Critical Access Hospitals & The HITECH Act

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Association of Washington Public Hospital Districts

Presenters

- **David Schoolcraft,**
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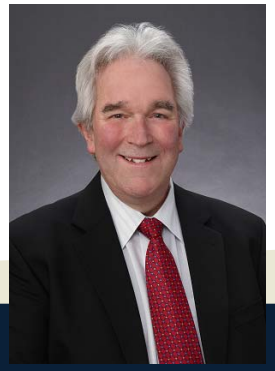

- **Jeff Mero, Executive Director, AWPHD**

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

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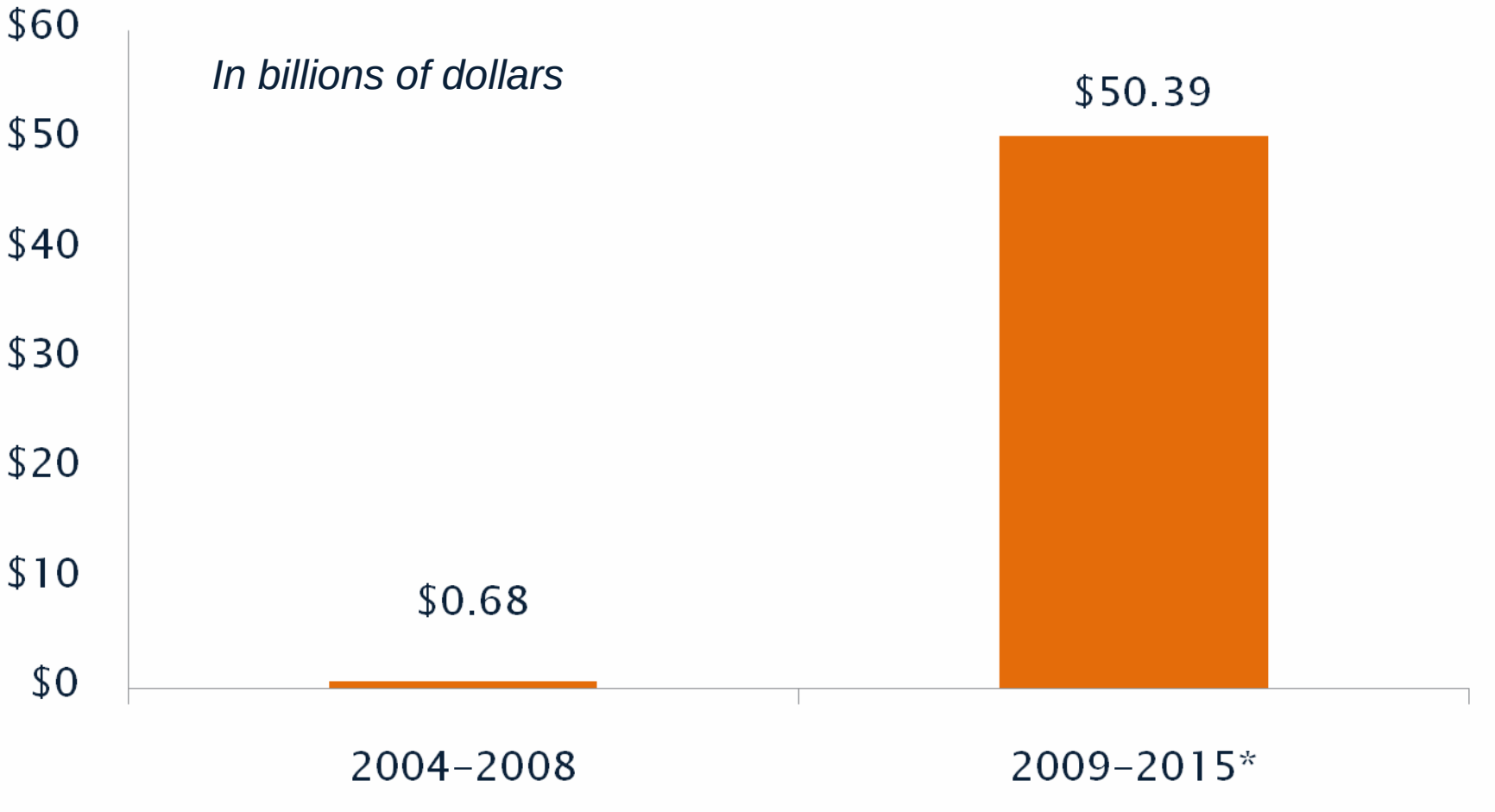
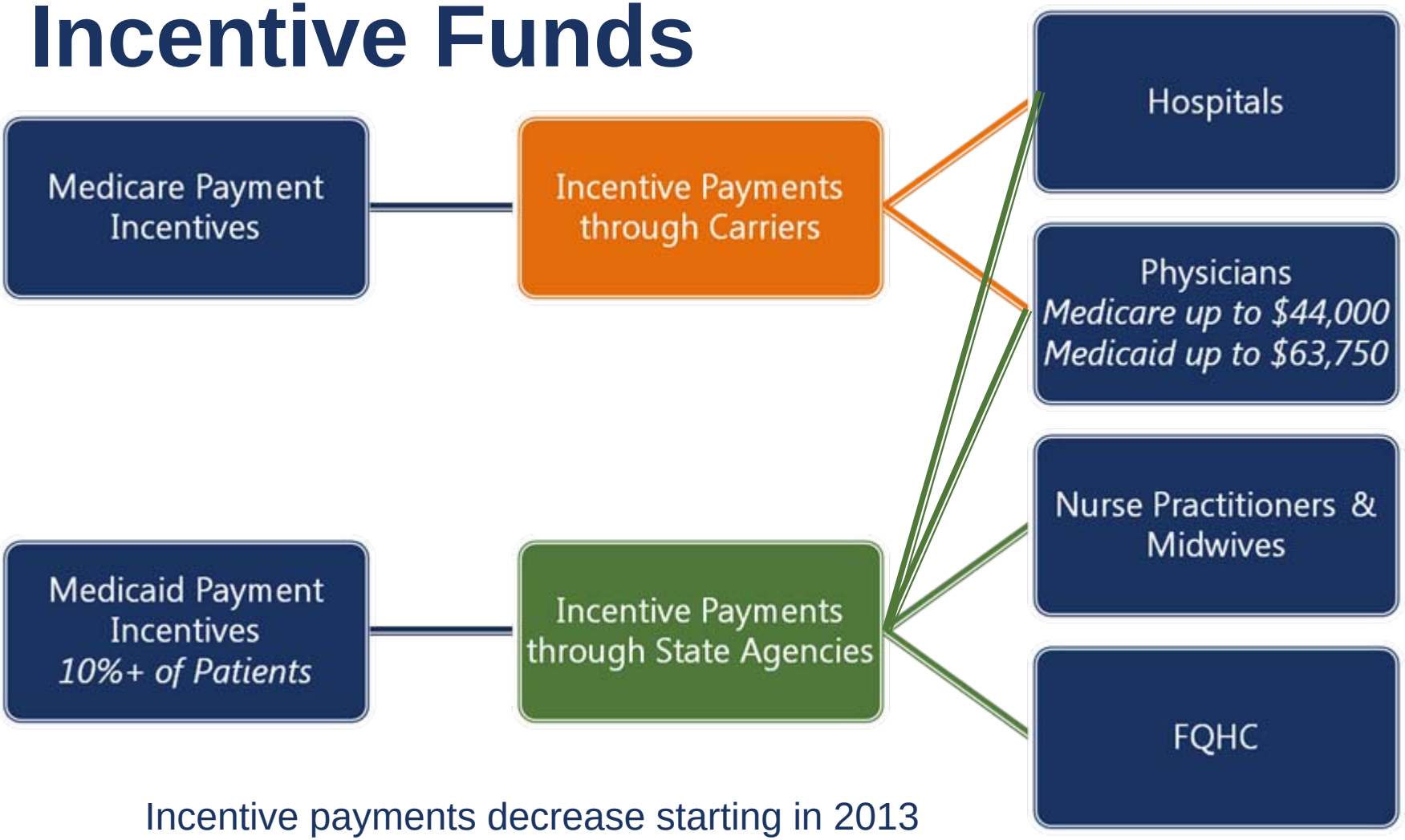
Part I
Federal Incentive Funds

Scope of Health IT Funding



*Estimated, includes incentive payments

Incentive Funds



Incentive payments decrease starting in 2013
Penalties (lower reimbursements) starting in 2015

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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

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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)

$$\frac{\text{Medical Assistance Inpatient Days (Medicaid)}}{\text{Total \# Inpatient Days}} * \left(\frac{\text{Total Amount of Hospital Charges - Charity Care}}{\text{Total Amount of Hospital Charges}}\right)$$

