

Georgia HFMA Spring Institute 2009

Session Four– May 7th, 2009, 7:45AM - 9:00AM

General Assembly – Keynote Speaker Presentation

Health Reform on the Fast Track: Understanding the Impact of the Stimulus and Proposed Budget on Healthcare and Where All the Dollars Are Going

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KING & SPALDING



Agenda

- Introductions
- Summary of Legislation and its Potential Impact
 - Overview
 - Legal Parameters
 - State of Georgia Implications
- Panel Discussion

Ref: H.R 1 Division B Title 1 Subtitle F Part 1; Ref (Div B-Title I-Section 1501) and (Div B-Title V-Section 5003) respectively

Healthcare policy in an Obama administration: Delivering on the promise of universal coverage*

February 2009



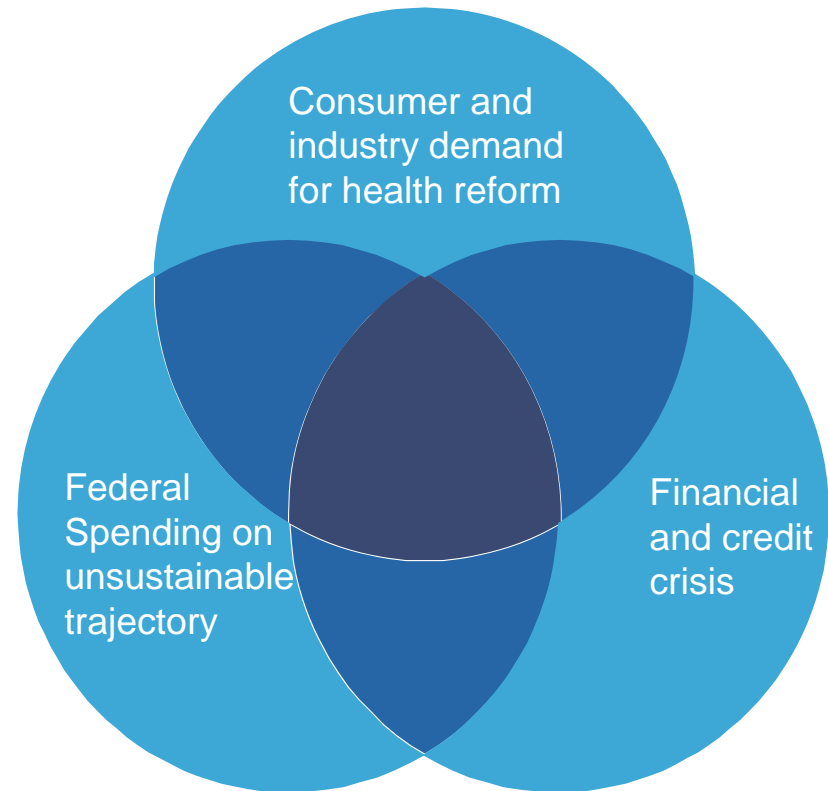
Introduction

President Obama came into office facing a trio of interrelated crises that he used to address a trio of health reform promises

Universal coverage

Modernize the system
to reduce costs

Promote wellness,
prevention

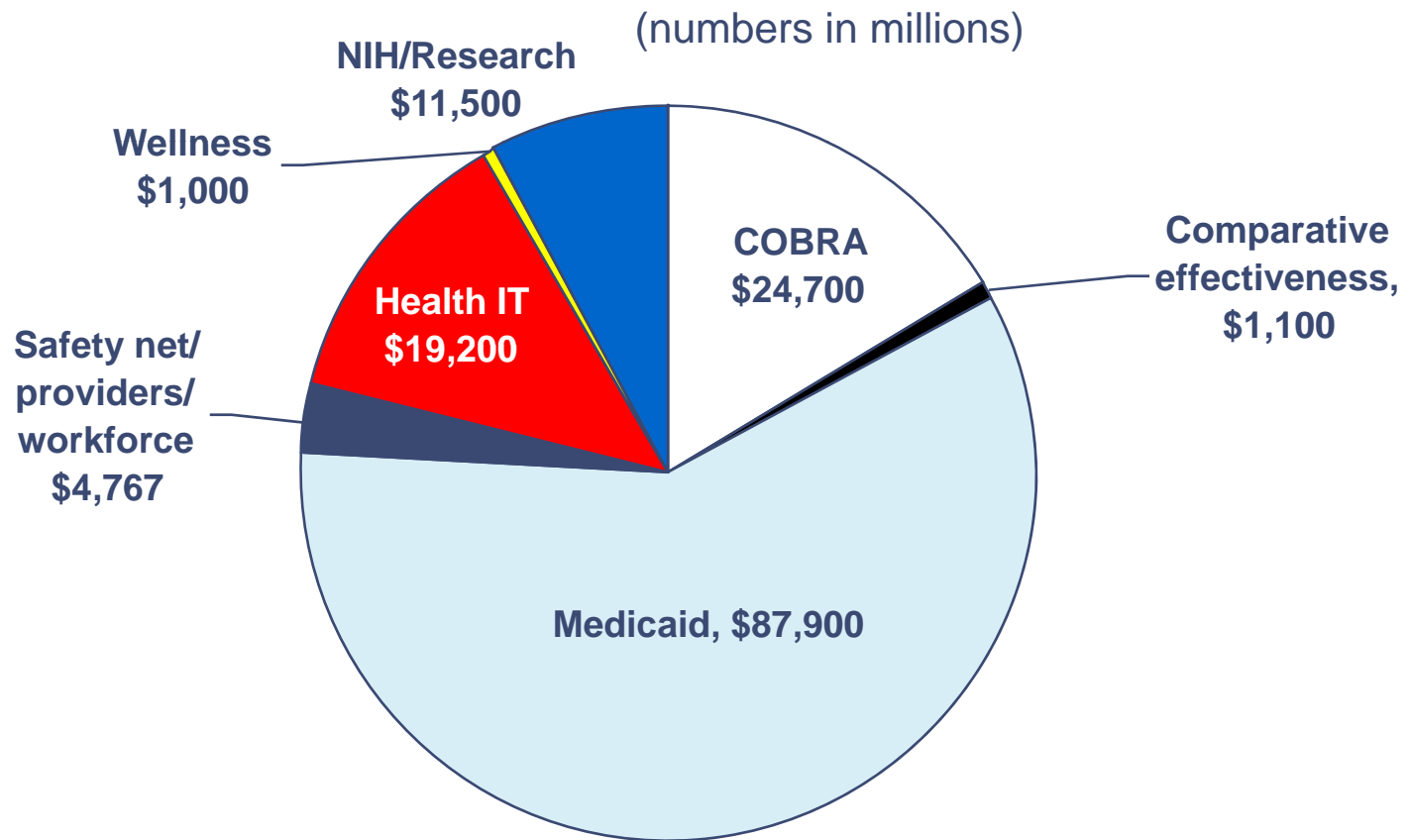


Economic recovery put Obama's health reform on fast track



Stimulus funding heavily weighted towards stabilizing insurance coverage; providers, health IT and NIH are big winners

