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American Recovery and Reinvestment Act of 2009

Background, overview, and implications for healthcare providers

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CAVEATS

AS DISCUSSED MORE FULLY IN THIS PRESENTATION, THERE ARE MANY UNKNOWNS AND UNANSWERED QUESTIONS AT THIS MOMENT

- In order to make this material comprehensible, the information presented here is, in some cases, oversimplified to give a sense of the situation.
- In some cases, inferences have been made in arriving at the conclusions or representations contained herein
- This presentation is not intended as specific guidance as to how to structure an arrangement that complies with the statutory or regulatory requirements.

THIS IS NOT LEGAL ADVICE.

- Legal advice can only be rendered by a qualified individual with full knowledge of the specific plans and situation in question.

Topics

Quick Summary

Healthcare-related Provisions of the American Recovery and Reinvestment Act of 2009

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Key Provisions Affecting Healthcare

- Medicare and Medicaid incentives to encourage use of health IT in patient care, followed by penalties for failure to adopt HIT
- Government-led development of IT standards that allow nationwide electronic information exchange
- Strengthening patient privacy and security law to prevent misuse of health information
- Additional funding for deployment of broadband infrastructure in un-served and under-served areas
- Mandate for HHS to develop and promulgate HIT solutions unless market is meeting need
- Expansion of responsibilities of Business Associates
- Breach notification
- Enhanced civil and criminal penalties
- States Attorney General enforcement of HIPAA

Source: Healthcare Advisory Board, ARRA

Funding is also provided for a variety of other, related areas

- Research and Development Funding
- Infrastructure Grants
- HIT Implementation Assistance
- Regional HIT Extension Centers
- State Grants
- Competitive Grants to States and Tribes for Loan programs
- Clinical Education Grants
- Medical Informatics Program Grants
- Broadband Expansion

Short legislative process for ARRA

- Technical Corrections Bill may alter substance of legislation
- Broad delegation to Agencies (e.g., HHS), means significant elements are yet to be defined.

It is difficult for Congress to draft well, let alone perfectly

Linda Jellum

Chevron's Demise: A Survey of Chevron from Infancy to Senescence

Source: Linda Jellum, Chevron's Demise: A Survey of Chevron from Infancy to Senescence, 59 Administrative Law Review, 725, 737 (2007)

Summary of ARRA 2009 spending

Description	Funds allocated	Estimated cost ($millions)
Food and farming	$26,466	$26,431
Commerce, justice and science	$15,920	$15,810
Defense	$4,555	$4,531
Energy and the environment	$50,825	$50,775
Government	$6,858	$6,707
Homeland security	$2,755	$2,744
Outdoors, Indian reservations and the arts	$10,950	$10,545
Labor and volunteering, healthcare and social services, education, social security	$72,564	$71,271
Oversight	$25	$25
Military and veterans	$4,281	$4,246
Foreign relations	$602	$602
Transportation and housing	$61,795	$61,051
Aid to states	$53,600	$53,600
Tax cuts	$301,278	$288,482
Individual aid	$45,788	$58,143
Individual healthcare aid	$24,749	$24,677
Incentive (Aid) payments to physicians and hospitals for EHRs	**$17,559**	**$17,559**
Aid to states for Medicaid (including EHR-related payments)	$90,044	$90,042
TOTAL	**$790,614**	**$787,241**

Getting to $787 Billion, The Wall Street Journal (17 February 2009) available at http://online.wsj.com/public/resources/documents/STIMULUS_FINAL_0217.html (last accessed 15 March 2009).

