The American Recovery and Reinvestment Act of 2009
Summary of Key Health Information Technology Provisions
July 1, 2009

This document is a summary of the ARRA and offered for information only. As the term "summary" implies, the following pages do not thoroughly address the depth, breadth, and complexity of the legislative language. For complete explanatory details and implications, please refer to the HIMSS Analysis of ARRA – available complimentary to HIMSS members. HIMSS strongly encourages readers to consult with independent legal counsel. Additional information concerning the Medicare and Medicaid incentive payments established through the legislation is available on Centers for Medicare and Medicaid Services (CMS) website.

On February 17, 2009, President Barack Obama signed into law the American Recovery and Reinvestment Act of 2009, H.R. 1. The Act aims to stimulate the economy through investments in infrastructure, unemployment benefits, transportation, education, and healthcare. It includes over $20 billion to aid in the development of a robust IT infrastructure for healthcare and to assist providers and other entities in adopting and using health IT. Total funding included for health IT is as follows:

- $2 billion for the Office of the National Coordinator (ONC)
- $20.819 billion in incentives through the Medicare and Medicaid reimbursement systems to assist providers in adopting EHRs
- $4.7 billion for the National Telecommunications and Information Administration's Broadband Technology Opportunities Program
- $2.5 billion for the U.S. Department of Agriculture's Distance Learning, Telemedicine, and Broadband Program
- $1.5 billion for construction, renovation, and equipment for health centers through the Health Resources and Services Administration
- $1.1 billion for comparative effectiveness research within the Agency for Healthcare Research and Quality (AHRQ), National Institutes of Health (NIH), and the Department of Health and Human Services (HHS).
- $85 million for health IT, including telehealth services, within the Indian Health Service
- $500 million for the Social Security Administration
- $50 million for information technology within the Veterans Benefits Administration

A breakdown of health IT provisions included under specific health IT sections of the legislation are as follows:

1. **Leadership:**
   a. Office of the National Coordinator: Establishment of the Office to be headed by a National Coordinator appointed by the Secretary of HHS. The National Coordinator is responsible for such duties as endorsing standards and certification criteria, coordinating health IT policy and programs, serves as leading members of the HIT Policy and HIT Standards Committees, and updating the Federal Health IT Strategic plan.

      The legislation authorizes and appropriates $2 billion for Office of the National Coordinator. The Congressional Budget Office (CBO) projects that of the $2 billion that is authorized and appropriated for the ONC, that $300 million will be spent in fiscal year 2009, $1.28 billion in fiscal year 2010, $360 million in fiscal year 2011, and $40 million in fiscal year 2012.

   b. HIT Policy Committee: The HIT Policy Committee, a federal advisory committee, is established to make recommendations to the National Coordinator relating to the implementation of a nationwide health IT infrastructure, including implementations of the strategic plan. The Committee is responsible for recommending the areas in which standards, implementation specifications, and certification criteria are needed for the electronic exchange and use of health information.
   c. HIT Standards Committee: The HIT Standards Committee is established to recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange and use of health information, which have been developed, harmonized, or recognized by the HIT standards Committee.
   d. National eHealth Collaborative: Nothing shall prohibit the National eHealth Collaborative (NeHC) from modifying its charter to allow the Secretary to recognize NeHC as the HIT Policy Committee or the HIT Standards Committee

2. **Funding and Incentives:**
   a. Program to Facilitate and Expand Electronic Movement and Use of Health IT: The Secretary, acting through the National Coordinator, shall establish a program to facilitate and expand electronic movement and use of health information among organizations according to nationally-recognized standards. The Secretary may award a grant to a State or qualified State-designated entity. Beginning with fiscal year 2011, the Secretary may not make a grant to a State unless that State agrees to make available non-federal contributions toward the costs of a grant:
      1) Fiscal year 2011, not less than $1 for each $10 of federal funds provided under the grant;
      2) Fiscal year 2012, not less than $1 for each $7 of federal funds provided under the grant; and,
      3) Fiscal year 2013 and each subsequent fiscal year, not less than $1 for each $3 of federal funds provided under the grant.

