HIMSS Summary of the
The American Recovery and Reinvestment Plan of 2009
S. 1
January 27, 2009

The following is a HIMSS summary of legislation, the American Recovery and Reinvestment Act of 2009 (economic stimulus legislation) to be considered by the Senate Finance and Appropriations Committees. The summary of the Senate Finance Committee's legislation is extracted from the "Chairman's Mark (Senator Max Baucus, D-MT) of the American Recovery and Reinvestment Act of 2009".The summary of the Senate Appropriations Committee's legislation is extracted from a legislative summary developed by the Committee. The two Committees are scheduled to hold markups of the legislation on January 27, 2009.

During the week of January 26, 2009, the House is expected to vote on the American Recovery and Reinvestment Plan. HIMSS' summary of the House legislation can be accessed at: HIMSS Summary .

For more information, contact the HIMSS Government Relations team.

Senate Finance Committee

The Senate Finance Committee's legislation would authorize and appropriate $18 billion for health IT, through increased reimbursement incentive payments to Medicare and Medicaid providers, and establish two federal advisory committees, the HIT Standards Committee and the HIT Policy Committee. The health IT provisions included in the Finance Committee's legislation reflect parallel legislative language as those same provisions included in legislation released by the House Ways and Means and Energy and Commerce Committees.

Below, please find text extracted from the "Chairman's Mark of the American Recovery and Reinvestment Act of 2009":

Title IV- Health Information Technology
Subtitle A- Promotion of Health Information Technology

Office of the National Coordinator for Health Information Technology. The Mark would establish within HHS the Office of the National Coordinator for Health Information Technology (ONCHIT). The National Coordinator would be appointed by

the Secretary and report directly to the Secretary. The purpose of ONCHIT would be to promote the development of a national health information technology infrastructure that allows the electronic use and exchange of information, in order to improve health care quality, reduce health care costs, improve public health, and facilitate research, among other things.

The National Coordinator would be charged with the following duties:

- First, the National Coordinator would be required to review and determine whether to endorse standards recommended by the HIT Standards Committee (described below).
- Second, the National Coordinator would be responsible for coordinating HIT policy and programs within HHS and with those of other Federal agencies and would be a leading member in the establishment of the HIT Policy Committee and the HIT Standards Committee and act as a liaison among these Committees and the Federal government.
- Third, the National Coordinator would be required to update the Federal Health IT Strategic Plan (developed as of June 3, 2008) to include specific objectives, milestones, and metrics with respect to the electronic exchange and use of health information, the utilization of an EHR for each person in the United States by 2014, and the incorporation of privacy and security protections for the electronic exchange of an individual's health information, among other things. The plan would include measurable outcome goals and the National Coordinator would be required to republish the plan, including all updates.
- Fourth, the National Coordinator would maintain and update a website to post relevant information about the work related to efforts to promote a nationwide health information technology infrastructure.
- Fifth, the National Coordinator would be required, in consultation with the National Institute of Standards and Technology (NIST), to develop a program for the voluntary certification of HIT as being in compliance with applicable certification criteria adopted by the Secretary.
- Sixth, the National Coordinator would have to prepare several reports, including a report on any additional funding or authority needed to evaluate and develop standards for a nationwide health information technology infrastructure; a report on lessons learned from HIT implementation by major public and private health care systems; a report on the benefits and costs of the electronic use and exchange of health information; an assessment of the impact of HIT on communities with health disparities and in areas that serve uninsured, underinsured, and medically underserved individuals; and an estimate of the public and private resources needed annually to achieve utilization of an EHR for each person in the United States by 2014. Seventh, the National Coordinator would be required to establish a national governance mechanism for the national health information network.
- Finally, the National Coordinator would be permitted to accept or request Federal detailees and would be required, within 12 months of enactment, to

appoint a Chief Privacy Officer of the Office of the National Coordinator to advise the National Coordinator on privacy, security, and data stewardship.

