

Federal Funding Opportunities

From ARRA In Health Information Technology

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Presentation Overview

- Review of ARRA
- Medicare Provisions
- Meaningful User
- Medicaid Provisions
- HIT in ARRA

Office of Rural Health Policy

- FLEX Critical Access Hospitals Health Information Technology Network
- State Offices of Rural Health
- Rural Hospital Flexibility
- Rural Health Outreach
- Network Development
- Network Development Planning
- Small Rural Hospital Improvement
- Small Health Care Provider Quality Improvement

HRSA/Office of Health Information Technology

- Division of HIT State and Community Assistance offers the following grant opportunities in FY 2009
 - EHR Implementation for Health Center Controlled Networks Grant
 - HIT Implementation for Health Center Controlled Networks Grant
- Office for the Advancement of Telehealth grant opportunities in FY 2009
 - Telehealth Network Grant Program
 - Licensure Portability Grant Program
 - Telehealth Resource Center Grant Program

What Funds Are Out There?

- Funds available from a number of Agencies
 - HRSA, AHRQ, CMS, NTIA, FCC, NIST
- ARRA has provided for funds to be distributed through above agencies and ONC
- Nothing is static

Summary of ARRA HIT Funding

- Total \$19.2 Billion for HIT
 - \$2 Billion for ONC
 - \$17.2 Billion for incentives through Medicare and Medicaid Reimbursement systems
- Codifies ONC, HIT Standards Committee, HIT Policy
- Provides grant and loan programs to assist providers and consumers in adopting HIT
- Privacy and Security provisions in HIPAA for electronic health info

Summary of ARRA HIT Funding (CONT)

- \$4.7 Billion for Broadband Technology (NTIA)
- \$2.5 Billion for USDA Distance Learning, Telemedicine, Broadband Program
- \$500 million to SSA
- \$85 million for IHS
- \$50 million for VA

The American Reinvestment and Recovery Act (ARRA)

- Title VI- BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM
- TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY; MISCELLANEOUS MEDICARE PROVISIONS
- TITLE XIII—HEALTH INFORMATION TECHNOLOGY

Title VI- BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM

- \$4.7 Billion for Broadband Technology Opportunities Program: grants to States and other entities for acquiring equipment and other technologies related to providing broadband service infrastructure
- \$2.5 Billion for broadband loans and loan guarantees. Recipients of these funds may not receive funds under the other program described above

Title VI- BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM

The purposes of the program are to—

- (1) provide access to broadband service to consumers residing in unserved areas of the United States;
- (2) provide improved access to broadband service to consumers residing in underserved areas of the United States;
- (3) provide broadband education, awareness, training, access, equipment, and support to schools, libraries, medical and healthcare providers, community colleges and other institutions of higher education, and other community support organizations
 - Facilitate Underserved Population Use
 - Job Creation
- (4) improve access to, and use of, broadband service by public safety agencies

Title VI- BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM

- Ensure that all funds are awarded by FY 2010
- Projects are to be completed within 2 years of award
- Eligible entities:
 - States (or political subdivision)
 - Nonprofits
 - Any other entity ruled by the Assistant Secretary of Commerce as acting in the public interest (broadband providers or infrastructure providers included)

2009 RURAL UTILITIES SERVICE BROADBAND INVESTMENT PROGRAM

- ARRA requires that funds be obligated by September 30, 2010
- RUS will offer grants, direct loans and loan/grant combo.
- Funds will be awarded on a competitive basis
- Fund projects that will support rural economic development and job creation beyond the immediate construction and operations of the broadband facilities
- 75% of the investment serves rural areas
- Implement in concert with NTIA and FCC
- <http://www.usda.gov/RUS/TELECOM>

Why is this
relevant?

TITLE IV—MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY PROVISIONS

- Medicare Incentives both Provider and Hospital Based
- Medicaid Incentives to Providers, RHCs, FQHCs, and Hospitals
- Based on “Meaningful HIT Adoption”
- The Law established maximum annual incentive amounts and include Medicare penalties for failing to meaningfully adopt EHRs
- Three broad criteria: 1) Meaningful use of EHR, 2) Information Exchange, and 3) reporting on measures using EHR

Medicare Incentives- Physicians

- Definition of Eligible Professional means a physician as defined in Section 1861 (r) of the Social Security Act:
 - Doctor of Medicine or Osteopathy
 - Doctor of Dental Surgery or of Dental Medicine
 - Doctor of Podiatric Medicine
 - Doctor of Optometry
 - Chiropractor
- Incentive value to be 75% of allowed Medicare charges for professional services for a payment year with yearly maximums

