White Paper

The Effect of the American Recovery and Reinvestment Act of 2009 on Health IT for Acute Care Facilities

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Healthcare facilities must adopt qualified, certified EHRs and demonstrate "meaningful use"

Earlier this year, the American Recovery and Reinvestment Act of 2009 was passed by the United States Congress and subsequently signed into law by President Barack Obama on February 17, 2009. In addition to incentives aimed at economic stimulation in infrastructure, transportation, education and healthcare, the Act contains nearly $20 billion to aid in the development of a robust IT infrastructure for healthcare and to assist healthcare providers and entities in acquiring, adopting and using information technology. This portion of the Act is often referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act. T-System has prepared this paper as an overview of the act in order to provide facilities with information regarding the provisions of the act and the anticipated effects on healthcare IT for the future.

Under the act, leadership for healthcare IT initiatives remains with Heath and Human Services (HHS) through the Office of the National Coordinator (ONC), it also provides for the formation of two new committees serving in an advisory capacity to the ONC: the HIT policy and HIT standards committees. The ONC, previously funded at less than $100 million yearly, will now receive $2 billion annually. The ONC, consulted by the National Institute of Standards and Technology, is charged with determining standards for the implementation of healthcare IT and recognizing a program or programs for voluntary certification of health IT.

In addition to funding for federal organizations, the act provides for incentives to states, healthcare providers and facilities for the adoption of health IT. Incentives to providers and facilities are available through both the Medicare and Medicaid programs; however, only one program may be utilized for incentives by any individual or organization. *Facility-based physicians (ED physicians, radiologists, etc.) are specifically excluded from receiving incentives, as healthcare providers, under the provisions of the act; however, facilities may be eligible for adopting and using IT solutions benefiting these providers.* The reminder of the information contained in this paper is geared toward acute care facilities.

Qualifying for incentives

To qualify for incentive eligibility, healthcare facilities must adopt qualified, certified EHRs and demonstrate "meaningful use." Qualified EHRs are defined as those that provide clinical decision support, capture and query relevant healthcare information, support physician order entry and exchange and integrate health information. The ONC must determine certification standards by December 31, 2009. Although the ONC is not mandated to select existing certification bodies to achieve this task, it seems reasonable to assume that this will occur and it is expected that the Certification Commission for Healthcare Information Technology (CCHIT) will be chosen for this task. In the same timeframe, the ONC must determine what constitutes "meaningful use."

Given the stated goals of the act, which are reducing healthcare costs and acquiring data, it is anticipated that "meaningful use" will encompass the utilization of IT solutions for physician order entry and prescribing, as well as sharing data discreetly. It is also anticipated that "meaningful use" will evolve over time, placing increasingly stringent requirements on providers and institutions using IT solutions.

What also remains to be determined is the role of the Emergency Department Information System (EDIS) in demonstrating "meaningful use." There is no language within the act that defines what systems must or may qualify for reimbursement incentives.

Effect on Facilities and Providers Choosing a Healthcare IT Solution

Choosing a healthcare IT solution is a detailed process, optimally facilitated by involving a team of evaluators including technical staff, healthcare providers, HIM and billing experts. Successful adoption of HIT solutions depends on careful selection based on an individual facility's needs. Demonstrating "meaningful use" will require not only the product provide functionality to support "meaningful use," but also promote provider adoption of the technology for daily activities.

Even before the President applied his signature to the act, many vendors had begun pushing their products and creating a sense of urgency for adoption. Facilities are feeling pressure to move rapidly as deployment of some solutions can be a lengthy process. Despite the urgencies created by some vendors, facilities should wait until HHS defines "meaningful use" and selects the certifying body, then use knowledge to select solutions appropriate for their situation.

Moving too rapidly may lead facilities to select solutions that will not provide sufficient functionality to meet the HHS requirements for incentives. As physician acceptance and utilization of chosen solutions will be paramount, rapid choice of solutions may lead to a "quick fix" that does not meet the needs of healthcare providers. Rushed, poorly thought out solutions may lead to long-term disincentives for providers that outweigh financial benefits gained through reimbursement under the act.

