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**Analysis of the Final Health Information Technology (HIT) Provisions
of the Economic Recovery Act**

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To follow is a brief summary and analysis of the final HIT provisions of the Economic Recovery Act just signed into law by President Obama. The total funding authorized for these final HIT provisions is reported to be \$20.8 billion.

The Alliance applauds this HIT funding support as part of the Federal economic recovery legislation. The HIT provisions represent a substantial step forward in federal leadership and support to make HIT a reality in the U.S.

The Medicare and Medicaid incentive payment provisions represent important, direct federal financial support to hospitals and physicians (and to children's hospitals, community health centers, and some professionals in addition to physicians in the case of the Medicaid incentive payment provisions), but these provisions will not meet all of their HIT funding needs--and do not address any of the needs of free-standing specialty hospitals other than children's hospitals (e.g., physical medicine and rehabilitation), nonprofit nursing homes, home care providers, and hospices. Also, these provisions appear to exclude any incentive payments to health care systems for HIT in their group practices, including integrated inpatient/outpatient EHRs.

\$2 billion is also authorized for federal grants to community health centers for renovation and HIT.

While the HIT provisions also require the Secretary to provide competitive HIT planning and implementation grants to the states, and authorize (but do not appear to require) the Secretary to provide competitive grants to states that establish loan funds for various types of health care providers that the individual states decide to assist, the amounts currently authorized for these grant programs cannot fill the gaps in the Medicare and Medicaid incentive payment provisions.

Several studies are required to identify and make recommendations on filling HIT assistance gaps, and the Alliance intends to help in any way it can in the conduct of these studies, should more immediate actions prove infeasible.

The Alliance is also pleased that the final HIT provisions on privacy do not preclude the use of the names and contact information on former patients for fundraising, which is more important than ever in the current economic crisis.

We will continue to work with Congressional leaders and with the Obama Administration on this vital initiative to improve health care safety and quality for all Americans while reducing unnecessary costs.

To follow is a summary of the major HIT provisions.

Office of the National Coordinator for Health Information Technology (ONCHIT)

- The duties of ONCHIT are codified, and ONCHIT is required to have a Chief Privacy Officer and to assemble and lead HIT Policy and Standards Committees. ONCHIT may use the bodies that currently exist if he so chooses.
- Initial standards, which may include existing standards, are to be adopted through the normal rule-making process by no later than December 31, 2009. ONCHIT must submit an annual operating plan to the House and Senate Appropriations Committees (the first one due within 3 months of enactment before any of these funds can be obligated), and report to the same bodies every 6 months on actual obligations and expenditures and unobligated balances. These funds must be used at least to invest in:
 - HIT architecture that will support the nationwide electronic exchange and use of health info in a secure, private and accurate manner, including connecting health information exchanges;
 - Integration of HIT, including EHRs, into the initial and ongoing training of health professionals and others in the industry;
 - Training on and dissemination of information on best practices to integrate HIT, including EHRs, into a provider's delivery of care
 - Infrastructure and tools for the promotion of telemedicine; and
 - Promotion of the interoperability of clinical data clinical data repositories or registries

Medicare Payment Incentives to Physicians

- Physicians who are “meaningful EHR users” (definition to be determined by the Secretary through the rule-making process, to include e-prescribing, connected in a manner to improve quality, such as promoting care coordination, and reporting on quality measures) will receive additional payments that decline over five years (\$15,000, \$12,000, \$8,000, \$4,000, and \$2,000)
- The earliest that such payments will be made is 2011, and the latest that incentive payments will be made is 2016.
- Physicians who are meaningful HER users in 2011 or 2012 would be paid \$18,000 in their first year
- Physicians who are meaningful EHR users and who practice in physician shortage areas will have 10% higher incentive payments
- Starting in 2015, physicians who are not meaningful EHR users by then will be penalized (1%, in 2015, 2% in 2016 and 3% in 2017 and every year thereafter. However, if less than 75% of physicians are meaningful users in any of those years, the penalties will

increase by one percentage point from the applicable percentage in the previous year, up to a maximum penalty of 5%