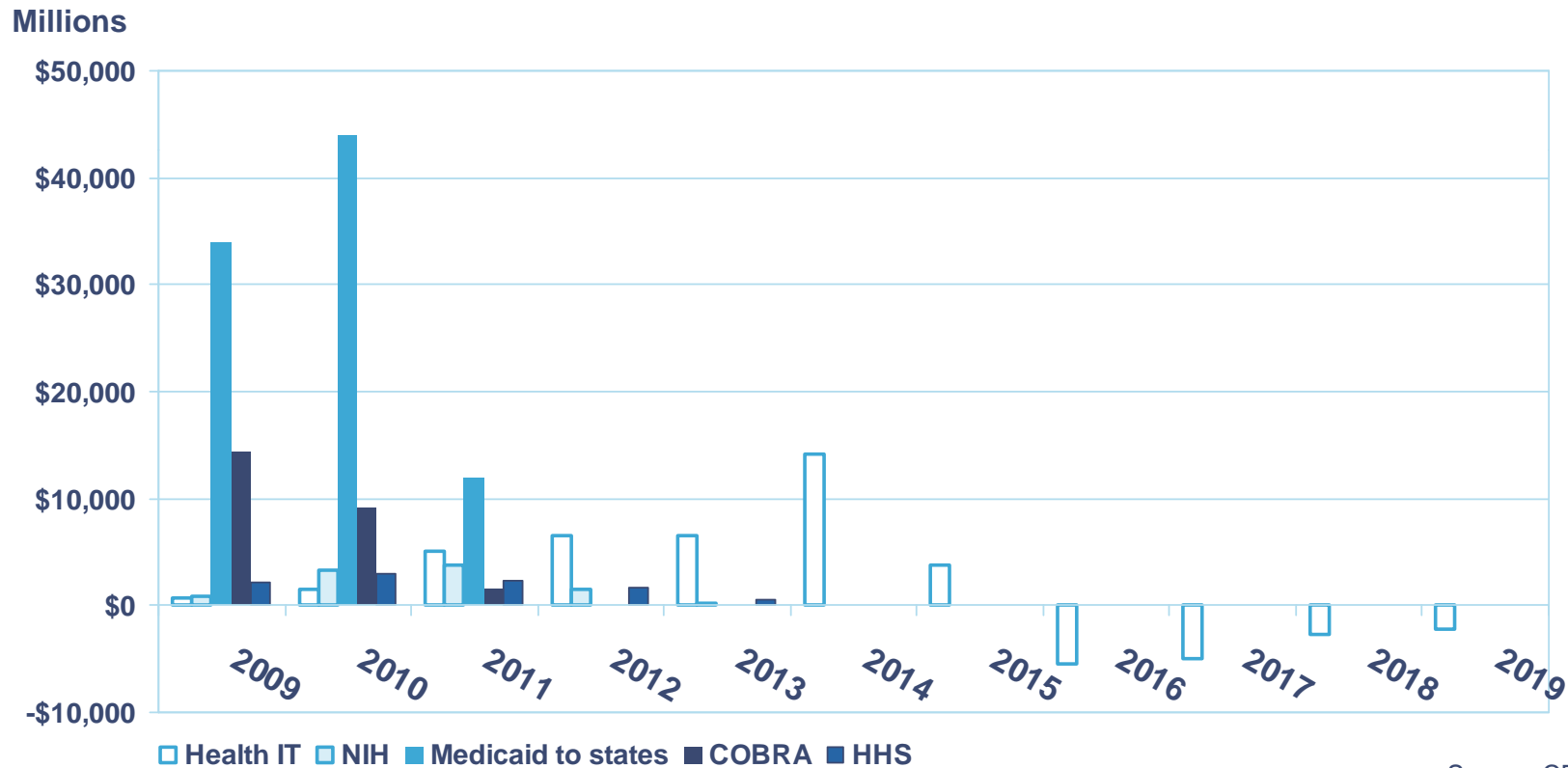
\$150.1 billion in healthcare spending in the stimulus package



Introduction

Stimulus injects most funds in first three years; Health IT funds pay out longer and generate savings by 2016

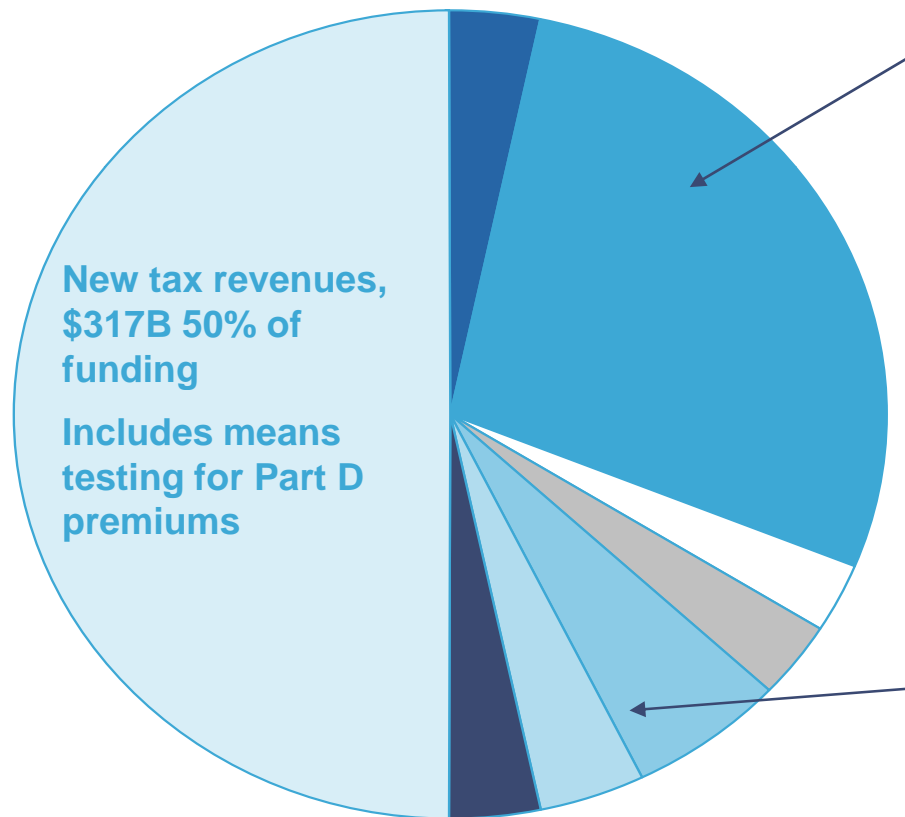
Estimated cost of spending by fiscal year



