Executive Briefing

The American Recovery & Reinvestment Act of 2009

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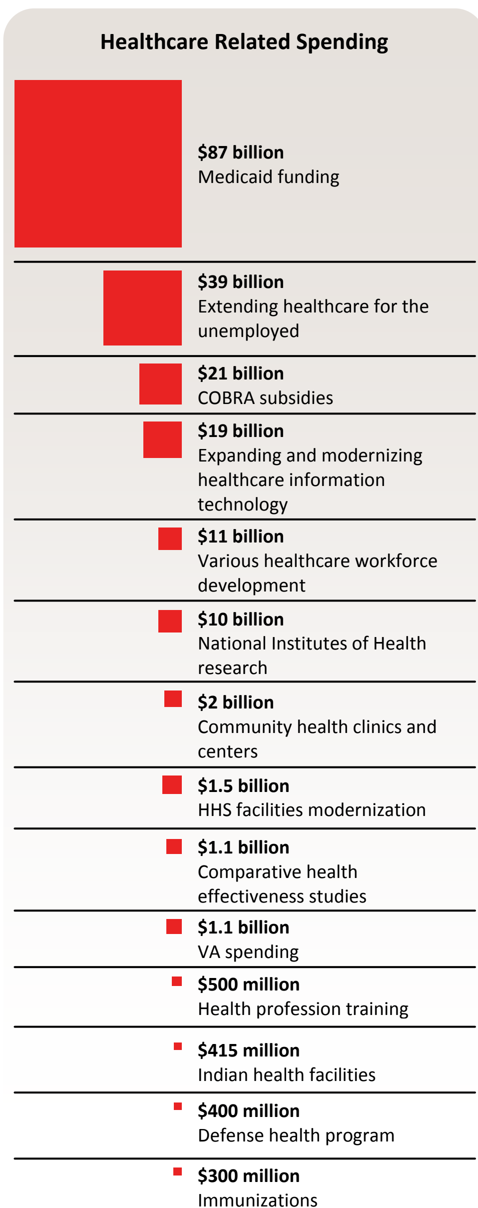
Stimulus Overview

On February 17, 2009 President Barack Obama signed The American Recovery and Reinvestment Act of 2009 (ARRA) into law. ARRA is a $787 billion stimulus package with over $150 billion in spending on the nation's infrastructure, with 24% committed to new federal spending, 38% for tax cuts and the remaining 38% for aid to states, school districts, communities and other entities. It is intended to create over 3.5 million jobs, with heavy investments in science, energy, healthcare, and technology. Of the $787 billion, more than $180 billion has been set aside for healthcare-related spending, with a significant portion of those funds aimed at improving the nation's health information technology (HIT).



Driving New Technology Into Healthcare

The over-arching goal for health IT spending is to expand health coverage to more Americans and facilitate the adoption of an electronic health record (EHR) for every American by 2014. The Congressional Budget Office (CBO) estimates that stimulus package funding will enable approximately 90% of doctors and 70% of hospitals to adopt and "meaningfully use" certified electronic health records within the next decade. The CBO estimates savings of more than $12 billion through improvements in quality of care, care coordination, and reductions in medical errors and duplicative care.

> "We know that healthcare cost is crippling businesses and making us less competitive, as well as breaking the banks of families all across America. And part of the reason is we've got the most inefficient healthcare system imaginable. We're still using paper. We're still filing things in triplicate. Nurses can't read the prescriptions that doctors have written out. Why wouldn't we want to put that on an electronic medical record that will reduce error rates, reduce our long-term costs of healthcare, and create jobs right now?"
>
> **– President Barack Obama**

The following is a breakdown of the authorized health IT spending:

- $86.7 billion for state Medicaid programs
- $39 billion to extend healthcare coverage to the unemployed
- $21 billion in COBRA subsidies
- $19.2 billion to expand and modernize health IT

Office of National Coordinator for Health Information Technology

The legislation codifies the Office of the National Coordinator for Health Information Technology (ONCHIT), and establishes an open and transparent process led by the Office of the National Coordinator (ONC). The goal is to develop standards by 2010 that allow for secure, nationwide electronic exchange of health information. The law also establishes a Health IT Standards Committee to review and recommend standards and other policy recommendations to the ONC.

