The American Recovery and Reinvestment Act (ARRA) of 2009: Health Information Technology (HIT)

Denise Webb and
Alice Page

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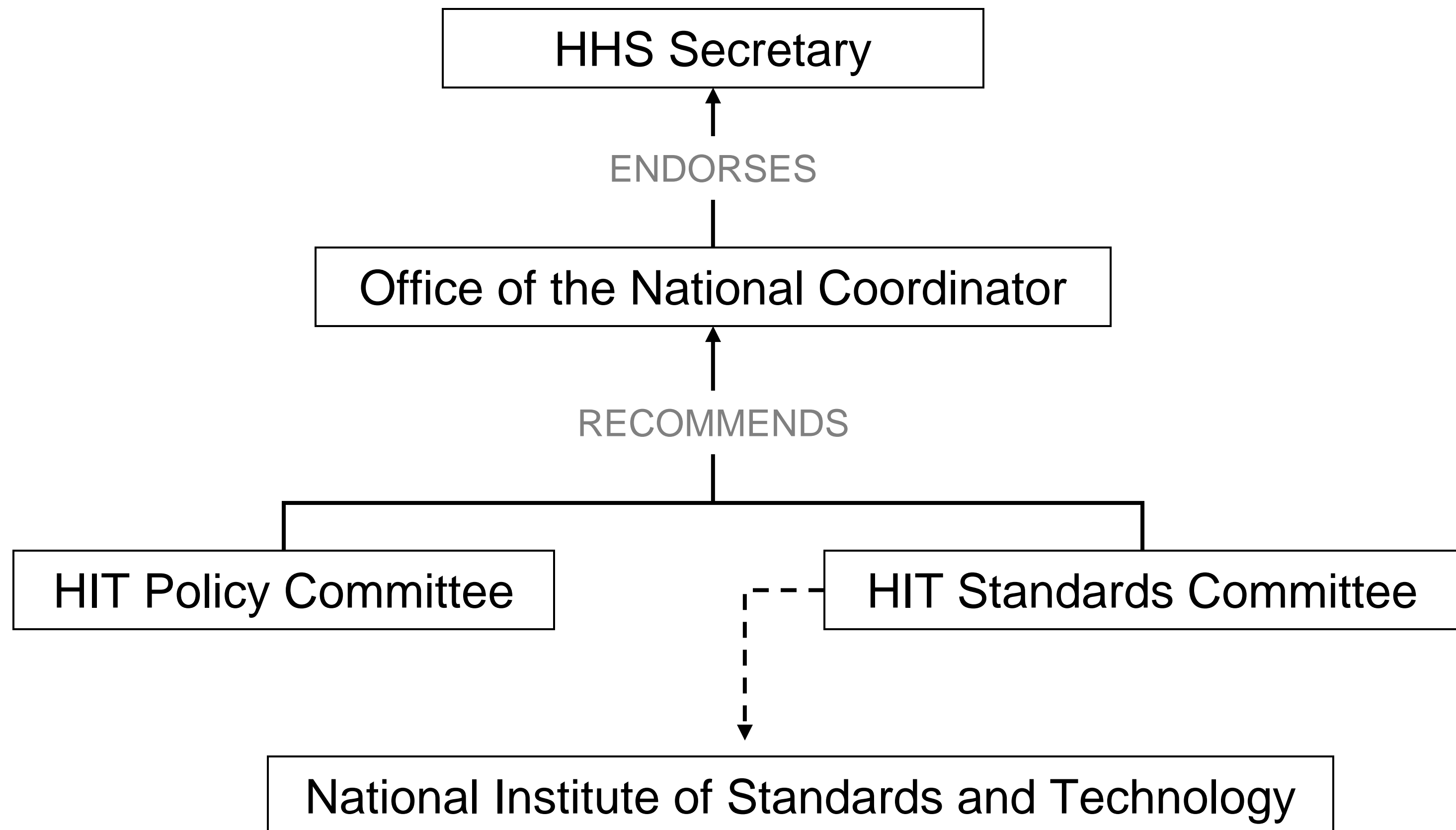
ARRA HIT for Economic and Clinical Health (HITECH) Provisions

