ICAHN
Illinois Critical Access Hospital Network

American Recovery and Reinvestment Act of 2009
Selected Funding Opportunities of Interest to Critical Access Hospitals

Within the ARRA of 2009 is Title XIII – Health Information Technology, Section 13001, cited as the **"Health Information Technology for Economic and Clinical Health Act"** or the HITECH Act. This act includes a variety of activities to be initiated by federal agencies, states, local organizations and educational institutions, and health care providers and facilities, all focused on transforming health care information management to improve health care quality, safety, and efficiency. Among the many activities, several are of immediate interest and importance to critical access hospitals – grants and payment incentives to support adoption of electronic health records and development of health information exchange capabilities and use, summarized below.

GRANT OPPORTUNITIES

The ARRA includes funding for multiple grant programs to assist health care providers implement health information technologies, especially electronic health records, and to participate in the electronic exchange of health information. Most of the funds will be awarded to large-scale entities such as states, state-designated entities, and educational institutions; providers and consortia of providers then will seek funding from those entities. The Illinois Critical Access Hospital Network is in a unique position to request funds on behalf of its members and their partners when proposal solicitations are announced. Key grant programs are described below.

Immediate Funding to Strengthen the Health Information Infrastructure

The Secretary of Health and Human Services will administer $2 billion for multiple programs; distribution methodologies for these funds are unknown at this time.

- Secretary is to invest funding in the infrastructure necessary to allow for and promote nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges
- Agencies involved include the Office of the National Coordinator for Health Information Technology, Health Resources and Services Administration, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, and Indian Health Service
- At least $300 million must be used to support regional or sub-national health information exchange efforts (such as the ICAHN health information exchange)

Health Information Technology Extension Program

The Office of the National Coordinator for Health Information Technology shall establish:

- HIT Research Center to provide technical assistance and develop or recognize best practices that can accelerate HIT adoption and implementation
- HIT Regional Extension Centers that will disseminate information gathered by the HIT Research Center
- Description of the centers to be published in the *Federal Register* by mid-May 2009

State Grants to Promote HIT

- Purpose is to facilitate and expand the electronic movement and use of health information
- States and state-designated entities may apply for funds for planning and/or implementation activities
- Requires non-federal source of matching funds

Loan Programs to Facilitate Widespread Adoption of Certified EHR Technology

- Grants awarded to states and Indian tribes to create a loan fund to assist providers in the purchase and implementation of EHR technology
- Interest rates not to exceed "market rate" with 10 year terms
- Requires non-federal source of matching funds
- Program to begin in January 2010

Demonstration Program to Integrate Information Technology into Clinical Education

- Grants to educational institutions to develop academic curricula to integrate EHR technology into health professional clinical education
- Eligible applicants include schools of medicine (osteopathic and allopathic), dentistry, pharmacy, graduate programs in behavioral or mental health, nursing and physician assistants, and graduate medical education programs
- Grants limited to 50 percent of project costs

Information Technology Professionals in Health Care

- National Science Foundation shall assist institutions of higher education establish or expand medical health informatics education programs

Additional grant programs administered by other agencies:

Clinical Comparative Effectiveness Research

- $1.1 billion to support research to evaluate development and use of clinical registries, clinical data networks, and other forms of electronic health data that can generate or obtain outcomes data
- Of the total, $300 million shall be awarded to the Agency for Healthcare Research and Quality, $400 million awarded to the National Institutes for Health, and $400 million will be awarded at the discretion of the Secretary of Health and Human Services

Distance Learning, Telemedicine, and Broadband Program

- This long-established Department of Agriculture, Rural Utilities Services program will receive $2.5 billion from the ARRA, a significantly larger appropriation than ever provided previously

Broadband Technologies Opportunities Program

- Another long-established program administered by the National Telecommunications and Information Administration will receive a $4.7 billion infusion

MEDICARE INCENTIVES FOR MEANINGFUL USE OF EHR TECHNOLOGY BY PHYSICIANS

Medicare incentives are available for physicians who become meaningful users of electronic health records with higher incentive amounts for earliest initiation (2011) and payment reductions for non-use beginning in 2015.

