Critical Access Hospitals &
The HITECH Act

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Presenters

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- Jeff Mero, Executive Director, AWPHD
Presentation Overview

- Part I – Federal Incentive Funds for Health IT
  - Special incentive payments for Critical Access Hospitals
  - Meaningful Use
- Part II – Additional HITECH Funding
  - Health Information Exchange
  - EHR Loans
  - Regional Extension Centers
Part I
Federal Incentive Funds
Scope of Health IT Funding

In billions of dollars

2004–2008: $0.68
2009–2015*: $50.39

*Estimated, includes incentive payments
Incentive payments decrease starting in 2013
Penalties (lower reimbursements) starting in 2015
Medicare Funds - Formulas & Key Factors

Formula

101% * Reasonable Cost of EHR System * (Medicare Share % + 20%)

- Inpatient Days
- Medicare Inpatient Days
- Total Hospital Charges
- Charity Care

Restrictions

- No payments after 2015
- No more than 4 consecutive payment years

Payments made through a prompt interim payment

- Subject to reconciliation
Penalties

- Starting in 2015 if CAH is not a “meaningful user”
  - Payment for inpatient critical access hospital services =
    - 2015 = 100.66% * Reasonable costs
    - 2016 = 100.33% * Reasonable costs
    - 2017+=100% * Reasonable Costs

- HHS may grant exemptions from these penalties if requiring a hospital to be a meaningful EHR user would result in a significant hardship
  - Example rural area without Internet access
  - No more than 5 year exemption
Medicaid Incentive Payments for Hospitals

- 10% of “Patient Volume” who receive “Medical Assistance”
  - To be defined by Secretary of HHS
  - Inpatient vs. outpatient volumes
  - Computation of Average Annual Growth Rate (3 years)

**Medical Assistance Inpatient Days (Medicaid)**

Total # Inpatient Days * (Total Amount of Hospital Charges - Charity Care Total Amount of Hospital Charges)

- States allocate the money
- Year 1 – Demonstrate efforts to adopt, implement or upgrade EHR system
- Years 2-6 – Demonstrate “meaningful use”
Medicare Incentive Payments for Employed Physicians

- Hospitals may be able to collect incentive payments for certain employed physicians, but note that “hospital-based” physicians are excluded.

<table>
<thead>
<tr>
<th>Excluded Physicians</th>
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<tbody>
<tr>
<td>Pathologists</td>
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<td>Anesthesiologists</td>
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<td>Emergency Physicians</td>
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Medicare Incentive Payments for Physicians

- Physician incentive payments are 75% of Medicare allowed charges
  - Penalties – reduction in physician fee schedule
- 10% increase in incentives if physician practices in a designated health professional shortage area

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<tr>
<td>FY 2011</td>
<td>$18,000</td>
<td>$12,000</td>
<td>$8,000</td>
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<td>FY 2012</td>
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<td>$18,000</td>
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<td>FY 2013</td>
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<td>FY 2014</td>
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<td>After FY 2015</td>
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<td>1% 2% 3%</td>
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After FY 2015
Medicaid Incentive Payments for Eligible Professionals

- Eligible professionals with 30%+ Medicaid patient volume, includes:
  - Physician
  - Dentist
  - Certified Nurse Mid-Wife
  - Nurse Practitioner
  - Physician Assistant who practices in a RHC or FQHC that is led by a Physician Assistant

- Physicians may not collect both Medicare and Medicaid incentive payments

- Special formula for pediatrician with at least 20% Medicaid patient volume
Medicaid Incentive Payments for Eligible Professionals

- Exception for Rural Health Centers & Federally Qualified Health Centers:
  - Eligible Professionals who practices in a RHC or a FQHC and at least 30% of patient volume is attributable to “needy individuals.”