- National HIT leadership, policies, and standards
- Widespread adoption and use of Electronic Health Record (EHR) technology by health care providers and hospitals
- Development of the nationwide health information exchange infrastructure
- Improved Privacy and Security

HIT Leadership

- Establishes the Office of the National Coordinator (ONC) for HIT. Responsible for
  - Endorsing HIT standards, implementation specifications, and certification criteria
  - Coordinating HIT policy
  - Updating, publishing, and maintaining the Federal Health IT Strategic Plan
  - Creating or recognizing a program or programs for the voluntary certification of health information technology
  - Appoint a Chief Privacy Officer

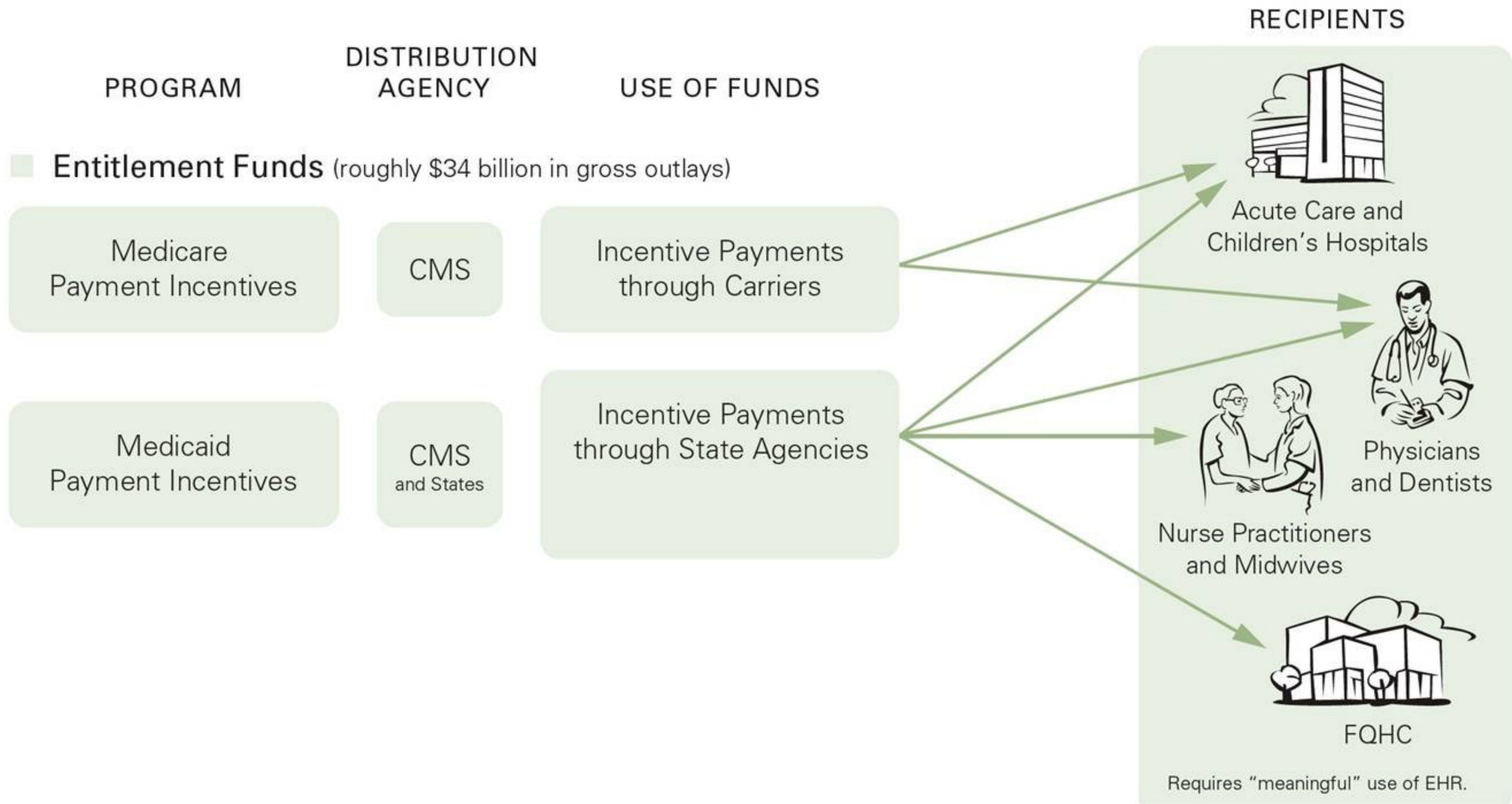
Federal HIT Policy and Standards Process