For fiscal years before fiscal year 2011, the Secretary may determine the extent to which there shall be required a non-federal contribution from a state receiving a grant under this section.

b. Loans to Providers: The National Coordinator may award competitive grants to eligible entities (State or Indian Tribe) for the establishment of programs for loans to healthcare providers. An eligible entity shall establish a certified EHR technology Loan Fund, and comply with other requirements contained in this section. A grant to an eligible entity this section shall be deposited in the Loan Fund established by the eligible entity. Each eligible entity must provide a strategic plan that identifies the intended uses of amounts available to the Loan Fund of such entity.

   Loans under this section may be used by a healthcare provider to carryout such activities as 1) facilitate the purchase of certified EHR technology; 2) Enhance the utilization of certified EHR technology; 3) Train personnel in the use of such technology; or, 4) Improve the secure electronic exchange of health information.

   The National Coordinator may not make a grant under this section to an eligible entity unless the entity agrees to make available non-Federal contributions (through donations of pubic or private entities or directly) in cash to the costs of carrying out the activities for which the grant is awarded in an amount equal to not less that $1 for each $5 of Federal funds provided under the grant.

   The Secretary may not make an award under this section prior to January 1, 2010.

c. Incentives through Medicare for the Meaningful Use of Certified EHR Technology: Establishment of incentive payments through Medicare for the meaningful use of certified EHR technology by "eligible professionals and hospitals". The CBO estimates the total cost of Medicare and Medicaid incentives for eligible professionals and hospitals that demonstrate a meaningful use of certified EHR technology to be $20.819. $20.819 is derived from the sum of the total costs of the incentives in fiscal year 2009 – fiscal year 2015 ($36.368 billion) and the total savings that are achieved in fiscal year 2016 – fiscal year 2019 through the incentives ($15.549 billion).

   Incentive payments to eligible professionals:
   An eligible professional (physician) will receive incentive payments as specified in the legislation, for the first five years (2011 –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 meaningful use by 2015, his/her reimbursement payments under Medicare will begin to be reduced. No incentive payment will be made after 2016.

A meaningful user is an eligible professional (physician) that:
1) Demonstrates to the satisfaction of the Secretary that during such period the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing as determined to be appropriate by the Secretary;
2) 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; and
3) Submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary.

Certified EHR technology means an EHR that is certified to meeting standards pursuant to this Act. To be qualified as a certified EHR technology, the certified technology must include patient demographic and clinical health information, such as medical history and problem lists, and has the capacity to provide clinical decision support to support physician order entry, to capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources.

Payment schedule for an eligible professional is as follows:

Payment Year	Incentive
First Payment Year	• $18,000 if the first payment year is 2011 or 2012 • $15,000 if the first payment year is 2013 • $12,000 if the first payment year is 2014
Second Payment Year	$12,000
Third Payment Year	$8,000
Fourth Payment Year	$4,000
Fifth Payment Year	$2,000
*For eligible professionals in a health professional shortage area (HPSA), the incentive payment amounts will be increased by 10% *Payments are not available to hospital-based professionals (such as a pathologist, emergency room physician, or anesthesiologist).	

Eligible professionals who adopt certified EHRs as early as 2011 or 2012 could be eligible for up to $44,000 in Medicare incenctive payments (over five years). This figure is increased by 10% for eligible professionals who predominately furnish services in a health professional shortage area.

If eligible professionals have not become meaningful users of EHRs by 2015, they will not receive full Medicare payments beginning in 2015. The reduction in the fee schedule is as follows:
2015 - 99%;
2016 - 98%
2017 - 97%
Subsequent years - between 3 to 5%

For 2018 and thereafter, if the Secretary finds that the proportion of eligible professionals who are meaningful EHR users is less than 75 percent, then the reductions will be increased by 1 percentage point each year, but by not more than 5 percent overall.