Medicare Incentives- Physicians

- 75% of allowed Medicare Charges for professional services a payment year
 - e.g. 2011 = \$18K, 2012 = \$12K, 2013 = \$8K, 2014 = \$4K, 2015 = \$2k... for 5 years
 - Maximum incentive of \$44K
 - only applicable for 2011-12, and is reduced starting 2013, all payments end in 2016
 - Incentive to adopt incurs a 1% reduction starting in 2015, and reduces 1% each year until 2018
 - In 2018 if its determined that less than 75% of eligible professionals are Meaningful Users, a reduction of no more than 5% can be assessed by the Secretary
 - If providing service in a HPSA, incentive can be bumped 10%

Medicare Incentives- Physicians

- Paid as a lump sum or in periodic payments determinant on the Secretary's Decision
- Hospital based providers are not eligible
- Secretary to establish rules for payments for professionals working in more than one practice as payments will not be duplicative

Medicare Incentives- PPS Hospitals

- Those that are meaningful users by 2013 are eligible for full 4 years of incentive payments
- Penalties for non-users starting in 2015
- Early adopters rewarded, since \$s are paid whether you implemented 5 years ago or any time prior to 2013

Medicare Incentives- CAHs

- CAHs that are meaningful users by 2011 are eligible for 4 years of enhanced Medicare payments (20% over Medicare Share with charity adjustment) with immediate full depreciation of certified EHR costs, including undepreciated costs from previous years.
- Penalties for non-users starting in 2015 (2015 .33% reduction in Medicare reimbursement increases to 1% reduction in 2017)
- Early adopters are not rewarded, since most of their investments have already been made and may be fully depreciated

Medicare Incentives- PPS Hospitals

Incentive payment per PPS Hospital for EHR Meaningful Use Adoption:

\$2M Base + Discharge Payment x Medicare Share

Discharge Payment

- 1st – 1,149th discharge = \$0/discharge
- 1,150th – 23,000th discharge = \$200/discharge
- 23,001st discharge or more = \$0/discharge

Medicare Share

Estimated # of inpatient-bed days with payment under Part A + Estimated # of inpatient-bed days for those enrolled with Medicare Advantage Part C

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Estimated total # inpatient days x Percentage of an eligible hospital's total charges that are not charity care

Medicare Incentives- CAHs

CAH enhanced Medicare payment formula (“formula”):

Total EHR Costs X (Medicare Share + 20%)

Medicare Share

(Estimated # of inpatient-bed days with payment under Part A +
Estimated # of inpatient-bed days for those enrolled with
Medicare Advantage Part C)

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(Estimated total # inpatient days x Percentage of an eligible
hospital's total charges that are not charity care)

Medicare Incentives Applied- CAHs

I. Est. Avg. Total “Eligible Certified EHR” Capital Cost per “Meaningful” CAH	\$1,500,000
II. Est. of Undepreciated Costs When CAH becomes “Meaningful” (80% of Line I)	\$1,200,000
III. Est. Avg. Medicare “Incentive” Share (Inpatient & Charity Stimulus Formula)	65%
IV. Estimated Accelerated Depreciation II x III	\$780,000
V. Incentive Add-on	20%
VI. Value of 20% Add-on (II x V)	\$240,000
VII. Est. Accelerated Depreciation + 20% Add-on (Total IV+V)	\$1,020,000
VIII. Est. Medicare Share Based on Traditional Allocation Cost Report	45%
IX. Est. Traditional Medicare Cost Reimbursement Would Have Received (II x VIII)	\$540,000
X. Est. Net Incentive Typical Eligible Hospital (VII-IX)	\$480,000

- This would be done through Interim Payments

What is Meaningful EHR User?

- Physician practices
 - Implement CCHIT certified physician practice EMR (though language says certified)
 - Participation in Information Exchange
 - Use CPOE for all orders
 - Electronic interfaces to receiving entities are not required in 2011
 - Quality reporting participation
 - E-prescribing

What is Meaningful EHR User?