HIT Policy Committee. The Mark would establish an HIT Policy Committee to make policy recommendations to the National Coordinator relating to the implementation of a nationwide health information technology infrastructure. The duties of the HIT Policy Committee would include providing recommendations on a policy framework for the development and adoption of a nationwide health information technology infrastructure, recommending areas in which standards are needed for the electronic exchange and use of health information, and recommending an order of priority for the development of such standards. The Committee would be required to provide recommendations in five areas: (1) technologies that protect the privacy and security of electronic health information; (2) a nationwide HIT infrastructure that enables electronic information exchange; (3) nationwide adoption of certified EHRs; (4) EHR technologies that allow for an accounting of disclosures; and (5) using EHRs to improve health care quality. The mark describes other areas that the committee might consider, including using HIT to reduce medical errors, and telemedicine. The membership of the HIT Policy Committee would reflect (at least) providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality and privacy and security. The National Coordinator must ensure that the Committee's recommendations are considered in the development of policies, and the Secretary would be required to publish all of the Committee's recommendations in the Federal Register and post them on a website. The provisions of the Federal Advisory Committee Act, other than section 14, would apply to the HIT Policy Committee.

HIT Standards Committee. The Mark would establish an HIT Standards Committee to recommend to the National Coordinator standards, implementation specifications, and certification criteria for the electronic exchange of health information. Duties of the HIT Standards Committee would include the development and pilot testing of standards, and serving as a forum for the participation of a broad range of stakeholders to provide input on the development, harmonization, and recognition of standards. Not later than 90 days after enactment, the HIT Standards Committee would outline a schedule for assessing the policy recommendations developed by the HIT Policy Committee, and this schedule would be published in the Federal Register. In addition, the Committee would be required to conduct open public meetings and develop a process to allow for public comment on this schedule. The membership of the HIT Standards Committee would reflect (at least) providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security. The National Coordinator would be required to ensure that the Committee's recommendations are considered in the development of policies; the Secretary would be authorized to provide financial assistance to Committee members that are non-profit or consumer advocacy groups in order to defray costs associated with participating in the Committee's activities, and the Committee would be required to publish all of its recommendations in the Federal

Register and post them on a website. The provisions of the Federal Advisory Committee Act, other than section 14, would apply to the HIT Standards Committee.

Process for Adoption of Endorsed Recommendations; Adoption of Initial Set of Standards, Implementation Specifications, and Certification Criteria. The Mark would require the Secretary, within 90 days of receiving from the National Coordinator a recommendation for HIT standards, implementation specifications, or certification criteria, to determine in consultation with representatives of other relevant Federal agencies, whether or not to propose adoption of such standards, implementation specifications, or certification criteria. Adoption would be accomplished through regulation, whereas a decision by the Secretary not to adopt would have to be conveyed in writing to the National Coordinator and the HIT Standard Committee. The Secretary would be required to adopt, through rulemaking, an initial set of standards by December 31, 2009.

Transitions. The Mark would provide for the transfer of all functions, personnel, assets, liabilities, and administrative actions of the existing ONCHIT, created under Executive Order 13335, to the new ONCHIT established by this Act. Similarly, all functions, personnel, assets, liabilities applicable to AHIC Successor, Inc., now operating as the National eHealth Collaborative (NeHC), would be transferred to the HIT Policy Committee or the HIT Standards Committee, as appropriate. Nothing in the mark would require the creation of a new entity to the extent that the existing ONCHIT is consistent with the provision of Section 3001. Similarly, nothing in the mark would prohibit NeHC from modifying its charter, duties, membership, and other functions to be consistent with Sections 3002 and 3003 in a manner that would permit the Secretary to recognize it as the HIT Policy Committee or the HIT Standards Committee.

