

Stimulus Package Contains \$19 Billion for Health Care Technology Spending and Adoption of Electronic Health Records

On February 17, 2009, President Barack H. Obama signed into law the American Recovery and Reinvestment Act of 2009 (ARRA). This article summarizes the provisions of the ARRA's stimulus expenditures and other stimulus measures relating to health information technology (HIT), including incentives for adoption of electronic health record (EHR) systems. We will address the provisions of the ARRA dealing with the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in a separate alert to be issued shortly.

Executive Summary

Medicare/Medicaid Incentives

The ARRA provides substantial stimulus expenditures in the health care industry — over \$20 billion — for the development and adoption of HIT. The largest allocation of funding — approximately \$17 billion — is for incentive payments through the Medicare and Medicaid reimbursement systems to encourage providers and hospitals to implement EHR technology systems. As described more fully below, the incentive payments are triggered when a provider or hospital demonstrates it has become a “meaningful EHR user.” Payments are paid over time, with larger payments in the early years and lower payments over time, totaling as much as \$48,400 for eligible professionals and up to \$11 million for hospitals. On the other hand, hospitals and eligible professionals suffer penalties through reduced Medicare reimbursement payments if they do not become meaningful users of EHR by 2015.

Government/Agency Leadership Infrastructure

The ARRA establishes additional government and agency involvement in setting policy, standards, specifications, and criteria for HIT and EHR systems. The Office of the National Coordinator for Health Information Technology (ONCHIT) is established within the U.S. Department of Health and Human Services (HHS), and will be the primary agency involved in this effort. ONCHIT will be headed by a national coordinator to be appointed by the Secretary of HHS (Secretary). The national coordinator is charged with developing a nationwide HIT infrastructure that improves health care quality, reduces health care costs, and protects patient health information. The national coordinator is required to update the Federal Health IT Strategic Plan to address the use of EHR technology, including privacy and security of health information. The law establishes a HIT Policy Committee to make policy recommendations to the national coordinator and a HIT Standards Committee to recommend standards, implementation specifications, and certification criteria. Detailed descriptions of these new government and agency changes are set forth below. When adopted, these standards and specifications will be used in assessing whether hospitals and eligible professionals are meaningful EHR users for purposes of the Medicare and Medicaid incentive payments discussed above.

Other Stimulus Measures

Finally, the ARRA adopts additional stimulus spending measures such as:

- Grants for HIT/EHR research and development programs
- Investment in the nationwide HIT infrastructure
- Funding for extension programs and regional centers to provide technical assistance with respect to adoption and use of HIT
- Grants to states and Native American tribes to provide funding to facilitate and expand the exchange of electronic health information
- Competitive grants to establish loan programs for health care providers to acquire and use EHR technology
- Grants for integrating information technology into clinical education
- Financial assistance to universities to establish or expand medical informatics programs

Summary of HIT/EHR Stimulus Provisions

Medicare Incentives for Meaningful Use of Certified EHR Technology

The ARRA establishes incentive payments through Medicare for the “meaningful use of certified EHR technology” by eligible professionals and hospitals. As specified in the legislation, an eligible professional will receive incentive payments for the first five years (2011 through 2015) for demonstrating a meaningful use of EHR technology and demonstrated performance during the reporting period for each payment year. If an eligible professional does not demonstrate a meaningful use of EHR technology by 2015, he or she will not

receive incentive payments, and his or her reimbursement payments under Medicare will be reduced as specified in the legislation. Professionals eligible for the incentive payments are physicians, dental surgeons, dentists, podiatrists and chiropractors who participate in Medicare.

Incentive Payments for Eligible Professionals

Incentive payments for eligible professionals are based on the amount of Medicare-covered professional services furnished during the year in question. The total possible amount of the incentive payment will decrease over time. The law provides a rolling period for implementation and associated payments. For example, incentives that start in 2011 will continue through 2015, while those that begin in 2012 run through 2016. For the first year, the maximum payment amount is \$18,000 if the eligibility criteria are met in 2011 or 2012 (and \$15,000 if implemented in 2013 or 2014). The highest annual payment amount for subsequent years decreases each year to \$12,000, \$8,000, \$4,000, and \$2,000, with no payments being made after 2016. The payments can be in the form of a single consolidated payment or may be made in periodic installments, as determined by the Secretary.

