LegalNotes

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LegalNotes is a regular online *Aligning Forces for Quality* (AF4Q) publication that provides readers with short, readable summaries of developments in the law that collectively shape the broader legal environment for efforts to improve quality, reduce health care disparities, and improve the transparency of price and quality information.

The American Recovery and Reinvestment Act of 2009
Part I – Health Information Technology Provisions

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On February 17, 2009, President Barack Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA), also called the "Recovery Act," into law.[1] ARRA provides hundreds of billions of dollars in new health and health care spending, including more than $19 billion to support and promote the adoption of electronic health records. In three short briefs, we address key areas of the law: health information technology (HIT), privacy and comparative effectiveness.

This first brief of the **Legal**Notes three-part series on ARRA focuses on the law's HIT provisions. ARRA creates a new federal infrastructure for setting HIT policy and standards and encourages adoption and meaningful use of HIT.

Federal Infrastructure

ARRA codifies the Office of the National Coordinator for Health Information Technology (ONCHIT), which had been created by an Executive Order in 2004. ONCHIT is tasked with developing a nationwide HIT infrastructure for health information exchange that: (1) keeps each patients' health information secure; (2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care; (3) reduces health care costs from inefficiency, medical error, inappropriate and duplicative care, and incomplete information; (4) provides information to help guide decision-making at the time and place of care; (5) ensures meaningful public input into infrastructure development; (6) improves coordination of care and information among health care entities; (7) improves public health activities and facilitates the early identification of and rapid response to public health threats and emergencies; (8) facilitates health and clinical research and quality; (9) promotes prevention of chronic diseases; (10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and (11) improves efforts to reduce health disparities.[2] The National Coordinator oversees the HIT Policy Committee and HIT Standards Committee, two new committees with very specific membership requirements to ensure broad-based representation and expertise. The National Coordinator also determines standards and criteria, coordinates HIT policy across federal agencies, updates the Federal HIT Strategic Plan, which the National Coordinator released in June 2008,[3] and produces other reports.[4] On March 20, 2009, President Obama appointed David Blumenthal, M.D., M.P.P., as the new National Coordinator.[5]

The National Coordinator will support the development and routine updating of qualified electronic health record (EHR) technology unless the Secretary of the U.S. Department of Health and Human Services (HHS) determines that the needs and

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demands of providers are being met through the marketplace, and may charge providers who adopt the approved EHR technology a nominal fee.[6] This provision allows the National Coordinator to act even if the Secretary has not yet made an assessment of the EHR marketplace.

Federal HIT Policy

The HIT Policy Committee is required to make recommendations on standards, specifications and certification criteria for the nationwide HIT infrastructure.[7] At a minimum, it is required to consider the following areas when making its recommendations: (1) privacy and security technology, including protecting sensitive individually-identifiable health information from disclosure; (2) a nationwide technology infrastructure that allows for electronic use and accurate exchange of health information; (3) technologies that allow information to be de-identified; (4) use of EHRs by everyone in the U.S. by 2014; (5) technologies that can account for HIPAA-permitted disclosures; (6) technologies that improve the quality of care through coordination, continuity, reduction of medical errors, improving population health, reducing population disparities, and advancing research and education; (7) use of electronic systems to ensure the comprehensive collection of patient demographic data, including race, ethnicity, primary language and gender information; and (8) technologies and design features that address the needs of children and other vulnerable populations.[8]

In addition, the Policy Committee *may* consider the following areas: (1) collection of quality data and public reporting; (2) public health and bio-surveillance; (3) medical and clinical research; (4) drug safety; (5) self-service technologies that facilitate the use and exchange of patient information and reduce wait times; (6) technologies that support telemedicine, home health care, reduction of medical errors, and continuity of care across settings; (7) methods to facilitate access by individuals, family members and representatives to the individual's health information; and (8) any other technology with the potential to improve quality and efficiency of health care.[9]

