

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

Rural Health Resources Live -- A
video conference for you

May 14, 2009

Michael McNeely, MBA, MPH
Public Health Analyst
Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services



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

The American Reinvestment and Recovery Act (ARRA)

- **Title VI- BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM**
- **TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY; MISCELLANEOUS MEDICARE PROVISIONS**
- **TITLE XIII—HEALTH INFORMATION TECHNOLOGY**

Title VI- BROADBAND TECHNOLOGY OPPORTUNITIES 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 TECHNOLOGY OPPORTUNITIES 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 TECHNOLOGY OPPORTUNITIES 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)

**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”

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”):

$$\begin{array}{c} \text{Total EHR Costs} \\ \times \\ \text{(Medicare Share + 20\%)} \end{array}$$

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

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
 - A good measure would be to Reach Stage 4 of HIMSS EMR Adoption model
 - Use of CCHIT certified vendors (though language says certified)
 - Participation in Information Exchange
 - Quality reporting participation
 - Details to be developed

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

4th Quarter 2008 Adoption Rates (Data Provided by HIMSS)

Hospital Type	Median Adoption Rate Score
Academic/Teaching	3.2520
Non-Academic	2.1690
General Medical/Surgical	2.2820
Others	2.0450
Rural	1.0905
Urban	2.2820
IDS	2.2420
Independent Hospital	2.0935
Critical Access Hospital	1.0860

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 HER
- 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- 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 = $\frac{3}{4}$ x (EHR cost)
 - Year 3 of adoption = $\frac{1}{2}$ x (EHR cost)
 - Year 4 of adoption = $\frac{1}{4}$ 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%

	<u>Overall Hospital EHR Amount</u>
Year 1 Transition Factor = 1	1 x \$5,000,000 = \$5,000,000
Year 2 Transition Factor = $\frac{3}{4}$	$\frac{3}{4}$ x \$5,000,000 = \$3,750,000
Year 3 Transition Factor = $\frac{1}{2}$	$\frac{1}{2}$ x \$5,000,000 = \$2,500,000
Year 4 Transition Factor = $\frac{1}{4}$	$\frac{1}{4}$ 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
- Three sections impact how rural will operate: Sections 3011, 3012, 3013, and 3014

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

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:

Year	Required Matching	
	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.

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 increase with EHR implementation

Questions?

THANKS!

Michael McNeely, MBA, MPH
Public Health Analyst
Office of Rural Health Policy
Health Resources and Services Administration
U.S. Department of Health and Human Services
mmcneely@hrsa.gov