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Details for: MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY: TITLE IV OF THE AMERICAN RECOVERY AND REINVESTMENT ACT

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MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY: TITLE IV OF THE AMERICAN RECOVERY AND REINVESTMENT ACT

Background

On Feb. 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (Recovery Act), a critical measure to stimulate the economy. Among other provisions, the new law provides major opportunities for the Department of Health and Human Services (DHHS), its partner agencies, and the States to improve the nation's health care through health information technology (HIT) by promoting the meaningful use of electronic health records (EHR) via incentives. For a copy of the full bill, go to: http://www.hhs.gov/recovery/overview/index.html

The HIT provisions of the Recovery Act are found primarily in Title XIII, Division A, Health Information Technology, and in Title IV of Division B, Medicare and Medicaid Health Information Technology. These titles together are cited as the Health Information Technology for Economic and Clinical Health Act or the HITECH Act. This fact sheet focuses on the provisions of Title IV only.

Funding

Under Title IV, funding is available to certain eligible professionals (EPs) and hospitals, as described below. Funds will be distributed through Medicare and Medicaid incentive payments to EPs, physicians, and hospitals who are "meaningful EHR users." In addition, with regard to the Medicaid program, federal matching funds are also available to States to support their administrative costs associated with these provisions.

Criteria for Qualifying for an Incentive

The qualification criteria for incentives (i.e., meeting specified HIT standards,

policies, implementation specifications, timeframes, and certification requirements) are still in development, and will be defined through regulation and additional guidance materials. However, CMS generally expects that under Medicare, "meaningful EHR users" would demonstrate each of the following: meaningful use of a certified EHR, the electronic exchange of health information to improve the quality of health care, and reporting on clinical quality and other measures using certified EHR technology. Medicaid programs will determine their own requirements in line with the Medicaid-related provisions of the Recovery Act. Funds will be distributed through Medicare and Medicaid incentive payments to EPs and hospitals who are "meaningful EHR users." CMS intends to publish a proposed rule in late 2009 to propose a definition of meaningful use of certified Electronic Health Records (EHR) technology and establish criteria for the incentives programs. CMS is working extensively with the Office of the National Coordinator for Health Information Technology (ONC) to identify the proposed criteria.

Medicare Payment Incentives for Eligible Professionals

- The Recovery Act establishes financial incentives beginning in January 2011 for eligible professionals (EPs) who are meaningful EHR users. Beginning in 2015, payment adjustments will be imposed on EPs who are not meaningful EHR users.
- Hospital-based physicians who substantially furnish their services in a hospital setting are not eligible.
- Incentive Payments
- The incentive payment is equal to 75 percent of Medicare allowable charges for covered services furnished by the EP in a year, subject to a maximum payment in the first, second, third, fourth, and fifth years of $15,000; $12,000; $8,000; $4000; and $2,000, respectively. For early adopters whose first payment year is 2011 or 2012, the maximum payment is $18,000 in the first year.
- There will be no payments for meaningful EHR use after 2016.
- There would be no payments to EPs who first become meaningful EHR users in 2015 or thereafter.
- For EPs who predominantly furnish services in a health professional shortage area (HPSA), incentive payments would be increased by 10 percent.

- Payment Adjustments
  - The Medicare fee schedule amount for professional services provided by an EP who was not a meaningful EHR user for the year would be reduced by 1 percent in 2015, by 2 percent in 2016, by 3 percent for 2017 and by between 3 to 5 percent in subsequent years.
  - For 2018 and thereafter, if the Secretary finds that the proportion of EPs who are meaningful EHR users is less than 75 percent, then the reductions will be increased by 1 percentage point each year, but by not more than 5 percent overall.

Medicare Payment Incentives for Hospitals

- Incentive payments are provided, beginning with October 2010, for eligible subsection (d) hospitals and critical access hospitals (CAHs) that are meaningful EHR users. Reduced payment updates beginning in FY 2015 will apply to eligible hospitals that are not meaningful EHR users.
- An eligible hospital that is a meaningful EHR user could receive up to four

years of financial incentives payments, beginning with fiscal year 2011. There will be no payments to hospitals that become meaningful EHR users after 2015.