Source: CBO, February 2009

Proposed HHS budget: Includes \$630 billion over 10 years in health reserve fund to pay for expanded access

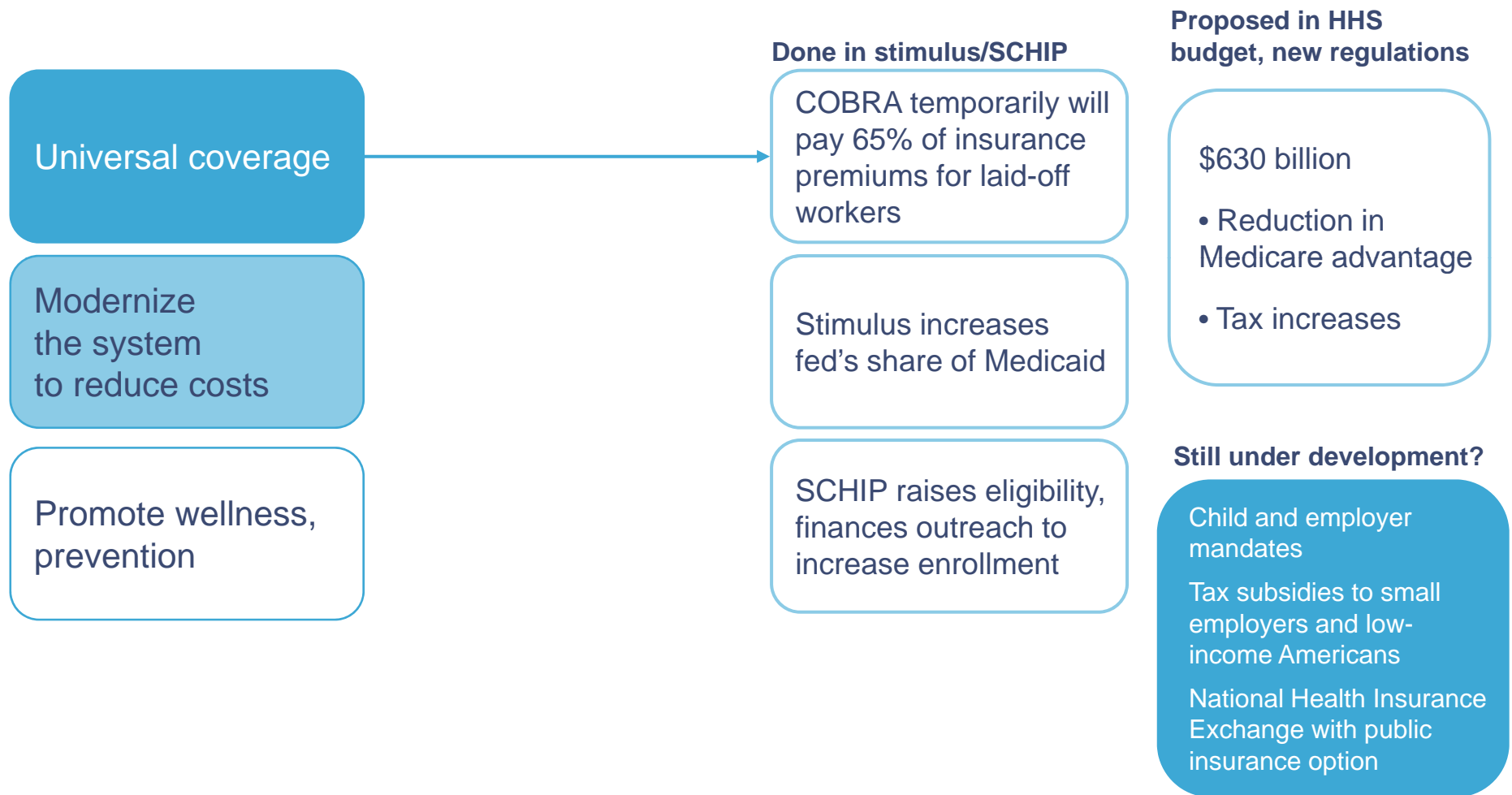
Half from increased taxes



Half in reduced spending by Medicare/Medicaid

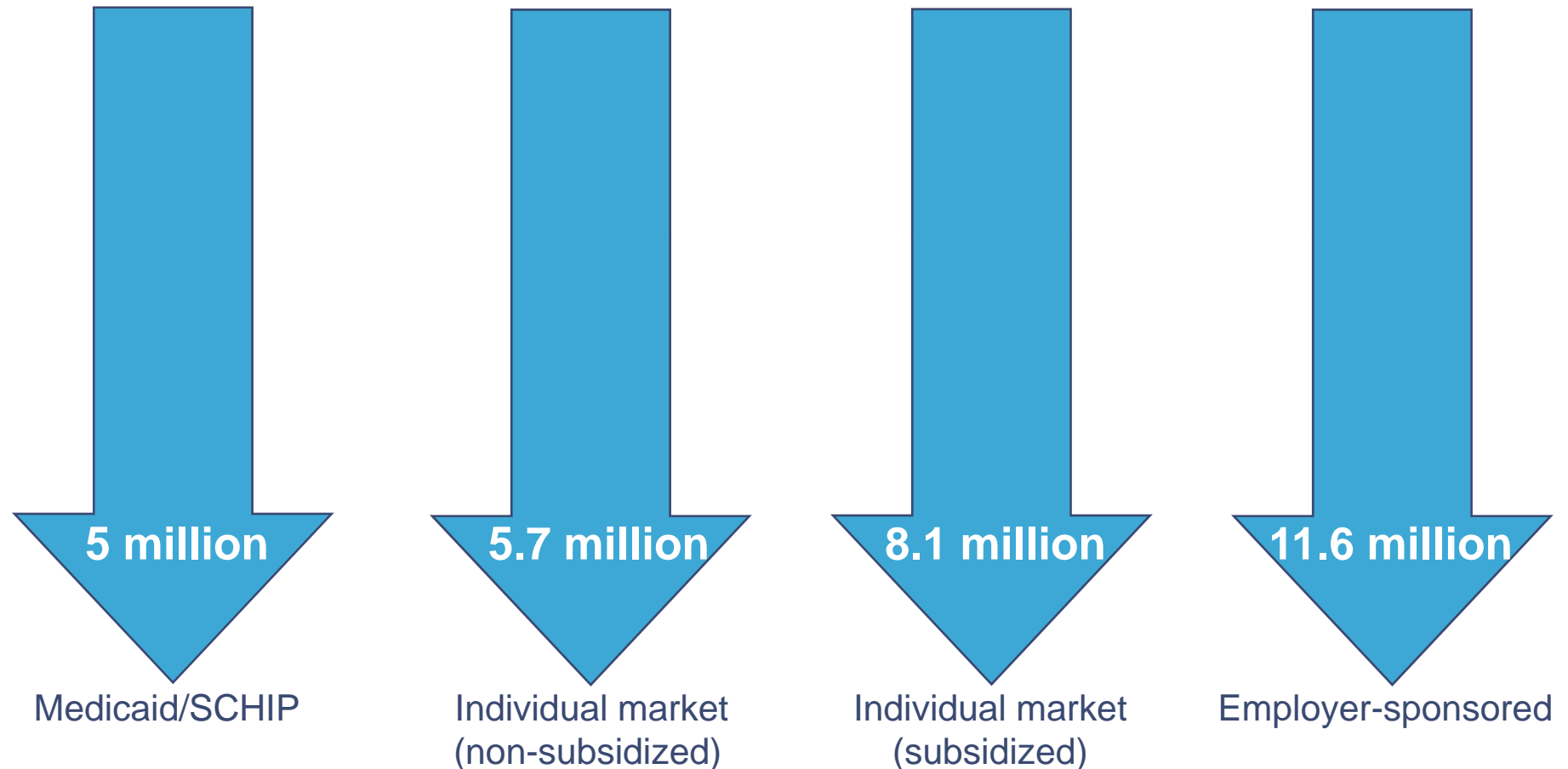
- \$176.6 billion, 28%, in Medicare Advantage reductions
- \$20.5 billion, 4%, reduce payments to hospitals with high readmission rates, low quality scores
- 17.8 billion, 3%, bundling acute and post-acute Medicare payments