Thus, to achieve the maximum incentive payment amount, eligible professionals must adopt a meaningful use of EHR technology in 2011 or 2012, thereby qualifying for five annual payments ending in 2015 or 2016, respectively, for an aggregate maximum payment of \$44,000. However, if a professional first adopts EHR technology in 2014, the maximum annual payments are \$15,000, \$12,000 and \$8,000, for an aggregate maximum payment of \$35,000.

Accordingly, there are direct financial benefits for eligible professionals becoming meaningful users of EHR technology in 2011 or 2012; reduced benefits for adopting EHR in 2013 or 2014; and no benefit for adopting in 2015. (As discussed below, penalties are assessed if the professional has not become a meaningful user by 2015.)

Eligible professionals may be eligible to receive a larger incentive amount or may be ineligible altogether under certain circumstances. Incentive payments are increased by 10 percent if the professional predominately serves in an area designated as a health professional shortage area.

The EHR incentive payments for professionals are not available to a hospital-based eligible physician such as a pathologist, anesthesiologist, or emergency physician who furnishes substantially all such services in a hospital setting using the hospital's facilities and equipment, including computer equipment. Incentive payments are made available to hospitals in Section 4312 of the ARRA, discussed below.

Meaningful Use of EHR Technology

An eligible professional will be treated as a meaningful user of EHR technology if the eligible professional meets the following three criteria:

- The eligible professional demonstrates to the satisfaction of the Secretary that, during the period, the professional is using a certified EHR technology in a meaningful manner, which will include the use of electronic prescribing as determined to be appropriate by the Secretary
- The eligible professional demonstrates to the satisfaction of the Secretary that, during such period, such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care such as promoting care coordination
- The eligible professional submits information on clinical quality measures (the Secretary will select the clinical quality measures and will provide preference to measures that have been endorsed by the consensus-based entity regarding performance measurement with which the Secretary has a contract under Section 1890(a) of the Social Security Act)

Certified EHR Technology

Certified EHR technology is an EHR that is certified to meet standards adopted by the national coordinator under the AARA. The EHR technology must include patient demographic and clinical health information (e.g., medical history and problem lists) and have the ability to provide clinical decision support for physician order entry, to capture and query information relevant to health care quality, and to exchange electronic health information with, and integrate such information from, other sources.

Professional Payment Adjustments (Penalties)

Fee schedule payments to eligible professionals for covered professional services will be adjusted under certain conditions. For covered professional services furnished by an eligible professional during 2015 or any subsequent payment year, if the professional is not a meaningful EHR user during the previous year's reporting period, the fee schedule amount will be reduced to 99 percent in 2015, 98 percent in 2016, and 97 percent in 2017 and in each subsequent year. For 2018 and each subsequent year, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users is less than 75 percent, the applicable fee schedule amount will be decreased by one percentage point from the applicable percent in the preceding year, but in no case will the applicable percent be less than 95 percent. There is a hardship exemption if being a meaningful EHR user will result in significant hardship.

Incentive Payments for Hospitals

Similar to incentives for professionals as addressed above, hospitals are entitled to receive incentive payments when they become meaningful users of EHR technology. Demonstrating meaningful use for hospitals is similar: (1) using EHR in a meaningful manner; (2) the EHR technology is connected to a health information exchange for improving quality of care; and (3) the hospital submits clinical quality measures and other measures selected by the Secretary (with preference provided to measures that have been selected for the Reporting Hospital Quality Data for Annual Payment Update program, or that have been endorsed by the entity with a contract with the Secretary under Section 1890(a) of the Social Security Act).

