Investments in Health Information Technology Driven by HITECH Act

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The authors review provisions of the new stimulus package that authorize billions of dollars to develop an electronic health information technology infrastructure.

The recently enacted Health Information Technology for Economic and Clinical Health ("HITECH") Act, a component of the American Recovery and Reinvestment Act of 2009, authorizes $36 billion of funding to put in place an electronic health information technology ("HIT") infrastructure. The legislation authorizes funds for administrative structures and processes for developing interoperable systems, as well as funding and incentives to deploy the electronic infrastructure and encourage its adoption. The statutory authority establishes solid lines of accountability within the U.S. Department of Health and Human Services ("HHS") for HIT initiatives. Highlights of new HIT provisions are described below.

EXECUTIVE BRANCH INFRASTRUCTURE: ONCHIT AND HIT FEDERAL ADVISORY COMMITTEES

The HITECH Act establishes statutory authority for the Office of the National Coordinator for Health Information Technology ("ONCHIT") within HHS. The law provides ONCHIT with a broad mandate to imple-

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ment a nationwide HIT infrastructure and ensure that each person in the United States has an electronic health record ("EHR") available to her or him by 2014.

The law provides for the establishment of two committees charged with advising ONCHIT on implementation and strategy in adopting HIT platforms: The HIT Policy Committee and the HIT Standards Committee. The HIT Policy Committee is tasked with making policy recommendations to the National Coordinator that relate to interoperable nationwide HIT infrastructure implementation, including priorities, privacy, and security. Members are to be appointed as follows: three appointed by the Secretary of HHS, four appointed by Congress, 13 appointed by the Comptroller General (to include representatives of patients, providers, organized labor, privacy and security interests, vulnerable populations, researchers, payers, IT vendors, employers, and health care quality experts); others are to be appointed by the President to represent other relevant federal agencies. The recommendations of the National eHealth Collaborative (the successor entity to AHIC, the American Health Information Community) are established as the benchmark policies for development of HIT until the new HIT Policy Committee is established, and the statute acknowledges that the Collaborative is not prohibited by the provisions of the new law from modifying its charter, duties, and membership in order to allow the Secretary to recognize it as either the new HIT Policy Committee or the HIT Standards Committee.

The HIT Standards Committee will recommend standards, implementation specifications, and certification criteria to the National Coordinator. The Standards Committee is to provide for development, harmonization, and testing of standards; the National Institute for Standards and Technology ("NIST") is directly charged with such testing, as discussed below. The Standards Committee also must assure that the standards are consistent with the latest recommendations of the Policy Committee, as well as the standards adopted under HIPAA relating to certain electronic payment and administrative transactions. The National Coordinator is responsible for establishing the Standards Committee, consistent with statutory criteria.

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IMMEDIATE INVESTMENTS FOR IMPLEMENTATION AND USE OF HIT — TECHNOLOGY INFRASTRUCTURE PROGRAMS

As an initial and immediate measure, until ONCHIT adopts formal implementation and certification standards, HHS is required by law to invest in technology infrastructure programs that meet current standards for interoperability of electronic exchange of health information. These investments are to be made through ONCHIT, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, and the Indian Health Service. The investments by HHS must foster continued training and dissemination of information on best practices in integrating technology into medical practice. The immediate investment must be established consistent with the goal of having EHRs for all individuals by 2014, and at least $300 million must be allocated to support regional and other local efforts. Funding may be used to support HIT activities provided for in laws already in effect.

IMPLEMENTATION ASSISTANCE: FUNDS FOR EXTENSION PROGRAMS AND HIT RESEARCH CENTERS

The Secretary of HHS, through ONCHIT, is instructed to develop an "extension service" to assist health care providers (such as community health centers, rural providers, small practices) to adopt, implement, and effectively use HIT. Although the details are not specified in the law, the language evokes the agricultural extension service that so effectively helped American farmers to modernize their farming methods and operations.

The Secretary of HHS also is tasked with establishing a national, as well as several regional, HIT research centers to "provide technical assistance and develop or recognize best practices to support and accelerate [industry] efforts to adopt, implement, and effectively utilize health information technology." The centers are meant to serve as central repositories for input and collaboration from industry stakeholders, other federal agencies, and the general public on a variety of HIT-related top-

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ics, including lessons learned from existing initiatives, and methods to best utilize HIT in medically underserved communities. A U.S.-based nonprofit institution that applies to HHS to establish a regional center can receive up to 50 percent of its capital and operational needs from HHS under this program.

STATE GRANT AND LOAN PROGRAMS FOR HEALTH CARE PROVIDERS

States, or entities designated to work on behalf of a state, will be eligible to apply to receive grants from HHS for the purpose of facilitating investment in electronic health exchanges and the use of electronic health records throughout the state. A "state-designated entity" can be a nonprofit entity chosen by a state that has a principal goal of improving health care quality through the use of technology. States will be free to utilize the grant funds for a variety of HIT-related activities. However, beginning in fiscal year 2011, grants will be contingent upon the state agreeing to match a certain percentage of the federal contribution. The percentage of matching funds escalates each year after 2011, with $1 for every $10 of federal funds required in 2011, increasing to $1 for every $3 of federal funds by 2013. For grants provided prior to 2011, the Secretary has the ability to assess a matching requirement, but is not required to do so.