Hospitals

- 10% of all orders (any type) directly entered by authorizing provider (e.g., MD, DO, RN, PA, NP) through CPOE
 - Electronic interfaces to receiving entities are not required in 2011
- The HIT Policy Committee recommends that incentives be paid according to an “adoption year” timeframe rather than a calendar year timeframe
 - Qualifying for the first-year incentive payment would be assessed using the “2011 Measures.
- Use of CCHIT certified vendors (though language says certified)
- Participation in Information Exchange
- Quality reporting participation

HIMSS EMR Adoption Model

Stage	Cumulative Capabilities
0	Laboratory, Radiology & Pharmacy Not Installed
1	Laboratory, Radiology & Pharmacy All Installed
2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support System (CDSS), may have Document Imaging
3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology
4	Computerized Physician Order Entry, CDSS (clinical protocols)
5	Closed loop medication administration
6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS
7	Medical record fully electronic; ability to contribute Continuity of Care Document as byproduct of EMR; Data warehousing in use

EMR Adoption ModelSM

		Urban	Rural
Stage 7	Medical record fully electronic; HCO able to contribute CCD as byproduct of EMR; Data warehousing in use	0.4%	0.0%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	1.1%	0.0%
Stage 5	Closed loop medication administration	4.4%	1.1%
Stage 4	CPOE, CDSS (clinical protocols)	3.5%	0.8%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	43.7%	17.1%
Stage 2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support, may have Document Imaging	31.3%	34.2%
Stage 1	Ancillaries – Lab, Rad, Pharmacy – All Installed	7.8%	12.6%
Stage 0	All Three Ancillaries Not Installed	7.9%	34.2%

EMR Adoption ModelSM

		CA	PPS
Stage 7	Medical record fully electronic; HCO able to contribute CCD as byproduct of EMR; Data warehousing in use	0.0%	0.4%
Stage 6	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	0.0%	1.0%
Stage 5	Closed loop medication administration	1.0%	4.4%
Stage 4	CPOE, CDSS (clinical protocols)	1.0%	3.4%
Stage 3	Clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	18.7%	42.9%
Stage 2	Clinical Data Repository, Controlled Medical Vocabulary, Clinical Decision Support, may have Document Imaging	29.6%	32.8%
Stage 1	Ancillaries – Lab, Rad, Pharmacy – All Installed	13.0%	7.7%
Stage 0	All Three Ancillaries Not Installed	36.7%	7.4%

Medicaid

- EHR Incentive Payments are available through the Medicaid program to:
 - Physicians
 - Nurse Practitioners
 - Nurse Midwives
 - Rural Health Clinics
 - Federally Qualified Health Centers
 - Hospitals



Medicaid Incentive Program Qualifications

- Provider must demonstrate meaningful use of the EHR technology through a means approved by the State and acceptable to the Secretary.
- In determining what is “meaningful use,” a State must ensure that populations with unique needs, such as children, are addressed.
- A State may also require providers to report clinical quality measures as part of the meaningful use demonstration.
- In addition, to the extent specified by the Secretary, the EHR technology must be compatible with State or Federal administrative management systems.

Medicaid Incentives- Providers

- Eligible Professionals are eligible for either Medicare or Medicaid Incentives – NOT BOTH
- Eligible Professional cannot be Hospital based and must have a patient load of 30% Medicaid
 - Payments cover up to 85% of net allowable costs to adopt and operate EHR Technology
 - Allowable costs for the first year are to be the average costs expended for the implementation or upgrade of an EHR system to not exceed \$25 K and cannot occur after 2016
 - Subsequent years are to be calculated at 85% of 10K to not exceed 2016

Defining “Average Allowable Costs”

- The term ‘average allowable costs’ means the average costs for the purchase and initial implementation or upgrade of such technology (and support services including training that is necessary for the adoption and initial operation of such technology).

Medicaid Incentives- Providers cont'd

- If provider is a Pediatrician, then patient volume must be 20% Medicaid and the incentives will be taken at 2/3 the rate
- If eligible provider practices at a FQHC or RHC then patient volume must be 30%
“needy” Individuals
 - Medicaid, sliding fee, uncompensated care, or receiving assistance under Title XIX

Medicaid Incentives- Hospitals

Example:

- If EHR Cost = \$5,000,000 and Medicaid Share = 15%

	<u>Overall Hospital EHR Amount</u>
Year 1 Transition Factor = 1	$1 \times \$5,000,000 = \$5,000,000$
Year 2 Transition Factor = $\frac{3}{4}$	$\frac{3}{4} \times \$5,000,000 = \$3,750,000$
Year 3 Transition Factor = $\frac{1}{2}$	$\frac{1}{2} \times \$5,000,000 = \$2,500,000$
Year 4 Transition Factor = $\frac{1}{4}$	$\frac{1}{4} \times \$5,000,000 = \$1,250,000$
Total 4 Year Sum	\$ 12,500,000

