

# Update on the HITECH Act and the Medicare/Medicaid EHR Incentives

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# Two e-Health Sections

The economic stimulus bill signed into law on February 17, 2009, formally known as the American Recovery and Reinvestment Act (or ARRA), has two sections that directly address health IT (HIT) and health information exchange (HIE).

- **Division A, Title XIII**, the HITECH Act, (1) codifies the Office of the National Coordinator, (2) creates a new federal framework for setting e-health policy and standards, (3) directs ONC to establish certain grant and loan funding programs, and (4) establishes significant new privacy laws. \$2 billion in funding.
- **Division B, Title IV** establishes incentives, in the form of Medicare and Medicaid reimbursements, starting in 2011, for professionals and hospitals that are “meaningful users” of electronic health records. CBO estimates gross 2009-2015 outlays for this program will be \$36.35 billion. DHHS now estimates outlays will be \$46.84 billion.

# Cost – Initial CBO Estimate

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
<b>Office of the National Coordinator</b>												
Budget Authority	\$2,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$2,000
Est. Outlays	\$300	\$1,280	\$360	\$40	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,980
<b>EHR Adoption Incentives for Medicare and Medicaid Providers</b>												
Budget Authority	\$438	\$178	\$4,741	\$6,469	\$6,463	\$14,231	\$3,848	\$0	\$0	\$0	\$0	\$36,368
Est. Outlays	\$417	\$178	\$4,741	\$6,469	\$6,463	\$14,231	\$3,848	\$0	\$0	\$0	\$0	\$36,347
Est. Savings	\$0	\$0	\$0	\$0	\$0	\$0	\$0	-\$5,535	-\$4,980	-\$2,780	-\$2,233	-\$15,528
Net Est. Cost												\$20,819
<b>Impact on Federal Tax Revenues (see note)</b>												
Est. Revenues	\$0	\$0	\$120	\$250	\$360	\$410	\$435	\$435	\$425	\$415	\$410	\$3,260
<b>Impact on Deficit (Net of Savings and Revenue)</b>												\$19,580
<b>Total ONC and CMS Estimated Outlays</b>												\$38,327
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<p>Note: The CBO scoring claims future federal tax revenues will increase due to lower future healthcare costs, which they claims will result in a higher share of employee compensation being in the form of taxable income and benefits, rather than tax exempt healthcare benefits.</p>												

# Cost – New DHHS/CMS Estimate

DHHS now estimates \$23.1 billion in Medicare incentive payments, \$21.64 billion in Medicaid incentive payments, and \$2.1 billion in administrative costs.

(Dollars in Millions)			
	Program Level	FY 2009	FY 2010 – FY 2019
Incentives (includes Medicare penalties)			
Medicare	\$23,100	\$0	\$23,100
Medicaid	21,640	0	21,640
Subtotal, Incentives	44,740	0	44,740
State Medicaid Administration	1,055	0	1,055
CMS Administrative Costs /1			
Medicare	745	35	710
Medicaid	300	14	286
Subtotal, CMS Administrative Costs	1,045	49	996
Total, Mandatory Recovery Act HIT Funds	46,840	49	46,791

Table from DHHS ARRA Implementation Plan, page 1

# The HITECH Act

Division A, Title XIII of the stimulus bill is the Health Information Technology for Economic and Clinical Health (HITECH) Act, and it has four subtitles

## **Subtitle A - Promotion of Health Information Technology**

- Codifies ONC and establishes the HIT Policy Committee and the HIT Standards Committee

## **Subtitle B - Testing of Health Information Technology**

- NIST to play a larger role in standards and testing

## **Subtitle C - Grants and Loan Funding**

- Federal funding to flow through multiple channels

## **Subtitle D - Privacy**

- Major changes to federal privacy law

# HITECH – Promotion of HIT

**Subtitle A** of the HITECH Act (entitled Promotion of Health Information Technology), has three major sections followed by a number of more technical sections.

