

Joint State Advisory

ADVISORY

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Health Information Technology Provisions of H.R. 1—The American Recovery and Reinvestment Act

The stimulus package as approved by both Houses on February 13, 2009 and signed by President Obama on February 17, 2009 contains two titles enacting the “Health Information Technology for Economic and Clinical Health” (“HITECH”) Act, which is designed to encourage the adoption of health information technology (“HIT”) to reduce medical errors, reduce health care costs, and improve health care quality.

The HITECH Act amends the Public Health Service Act to (1) codify the Office of the National Coordinator for Health Information Technology under the Department of Health and Human Services (“HHS”);¹ (2) establish two advisory committees, the HIT Policy Committee and the HIT Standards Committee; (3) empower the National Coordinator to recommend standards and policy for the adoption of HIT; (4) authorize HHS to award grants to encourage the development of HIT; and (5) expand upon the existing Health Information Portability and Accountability Act (“HIPAA”) standards for the privacy and security of identifiable health information.² The HITECH Act also amends titles XVIII and XIX of the Social Security Act to create a system of financial incentives designed to encourage Medicare and Medicaid providers to become “meaningful users” of certified electronic health record (“EHR”) technology.

Two provisions of the HITECH Act will be of particular interest to States—grants to help States promote the use of HIT, and an enhanced Medicaid match for HIT-related payments to eligible providers and hospitals. Below is an overview of the HITECH Act, with particular focus on these provisions.

I. KEY DEFINITIONS

The HITECH Act defines “health information technology” as

hardware, software, integrated technologies, or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information.

“Health information” is given the same meaning that is currently set forth at Section 1171(5) of the Social Security Act and includes “any information” that has been “created or received by a health care provider” and other listed entities, and that “relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.”

The HITECH Act defines a “qualified electronic health record” as

¹ This office was created by Executive Order 13,335 in 2004.

² The HIPAA standards are currently set forth in regulations at 45 C.F.R. Parts 160 and 164.

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an electronic record of health-related information on an individual that (A) includes patient demographic and clinical health information, such as medical history and problem lists; and (B) has the capacity –

- (i) to provide clinical decision support;
- (ii) to support physician order entry;
- (iii) to capture and query information relevant to health care quality; and
- (iv) to exchange electronic health information with, and integrate such information from other sources.”

The HITECH Act defines “certified EHR technology” as “a qualified electronic health record that is certified ... as meeting standards adopted” by the Secretary of HHS “that are applicable to the type of record involved.”

II. OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY

The HITECH Act codifies the Office of the National Coordinator for Health Information Technology (“ONCHIT”), and establishes two advisory committees, the HIT Policy and Standards Committees. ONCHIT is headed by a National Coordinator who is appointed by, and reports to, the Secretary of Health and Human Services. The National Coordinator’s tasks include the development of HIT standards and policies; the coordination of HIT policy across federal agencies; the development of a strategic plan for the wholesale adoption of HIT by 2014; the development of a voluntary HIT certification program; the establishment of HIT Regional Extension Centers; and the generation of reports, studies, and public information related to all these activities.

III. ADOPTION OF AN INITIAL SET OF STANDARDS FOR HIT

By December 31, 2009, the HITECH Act requires the Secretary of HHS to adopt, through regulation, an initial set of HIT standards, implementation specifications, and certification criteria. These standards, specifications, and criteria are to be developed by the HIT Policy and Standards Committees and the National Coordinator, and must address the following: (1) technologies that protect the privacy and security of health information in an electronic health record; (2) a nationwide HIT infrastructure enabling electronic information exchange; (3) nationwide adoption of certified EHRs by 2014; (4) EHR technologies that allow for tracking of disclosures of health information; (5) use of EHRs to improve health care quality; (6) encryption technologies that render individually identifiable health information unintelligible to unauthorized individuals; (7) the use of electronic systems to collect patient demographics data; and (8) technologies that address the needs of children and other vulnerable populations.

The HITECH Act permits the Secretary to adopt the initial set of standards through an interim final rule. However, the standards development process at the HIT Policy and Standards Committees will be publicized in the Federal Register and on the Internet, and at least some of the meetings of the Standards Committee will be open to public participation.