- Needy Individuals:
  - Patient receiving assistance under the Medical Assistance Program (Medicaid)
  - Patient receiving assistance under SCHIP
  - Patient receiving uncompensated care by the provider
  - Patient for who charges are reduced by the providers on a sliding scale basis based on their ability to pay.
Medicaid Incentive Payments for Eligible Professionals

- 85% of the “net average allowable costs”
  - Capped at $25,000 in year 1
  - Capped at $10,000 for years 2-6
- Pediatrician incentive reduced by 2/3rds unless Medicaid patient volume is 30%+
- No initial payments after 2016
- No subsequent payments after 2021

**Eligible Professional:**
85% * $25,000 + 85% * 50,000 = $63,750

**Pediatrician (20-29% Medicaid):**
85% * $25,000 * (2/3) + 85% * $50,000 * (2/3) = $42,500
Scope of Incentive Funds-Example #2

- Washington Grace Hospital = 25 beds, Critical Access Hospital
  - 2 Employed Physicians – Medicare ($44,000)

Total Incentive Payments = $1,894,351

- Hospital Medicare
- Hospital Medicaid
- Physician Medicare

Estimates based on certain factual assumptions. Subject to revision under final HHS regulations.
Key Terms for Medicare/Medicaid

Incentives for Adoption and “Meaningful Use” of “Certified EHR Technology”
“Meaningful Use” - Policy Process

HIT Policy Committee

HIT Standards Committee

Public Comments
  • Over 800 received

Office of the National Coordinator

CMS
## Meaningful Use Matrix

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<td>Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions</td>
<td>Report quality measures to CMS including:</td>
<td>Additional quality reports using HIT-enabled NQF-endorsed quality measures</td>
<td>Achieve minimal levels of performance on quality, safety, and efficiency measures</td>
<td>Clinical outcome measures (TBD) [IP, OP]</td>
<td>Efficiency measures (TBD)</td>
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<td>Improve quality, safety, efficiency, and reduce health disparities</td>
<td>• Provide access to comprehensive patient health data for patient’s health care team</td>
<td>• Use CPOE for all orders</td>
<td>• Use CPOE for all orders</td>
<td>• Use CPOE for all order types</td>
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<td>• Use evidence-based order sets and CPOE</td>
<td>• Implement drug-drug, drug-allergy, drug-formulary checks</td>
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<td>• Apply clinical decision support system</td>
<td>• Maintain an up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED</td>
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<td>• Conduct closed loop medication management</td>
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<td>• Generate and transmit permissible prescriptions electronically (eRx)</td>
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Matrix describes objectives and measures for 2011, 2013 and 2015 for both providers and hospitals based on certain health outcome policy priorities.
“Meaningful Use” - Timeline

2009

HITECH Policies

HHS to define terms and issue regulations

2011

Capture/Share Data

Incentive Payments

2013

Advanced care processes with decision support

2015

Improved Outcomes

Penalties

Phased HIT-Enabled Health Reform
Part II
Additional HITECH Funding
Appropriate Funds

Additional funds available for Workforce Training Grants and New Technology Research & Development Grants

Contact:
Washington State Health Care Authority
Regional Extension Centers

- Qualis Health – WA REC applicant
  - $643 million in Federal Grant money available
  - Approximately $1 million to $30 million per Regional Center, with an estimated average of around $8.5 million.
- Provide technical assistance and education regarding the selection, implementation, and use of EHRs
- Commence delivery of service **January 2010**
“Information should follow the patient, and artificial obstacles – technical, business related, bureaucratic – should not get in the way.”

David Blumenthal, M.D.
National Coordinator for Health Information Technology
November 12, 2009
Health Information Exchange

- OneHealthPort - lead organization for WA HIE
  - Leading initial development of HIE in Washington
  - Satisfying the grant objectives of the HITECH Act
  - Must attract private and public sector stakeholders to invest and participate in HIE.
- $11.3 Million in federal funding available for WA HIE
  - Expected during the 1Q 2010.
- Creation of a new governance model between OneHealthPort and HCA
States may award loans to healthcare providers based on the State’s Strategic Plan
  ◦ Section 3014 of HITECH Act

Funds may be used to
  ◦ Facilitate purchase of EHR technology
  ◦ Enhance utilization of EHR technology (includes upgrade)
  ◦ Train personnel
  ◦ Improve secure electronic exchange

State must provide matching funds ($1/every $5 of Federal funds)

Effective January 1, 2010
Questions?

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Health Law Blog: www.omwhealthlaw.com with a
Special Section for Critical Access Hospitals