SUBTITLE B—INCENTIVES FOR THE USE OF HEALTH INFORMATION TECHNOLOGY

Part I—Medicare Program

Incentives for Eligible Professionals

The Chairman's Mark would amend Title XVIII of the Social Security Act to add an incentive payment to the Medicare Part B program for the adoption and meaningful use of a certified electronic health record system by an eligible Medicare professional. Eligible Medicare professionals who provide covered services during the designated period and who are "meaningful EHR users" would be eligible for an incentive payment. The incentive payment would come from the Federal Supplementary Medical Insurance Trust Fund (Medicare Part B Fund) and would be equal to 75 percent of the Secretary's estimate of the allowed Part B charges during the reporting period. The estimate would be based on claims submitted not later than 2 months after the end of the reporting period.

The amount of EHR incentive payments that providers could receive in a given year would be capped and the amount of the annual incentive payment cap would decrease over time. For the first year of participation the annual limit would be $15,000. Over the

next four calendar years, the amount would decrease to $12,000, then to $8,000, then $4,000, and then $2,000, respectively. For early adopters whose first payment year is 2011 or 2012, the limit in those years would be increased to $18,000.

The phase down is different for eligible professionals first adopting EHR in 2014. For these eligible providers, the limit on the amount of the incentive payment would equal the limit for someone whose first payment year is 2013. For example, in 2014 the payment limit would equal $12,000. If the first payment year is after 2014 then the limit on the incentive payments for that year and any subsequent year would be $0. No bonus payments would be made for designated periods after 2015. For eligible professionals predominantly furnishing services in a rural health professional shortage area, the incentive payment amounts would be increased by 25 percent.

The EHR incentive payments would not be available to hospital-based eligible professionals, such as a pathologist, anesthesiologist or emergency room physician who furnishes substantially all such services in a hospital setting (inpatient or outpatient) and through the use of the facilities and equipment, including computer equipment, of the hospital.

The payment(s) could be in the form of a single consolidated payment or in periodic installments, as determined by the Secretary. The Secretary would establish rules to coordinate the limits on the incentive payments for eligible professionals who provide covered professional services in more than one practice (as specified by the Secretary). The Secretary would seek to avoid duplicative requirements from Federal and state governments to demonstrate meaningful use of certified EHR technology under the Medicare and Medicaid programs. In doing so, the Secretary could deem that the satisfaction of state requirements under Medicaid would be sufficient to qualify the professional as a meaningful user under the Medicare incentive program and vice versa. The Secretary would be allowed to adjust the reporting periods in order to carry out this clause.

For purposes of the EHR incentive program, the payment year is defined as a year beginning with 2011. The term ‘first payment year’ means the first year for which an incentive payment is made for such services under this subsection. The terms ‘second payment year’, ‘third payment year’, ‘fourth payment year’, and ‘fifth payment year’ mean, with respect to an eligible professional, each successive year immediately following the first payment year for that professional.

For purposes of the EHR incentive payment, an eligible professional would be treated as a meaningful EHR user if the eligible professional meets the following three criteria: (1) the eligible professional demonstrates to the satisfaction of the Secretary that during the period the professional is using a certified EHR technology in a meaningful manner, which would include, at minimum, the use of electronic prescribing as determined to be appropriate by the Secretary; (2) the eligible professional 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 professional uses certified EHR technology to submit information for the period, in a form and manner specified by the Secretary, on clinical quality measures and other measures as selected by the Secretary.

The Secretary could provide for the use of alternative means for meeting the above requirements in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary).

The Secretary would select the clinical quality measures and other measures but must be consistent with the following: (1) the Secretary would provide preference to clinical quality measures that have been endorsed by the consensus-based entity regarding performance measurement with which the Secretary has a contract under section 1890(a) of the Social Security Act; and (2) prior to any measure being selected for the purposes of this provision, the Secretary would publish the measure in the Federal Register and provide for a period of public comment. The Secretary could not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically.

A professional could satisfy the demonstration of meaningful use requirement through means specified by the Secretary, which may include the following: (1) an attestation; (2) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology); (3) a survey response; (4) reporting the clinical quality and other measures mentioned above; and (5) other means specified by the Secretary. The Secretary would seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use within the categories specified in this paragraph. Notwithstanding some sections of the Social Security Act that place restrictions on the use of Part D data, the Secretary could use data regarding drug claims submitted for purposes of determining payment under Part D that are necessary for purposes of determining the EHR incentive payments described here.