Allocation of Funds for HIT

- $36 billion total outlay for HIT over 6 years
  - ~$34 billion for Medicare and Medicaid incentive payments to providers
  - $2 billion for the Office of the National Coordinator for HIT (ONC)
- $85 million for HIT, including telehealth services within Indian Health Services
- $1.5 billion for health center construction, renovation, and HIT through the Health Resources and Services Administration
- $500 million for the Social Security Administration

Provider Incentives



Adapted from, An Unprecedented Opportunity, California Healthcare Foundation, 2009

Medicare Incentive Payment Provisions

Funding Mechanism	Entitlement
Funding Entity	Centers for Medicare and Medicaid Services (CMS)
Allocation Process	Reimbursement
Matching Funds Requirement	None
Timing	Begins in 2011, ends in 2016
Funds Flow Through	Medicare carriers
Eligible Recipients	- Hospitals that are “meaningful users” of EHRs - Physicians who are “meaningful users” of EHRs
Level of Federal Funding	CBO has estimated outlays for the combined Medicare/Medicaid incentives to be approximately $34 billion over the fiscal years 2009 through 2016. The CBO also estimates net savings to the federal health entitlement programs beginning in fiscal year 2016, but it is not clear what the savings estimates assume
Requirements for Funding	Physicians receiving Medicare payments must demonstrate (through self-reporting or claims reporting) “meaningful EHR use,” defined as: use of a certified EHR, including electronic prescribing, that’s “connected” to an HIE, and submission of clinical quality and other required measures. All criteria must be met and reconfirmed each payment year. The HHS secretary has discretion in allowing alternative means for meeting requirements and can make requirements more stringent over time

Adapted from, An Unprecedented Opportunity, California Healthcare Foundation, 2009

Medicare Incentive Payments for Physicians *

	Incentive Payments** for Meaningful Use of Certified EHR								
Adoption and Meaningful EHR Use in:	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**Total**
2011	$18K	$12K	$8K	$4K	$2K	$0K	$0K	$0K	$44K
2012		$18K	$12K	$8K	$4K	$2K	$0K	$0K	$44K
2013			$15K	$12K	$8K	$4K	$0K	$0K	$39K
2014				$12K	$8K	$4K	$0K	$0K	$24K
2015					$0K	$0K	$0K	$0K	$0K

	Penalties for EHR Reporting Period								
No meaningful EHR use	0%	0%	0%	0%	-1%	-2%	-3%	-3%**	

****Eligible professionals who predominately furnish services in an area designated as a health shortage area will receive an additional 10%**

*Non-hospital based

Medicare Incentive Payments for Hospitals—Formula

Initial Amount = (BA + DRA) * MS

MS = (MPAIPBD + MPCIPBD) / (TIPBD * (THC-CC/THC)

1. BA is Base Amount = $2 million
2. DRA is Discharge Related Amount for a 12-month period = $200 for each discharge from the 1,150th through the 23,000th
3. MS is the Medicare Share
4. MPAIPBD are the estimated Medicare Inpatient Bed Days attributable to a patient whom payment was made under Part A
5. MPCIPBD are the estimated Medicare Inpatient Bed Days attributable to a patient enrolled in Medicare Advantage under Part C
6. TIPBD are the estimated Total Inpatient Bed Days
7. THC are the estimated Total Hospital Charges during the 12 month period
8. CC are the charges attributable to Charity Care

Medicare Incentive Payments for Hospitals—WI Example

440-bed hospital in Madison (based on 2007 WHA hospital financial survey data)