Provisions also apply to Medicare Advantage Organizations.

Incentive payments to eligible hospitals:
An eligible hospital will receive incentive payments as specified in the legislation, for the first five years (fiscal year 2011 – fiscal year 2015), for demonstrating a meaningful use of EHR technology and demonstrated performance during the reporting period for each payment year. If an eligible hospital does not demonstrate meaningful use by fiscal year 2015, its applicable Medicare percentage increase will begin to be reduced.

An eligible hospital shall be treated as a meaningful EHR user for an EHR reporting period for a payment year if each of the following requirements are met:

1)The eligible hospital demonstrates to the satisfaction of the Secretary that during such period the hospital is using certified EHR technology in a meaningful manner;
2) The eligible hospital 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; and
3) The eligible hospital submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary.

Certified EHR technology means an EHR that is certified to meeting standards pursuant to this Act. To be qualified as a certified EHR technology, the certified technology must include includes patient demographic and clinical health information, such as medical history and problem lists, and has the capacity to provide clinical decision support to support physician order entry, to capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources.

The payment formula for a hospital for a payment year is equal to the product of the following:

1) Initial amount – The sum of the base amount* specified plus the discharge related amount** for a 12- month period selected by the Secretary with respect to such payment year.
2) The Medicare share*** for the hospital for a period selected by the Secretary with respect to such payment year.
3) The transition factor**** for the hospital for the payment year.

* The base amount specified in the subparagraph is $2 million.

** The discharge related amount specified in this subparagraph for a 12-month period selected by the Secretary shall be determined as the sum of the amount, based upon total discharges (regardless of any source of payment) for the period, for each discharge up to the 23,000th discharge as follows:

(i) For the first through 1,149th discharge, $0.
(ii) For the 1,150th through the 23,000th discharge, $200.
(iii) For any discharge greater than the 23,000th, $0.

*** The Medicare share specified under this subparagraph for an eligible hospital for a period selected by the Secretary for a payment year is equal to the fraction--
(i) the numerator of which is the sum (for such period and with respect to the eligible hospital) of —

(I) the estimated number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and
(II) the estimated number of inpatient-bed-days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and

(ii) the denominator of which is the product of –

(I) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and
(II) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the estimated total amount of the hospital's charges during such period.

**** Transition factor for an eligible hospital for a payment year is as follows:

(I) for the first payment year for such hospital, 1.
(II) for the second payment year for such hospital, ¾
(III) For the third payment year for such hospital, ½
(IV) For the fourth payment year for such hospital, ¼; and,
(V) For any succeeding payment year for such hospital, 0.

For fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital that is not a meaningful EHR user for the reporting period for such fiscal year, three quarters of the applicable Market Basket Adjustment percentage increase otherwise applicable for such fiscal year shall be reduced by:
Fiscal year 2015 - 33 1/3 percent
Fiscal year 2016 - 66 2/3 percent
Fiscal year 2017 and each subsequent fiscal year - 100 percent

The payment formula for a critical access hospital, that is an eligible hospital in accordance with the Act, which is a meaningful user of certified EHR technology, is computed by expensing such costs in a single payment year, rather than depreciating over time. In addition, incentive payments for critical access hospitals would be based on the Medicare share formula used for subsection (d) hospitals, plus 20 percentage points (not exceeding a total of 100 percent). Critical access hospitals would receive a prompt interim payment for the Medicare share of such costs (subject to reconciliation). In addition, payments would not be made with respect to a cost reporting period beginning during a payment year after 2015. In no case shall a critical access hospital receive more than 4 consecutive payments.

In addition, the legislation includes a separate formula for a critical access hospital that is not a meaningful EHR user by fiscal year 2015 and each subsequent fiscal year. Specifically, three quarters of the applicable Market Basket Adjustment percent increase otherwise applicable for such fiscal year shall be reduced by:
Fiscal year 2015 – 100.66 percent;
Fiscal year 2016 – 100.33 percent; and
Fiscal year 2017 and each subsequent year -100 percent.