Summary of ARRA Health-related Spending

Description	Cost ($millions)
Renovation and health IT purchases for community health centers	$2,000
Training of nurses, primary care physicians, dentists to practice in underserved communities in the National Health Service Corps	$500
National Institutes of Health biomedical research	$9,500
National Institutes of Health buildings and facilities repairs and renovations	$500
Funding for research comparing effectiveness of treatments funded by Medicare, Medicaid and SCHIP	$1,100
Grants to states for childcare services for low-income working parents	$2,000
"Head Start" programs for low-income preschoolers	$1,000
"Early Head Start" programs for low-income infants	$1,100
Grants for community employment, food, housing and healthcare projects	$1,000
Grants to faith-based and community organizations	$50
Grants for elderly nutrition services including Meals on Wheels	$100
Extra money for Office of the National Coordinator for Health Information Technology	$2,000
Funding for community preventative health campaigns, vaccination programs, healthcare-associated infection reduction strategies	$1,000
Funding to improve IT security at the Department of Health and Human Services	$50
Oversight of Department of Health and Human Services spending	$17
TOTAL	**$21,197**

Note: EHR incentives are not ‘spending’ but are classified as ‘aid’

Getting to $787 Billion, The Wall Street Journal (17 February 2009) available at http://online.wsj.com/public/resources/documents/STIMULUS_FINAL_0217.html (last accessed 15 March 2009).

WHAT EXPERIENCE AND HISTORY TEACH US IS THIS – THAT PEOPLES AND GOVERNMENT HAVE NEVER LEARNED ANYTHING FROM HISTORY OR ACTED ON PRINCIPLES DEDUCED FROM IT.

Georg Wilhelm Friedrich Hegel
Philosophy of History, Introduction

Electronic Health Records

Incentives for Meaningful Use – Physicians

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Carrots and Sticks for meaningful EHR use

TO ENCOURAGE PHYSICIAN USE OF EHRS, ARRA PROVIDES INCENTIVES WHICH MORPH INTO PENALTIES

- Physicians with low levels of Medicare revenue or those planning to retire in the near-term may not find the incentives or penalties to be a significant motivator for adoption.
- Hospital-based physicians (e.g., ED, pathology, anesthesiology) are not eligible for incentive payments.
- Failure to be a meaningful user of a qualified EHR by 2015 will result in reduction in Medicare payments (1% per year, capped at a 5% reduction).
  - There is no penalty in ARRA under Medicaid for failure to become a meaningful EHR user.
- Medicare incentives are not based upon cost of the chosen EHR solution.
  - Medicaid monies (discussed below) are based upon actual physician cost.
- Potential for early adopter physician to obtain subsidy under STARK/AKS allowance and collect Medicare incentive monies.
  - STARK/AKS allowance expires in 2013.
- EHR incentives may be limited or require additional regulatory action for certain states and provider types.
- Also, do not forget e-prescribing penalties (MIPPA 2008)

Carrots and Sticks for meaningful EHR use

Physicians may be eligible for up to $44,000 for meaningful EHRs use. Failure to become a meaningful user will result in penalties.

- There is a slight benefit to engaging in meaningful use in 2011 or 2012 versus later ($5,000), which may or may not be worth the cost of rushing.
- Penalties are a reduction in Medicare payment rates.
- Physicians in designated health professional shortage areas get a 10% bump in incentive payment amounts (e.g., total of $48,400 versus $44,000)
- Payments are capped at the lesser of 75% of Medicare allowable professional charges or the amount in the table, below.

MU year	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
2011	18	12	8	4	2					44
2012		18	12	8	4	2				44
2013			15	12	8	4				39
2014				12	8	4				24
2015										
None					(1%)	(2%)	(3%)	(4%)	(5%)	(??)

MU year – first full year of meaningful EHR use.

Carrots for meaningful EHR use under Medicaid

There are parallel, but different EHR use incentives under Medicaid

- Medicaid is a program funded by the federal government and administered by the states
- ARRA funds:100% of the direct payment outlays by the states; 90% of the administrative costs for the EHR use incentives
- Key items
  - 85% of actual EHR adoption cost, subject to caps
  - Parallel requirements for qualified use of a certified EHR
- Eligibility
  - Physicians, dentists, certified nurse midwives, nurse practitioners, and others
  - Minimum 30% Medicaid patient load (20% for pediatricians)
- Payments funded by Feds
  - Up to $21,250 to acquire (maximum 85% of $25,000 acquisition cost)
    - Until 2016
  - Up to $8,500 annually for five years for operating costs (maximum 85% of $10,000/year)
    - Until 2021
  - Total $63,750 over five years – could be reduced if HHS believes average cost to acquire and maintain would be less (the Wal-Mart sale price?)
  - States could use own money to pay more (unlikely)