Base Amount		$ 2,000,000
Discharge-Related Amount	*21,521 discharges*	$ 4,074,400
Total		$ 6,074,400
Total Hospital Charges		$ 134,703,000
Charity Care		$ 13,317,000
Difference		$ 121,386,000
Percentage paid care		90%
Medicare (A&C) Inpatient Bed Days		46,079
Total Inpatient Bed Days		94,628
Total Paid Inpatient Bed Days		85,165
Medicare Share		54%
Initial Amount		$ 3,280,176

	Year 1	Year 2	Year 3	Year 4	
Transition Factor	100%	75%	50%	25%	
Meaningful use in 2011	**2011**	**2012**	**2013**	**2014**	**Total**
Incentive payment	$ 3,280,176	$ 2,460,132	$ 1,640,088	$ 820,044	$ 8,200,440
Meaningful use in 2014	**2014**	**2015**	**2016**	**2017**	**Total**
Incentive payment	$ 2,460,132	$ 1,640,088	$ 820,044	$ -	$ 4,920,264

Medicaid Incentive Payment Provisions

Funding Mechanism	Entitlement
Funding Entity	CMS and the State
Allocation Process	Reimbursement
Matching Funds Requirement	10% state match on administrative expenses, including tracking of meaningful use, conducting oversight, and pursuing initiatives to encourage adoption
Timing	Begins in TBD, ends in 2021
Funds Flow Through	Wisconsin Department of Health Services
Eligible Recipients	• Physicians, dentists, nurse practitioners, nurse midwives, physicians assistances practicing in certain circumstances, who are not hospital based and have at least 30% of patient volume attributable to Medicaid beneficiaries • Pediatricians who are not hospital based and have at least 20% of patient volume attributable to Medicaid beneficiaries • Acute care hospitals with at least 10% of patient volume attributable to Medicaid • Children's hospitals • FQHC or rural clinics that have at least 30% of patient volume attributable to "needy individuals," including but not limited to Medicaid beneficiaries
Level of Federal Funding	CBO has estimated outlays for the combined Medicare/Medicaid incentives to be approximately $34 billion over the fiscal years 2009 through 2016. The CBO also estimates net savings to the federal health entitlement programs beginning in fiscal year 2016, but it is not clear what the savings estimates assume
Requirements for Funding	Demonstrated use of certified EHR technology connected in a way that provides health information exchange; compliance with reporting requirements

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Medicaid Incentive Payments for Eligible Professionals

Adoption Year	Incentive Payments for Adoption and Meaningful Use of Certified EHR											
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
2011	$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	$0	$0	$63,750
2012		$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	$0	$63,750
2013			$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$0	$63,750
2014				$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$0	$63,750
2015					$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$0	$63,750
2016						$21,250	$8,500	$8,500	$8,500	$8,500	$8,500	$63,750

Note: Pediatricians must have a Medicaid patient volume of 20% to be eligible and get 2/3 of the dollar amounts specified above unless their Medicaid patient volume is 30% or higher

Medicaid Incentive Payments for Hospitals—Formula

- Aggregate incentive payments can't exceed the Overall Hospital EHR Amount * Medicaid Share
  - Payments can't exceed 50% of this product in any year or 90% of this product in any 2-year period
- Overall Hospital EHR Amount = the total of the four payment year amounts using the Medicare hospital formula and a Medicare Share = 1. Medicaid Share is calculated using the same method used to calculate Medicare Share
- No payments after 2016 unless hospital received a payment for the previous year and payments cannot exceed a maximum of 6 years

Medicaid Incentive Payments for Hospitals—WI Example

440-bed hospital in Madison (based on 2007 WHA hospital financial survey data)

Base Amount		$ 2,000,000
Discharge-Related Amount	*21,521 discharges*	$ 4,074,400
Total		$ 6,074,400
Total Hospital Charges		$ 134,703,000
Charity Care		$ 13,317,000
Difference		$ 121,386,000
Percentage Paid Care		90%
Medicaid Inpatient Bed Days		12,246
Total Inpatient Bed Days		94,628
Total Paid Inpatient Bed Days		85,165
Medicaid Share		14.4%

	Year 1	**Year 2**	**Year 3**	**Year 4**	
Transition factor	100%	75%	50%	25%	**Total**
Overall Hospital EHR Amt:	$ 6,074,400	$4,555,800	$3,037,200	$1,518,600	$ 15,186,000