- Section 3001 codifies ONC
- Section 3002 establishes the Federal HIT Policy Committee
- Section 3003 establishes the HIT Standards Committee; and
- Sections 3004-3009 contain various other provisions

# HITECH – Promotion of HIT (cont.)

## Section 3001:

- Establishes ONCHIT within DHHS, headed by a National Coordinator appointed by the Secretary;
- Includes lots of nice “purpose” language about a nationwide health information technology infrastructure, privacy, quality, public health, cost reductions, etc.;
- Describes the duties of the National Coordinator as being: (1) promotion of standards, (2) coordination of federal HIT policy, (3) maintenance of the Federal Health IT Strategic Plan, (4) maintenance of a website, (5) working with NIST on an HIT certification regime, (6) submitting various reports to Congress, (7) providing assistance to non-profits involved in technology transfer, and (8) establishing a governance mechanism for the nationwide health information network; and
- Directs the Secretary to name a Chief Privacy Officer for ONC within 1 year.

# HITECH – Promotion of HIT (cont.)

## Section 3002

- Establishes the HIT Policy Committee “to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure, including implementation of the strategic plan”;
- Describes the duties of the HIT Policy Committee as being: (1) recommending a policy framework for the development and adoption of a nationwide health information technology infrastructure; (2) recommending and prioritizing areas in which standards, implementation specifications, and certification criteria are needed; and (3) serving as a forum for broad stakeholder input; and
- Directs the National Coordinator to take a leading position in establishing and operating the committee, describes the membership of the committee, and applies the Federal Advisory Committee Act to the committee.

# HITECH – Promotion of HIT (cont.)

## Section 3003

- Establishes the HIT Standards Committee “to recommend to the National Coordinator standards, implementation specifications, and certification criteria.”
- Describes the duties of the HIT Standards Committee as being: (1) recommending standards, implementation specifications, and certification criteria to the National Coordinator; (2) pilot testing standards and implementation criteria; and (3) serving as a forum for the participation of a broad range of stakeholders to provide input on the development, harmonization, and recognition of standards, implementation specifications, and certification criteria.
- Directs the National Coordinator to take a leading position in establishing and operating the committee, describes the membership of the committee, and applies the Federal Advisory Committee Act to the committee.

# Subtitle A – Updates as of July, 2009

Subtitle A of the HITECH Act codifies ONC, establishes the Federal HIT Policy Committee, and establishes the HIT Standards Committee. Since passage, major developments have been:

- David Blumenthal has been named National Coordinator for Health Information Technology;
- The HIT Policy Committee has been named and has begun to meet;
- The HIT Standards Committee has been named and has begun to meet;
- Information on the committees is available at [healthit.hhs.gov](http://healthit.hhs.gov)

# HIT Policy Committee Members

Chair - David Blumenthal, HHS/Office of the National Coordinator for Health Information Technology

David Bates, Brigham and Women's Hospital

Christine Bechtel, National Partnership for Women & Families

Neil Calman, The Institute for Family Health

Richard Chapman, Kindred Healthcare

Adam Clark, Lance Armstrong Foundation

Arthur Davidson, Denver Public Health Department

Connie White Delaney, University of Minnesota/School of Nursing

Paul Egerman, Businessman/Entrepreneur

Judith Faulkner, Epic Systems Corporation

Gayle Harrell, Former Florida State Legislator

Charles Kennedy, WellPoint, Inc.

Michael Klag, Johns Hopkins University, Bloomberg School of Public Health

David Lansky, Pacific Business Group on Health

Deven McGraw, Center for Democracy & Technology

Frank Nemec, Gastroenterology Associates, Inc.

Marc Probst, Intermountain Healthcare

Latanya Sweeney, Carnegie Mellon University

Paul Tang, Palo Alto Medical Foundation

Scott White, 1199 SEIU Training and Employment Fund

# HIT Standards Committee Members

Chair, Jonathan Perlin, Hospital Corporation of America  
Vice Chair, John Halamka, Harvard Medical School

Dixie Baker, Science Applications International Corporation  
Anne Castro, BlueCross BlueShield of South Carolina  
Christopher Chute, Mayo Clinic College of Medicine  
Janet Corrigan, National Quality Forum  
John Derr, Golden Living, LLC  
Linda Dillman, Wal-Mart Stores, Inc.  
James Ferguson, Kaiser Permanente  
Steven Findlay, Consumers Union  
Douglas Fridsma, Arizona State University  
C. Martin Harris, Cleveland Clinic Foundation  
Stanley M. Huff, Intermountain Healthcare  
Kevin Hutchinson, Prematics, Inc.  
Elizabeth O. Johnson, Tenet Healthcare Corporation  
John Klimek, National Council for Prescription Drug Programs  
David McCallie, Jr., Cerner Corporation  
Judy Murphy, Aurora Health Care  
J. Marc Overhage, Regenstrief Institute  
Gina Perez, Delaware Health Information Network  
Wes Rishel, Gartner, Inc.  
Sharon Terry, Genetic Alliance  
James Walker, Geisinger Health System