- \$23.9 billion, or 4%, to reallocate resources toward fraud
- \$19.6 billion, or 3%, extending Medicaid rebates
- \$20.3 billion, or 3 %, in other Medicare, Medicaid savings, including establishing pathway for generic biologics and reducing imaging spending
- \$37 billion, 6%, in reduced Medicare home health payments

From proposal to implementation: universal coverage



Universal coverage

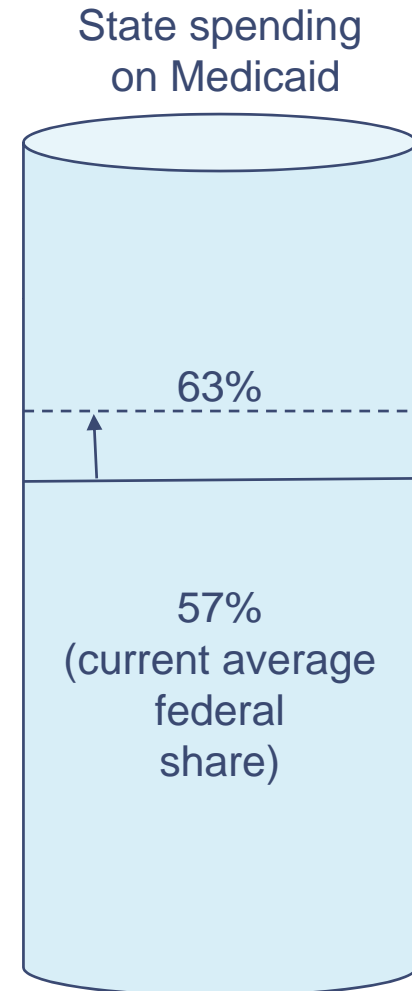
PwC's estimates are that expansions would eliminate 2/3s of uninsured at about \$75 billion a year, \$1 trillion in 10 years