Aggregated payment maximum $ 2,186,784

Medicare/Medicaid Incentive Payment Estimates for Wisconsin

	Incentive payments (in millions)		
	Low est.	High est.	
Medicare - Eligible professionals	$ 300	$ 400	1
Medicare - Hospitals, Non-Critical Access	$ 200	$ 275	2
Medicare - Critical Access Hospitals	$ 11	$ 20	3
Medicaid - Eligible professionals	$ 10	$ 20	4
Medicaid - Hospitals[6], Acute/Children's	$ 30	$ 60	5
Total	**$ 551**	**$ 775**	

[1] 8,500 eligible prof. by 2012 and 10,000 eligible prof. by 2016

[2] 2007 WHA hospital financial survey data, ~72 hospitals

[3] RWHC estimate for 59 CAHs

[4] 300 eligible prof. by 2012, 400 eligible prof. by 2015

[5] 2007 WHA hospital financial survey data, ~35 hospitals >10% Medicaid

[6] Critical Access Hospitals not eligible

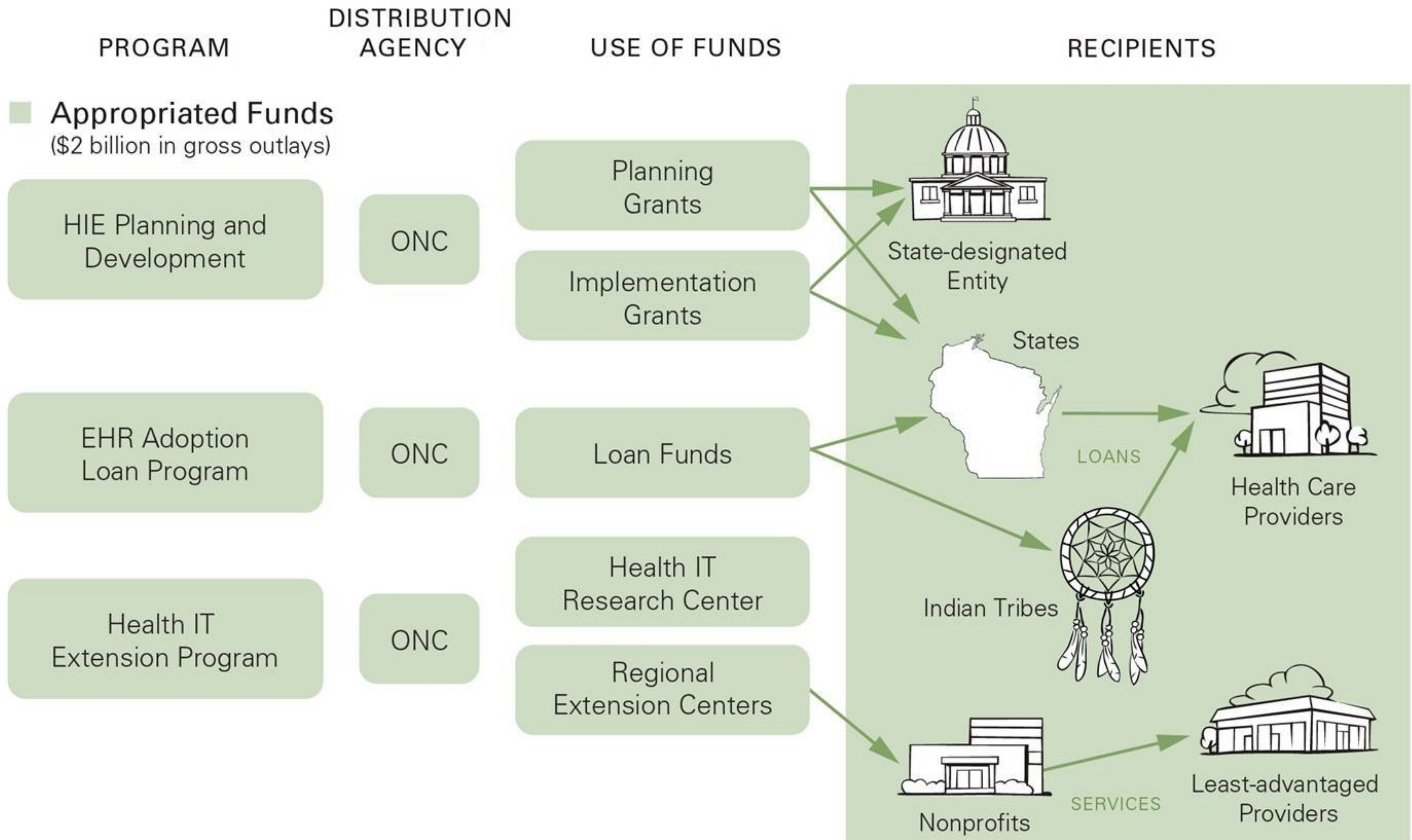
Funding Appropriated for the ONC

- $2 billion allocated to support strategic planning, infrastructure development, and technical assistance with some specific earmarks
- Has wide discretion on how to allocate remaining ~$1.7 billion for grants, loans, and other programs

Office of the National Coordinator

- Authorized areas of investment
  - EHR provider loan programs (funds flow through States and Indian Tribes)
  - HIT technical and implementation assistance for providers (i.e., Regional Extension Centers)
  - HIE grants to States or qualified State-designated entities
  - HIT training and research

HIT Grants, Loans, and Technical Assistance



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EHR Loan Fund

Funding Mechanism	Federal appropriations
Funding Entity	HHS through ONC
Allocation Process	Competitive grant process
Matching Funds Requirement	States or Indian tribes must provide a cash match equal to $1 in state funds for every $5 in federal funds. States may couple their grants with private sector contributions in an attempt to increase the amount of loan funding they can offer providers
Timing	ONC may not award grants prior to January 1, 2010
Funds Flow Through	ONC to states or Indian tribes, which are to use the grants to provide loans to health care providers for EHR adoption
Eligible Recipients	States or Indian tribes
Level of Federal Funding	To be determined