# HITECH – Testing of HIT

**Subtitle B** of the HITECH Act (entitled Testing of Health Information Technology) has two sections.

- Directs the National Institute of Standards and Technology (NIST) to test the standards and implementation specifications developed by the HIT Standards Committee and to develop a federal conformance testing infrastructure.
- Directs NIST, in consultation with NSF, to establish a program of assistance to higher education institutions and consortia to establish multidisciplinary Centers for Health Care Information Enterprise Integration. These centers are designed “to generate innovative approaches to health care information enterprise integration by conducting cutting-edge, multidisciplinary research on the systems challenges to health care delivery.”

# HITECH – Grants and Loan Funding

**Subtitle C** of the HITECH Act (entitled Grants and Loan Funding) has six major sections.

- Section 3011 – Immediate Funding
- Section 3012 – HIT Implementation Assistance
- Section 3013 – State Grants to Promote HIE
- Section 3014 – Competitive Grants for Loans
- Section 3015 – Integrating IT in Clinical Education
- Section 3016 – IT Professionals in Health

# HITECH – Grants & Loans (cont.)

## Section 3011 – Immediate Funding

- Entitled “Immediate Funding to Strengthen the Health Information Technology Infrastructure.”
- Directs the Secretary to invest funds in HIT infrastructure through ONC, HRSA, AHRQ, CMS, CDC, and IHS to support various objectives.
- The specified objectives of the immediate funding are: nationwide HIE, development and adoption of certified EHRs, training and dissemination of best practices, telemedicine, interoperability of clinical data repositories, technologies and practices that protect PHI, and public health.
- ONC can also use these funds for current activities.

# HITECH – Grants & Loans (cont.)

## Section 3012 – Implementation Assistance

- Creates an HIT Extension Program to assist health care providers to adopt, implement, and effectively use certified EHR technology.
- Creates a Health Information Technology Research Center to provide technical assistance and develop or recognize best practices.
- Directs the Secretary to provide assistance for the creation of HIT Regional Extension Centers to provide technical assistance and develop or recognize best practices.
- Financial support for regional centers is capped at 4 years and may not exceed 50% of the cost of a center, except the Secretary may waive the cost-share requirement.
- Not later than May 17, 2009 the Secretary shall publish a draft description of the regional centers program.

# Regional Extension Center Update

- ONC published a draft description of the REC program in the Federal Register on May 28, 2009.
- Regions will be self-defined but will not overlap.
- On-site assistance to prioritized providers will be “a significant portion” of each center’s activities.
- Priority given to public or not-for-profit hospitals or critical access hospitals; federally qualified health centers; entities located in rural or underserved areas; and individual or small group practices focused on primary care.
- Matching requirement waived for 2010 awards.
- Anticipated average award value of \$2 million per center, with a maximum of \$10 million.

# HITECH – Grants & Loans (cont.)

## Section 3013 – State Grants to Promote HIE

- Directs the Secretary, acting through ONC, to establish a program to facilitate HIE.
- Grants may be made to a State or a qualified State-designated entity (multi-stakeholder non-profit).
- Grants may be Planning Grants or Implementation Grants.
- To qualify for an implementation grant a State must submit an HIE plan for the Secretary's approval.
- Funds must be used to facilitate HIE, though the definition is broad.

# HITECH – Grants & Loans (cont.)

## Section 3014 – Competitive Grants for Loan Programs

- Authorizes the National Coordinator to award competitive grants to States for loan programs for healthcare providers.
- Providers that accept such loans must comply with requirements, such as submitting quality reports.
- There is a 1/5 match requirement, and an explicit authorization for private contributions to the loan funds.
- No awards may be made prior to 1/1/10.

# HITECH – Grants & Loans (cont.)

## **Section 3015 – Clinical Education**

- Secretary may award competitive grants for demonstration projects to develop academic curricula integrating certified EHR technology in the clinical education of health professionals.

## **Section 3016 – IT Professionals in Healthcare**

- Secretary may 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 health care and information technology students.

