HealthReformGPS
NAVIGATING IMPLEMENTATION
A project of the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation

Health Information Technology – Adoption Incentives

Note: The health reform law makes no major revisions to provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 to move the nation toward a national health information policy and create incentives for the adoption and meaningful use of health information technology (HIT). However, because the adoption and use of HIT is foundational to the implementation of many aspects of health reform, this entry summarizes the key provisions of the 2009 law.

Background

Despite the potential for HIT to improve the efficiency and quality of patient care, reduce medical errors, and improve care coordination, only about 20 percent of physicians and hospitals reported at least basic use of HIT, such as computerized provider order entry or electronic medical records, by 2009.[1]

Recognizing that expanded use of HIT can improve quality and efficiency, Congress enacted the American Recovery and Reinvestment Act (also termed the "stimulus bill" or "Recovery Act") which incorporated the Health Information Technology for Economic and Clinical Health (HITECH) Act.[2] HITECH established the Office of the National Coordinator for Health Information Technology (ONC) and empowered the Coordinator to oversee the development of a national health information network as well as to oversee a strategic health information plan for the nation. An initial strategic plan had been published in June 2008,[3] as authorized by Executive Order 13335 in 2004,[4] and ONC is charged with its update.[5]

HITECH strengthened standards for health information privacy and security[6] and authorized grantmaking activities designed to assist state and local governments and health care providers to adopt and use HIT.[7] In addition, ARRA authorized a program of financial incentives payments under Medicare and Medicaid that encourage eligible hospitals, physicians, and other health professionals to adopt and become "meaningful users" of certified electronic health records.[8] The Medicare statute, as amended by ARRA, defines a "meaningful user" as a provider who uses certified electronic health record (EHR) technology in a way that allows the electronic exchange of health information to improve the quality of health care and has the ability to report information on the clinical quality of care.[9]

ARRA encourages (but does not require) state Medicaid agencies to establish a parallel "meaningful user" incentive program and permits Medicaid agencies to develop a separate definition of a "meaningful user."[10]In the case of Medicaid, the incentive program applies to physicians and hospitals that can satisfy a specified Medicaid patient threshold percentage, as well as eligible health professionals who practice in federally qualified health centers or rural health clinics with "needy" patients that meet certain thresholds.[11]

The Medicare payment incentives for adoption and meaningful use of EHRs will begin in 2011 and phase out gradually until penalties for providers who are not meaningful users begin 2015.[12] The statute does not require a specific start date for Medicaid payment incentives, since those will depend on state Medicaid programs' participation.

On January 13, 2010, the Centers for Medicare and Medicaid Services (CMS) issued a Notice of Proposed Rulemaking for the EHR incentive programs.[13] The proposed rule set forth "Stage 1" performance measures for determining whether physicians and hospitals are meaningful users of HIT and therefore qualified to receive incentive payments. The proposed rule also establishes the Medicare meaningful use definition as the default definition for Medicaid programs while also permitting state Medicaid agencies to seek secretarial approval for alternative measures.

On January 13, 2010, ONC issued an Interim Final Rule setting forth an initial set of standards for implementation, including certification criteria for EHRs.[14] The intent of the rule is to ensure the interoperability, functionality, utility, and security of health information technology in time for providers to demonstrate Stage 1 meaningful use and receive incentive payments for 2011.

On March 10, 2010, ONC issued an Notice of Proposed Rulemaking that proposed procedures for testing and certifying HIT.[15] ONC proposed a temporary certification program to ensure that certified EHR technology will be available for providers to use in 2011 to qualify for the meaningful use incentive payments. Under the proposed rule, this temporary certification program would be followed by a permanent program.

ONC has also taken steps to implement the strengthened health information privacy and security standards in HITECH, including the preparation of white papers on privacy and security and guidance describing applicable laws.

Changes Made by the Health Reform Law
Health reform makes no further changes in HITECH or in the Medicare and Medicaid meaningful use statutes.

