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# **What's in the stimulus bill and what does it mean for your hospital**

Premier Advocacy

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# What's in the stimulus bill and what does it mean for your hospital

## American Recovery and Reinvestment Act (P.L. 111-5) Healthcare Issues

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# Overview

- President Obama signed H.R. 1 into law on February 17, 2009 as Public Law 111-5.
- \$785 billion economic stimulus package (2009-2019)
- Most money to be used within two years
- Will increase employment by 1.2 and 3.6 million (CBO)
- Compared against a baseline assuming significant job loss
- About \$150 billion is for health-related spending
- Implementation details due from federal agencies by late February (formula-based programs) and May 20, 2009 (competitive grants and contracts)
- Within 20 days of enactment, agencies shall post funding opportunity announcements (i.e., “synopses”) to [www.Grants.gov](http://www.Grants.gov)
- Within 30 days of enactment, the [Grants.gov](http://www.Grants.gov) synopsis shall link to the full announcement on the agency website
- Transparency and accountability – [www.Recovery.gov](http://www.Recovery.gov)

Note: All spending estimates are for 10 years, unless otherwise noted.

## P.L. 111-5: Two Major Sections

- Division A – Appropriations Provisions, which includes new funding for NIH, AHRQ and HRSA as well as part of the funding for HIT and comparative effectiveness initiatives.
- Division B – Tax, Unemployment, Health, State Fiscal Relief and Other Provisions, including new COBRA subsidies, Trade Adjustment Act, health coverage tax credits, increased Medicaid funding and miscellaneous Medicare changes.

# Division A – Appropriations Provisions

- Health Resource and Service Administration (HRSA) = \$2.5 billion
  - Community Health Centers Grants (\$2b)
    - Unrestricted grants (\$500m)
    - Construction/renovation, equipment acquisition including HIT systems, (\$1.5b)
  - Health professions workforce shortage (scholarships, loan repayment and grants to training programs for equipment) (\$500m)
    - \$300m allocated to National Health Service Corps for extending contracts
    - \$200m for nurse and physician training
  - Timeline for expenditures due w/in 90 days of enactment
- National Institutes of Health (NIH) = \$10b
  - Office of the Director of NIH (\$8.2b)
    - Proportionally transfer to various Institutes, Centers, and the Common fund. (\$7.4b)
  - NIH Center for Research Resources (\$1.3b)
    - Construction/repair existing non-federal biomedical and behavioral research facilities (\$1b)
    - Share capital research equipment for entities receiving grants/contracts (\$300m)
  - Improvement/repairs for NIH buildings and facilities (\$500m)

## Division A - Appropriations Provisions (cont.)

- Public Health and Social Services Emergency Fund = \$50m to improve information system security at DHHS
- Preventive and Wellness Fund = \$1b
  - CDC for Immunization (\$300m)
  - Evidence-based strategies addressing chronic disease rates (\$650m)
  - State grants for infection control strategies (\$50m)
  - Timeline for expenditures due w/in 90 days of enactment

## Division A - Appropriations Provisions (cont.)

- Comparative Effectiveness Research (CER) (\$1.1b):
  - Funding for research and development :
    - AHRQ (\$300m) and NIH (\$400m)
    - DHHS (\$400m)
    - Funds cannot be disbursed until 2009 operating plan submitted
  - Funding Conditions:
    - DHHS funding to support accelerated dissemination of CER
      - Such funding cannot to be used to mandate coverage, reimbursement, or other policies for any public or private payer. Purpose is for comparative research; no mention of cost effectiveness (conference report).
  - Establishes Federal Coordinating Council for Comparative Effectiveness Research.
    - 15 members; senior officials of federal agencies; appointed w/in 30 days of enactment.

## Division A - Appropriations Provisions (cont.)

- Health Information Technology (\$2b)
  - Promotion of Health Information
    - Improving health care quality, safety, and efficiency.
  - Development/Adoption of HIT Standards
  - Use of Adopted HIT Standards
  - Testing of HIT Technology
  - Grants and Loans
  - Privacy (See below)
  - (See Division B for Medicare/Medicaid payment incentives)