CERTIFIED EHR -- THE CLIFF NOTES VERSION

- Certified by HHS
- Meet standards adopted by the National Coordinator for Health Information Technology
- Must include demographics, medical history, problem lists, quality indicators
- Clinical decision support and provider order entry
- Exchange clinical information to/from other organizations
- Voluntary Certification Program in collaboration with NIST

Electronic Health Records – Meaningful Use

To obtain the incentives, the physician must be a meaningful EHR user

- Use a *certified EHR*;
- Use the electronic prescribing function of the EHR;
- Use the EHR in a manner which leads to the electronic exchange of health information to improve the quality of care, such as care coordination; and
- Submit clinical quality measures.

Certified EHR Technology

- A *qualified electronic health record* that is certified by HHS

Qualified electronic health records

- ‘‘(A) includes patient demographic and clinical health information, such as medical history and problem lists; and
- ‘‘(B) has the capacity— *[does not say you must use it]*
  - ‘‘(i) to provide clinical decision support;
  - ‘‘(ii) to support physician order entry;
  - ‘‘(iii) to capture and query information relevant to health care quality; and
  - ‘‘(iv) to exchange electronic health information with, and integrate such information from other sources.

42 U.S.C. 1395w-4(o)(1)(A)(ii)

Electronic Health Records

Incentives for Meaningful Use – Hospitals

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Hospital Incentive Payment Calculation

FORMULA IS

- **Initial Amount** multiplied by **Medicare Share** multiplied by **Transition Factor**
  - "Initial Amount" is
    - $2M + $200 for each eligible discharge
      - *Eligible discharges* -- between the 1,150th to 23,000th discharge in a 12 month period
        - Essentially $0 for first 1,149 discharges and $0 for each discharge after 23,000
  - Medicare share calculation:
    - *Medicare inpatient days* divided by *non-charity care inpatient days*
      - Non-charity care days = total inpatient days multiplied by (1-charity care percentage)
        - Charity care percentage
          - (gross revenue – charity revenue forgone) / gross revenue
  - Transition factor
    - Depends on
      - year Hospital first qualifies for meaningful use
      - Ordinal year from first qualifying for meaningful use
      - See table next slide

Hospital Medicare Incentives are based upon Medicare Discharges and Inpatient Days

- Failure to adopt results in a reduction in the Market Basket Adjustment Percentage

MU year	2011	2012	2013	2014	2015	2016	2017
2011	100%	75%	50%	25%			
2012		100%	75%	50%	25%		
2013			100%	75%	50%	25%	
2014				75%	50%	25%	
2015					50%	25%	
None					(25%)	(50%)	(75%)

- Meaningful use and other terms very similar for Hospital as for Physician
- Medicaid
  - Medicaid will pay 85-90% of allowable costs for adoption/maintenance of EHRs up to caps – somewhat unclear pending HHS regulations and state decisions
  - No penalties under Medicaid
  - EHR incentives may be limited or require additional regulatory action for certain states and provider types..

MU year – first full year of meaningful EHR use.

Hospital Incentive – Medicare Example

Line item	Amount	Comment
Discharges	33,087	Assumption #1
Lesser of actual or 23,000	23,000	No payment over 23,000 Discharges
Less floor	(1149)	No payment for first 1,149 discharges
Eligible discharges	21,851	
Incentive per eligible discharge	$200	Per ARRA
Discharge-based incentive	$4,370,200	
Based amount	$2,000,000	Base Amount
Subtotal	$6,370,200	
Medicare share	52%	Assumption #2
Incentive Payment	**$3,312,504**	**Year 1, 100% payment**

Expanding Health and Human Services

Office of the National Coordinator, Committees

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Adding More Hands To Carry Out The Instructions