- States allocate the money
- Year 1 – Demonstrate efforts to adopt, implement or upgrade EHR system
- Years 2-6 – Demonstrate "meaningful use"

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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

Excluded Physicians
Pathologists
Anesthesiologists
Emergency Physicians

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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

Meaningful EHR User	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	Total
FY 2011	$ 18,000	$ 12,000	$ 8,000	$ 4,000	$ 2,000			$ 44,000
FY 2012		$ 18,000	$ 12,000	$ 8,000	$ 4,000	$ 2,000		$ 44,000
FY 2013			$ 15,000	$ 12,000	$ 8,000	$ 4,000		$ 39,000
FY 2014				$ 12,000	$ 8,000	$ 4,000		$ 24,000
After FY 2015					1%	2%	3%	

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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

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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.

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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

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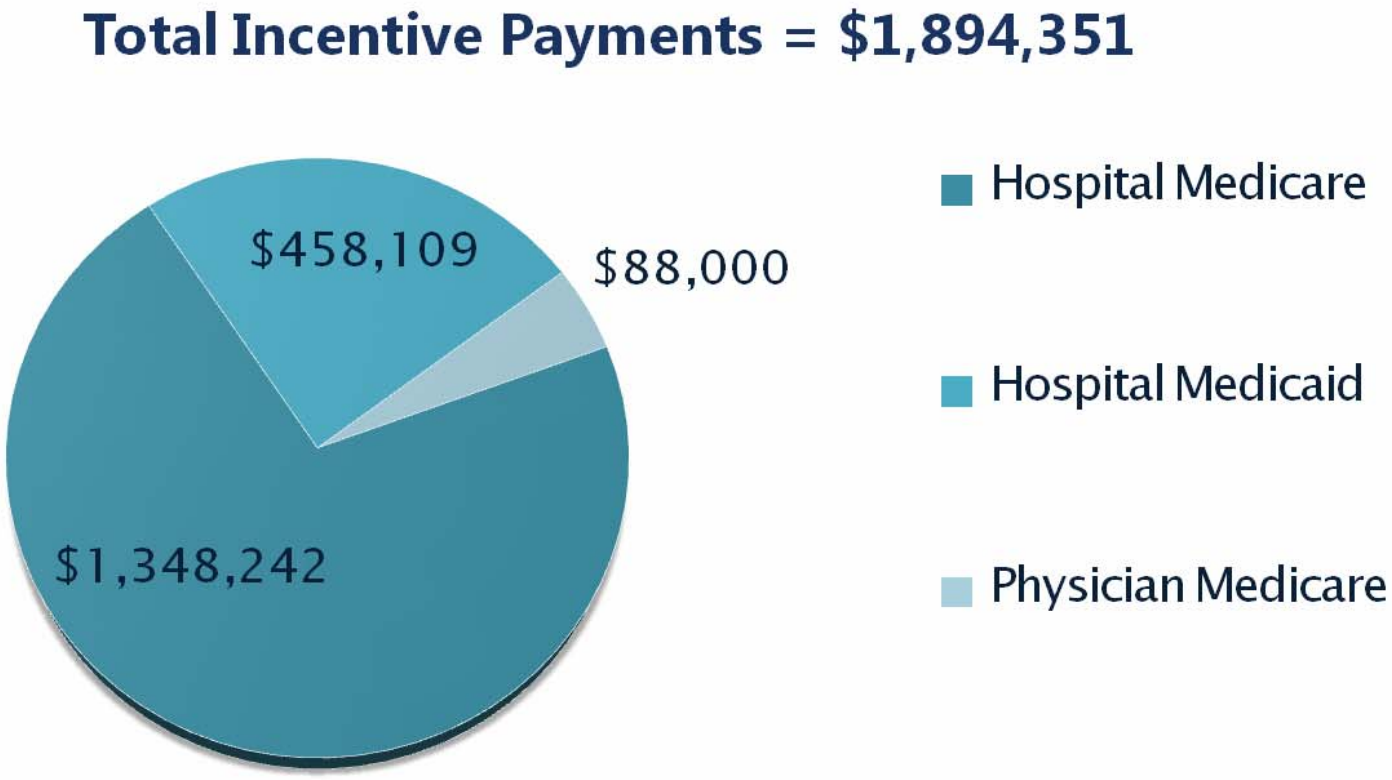
Scope of Incentive Funds-Example #2

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



Estimates based on certain factual assumptions.
Subject to revision under final HHS regulations.