Subject to certain limitations, each qualified hospital can receive an incentive payment calculated as the sum of a base amount (\$2 million), plus a discharge-related payment, the amount of which is then be multiplied by its Medicare share. This amount is then multiplied by a "transition factor" resulting in reduced payments over a four-year transition period. A qualified hospital will receive \$200 for each discharge paid under the inpatient prospective payment system (IPPS) starting with discharge number 1,150 through discharge number 23,000. A hospital's Medicare share is calculated according to a specified formula based on inpatient bed days attributable to individuals for whom a Part A payment may be made, and the total number of inpatient bed days in the hospital adjusted by a hospital's share of charges attributed to charity care. Critical access hospitals (CAHs) that are meaningful users of EHR are entitled to certain bonus payments.

The law provides a four-year incentive payment transition schedule. A hospital that is a meaningful EHR user can receive the full amount of the incentive payment in its first payment year; 75 percent of the amount in its second payment year; 50 percent of the amount in its third payment year; and finally, 25 percent of the amount in its fourth payment year. The first payment year for a meaningful EHR user is 2011 or, alternatively, the first fiscal year for which an eligible hospital qualifies for an incentive payment. Hospitals that first qualify for the incentive payments after 2013 can receive incentive payments on the transition schedule as if their first payment year is 2013. Hospitals that become meaningful EHR users after 2015 will not receive incentive payments.

Accordingly, there are direct financial benefits for hospitals becoming meaningful users of EHR technology in 2011 or 2012; reduced benefits for adopting EHR in 2013 or 2014; and no benefit for adopting in 2015. (As discussed below, penalties are assessed if the hospital has not become a meaningful user by 2015.)

Hospital Penalties

Starting in 2015, eligible hospitals that are not meaningful EHR users and do not submit the required quality data will be subject to a 25 percent reduction in their annual Market Basket update, rather than the two percent reduction under current law. Additionally, hospitals that are not meaningful EHR users by 2015 are subject to a reduction in their annual Market Basket update for the remaining three-quarters of the update. This reduction is implemented over a three-year period.

Three-quarters of the applicable update amount will be reduced by one-third in 2015; two-thirds in 2016; and 100 percent in 2017 and each subsequent year the hospital is not a meaningful EHR user. These reductions apply only to the fiscal year involved and are not taken into account in subsequent fiscal years. Starting in 2015, payments to acute care hospitals that are not meaningful EHR users in a state operating under a Medicare waiver under section 1814(b)(3) of the Social Security Act will be subject to comparable aggregate reductions.

Medicaid Incentives

The ARRA also provides Medicaid incentives toward the use of certified EHR technology based on a provider's involvement in the Medicaid program. The law further provides for expanded funding to pediatricians, federally qualified health clinics (FQHCs), rural health clinics (RHCs), and physician assistants in physician assistant-led RHCs.

The law provides up to \$63,750 in federal contributions towards the adoption, implementation, upgrade, maintenance, and operation of certified EHR technology for eligible professionals. Up to 85 percent of \$25,000, or \$21,250, subject to a cap on average allowable costs, is provided to eligible professionals to aid in adopting, implementing, and upgrading certified EHR systems. Additionally, up to 85 percent of \$10,000, or \$8,500, is provided to eligible professionals for purposes of operation and maintenance of such systems over a period of up to five years.

Payments to hospitals are limited to amounts analogous to those specified for eligible hospitals in Medicare in Section 4102. The payment limit for such hospitals is calculated as a base amount plus an amount related to the total number of discharges for such a hospital. States may not pay more than 50 percent of the aggregate amount to a hospital in any year, and must spread payments to hospitals out over at least three years (contingent on demonstration of meaningful use of certified electronic health records).

Government/Agency Leadership Infrastructure

The ARRA further implements ONCHIT within the HHS¹. ONCHIT will be headed by a national coordinator to be appointed by the Secretary. The national coordinator is charged with developing a nationwide HIT infrastructure that improves health care quality, reduces health care costs, and protects patient health information.