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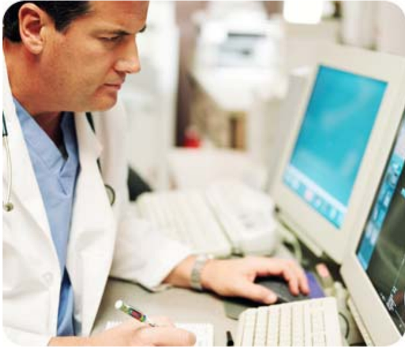
The ONCHIT is also responsible for:

- Coordinating HIT policy and programs with other federal agencies
- Working in consultation with the National Institute of Standards and Technology (NIST) to develop a voluntary certification program for HIT
- Establishing a national governance mechanism for the national health information network



There is an immediate $2 billion in discretionary funding available to the ONC for health information technology infrastructure, training, dissemination of best practices, telemedicine, inclusion of health information technology in clinical education, and state grants to promote health information technology.

The legislation also expands the definition of what constitutes a "healthcare provider" in order to enable these providers to qualify for Medicare and Medicaid incentive payments for EHR use.

HIT Policy Committee

The HIT Policy Committee will recommend what policies and regulations are necessary for implementing "meaningful use" of EHRs and to ensure effective implementation. Members will include providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant federal agencies and individuals with technical expertise in healthcare quality, privacy and security.

The Committee will oversee the following required policy recommendations:

- Privacy and data security technologies
- HIT infrastructure that allows electronic information exchange
- Nationwide adoption
- Use of EHRs to improve care
- Encryption technology

HIT Standards Committee

The Health Information Technology Standards Committee will recommend health information technology standards, EHR applications certification standards, and other reporting and certification criteria to the National Coordinator. Much like the HIT Policy Committee, members will include providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant federal agencies, and individuals with technical expertise in healthcare quality, privacy and security. Membership is developed through nominations made by congressional leaders and the Secretary of HHS. The HIT Standards Committee, which is required to create EHR standards by 2010, must implement an open and transparent process for developing new EHR standards and certification criteria and is responsible for updating the Federal Health IT Strategy Plan. The Committee's primary goal is to establish objectives, milestones, and metrics for the healthcare provider community to promote the utilization of EHRs

Expanded Definition of Healthcare Provider

Hospital

Skilled nursing facility

Nursing facility

Home health entity

Long-term care facility

Health care clinic

Community mental health center

Renal dialysis facility

Blood center

Ambulatory surgical center

Emergency medical services provider

Federally-qualified health center or group practice

Rural clinic

Pharmacist

Pharmacy

Laboratory

Physician

Practitioner

Provider operated by or under contract with the Indian Health Service or Indian Tribe, tribal organization, or urban Indian organization

Key Definitions:

EMR - An electronic medical record is the computerized recording of care provided by a particular provider in a single healthcare setting; it is not necessarily longitudinal and does not contain a full record of all the healthcare encounters a patient has experienced

EHR - An electronic health record is more comprehensive than an Elelctronic medical record (EMR in that it con)tains information about care received in multiple settings and care provided by multiple providers; it attempts to capture a full record of all the healthcare encounters a patient has experienced

and to develop an EHR for every person in the United States by 2014. Finally, the law stipulates that nothing in the statute prevents the Secretary from creating a new ONCHIT office **or** allowing the National eHealth Collaborative from modifying its structure and mission accordingly to serve as the HIT Standards Committee.

HIT Standards Committee duties include the following:

- Recommend (through a consensus approach) standards, implementation specifications, and certification criteria for electronic exchanges of health information
- Pilot the testing of standards
- Serve as a forum for the participation of a broad range of stakeholders
- Develop, within 90 days, a long-range plan for addressing policy recommendations for the HIT Policy Committee
- Meet openly in public and manage an inclusive evaluation process
- Publish all standards and criteria recommendations in the Federal Register

Adoption of Initial EHR Standards by 2010

The ARRA also requires the Secretary of Health and Human Services to establish a standard for EHRs by 2010. The law directs the Secretary to determine whether or not to propose adoption through regulation any proposed HIT standard, specification, or certification criteria within 90 days of receiving the recommendation from the National Coordinator. The law also permits the Secretary to issue interim final rules so that the agency can facilitate widespread industry adoption.

The ARRA also requires healthcare payers and providers that contract with the federal government to use HIT systems and products that meet the standards adopted by the Secretary.