HIT Standards, Implementation Specifications and Certification Criteria

The HIT Standards Committee is charged with developing, harmonizing, or recognizing standards, implementation specifications, and certification criteria consistent with the Federal HIT Strategic Plan and the HIT Policy Committee's recommendations.[10] The HIT Strategic Plan was previously developed by the National Coordinator and published in June 2008, as authorized by Executive Order 13335 (issued April 27, 2004). The Secretary must review the recommended standards, specifications and criteria within 90 days of receiving them and must adopt an initial set of standards by December 31, 2009.[11] The standards are voluntary for private entities for the non-contract portion of their work, but federal contracts must require that any provider, plan or insurer that "implements, acquires, or upgrades health information technology systems" use systems and products that meet the federal standards.[12] This provision is not limited to the HIT used for the federally-funded work, so it is possible that future federal contracts will require organizations that receive some federal funding and are implementing, acquiring or upgrading an HIT system to comply with federal standards for that system, even if it is not used for the federally-funded work.

Funding for HIT Infrastructure

ARRA gives ONCHIT $2 billion to carry out its work, of which $300 million is dedicated to supporting regional or sub-national efforts toward health information exchange. The Recovery Act authorizes the Secretary to make state-based implementation grants, loans and other investments to support a nationwide HIT infrastructure.

Definition of Meaningful EHR Use

ARRA defines meaningful EHR use as: (1) use of certified EHR technology in a demonstrably meaningful manner, including e-prescribing; (2) use of certified EHR technology that allows for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination; and (3) reporting on clinical quality measures and other measures selected by the Secretary using certified EHR technology.[13] The Secretary may allow providers in a group practice to demonstrate meaningful use in an alternate way. The Recovery Act specifically requires the Secretary to seek to improve the use of EHRs and to improve health care quality over time by requiring more stringent measures of meaningful use.

Incentives for EHR Adoption

ARRA establishes a system of Medicare payment incentives, beginning in 2011, and penalties, beginning in 2015, to encourage physicians and hospitals to adopt and meaningfully use EHRs.[14]

Physicians who begin meaningful EHR use in 2011 or 2012 are eligible for incentive payments that start at $18,000; those who begin in 2013 will receive $15,000 for the first year; and those who begin in 2014 will receive $12,000 for the first year. All three groups' incentive payments will phase down according to the same schedule over five years. Physicians who begin after 2014 will not be eligible for incentive payments, and no incentive payments will be made after 2016. Physicians who predominately serve in designated shortage areas will receive an additional 10 percent. Beginning in 2015, payments will be limited for physicians who are not meaningful EHR users, beginning at 99 percent reimbursement for 2015, 98 percent for 2016, and 98 percent for 2017 and each subsequent year, although the Secretary has discretion to go as low as 95 percent if less than 75 percent of providers are meaningful EHR users by 2018. Certain Medicare Advantage organizations who employ physicians may receive incentive payments if at least 80 percent of the physician's services are provided through the organization and the physician does not receive their full incentive payment under the provisions for physicians.[15]

The Recovery Act establishes a similar system of incentive payments for hospitals, with incentive payments beginning in 2011 for hospitals that become meaningful EHR users and phasing down over four years, with reduced payments for hospitals that become meaningful users in 2013 or 2014, and no payments for those that become meaningful users in 2015.[16]

ARRA also authorizes federal matching funds for a portion of state incentive payments to Medicaid providers.[17] Only certain providers are eligible and must waive Medicare EHR payment incentives to receive the Medicaid incentives. Children's hospitals and acute care hospitals with more than 10 percent of their patients on Medicaid can receive incentive payments up to the amount allowed under the Medicare program for hospitals. For non-hospital physicians, nurse-midwives, nurse practitioners and dentists, 30 percent of the providers' patients must be on Medicaid to be eligible for the incentive payments. Pediatricians can qualify for a reduced incentive payment if 20 percent of their patients are on Medicaid. Finally, incentives are available for physicians who practice predominantly in a federally qualified health center or rural health clinic and for whom 30 percent of their patients are "needy individuals," which includes Medicaid and State Children's Health Insurance Program (SCHIP) patients and those receiving care at no charge (uncompensated care) or based on their ability to pay (sliding scale).