There would be no administrative or judicial review of any EHR incentive payment, including the determination of a meaningful EHR user or the cap on EHR incentive payments as described above. The Secretary would post a list of the names, business addresses, and business phone numbers of the eligible professionals who are meaningful EHR users and, as determined appropriate by the Secretary, of group practices receiving incentive payments in an easily understandable format on the Internet website of the Centers for Medicare & Medicaid Services.

For purposes of the EHR incentive payment, the following definitions would apply. The term ‘certified EHR technology’ would mean health information technology (as defined in section 3000 of the mark) that constitutes or supports a qualified electronic health record (as defined in section 3000) and that is certified pursuant to the standards adopted under section 3004 that are applicable to the type of record involved (as determined by

the Secretary, such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals). The term ‘covered professional services’ would have the meaning given such term under current law. The term ‘eligible professional’ would mean a physician, also as defined under current law. The term ‘reporting period’ would mean any period (or periods), with respect to a payment year, as specified by the Secretary.

For covered professional services furnished by an eligible professional during 2015 or any subsequent payment year, if the eligible professional is not a meaningful EHR user for a prior reporting period, the fee schedule amount would be reduced to 99 percent in 2015 (or, in the case of an eligible professional who was subject to the application of the payment adjustment under the current electronic prescribing program for 2014, 98 percent), 98 percent in 2016, and 97 percent in 2017 and in each subsequent year.

For 2018 and each subsequent year, if the Secretary were to find that the proportion of eligible professionals who are meaningful EHR users is less than 75 percent, the applicable fee schedule amount would be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case would the applicable percent be less than 95 percent.

The Secretary could, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment above if the Secretary determines, subject to annual renewal, that compliance with the requirement for being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case would an eligible professional be granted such an exemption for more than 5 years. This adjustment would not apply to hospital-based eligible professionals.

Beginning in 2011, the Chairman’s Mark also establishes incentive payments and adjustments to encourage the adoption and meaningful use of certified EHR technology by eligible professionals who are affiliated with certain Medicare Advantage organizations. In general, with respect to eligible professionals in a qualifying MA organization who the organization attests are meaningful EHR users (see below) but who do not bill for services under Medicare Part B or do so on a limited basis, incentive payments would be available and payment adjustments applicable. Incentive payments and adjustments would 1) apply in a similar manner as they apply to eligible non-MA professionals and 2) be made to and apply to the qualifying MA organizations.

With respect to qualifying MA organizations, an eligible professional is one who: (1) is employed by the organization or is employed by or is a partner of an entity that through contract furnishes at least 80 percent of the entity’s patient care services to enrollees of the organization; and furnishes at least 75 percent of their professional services to enrollees of the organization; and (2) furnishes, on average, at least 20 hours per week of patient care services. The Secretary may substitute an amount similar to the estimated amount that would be payable in the aggregate if the eligible professional’s services furnished were payable under Medicare Part B instead of under Part C. To account for

economies of scale within large MA organizations, incentive payments to qualifying MA organizations would be capped to reflect no more than 5,000 eligible professionals per organization.

The Secretary would be required to avoid duplicate payments to eligible professionals. If an eligible professional is both MA-affiliated and eligible for the maximum EHR incentive payment under Medicare Part B, then the incentive payment could only be made under the Part B program. For eligible professionals who are both MA-affiliated and qualify for the FFS EHR incentive program but do not reach the incentive payment limit, the Secretary would develop a process to ensure that duplicate payments are not made and collect data from MA organizations to ensure against duplicate payments. Qualifying MA organizations would be required to specify the first payment year (not earlier than 2011) for which it receives incentive payments for all eligible professionals.