Other Stakeholders

Although it is currently unknown precisely how the following organizations will impact the creation of standards for the implementation and use of EHRs, the following list of stakeholders are to be involved:

- National eHealth Collaborative (the successor to the American Health Information Community)
- National Institute of Standards and Technology -- A Federal Agency for Standards Development and Research
- American National Standards Institute (ANSI)
- Healthcare Information Technology Standards Panel
- Certification Commission for Healthcare Information Technology

ONCHIT Grants and Loan Authority

The ARRA provides for more than $2 billion in immediate funding to strengthen the nation's Health Information Technology infrastructure, and the Health and Human Services Secretary is required to invest, consistent with the National Coordinator's strategic plan, in Health Information Technology "so as to promote the use and exchange of electronic health information." Funds for this investment will likely be distributed through different federal agencies with relevant expertise, such as: ONCHIT, AHRQ, CDC, CMS, and the Indian Health Service. However, it is important to note that nothing in the law explicitly prevents the Secretary from issuing direct grants and funding awards to certain providers, hospitals, health information exchanges, universities and other entities involved in EHR pilot programs, demonstrations, and other efforts designed to successfully implement the Health IT and EHR provisions of the law. However, the law does state that the $2 billion in "jump-start" funds should support the following:

- HIT architecture
- EHRs for providers not eligible under incentive payments program
- Training
- Telemedicine
- Interoperable clinical data repositories
- Technology and best practices development
- HIT use by public health departments

An additional $300 million must be invested to support regional health information exchanges.

In addition to the creation of an HIT Research Center, the law includes a provision for states to distribute grants in order to promote Health IT and EHR implementation. In order to qualify for state grants, entities must be non-profit with broad stakeholder representation on their governing boards and adopt nondiscrimination and conflict of interest policies. The grants would require the state to match the funding at a ratio of one dollar for every 10 federal dollars.

ONCHIT Allocation

2008 ONC Budget: $63 million

"Jump-start" ONCHIT Budget: $2 billion

Other initiatives include a Competitive Grants Program for states and Indian Tribes. This program is designed to establish loan programs for healthcare providers to purchase certified EHR technology, train personnel, and improve the secure exchange of information. Grantees would be required to establish a qualified HIT loan fund, submit a strategic plan and contribute provider matching funds.

In order to facilitate the training of the workforce that will implement and maintain health IT systems, the ARRA requires the creation of a demonstration program to integrate information technology into clinical education. The HHS Secretary is able to create a program awarding competitive grants to medical, dental, and nursing schools to integrate HIT into clinical education. This also requires the Secretary to provide, in consultation with the National Science Foundation, funding to universities to establish informatics programs.

The Funding

The funding for the implementation of EHRs will be administered through incentive payments via Medicare and Medicaid for hospitals and healthcare professionals that implement compliant EHRs.

Medicare Incentives for Hospitals

The Medicare incentive payment structure is established where entities receive enhanced Medicare reimbursements starting in 2011, with up to $11 million being made available for each qualifying hospital over a four-year transition period.

The law also creates an incentive for hospitals to implement EHRs by initiating a declining Medicare reimbursement rate for those hospitals that fail to implement "meaningful use" (see definition below) of EHRs by 2016. This approach creates an added incentive to facilitate industry-wide implementation of EHR use sooner rather than later. The criteria for compliance with the requirement is that hospitals "meaningfully use" EHRs, thereby qualifying for incentive payments. Each must implement a certified EHR system that enables: 1) clinical decision support, 2) clinical physician order entry, 3) the exchange of data, 4) and quality reporting.

Medicare Incentives for Healthcare Professionals

The Medicare incentive payments for healthcare professionals are estimated to be between $44,000 and $64,000 per qualified provider for the "meaningful use" of an EHR. As with the reimbursements for hospitals, there is a diminishing reimbursement over time, and ultimately a penalty for late adopters. The penalty takes the form of a reduction in the normal reimbursement schedule by 2016 for those who are not "meaningful users" of a certified EHR. EHR criteria for healthcare professionals include: 1) e-prescribing, 2) the ability to exchange data, 3) and the ability to conduct quality reporting.

Payments are increased by 10% for providers located in a "health professional shortage area."

