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American Recovery and Reinvestment Act (ARRA)

An In-Depth Look into the Revolution of Health IT

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Agenda

- I. Introduction to ARRA/HITECH
- II. Hospital Incentives
- III. Physician Incentives
- IV. Meaningful Use
- V. What to do with the facts



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I. INTRODUCTION TO ARRA

What is the Objective of ARRA?

The objective of the American Recovery and Reinvestment Act (ARRA) is to stimulate the economy through the investment of \$787 billion between 2009 and 2019 in five key areas:

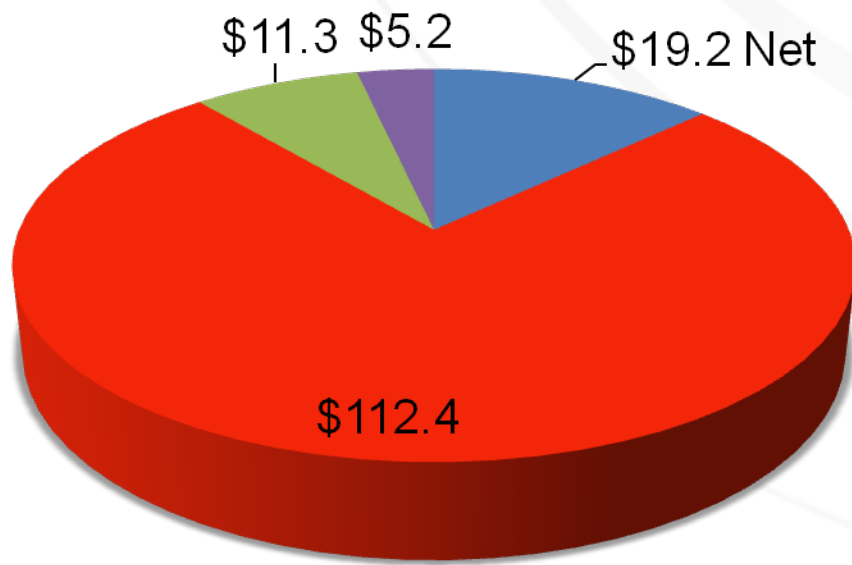
1. **Healthcare**
2. Education
3. Infrastructure
4. Unemployment Benefits
5. Transportation

ARRA and the Healthcare Industry

Approximately \$148 billion is dedicated to the healthcare industry

Health Programs

- Health IT
- Health Insurance Coverage
- Improvement in Delivery System Effectiveness
- Public & Government Programs



Health Information Technology (HIT)

- **\$2 billion** to the Office of the National Coordinator for Health Information Technology (ONC) to develop, plan, and promote HIT adoption
 - **\$17.2 billion** in *net* incentives through the Medicare and Medicaid reimbursement systems to health care providers to assist in adopting Electronic Health Records (EHRs)
-
- **\$19.2 billion** in net total HIT spending

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

- A separate act within ARRA which provides over \$36 billion of the \$787 billion ARRA stimulus towards health information technology, health information exchange, privacy, and security
- Builds on existing federal efforts to encourage HIT adoption and use
- Provides financial incentives for HIT use among health care providers
- Strengthens enforcement of the HIPAA privacy rule and creates a right to be notified in the event of a breach of identifiable health information



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II. Hospital Incentives

Hospital Incentives - Requirements

- What must hospitals do to receive incentive payments?
 - Demonstrate “meaningful use” of ***certified*** EHR technology¹ to the Secretary of the Department of Health and Human Services (Secretary)
 - Connect EHR technology in a manner that provides for the electronic exchange of health information and care coordination
 - Submit information on clinical quality measures and ***other measures*** as selected by the Secretary

¹**Certified EHR technology** meets standards put forth by the HIT Standards Committee and includes: Patient demographic, Clinical health information, Clinical decision support, Information Storage on healthcare quality, Ability to exchange and integrate electronic health info with other sources