Beginning in January 2010, the National Coordinator is authorized to provide grants to states and Indian tribes to establish loan programs for providers and other entities to defray the costs of purchasing and adopting EHR programs. Like the implementation grants, the loan program grant will be contingent upon the state committing to matching the federal amount with a percentage of state funds. Under the loan program, however, the state must match at least $1 for every $5 of federal funds, which may be supplemented by private sector contributions.

Loans made to providers will be contingent upon the provider agreeing to, among other things, periodically report on certain clinical quality measures, demonstrate that the HIT mechanisms adopted by the provider will improve the quality of health care, and develop a plan for maintaining and supporting the HIT program.

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HIT GRANTS FOR CLINICAL AND TECHNICAL EDUCATION

Grants will be made available by HHS to establish demonstration projects to develop programs to integrate EHR technology in clinical education programs. These grants will be awarded to institutions of higher education on a competitive basis, and will be limited to 50 percent of the estimated costs of the project. Additionally, grants will be made available though HHS to expand educational programs related to health information technology professions. The focus of these grants will be to expand existing programs that train professionals on health information platforms, and will favor already-established programs and those designed to be completed in less than six months.

DIRECT INCENTIVES TO PROMOTE PURCHASE AND USE OF CERTIFIED HIT

In addition to the grants and technical assistance, the law establishes direct incentives through Medicare and Medicaid payment as well as government contracting requirements.

Medicare Incentives

Beginning in 2011, "meaningful user" health care professionals will be eligible to receive a premium on covered Medicare services. The premium will be 75 percent of the Secretary's estimate of the allowed charges for professional services furnished by that professional during the year. A "meaningful user" means a professional who demonstrates to the HHS Secretary that he or she is using certified EHR technology, including electronic prescribing, in a meaningful and interoperable manner, and also reports to the Secretary on clinical quality and other measures affected by the use of EHRs. The premium to a professional will be capped each year, and the total incentive will decrease each subsequent year a physician continues to be a "meaningful user"; after five years, no premium will be available. Also, no premiums will be available to anyone after 2016, regardless of when they became "meaningful users."

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Beginning in 2015, physicians who cannot demonstrate that they are meaningful users of EHRs will be penalized with reduced Medicare reimbursement rates. In 2015, a physician will receive only 99 percent of the covered payment, and each subsequent year the payment rate will further decrease, subject to a significant hardship exception.

Hospitals that attain "meaningful user" status — a standard similar to that under the professional program — in 2011 or later will be eligible for incentives through the Inpatient Prospective Payment System ("IPPS"), with a diminishing payment premium for each subsequent year a hospital maintains its meaningful user status, up to four years. The incentive payment program for hospitals is based on the "Medicare share" of a base payment amount of $2 million, adjusted based on the hospital's discharge data. The "Medicare share" takes into account the proportion of inpatient bed days that are paid by Medicare as well as an adjustment for charity care.

Similar to the professionals program, starting in 2016, hospitals that are not "meaningful users" will be penalized through reduced payments from Medicare, subject to a hardship exemption.

Medicaid Incentives

Incentives under the Medicaid program involve a 100 percent federal match for a portion of payments meant to encourage Medicaid providers to adopt EHR programs, and 90 percent of the expenses of administering the HIT incentive program. Subject to certain conditions, eligible providers include nonhospital-based physicians and other professionals who have at least a 30 percent Medicaid patient volume; pediatricians who have at least 20 percent Medicaid patient volume; professionals who practice predominantly in a federally qualified health center or rural health center with at least 30 percent Medicaid volume; children's hospitals; and acute care hospitals with at least 10 percent Medicaid patient volume. Under these provisions, a State Medicaid program may pay providers up to 85 percent of the cost of certified EHR technology and support services, adjusted by the Medicaid share (computed using the same formula used in computing the Medicare share, discussed above) and certain maximum limitations. States also can make these payments to an entity designated by the State

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to promote the adoption of certified EHR technology, with certain limitations. The Secretary of HHS also will coordinate and track payments to ensure there is no duplicate funding through both the Medicare and Medicaid programs.

Mandatory Public Sector Adoption

Federal agencies that implement, acquire, or upgrade HIT systems used for direct exchange of individually identifiable health information between agencies and with nonfederal entities are required to use HIT systems that meet the new standards. Moreover, federal activities involving the broad collection and submission of health information also are to conform with new standards and implementation specifications, within three years after the date adopted.

Private Sector Impact Through Government Contracts

Each agency that administers a federal health care program, including Federal Employees Health Benefits, Medicare, TriCare, Department of Veterans Affairs, Department of Defense, and Indian Health Service, is required to include in contracts and agreements with health care providers, health plans, and insurance issuers requirements that as the contractor implements, acquires, or upgrades HIT systems, it must utilize products and systems that meet the new standards.

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