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Key Terms for Medicare/Medicaid

Incentives for Adoption and "Meaningful Use" of "Certified EHR Technology"

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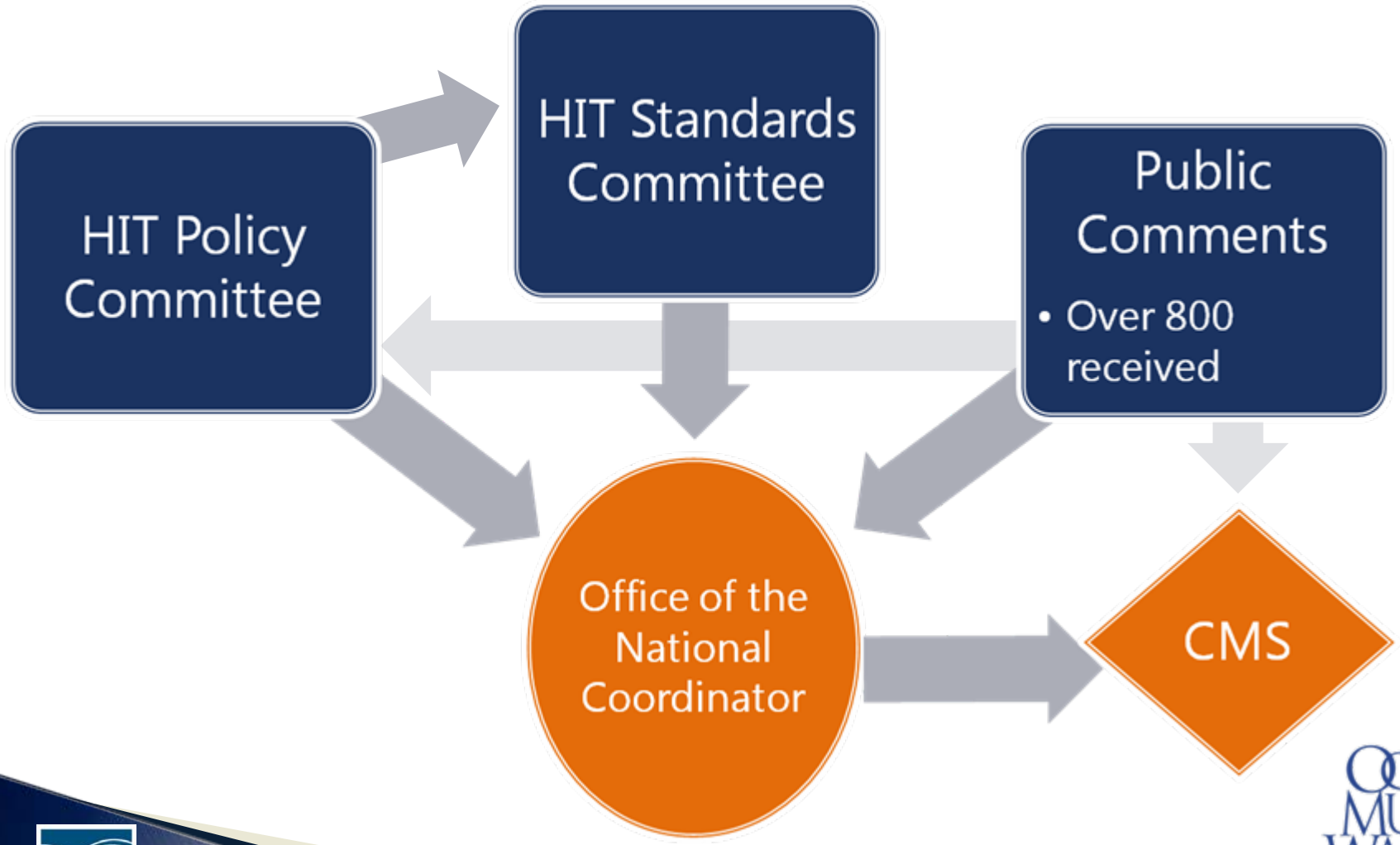
“Meaningful Use”- Policy Process