Feds are filling Medicaid glass almost 2/3 full

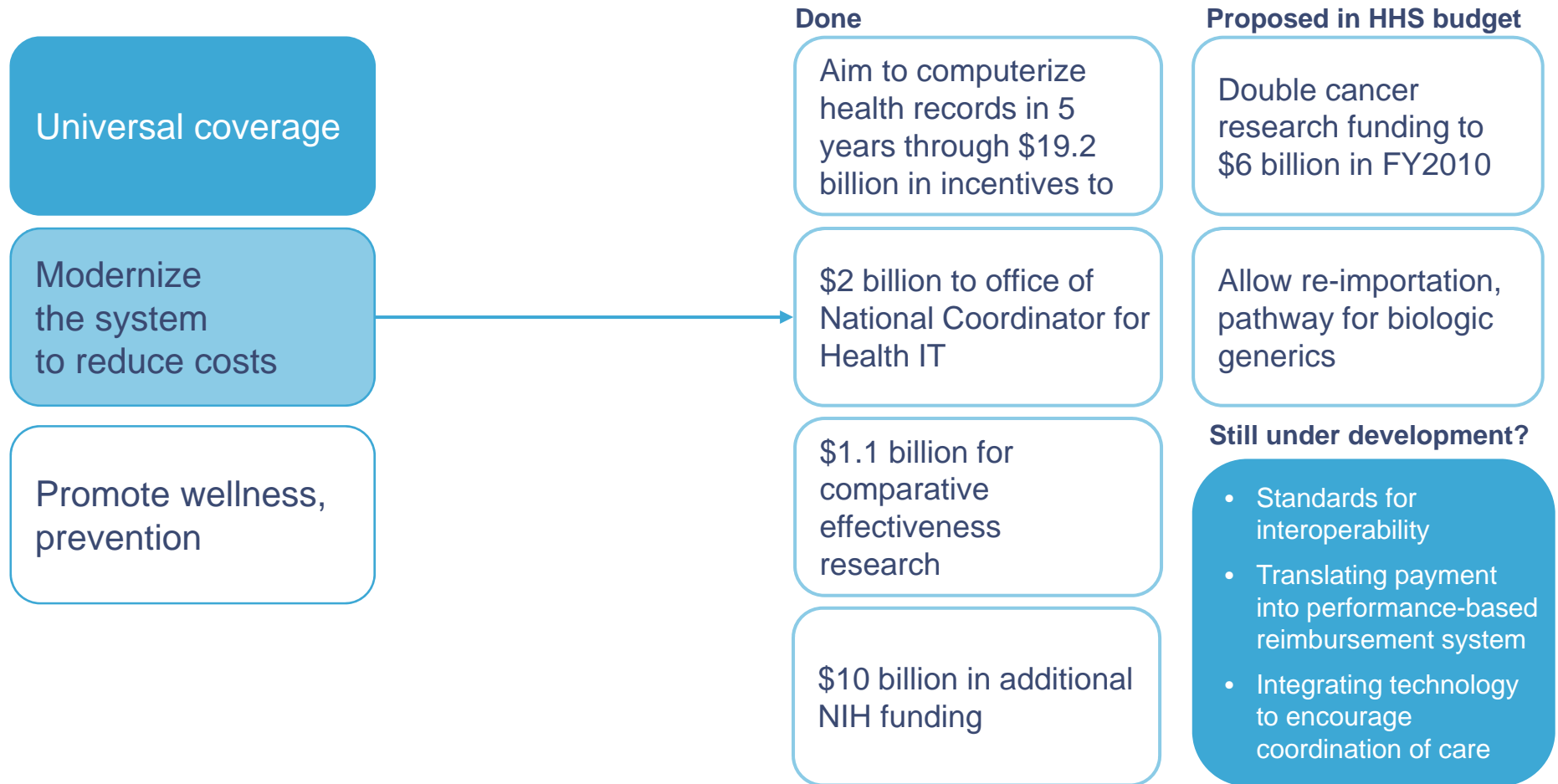
- Largest share of stimulus money -- **\$87 billion**, 58% of healthcare funds
- Estimated to protect health benefits for 20 million
- Increase is **temporary** change in the FMAP (matching rate) – will return to baseline in **2012**. Each state's matching rate is different.
- Another \$1.3 billion for Transitional Medical Assistance (TMA) payments -- Medicaid payments to certain low-income families.

Federal share moves from **57%** to **63%**; giving states room to reduce their spending or use funds for other purposes



Ref: Increase in FMAP - Division B Title V Sec 5001 and Sec 5002

From proposal to implementation: modernize the system



Incentives are skewed to reward EHR early adopters

Hospitals at least \$3 million each

Physicians up to \$44K each

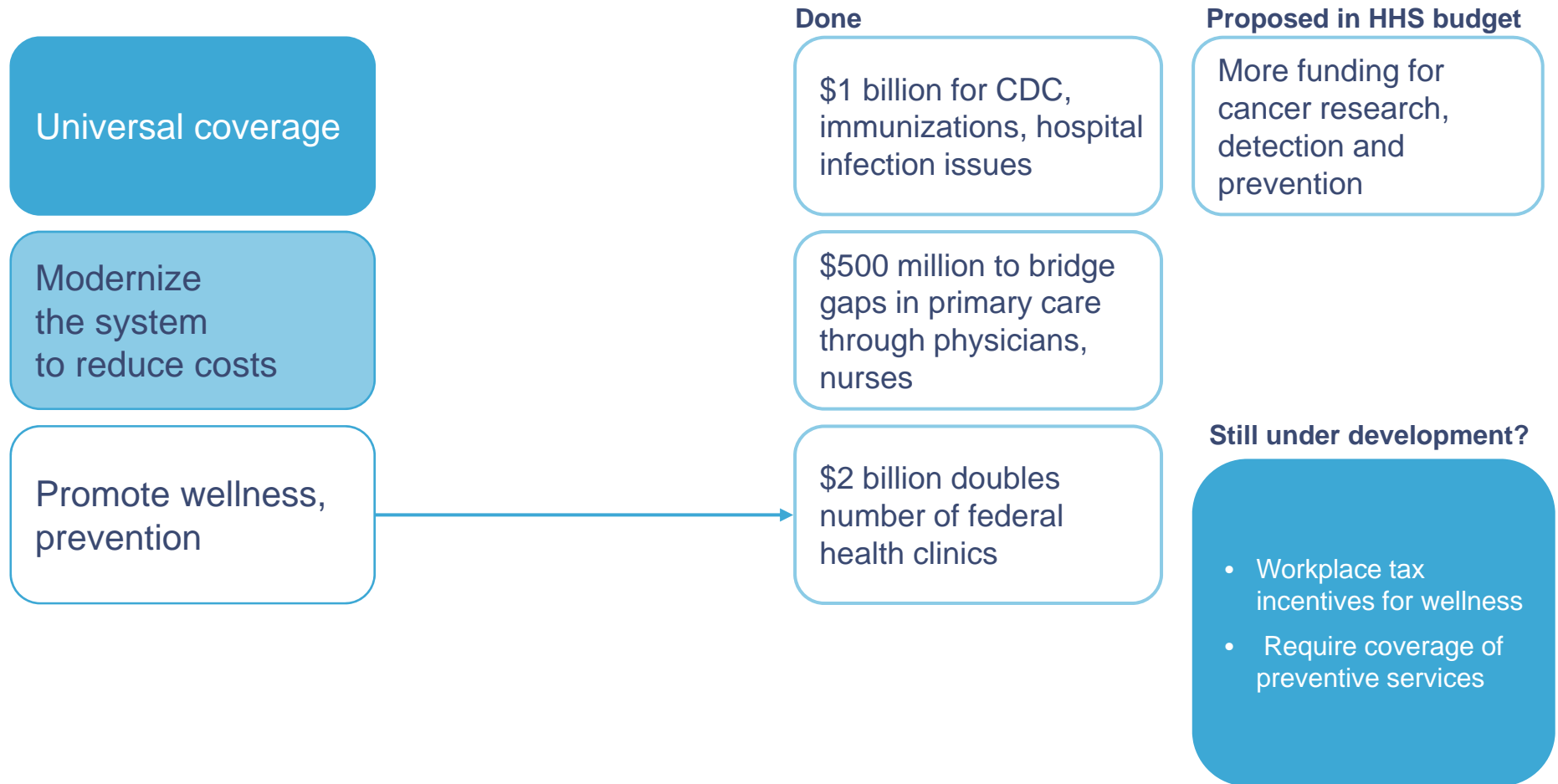
Government starts to pay bonuses in 2011

