



# The American Recovery and Reinvestment Act, Health IT, & Oregon

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# American Recovery and Reinvestment Act

- President Obama signed the American Recovery and Reinvestment ACT in February 2009
- \$787 billion nationally over the next three years

# ARRA Funding Works as a Bridge



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- Provides direct assistance & benefits to individual Oregonians through existing programs, tax incentives, etc.
  - Provides *some* assistance to state governments to fill state budget deficits.
  - Provides additional state funding through a number of existing state administered programs.
  - Provides direct funding opportunities for local communities and cities.
  - Funding opportunities are staggered throughout a 3 year period

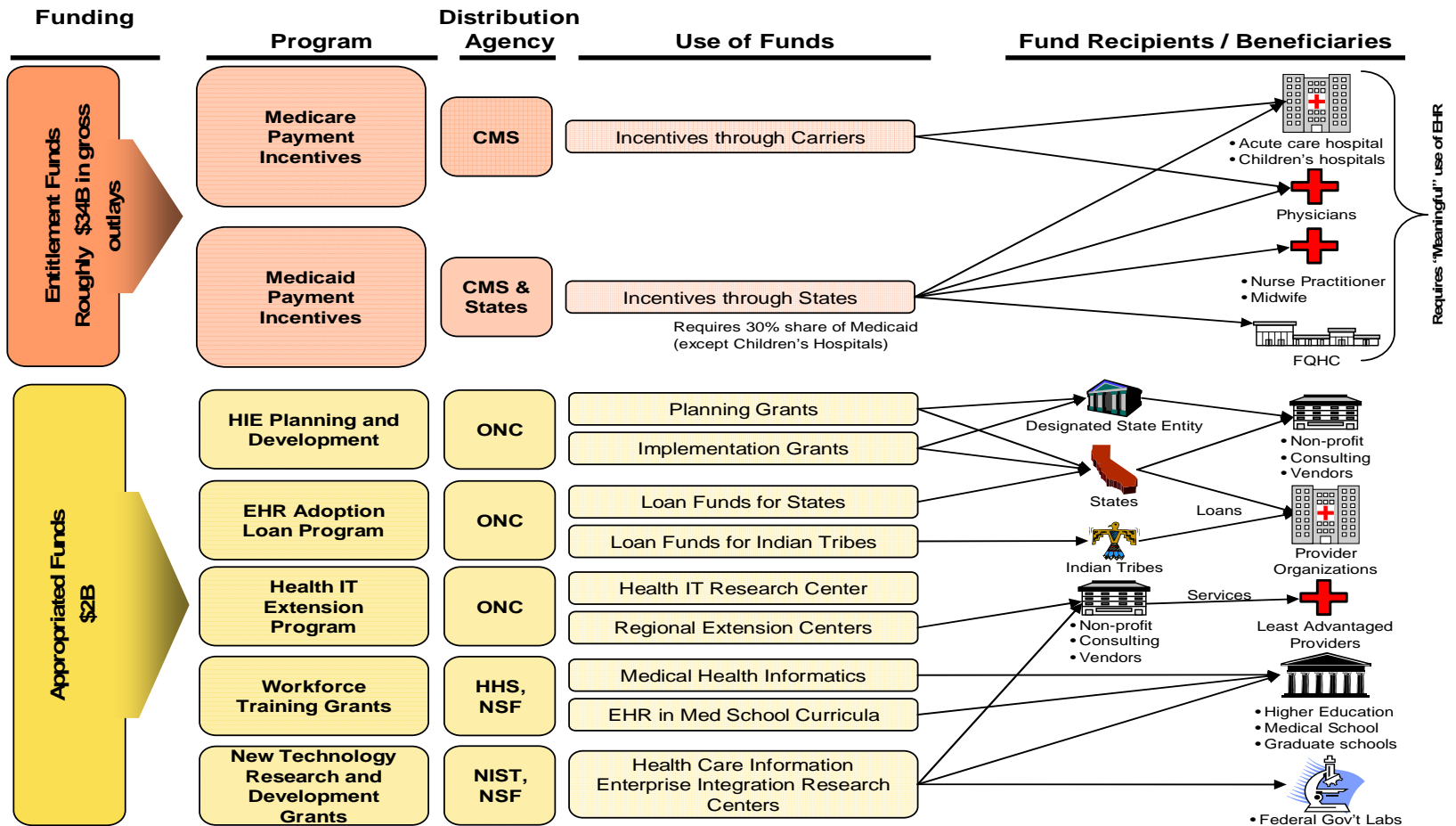
# One Small Step . . .

