

**American Recovery and Reinvestment Act**

**An Overview of the Health Information Technology for Economic and Clinical Health Act ("HITECH")**

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**HITECH – Introduction and Overview**

- On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act
- Title XIII of Division A comprises the provisions of HITECH, the Health Information Technology for Economic and Clinical Health Act

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**HITECH – Introduction and Overview**

- HITECH enacts five major components of a new national health information technology (HIT) strategy
  - A restructured role for the federal government as the coordinator of federal HIT policy
  - An expanded role for the federal government in HIT testing and research
  - A federally subsidized role for states, nonprofits and educational organizations in promoting and implementing HIT
  - Revisions to current privacy and security rules
  - \$17.5 Billion in incentive payments for adoption of electronic health records (EHRs)

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**HITECH – Introduction and Overview**

- Redefines the federal role in HIT
  - Prior federal role defined by executive order to create:
    - Office of National Coordinator of Health Information Technology (ONCHIT)
    - Healthcare Information Technology Standards Panel
    - Certification Commission for Health Information Technology
  - HITECH creates expanded federal role:
    - Authorizes ONCHIT
    - Establishes a HIT Policy Committee
    - Establishes a HIT Standards Committee
    - Authorizes National Institute for Standards and Technology (NIST) to test and certify HIT, including EHRs

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**HITECH – Introduction and Overview**

- Promotion of EHRs is HITECH's most dramatic break with past approaches
- Before HITECH, federal government relied upon small demonstration awards for physicians, federal agency purchasing initiatives and prototype subsidies to promote e-prescribing
- Now, HITECH provides an estimated \$17.5 Billion in incentives for the adoption of EHRs by meaningful users

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**HITECH – Why Now?**

- HITECH intends for HIT to play a transformative role in healthcare
  - EHRs can reduce adverse events
  - HIT can generate savings by eliminating errors and duplication
  - EHRs can accelerate and expand the pool of useful data by which to:
    - Conduct comparative effectiveness research
    - Identify provider variations and inefficiencies

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**Federal Policy – ONCHIT**

- Office of National Coordinator
  - Develops nationwide HIT infrastructure for electronic use and exchange of information
  - Coordinates Health and Human Services' (HHS) HIT policy and programs
  - Recommends to HHS standards, implementation specifications, and certification criteria for electronic exchange and use of health information

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**Federal Policy – ONCHIT**

- ONCHIT is advised by new ONC Federal Advisory Committees
  - HIT Policy Committee
    - Recommends policy for the development and adoption of nationwide HIT infrastructure permitting the electronic exchange and use of health information
    - Recommends order of priority for development, harmonization and recognition of standards, specifications and certification criteria
  - HIT Standards Committee
    - Recognize and recommend standards, implementation specifications and certification criteria
    - Provide for standards and technology testing with NIST
    - Ensure consistent with HIPAA standards

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### Financial Incentives for EHRs

- Overview
  - Incentives require "meaningful use" of "certified EHRs"
  - Reports on "clinical quality" also required
  - "Meaningful use" is to be demonstrated to the satisfaction of the HHS Secretary
    - Details to follow regarding how demonstrated (e.g., attestation requirement; actual demonstration)
  - EHRs must be connected in a manner that provides for electronic exchange of health information to improve the quality of health care (e.g., promoting care coordination)
  - Physicians – must use electronic prescribing (eRx)

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### Financial Incentives for EHRs

- Certified EHRs
  - Certified EHR technology is defined as a qualified electronic health record that is certified as meeting standards applicable to the type of record involved
  - ONC, in consultation with NIST, will develop a program for certification of compliance with HITECH criteria
    - HIT Standards Committee recommends standards, implementation specifications and certification criteria
    - HIT Policy Committee makes policy recommendations regarding these issues
    - December 31, 2009 deadline for initial standards, implementation specifications and certification criteria

11



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### Financial Incentives for EHRs

- Qualified EHR
  - Defined as an electronic record of health-related information on an individual that:
    - Includes demographic and clinical health information, and
    - Has the capacity to:
      - Provide clinical decision support
      - Support physician order entry
      - Capture and query information relevant to health care quality; and
      - Exchange electronic health information and integrate such information with other sources

12



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**Financial Incentives for EHRs**

- Medicare Incentives are available for Eligible Professionals (EPs)
  - An EP is defined as a physician
  - EPs will not receive incentives if "hospital based"
    - Substantially all services furnished in a hospital setting
    - Use of facilities and equipment of the hospital
    - Focus on site of service, not identity of employer or billing arrangement
  - Excludes most pathologists, anesthesiologists and emergency room physicians

13 

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**Financial Incentives for EHRs**

- The EP must be a "meaningful user" of EHRs
  - Must be demonstrated to the satisfaction of HHS
  - For physicians, includes the use of eRx
  - EHR must connect in a manner that provides for the electronic exchange of health information to improve the quality of care
  - EHR must be able to report on clinical quality and other measures as determined by HHS

14 

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**Financial Incentives for EHRs**