Beginning in 2015, payments to qualifying MA organizations would be reduced if they have eligible professionals that have not adopted and meaningfully used EHRs in a prior reporting period. The payment adjustment would be equal to 100 percent minus the product of the applicable Part B fee schedule adjustment (1 percent in 2015, 2 percent in 2016, and 3 percent in 2017 and each subsequent year) and the Secretary's estimate of Medicare FFS physician expenditures as a proportion of total Medicare FFS expenditures for the year. If a qualifying MA organization attests that not all their eligible professionals are meaningful EHR users with respect to a year, the Secretary would apply the payment adjustment described here based on the proportion of such eligible professionals that are not meaningful EHR users for such year. The payment adjustment would be based on a maximum of 5,000 eligible professionals per MA organization.

The term 'qualifying MA organization' would mean a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act). In addition, a qualifying MA organization would submit an attestation, in a form and manner specified by the Secretary as part of submission of the initial bid identifying (a) whether each MA-affiliated eligible professional described above is a meaningful EHR user, and (b) whether each MA-affiliated eligible hospital is a meaningful EHR user for an applicable period specified by the Secretary. The Secretary would post a list of the names, business addresses, and business phone numbers of the MA-qualifying organizations that have eligible professionals who are meaningful EHR users.

Incentives for Hospitals

The Chairman's Mark would amend Title XVIII of the Social Security Act to establish payment incentives for eligible IPPS hospitals and CAHs that are meaningful EHR users beginning in FY2011. Starting in FY2015, eligible hospitals that are not meaningful EHR users would receive lower Medicare payments.

Regarding the payment incentives, starting in FY2011, eligible hospitals would receive additional payments from the Medicare Federal Hospital Insurance (Part A) trust fund.

These incentive payments would be calculated based on a base amount, increased by payment add-ons for certain discharge levels. This total amount would be further adjusted by the hospital's overall Medicare share.

Specifically, incentive payments for qualified hospitals would be calculated as the sum of a base amount ($2 million) added to its discharge related payment multiplied by its Medicare's share. Although the base amount is constant, a hospital's discharge related payment amount would change depending on the number of its total discharges (regardless of payer) up to its 23,000th discharge, according to the following. A qualified hospital would receive $200 for each discharge starting with its 1,150th discharge through its 9,200th discharge, an additional $100 for each discharge from its 9,201st through its 13,800th discharge, and an additional $60 for each discharge from its 13,801st to its 23,000th discharge. This total amount would be further adjusted by the Medicare share.

The Medicare share would be calculated according to a specified formula. The numerator would equal inpatient bed days attributable to individuals for whom Part A payment may be made, either under traditional fee-for-service Medicare or for those who are enrolled in Medicare Advantage (MA) organizations under Part C of Medicare. The denominator would equal the total number of inpatient bed days in the hospital adjusted by a hospital's share of charges attributed to charity care. If a hospital's charge data on charity care is not available, the Secretary would be required to use the hospital's uncompensated care data adjusted to eliminate bad debt. If hospital data to construct the charity care factor is unavailable, the fraction would be set at 1.0. If hospital data necessary to include MA days is not available, that component of the formula would be set at 0.0.

Eligible hospitals would receive four years of incentive payments based on this calculation, which would be phased down over four years according to the following: A hospital that demonstrates it is a meaningful EHR user starting in FY2011-FY2013 would receive the full amount of the incentive payment based on the above incentive payment formula in its first payment year; 75 percent of the amount in its second payment year; 50 percent of the amount in its third payment year; and 25 percent of the amount in its fourth payment year. A hospital that first qualifies for the incentive payments starting in FY2014, would receive three years of incentive payments, starting with 75 percent of the incentive payment amount in its first year; 50 percent in the second year; and 25 percent in the third year. A hospital that first qualifies for incentive payments in FY2015 would receive two years of incentive payments, receiving 50 percent of the amount in its first year and 25 percent of the amount in its second year. Hospitals that become meaningful EHR users starting in FY2016 would not qualify for incentive payments. The incentive payments may be made as a single consolidated payment or may be made as periodic payments, as determined by the Secretary. In no case would the total payments to any CAH in any payment year exceed $1,000,000.