- **Appropriated Funds: \$2 billion**
  - Grant and Loan programs
  
- **Entitlement Funds: \$34 billion**
  - Medicare and Medicaid payment incentives

# One Giant Leap . . .

- HIT Funding Opportunities within ARRA serve as the initial stages of National health care reform.

# HIT Funding Streams



# Appropriated Funds

- \$2 billion
  - Health Information Exchange Grants
  - Electronic Health Record Adoption Loan Program
  - Health IT Extension Program
  - Workforce Training Grants
  - New Technology Research and Development Grants

# Health Information Exchange Grants



- What we know:
  - FROM: Office of the National Coordinator for HIT
  - TO: States or Qualified State-Designated Entities
  - FOR: Grants for both planning and implementation
  
- What we do not know:
  - How much?
  - The application process

# Electronic Health Record Adoption Loan Program



## ■ What we know:

- FROM: Office of the National Coordinator for HIT
- TO: States or Tribes
- FOR: Establishing loan programs for health care providers.
- There will be a state match, this funding stream is at ONC's discretion

## ■ What we do not know:

- How much?
- The application process

# Health IT Extension Program



- What we know:
  - FROM: Office of the National Coordinator for HIT
  - TO: Regional Extension Centers
  - FOR: Supporting the centers as research and consulting organizations that assist least-advantaged providers.
  - Funding will be up to 50 percent of capital and annual operating budget for two years
  
- What we do not know:
  - The application process

# Workforce Training Grants

- What we know:
  - FROM: HHS, National Science Foundation
  - TO: Higher education institutions
  - FOR: Promote HIT workforce development
  
- What we do not know:
  - How much?
  - The application process

- What we know:
  - FROM: National Institute of Standards and Technology, National Science Foundation
  - TO: Higher education, government labs, non-profits
  - FOR: promoting research and innovation
  
- What we do not know:
  - The application process

# Entitlement Funds

- **\$34 billion**
  - dedicated to Medicare and Medicaid as incentives for physicians and hospitals who purchase and use Electronic Health Records

# Medicare, physicians, EHR

- Funds will be available commencing in calendar year 2011
- Compensation for “meaningful EHR users” in an equal amount, or up to 75% of allowable charges for professional services furnished by physicians
- Incentives are for 5 years, with a declining schedule each year
- Phasedown for physicians adopting after CY 2013
- Beginning CY 2015, reductions in Medicare reimbursements by 1 to 3% annually will impact physicians that are not “meaningful EHR users”
- Incentives are available to physicians of qualified Medicare Advantage organizations
- No incentives will be available after CY 2016 when disincentives begin
- Certain hospital-based professionals such as pathologists, anesthesiologists, and emergency room physicians are specifically mentioned as being ineligible.

# Defining Terms -

- The Health IT Policy Advisory Committee:  
**Meaningful Use** [mee-ning-fuh l yoos] –

“ultimate goal of meaningful use of an Electronic Health Record is to enable significant and measurable improvements in population health through a transformed health care delivery system. The ultimate vision is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities.”

# Medicare Incentives for Physicians



Calendar Year	Adopt 2011	Adopt 2012	Adopt 2013 Phase down	Adopt 2014 Phase down	Adopt 2015 & Beyond
2011	\$18K	--	--	--	--
2012	\$12K	\$18K	--	--	--
2013	\$8K	\$12K	\$15K	--	--
2014	\$4K	\$8K	\$12K	\$12K	--
2015	\$2K	\$4K	\$8K	\$8K	--
2016	\$0	\$2K	\$4K	\$4K	--
2017	\$0	\$0	\$0	\$0	--
<b>Total</b>	<b>\$44K</b>	<b>\$44K</b>	<b>\$39K</b>	<b>\$24K</b>	<b>\$0</b>
Health Shortage Area	\$48,400 (additional 10%)	\$48,400 (additional 10%)	\$42,900 (additional 10%)	\$26,400 (additional 10%)	

# Medicare, Hospitals, EHR

- Provided to Subsection D Hospitals
- Incentives start in Fiscal Year 2011 (October 2010)
- Hospitals are compensated according to a formula
- Transition factors of which decreases each year
- “Phasedown” starts in FY 2013 for hospitals newly adopting
- No incentive for hospitals adopting after FY 2015
- Adjustments, beginning in FY 2015, for those hospitals who are “not meaningful EHR users”:
  - Market Basket Adjustment percentage reduced for non-critical access hospitals
  - Rate of payment for inpatient critical access hospital services reduced for critical access hospitals
- Hospitals that are under common governance with a qualified Medicare Advantage Organization will also qualify