HIT Policy Committee

The ARRA establishes a HIT Policy Committee to make policy recommendations to the national coordinator relating to implementation of a nationwide HIT infrastructure, including implementation of the Federal Health IT Strategic Plan. The policy recommendations will address standards, implementation specifications, and certification criteria, and recommend the priority for development, harmonization, and recognition of the standards, specifications, and certification criteria, including authentication, privacy, and security of individually identifiable health information as needed to ensure interoperability. Recommendations also will cover accounting for disclosures of health information; encryption of health information, including during transmission over the nationwide health information network; comprehensive collection of patient demographic information; and the needs of children and other vulnerable populations.

The ARRA specifies other areas that the HIT Policy Committee may consider, including use of the nationwide HIT infrastructure for biosurveillance, public health, clinical research and drug safety; self-service technologies; telemedicine technologies; home health care; and patient and family member secure access to health information.

The makeup of the HIT Policy Committee will represent a broad spectrum of constituents, including patients, health care providers, health care workers, and information privacy and security, insurance, and information technology vendors.

HIT Standards Committee

The ARRA established a HIT Standards Committee to recommend standards, implementation specifications, and certification criteria. The standards will address harmonizing, updating, and testing standards and specifications to achieve uniform and consistent implementation of the applicable technologies and solutions. The membership of the HIT Standards Committee will include providers, workers, purchasers, health plans, technology vendors, researchers, experts, and outside advisors involved in the privacy, security, exchange, and use of health information.

No later than 90 days after receiving recommended standards, implementation specifications, or certification criteria from the national coordinator, the Secretary shall review such recommendations and determine whether they should be adopted through regulation. The Secretary has until December 31, 2009 to adopt an initial set of standards, implementation specifications, or certification criteria.

The ARRA provides that use of standards and implementation specifications adopted by the Secretary shall be voluntary, except that federal agency contracts must require providers and insurers to use such standards and implementation specifications as they implement, acquire, or upgrade HIT systems.

No later than two years after enactment (and annually thereafter), the Secretary must submit a report describing specific actions taken by the federal government and the private sector to facilitate the adoption of a nationwide system for the electronic use and exchange of health information, including barriers to and recommendations to achieve full implementation of such a system. The Secretary also must study and submit a report examining (a) methods to create efficient reimbursement incentives for improving health care in FQHCs, RHCs, and free clinics; and (b) new technology to assist seniors, individuals with disabilities, and their caregivers.

Chief Privacy Officer

No later than 12 months after enactment, the national coordinator is required to appoint a chief privacy officer of the OCNHIT to advise the national coordinator on privacy, security, and data stewardship of electronic health information and to coordinate with states and other agencies with respect to privacy, security, and data stewardship.

Federal Health IT Strategic Plan

The national coordinator is required to update the Federal Health IT Strategic Plan addressing HIT issues, including:

- The electronic exchange of health information
- Utilization of electronic health records for each person in the United States by 2014
- Use of privacy and security protections (including encryption standards) for electronic exchange of identifiable health information
- Improving quality of health care
- Specifying plans for individuals with unique needs such as children

The national coordinator will establish a Web site to provide information concerning the work, schedules, report, recommendations, and other information to ensure transparency in the promotion of a nationwide HIT infrastructure.

Voluntary Certification

The national coordinator, together with the director of the National Institute of Standards and Technology, will maintain a voluntary certification program for HIT. The coordinator is required to provide several reports, including a report within 12 months after enactment of the ARRA that shall set forth any additional funding or authority the national coordinator, the HIT Policy Committee, or the HIT Standards Committee requires to develop standards, implementation specifications, and certification criteria, or to otherwise achieve "full participation of stakeholders in the adoption of a nationwide HIT infrastructure that allows for the use and exchange of health information."