- Incentive Payments for Hospitals
  - The incentive payment for each eligible hospital would be calculated based on the product of (1) an initial amount, (2) the Medicare share, and (3) a transition factor.

(a)The initial amount is the sum of a $2 million base year amount plus a dollar amount based on the number of discharges for each eligible hospital.

(b)The Medicare share is a fraction based on estimated Medicare fee-for-service and managed care inpatient bed days divided by estimated total inpatient bed-days and modified by charges for charity care.

(c)The transition factor phases down the incentive payments over the four-year period. The factor equals 1 for the first payment year, ¾ for the second payment year, ½ for the third payment year, and ¼ for the fourth payment year, and zero thereafter.

The Secretary has discretion to use other data if the required data to calculate the incentive payment formula does not exist.

- The transition factor is modified for those eligible hospitals that first become meaningful EHR users beginning in 2014. Such hospitals would receive payments as if they became meaningful EHR users beginning in 2013 (i.e., if a hospital were to begin EHR meaningful use in 2014, the transition factor used for the year would be ¾ instead of 1, ½ for the second year, ¼ for the third year, and zero thereafter).
- o For CAHs that are meaningful EHR users, reasonable costs for the purchase of certified EHR technology would be computed by expensing such costs in a single payment year, rather than depreciating them over time. In addition, incentive payments for CAHs would be based on the Medicare share formula used for subsection (d) hospitals, plus 20 percentage points (not to exceed a total of 100 percent). CAHs would receive a prompt interim payment for the Medicare share of such costs (subject to reconciliation). Payments would not be made with respect to a cost reporting period beginning during a payment year after 2015, and in no case would a CAH receive payment with respect to more than 4 consecutive payment years.
- Market Basket Adjustments for Hospitals that are not Meaningful Users
  - Eligible subsection (d) hospitals that are not meaningful users for a fiscal year would receive a net reduction of ¼, ½, and ¾ of the market basket update that would apply in 2015, 2016, 2017 and thereafter, respectively.
  - The Secretary of HHS may, on a case-by-case basis, exempt a hospital if requiring the hospital to be a meaningful EHR user would result in a significant hardship.
  - Eligible CAHs that are not meaningful EHR users for a fiscal year and otherwise would be paid at 101 percent of reasonable costs are subject to the following payment adjustments: in FY2015, reimbursement for inpatient services at 100.66 percent of reasonable costs; in FY2016, reimbursement for inpatient services at 100.33 percent of reasonable costs; and in FY2017 and each subsequent year, 100 percent of reasonable costs.

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Medicaid Payment Incentives

The Recovery Act establishes 100 percent Federal Financial Participation (FFP) for States to provide incentive payments to eligible Medicaid providers to purchase,

implement, and operate (including support services and training for staff) certified EHR technology. It also establishes 90 percent FFP for State administrative expenses related to carrying out this provision.

Incentive Payments to Providers

- Certain classes of Medicaid professionals and hospitals are eligible for incentive payments to encourage the adoption and use of certified EHR technology. Eligible professionals include physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who are practicing in Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) led by a physician assistant.
- Eligible professionals must meet minimum Medicaid patient volume percentages, and must waive rights to duplicative Medicare EHR incentive payments. Eligible professionals may receive up to 85 percent of the net average allowable costs for certified EHR technology, including support and training (determined on the basis of studies that the Secretary will undertake), up to a maximum level, and incentive payments are available for no more than a 6-year period.
- Acute care hospitals with at least 10 percent Medicaid patient volume would also be eligible for payments, as would children's hospitals of any patient volume. Entities that promote the adoption of certified EHR technology, as designated by the State, are also eligible to receive incentive payments through arrangements with eligible professionals under certain conditions.