IV. GRANTS TO STATES

The HITECH Act authorizes the National Coordinator to award several types of grants to further the development and expansion of HIT. Two of these grants are directed to States: grants promoting HIT, and grants enabling States to develop loan programs to facilitate widespread adoption of HIT. The final version of the stimulus package appropriated \$2 billion to the National Coordinator for administration of all its activities; \$300 million of this will support “regional or sub-national efforts toward health information exchange.” Presumably, this \$300 million will be spread among all the grant programs

created by the HITECH Act, including the State-directed grants.

A. GRANTS TO STATES FOR THE PROMOTION OF HIT

The National Coordinator may award grants to States or “qualified State-designated entities”³ for planning or implementing activities designed to “facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards.” Activities eligible for funding include: (1) “enhancing broad and varied participation in the authorized and secure nationwide electronic use and exchange of health information”; (2) “identifying State or local resources available” to the nationwide effort to promote HIT; (3) “complementing other Federal grants” promoting HIT; (4) developing and disseminating “technical assistance” designed to overcome barriers to the exchange of electronic health information; (5) “promoting effective strategies to adopt and utilize [HIT] in medically underserved communities”; (6) “assisting patients in utilizing [HIT]”; (7) “encouraging clinicians to work with [HIT] Regional Extension Centers”; (8) “supporting public health agencies’ authorized use of and access to electronic health information”; (9) “promoting the use of [EHR] for quality improvement including through quality measures reporting”; and (10) “such other activities as the Secretary may specify.”

Successful applications for implementation grants must include a plan describing the State’s activities that (1) is “pursued in the public interest”; (2) consistent with the National Coordinator’s strategic plan; and (3) includes a description of how the State will carry out the qualifying activities. Grant awardees must consult with several categories of stakeholders in carrying out both planning and implementation grants; stakeholders should include health care providers, health plans, patients, HIT vendors, public health agencies, health professions educators, and clinical researchers.

Starting in 2011, States must contribute an increasing share of non-federal funds (which may include in-kind contributions) toward the costs of these grants. In 2011, the required State share is \$1 for each \$10 of federal funds; in 2012 it is \$1 for each \$7 of federal funds; and in 2013 and beyond, it is \$1 for each \$3 in federal funds. The Secretary also has the option of requiring non-federal matching funds in years prior to 2011.

B. GRANTS TO STATES FOR THE DEVELOPMENT OF LOAN PROGRAMS

Beginning on January 1, 2010, the National Coordinator may also award grants to States and Native American tribes to help them establish certified EHR technology loan funds. Loan funds established under these grants may be used to award loans or loan guarantees, make reimbursements to private entities contributing to the funds, or as a source of reserve and security for leveraged loans. Loans may be awarded from the funds only to health care providers to facilitate the purchase of certified EHR technology, to enhance the utilization of such technology (including through technology upgrades), to train personnel to use such technology, or to improve the secure electronic exchange of health information.

To be eligible for these grants, States must create loan funds meeting several requirements set forth in the HITECH Act, and must submit annually updated strategic plans describing the intended uses of the loan funds and providing assurances that the loan funds are being disbursed to qualifying providers. They must also match each \$5 of the federal grant with \$1 of non-federal funds. The non-federal match may consist of contributions from private sector entities, so long as the private donor does not specify any particular loan recipients, and so long as the grantee publishes the identity of private

³ A “qualified State-designated entity” is defined as a not-for-profit entity designated by the State to receive grant funds. It must have in place nondiscrimination and conflict-of-interest policies “that demonstrate a commitment to open, fair, and nondiscriminatory participation by stakeholders.” One of its “principal goals” must be “to use information technology to improve health care quality and efficiency through the authorized and secure electronic exchange and use of health information.”

donors and the amounts they contribute to the fund. The National Coordinator may promulgate additional guidance and regulations regarding the grants and the loan funds established through them.