Aggregated payment maximum = Total 4 Year Sum x Medicaid Share = **\$1,875,000**

50% of aggregated payment maximum could be received in one year

Or

90% could be received in a two-year period

- 10% administrative fee for State match, including tracking of meaningful use, conducting oversight, and pursuing initiatives to encourage adoption

TITLE XIII—HEALTH INFORMATION TECHNOLOGY

- ARRA provides \$2,000,000,000 to the Office of the National Coordinator to carry out Title XIII until the funds are expended
 - Title XIII – Health Information Technology for Economic and Clinical Health Act (HITECH) – Inserted
- ARRA is required to direct \$300,000,000 of the \$2,000,000,000 to support regional or sub-national health information exchanges
- Four sections impact how rural will operate: Sections 3011, 3012, 3013, and 3014*

Title XIII (Cont)

Four main focus areas:

- Public Health Information Exchange
- Health Professions
- Health Information Exchange
- Regional Extensions Centers

Section 3011: IMMEDIATE FUNDING TO STRENGTHEN THE HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE

- (1) Health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges
- (2) Development and adoption of appropriate certified electronic health records for categories of health care providers not eligible for support under title XVIII or XIX of the Social Security Act
- (3) Training on and dissemination of information on best practices to integrate health information technology
- (4) Infrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine
- (5) Promotion of the interoperability of clinical data repositories or registries
- (6) Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information
- (7) Improvement and expansion of the use of health information technology by public health departments

SEC. 3012: HEALTH INFORMATION TECHNOLOGY IMPLEMENTATION ASSISTANCE

1. HEALTH INFORMATION TECHNOLOGY EXTENSION PROGRAM
 - To assist health care providers to adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information
2. HEALTH INFORMATION TECHNOLOGY RESEARCH CENTER
 - To provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize health information technology
3. HEALTH INFORMATION TECHNOLOGY REGIONAL EXTENSION CENTERS
 - creation and support of regional centers to provide technical assistance and disseminate best practices and other information learned from the Center to support and accelerate efforts to adopt, implement, and effectively utilize health information technology

HIT Extension Centers

- The Extension Program will establish cooperative agreements through a competitive process to support an estimated 70 (or more) Regional Centers each serving a defined geographic area
- The HITECH Act clearly prioritizes access to health information technology for historically underserved and other special-needs populations, and use of that technology to achieve reduction in health disparities
- The Regional Centers will focus their most intensive technical assistance on clinicians (physicians, physician assistants, and nurse practitioners) furnishing primary-care services, with a particular emphasis on individual and small group practices
- \$643 million is devoted to the Regional Centers

Extension (Cont)

- The Regional Centers will support health care providers with direct, individualized and on-site technical assistance in:
 - Selecting a certified EHR product that offers best value for the providers' needs;
 - Achieving effective implementation of a certified EHR product;
 - Enhancing clinical and administrative workflows to optimally leverage an EHR system's potential to improve quality and value of care, including patient experience as well as outcome of care; and,
 - Observing and complying with applicable legal, regulatory, professional and ethical requirements to protect the integrity, privacy and security of patients' health information.

Eligibility

- For purposes of the Regional Centers cooperative agreements, a “primary-care provider” is any doctor of medicine or osteopathy, any nurse practitioner, nurse midwife, or physician assistant with prescriptive privileges in the locality where s/he practices, who is actively practicing one of the following specialties: family, internal, pediatric, or obstetrics and gynecology.
- The Regional Centers will give priority for intensive, individualized technical assistance to primary-care providers in individual and small-group practices, community and rural health centers, public and critical access hospitals, and other settings predominately serving uninsured, underinsured, or medically underserved patients

SEC. 3013: STATE GRANTS TO PROMOTE HEALTH INFORMATION TECHNOLOGY

- Planning Grants- To be awarded to States or State Designated Entities to expand the exchange of electronic health information, technical assistance (public stakeholders), promotion of HIT in Underserved Populations
- Implementation Grants- To be awarded to States or State Designated Entities to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications
- There is a required match by States:

Required Matching		
Year	State Dollar	Federal Dollar
2011	At least \$1	\$10
2012	At least \$1	\$7
2013	At least \$1	\$3

3013 (Cont)

- Over the next several months, cooperative agreements will be awarded through the **State Health Information Exchange Cooperative Agreement Program** to states and qualified State Designated Entities (SDEs) to develop and advance mechanisms for information sharing across the health care system
- Under these State cooperative agreements \$564 million will be awarded
- The grant programs will support states and/or SDEs in establishing HIE capacity among health care providers and hospitals in their jurisdiction