Medicaid Incentive Program Qualifications

To be eligible for incentive payments not associated with the initial adoption/implementation/upgrade of EHR technology, the provider must demonstrate meaningful use of the EHR technology through a means approved by the State and acceptable to the Secretary. In determining what is "meaningful use," a State must ensure that populations with unique needs, such as children, are addressed. A State may also require providers to report clinical quality measures as part of the meaningful use demonstration. In addition, to the extent specified by the Secretary, the EHR technology must be compatible with State or Federal administrative management systems.

EPs may not receive an incentive under both Medicare and Medicaid in a given year. CMS and the States will develop means to prevent such duplicate payments. CMS expects that the prevention of duplicative payments will be addressed more fully through notice and comment rulemaking.

Frequently Asked Questions (FAQs)

Question: When will the Centers for Medicare & Medicaid Services (CMS) publish regulations to define certified Electronic Health Records and "meaningful use?"

Answer: CMS intends to publish a proposed rule in late 2009 to define meaningful use of certified Electronic Health Records (EHR) technology and establish criteria for the incentives programs. We are working extensively with the Office of the National Coordinator for Health Information Technology(ONC) to identify the proposed criteria.

Question: What is CMS' overall time frame for actions and activities related to the incentive program?

Answer: Although further details will be developed, CMS can provide the following timeline based on the current implementation plan:

Date	**Milestone**
2009	• Coordinate with ONC to develop policies such as the definition of meaningful use • Develop proposed rules to allow public input to the incentive program policies • Plan systems and other requirements needed to support the incentives programs • Plan national outreach program
2010	• Conduct outreach to eligible professionals and providers and to State Medicaid Agencies • Develop systems to support the payment of incentives • Develop final rules to establish policies needed to pay incentives • Develop systems to monitor and evaluate incentive payments
No sooner than October 2010	Start to pay hospital incentives for Medicare and monitor payments
No sooner than January 2011	• Start to pay eligible professionals for Medicare and monitor payments • Begin and monitor Medicaid incentive payments to eligible professionals and hospitals
2011 - 2016	Continue paying hospital incentives for Medicare and monitor payments
2011 – 2016	Continue paying eligible professionals incentives for Medicare and monitor payments
2011 - 2021	Continue paying Medicaid incentives to eligible professionals and hospitals and monitor payments
2015 and thereafter	Initiate payment reductions to Medicare hospitals and eligible professionals that fail to adopt EHRs

Question: When will the Centers for Medicare & Medicaid Services (CMS) begin to pay incentives to eligible professionals and hospitals for using certified Electronic Health Records (EHRs)?

Answer: By statute, the earliest dates that CMS will be able to pay an incentive under Medicare is October 1, 2010, for hospitals and January 1, 2011, for eligible professionals.

The statute does not define a date for the Medicaid incentives program. Given the range of regulatory and planning activities that must precede States being able to make provider incentive payments, as well as the importance of coordinating

Medicaid and Medicare payments to prevent duplication, CMS does not expect that States will be able to make such payments until 2011.

Work is underway to define the meaningful EHR user criteria, as well as the requirements for applying for and receiving the EHR payment incentives, CMS expects to issue a proposed rule in late 2009.

Question: If an eligible professional uses a certified Electronic Health Record (EHR) in a meaningful way in accordance with the adopted regulations, and meets the requirements established by CMS, could that professional receive both the Medicare EHR payment incentive as well as the Medicaid EHR payment incentive?

Answer: No, an eligible professional may only receive an EHR payment under either Medicare or Medicaid. CMS expects to more fully address the issue of duplicative payments under Medicare and Medicaid through rulemaking.

Question: If I already have an Electronic Health Record (EHR) that has been certified by the Certification Commission for Healthcare Information Technology (CCHIT), will I have to buy a new system if the government mandates that only EHRs that meet a higher certification level are considered certified EHRs?

Answer: Decisions about EHR standards, implementation specifications and certification criteria have not been made yet, and are under development. Policies will be proposed in the regulation to be published in late 2009.