# Medicare Incentives for Hospitals

- The Compensation formula is the “Initial Amount” *times* “Medicare Share” *times* “Transition Factor”
  
- “Initial Amount” is \$2 Million *plus*
  - \$200 for each discharge between the 1,150<sup>th</sup> to 23,000<sup>th</sup> discharge in a 12 month period
  - \$0 for the first 1,149 and \$0 for each discharge after 23,000

# Medicare Incentives for Hospitals



- “Medicare Share” is a fraction:
  - Numerator equals: Inpatient-bed days attributed to Part A *plus* inpatient-bed days attributable to Part C
  - Denominator equals: Total number of inpatient-bed days *times* (a) Non-charity care charges *divided by* (b) Total amount of charges
  
- Critical Access Hospitals increase the Medicare Share by 20 percentage points as long as the Medicare Share does not exceed 100 percent
  
- “Transition Factor” is a point value which declines each year from 1.0 to 0

# Medicare Incentives for Hospitals



<b>Federal Fiscal Year</b>	<b>Adopt FY 2011</b>	<b>Adopt FY 2012</b>	<b>Adopt FY 2013</b>	<b>Adopt FY14 Phasedown</b>	<b>Adopt FY15 Phasedown</b>	<b>Adopt FY16 &amp; Beyond</b>
2011	1.0	--	--	--	--	--
2012	0.75	1.0	--	--	--	--
2013	0.50	0.75	1.0	--	--	--
2014	0.25	0.50	0.75	0.75	--	--
2015	0	0.25	0.50	0.50	0.50	--
2016	0	0	0.25	0.25	0.25	--
2017	0	0	0	0	0	--

# Medicaid Incentives

- States may make payments to Medicaid providers to encourage adoption and use of certified EHR technology
- No duplicative Medicare and Medicaid Payments
- Medicaid providers include:
  - Physicians, dentists, certified nurse midwives, nurse practitioners, physicians assistants that are practicing in rural health clinics or FQHCs
  - Children and acute hospitals
- Requires a percentage of patient volume allocated to either individuals receiving medical assistance, or to needy individuals

# Medicaid Incentives

<b>Category</b>	<b>Eligibility Criteria</b>
Non-Hospital Based Pediatricians ("Medicaid Pediatricians")	At least 20% of patient volume is attributable to individuals receiving medical assistance
Other Non-Hospital Based Providers	At least 30% of patient volume is attributable to individuals receiving medical assistance
Non-Hospital Based Providers that practice predominately in FQHCs or RHCs	At least 30% of patient volume is attributable to needy individuals (receiving medical assistance, SCHIP assistance, uncompensated care, and those on a sliding scale/ability to pay)
Children's Hospitals	No requirement of patient mix
Acute Care Hospitals	At least 10% of patient volume is attributable to individuals receiving medical assistance

# Medicaid Incentives

- Start of incentive payment not specified in legislative language
- First year must “engage in efforts to adopt, implement upgrade of technology”
- Must demonstrate “meaningful use” of certified EHR technology in second & subsequent years of incentives
- Legislation does not address reduction in Medicaid payments for failure to demonstrate “meaningful use”

# Medicaid Incentives for Non-Hospital Based Providers



- Up to 85% of certain costs for certified EHR technology which is subject to caps
  
- 1<sup>st</sup> year of payment capped at \$25K (or less based on studies)
  - Costs for purchase & implementation or upgrade of EHR technology & support & training services
  - Engaging in efforts to adopt, implement, or upgrade a certified EHR technology, or
  - Investment was made prior to beginning of funding period with demonstration of “meaningful use” of certified EHR technology
  
- Subsequent years of payment, capped at \$10K/year, for costs relating to the operation, maintenance & use of certified EHR technology

# Medicaid Incentives for Non-Hospital Based Providers

- First year cost must not be later than CY 2016
  
- No payments made after CY 2021 or for more than 5 years
  - Maximum incentive will be \$65K
  - Medicaid Pediatricians are eligible for 2/3 the amount otherwise specified (approx. \$43K)