- Meaningful use, cont.
  - Details to follow regarding:
    - How much and what type of use is "meaningful"
    - What type of electronic exchange is sufficient
    - What clinical information must be provided
    - How much eRx will be required
  - Standards for "meaningful use" will evolve as HHS will require more stringent measures of meaningful use over time

15 

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**The Carrot - Calculation of Financial Incentives**

- Medicare incentives for EPs are 75 percent of estimated allowed charges for a payment year, subject to caps (see chart)
- Earliest payment year is calendar year 2011
- If the first year of meaningful use is 2013 or after, incentive payments “phase down”
- No incentives if the first payment year is after 2014
- No incentives paid for years after 2016

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**The Carrot - Calculation of Financial Incentives**

Summary of Possible Incentive Payments to EPs

	1 <sup>st</sup> payment year is 2011	1 <sup>st</sup> payment year is 2012	1 <sup>st</sup> payment year is 2013	1 <sup>st</sup> payment year is 2014	1 <sup>st</sup> payment year is 2015 or after
2011	\$18,000	0	0	0	0
2012	\$12,000	\$18,000	0	0	0
2013	\$8,000	\$12,000	\$15,000	0	0
2014	\$4,000	\$8,000	\$12,000	\$12,000	0
2015	\$2,000	\$4,000	\$8,000	\$8,000	0
2016	0	\$2,000	\$4,000	\$4,000	0
2017	0	0	0	0	0

17 

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**The Stick – Decreases in Fee Schedule**

- If an EP is not a meaningful user of EHR by 2015 or thereafter, the Medicare fee schedule amount for that EP will be cut as follows:
  - 1 percent for 2015
  - 2 percent for 2016
  - 3 percent for 2017 and thereafter
- HHS may establish hardship exceptions

18 

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**Financial Incentives for Eligible Hospitals**

- An eligible hospital (EH) excludes rehab hospital, cancer and children's hospitals or hospitals with average stays of 25 or more days
- Separate incentives are available for critical access hospitals

19 

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**Financial Incentives for Eligible Hospitals**

- Calculation of the incentive for an EH is the product of three elements for the payment year in question:
  - The Initial Amount, *multiplied by*
  - The Medicare Share, *multiplied by*
  - The Transition Factor

20 

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**Financial Incentives for Eligible Hospitals**

- The Initial Amount is the sum of:
  - The Base Amount (\$2,000,000), *plus*
  - The Discharge Related Amount
    - Zero for the first 1,149 total (not just Medicare) discharges
    - \$200 per discharge for discharges between 1,150 and 23,000; and
    - Zero for discharges in excess of 23,000
    - Provides more incentive money for larger hospitals

21 

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**Financial Incentives for Eligible Hospitals**

- The Medicare Share for a period is a fraction
  - Intended to calculate the percentage of inpatient bed days that are Medicare bed days
- The Transition Factor is:
  - 1.0 for payment year one
  - 0.75 for payment year two
  - 0.50 for payment year three
  - 0.25 for payment year four
  - Zero thereafter
- The earliest payment year is fiscal 2011 and the transition factor will be reduced if the first payment year is after 2013.
- The transition factor will be zero if the first payment year is after 2015 (resulting in no incentive payments)

22 

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**Financial Incentives for Eligible Hospitals**

- Example: Assume an EH with 15,000 discharges and 50 percent Medicare bed days
  - Initial Amount = \$5,000,000 (\$2,000,000 (base amount) plus \$3,000,000 (\$200 x 15,000 discharges))
  - Medicare Share = 50 percent, resulting in \$2,500,000 (\$5,000,000 x 0.50)
  - If the payment year is payment year 1 and occurs in fiscal year 2011, 2012 or 2013, then transition factor is 1.0 and the incentive for that year is \$2,500,000

23 

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**Financial Incentives for Eligible Hospitals**

- “Meaningful Use” requirement
  - Requires demonstration of meaningful use of EHR to the satisfaction of HHS
  - Substantially similar requirements and issues as applicable to EPs
  - However, no requirement for eRx
  - As with EPs, standards for meaningful will change as HHS requires more stringent measures of meaningful use over time

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**The Stick for Eligible Hospitals**

- If an EH is not a meaningful user of EHR by 2015, then 3/4ths of the applicable fee schedule percentage increase otherwise due will be reduced as follows for the fiscal year in question:
  - 33 1/3 percent for FY 2015
  - 66 2/3 percent for FY 2016; and
  - 100 percent for FY 2017

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**Medicaid Incentives**

- Alternative incentive system is included for professionals with specific percentages of patients receiving medical assistance or meeting a definition of “needy”
- Incentives may not exceed 85 percent of net allowable costs (as determined by HHS) for certified EHR technology, support and training, subject to caps:
  - \$25,000 in the first year
  - \$10,000 for the second and subsequent years
  - No payments for more than 5 years or after 2021 (later than Medicare incentive program)
  - Pediatricians limited to 2/3 of these amounts