An eligible hospital would be treated as a meaningful EHR user if it demonstrates that it uses certified EHR technology in a meaningful manner and provides for the electronic exchange of health information (in accordance with applicable legal standards) to improve the quality of care. A hospital would satisfy the demonstration requirements

through: an attestation; the submission of appropriately coded claims; a survey response; EHR reporting on certain measures; or other means specified by the Secretary. These EHR measures would include clinical quality measures and other measures selected by the Secretary. Prior to implementation, the measures would be published in the Federal Register and subject to public comment. The electronic reporting of the clinical quality measures would not be required unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis. When establishing the measures, the Secretary would seek to avoid redundant measures or duplicative reporting. Not withstanding restrictions placed on the use and disclosure of Medicare Part D information, the Secretary would be able to use data regarding drug claims.

There would be no administrative or judicial review of the determination of any incentive payment or payment adjustment (described subsequently), including: the determination of a meaningful EHR user; the determination of the measures; or the determination of an exception to the payment adjustment.

The Secretary would post a listing of the eligible hospitals that are meaningful EHR users and other relevant data on the CMS website. Hospitals would have the opportunity to review the relevant data prior to the data being made publicly available.

Starting in FY2015, IPPS hospitals that do not submit the required quality data according to rules of the RHAQDPU program would be subject to a 25 percent reduction in their annual update. Those hospitals that are not meaningful EHR users in a prior reporting period would be subject to a further reduction in their annual MB update. This reduction would be phased-in over a three-year period. Specifically, in FY2015, 33.33 percent of the remainder of the MB update would be subject to the payment reduction and in FY2016, 66.66 percent of the remainder of the MB update would be subject to the payment reduction. In FY2017 and beyond, the full 75 percent adjustment to the MB update (i.e. the percentage not subject to RHAQDPU) would be subject to the payment reduction. These reductions would apply only to the fiscal year involved and would not be taken into account in subsequent fiscal years. Starting in FY2015, acute care hospitals being paid under a state's Medicare waiver would be subject to reductions in a manner that is comparable to the IPPS hospitals.

Starting in FY2015, Medicare payments for inpatient services provided by eligible CAHs that do not become meaningful EHR users in a prior reporting period would also be subject to a payment reduction. In FY2015, the inpatient services provided by these CAHs would be reimbursed at 100.66 percent of reasonable costs and in FY2016, the percentage would be 100.33 percent. In FY2017 and each subsequent year, 100 percent.

The Secretary would be allowed to exempt certain IPPS hospitals and CAHs from these payment reductions for a fiscal year if the Secretary determines that requiring a hospital to be a meaningful EHR user during that year would result in significant hardship, such as in the case of a facility that does not have adequate Internet access. Such determinations would be subject to annual renewal. In no case would a hospital be granted an exemption for more than five years.

Beginning in 2011, payment incentives and adjustments would be established for qualifying MA organizations to provide incentives for eligible hospitals to become meaningful EHR users. An eligible hospital would be one that is under common corporate governance with a qualifying MA organization and serves enrollees in an MA plan offered by the organization.

The Secretary would be required to determine incentive payment amounts similar to the estimated amount in the aggregate that would be paid if the hospital services had been payable under Part A as described above. If discharge data is not available, the Secretary would use appropriate alternative data and methodologies to estimate discharges. If data to determine the Medicare share are not available, the Secretary would be able to use alternative data and methodologies to estimate the share for the eligible hospital, such as inpatient bed days or discharges for individuals whose care is paid under Part A or Part C as a proportion of the total number of patient-bed-days or discharges.

The Secretary would be required to avoid duplicative EHR incentive payments to hospitals. If an eligible hospital under Medicare Part C was also eligible for EHR incentive payments under Part A, and for which at least 33 percent of hospital discharges (or bed days) were covered under Medicare Part A, the EHR incentive payment would only be made under Part A and not Part C. If fewer than 33 percent of discharges are covered under Part A, the Secretary would be required to develop a process to ensure that duplicative payments were not made and to collect data from MA organizations to ensure against duplicative payments.