ARRA creates new committees and Formalizes existing roles

- Office of the National Coordinator (ONCHIT) charged with developing a nationwide HIT infrastructure to improve quality, reduce costs, and protect privacy
  - Transition from an Executive-creation to Congressionally chartered
  - Gives Congress more leeway to direct ONCHIT
- Chief Privacy Officer to be appointed by ONCHIT within 12 months
- HIT Policy Committee
  - Federal Advisory Committee to make recommendations to ONCHIT regarding nationwide infrastructure and Federal Health IT strategic plan
  - Includes policies that will address standards, implementation specifications, certification criteria, authentication, and privacy/security
- HIT Standard Committee
  - Federal Advisory Committee to recommend standards, implementation specifications and certification criteria needed to achieve interoperability
  - Secretary of HHS has until December 31, 2009 to adopt the initial set of standards
  - Acts on recommendations of Policy Committee
  - Secretary must submit a report within 2 years (and annually thereafter) describing actions taken to create a nationwide health IT network

Security and Privacy

HIPAA Redux and Breach Notification

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Hegel remarks somewhere that all great, world-historical facts and personages occur, as it were, twice. He has forgotten to add: the first time as tragedy, the second as farce.

Karl Marx

The Eighteenth Brumaire of Louis Napoleon

ARRA expands HIPAA to impose new Privacy and Security requirements

- New requirements imposed upon
  - Covered Entities
  - Business Associates
  - Personal health record (PHR) vendors and various other PHR-related entities
- Expands HIPAA Privacy and Security requirements
  - Strengthens and expands the scope of the HIPAA privacy and security rules,
  - Enhances the HIPAA penalty provisions,
  - Provides for HIPAA enforcement by state attorneys general,
  - Regulates PHR vendors, and
  - Establishes a federal data breach notification law.
- Operational changes will be required of covered entities and others
- Stepped up penalties – civil and criminal
  - Penalties apply to employees and other individuals
- HHS required to undertake audits, with bias towards penalties
- State Attorneys General may enforce HIPAA
- Disclosure accounting requirements – especially on providers with EHRs
- Limits on marketing and fund raising

New Breach law applies to covered entities and business associates

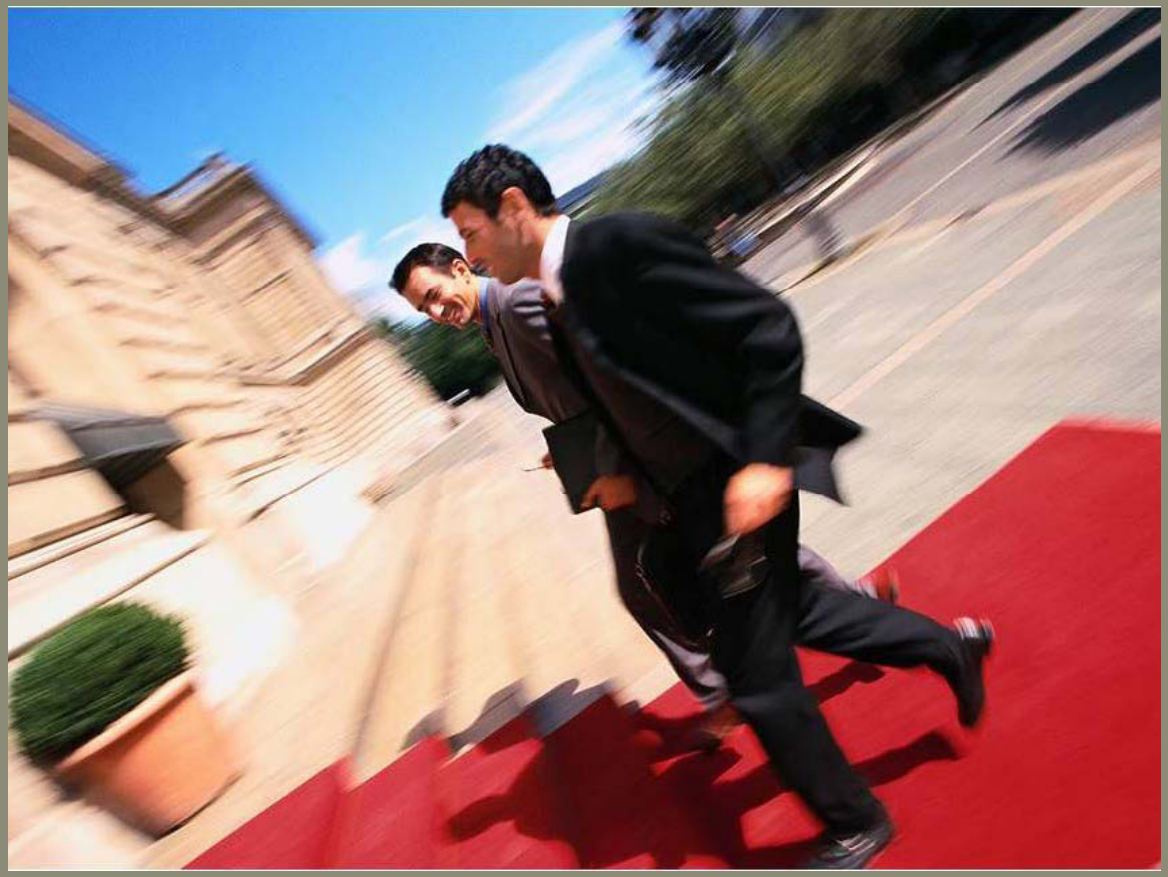
- Must notify each individual
  - whose “unsecured protected health information”
  - is reasonably believed to have been
  - accessed, acquired, or disclosed by a “breach.”
- Breach has a complex and potentially confusing definition
- Specifics on content, timeliness and modality of notification set forth
- If over 500 individuals affected by breach, must notify
  - Secretary HHS (HHS to post breach notice on its own website)
  - Media
- Applies to all health information, not just electronic health information