Requirements for Funding	Loan funds may be used by providers to: (1) facilitate the purchase of certified EHR technology; (2) enhance the utilization of certified EHR technology (which may include costs associated with upgrading HIT 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. The state must create an annual strategic plan that: identifies the projects to be assisted through the loan fund; describes the criteria and methods established for the distribution of funds from the loan fund; describes the financial status of the loan; and specifies the short-term and long-term goals of the fund

Adapted from, An Unprecedented Opportunity, California Healthcare Foundation, 2009

Funding Mechanism	Federal appropriations
Funding Entity	HHS through ONC
Allocation Process	To be determined
Matching Funds Requirement	ONC may not provide more than 50 percent of the capital and annual operating and maintenance funds required to create and operate a Regional Extension Center. ONC may provide such funding for no longer than four years
Timing	2009 to 2011
Funds Flow Through	ONC
Eligible Recipients	Nonprofits, likely to be broad array of competing applicants
Level of Federal Funding	To be determined
Requirements for Funding	To be determined

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HIE Planning and Implementation Grants

Funding Mechanism	Federal appropriations
Funding Entity	HHS through ONC
Allocation Process	Competitive grant process
Matching Funds Requirement	State matching funds may be required in federal fiscal years 2009 and 2010 (and will be required in 2011). The statute notes that matching funds may be in-kind, but does not provide further detail
Timing	Funds are available upon the delivery of ONC's strategic plan to Congress, due within 90 days of passage of the bill
Funds Flow Through	ONC
Eligible Recipients	States or qualified state-designated entities. To be considered a state-designated entity, an organization must be formally designated by the state, be nonprofit, and be committed to improving health care quality and efficiency through HIE
Level of Federal Funding	To be determined
Requirements for Funding	Grants must be used to support HIE planning or implementation. Minimal criteria to receive the larger implementation grants are likely to include operational governance, a technical plan, well defined clinical use cases, and statewide privacy and security policy guidance