Beginning in 2015, if one or more eligible hospitals under a common corporate governance with a qualifying MA organization are not meaningful EHR users, payment to the organization would be reduced by a specified percentage. The percentage is defined as 100 percent minus the product of the percentage point reduction to the hospital payment update for the period as described above and the Secretary's estimate of Medicare FFS hospital expenditure as a proportion of total Medicare FFS expenditures for the year. The Secretary would be required to apply the payment adjustment taking into account the proportion of eligible hospitals or discharges from eligible hospitals that are not meaningful EHR users for the period.

The calculation of the annual MA capitation rates, the national per capita MA growth percentage, and the payments from the Medicare trust funds would be held harmless, as the FFS incentive payments and payment adjustments described above (for physicians and hospitals) would not affect these MA calculations. The Secretary would post a list of the names, business addresses, and business phone numbers of the MA-qualifying organizations that have hospitals that are meaningful EHR users.

Premium Hold Harmless and Implementation Funding

The annual amount of Medicare physician expenditures used to calculate the Part B premium would not include the additional incentive payments to physicians for EHR as

described above; beneficiaries would be held harmless from potential premium increases due to the increased Part B expenditures that result from this added payment. Further, the Chairman's Mark authorizes the transfer of funds from the Treasury to the Supplementary Medical Insurance (Part B) Trust Fund to cover the amount of payment incentives payable under the EHR incentive program.

To implement the provisions in and amendments made by this section, $100 million for each of FY2009 through FY2015 and $45 million for each succeeding fiscal year through FY2018 would be appropriated to the Secretary for the CMS Program Management Account. The amounts appropriated would be available until expended.

Study on Application of HIT Payment Incentives for Providers Not Receiving Other Incentive Payments

This Chairman's Mark would amend Title XVIII of the Social Security Act to require the Secretary of Health and Human Services to conduct a study to determine whether payment incentives to implement and use qualified health information technology should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, from Medicare or Medicaid, or any other funding. These health care providers could include non-physician professionals, skilled nursing facilities, home health agencies, hospice programs, and laboratories.

The study would include an examination of the following: (A) the adoption rates of qualified health information technology by such health care providers; (B) the clinical utility of HIT by such health care providers; (C) whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology; (D) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act, Medicare or Medicaid, or otherwise; (E) the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and (F) any other issues the Secretary deems to be appropriate. The Secretary would submit a report to Congress on the findings and conclusions of the study by June 30, 2010.

Part II—Medicaid Funding

Medicaid Provider EHR Adoption and Operation Payments; Implementation Funding

The Chairman's Mark would amend Title XIX of the Social Security Act to authorize a 100 percent Federal match for a portion of payments attributable for certified electronic health records (EHR) technology (including support services and maintenance) to certain Medicaid providers who meet certain requirements. The state must provide assurances to the Secretary that all allowable costs are paid directly to the provider without any deduction or rebate; the provider is responsible for payment of the EHR technology costs not provided for; and, that for costs not associated with purchase and initial implementation, the provider certifies meaningful use of the EHR technology. Finally,

the certified EHR technology should be compatible with state or Federal administrative management systems.

Eligible providers would include physicians, nurse mid-wives, and nurse practitioners who are not hospital-based and that have at least 30 percent of their patient volume made up of Medicaid patients. In order to qualify as a Medicaid provider, the professional would have to waive any right to Medicare EHR incentive payments for professionals detailed in Section 4311. This group of providers would be eligible for a payment equal to 85 percent of their net allowable technology costs. However, the allowable costs for the purchase and initial implementation of EHR technology cannot exceed $25,000 or include costs over a period of more than 5 years. Annual allowable costs not associated with initial implementation or purchase of the EHR technology could not exceed $10,000 per annum or be made over a period of more than 5 years. Aggregate allowable costs for these eligible professionals could not exceed $75,000.