> **Key Definition: Meaningful User**
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> According to the legislation, a meaningful EHR user must demonstrate it is using certified EHR technology, that the technology is connected in a manner that allows for the exchange of healthcare information, and that the EHR user can effectively demonstrate the technology's "meaningful" use. The Secretary shall seek to improve the use of EHR technology by requiring a more stringent measure of "meaningful" during implementation.

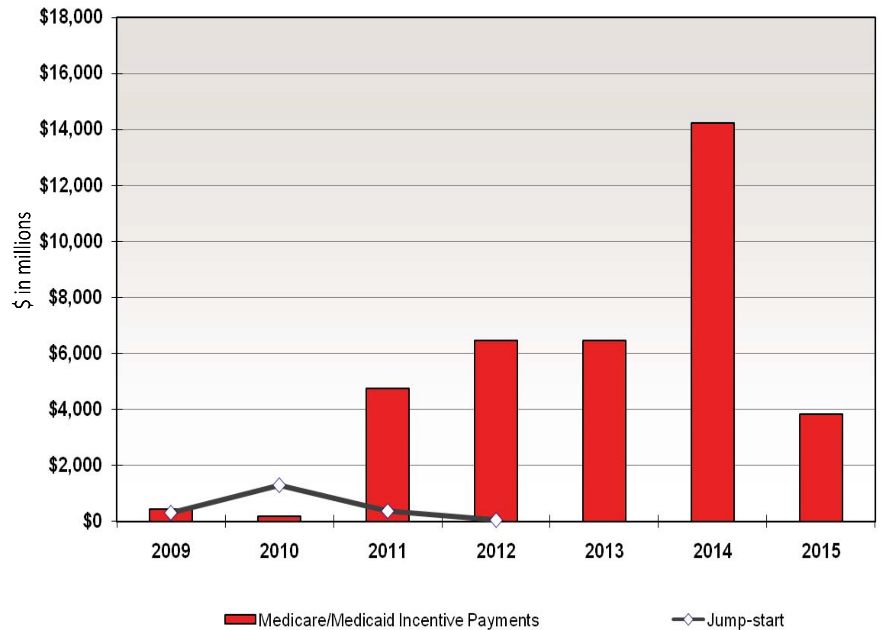
Exclusions

The legislation clearly excludes hospital-based professionals (such as radiologists, pathologists, etc.) who work in an in-patient facility. There is an exception for professionals employed by a hospital, but who work in an ambulatory clinic or have billing arrangements where physicians submit claims to Medicare together with hospitals or other entities. The test for this is based on the setting where the provider furnishes services rather than billing or employment between a provider and hospital or other entity.

Medicaid Incentives

The federal government pays a share of every state's spending on Medicaid. The federal government also makes payments to states for certain Medicaid-related administrative expenditures, but certain functions receive higher amounts. The Social Security Act (SSA) authorizes a 90% match for expenditures attributable to the design, development or installation of mechanized claims processing and information retrieval systems referred to as Medicaid Management Information Systems (MMISs) and a 75% match for the operation of MMISs that are approved by the Secretary.

The ARRA amended the SSA to authorize a 100% federal match for a portion of payments to encourage the adoption of EHRs (including support services and maintenance) to certain Medicaid providers who meet certain requirements. The state must prove to the Secretary that allowable costs are paid directly to the healthcare provider without any deduction or rebate, that the provider is responsible for payment of the EHR technology costs, that the user certifies "meaningful use," and that the technology is compatible with federal administrative management systems.



Eligible providers would include: physicians, nurse mid-wives, pediatricians, and nurse practitioners who are not hospital-based and who have patient volume of at least 30% attributable to Medicaid patients. In order to be eligible, the provider would be required to waive any right to Medicare EHR incentive payments.

This provider group would be eligible for payments of up to 85% of their net allowable technology costs. However, the allowable costs of the purchase and initial implementation of EHR technology cannot exceed $25,000 or include costs over a period of five years. Annual allowable costs not associated with the initial implementation or purchase of the EHR technology may not exceed $10,000 per year or be made over a period of five years. Aggregate allowable costs, after application of the 85% adjustment, may not exceed $63,750.

Note: Since payments to eligible professionals will be sufficient to cover most or all of the costs of acquiring a certified EHR under the Medicaid incentive program, the law does recognize that some providers may be eligible to receive incentive payments under both Medicare and Medicaid, but they are required to choose one incentive payment program.