Question: What is the maximum incentive an eligible professional can earn for using an Electronic Health Record under Medicaid?

Answer: The statute does not define fixed amounts for the incentive payments, only ceilings that cannot be exceeded. CMS expects that the actual payment amounts will be more fully addressed through notice and comment rulemaking.

Question: What is the maximum Electronic Health Record(EHR) incentive an eligible professional can earn under Medicare?

Answer: Eligible professionals(EPs), who adopt Electronic Health Records as early as 2011 or 2012 may be eligible for up to $44,000 in Medicare incentive payments spread out over five years (increased by 10 percent for EPs who predominantly furnish services in a health professional shortage area).

Question: What if my Electronic Health Record (EHR) system costs much more than the incentive the government will pay? May I request additional funds?

Answer: The Recovery Act does not provide for incentive payments under Medicare or Medicaid beyond the limits established by the legislation, regardless of the cost of the EHR system chosen by eligible professionals or hospitals. With regard to Medicaid, the purpose of the 100 percent FFP provider incentive payments to certain eligible Medicaid providers is to encourage the adoption and meaningful use of certified EHR technology. While the incentive payments are expected to be used for certified EHR technology and support services, including maintenance and training necessary for the adoption and operation of such technology, the incentive payments are not direct reimbursement for such activities, but rather are intended to serve as an incentive for eligible professionals and hospitals to adopt and meaningfully use certified EHR technology

Question: What is the earliest date the payment adjustments will start to be imposed for eligible professionals and hospitals that are not meaningful Electronic Health Record (EHR) users under the HITECH provisions of the Recovery Act?

Answer: The HITECH provisions of the Recovery Act establish 2015 as the first year that payment adjustments will start to be imposed on Medicare eligible professionals and hospitals that are not meaningful EHR users. There are no payment adjustments associated with the Medicaid provisions under Section 4201.

Question: How will eligible providers and hospitals apply for incentives if they are using certified Electronic Health Records (EHRs) in accordance with the standards established by Health and Human Services (HHS) under the HITECH portion of the Recovery Act?

Answer: The Department of Health and Human Services (HHS) will publish a rule establishing the criteria which eligible professionals and hospitals must meet in order to qualify for the EHR incentive payments, including defining meaningful EHR users. The rule will also explain how to apply for those incentives.

Question: How will the public know who has received incentive payments under the Recovery Act?

Answer: CMS will post the names of those receiving Medicare incentives online. The list will include the elements identified in the Recovery Act: name, business addresses, and business phone number of all Medicare eligible professionals and hospitals who received incentive payments under the Recovery Act. There is no such requirement for CMS to publish the names of those receiving Medicaid incentive payments under Section 4201 though States may opt do so.

Question: What will be done to help prepare providers to take advantage of the incentive payments for the meaningful use of an Electronic Health Record (EHR)?

Answer: A set of supportive programs will be announced after CMS publishes a proposed rule in late 2009, that is, regarding a definition of meaningful use of certified EHR technology and criteria for the incentives programs. These programs are intended to educate and support providers, enable health information exchange, and build the workforce that will be needed for success. Information about these supportive efforts will be communicated to eligible providers through many channels.

For additional information, visit http://www.cms.hhs.gov/Recovery/

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Meaningful Use

The nation's healthcare system is undergoing a transformation in an effort to improve quality, safety and efficiency of care from the upgrade to ICD-10 to information exchanges of EHR technology. The Medicare and Medicaid EHR incentive programs are designed to support providers in this period of transition, but the impact of this historic change on both providers and patients will stretch far beyond the duration of these programs.

The Medicare and Medicaid EHR incentive programs provide a financial reward for the meaningful use of qualified, certified EHRs to achieve health and efficiency goals. By implementing and meaningfully using an EHR system, providers will reap benefits beyond financial incentives - like reduction in errors, availability of records and data, reminders and alerts, clinical decision support and e-Prescribing/refill automation.