- Incentives are for “adoption and meaningful use of certified EHR technology”.
- Payment is \$2 million times a discharge formula that includes Medicare admissions, charges, charity care data
- Those adopting between 2011 and 2013 will get four years of payments; in 2014 get three years, in 2015, two years of payments.
- Critical Access Hospital receive up to 120% of Medicare's portion of EHR's cost for up to 4 years.
- \$3,000 bonus if they implement by 2012. First-year payments drop to \$15,000 in 2013 and \$12,000 in 2014. Late adopters - after 2014 - get no incentive.
- Incentive payments increase by 10% if provider predominately serves Medicare beneficiaries in a health professional shortage area.
- No incentive payment for hospital-based physicians.

Penalties begin in 2015

- Those not adopting would be penalized through Medicare's annual update.
 - Medicare payment to physicians who have not adopted EHRs would receive 99% in 2015, 98% in 2016, and 97% in 2017
 - If there is less than 75% adoption rate the Secretary can reduce the rate by 1% per year starting in 2018 with a limit of 95%.
-

From proposal to implementation: promote prevention

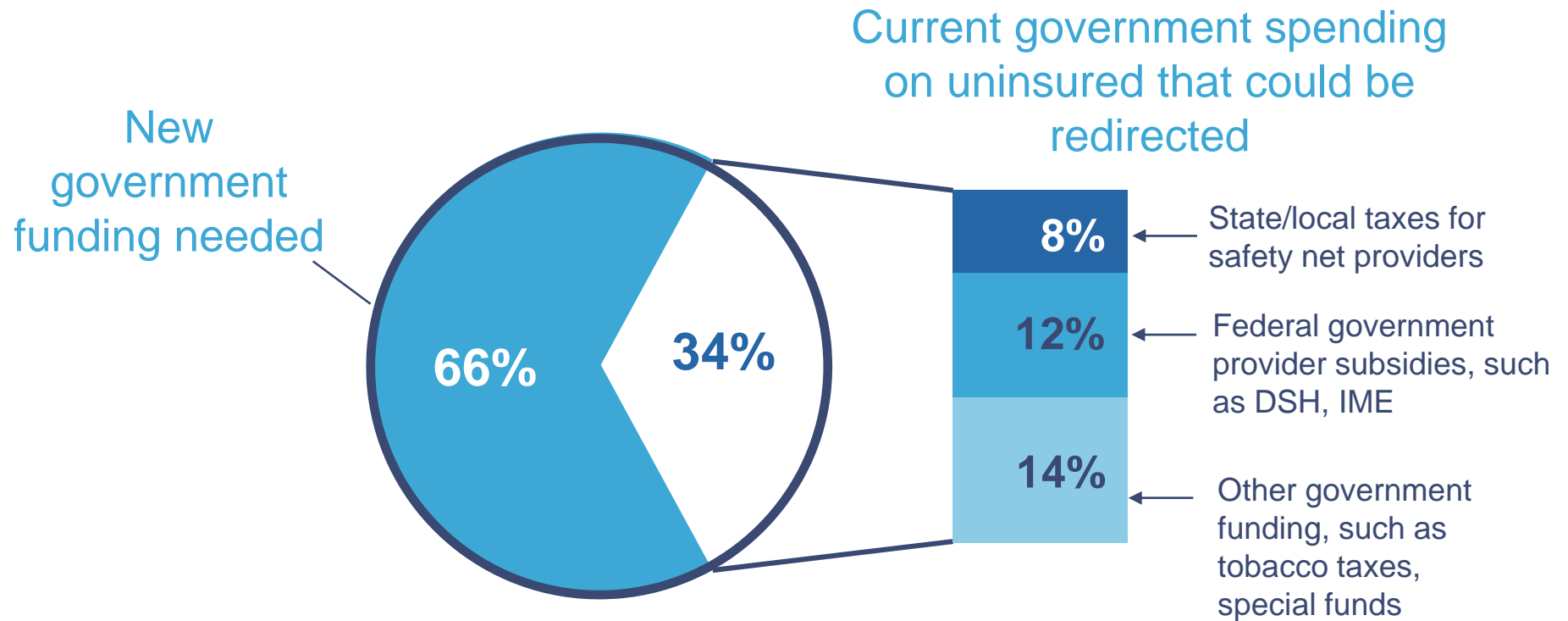


Obama's expansion would cost about \$75 billion in 2009, and increase to more than \$1 trillion cumulatively in 2018

\$75 billion	Uses of funding in 2009
\$48 billion	Spending for those currently uninsured
\$34 billion	Replaces previous spending by the uninsured
\$14 billion	New spending by the uninsured
\$27 billion	Spending for those currently insured