V. MEDICARE AND MEDICAID INCENTIVE PAYMENTS

The HITECH Act also contains provisions designed to encourage Medicare and Medicaid providers to adopt and use certified EHR technology. Under the Medicare program, the Act creates a complex system of incentive payments and penalties applicable to non-hospital-based⁴ physicians and hospitals that are adopting EHR technology or engaged in its meaningful use. A health care provider engaged in the “meaningful use” of certified EHR technology (1) uses such technology in a meaningful manner, for example, by e-prescribing; (2) uses technology that is connected, so that health information can be shared electronically; and (3) submits information on clinical quality measures. For physicians, incentive payments will be staggered over five years beginning in 2011, 2012, and 2013. Penalties will begin in 2015. Incentive payments to hospitals will commence in 2011, and penalties against hospitals will be assessed starting in 2016. Medicare Advantage health maintenance organization plans affiliated with eligible providers and hospitals are also eligible for incentives, and there are special rules governing payment to providers affiliated with such a plan.

To encourage the adoption of certified EHR technology by Medicaid providers, the HITECH Act amends Section 1903 of the Social Security Act to provide for a 100 percent federal match in State payments to eligible Medicaid providers “to encourage the adoption and use of certified EHR technology.” It further provides for a 90 percent match in State administrative expenditures related to such payments, so long as the State is using the funds for administering enhanced HIT-related payments to providers (including tracking such payments), conducts adequate oversight of the incentive payments (including tracking meaningful use attestations and reporting mechanisms), and is “pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information.” For payments qualifying for the enhanced match, Congress has appropriated \$40 million annually from 2009 through 2015 and \$20 million for 2016.

Payments qualifying for the 100 percent match may be made to providers in the following categories: (1) non-hospital-based physicians, dentists, nurse-midwives, and nurse practitioners with at least 30 percent Medicaid patient volume; (2) non-hospital-based pediatricians with a 20 to 30 percent Medicaid patient volume; (3) professionals who practice predominantly at federally qualified health centers (“FQHCs”) or rural health clinics (“RHCs”) with at least 30 percent “needy” patient volume;⁵ (4) physician assistants in FQHCs and RHCs if these facilities are led by physician assistants and have at least 30 percent “needy” patient volume; (5) children’s hospitals; and (6) acute care hospitals with at least 10 percent Medicaid patient volume. Patients enrolled in Medicaid managed care may be included in the qualifying patient volumes for professionals and acute care hospitals. Payments in the first year must support qualifying providers’ “efforts to adopt, implement, or upgrade certified EHR technology” (unless the provider has already taken these measures); payments in subsequent years must support their “meaningful use of

⁴ For purposes of its Medicare and Medicaid provisions, the HITECH Act defines a “hospital-based” practitioner as “a professional (such as a pathologist, anesthesiologist, or emergency physician) who furnishes substantially all ... services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital.”

⁵ The “needy” patient volumes for FQHCs and RHCs may include State Children’s Health Insurance Program beneficiaries, patients receiving uncompensated care, and patients receiving care on a sliding scale, in addition to Medicaid recipients. Uncompensated care data may be adjusted “so that it would be an appropriate proxy for charity care, including a downward adjustment to eliminate bad debt data from uncompensated care.” Further, although the actual language of the HITECH Act is unclear on this point, the Conference Report indicates that FQHCs and RHCs will receive payment on behalf of professionals affiliated with them: it states that these facilities will “be paid an amount for the adoption and use of certified EHRs proportional to the number of eligible professionals practicing predominantly in such settings” up to the payment limits otherwise applicable to eligible professionals.

certified EHR technology.” In order to receive the payments, providers will be required to demonstrate that they are engaged in these activities.

The HITECH Act sets limits on both the amount and duration of qualifying payments. Payments to professionals and hospitals must commence by 2016 and may not be made for more than six years. The Act sets initial annual and aggregate dollar limits on amounts paid to professionals. States may receive enhanced federal match on payment of 85 percent of the net⁶ average allowable costs of eligible professionals, other than pediatricians. The “average allowable costs” shall be set by the Secretary based on studies of the average costs to providers of establishing and maintaining certified EHR technology. In studying and determining average allowable costs, the Secretary may utilize studies submitted by States.