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Medicare Incentives

Incentives to facilities under the Medicare program begin in 2011 and follow the federal fiscal year, beginning October 1, 2011. Incentives are calculated according to a formula and can be earned at 100 percent eligibility if the facility adopts qualifying healthcare IT prior to fiscal year 2013. Incentives decrease over a 4-year period, by 25 percent each year and may not be earned if a facility does not adopt qualified solutions prior to fiscal year 2015. Beginning at that time, facilities that have not adopted qualified, certified health IT solutions will recognize a decrease in Market Basket Adjustment, or, in the case of critical access hospitals, a decrease in inpatient hospital service payments.

It is unclear, at this time, as to what the reimbursement schedule will be. While the incentives will be distributed at some point during the federal fiscal year, it remains to be seen if reimbursements will be made in single or multiple instances, as well as when during the fiscal year these payments will be made to facilities.

Formula for initial incentive = $2 million + $200 for each discharge between 1,500 and 23,000, per 12 months, times the Medicare Share.

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Medicare Share = $\frac{\text{(Part A + Part C inpatient bed days)}}{\text{Total inpatient bed days * (non-charity charges/total charges)}}$

*Note: *Critical Access Hospitals increase the Medicare share by 20 percentage points, not to exceed 100 percent.*

Transitional Payment Schedule for Facilities Under Medicare

Medicaid Incentives

Medicaid incentives are available to acute care facilities that have at least 10 percent of their patient volume attributable to individuals receiving Medicaid, and to all children's hospitals, regardless of Medicaid volume. The act does not specify the beginning date for these incentives, but adoption of qualified, certified ealth IT must occur prior to fiscal year 2017 and incentives are limited to six years. Additionally, unlike Medicare incentives, the act does not reduce Medicaid incentives for failure to demonstrate "meaningful use." Once again, facilities are eligible for reimbursement under Medicare or Medicaid, but not both.

The incentive calculation is based on the number of hospital days attributable to patients receiving non-Medicare public assistance for a 4-year period. In any year the incentive may not include 50 percent of the total incentive, and in a 2-year period, no more than 90 percent.

New Security Provisions

In addition to certification and "meaningful use" provisions, the act calls for new security requirements. These include:

Incentives paid during	Certified, qualified health IT adopted on or before					
	Oct 1, 2011	Oct 1, 2012	Oct 1, 2013	Oct 1, 2014	Oct 1, 2015	Oct 1, 2016
FY 2011	100%	----	----	----	----	----
FY 2012	75%	100%	----	----	----	----
FY 2013	50%	75%	100%	----	----	----
FY 2014	25%	50%	75%	75%	----	----
FY 2015	----	25%	50%	50%	50%	----
FY 2016	----	----	25%	25%	25%	----
FY 2017	----	----	----	----	----	----

1. Accounting of all disclosures of Protected Health Information (PHI) to patients

2. Restrictions on the sale and marketing of PHI

3. Requirement to notify HHS of PHI security breaches

4. Ensure patient access to electronic health information

5. New penalties and HIPAA regulations regarding business partners such as Health Information Exchanges (HIEs) and Personal Health Records (PHRs)

Perspective on Activities During 2009

In the next several months, as the ONC further defines "meaningful use" and determines the certification methodology, there will be an increased momentum by healthcare facilities, providers and vendors to ensure their solutions comply with the standards set. Facilities and providers should evaluate their needs and begin planning as quickly as possible to evaluate and install health IT solutions, after the release of detailed information by HHS relating to certification and "meaningful use."

Additional Information

This brief summary provides an overview of the major provisions of the act.

A downloadable copy of the act can be found at:
http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf

This copy of the act reflects its original language and provisions. Even detailed reading and understanding of the text will not reflect the full consequences of the act, as much has yet to be determined.

T SystemEV® and Reimbursement Incentives

T-System remains dedicated to providing industry-leading solutions for healthcare delivery. We are also dedicated to providing a qualified, certified EDIS that can be used to demonstrate "meaningful use," in a timeframe that allows are clients to receive maximal reimbursements under the provisions of the act.

The information contained herein has been gathered and distilled from multiple sources. The information should not be considered truly authoritative, is subject to change and interpretation. Financial decisions should not be made based solely on this information.

Facilities and providers should evaluate their needs and begin planning as quickly as possible

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