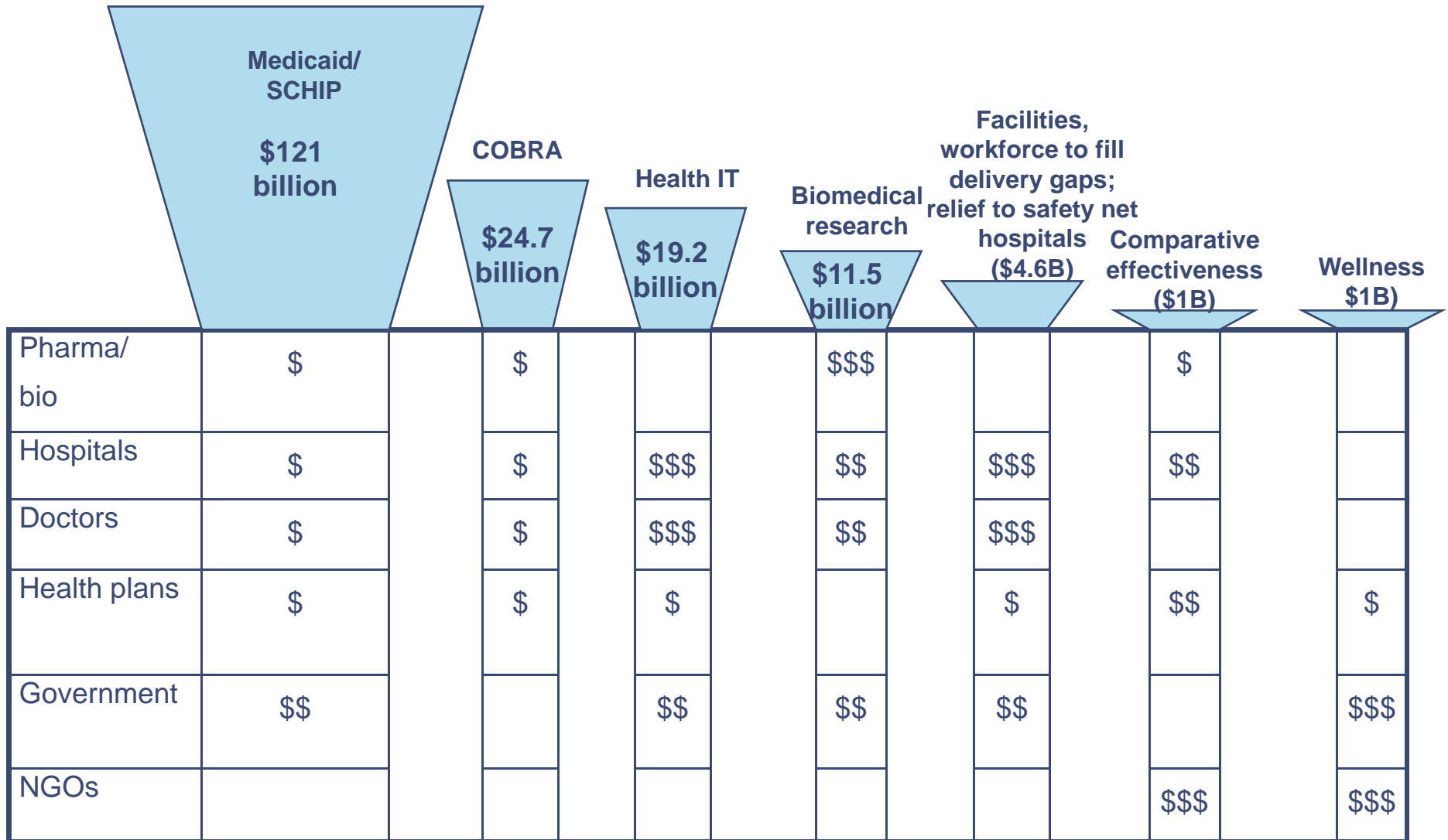
Estimates assume expansion spending would grow ~3% faster than combined growth of CPI and population and do not reflect potential savings from yet-unspecified plans

About one-third of the needed \$75 billion could come from existing government funding that now goes to hospitals



Source: PricewaterhouseCoopers' estimates, 2008

Stimulus plus SCHIP spread spending across the industry



\$\$\$ big winner; \$\$ winner; \$ even money

American Recovery and Economic Reinvestment Act of 2009

EHR Incentives
Privacy and Security

EHR Incentives

Key Terms

“Meaningful EHR user”

- using **certified EHR technology** (including e-prescribing) in a meaningful manner
- **connected** in a manner that provides for the electronic exchange of health information
- reporting information on clinical quality measures

Key Terms

“Certified EHR technology” means a “qualified electronic health record” certified as meeting standards adopted by the HHS Secretary.

“Qualified electronic health record”

- includes patient demographic and clinical health information
- has the capacity
 - to provide clinical decision support
 - to support physician order entry
 - to capture and query information relevant to health care quality
 - to exchange electronic health information with, and integrate such information from, other sources.

Key Terms

“Hospital-based eligible professional”

- furnishes substantially all covered professional services in a hospital setting through use of the hospital’s facilities, equipment and EHR.
- to be determined on the basis of the “site of service” as defined by the HHS Secretary.
- for example (but not limited to), pathologists, anesthesiologists and ER physicians.

HHS Guidance

Interim final regulations required by Dec. 31, 2009.

HIT Infrastructure

Funding for Health Information Technology Regional Extension Centers (“HITRECs”).

HHS Secretary may provide support for up to 50% of capital and annual operating and maintenance funds for up to 4 years.

HITRECs to provide technical assistance, best practices, etc. to support and accelerate efforts to adopt HIT permitting electronic exchange that meets HHS standards.

Draft program guidelines to be issued by May 17, 2009.

Security and Privacy

Security and Privacy - Overview

Extension of certain HIPAA security and privacy requirements to business associates.

Privacy/security breach notification requirements.

Strengthening of certain pre-existing requirements:

- individual right to request restrictions on disclosure
- minimum necessary obligation
- accounting obligation

Restriction on sale of health information.

Security and Privacy - Overview

Limitations on receipt of payment for certain marketing communications.

Temporary breach notification obligations for “vendors of personal health records.”

Clarification of applicability of HIPAA criminal sanctions.

Expanded enforcement provisions.

New requirements effective on February 17, 2010, unless otherwise specified.