# Medicaid Incentives for Hospitals

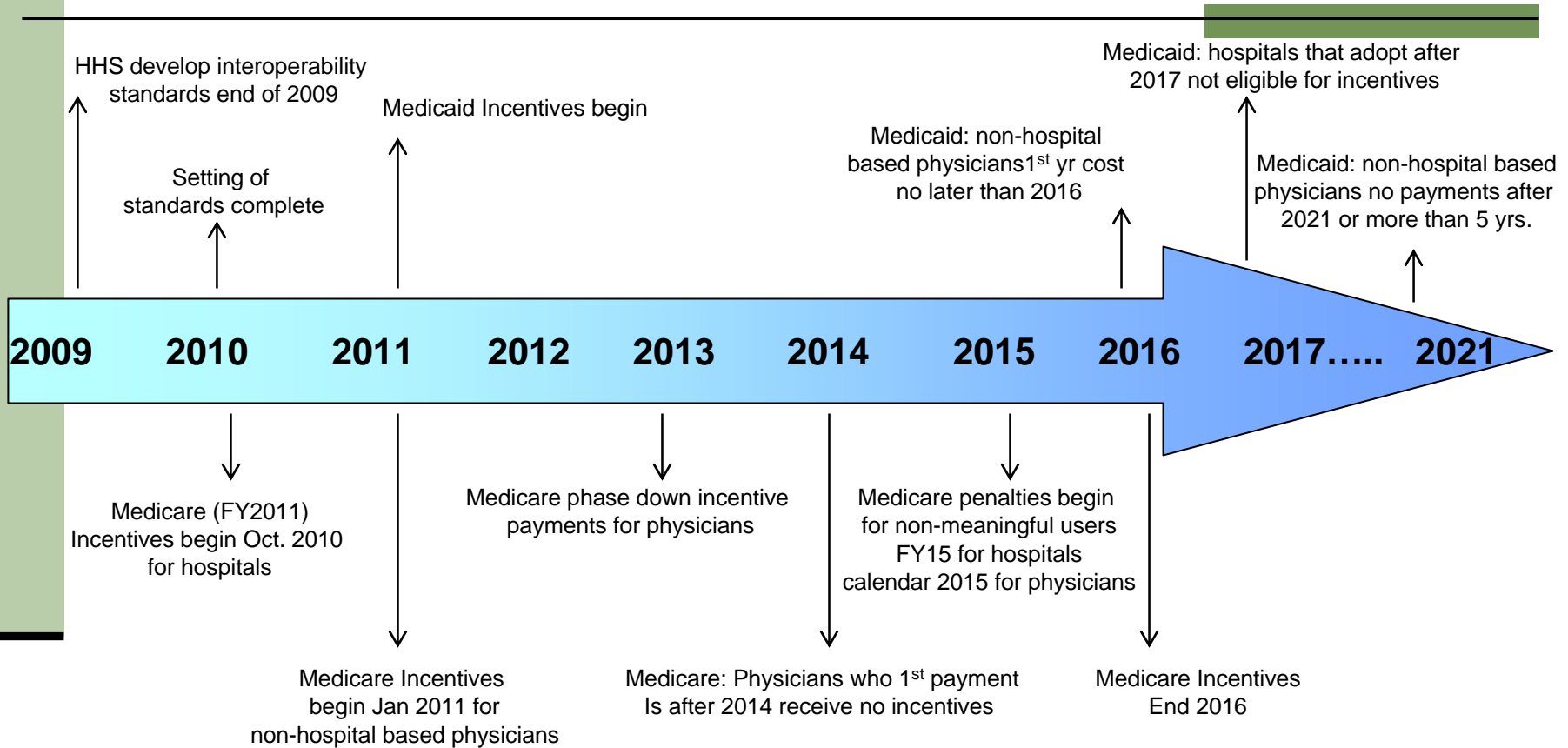
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- Hospitals that adopt in FY 2017 or later are not eligible for any incentives
- Incentives are limited to 6 years
- Incentives equal the product of the overall Hospital EHR Amount & the Medicaid Share for such provider (“Medicaid Incentive”)
- In any year, the total amount shall not exceed 50% of the Medicaid Incentive and in any two year period shall not exceed 90% of the Medicaid Incentive

# Medicaid Incentives for Hospitals

- Overall “Hospital EHR Amount” is the sum of the applicable Medicare amounts for such provider for the first 4 payment years:
  - Determined as if the Medicare Share were 1, &
  - Assuming that discharge rates will increase each year at the average annual rate of growth based upon the past 3 years
  
- “Medicaid Share” shall be calculated in the same manner as the Medicare Share except using the number of inpatient bed days attributable to the individuals who are receiving medical assistance instead of Medicare

# Medicare and Medicaid Timeline



Sources: HIMSS <http://www.himss.org/ASP/index.asp>  
and AHIMA <http://www.ahima.org/>

# Questions & Answers



Thank you

Sources: Department of Health and Human Services  
Office of National Coordinator of Health Information Technology  
Recovery.gov

State of New York, Department of Health  
State of South Carolina, Health and Human Services