Meaningful Use Matrix

Health Outcomes Policy Priority	Care Goals	2011[1] Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions*		2011[1] Measures	2013 Objectives *Goal is to electronically capture in coded format and to report health information and to use that information to track key clinical conditions*		2013 Measures	2015 Objectives Goal is to achieve and improve performance and support care processes and on key health system outcomes	2015 Measures
		Eligible Providers	Hospitals		Eligible Providers	Hospitals			
Improve quality, safety, efficiency, and reduce health disparities	• Provide access to comprehensive patient health data for patient's health care team • Use evidence-based order sets and CPOE • Apply clinical decision support at the	• Use CPOE for all orders[2] • 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)	• 10% of all orders (any type) directly entered by authorizing provider (e.g., MD, DO, RN, PA, NP) through CPOE[2] • 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	• 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]	• Use CPOE for all orders • Use evidence-based order sets • Record family medical histo	• Use CPOE for all order types • Use evidence-based order sets • Conduct closed loop medication management,	• Additional quality reports using HIT-enabled NQF-endorsed quality measures [EP, IP]	• Achieve minimal levels of performance on quality, safety, and efficiency measures	• Clinical outcome measures (TBD) [OP, IP] • Efficiency measures (TBD)

Matrix describes objectives and measures for 2011, 2013 and 2015 for both providers and hospitals based on certain health outcome policy priorities

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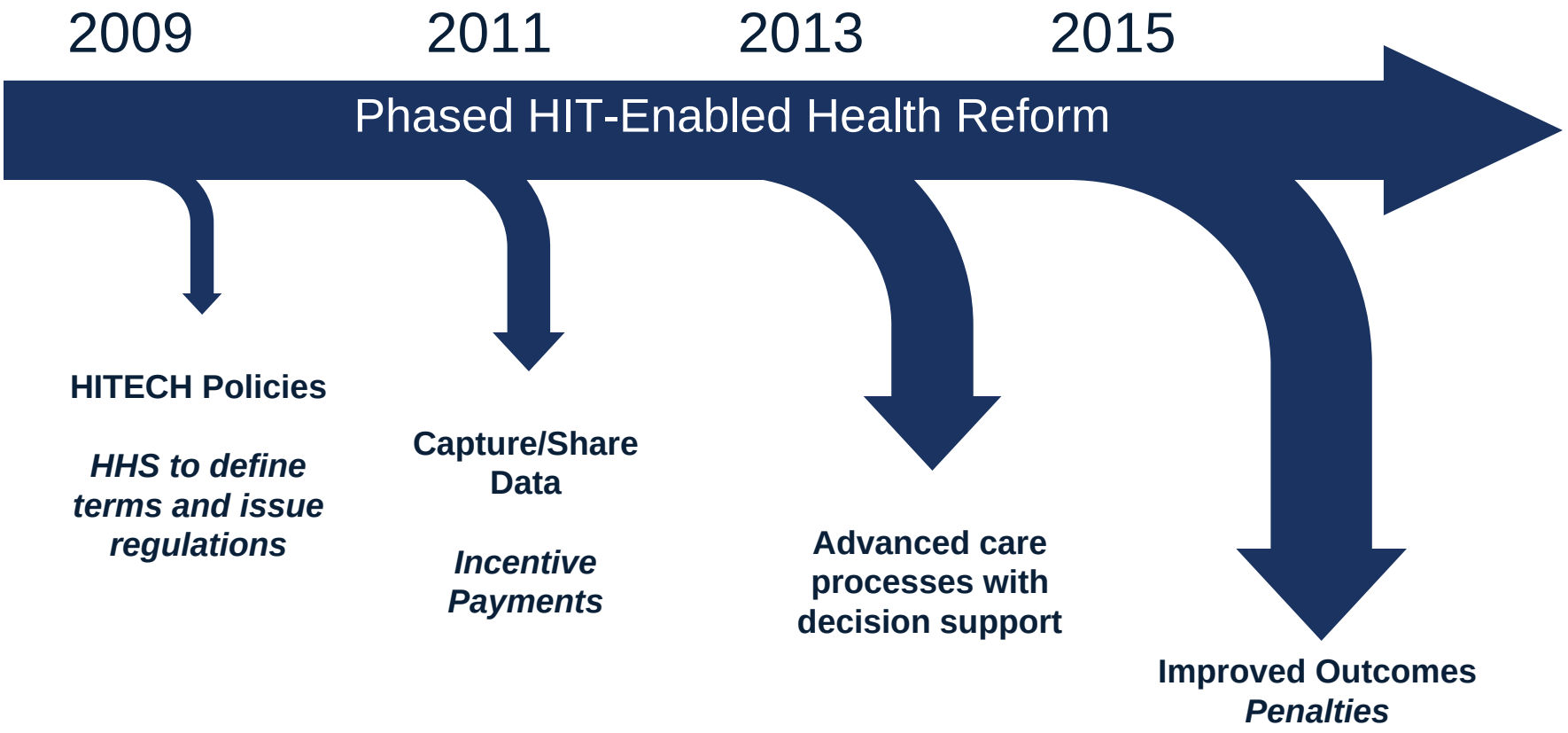
“Meaningful Use” - Timeline