- Incentive payments for HMO-based physicians under the Medicare Advantage program will be either a single consolidated payment or periodic installments, as the Secretary determines through the rule-making process. The payments are capped at 5,000 physicians in the HMO
- Hospital-based physicians are excluded from incentive payments. They are defined as “those furnishing substantially all of their services in a hospital inpatient or outpatient setting through the use of hospital facilities and equipment, including EHRs, of the hospital. The determination of whether an eligible professional is a hospital-based eligible professional is required to be made on the basis of site of service (as defined by the Secretary) and without regard to any employment or billing arrangement between the eligible professional and any other provider.” This language is confusing, but it would appear that there will no incentive payments for hospital outpatient HIT or for health system group practice HIT, including integrated inpatient/outpatient EHRs
- No administrative or judicial review will be permitted regarding: the methodology and standards for determining payment adjustments; the methodology and standards for determining eligible professionals; or the methodology and standards for determining a meaningful EHR user
- The Secretary can provide hardship exceptions from penalties on a case-by-case basis, but for no longer than five years

Medicare Incentive Payments to Hospitals

- Hospitals that are “meaningful users” (under the same definition that applies to physicians) will receive additional payments--through a rather complicated formula taking into account annual volume of total discharges, percentage of patient days that are Medicare and percentage patient revenues that are charity care--that decline over five years (100%, 75%, 50%, 25%, and 0%)
- The payment will be either a single consolidated payment or periodic installments, as the Secretary determines
- The earliest that such payments will begin is 2011, and no incentive payment will be made to a hospital whose first year as a meaningful user is 2016 or later
- Critical access hospitals will receive higher incentive payments
- Starting in 2015, hospitals that are not meaningful users will be penalized a percentage of the otherwise applicable market basket adjustment (33 1/3% in 2015, 66 2/3% in 2016, and 100% in 2017 and thereafter)
- HMO-based hospitals that are meaningful users will receive incentive payments of a similar nature
- The previously described limits on administrative and judicial review also apply here

- The Secretary can provide hardship exceptions on a case-by-case basis, but for no longer than 5 years

Medicaid Incentive Payments

- The federal government will reimburse the state for payment of Medicaid net allowable HIT costs to the following categories of providers¹ that are meaningful EHR users (85% reimbursement in the case of physicians and other eligible professionals and 100% in the case of other eligible providers):
 - Physicians and other eligible professionals (dentists, certified nurse mid-wives, nurse practitioners, and physician assistants in certain circumstances) with at least 30% Medicaid patient volume;
 - Pediatricians with at least 20% Medicaid patient volume
 - Children’s hospitals;
 - Other hospitals with at least 10% Medicaid patient volume; and
 - Federally-qualified health centers and rural health centers with at least 30% Medicaid patient volume
- The federal government will also reimburse the states for 90% their reasonable costs of administering these payments
- Limits are specified on the amounts and years of such payments (e.g., not to exceed \$25,000 to eligible professionals for the first year and not to exceed \$10,000 for each year thereafter), although the Secretary has the option to establish a different set of annual or aggregate limits

Federal Grants to States

- Through ONCHIT, the Secretary is required to establish a competitive grant program starting in 2011 for state HIT planning and implementation efforts. The state match is to be 1-to-10 in 2011, 1-to-7 in 2012, and 1-to-3 in 2013 and thereafter. If the Secretary makes any such grants prior to 2011, he can determine the extent of any required match by the state. The grants can be for such purposes as:
 - Identifying state or local resources available toward a nationwide effort to promote HIT
 - Enhancing broad and varied participation in the authorized and secure nationwide use and exchange of health information
 - Complementing other federal grants, programs, and efforts towards the promotion of HIT The state match is to be 1-to-10 in 2011, 1-to-7 in 2012, and 1-to-3 in 2013 and thereafter. If the Secretary makes any such grants prior to 2011, he can determine the extent of any required match by the state
- ONCHIT may (but does not appear to be required to) award competitive grants beginning after January 1, 2010 to states that develop loan programs to assist health care providers in