## Division B - Health, State Fiscal Relief, Medicare, Medicaid

- Tax Provisions
  - Increase marketability of tax-exempt bonds during 2009 and 2010. (\$3.2b)
    - Modifies rules applicable to financial institutions for interest expense related to tax-exempt income
    - Effective for obligations issued after December 31, 2008.
- Premium Assistance
  - Trade Adjustment Act Health Coverage Improvement
    - Increases from 65% to 80% refundable tax credit to certain unemployed/pension recipients through December 31, 2010.
    - Effective 60 days after enactment
  - Premium Assistance for COBRA Continuation of Coverage Benefits (\$25b).
    - Provides a 65% subsidy of COBRA for up to 9 months for fired workers and their families who fall below a specific income threshold.
      - \$125,000 individuals; and \$250,000 for family
      - Termination period: Sep 31, 2008 – Jan 1, 2010.
    - Premium subsidy administered through group health plan sponsor (reduction in employer's payroll tax)
      - New employer notice/disclosure requirements
    - Help 7 million Americans keep group health insurance (Joint Cmte on Taxation)

## Division B - Health, State Fiscal Relief, Medicare, Medicaid

- Medicare HIT Payment Incentives(\$17.2b)
  - Incentives for eligible professionals (effective 2011)
    - Physicians (Medicare defined)
      - No hospital-based physicians
    - “Meaningful user” of certified EHRs
    - Up to \$44,000 over 5 years
    - Health professional shortage area practice = +10%
    - No incentive payment by 2015 if not qualified.
      - Payment penalties
    - No incentive payments after 2016.
    - Further payment penalties allowed if <75% of physicians have adopted HIT by 2018 and beyond.
    - Reporting of performance measures required

## Division B - Health, State Fiscal Relief, Medicare, Medicaid

- Medicare HIT Payment Incentives (cont.)
  - Incentives for Hospitals (effective 2011)
    - Medicare participating inpatient hospitals and critical access hospitals
      - Hospitals under common corporate government with Medicare Advantage organizations (HMOs only).
    - “Meaningful user” of certified EHRs
    - Incentive payments for up to 4 years
    - Payment formula driven for subsection (d) hospitals (base amount, discharge-related amount, Medicare share, adjustment for charity care)
    - CAHs can expense EHR purchase costs in single year, rather than use depreciation schedule
    - No incentive payment by 2015 if not qualified
    - No incentive payments after 2016
    - Payment penalties beginning in 2015 if not meaningful users

## Division B - Health, State Fiscal Relief, Medicare, Medicaid

- Medicaid Provider HIT Incentive Payments
  - Qualified (>30% Medicaid) health professionals, incentive payments = up to 85% of net allowable costs for adoption and operation of EHR technology:
    - \$25,000 limit for first year for EHR purchase/upgrade and related support services
    - \$10,000 limit for each of the next five years for EHR operations for meaningful EHR users.
    - Must waive rights to Medicare payment incentives.
  - Children's and acute care hospitals w/  $\geq 10\%$  Medicaid volume, incentive payments based on Medicare formula but using Medicaid data.
    - Incentive payments limited to 6 years and none after 2016.
    - CMS to publish HIT amount for each eligible hospital.

## Division B - Health, State Fiscal Relief, Medicare, Medicaid

- Moratoria on Certain Medicare Regulations
  - Delay in Phase-out of Medicare Hospice Wage Index Budget Neutrality Adjustment Factor for FY 2009 (\$134m)
  - Delay in Phase-out of the Indirect Medical Education Capital Adjustment Factor for FY 2009 (\$191m)
  - Long Term Care Hospital Technical Corrections (\$12m)

## Division B - Health, State Fiscal Relief, Medicare, Medicaid

- State Fiscal Relief
  - Temporary Increase in Medicaid FMAP = \$87b
    - October 1, 2008 – December 31, 2010
    - Relief components:
      - Hold harmless for FMAP reduction
      - 6.2% base FMAP update for all states
      - Bonus for states with relative high growth in unemployment rates.
    - Conditions
      - No decrease in eligibility (states would be allowed to reduce provider payments and optional benefits).
      - Meet prompt pay requirements; extended to SNFs and hospitals. (\$680m)

## Division B - Health, State Fiscal Relief, Medicare, Medicaid

- Additional Medicaid & Other Provisions
  - DSH payments increased 2.5% in 2009 and 2010. (\$460 m)
  - Extension of moratoria on three Medicaid final regulations (provider taxes, targeted case management, and school-based transportation services). Adds new Medicaid rule – hospital outpatient services. June 30, 2009 (\$105 m)
    - Sense of Congress to withdraw other three Medicaid rules subject to the moratoria: Cost limit, GME, and Rehabilitative Services.
  - Extension of work-related Transitional Medical Assistance through December 31, 2009. (\$1.3b)
  - Extension of Qualifying Individual (QI) Program through 2010 (\$550m)
  - Protections of Native Americans under Medicaid and SCHIP (\$500m)