Implications for Public Reporting of Quality Measures

The Recovery Act gives the HIT Policy Committee discretion to consider the collection and public reporting of quality data as part of its recommendations to the National Coordinator. Although this is the only mention of public reporting in ARRA, other provisions encourage creation of an infrastructure that will enable better collection of quality data, which may then provide a basis for public reports. For example, in order for a physician or hospital's EHR use to be "meaningful" for the purpose of incentive payments, the provider must use the EHR to report on quality measures selected by the Secretary, who must give preference to clinical quality measures endorsed by a consensus organization like the National Quality Forum and must provide a public comment period before selecting measures.[18]

Other provisions anticipate the reporting of quality data, presumably for quality improvement purposes. For example, the HIT Policy Committee must have at least one person with "expertise in health care quality measurement and reporting."[19] State implementation grants funded through ARRA may be used for "promoting the use of electronic health records for quality improvement including through quality measures reporting."[20] Finally, the National Coordinator is specifically tasked with promoting the use of HIT in a way that "improves health care quality, reduces medical errors, reduces health disparities, advances the delivery of patient-centered medical care, [and] reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information."[21] Public reporting of quality measures is one tool that may be used to help achieve these goals.

Implications for Collection of Race, Ethnicity and Language

The Recovery Act requires the HIT Policy Committee to develop recommendations regarding the "use of electronic systems to ensure the comprehensive collection of patient demographic data, including, at a minimum, race, ethnicity, primary language, and gender information."[22] Since the Committee's recommendations will guide the national policy on HIT, this provision is a major step toward collecting accurate demographic information about patients at the point of care in a format that can be combined with quality data to reduce disparities.

In addition, the definition of qualified EHR requires that the record collect "demographic" data.[23] Although the term "demographic" is not defined there, it opens the door for HHS to require in a later regulation that an EHR collect specific data elements, such as race, ethnicity and language, in order to be qualified.

Conclusion

There is an emphasis on quality throughout the HIT provisions of ARRA, which sends a powerful message that ways to improve the quality of health care will be built into the future health care system. The HIT infrastructure that will be developed and incentivized will enable reporting of quality measures, though not necessarily public reporting, and the collection of patient race, ethnicity, language and gender data. However, ARRA leaves many issues of particular interest to AF4Q communities subject to agency interpretation. Federal regulations are likely to be issued to provide more details on exactly how the program of incentives for HIT adoption will be implemented, how the HIT infrastructure will be developed, and how HIT systems will be used to improve quality of care.

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[1]The American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, 111th Cong., 1st sess. (2009).

[2]ARRA, § 3001(a)-(b).

[3]"The ONC-Coordinated Federal Health IT Strategic Plan: 2008-2012, June 3, 2008," U.S. Department of Health and Human Services, *http://healthit.hhs.gov/portal/server.pt/gateway/PTARGS_0_10731_848083_0_0_18/HITStrategicPlan508.pdf* (accessed May 8, 2009).

[4]ARRA, § 3001(c).

[5]Assistant Secretary for Public Affairs' News Release, "HHS Names David Blumenthal as National Coordinator for Health Information Technology," U.S. Department of Health and Human Services, *http://www.hhs.gov/news/press/2009pres/03/20090320b.html* (accessed May 8, 2009).

[6]ARRA, § 3007.

[7]ARRA, § 3002(b)(2)(A).

[8]ARRA, § 3002(b)(2)(B).

[9]ARRA, §.3002(b)(2)(C).

[10]ARRA, § 3003.

[11]ARRA, § 3004(b).

[12]ARRA, §§ 3007, 13112.

[13]ARRA, §.4101(a) (new section 1848(o)(2)(A) of the Social Security Act (42 U.S.C. 1395w–4).

[14]*Id.*

[15]ARRA, § 4101(c).

[16]ARRA, § 4102.

[17]ARRA, § 4201(a).

[18]*Id.*

[19]ARRA, § 3002(c)(2)(G)(x).

[20]ARRA, § 3013(d)(9).

[21]ARRA, § 3001(b)(2), 3001(b)(3).

[22]ARRA, § 3013(d)(9).

[23]ARRA, § 3000(13).