¹ The House-passed HIT provisions would have also required the Secretary to provide grants to up to ten states (giving priority to those with the highest numbers of Medicaid nursing facility patient days) to make Medicaid incentive payment incentive payments to targeted nursing facilities--those making meaningful use of HIT with higher Medicaid patient percentages than the state-average.

investing in HIT, with the state match to be at least 1-to-5 and state costs of administering the loan support program to be no greater than 4%. Loans may be used by the provider to: facilitate purchase of certified EHR; enhance use of EHRs; train personnel in use of such technology; or improve the secure exchange of health information. Interest rates must not exceed the market interest rate, payments of principal and interest must commence in one year, and be fully amortized in no more than 10 years. The state loan fund may be used:

- For making loans;
- For guaranteeing or purchasing insurance for a local obligation; or
- As a source of security for the payment of principal and interest on revenue or general obligation bonds, if the proceeds of the bond sale are deposited in the state loan fund. Loans may be used by the provider to: facilitate purchase of certified EHR; enhance use of EHRs; train personnel in use of such technology; or improve the secure exchange of health information. Interest rates must not exceed the market interest rate, payments of principal and interest must commence in one year, and be fully amortized in no more than 10 years

Required Studies

- The Secretary is required to conduct a study and report to the Congress findings and conclusions by no later than June 30, 2010 on whether payment incentives and other funding should be made available to health care providers receiving minimal or no payment incentives under this Act or Titles XVII or XIX
- The Secretary is required to conduct a study and report to the Congress by no later than October 1, 2010 on the availability of open source HIT systems for safety-net providers, including their total costs compared to commercial products, their applicability to various populations, and their capacity for interoperability
- The Secretary is required to conduct a study and report within two years on the potential use of new aging services technology to assist seniors, the disabled, and caregivers

Technical Assistance and Clinical Education

- The Secretary is required to support the creation and operation of regional centers (affiliated with nonprofit institutions) to provide technical assistance and dissemination of best practices learned through a new HIT Research Center that the Secretary is required to establish. Priorities for assistance are: public and nonprofit hospitals, community health centers, entities located in medically underserved areas and areas with high portions of uninsured and underinsured residents, and individual or small group practices primarily focused on primary care. Funding support is to be for up to four years, covering no more than 50% of capital and operating costs--unless the Secretary determines that national economic conditions require more support
- The Secretary may award competitive grants for demonstration projects integrating HIT into clinical education, covering no more than 50% of capital and operating costs--unless the Secretary determines that national economic conditions require more support
- The Secretary is required to provide assistance to institutions of higher learning to establish “Centers of Health Care Information Enterprise Integration”

Comparative Effectiveness Research (CER)

- AHRQ, NIH, as well as the Secretary, are provided special funding to conduct comparative effectiveness research. A National Coordinating Council for CER is required to be established, with up to 15 senior health officers or employees appointed by the Secretary (including one each from AHRQ, CMS, NIH, ONCHIT, FDA, VHA, and Dept. of Defense military health system)

Privacy

- The Secretary is required to issue during the first year and annually thereafter, in consultation with industry stakeholders, guidance on the most appropriate HIT privacy and security protections
- Requirements are established for timely notification of individuals (or in some cases to prominent media) by a provider, health plan or other entity if it discovers a breach of security of that individual's protected health information. Business associates of covered entities must report breaches they discover to the entities
- Breaches must also be reported by covered entities to the Secretary (immediately if more than 500 individuals involved or annually based on a log if less than 500), who will post on a public web site a list of entities whose breaches involve more than 500 individuals and who will report annually to the Congress on breaches
- Individual and annual penalties are specified under three categories for breaches
- The Secretary is required within 60 days, and annually thereafter, to publish guidance, in consultation with industry stakeholders, on which technologies protect health information
- Upon specific request by individuals, covered entities must provide them with an audit trail on disclosures of their protected health information and an electronic copy of their information
- Any written fundraising solicitations using a former patient's name and contact information must clearly and conspicuously provide an opt-out to that individual from further such communications
- Commercial sales of protected health information without valid authorization are prohibited