# Key Issues Regarding HIT Funds for PPS Hospitals

## Overview

- Four years of Medicare and Medicaid HIT incentive payments available for PPS hospitals that qualify as “Meaningful EHR Users” before FY 2015
- Penalties for non-qualifying hospitals commencing in 2015
- Funding available for “Health Information Technology Regional Extension Centers” (apparently includes RHIOs)
- HIT incentive payments for non-hospital based physicians, including physicians in hospital-affiliated physician practices

## Focus

1. Accessing HIT incentive payments for PPS hospitals (and avoiding penalties)
2. Accessing HIT funding for RHIOs
3. Accessing and maximizing HIT funding for hospital-affiliated physician practices

## Accessing HIT Incentive Payments for PPS Hospitals

- Qualifying as a “Meaningful EHR User” - A PPS hospital must be:
  - Using “*certified EHR technology*”
  - Using the EHR technology “*in a meaningful manner*”
  - Using EHR technology that is “*connected ...for electronic exchange of health information*”
  - Using EHR technology in the “*EHR Reporting Period*” applicable to the year for which the HIT incentive payment is made
- CMS must issue regulations defining all these terms and requirements

## Accessing HIT Incentive Payments for PPS Hospitals

What do we know for sure about qualifying as a Meaningful EHR User:

1. FY 2011 is the earliest payment year for HIT incentives (i.e., hospital fiscal years beginning on or after 10/1/10)
2. Hospitals qualifying as Meaningful EHR Users after FY 2013 will receive reduced HIT incentive payments under Medicare and Medicaid (because the Transition Factor decreases each year starting in FY 2014)
3. Hospital must be using EHR technology in the EHR Reporting Period for the applicable payment year
4. EHR technology must be connected

## Accessing HIT Incentive Payments for PPS Hospitals

What is likely to be required to qualify as a Meaningful EHR User:

1. Using means something more than “engaged in efforts to adopt, implement or upgrade certified EHR technology”
2. Connected means something more than being able to electronically exchange information within a hospital, and probably entails some ability to electronically exchange information with third parties (e.g., Medical Staff, other hospitals, etc.)
3. The EHR Reporting Period for the earliest payment year - FY 2011 - will be prior to 10/1/10
4. If CMS requires a hospital to submit utilization data or other data to meet the “using” or “connected” requirements, the data available to the hospital at the time of submission is likely to be 1 to 2 years old
5. Certified EHR technology probably will include all major EHR products currently in the market

## Accessing HIT Incentive Payments for PPS Hospitals

### Implications:

1. PPS hospitals must qualify as Meaningful EHR Users before 10/1/13 to maximize their HIT incentive payments
2. If “using EHR technology” and “connected” must be demonstrated using data, the data available to many hospitals as of 10/1/13 is likely to be data from 2011 or 2012.
3. Therefore, qualifying as a Meaningful EHR User by 10/1/13 may require a hospital to submit data from as early as 2011 showing that the hospital was meeting the “using” and “connected” requirements.

# Accessing HIT Funding for RHIOs

1. Meeting the “connected” requirement is likely to be easier if there is an operating RHIO in a hospital’s market
2. The “Health Information Technology Regional Extension Centers” described in the Stimulus Legislation apparently are RHIOs
3. CMS is authorized to provide up to 4 years of funding for a Center, with an annual maximum of up to 50% of the Center’s capital and annual operating and maintenance costs
4. CMS must issue draft regulations, within 90 days following enactment of the Stimulus Legislation, regarding how to apply and qualify for such funding

## Accessing and Maximizing HIT funding For Hospital-Affiliated Physician Practices

1. HIT incentives for professionals are available for physicians in hospital-affiliated practices (not including hospital-based physicians, defined as physicians who furnish substantially all their medical services in a hospital setting through the use of hospital facilities/equipment)
2. For each eligible physician, the affiliated hospital must decide whether to accept the Medicare HIT incentive or the Medicaid HIT incentive
  - a. The maximum Medicare HIT incentive for most eligible physicians will be \$44K over 5 years (10% more for physicians practicing in a HSPA)
  - b. The maximum Medicaid HIT incentive for most eligible physicians will be \$63,750 over 5 years (approximately \$42,460 for each eligible pediatrician).