Personal Health Records Breach

- Non-HIPAA covered entities
- Requires notification to
  - Individual
  - Federal Trade Commission
    - FTC then tells HHS
- Encompasses service providers to PHR vendors
- Defines failure to notify as an unfair or deceptive trade practice
  - Allowing full power of FTC to investigate and prosecute
- FTC to promulgate regulations within 180 days
- Expansive definition of breach of security
  - acquisition of unsecured PHR identifiable health information of an individual in a personal health record without the authorization of the individual [ARRA §13407(f)]

Relationship to State Breach Notification Laws is Ill-defined

- Total preemption and/or
- Only if more stringent



Action Steps

What Healthcare Providers Should Do

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The Specific Action Steps Vary by Provider

- Electronic Health Records
  - Acute-Care
  - Ambulatory
    - Owned Practices
    - Community Physicians
  - Health Information Exchange (HIE) and Regional Health Information Organizations (RHIOs)
- Privacy and Security
- Academic Medical Centers
  - Research
  - Facilities (Buildings)
  - Education
- Other
  - Bonds
  - Track: regulations, grants, state actions
  - Broadband funding
- Lead, educate, promote!

ACTION ♦ STEPS

Action Steps – Electronic Health Records

Hospital – Acute Care

- Timeline
  - What is the timeline for achieving meaningful use?
  - Is acceleration needed or even possible?
- Obstacles
  - Identify barriers
  - Plan to surmount obstacles
- Money
  - Project potential incentive payments
  - Estimate potential penalties in 2015 and beyond
  - Funding needed to achieve earliest possible meaningful use
- Prioritize
  - Clear the decks for EHR push
  - Assess staffing levels and begin training/hiring now
- Software issues
  - Modify contracts to require certified EHR, and ongoing compliance
  - Get in vendor's queue now and lock in vendor staff commitments

ACTION ♦ STEPS

Hospital – Physician Office Solutions

- Timeline
  - What is the timeline for providing a solution?
    - Employed physicians
    - Community physicians
  - Is acceleration needed or even possible?
- Obstacles
  - Identify barriers and plan to surmount obstacles
- Review and revise Ambulatory strategy
- Communicate with physicians
  - Communication and education plan
  - Correct myths and misconceptions
- Health information interchange challenges
- Use of Stark and AKS donation exception/safe harbor before end of 2013?
- Software issues
  - Modify contracts to require certified EHR, and ongoing compliance
  - Get in vendor's queue now and lock in vendor staff commitments