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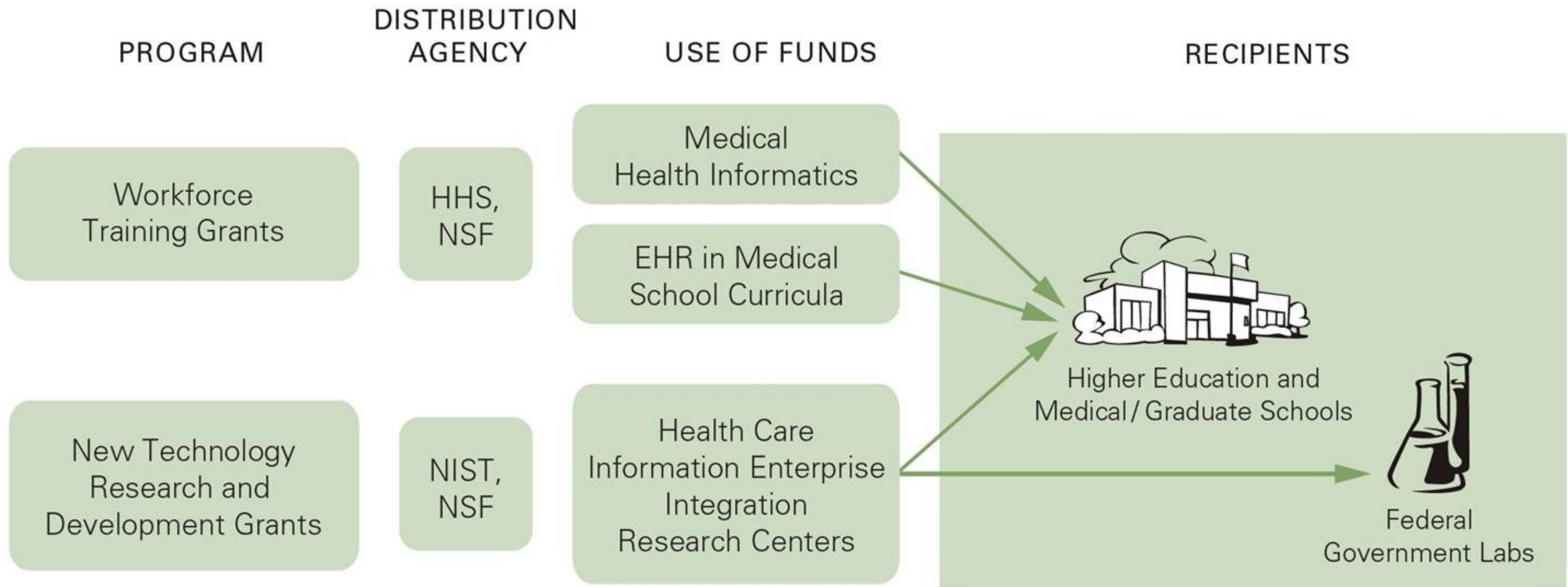
State-Level HIE Planning and Design

- “Shovel-ready” project for state-level HIE planning and design for a statewide HIE business and technical architecture and infrastructure
- Notice of Intent to Award issued to Deloitte Consulting, LLP this week
- Project work is broken up into two phases, with funding available to complete the first phase

HIT Training and Research



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ARRA Privacy and Security Provisions

- Alice Page

Significant Expansion of HIPAA Privacy and Security Rules

- Direct application of HIPAA to business associates
- New privacy requirements
  - Restrictions on uses and disclosures
  - Accounting of disclosures for EHRs
  - Marketing and fundraising restrictions

Significant Expansion of HIPAA Privacy and Security Rules

- Security breach notice obligations
- Enhanced penalties for non-compliance
- Enhanced enforcement authority (i.e., State Attorneys General)

Significant Expansion of HIPAA Privacy and Security Rules

- General compliance date is February 17, 2010
- Different effective dates for the security breach notice requirement and some of the new privacy provisions

Next Steps

- Complete contract negotiations with Deloitte and initiate Phase 1 of the HIE planning and design project
- Prepare strategic plan in anticipation of ARRA grant opportunities
  - Review the Wisconsin eHealth Action Plan and revise or supplement as necessary to align with updated federal HIT strategic plan
- Determine a source of matching funds for an EHR loan fund
- Revise the DHS privacy and security policy agenda, and work plan in light of new privacy and security provisions in the ARRA
- Others?