Hospital Incentives - Requirements

- Eligible hospitals must convert their record management systems to an Electronic Health Record (EHR) system to achieve “meaningful use”
- If eligible hospitals demonstrate “meaningful use” of certified EHR technology, the hospitals can receive:
 - Financial incentives
 - Loans/grants to help offset any costs associated with HIT
- Up to 4 years of incentive payments – starting fiscal year 2011 through 2015 – can be paid out to eligible hospitals demonstrating meaningful use of a certified EHR system

Hospital Incentives - Penalties

- Eligible hospitals which are not demonstrating meaningful use, by FY 2015 will face financial penalties under Medicare
- Penalty
 - Reduction in the Medicare Inflation Adjustment in FY 2015 and 2016, with elimination in each subsequent FY until compliance
 - Fiscal year 2015 – 33.33%
 - Fiscal year 2016 – 66.66%
 - Fiscal year 2017 and each subsequent fiscal year – 100%
 - For example, please refer to appendix

Hospital Incentives - Calculation

- Maximum incentive payments for a hospital:
 - \$6.37 million in the first year
 - \$15.9 million over four years
- Must become certified EHR technology users before FY2012 to achieve the full incentive amount
- Incentive amount is calculated using three factors



Hospital Incentives - Calculation

- **Initial Amount:** Base + Discharge Related
 - $(\$2 \text{ mil}) + \{200 \times (D)\}$
 - D = every discharge above 1,150, but not exceeding 23,000; Maximum $D = 21,850$
- **Medicare Share:**
$$MS = \frac{I_{MA} + I_{MC}}{I_T + \frac{(C - X)}{T}}$$
- **Transition Factor:**
 - Payments will be reduced by 25% each year after the first payment year
 - Example - 1st year = 1; 2nd year = $\frac{3}{4}$; 3rd year = $\frac{1}{2}$; 4th year = $\frac{1}{4}$; 5th and succeeding years = 0

Hospital Incentives - Calculation

- The incentive payment structure for hospitals is not yet established
- The payment may be in the form of a single consolidated payment or periodic installments as determined by the Secretary
- For both Hospitals and Eligible Providers, qualifying for incentives will use the “adoption-year” approach rather than a calendar year approach
- The first-year incentive payment will be assessed using the “2011 Measures” no matter the starting year
- The payment rate and phaseout of payments would follow the calendar dates in the statute

Hospital Incentives - State Loans

- Grants may be awarded to a state, by the Secretary, *if* the state agrees to make funds available toward the cost of the grant
- Grant money will be used to conduct activities to facilitate and expand the electronic movement and use of HIT among organizations

Fiscal Year	States' Contribution	Federal Funds Awarded
2010	\$1	Secretary's Discretion
2011	\$1	\$10
2012	\$1	\$7
2013	\$1	\$3
2014	\$1	\$0

Hospital Incentives - State Loans

- Competitive grants may be awarded to a state
- Grants will be used to establish programs to distribute loans to hospitals
- Grants will be deposited in the states' Certified EHR Technology Loan Fund
- Hospitals must provide a strategic plan that identifies the intended uses of the loan money

Hospital Incentives - State Loans

- Hospitals can obtain loans from their State's Certified EHR technology Loan Fund to carry out such activities as:
 - Facilitate the purchase of certified EHR technology
 - Enhance the utilization of certified EHR technology
 - Train personnel in the use of certified EHR technology
 - Improve the secure electronic exchange of health information



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III. PHYSICIAN INCENTIVES

Physician Incentives - Requirements

- What must physicians do to receive incentive payments?
 - Demonstrate “meaningful use” of certified EHR technology¹ to the Secretary of the Department of the Health and Human Services (Secretary); including e-prescribing
 - Connect EHR technology in a manner that provides for the electronic exchange of health information and care coordination
 - Submit information on clinical quality measures and other measures as selected by the Secretary

¹**Certified EHR technology** meets standards put forth by the HIT Standards Committee and includes: Patient demographic, Clinical health information, Clinical decision support, Information Storage on healthcare quality, Ability to exchange and integrate electronic health info with other sources