Eligible providers would also include acute care hospitals that have at least 10 percent of their patient volume attributable to Medicaid patients and children's hospitals. For these providers, incentive payment limitations would be calculated based on the Medicare incentive payment formula (described in Section 4312), with some modifications. These modifications include calculating the Medicaid share (in lieu of the Medicare share). To do so, the numerator in the Medicare share component of the incentive formula would equal Medicaid inpatient days. Incentive payments would be available for four years and would be made available to the state in year one to distribute to eligible professionals as the state deems appropriate. After the first payment year, the Secretary should assume that Medicaid discharges increase at an annual rate of growth reflective of the most recent three years for which discharge data are available. The calculations for acute care hospitals and children's hospitals should also take into account Medicaid managed care beneficiaries, as well as other Medicaid beneficiaries.

Rural health clinics and Federally-Qualified Health Centers that have at least 30 percent of their patient volume attributable to Medicaid patients would also be eligible for a payment equal to not less than 85 percent of their net allowable technology costs. Payments to these eligible providers would be subject to aggregate or annual limitations established by the Secretary.

The Secretary shall ensure coordination of the different programs for health information technology between providers, as well as payments provided under Medicare or Medicaid to assure no duplication of funding. The Secretary should attempt to avoid duplicative requirements for Federal and state governments to demonstrate meaningful use of EHR technology under Medicaid or Medicare.

The Chairman's Mark would authorize a 90 percent Federal match for payment to the states for administrative expenses related to EHR technology payments. In order for a state to receive the match it must show that: it is using the funds provided for these purposes to administer these systems including tracking of meaningful use by providers; conducting adequate oversight of meaningful use of the systems; and pursuing initiatives

to encourage the adoption of certified EHR technology to promote health care quality and the appropriate exchange of information. In determining meaningful use, including through the electronic reporting of clinical quality measure, states shall ensure that populations with unique needs, such as children, are appropriately addressed.

The Chairman's Mark would further require that the Secretary shall periodically submit reports to the House Committee on Energy and Commerce and the Senate Finance Committee on the status, progress and oversight of payments to Medicaid providers for EHR technology adoption and operation.

The Chairman's Mark would appropriate $40 million for each of fiscal years 2009 through 2015 and $20 million for each succeeding fiscal year through 2019 for these payments.

Senate Appropriations Committee

Although specifics of the Senate Appropriations Committee's legislation have not been released, the Committee released a summary of the legislation. In addition, the Committee indicates that $5 billion will be included in the legislation for health IT.

As cited in their summary of the legislation, the Committee includes health IT provisions within Title XIII of the legislation. Specifically, the Committee authorizes the HITECH Act, as also referenced in House legislation. The legislation encourages the development of standards for health IT through codifying the role of the National Coordinator for Health Information Technology in coordinating initiatives on health IT, establishing the HIT Standards Committee and the HIT Policy Committee. The legislation also encourages the adoption of health IT that meets standards for interoperability by providing enhanced support for short-term, high-value investments in current initiatives to pilot test the best ways to use health IT, establishing a health IT extension program to provide assistance to healthcare providers to effectively use health IT, providing planning and implementation grants to States to facilitate and expand the electronic exchange of health information according to recognized standards, and providing grants to States and Indian tribes.

According to the Committee, the legislation also aims to ensure privacy protections for electronic health information. The legislation applies privacy protections under HIPAA to business associates of covered entities, requiring notification of patients if the privacy of their medical information has been breached, requiring accounting for disclosures of health information made through health IT systems, prohibiting the sale of patients' private health information without their consent, and prohibiting the use of private medical information for marketing without the consent of patients.

HIMSS Comments

HIMSS Government Relations will continue to provide HIMSS members with the most up-to-date information concerning the inclusion of health IT in the American Recovery

and Reinvestment Act of 2009. A copy of a letter from HIMSS' President and CEO to Congressional leaders concerning HIMSS' recommendations for health IT in economic stimulus legislation can be accessed at: Letter to Chairman Baucus and Ranking Member Grassley, Senate Finance Committee. For more information, contact the HIMSS Government Relations team.