1. *Meaningful use* requires that providers use EHR technology that meets a minimum set of standards:

- Certified EHR technology; not specified yet but most likely CCHIT-certified
- Capacity to provide patient demographics and clinical health information, medical history and problem lists; capacity for clinical decision support, and CPOE; ability to capture and query information relevant to healthcare quality; and to exchange health information with, and integrate such information from other sources
- Prescribe electronically
- Connect to a health information exchange
- Submit clinical quality measures in the reporting format selected by Secretary of HHS

2. Incentive payments begin in 2011, if provider can demonstrate *meaningful use* of EHR.

3. Payment reductions begin in 2015 if provider has not initiated *meaningful use* of EHR.

4. Physicians who are hospital based and are expected to use the hospital's inpatient EHR system are not eligible for incentives. Examples of such physicians include emergency medicine physicians working in the ER, pathologists, and anesthesiologists.

5. Physicians who initiate *meaningful use* of EHRs in 2011 and 2012 will receive the largest amount of incentive payments. Payment penalties will begin in 2015 for physicians who have not initiated EHR use, as illustrated in the table below.

Medicare Incentive Amounts for Physicians
By Year of Initiation of Meaningful Use of EHR Technology

Payment Years	2011 Initiation	2012 Initiation	2013 Initiation	2014 Initiation	2015 Initiation
2011	$18,000	-0-	-0-	-0-	-0-
2012	$12,000	$18,000	-0-	-0-	-0-
2013	$8,000	$12,000	$15,000	-0-	-0-
2014	$4,000	$8,000	$12,000	$12,000	-0-
2015	$2,000	$4,000	$8,000	$8,000	-0-
2016	-0-	$2,000	$4,000	$4,000	-0-
2017	-0-	-0-	-0-	-0-	-0-
TOTAL	$44,000	$44,000	$39,000	$24,000	-0-

6. Bonus payments of 10 percent are added for physicians who practice in health professional shortage areas.

7. Secretary of HHS will determine how to allocate incentives if physician provides services in multiple practices.

8. Physicians cannot receive incentive payments from both Medicare and Medicaid; must choose.

9. Payment penalties begin in 2015 if a physician has not initiated *meaningful use* of an EHR as described in the table below.

Medicare Incentive Payment Reductions
if EHR Not Initiated

Year	Percent Reduction
2015	1 %
2016	2 %
2017	3 %

10. If EHR adoption proportion is not at a level of 75 % by 2018 and succeeding years, the Secretary of HHS may further increase penalties to a maximum of 5 % reductions.

MEDICARE INCENTIVES FOR MEANINGFUL USE OF EHR TECHNOLOGY BY CRITICAL ACCESS HOSPITALS

Medicare incentives are available to critical access hospitals that are *meaningful users* of EHRs for inpatient services provided in 2011 through 2014. A complex formula is used to determine the incentive amounts.

1. *Meaningful user* has nearly the same requirements as previously listed for physicians:
   - Certified EHR technology; not specified yet but most likely CCHIT-certified
   - Capable of providing patient demographics and clinical health information, medical history and problem lists; capacity for clinical decision support, CPOE; ability to capture and query information relevant to healthcare quality; and to exchange health information with, and integrate such information from other sources
   - Connected to a health information exchange
   - Submit clinical quality measures in the reporting format selected by Secretary of HHS
   - No e-prescribing requirement for hospitals

2. Three factors are used to determine the hospital incentives and include:
   - Initial amount that includes base amount of $2 million and a discharge-related adjustment
   - Medicare share
   - Annual transition factor

   The initial amount multiplied by the Medicare share multiplied by the annual transition factor determines the incentive amount.