Implementation

Agency and Timeline
ONC oversees health information technology policy generally. The office is charged with developing standards and criteria for EHRs and updating the national strategic plan. ONC will also coordinate HIT policy across various federal agencies. CMS will oversee the Medicare and Medicaid incentive payments as part of its administrative authority over those programs. In particular, CMS will define meaningful use for the purpose of Medicare provider incentive payments and administer the execution of those payments. CMS will also coordinate with state Medicaid programs to implement the Medicaid incentive payments for states that opt in. CMS has begun that process by issuing initial guidance to state Medicaid directors.[16]

Process
HITECH and the Medicare and Medicaid meaningful user amendments authorize implementation by the Secretary, who has used both rulemaking and policy guidance to implement the provisions of ARRA.

Key Implementation Issues

- *Standards*: The final rules setting standards for implementing the Medicare and Medicaid HIT adoption incentive program have not yet been issued. The public comment period for the proposed rule issued in January 2010 closed in March 2010. What will the final regulations require?
- *Meaningful use criteria*: The criteria for demonstrating meaningful use of EHRs in order to qualify for Medicare incentive payments have been determined only for Stage 1 incentive payments. What criteria will be required for Stages 2 and 3?
- *Adoption*: How quickly will eligible hospitals, physicians and health professionals engaged in high-volume practice for Medicaid achieve meaningful use of HIT? And how many state Medicaid programs will implement the Medicaid provisions of ARRA and how quickly will that be accomplished? How effectively will grantmaking under HITECH speed the rate of HIT adoption and its meaningful use by health care providers and state public health and Medicaid agencies?

Recent Agency Action

Proposed and interim final regulations implementing HITECH and the Medicare and Medicaid incentives programs were published beginning January 2010, as described above. Future regulations and documents related to implementation can be found at this link.

ONC also has issued grantmaking notices and other policy guidance for a range of programs related to HIT incentives, such as the State Health Information Exchange Cooperative Agreement Program, the Health Information Technology Extension Program, the Strategic Health IT Advanced Research Projects Program, the Beacon Community Cooperative Agreement Program, and a series of educational and training programs. These programs are other pieces of the government's overall HIT strategy that support the adoption and meaningful use of HIT by health care providers. Information about the implementation of these programs can be found at this link.

Authorized Funding Levels

ARRA gives ONC two billion dollars to carry out its work, of which $300 million is dedicated to support regional or sub-national efforts toward health information exchange. The ARRA authorizes the Secretary to make state-based implementation grants, loans and other investments to support a nationwide HIT infrastructure. The Medicare and Medicaid meaningful user incentives constitute entitlement funding for qualifying providers and thus no aggregate upper limit on payments is imposed.

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[1] DesRoches CM, et al. Electronic health records in ambulatory care – a national survey of physicians. N Engl J Med 2008;359:50-60; Jha A, et al. Use of Electronic Health Records in U.S. Hospitals. N Engl J Med 2009;360:1628-38.
[2] Pub. L. 111-5 (Division A, Title XIII and Division B, Title IV), 123 Stat. 226-279, 467-496 (2009).
[3] U.S. Department of Health and Human Services, The ONC-Coordinated Federal Health IT Strategic Plan: 2008-2012, June 3, 2008.
[4] 69 Fed. Reg. 24059.
[5] The HIT Policy Committee Strategic Plan Workgroup released a pre-decisional draft of the updated Health IT Strategic Framework on January 11, 2010, for public comment. Office of the National

Coordinator for Health Information Technology, Health IT Strategic Framework (Pre-Decisional Draft), January 11, 2010
[6] ARRA, § 13400 et seq.
[7] ARRA, § 13111-13301.
[8] ARRA, § 4001 et seq.
[9] SSA §§1848(o)(2)(A), 1886(n)(3) (42 U.S.C. §§42 U.S.C. 1395w–4(o)(2)(A), 42 U.S.C. 1395ww(n)(3)).
[10] SSA § 1903(t)(6)(C)(i)(II) (42 U.S. C. § 1396b(t)(6)(C)(i)(II)).
[11] ARRA, §§ 4102, 4201.
[12] ARRA, § 4101(a).
[13] 75 Fed. Reg. 1843.
[14] 75 Fed. Reg. 2013.
[15] 75 Fed. Reg. 11328.
[16] Centers for Medicaid and Medicare Services, Letter to State Medicaid Directors, September 1, 2009.