## Accessing and Maximizing HIT funding For Hospital-Affiliated Physician Practices (cont.)

3. Physicians eligible for the Medicaid HIT incentive:
  - a. Non-hospital based pediatricians with at least 20% Medicaid patients
  - b. Other non-hospital based physicians with at least 30% Medicaid patients
  - c. Physicians practicing mainly at an FQHC or rural health clinic, and who have at least 30% Medicaid patients, SCHIP patients, or patients receiving uncompensated care (in whole or on a sliding scale based on ability to pay)

# Stimulus package privacy provisions

***Unless otherwise specified, the privacy provisions of H.R. 1 take effect 12 months following enactment – February 17, 2010***

- **Breach requirements for notification**
- **Limited data set**
- **Accounting for disclosures**
- **Right to individual access**
- **Fundraising**
- **Enforcement**
- Marketing
- Prohibition on sale of data
- Personal health records
- Business associates
- Restrictions on information paid for out-of-pocket expenses
- RHIOs and other HIEs
- Education and studies

## Privacy provisions – Breach requirements for notification

- Breach includes “all unauthorized acquisition, access, use, or disclosure of protected health information (PHI)”
- Covered entities must notify each individual whose information is or reasonably believe to have been breached without unreasonable delay (never more than 60 calendar days)
- Business associates must notify covered entities of breaches and include identification of each individual compromised
- Written notification:
  - If written notification cannot be made to an individual by mail, substitute notification can be made on covered entity’s Web site or by public notice, including toll-free #
  - If unsecured information of more than 500 individuals of a jurisdiction is involved, notice must be made to local media and HHS must be notified immediately (HHS will post covered entity’s identity on its Web site)
  - Smaller breaches must be submitted and reported to HHS annually

## Privacy provisions – Breach (cont.)

- Exceptions include:
  - Where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information
  - Any unintentional acquisition, access or use by an employee or individual **IF** made in good faith and within course and scope of employment and not further acquired, accessed, used, or disclosed
- After consulting with stakeholders, HHS is required to issue guidance specifying technologies and methodologies that render PHI “secure” by April 17, 2009 and annually update guidance
- Breach requirements require interim final rule no later than August 17, 2009 to be effective 30 days following
- Within one year and annually thereafter, HHS must submit report to Congress on complaints regarding potential HIPAA violations and audit findings

# Privacy provisions – Accounting for disclosures

- Covered entities must account for all non-oral disclosures of PHI used or maintained in an EHR (in addition to all non-routine disclosures as required under HIPAA)
  - An EHR is defined as “an electronic record of health-related information on an individual that is created, gathered, managed and consulted by authorized health care clinicians and staff”
  - HHS must promulgate regulations on what information must be included in the accounting 6 months after the date HHS adopts technical standards for accounting for disclosure (technical standards are due no later than 12/31/09). HHS must consider the interest of the individual in learning of the circumstances in which their PHI has been disclosed and the administrative burden of accounting for such disclosures.
  - Covered entities may account for business associate disclosures **or** provide a list of all business associates to an individual
  - Effective date for covered entities with an EHR in place on 01/01/09 is 2014. Effective date for covered entities who adopt an EHR after 01/01/09 is the date of EHR adoption or 2011, whichever comes later. (HHS may delay up to two years beyond these dates)

## Privacy provisions – Limited data set

- To be in compliance with the “minimum necessary” standard, covered entities must “to the extent practicable” limit disclosures to the “limited data set,” or if needed, to the minimum necessary to accomplish the intended purpose
- Limited data set guideline will sunset once HHS issues guidance (due by August 17, 2010), as to what constitutes “minimum necessary”

## Privacy provisions – Right to individual access

- Individuals have right to obtain a copy, or designate a recipient, of information in an electronic format from any covered entities that use or maintain an EHR with respect to PHI regarding that individual
- Entities may not impose a fee that exceeds the labor costs for doing so

## Privacy provisions - Fundraising

- Fundraising communications sent by covered entities must clearly indicate how recipients can opt out of receiving future communications of this type
- Effective February 17, 2010

## Privacy provisions - Enforcement

- Specifies that violations of the Privacy Rule due to willful neglect require HHS to investigate and impose civil penalty
- Creates tiered increase in civil penalty amounts tied to level of intent and neglect (\$100 per violation not to exceed \$25,000 to \$50,000 per violation, not to exceed \$1.5 M total)
- Stipulates that civil penalties collected should be used to fund OCR and that within 3 years HHS must establish method based on GAO report by which affected individuals receive a percentage of penalties collected
- Authorizes a state attorney general to file suit on behalf of their residents