ACTION ♦ STEPS

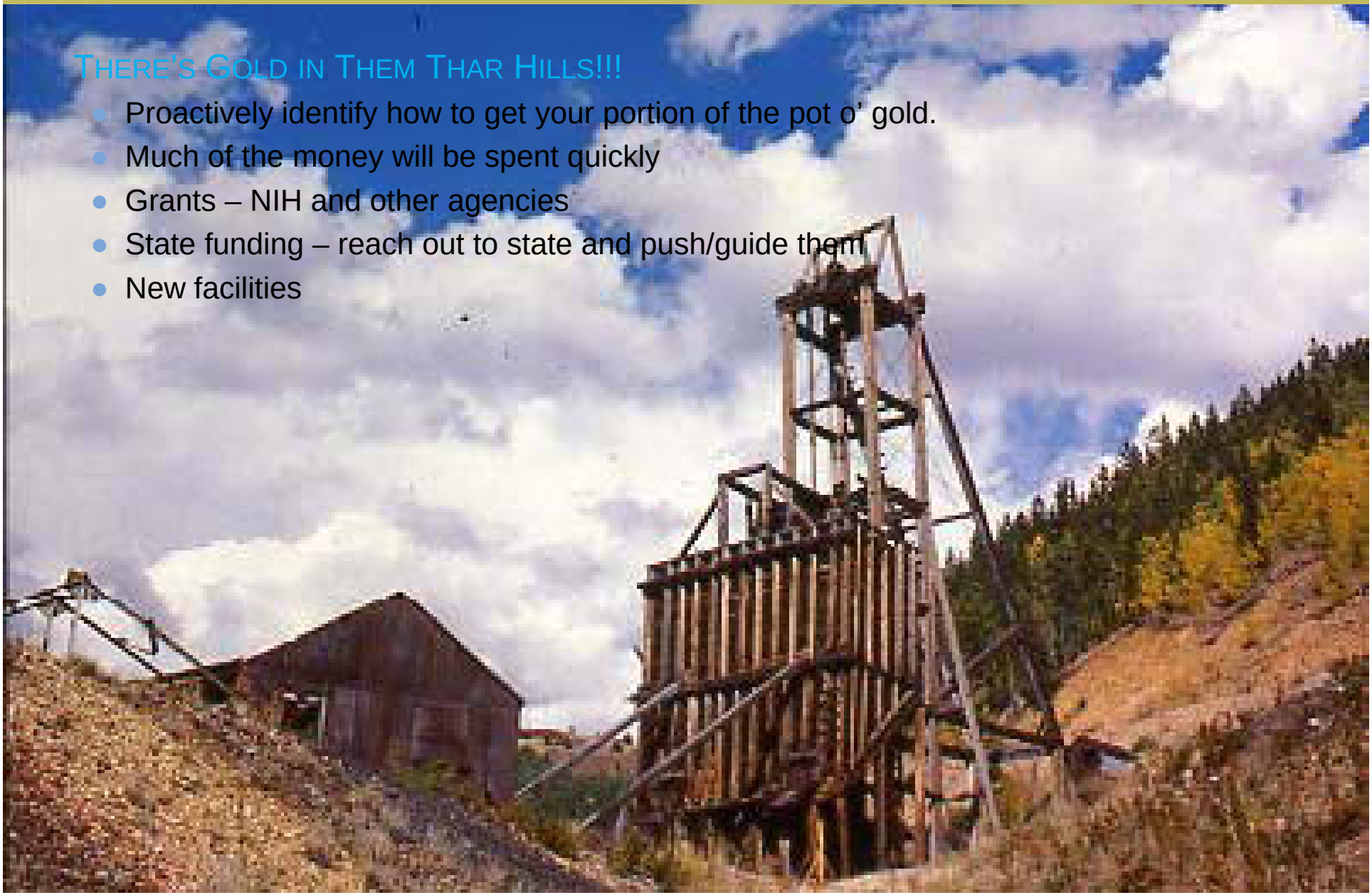
Action Steps – Security and Privacy

FULLY PREPARING FOR THE SECURITY AND PRIVACY CHANGES WILL REQUIRE CONTINUAL AWARENESS OF THE REGULATIONS

- Review and revised business associate agreements (BAAs)
  - Inventory all BAAs
  - Re-qualify BAAs – can your BAAs realistically meet new requirements?
- Update employee education
- Assess data encryption needs
- Review
  - Fundraising
  - Marketing
  - Disclosure approaches and policies
- Enhanced audit trails
  - Identify software updates needed to comply with audit trail requirements
  - Discuss capabilities with vendors
  - Define storage requirements for enhanced audit trails
  - Diagram all flows as they exist – what changes may be required
- Educate senior management and Board