Research and Development Programs

The ARRA provides for development of a program and funding for universities and research consortia to establish multidisciplinary Centers for Health Care Information Enterprise Integration (Centers). Grants will be awarded on a merit-reviewed, competitive basis. The purposes of the Centers include generating innovative approaches to technology integration through cutting-edge, multidisciplinary research, and HIT development. Eligible research areas include:

- Interfaces between human information and communications systems
- Voice recognition systems
- Software that improves interoperability and connectivity among health information systems
- Software dependability of systems critical to health care delivery
- Measurement of technologies on the quality and productivity of health care
- Health information enterprise management
- Health information security and integrity
- Technology to reduce medical errors

Funding to Strengthen HIT Infrastructure

The Secretary is required to use appropriated funds to invest in the HIT infrastructure to allow for and promote the electronic exchange and use of health information consistent with the goals outlined in the strategic plan to be developed by the national coordinator. Funds will be invested through agencies with appropriate expertise, including ONCHIT, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, and the Indian Health Service.

HIT Implementation Assistance

The Secretary, acting through OCNHIT, will establish a HIT extension program to assist health care providers to adopt, implement, and effectively use certified EHR technology that allows for the electronic exchange and use of health information. In this regard, the Secretary shall create a Health Information Technology Research Center to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively utilize HIT that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted by the national coordinator.

Regional Centers

The Secretary will provide assistance for the creation and support of regional centers to provide technical assistance and disseminate best practices and other information learned from the Health Information Technology Research Center to support and accelerate efforts to adopt, implement, and effectively utilize HIT that allows for the electronic exchange and use of information in compliance with standards, implementation specifications, and certification criteria adopted by the national coordinator. Funding awards will be merit-based, and regional centers must be affiliated with a nonprofit institution or organization based in the United States that receives funding under the ARRA. As a general rule, financial support can be provided to regional centers for a period not to exceed four years, and cannot exceed more than 50 percent of the of the capital and annual operating and maintenance funds required to create and maintain a regional center.

State Grants to Promote HIT

The national coordinator is authorized to award planning and implementation grants to states or qualified state-designated entities to facilitate and expand electronic health information exchange. To qualify as a state-designated entity, an entity must be a nonprofit organization with broad stakeholder representation on its governing board and must adopt nondiscrimination and conflict of interest policies.

Competitive Grants to States and Native American Tribes for Loan Programs

The law authorizes the national coordinator to award competitive grants to states or Native American tribes to establish loan programs for health care providers to purchase certified EHR technology, train personnel in the use of such technology, and improve the secure electronic exchange of health information. To be eligible, grantees are required to:

- Establish a qualified HIT loan fund
- Submit a strategic plan, updated annually, describing the intended uses of the funds and providing assurances that loans will only be given to health care providers that submit required reports on quality measures and use the certified EHR technology supported by the loan for the electronic exchange of health information to improve the quality of care
- Provide matching funds of at least \$1 for every \$5 of federal funding

Integration of HIT Into Clinical Education

The ARRA authorizes the Secretary to create a demonstration program for awarding competitive grants to medical, dental, and nursing schools and to other graduate health education programs to integrate HIT into the clinical education of health care professionals. To be eligible, grantees have to submit a strategic plan. A grant cannot cover more than 50 percent of the costs of any activity for which assistance is provided, though the Secretary has the authority to waive the cost-sharing requirement.

Information Technology Professionals in Health Care

The law requires the Secretary, in consultation with the director of the National Science Foundation, to provide financial assistance to universities to establish or expand medical informatics programs. A grant cannot cover more than 50 percent of the costs of any activity for which assistance is provided, though the Secretary has the authority to waive the cost-sharing requirement.

¹ While ONCHIT was created by Executive Order 13335 (April 27, 2004), prior to the ARRA, there were no statutory provisions regarding ONCHIT.

Please join Foley for a Web Conference this Friday, February 20, 2009 at 12:30 p.m. Eastern, to discuss the health care technology spending and HIPAA privacy changes contained in the ARRA. For more information on this event, please visit http://www.foley.com/news/event_detail.aspx?eventid=2652.

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