Incentives through Medicaid for the Meaningful Use of Certified EHR Technology: This section sets-forth funding through State Medicaid programs to Medicaid providers (professionals and hospitals as described in the Act), at 100% Federal Financial Participation (FFP) for states to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate (including support services and training for staff) certified EHR technology. In addition, the legislation establishes 90% FFP for state administrative expenses to help carryout the provision. The legislation does not specify a year in which funding begins. According to CMS, Medicaid programs will determine their own requirements in line with the Medicaid-related provisions of the Recovery Act.

d. The definition of “meaningful use” must be established through a means that is approved by the State and acceptable to the Secretary. In determining meaningful use, a state must ensure that populations with unique needs, such as children, are addressed. In addition, as part of meaningful use, the state mush require providers to report clinical quality measures as part of demonstrating meaningful use. As a further step, the definition must be in alignment with the one used for Medicare.

Certified EHR technology means a qualified EHR that is certified to meeting standards pursuant to this Act and includes patient demographic and clinical health information, such as medical history and problem lists, and has the capacity to provide clinical decision support to support physician order entry, to capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources.

The State is authorized to make payments to Medicaid providers totaling no more than 85% percent of net average allowable costs for certified EHR technology, including support and training (determined on the basis of studies that the Secretary will undertake), up to a maximum level, and incentive payments are available for no more than a 6-year period.

Under this section Medicaid providers eligible for funding are defined as:

i. An non-hospital-based professional who has at least 30 percent of the professional's patient volume attributable to individuals who are receiving medical assistance under this title;
ii. A non-hospital-based pediatrician who has at least 20 percent of his/her patient volume attributable to individuals who are receiving medical assistance under this title; and
iii. An eligible professional who practices predominately in a Federally-qualified health center or rural health clinic and has at least 30 percent of the professional's patient volume attributable to needy individuals.
iv. Children's hospitals – or an acute care hospital that is not a children's hospital – and that have at least 10 percent of the hospital's patient volume attributable to individuals who are receiving medical assistance under this title may receive not in excess of the maximum amount permitted for the provider involved.

No reductions in Medicaid payments are to be made if a provider does not adopt certified EHR technology.

The legislation instructs the Secretary to ensure the coordination of incentive payments to eligible professionals through Medicare and Medicaid. Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services using national provider identifiers. To carry-out these activities, the Secretary may require the submission of such data relating to payments to such Medicaid providers as the Secretary may specify. Eligible professionals can not receive an incentive payment under both Medicare and Medicaid in a given year. Prevention of duplicative payments is expected to be addressed through notice and comment rulemaking.

3. **Standards:**
   a. Initial Set of Standards: No later than December 31, 2009, the Secretary shall, through the rule making process, adopt an initial set of standards, implementation specifications, and certification criteria (these items that were adopted by the National Coordinator, before enactment of the legislation may be applied towards meeting the requirement).
   b. Standards Harmonization: The National Coordinator may recognize an entity or entities for the purpose of harmonizing or updating standards and implementation specifications in order to achieve uniform and consistent implementation of the standards and implementation specification.
   c. Standards and Technology Testing: The Director of NIST shall support the establishment of a conformance testing infrastructure, in collaboration with the Certification program, and in coordination with the HIT Standards Committee, that includes the development of technical test best. The development of this conformance testing infrastructure may include a program to accredit independent, non-Federal laboratories to perform testing.

4. **Certification:**
   a. Voluntary Certification Program of Health IT: The National Coordinator, in consultations with the Director of NIST, shall recognize a program or programs for the voluntary certification of health IT.

5. **Research and Development**
   a. Centers for Health Care Information Enterprise Integration: The Director of NIST, in consultations with the Director of the National Science Foundation (NSF), and other appropriate Federal agencies, shall establish a program of assistance to institutions of higher education (or consortia thereof which may include nonprofit entities and Federal Government laboratories) to establish multidisciplinary Centers for Health Care Information Enterprise Integration. The Centers shall generate innovative approaches to healthcare information enterprise integration and the development of health IT and other complementary fields.