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**Medicaid Incentives**

- Types of professional eligible are broader than under Medicare incentive program and includes:
  - Physicians
  - Dentists
  - Certified nurse midwives
  - Nurse practitioners
  - Physician assistants leading rural health clinics or federally qualified health centers
- Professional seeking Medicaid incentives must waive their right to receive the Medicare incentives

27 

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**Medicaid Incentives**

- To qualify, professional must have the following patient volumes:
  - Professionals (not hospital based) – at least 30 percent of patients receiving medical assistance
  - Pediatricians (not hospital based) – at least 20 percent of patients receiving medical assistance
  - Professionals in rural health clinics/federally qualified health centers – at least 30 percent of patients are “needy”
    - Receiving Medicaid assistance, SCHIP assistance, uncompensated care or being charged on a sliding scale based on ability to pay

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**Medicaid Incentives**

- Professional must demonstrate “meaningful use” of certified EHR technology by second and in later years of incentives
  - Demonstrate by means acceptable to HHS and to the State
- First year of costs must occur by 2016 (later than for Medicare incentive program)

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**Medicaid Incentives**

- Incentives available for hospitals
  - Acute care hospitals with at least 10 percent of patient volume receiving medical assistance
  - Children’s hospitals regardless of volume
- Hospitals must adopt EHR by 2016
- Payments limited to 6 years (longer than Medicare incentive)

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31

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**Medicare Recovery Audit Contractor Program**

**An Overview of the Recovery Audit Contractor ("RAC") Program and its Procedures**

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33

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**RAC Program** – Intended to identify Medicare over- and underpayments, and recover the overpayments.

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**Demonstration Project**

- 2005 through 2008.
- 6 states.
- Examined claims from 2001 through 2005.

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**Demonstration Project**

- Over 500,000 overpayment claims identified.
- \$1.03 billion in incorrect payments .

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**Demonstration Project**

- 85% of overpayments were collected from hospitals.
- Overall:
  - 35% - incorrect coding,
  - 40% - medically unnecessary services or setting,
  - 8% - insufficient documentation, and
  - Remaining 17% - other issues.

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**Demonstration Project**

- RAC's are paid on a contingency basis (for both under- and overpayments).
- Collectively earned fees of \$187 million during the demonstration project.

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**Permanent RAC Program**

- Tax Relief and Health Care Act of 2006 made RAC program permanent.
- Requires full implementation by January 1, 2010.

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**Permanent RAC Program**

- Rolling Start:
  - Texas program scheduled to start March 1, 2009.
  - After delay, RAC has received claims data for Texas from CMS and begun review. No providers have been contacted.

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**Permanent RAC Program**

- Connolly Consulting Associates, Inc. of Wilton, Connecticut.
- Viant Payment Systems, Inc.

41 

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**Permanent RAC Program**

- Will review claims for:
  - incorrect payment amounts;
  - non-covered services;
  - incorrectly coded services; and
  - duplicate services.

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**Permanent RAC Program**

- Maximum look-back period of three years.
- Begin with claims paid on or after October 1, 2007.

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**Permanent RAC Program**

- CMS provides claims histories and monthly updates to RACs.
- May not select claims for review at random.
- Use propriety software to identify claims likely to contain improper payments.

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**Permanent RAC Program**

- Two Types of Reviews:
  - Automated.
  - Complex.

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**Permanent RAC Program**

- Must abide by standard coverage policies.
- Must use the same review staff used by Medicare fiscal intermediaries, including a medical director and a certified coder

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**Permanent RAC Program**

- Records Requests:
  - 45 days to respond.
  - Limits on number of requests.

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**RAC Appeals**

- Five Levels of Appeals.
- Note: interest is accruing at 11.375% from date of determination.
- RACs must reimburse contingency fees received for any denial overturned at any level.
  - During demonstration program, RACs only required to pay back if overturned at first level.

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**RAC Appeals**

- Demonstration project appeals.
  - As of August 2008:
    - 22.5% of claims overpayments appealed.
    - 34% of claims overpayments appealed have been reversed.
    - 4.9% of all overpayment determinations overturned on appeal.

49

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**RAC Appeals**

- First Level Appeal:
  - Request for re-determination.
  - Within 120 days of receipt of demand letter.

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**RAC Appeals**

- Second Level Appeal:
  - Request for reconsideration.
  - Within 180 days of re-determination.

51

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**RAC Appeals**

- Third Level Appeal:
  - Administrative Law Judge Hearing.
  - Within 60 days of reconsideration.

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**RAC Appeals**

- Fourth Level Appeal:
  - Medicare Appeals Council Review.
  - Within 60 days of ALJ decision.

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**RAC Appeals**

- Fifth (and final) Level Appeal:
  - Federal Lawsuit.
  - Within 60 days of MAC determination.

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**Tips:**

- Assemble a response team in advance.
- Create a system to calendar requests received and keep track of 45-day response period.
- Attempt to determine accuracy of recovery within two weeks of receipt of the RAC request.
- Consider self-audits of likely areas of interest.

56

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**Questions & Answers Segment**

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57

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