hospitals.
- For example:
 - Measure 8: At least 50 percent of all clinical lab tests results ordered by the authorized provider of the hospital during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
 - Measure 18: CPOE is used for at least 10 percent of all orders.
- CMS estimates that the measurement burden for hospitals would only be 8 hours per year.

Limited Incentives for CAHs

- HITECH Act did not provide same Medicare incentive for CAHs and PPS hospitals.
 - Generally, CAHs only able to advance depreciation costs for achieving meaningful use.
- The proposed rule also appears to exclude CAHs from Medicaid incentive payments.
 - Definition of acute care hospital used by CMS appears to be the problem.

Hospital-based Providers are Ineligible

- “Hospital-based” providers are ineligible for eligible professional incentive payments...but they also are not subject to future penalties as an eligible professional.
- Rule’s definition of “hospital-based” –
 - The provider provides 90 percent or more of their services in a hospital setting (including all hospital inpatient, outpatient, and emergency department settings).
- Potentially very significant impact on IDNs that employ physicians practicing in an outpatient or "provider-based" clinic that qualifies as part of the hospital for billing purposes.
- AHA: e-Prescribing program may be an alternative model.

Multi-campus Hospitals

- The proposed rule defines a hospital by its provider number.
- This is significant because each hospital starts with a \$2m base figure in calculating the incentive payments.
- If a system uses a single provider number for multiple hospital campuses, it appears the system starts with a single \$2m base.
- But if a system uses a unique provider number for each hospital campus, the, each campus starts with its own \$2m base.

No Grandfathering of CCHIT Certification

- All EHRs must meet the new certification rule, regardless if the EHR has already been certified by CCHIT. ONC rejected idea of grandfathering CCHIT certified EHRs.
- Thus, all existing EHRs will need to be recertified.
- Problem – Certification process rules have yet to be developed. Not expecting certification process to begin until late summer. It is unlikely that certified products will be available by October 2010.
- AHA: Certification rules put all burden on the provider. It will be the hospital's responsibility to show that the EHR is certified.
- Can ONC de-certify an EHR product? If so, what are hospitals' options, especially after 2015?

Other Issues

- Objective 20: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, and procedures), upon request.
- Some of the requirements for achieving meaningful use are outside hospitals' control. Certification is an example.
- CMS estimates that it will disburse between \$14b and \$28b in Medicare HIT payments. This is lower than CBO's estimate of \$34b. Furthermore, according to AHA, CMS's estimates rely on likely overstated assumptions that providers will be able to meet the challenging meaningful use definition.

Questions and Group Discussion