6. **Education and Outreach**
   a. Health Information Technology Extension Program: The National Coordinator shall develop a health IT extension program to provide health IT assistance services to be carried out through HHS. A Health IT Research Center is to be established to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt and implement, and effectively utilize health IT. Regional Centers shall also be developed to provide technical assistance and disseminate best practices from the National Center. The Secretary shall publish in the *Federal Register*, no later than 90 days after the date of the enactment of this Act, a draft description for establishing regional centers under this subsection.

b. Academic Curricula Concerning the Integration of Certified EHR Technology: The Secretary may award grants under this section to carry out demonstration projects to develop academic curricula integrating certified EHR technology in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review. The Secretary may not provide more than 50 percent of the costs of any activity, except in an instance of national economic conditions which would render the cost-share requirement under this section as detrimental to the program and upon notification to Congress as to the justification to waive the cost-share requirement. The Secretary shall submit to Congress a report that describes the specific projects and contains recommendations to Congress based upon the evaluations conducted under this subsection, no later than one year after the date of enactment of this title, and annually thereafter.

c. Medical Health Informatics Education Programs: The Secretary, in consultation with the Director of the National Science Foundation, shall provide assistance to institutions of higher education to establish or expand medical health informatics education programs, including certification, undergraduate, and masters degree programs, for both healthcare and IT students to ensure the rapid and effective utilization and development of health information technology.

7. <u>Privacy and Security:</u>

a. <u>Security Breach Notification</u> - Establishes a federal security breach notification requirement for health information that is not encrypted or otherwise made indecipherable. It requires that an individual be notified if there is an unauthorized disclosure or use of their health information.

b. <u>New HIPAA Business Associates</u> - Ensures that new entities that were not contemplated when HIPAA was written (such as PHR vendors, RHIOs, HIEs, etc.) are subject to the same privacy and security rules as providers and health insurers, by requiring Business Associate contracts and treating these entities as Business Associates under HIPAA.

c. <u>Accounting of Disclosures</u> – Gives patients the right to request an accounting of disclosures of their health information made through an electronic record. It requires the Secretary of HHS to promulgate regulations regarding accounting of disclosures that take into account the "interests of individuals" in learning the circumstances under which their protected health information is being disclosed and takes into account the administrative burden of accounting for disclosures.

d. <u>Sale/Marketing of Protected Health Information (PHI)</u> – provides new restrictions on marketing using PHI and on the circumstances under which an entity can receive remuneration for PHI.

e. Access – provides an individual the right to have access to certain information about them in electronic format.

f. Enforcement – Modifies distribution of certain civil monetary penalties collected and provides for enforcement of HIPAA by States Attorneys General and local law enforcement.

8. Additional Items:

a. Development and Routine Updating of a Qualified EHR Technology: The National Coordinator shall develop and routinely update a qualified EHR technology and make such technology unless the Secretary determines through an assessment that the needs and demands of providers are being substantially and adequately met through the market place.

b. Study Concerning Open Source Technology: The Secretary shall, in consultation with the Under Secretary of Health of the Veterans Health Administration, the Director of the HIS, the Secretary of Defense, the Director of the AHRQ, the Administrator of HRSA, and the Chairman of the Federal Communications Commission, conduct a study on the:
(A) current availability of open source health IT systems to Federal safety net providers (including small, rural, providers);
(B) total cost of ownership of such systems in comparison to the cost of proprietary commercial products available;
(C) ability of such systems to respond to the needs of , and be applied to, various populations (including children and disabled individuals); and
(D) capacity of such systems to facilitate interoperability.

No later than October 1, 2010, the Secretary shall submit to Congress a report on the findings and the conclusions of the study conducted, together with recommendations for such legislation an administrative action as the Secretary determines appropriate.