Business Associates

Currently, HIPAA applies only to “covered entities” (“CEs”) and not directly to “business associates” (“BAs”)

Covered entities must require BAs to agree **contractually** to limit use/disclosure of protected health information (“PHI”)

HIPAA amended to require that key provisions of the security rule will apply to BAs directly:

- administrative, physical and technical safeguards
- policies and procedures
- 45 C.F.R. §§ 164.308-312 & 316 (e-PHI)

Business Associates

The BA requirements of the privacy rule (45 C.F.R. § 164.504(e)) will apply directly to BAs.

“The additional requirements of this subtitle that relate to [security and] privacy and that are made applicable with respect to covered entities shall also be applicable to such a business associate.”

Civil/criminal sanctions will apply to BAs in the same manner as for covered entities.

BA privacy/security compliance takes effect in 12 months.

Breach Notification

A CE that discovers a breach of “unsecured” PHI shall notify each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired or disclosed.

A BA must give notice to its covered entity.

All required notifications must be given w/o unreasonable delay and not later than 60 days after discovery.

“Discovery” occurs when breach is actually known or reasonably should be known.

Breach Notification

“Unsecured” PHI means:

- PHI that is not secured through use of a technology/methodology listed in HHS guidance to be issued within 60 days; or
- if no such guidance is issued, “unsecured” will mean PHI not rendered unusable to unauthorized individuals in accordance with recognized methods.

“Breach” means unauthorized acquisition, access, use or disclosure of PHI which compromises its security or privacy.

Breach Notification

Notice to individuals:

- first class mail, or e-mail if preferred by the individual
- if insufficient or out-of-date contact information for 10 or more individuals, general notice must be posted on the CE's website or published in major print or broadcast media, with a toll-free number that individuals can call

Media notice required if breach involves 500 or more residents of a state or jurisdiction

Must report to HHS at least annually, but immediately if breach involves 500 or more.

HHS will publish on its website a list of entities suffering breaches applicable to 500 or more.

Breach Notification

Content of notice to individuals:

- dates of breach and discovery
- description of what happened
- description of types of information involved
- steps individuals should take to protect themselves
- description of covered entity's remedial actions
- contact information for individuals to learn more

HHS to publish implementing regulations not later than Aug. 17, 2009.

Breach notification requirements will take effect 30 days later.

Breach Notification

HHS Secretary required to issue guidance within 60 days regarding technologies and methodologies that render PHI unusable, etc.

Guidance published April 27, 2009 (74 Fed. Reg. at 19006).

Refers to HIPAA Security Rule encryption standard.

Identifies NIST-tested methods judged as adequate for meeting the HIPAA standard.

Improved Enforcement

Civil penalties will be mandatory for HIPAA violations arising from willful neglect.

HHS must investigate any complaint if a preliminary investigation reveals a possible violation due to willful neglect.

HHS will publish implementing regulations within 18 months.

The willful neglect provisions will take effect in 24 months.

Improved Enforcement

Enhanced civil penalties:

- Civil penalties previously were limited to \$100 per violation, up to a total of \$25,000 per calendar year for all violations of an identical requirement.
- Statute establishes tiers for enhanced penalties:
 - unknowing violations: min. \$100 per violation not to exceed \$25,000 annual aggregate for violations of identical requirement
 - violations due to reasonable cause: min. \$1,000 per violation not to exceed \$100,000 annual aggregate
 - violations due to willful neglect that are corrected: min. \$10,000 per violation not to exceed \$250,000 annual aggregate
 - violations due to willful neglect that are not corrected: min. \$50,000 per violation not to exceed \$1.5 million annual aggregate

Improved Enforcement

- State AGs authorized to bring civil enforcement actions to seek injunctive relief or damages.
- Damages equal to \$100 per violation up to \$25,000 for all violations of an identical requirement during a calendar year.
- State AG also may recover attorney fees.
- These changes also are effective IMMEDIATELY.

Improved Enforcement

- Statute clarifies that individuals may be subject to criminal enforcement under HIPAA for wrongfully obtaining or disclosing PHI.
- Reverses conclusion of June 2005 memorandum to HHS General Counsel.

Department of Community Health Role MEDICAID

*Federal Funding **Transparent** to Medicaid Providers*

- Enhanced Federal Medical Assistance Payments (FMAP)
- Qualifying Individuals (QI) Block Grant increase

*Federal Funding Provides a **Value-Add** for Medicaid Providers*

- Disproportionate Share Hospital (DSH) Add-On of 2.5%
- Reimbursement for Electronic Health Record (EHR) System purchases

Department of Community Health Role HEALTH INFORMATION TECHNOLOGY

DCH already had a strategic plan for Health Information Technology before ARRA

Vision: Improve quality and efficiency by the use of Health Information Technology.

ARRA WILL PROVIDE FUNDING NEEDED TO CARRY OUT THE PLAN...

FIRST: Give providers the tools to build HIT infrastructure

HOW? Loans and reimbursement to Medicaid providers for the purchase of electronic health record (EHR) systems.

THEN: Provide incentives to use HIT in the practice of medicine (e.g., e-prescribing) and reporting health care outcomes for patients.

HOW? Medicare incentive payments

Department of Community Health Role

HEALTH INFORMATION TECHNOLOGY

DCH must compete for grants in the following areas:

- Planning and implementation for Health Information Exchange
- Privacy and Security education and research to increase awareness
- Technology Loan Fund for purchase of EHR's

DCH must compete for “Regional HIT Extension Center” designation

- The Center would provide technical expertise for the provider community implementing HIT
- Partnership with academia to develop subject matter expertise that can be shared with the provider community

DCH in “wait” mode for federal guidelines.

Department of Community Health Role

OTHER GRANT OPPORTUNITIES

1. Rural Health

- Increased Demand for Services at Migrant Health Centers*
- Direct Awards to FQHC's, Rural Health Centers

2. Wellness Initiatives

- Partnership with Public Health on various initiatives
- State Health Benefit Plan members

3. Broadband

- Partnership with Georgia Technology Authority
- Can expand telemedicine opportunities

DCH in “wait” mode for grant solicitations.

*funding already awarded to Georgia DCH

Department of Community Health Role OTHER

Federal regulation moratoria extended to June 30, 2009

- No immediate direct fiscal impact
- Impacted a variety of provider types
- Expect further Congressional extension or HHS rescission if HHS cannot address issues before June 30, 2009 (likely with delay of HHS Secretary confirmation)

Transition Medical Assistance extension

- State did not elect to utilize this provision

Q&A