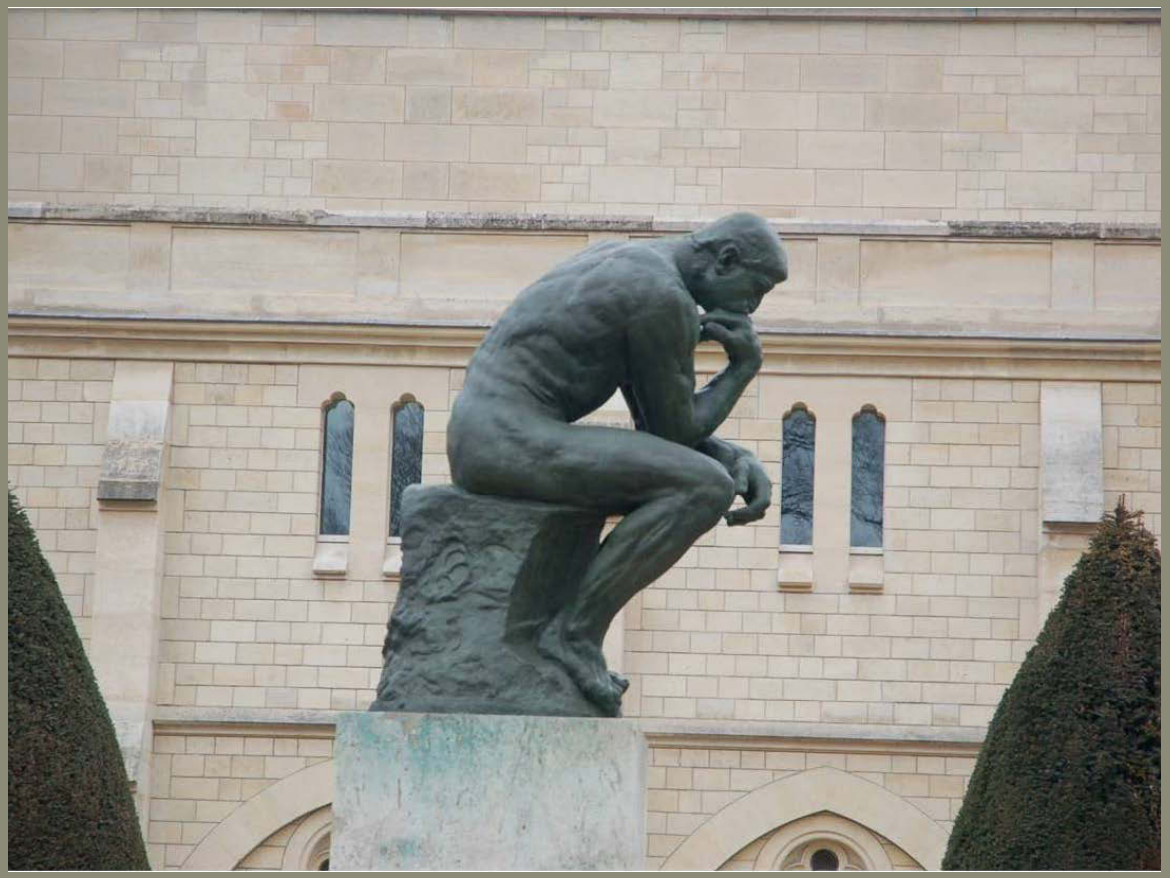
ACTION ♦ STEPS

Action Steps – Money



There's Gold in Them Thar Hills!!!

- Proactively identify how to get your portion of the pot o' gold.
- Much of the money will be spent quickly
- Grants – NIH and other agencies
- State funding – reach out to state and push/guide them
- New facilities



Questions?

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