3. Initial amount is the sum of:
   Base amount of $2 million + $200 for each discharge between 1,150th and 23,000th

4. Medicare share is a fraction derived from:

   Numerator: Sum of the estimated number of inpatient-bed-days for Part A eligible patients and Part C Medicare Advantage-enrolled individuals (as established by the Secretary of HHS)

   Denominator: Quotient of estimated total inpatient-bed-days, not including charges attributable to charity care, divided by estimated total amount of charges

   Critical access hospitals add 20 percentage points to the derived Medicare share, not to exceed 100 %.

5. Transition factor is applied to each of the maximum of four payment years that hospitals can receive incentive payments in amounts shown in the table below. Hospitals that initiate *meaningful use* in 2014 use the same transition factor in 2014 as allowed for hospitals that initiated in 2013. There is no transition factor for hospitals that initiate *meaningful use* in 2016 and beyond.

Transition Factor by EHR Initiation Year and Payment Year						
Payment Years	2011 Initiation	2012 Initiation	2013 Initiation	2014 Initiation	2015 Initiation	2016 Initiation
2011	1.00					
2012	0.75	1.00				
2013	0.50	0.75	1.00			
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	-0-
2017	-0-	-0-	-0-	-0-	-0-	-0-

6. Incentive determinations specific to critical access hospitals described in the act include:

> "The Secretary shall compute reasonable costs by expensing such costs in a single payment year and not depreciating such costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved.)''
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> "The payment …shall be paid through a prompt interim payment (subject to reconciliation) after submission and review of such information (as specified by the Secretary) necessary to make such payment.''

7. Hospitals that have not initiated *meaningful use* by fiscal year 2015 shall be subject to payment reductions. Critical access hospitals will see payments reduced to 100.66 percent of costs in fiscal year 2015; to 100.33 percent in fiscal year 2016; and to 100 percent in fiscal year 2017 forward.

MEDICAID INCENTIVES FOR MEANINGFUL USE OF EHR TECHNOLOGY BY ELIGIBLE PROVIDERS, INCLUDING CRITICAL ACCESS HOSPITALS

1. Providers and hospitals must choose to participate in either the Medicaid or the Medicare incentive program; cannot receive incentives from both.

2. Start date for the Medicaid program not specified in the act, presumed to be 2011.

3. Medicaid will not reduce payments to providers who elect not to implement EHR technology.

4. States are authorized to make payments totaling no more than 85% of net average allowable EHR costs (unclear how determined) including software and support services such as operations, maintenance, and training expenses.

5. Eligible Medicaid providers include the following:

- Physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants that practice in rural health clinics or physician assistant-led federally qualified health centers and at least 30% of their patients are Medicaid-reimbursed, are provided uncompensated care, or are charged on a sliding scale according to ability to pay
- Non-hospital-based providers with at least 30% of their patients Medicaid-reimbursed
- Non-hospital-based pediatricians with at least 20% of their patients Medicaid-reimbursed
- Children's hospitals (no other requirement)
- Acute care hospitals with at least 10% Medicaid-reimbursed patients

6. *Meaningful use* must be defined by the states but must be consistent with the Medicare definition, and eligible providers must demonstrate same by the second and subsequent years of the incentives.

7. Incentive payments for eligible health care providers shall be as follows:

- Not exceed $25,000 in the first year and $10,000 in each subsequent year (or less if Secretary of HHS determines average costs dictate a reduction)
- Payments can be made for a maximum of five years, end after 2021, and may not exceed $65,000
- Eligible pediatricians receive only two-thirds of the payments described

8. Incentive payments for hospitals:

- Facility must implement EHRs and be eligible for incentive payments by at least 2016
- Payments are limited to six years
- Medicaid incentive amounts are the product of the "overall hospital EHR amount" and the Medicaid share

  i) the overall hospital EHR amount is the sum of the calculated Medicare amounts for the first four years, determined as if the Medicare share were 1

  ii) the Medicaid share is determined by using the methodology described to determine the Medicare share and substituting the number of inpatient-bed-days for Medicaid-reimbursed individuals

Sources: American Recovery and Reinvestment Act of 2009; and HIMSS Legislative Overview, Policy Implications, and Healthcare Ramifications