# HITECH - Privacy

**Subtitle D** of the HITECH Act (entitled Privacy) contains significant changes in federal privacy law. Major provisions include the following:

- HIPAA regulations apply to business associates in the same manner that they apply to covered entities.
- Covered entities and BAs must notify each person affected by a breach when health data is accessed, acquired, or disclosed because of the breach, within 60 days.
- Notice must be provided to the Secretary and “prominent media outlets” if the breach involves more than 500 people.
- HHS to post a list of covered entities involved in breaches on its Website.
- Creation of DHHS regional office privacy advisors and a national education initiative.

# HITECH – Privacy (Cont.)

- Allows patients to restrict disclosures to health plans of information relating to privately paid services.
- Contains new language relating to the “minimum necessary “ standard and introduces the concept of “limited data set.” The Secretary will issue guidance on what constitutes minimum necessary within 18 months.
- Covered entities that use EHRs will be required to account for three years of disclosures of PHI.
- Covered entities and business associates prohibited from receiving payment for protected health information unless authorized by patient. Certain exceptions, such as public health activities, research (price to reflect cost of preparation and transmittal of data), treatment, healthcare operations, and purposes determined by HHS in regulations.
- Contains new restrictions on marketing communications and creates an opt-out right for fundraising communications.

# HITECH – Privacy (Cont.)

- PHR vendors, following a breach of PHR data, must notify each person affected and the Federal Trade Commission. A third-party service provider that delivers services to a PHR vendor must notify the vendor of a breach, including the people affected. FTC to notify HHS.
- Organizations that transmit PHI to covered entities or BAs, including RHIOs and e-prescribing gateways, are required to enter into a written contract with the covered entity and will be treated as a BA.
- Fines on tiered level: if unaware of violation, \$100 each up to \$25,000; if due to reasonable cause but not willful neglect, \$1000 each up to \$100,000; if due to willful neglect, \$10,000 each up to \$250,000; and if uncorrected, \$50,000 each up to \$1.5 million.
- State Attorneys General can now bring civil actions to enforce HIPAA.
- Losing parties can be assessed attorneys fees.

# HITECH Privacy Timeline Update

## DESCRIPTION

## DATES(S)

For breach notification purposes, issue guidance specifying the technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals

April 18, 2009;  
annual updates

Issue interim final regulations to implement breach notification for HIPAA covered entities and business associates

August 18, 2009

Issue regulations to modify the HIPAA Enforcement Rule to implement revised penalty structure

February 18, 2010

Issue regulations to extend certain HIPAA Security Rule provisions to business associates

February 18, 2010

Issue guidance on technical safeguards to carry out security

February 18,  
2010; annual  
updates

Report to Congress on breaches for which notice was provided to the Secretary

February 18, 2010  
and annually  
thereafter

Issue regulations to extend certain HIPAA Privacy Rule provisions to business associates

February 18, 2010

# HITECH Privacy Timeline Update

Issue regulations to modify the HIPAA Privacy Rule's provisions regarding right to request restrictions, minimum necessary, access	February 18, 2010
Issue regulations to modify the HIPAA Privacy Rule's provisions regarding marketing and fundraising	February 18, 2010
Issue regulations to clarify that certain entities are HIPAA business associates	February 18, 2010
Report to Congress on Compliance	HIPAA Privacy and Security
Study and report to Congress on privacy and security requirements for entities that are not HIPAA covered entities or business associates	
Issue guidance on the HIPAA Privacy Rule's requirements for de-identification	February 18, 2010 and annually thereafter
Study the HIPAA Privacy Rule's definition of "psychotherapy notes" with regard to including certain test data and mental health evaluations	February 18, 2010
Issue regulations to modify the HIPAA Privacy Rule's accounting of disclosures provisions	February 18, 2010
Issue guidance on what constitutes "minimum necessary" for purposes of the HIPAA Privacy Rule	June 18, 2010
	August 18, 2010

# HITECH Privacy Timeline Update

Issue regulations to modify the HIPAA Enforcement Rule to implement willful neglect provisions	August 18, 2010
Issue regulations to modify the HIPAA Privacy Rule to generally prohibit exchanging health information for remuneration without individual authorization	August 18, 2010
Issue regulations to modify the HIPAA Enforcement Rule to implement provisions for sharing civil money penalties or settlements with harmed individuals	February 18, 2012

# Division B, Title IV

Division B, Title IV has two subtitles

Subtitle A - Medicare Incentives

Subtitle B - Medicaid Incentives

Update - DHHS now estimates spending under these sections will total \$46,840,000,000:

\$23.10 billion – Medicare Incentives

\$21.64 billion – Medicaid Incentives

\$1.055 billion – State Medicaid Administration

\$1.045 billion – CMS Administrative Costs

# Medicare Incentives

## Incentives for Eligible Professionals

- Incentives are paid through Medicare Part B and are for eligible professionals that are meaningful EHR users. These payments are not available for providers based primarily in hospitals. Incentive amounts can be up to the following:
  - 1<sup>st</sup> year - \$15K (\$18K if 2011 or 2012)
  - 2<sup>nd</sup> year - \$12K
  - 3<sup>rd</sup> year - \$8K
  - 4<sup>th</sup> year - \$4K
  - 5<sup>th</sup> year - \$2K
- No incentive payments for those adopting after 2014. All incentives end in 2016.
- 10% increase in incentive payments for providers in a “health professional shortage area.”
- Meaningful use means demonstrating to the satisfaction of the Secretary that the professional is using a certified EHR in a meaningful manner, which includes the use of e-prescribing, electronic HIE, and submission of information on clinical quality measures.

# Medicare Incentives (cont.)

## Incentives for Eligible Professionals (cont.)

- The Secretary may develop more stringent measures of meaningful use over time.
- For eligible professionals that are not meaningful users of EHRs, Medicare reimbursements will be cut 1% in 2015, 2% in 2016, and 3% in 2017.
- If less than 75% of professionals are meaningful users in 2018, Secretary can cut reimbursements another 1 percentage point, to maximum of 5%.
- Exceptions to the reimbursement reductions may be made on a case-by-case basis for hardships.
- CMS website to list eligible professionals who are meaningful EHR users.

# Medicare Incentives (cont.)

## Incentives for Hospitals

- For hospitals that are meaningful EHR users, paid out of Medicare Part A beginning in 2011. Secretary to improve use of EHRs and quality over time by requiring more stringent measures of meaningful use, and Secretary will select quality measures.
- Payments equal to up to \$2 million, plus formula-determined payments based on number of Medicare payments and transitional considerations. For discharges between 1150 and 23,000 patients, hospitals receive \$200 per discharge.
- Four year incentive payment schedule: 100%, 75%, 50%, 25%. No incentives for adoption after 2015.
- CMS website to post list of hospitals that are meaningful EHR users.
- Hospitals that fail to adopt will be penalized beginning in 2015.
- Secretary may exempt hospitals on a case-by-case basis, not to exceed 5 years.

# Medicaid Incentives

Medicaid incentives are paid to:

- Professionals who are not hospital-based and have at least 30 percent patient volume attributable to individuals on Medicaid;
- Pediatricians who are not hospital-based and who have at least 20 percent patient volume attributable to Medicaid;
- Professionals who practices predominantly in a Federally qualified health center or rural health clinic and have at least 30 percent patient volume attributable to needy individuals;
- Children's hospitals; and
- Acute-care hospitals that have at least 10 percent of the hospital's patient volume attributable to Medicaid.

# Medicaid Incentives (cont.)

- Physicians who are meaningful users of certified EHRs will be eligible for up to 85% of the costs for certified EHR technology and support services, up to a maximum of \$21,250 in the first year, and \$8,500 in subsequent years, up to a total of \$63,750.
- Pediatricians who meet the 20 percent Medicaid volume threshold can receive up to \$42,500.
- Payments can only be made for a maximum of six years, and in no event after 2021.
- Medicaid hospital incentive payments are based on a formula, and unlike incentives for doctors, hospitals can receive incentives from both Medicare and Medicaid if they qualify.

# Meaningful Use Update

At the June 16, 2009 meeting of the HIT Policy Committee, the Meaningful Use Workgroup presented a draft definition of meaningful use in the form of a preamble and a matrix.

The Matrix is organized along five policy priorities and includes objectives and measures for 2011, 2013, and 2015.

- Improve Quality, Safety, Efficiency, & Reduce Disparities
- Engage Patients and Families
- Improve Care Coordination
- Improve Population and Public Health
- Ensure Privacy and Security Protections for PHI

The Meaningful Use Workgroup is working on a new draft for presentation at the July 16, 2009 meeting of the HIT Policy Committee.

It will be late 2009 before the definition of meaningful use is finally settled, which is poor timing for those planning to qualify for incentives in 2011.