The Act provides that in no case shall the net average allowable costs exceed \$25,000 in the first year of payment (for costs of adopting, implementing or upgrading certified EHR technology) or \$10,000 in subsequent years (for costs related to the meaningful use of such technology). Although not entirely clear from the language of the Act, it appears that the State could not pay the higher initial-year limits to a professional who has already implemented, adopted, or upgraded EHR technology prior to the first year of enhanced payments. The “subsequent years” payments cannot be made after 2021 or over a period of longer than five years. In effect, this language limits the total amount that can be paid to professionals for EHR to a maximum of \$63,750 (85 percent of a total of \$75,000, representing the maximum net average allowable costs in the initial year plus five subsequent years). The limits on payments to pediatricians with 20 to 30 percent Medicaid patient volume are set at two-thirds of the limits on payments to other professionals. The professional, the State, or a local government must put up at least 15 percent of the average allowable costs.

Aggregate dollar limits are also imposed on payments to hospitals. Broadly speaking, the Secretary (in consultation with the State) will calculate an amount for each provider. The amount is based on a formula that first calculates a base amount of \$2 million plus \$200 per each discharge in excess of 1,150 (up to a maximum of 23,000). This amount is then multiplied by the hospital’s “Medicaid patient share.”⁷ Next, the calculation looks to what would be paid out under the formula for Medicare EHR incentives over four years (100 percent of the calculated amount in year 1, 75 percent in year 2, 50 percent in year 3, and 25 percent in year 4). This total is the overall hospital EHR amount. States may then reimburse hospitals up to this total amount, payable over a minimum period of three years. Additionally, they may not pay more than 50 percent of the aggregate limit in any one year, or more than 90 percent of the aggregate limit in any two years.

States must pay the federal share of qualifying payments directly to providers or their assignees, “without any deduction or rebate.” The federal share may also be paid directly to “an entity promoting the adoption of certified EHR technology” designated by the State, to which providers assign their rights to payment. Payments to such entities are permissible so long as providers join them voluntarily, and so long as the entity does not retain more than 5 percent of the payment for costs unrelated to certified EHR technology and related support services.

Safeguards are written into the HITECH Act’s Medicaid provisions to prevent duplication of the Medicare HIT incentive payments and requirements. To be eligible for Medicaid

⁶ Costs matched at the enhanced rates must be “net” of any other payments related to certified EHR technology, except State and local government payments and the enhanced Medicaid payments established by the Act.

⁷ The Medicaid patient share is defined as a fraction, the numerator of which is the number of inpatient bed days attributable to Medicaid beneficiaries or Medicaid managed care enrollees (and who are not patients for whom payment can be made under Medicare Part A, or who are enrolled in Medicare Advantage plans), and the denominator of which is the product of the total number of bed days and another fraction representing the ratio of estimated total hospital charges minus charges for charity care to the hospital’s estimated total charges. If data is unavailable on charity care, uncompensated care costs adjusted to eliminate bad debt data will be used instead.

incentive payments, professionals (but not hospitals) must waive their rights to Medicare HIT incentive payments “in a manner specified by the Secretary.” As a further safeguard, the Secretary will coordinate payments to qualifying professionals to avoid duplicate payments. Further, if a provider meets the Medicare requirements for “meaningful use” it may be deemed to meet the corresponding Medicaid requirement.

VI. PRIVACY AND SECURITY REQUIREMENTS

The HITECH Act also includes extensive provisions designed to protect the privacy and security of identifiable health information. These provisions expand upon the current HIPAA standards, which will remain in effect to the extent they are consistent with the standards set forth in the bills. In general, the Act extends the existing HIPAA standards by (1) requiring notification of individuals if the security of unencrypted health information is breached; (2) increasing penalties for violations of HIPAA; (3) extending the privacy and security provisions of HIPAA and HIPAA liability to business associates of covered entities; (4) restricting the use of health information for marketing activities; and (5) granting patients greater control over disclosures of their health information, including the right to an accounting of disclosures.

The complete text of the stimulus bill can be accessed at http://www.house.gov/billtext/hr1_legtext_crb.pdf. The complete text of the conference report can be accessed at http://www.house.gov/billtext/hr1_cr_jesb.pdf. The HITECH Act appears at title XIII of Division A and title IV of Division B of the bill.

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