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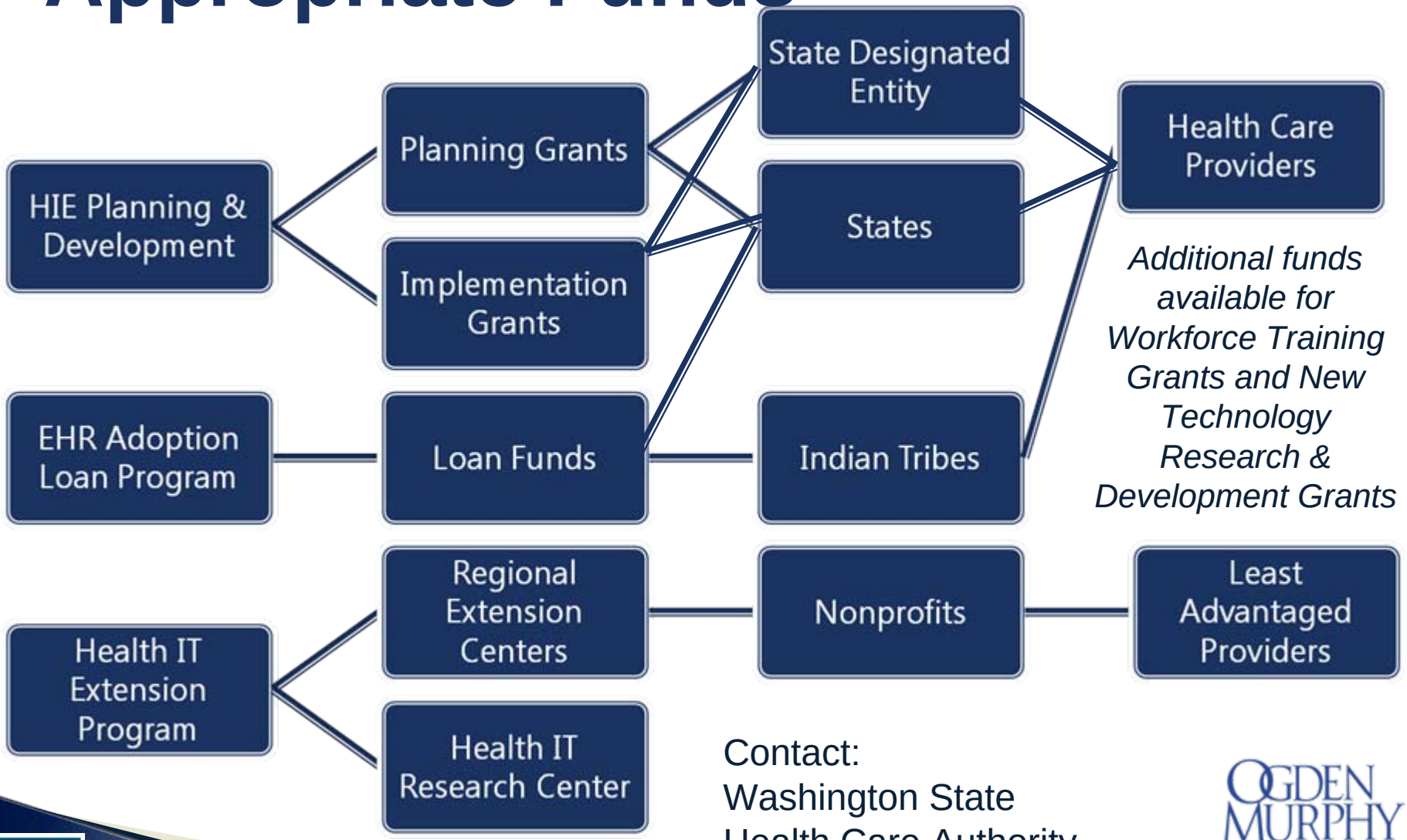
Part II
Additional HITECH Funding

Appropriate Funds



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**

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Health Information Exchange

Dr. David Blumenthal

"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

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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.

    http://www.onehealthport.com/HIE/index.php
- Creation of a new governance model between OneHealthPort and HCA

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EHR Loans

- 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

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Questions?

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