The following is a review of the key provisions of the Medicaid incentive program:

- Payments of up to 90% to states for reasonable administrative expenses related to the administration of payments to providers
- Allows for payments to states of up to 100% of costs for implementing EHR technology to be provided in the form of increased reimbursements to providers (including maintenance, training, adoption, operation)
- In no case shall the aggregate allowable costs exceed $25,000 with respect to a Medicaid provider for the purchase and initial implementation
- Additional costs are also not to exceed $10,000 per year over a period of no longer than five years; and not to exceed a total of $75,000 per provider

Acute Care Hospital Incentive Payments

Acute care hospitals with at least 10% Medicaid patient volume would be eligible for payments, as would children's hospitals with any Medicaid patient volume. Payments to hospitals would be limited to amounts analogous to those specified for eligible hospitals in Medicare. Hospital limitations for Medicare and Medicaid are assessed on a proposal basis depending upon a hospital's patient volume from each payer, so the ARRA does anticipate that certain hospitals could receive funding from both incentive programs.

Rural Healthcare Clinics and Federally-Qualified Health Centers Incentive Payments

Rural healthcare clinics, physician assistant-led rural clinics, and federally-qualified health centers with at least 30% patient volume attributable to Medicaid patients would also be eligible for Medicaid incentive payments at amounts to be determined by the Secretary.

Personal Health Information Privacy

Privacy is an issue that has derailed previous attempts at health IT implementation and the wide-spread implementation of EHRs. In passing the ARRA Congress did increase federal privacy laws for Personal Health Information (PHI) provided a definition of a data "breach," and outlined the steps providers or other qualified users of PHI must take in the event of a breach where PHI has been stolen, used or viewed by a non-qualified user.

Clarifications on the definition of a breach include:

- An unintended disclosure where a person would not reasonably be able to retain information disclosed does not constitute a breach requiring notification
- Any inadvertent disclosures from an individual who is otherwise authorized to access protected health information at a facility

Breach notification requirements include:

- Notify each individual whose information has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of such breach
- Exceptions to the breach notifications are for unintended acquisition, access, use or disclosure of protected health information
- For a breach of unsecured PHI under the control of a business associate, the business associate would be required to notify the covered entity
- Notice would be made to the Secretary and prominent media outlets serving the area in the event of a breach of more than 500 individuals
- If the breach is fewer than 500, the covered entity would have to maintain a log of such breaches and annually submit it to the Secretary
- The Secretary is required to issue interim final rules within 180 days of enactment on privacy provisions
- Requires Personal Health Record (PHR) vendors and entities offering products and services through PHR vendor's Web sites, upon discovery of a breach of security of unsecured PHR information, to notify the individuals and the Federal Trade Commission
- Legislation amends HIPAA to permit OCR to pursue an investigation and the imposition of civil monetary penalties against an individual for an alleged criminal violation of the Privacy and Security Rule of HIPAA, if the DOJ has not prosecuted (once regulations were issued on the provision)

The law also prohibits the sale of PHI by a covered entity or business associate without patient authorization (except in specified circumstances) and outlines the civil and criminal penalties that can be imposed for the unlawful use of PHI.

Additional Medicaid Stimulus Funding (Not Related to HIT)

The ARRA provides increased Medicaid funding under the following provisions:

- A 6.2% across-the-board increase of Federal Medical Assistance Percentage (FMAP)
- FMAP payments to states for 27 months through Dec. 31, 2010 (projected to cost $86.7 billion)
- Reductions in state share for states with increases in unemployment rates would be 5.5%, 8.5%, and 11.5%
    - These percentage reductions would be applied against the state share after the hold harmless reduction and after an across-the-board increase of 3.1%
- Each territory would be allowed to choose between a regular FMAP increase of 6.2% along with a 15% increase in its spending cap, or its regular FMAP along with a 30% increase in its spending cap
- Prohibits states from receiving the temporary payment increases if they are not in compliance with existing requirements for prompt payment of practitioners
- Provides a 2.5% increase above the base rate for Disproportionate Share (DSH) Allotments in FY2009 and an additional 2.5% above the adjusted new base of FY2009 and in FY2010

The ARRA also extends moratoria on the following regulations:

- Targeted Case Management
- Provider Taxes
- School Based Services
- Outpatient Hospital Services

For more information and to stay abreast of continuing developments related to the ARRA and its impact on the healthcare community, please visit **perotsystems.com/insights** or call **866.665.1241**.

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