Physician Incentives - Payouts

- Eligible physicians can begin to receive incentive payouts for either Medicare or Medicaid beginning FY 2011 – 2015

**Medicare
Incentives**

OR

**Medicaid
Incentives**

- Up to \$44,000 over 5 years

- Up to \$63,750 over 6 years
- Payments of up to 85% of EHR technology costs

Physician Incentives - Medicare

- Eligible physicians can earn up to \$44,000 through Medicare incentives
- To achieve the full Medicare incentive, physicians must begin demonstrating meaningful use of EHR technology prior to FY 2012

Physician Medicare Incentive Schedule						
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	Penalty*
2011	\$18,000					None
2012	\$12,000	\$18,000				None
2013	\$8,000	\$12,000	\$15,000			None
2014	\$4,000	\$8,000	\$12,000	\$12,000		None
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0	99%
2016	\$0	\$2,000	\$4,000	\$4,000	\$0	98%
2017	\$0	\$0	\$0	\$0	\$0	97%
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0	

- A 10% increase in payout will be awarded to eligible physicians in a health professional shortage area (HPSA)
- Hospital based professionals cannot receive Medicare payments
- *Penalty – reduction in potential Medicare reimbursements; If 75% of all physicians are not using EHR by FY 2018, the Medicare penalty reductions can continue to decrease by 1% and may go as low as 95%

Physician Incentives - Medicaid

Medicaid payments

- Providers can obtain funds in advance of purchasing EHR technology or demonstrating meaningful use
- States will make payments $\leq 85\%$ of costs for certified EHR technology for no more than a 6-year period
 - First year costs of up to \$25,000 include:
 - Purchase
 - Initial implementation
 - Upgrade
 - Second year and beyond costs of up to \$10,000 include:
 - Operation
 - Maintenance
 - Usage

Physician Incentives - Medicaid

Eligible Provider	% of patients receiving Medicaid	Max Medicaid Payment for 1 st Year	Max Medicaid Payment for Years 2-6	Maximum Incentive Payments
Non-Hospital-Based Physician (non-pediatricians)	≥ 30%	\$21,250	\$8,500	\$63,750
Non-Hospital-Based Pediatricians	≥ 20%	\$14,025	\$5,610	\$42,500

Eligible Provider	% of Needy Individual Patients	Max Medicaid Payment for 1 st Year	Max Medicaid Payment for Years 2-6	Maximum Incentive Payments
Physician Practicing in a Federally-Qualified Health Center or Rural Health Clinic	≥ 30%	\$21,250	\$8,500	\$63,750

Eligible Providers includes:

- Physicians
- Dentists
- Certified nurse midwives
- Physician assistants in rural health clinics or Federally-qualified health center

Physician Incentives – State Loans

- Eligible physicians can obtain loans from their State's Certified EHR Technology Loan Fund to carry out such activities as:
 - Facilitate the purchase of certified EHR technology
 - Enhance the utilization of certified EHR technology
 - Train personnel in the use of certified EHR technology
 - Improve the secure electronic exchange of health information



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IV. MEANINGFUL USE

Meaningful Use - Defined

- The definition of Meaningful Use is currently being revised and refined by the HIT Policy Committee and will be decided on by the ONC by 12/31/09
- The most recent recommendations by the HIT Policy Committee on the [definition of Meaningful Use](#) was on August 14, 2009
- healthit.hhs.gov/meaningfuluse

Meaningful Use - Defined

- The HIT Policy Committee was established to make recommendations to the National Coordinator regarding the implementation of a nationwide health IT infrastructure and implementation of the strategic plan
- The Committee has made final recommendations regarding meaningful use for 2011 and are working on recommendations for 2013 and 2015

Meaningful Use - Defined

Vision:

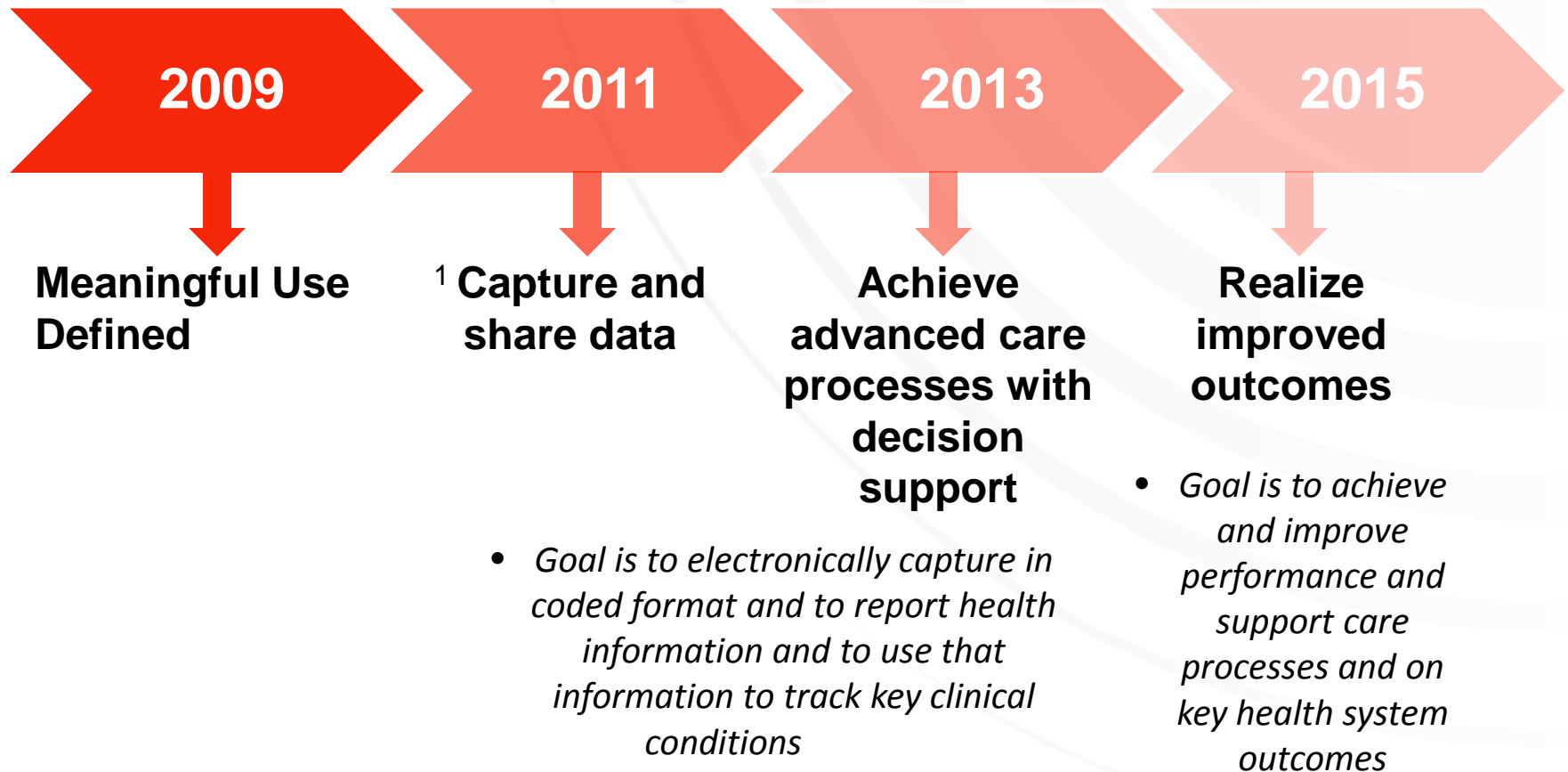
- To enable significant and measurable improvements in population health through a transformed health care delivery system

By 2015:

- **Prevention and management of chronic diseases**
 - A million heart attacks and strokes prevented
 - Heart disease no longer the leading cause of death in the US
- **Decrease medical errors**
 - 50% fewer preventable medication errors
- **Decrease health disparities**
 - The racial/ ethnic gap in diabetes control halved
- **Increase care coordination**
 - Preventable hospitalizations and re-admissions cut by 50%
- **Involve patients and families**
 - All patients have access to their own health information
 - Patient preferences for end of life care are followed more often
- **Improve Public health**
 - All health departments have real-time situational awareness of outbreaks

Meaningful Use - Timeline

Meaningful Use



¹ The HIT Policy Committee recommends that incentives be paid according to an "adoption year" timeframe rather than a calendar year timeframe. Under this scenario, qualifying for the first-year incentive payment would be assessed using the "2011 Measures." The payment rate and phaseout of payments would follow the calendar dates in the statute, but qualifying for incentives would use the "adoption-year" approach.

Meaningful Use - HOPP

- 5 Health Outcomes Policy Priorities (HOPP) used to achieve meaningful use:
 - Improve quality, safety, efficiency, and reduce health disparities
 - Engage patients and families
 - Improve care coordination
 - Improve population and public health
 - Ensure adequate privacy and security protections for personal health information

Meaningful Use – HOPP 1

Improve quality, safety, efficiency, and reduce health disparities

2011 HOPP for Eligible Providers

● Objectives

- Use CPOE for all orders²
- 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
- Generate and transmit permissible prescriptions electronically (eRX)
- Maintain active medication list
- Maintain active medication allergy list
- Record demographics: preferred language, insurance type, gender, race³, ethnicity
- Record advance directives
- Record vital signs: height, weight, blood pressure, Calculate and display BMI
- Record smoking status
- Incorporate lab-test results into EHR as structured data
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach
- Report ambulatory quality measures to CMS
- Send reminders to patients per patient preference for preventive/follow up care
- Implement one clinical decision rule relevant to specialty or high clinical priority
- Document a progress note for each encounter
- Check insurance eligibility electronically from public and private payers, where possible
- Submit claims electronically to public and private payers

● Measures

- Report quality measures to CMS including:
 - % diabetics with A1c under control [EP]
 - % hypertensive patients with BP under control [EP]
 - % of patients with LDL under control [EP]
 - % of smokers offered smoking cessation counseling [EP, IP]
- % of patients with recorded BMI [EP]
- % of orders (for medications, lab tests, procedures, radiology, and referrals) entered directly by physicians through CPOE
- Use of high-risk medications (Re: Beers criteria) in the elderly
- % of patients over 50 with annual colorectal cancer screenings [EP]
- % of females over 50 receiving annual mammogram [EP]
- % patients at high-risk for cardiac events on aspirin prophylaxis [EP]
- % of patients who received flu vaccine [EP]
- % lab results incorporated into EHR in coded format [EP, IP]
- Stratify reports by gender, insurance type, primary language, race ethnicity [EP, IP]
- % of all medications, entered into EHR as generic, when generic options exist in the relevant drug class [EP, IP]
- % of orders for high-cost imaging services with specific structured indications recorded [EP,IP]
- % claims submitted electronically to all payers [EP, IP]
- % patient encounters with insurance eligibility confirmed [EP, IP]

² CPOE requires computer-based entry by providers of orders (medication, laboratory, procedure, diagnostic imaging, immunization, referral) but electronic interfaces to receiving entities are not required in 2011

³ Race and ethnicity codes should follow federal guidelines (see Census Bureau)

Meaningful Use - Summary

- The definition of meaningful use is currently being revised and will be finalized by December 2009
- Meaningful use is about achieving improved and measurable health outcomes, not about implementing the software or hardware
- Meaningful use will be determined by the objectives and measures
- Proposed meaningful use criteria for 2011 and beyond present increasing potential of HIT
- Meaningful use will attempt to transform the health system through HIT
- A complete HIT-enabled ecosystem will:
 - Capture coded data electronically
 - Adopt advanced care processes
 - Measure and improve outcomes
- Meaningful use of HIT will lead to an effective and efficient healthcare system
- Meaningful use will aid in the successful realization of health care reform



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AND NOW, WHAT TO DO