3013 (Cont)

- Participating states will also be expected to use their authority and resources to:
- Develop and implement up-to-date privacy and security requirements for HIE; Develop directories and technical services to enable interoperability within and across states;
- Coordinate with Medicaid and state public health programs to enable information exchange and support monitoring of provider participation in HIE.
- Remove barriers that may hinder effective HIE, particularly those related to interoperability across laboratories, hospitals, clinician offices, health plans and other health information exchange partners;
- Ensure an effective model for HIE governance and accountability is in place; and
- Convene health care stakeholders to build trust in and support for a statewide approach to HIE



SEC. 3014. COMPETITIVE GRANTS FOR THE DEVELOPMENT OF LOAN PROGRAMS TO FACILITATE THE WIDESPREAD ADOPTION OF CERTIFIED EHR TECHNOLOGY***

The National Coordinator may award competitive grants to eligible entities for the establishment of programs for loans to health care providers

- (1) facilitate the purchase of certified EHR technology;
- (2) enhance the utilization of certified EHR technology
(which may include costs associated with upgrading health information technology so that it meets criteria necessary to be a certified EHR technology);
- (3) train personnel in the use of such technology; or
- (4) improve the secure electronic exchange of health information.

***Currently not part of the ONC plan

Recent ARRA Awards- 9/29/09

“HHS Secretary Kathleen Sebelius today announced awards totaling \$27.8 million to health center-controlled networks and large multi-site health centers to implement electronic health records (EHR) and other health information technology (HIT) innovations. The funds are part of the \$2 billion allotted to HHS’ Health Resources and Services Administration (HRSA) under the American Recovery and Reinvestment Act of 2009 (ARRA) to expand health care services to low-income and uninsured individuals through its health center program.”

ORHP Resources

■ **Rural Health Clinic TA Series**

- Quarterly Conference Call Series & Listserv for all RHCs
- <http://www.narhc.org>

■ **Rural Assistance Center (RAC)**

- One stop shopping for all rural health and human services
- <http://raconline.org>

■ **Rural Health Research Gateway**

- Learn more about past and ongoing studies
- <http://www.ruralhealthresearch.org/>

HIT TA from ORHP

http://healthit.ahrq.gov/portal/server.pt?open=512&objID=1135&mode=2&cid=DA_1127065&p_path=/DA_1127065

The screenshot shows a Mozilla Firefox browser window displaying the Rural Health IT Adoption Toolbox website. The browser's address bar shows the URL: http://healthit.ahrq.gov/portal/server.pt?open=512&objID=1135&mode=2&cid=DA_1127065&p_path=/DA_1127065. The website header includes the U.S. Department of Health & Human Services logo and the AHRQ Agency for Healthcare Research and Quality logo. The main content area features a navigation menu with links such as "Health IT Home", "AHRQ", "Questions?", "Contact Us", "Site Map", "What's New", "Browse", "Print", and "E-mail Updates". The central banner reads "AHRQ NATIONAL RESOURCE CENTER HEALTH INFORMATION TECHNOLOGY HRSA Health IT Community". Below the banner, the text states: "Welcome to the Rural Health IT Adoption Toolbox, developed by the Office of Rural Health Policy (ORHP) in the Health Resources Services Administration (HRSA). This resource is meant to serve rural health providers seeking to implement health IT to improve the overall effectiveness of their institutions. We have organized this resource in a question-and-answer format and have attempted to compile a range of resources relevant to all stages of considering, planning, executing, and evaluating the implementation of health IT." The "Rural Health IT Adoption Toolbox Modules" section lists: 1. Introduction to Rural Health, 2. Getting Started, 5. Financing and Sustainability, and 6. Opportunities for Collaboration. A sidebar on the left contains a "Rural Health IT Adoption Toolbox" menu with items like "About the Toolbox", "Introduction to Rural Health", "Getting Started", "Health IT Selection and Implementation in Rural Settings", "Project Management and Staffing", "Financing and Sustainability", "Opportunities for Collaboration", "Telehealth", and "Patient Quality Improvement, Evaluation and Optimization in Rural Settings". A "Related Links" section at the bottom of the sidebar includes "AHRQ-NRC Home" and "Health IT Adoption". The browser's taskbar at the bottom shows the Start button and several open applications: Microsoft Office, Updated Network We..., Toolbox - Mozilla Firefox, and Microsoft PowerPoint. The system clock in the bottom right corner displays 4:12 PM.

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- ORHP RHC TA Series: www.ruralhealth.hrsa.gov/rhc/