To qualify for incentive payments, meaningful use requirements must be met in the following ways:

- Medicare EHR incentive program - Eligible professionals and hospitals must successfully demonstrate meaningful use of certified electronic health record technology every year they participate in the program.
- Medicaid EHR incentive program - Eligible professionals and hospitals may qualify for incentive payments for the adoption, implementation, upgrade or the demonstration of meaningful use in their first year of participation. They must successfully demonstrate meaningful use for the remaining years they participate in the program.

The Definition of Meaningful Use Requirements
The requirements of meaningful use to qualify for incentive payments was released on July 13, 2010. The final rule definitively outlines all the specifics of Stage 1 meaningful use and clinical quality measure reporting to receive the incentive payments in 2011 and 2012.

The Recovery Act specifies three main components of Meaningful Use:

- The use of a certified EHR in a meaningful manner (e.g.: e-Prescribing);
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care; and
- The use of certified EHR technology to submit clinical quality and other measures.

The definition of meaningful use harmonizes criteria across CMS programs as much as possible and coordinate with existing CMS quality initiatives. It also closely links to the certification standards criteria in development by the Office of the National Coordinator (ONC) and provides a platform for a staged implementation over time.

Specifics of Stage 1 Meaningful Use (2011 and 2012)
Meaningful use includes both a core set and a menu set of objectives that are specific for eligible professionals and hospitals. For Eligible Professionals, there are a total of 25 meaningful use objectives. 20 of the objectives must be completed to qualify for an incentive payment. 15 are core objectives that are required, and the remaining 5 objectives may be chosen from the list of 10 menu set objectives. For Hospitals, there are a total of 24 meaningful use objectives. 14 are core objectives that are required, and the remaining 5 objectives may be chosen from the list of 10 menu set objectives.

The definition of meaningful use includes reporting of clinical quality measures. See the link titled "Meaningful Use Clinical Quality Measures" in the Links Inside CMS section below to learn more about these specifications for eligible professionals and hospitals. More information on the final rule and fact sheets regarding meaningful use are available below.

To realize improved health care quality, efficiency and patient safety, the criteria for meaningful use will be staged in three steps over the course of the next five years. Stage 1 sets the baseline for electronic data capture and information sharing. Stage 2 (est. 2013) and Stage 3 (est. 2015) will continue to expand on this baseline and be developed through future rule making.

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HEALTH PRIVACY IN THE ELECTRONIC AGE

Mark A. Rothstein, J.D.*

INTRODUCTION

Health care expenditure in the United States exceeds $2 trillion a year,[1] and on a per capita basis far exceeds the expenditure of any other country.[2] Much of this money is not well spent, as many studies have documented the inefficiency and waste in the public and private health care systems.[3] Furthermore, despite the high cost of American health care, key measures of the nation's health, such as infant mortality[4] and life expectancy,[5] lag well behind other developed countries.

One assumed method of increasing efficiency and improving outcomes is to expand and improve the use of health information technology, including the universal adoption of electronic health records (EHRs).[6] Supporters of EHRs assert that they avoid duplication of history taking and tests, promote coordination of care, reduce medical errors, ensure access to records from

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* Herbert F. Boehl Chair of Law and Medicine and Director, Institute for Bioethics, Health Policy and Law, University of Louisville School of Medicine. This article is based on a speech given March 21, 2007 at Southern Illinois University School of Law as the John and Marsha Ryan Bioethicist-in-Residence. The author is Chair of the Subcommittee on Privacy and Confidentiality of the National Committee on Vital and Health Statistics, which is referenced in the article. The views expressed herein are solely those of the author.

[1] Christine Borger et al., *Health Spending Projections Through 2015: Changes on the Horizon*, 25 HEALTH AFFAIRS WEB EXCLUSIVE 2, w61 (Mar./Apr. 2006), *available at* http://content.healthaffairs.org/cgi/reprint/25/2/w61 (last accessed June 1, 2007) (estimating 2006 expenditures at $2.16 trillion).

[2] UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH, UNITED STATES, 2006 WITH CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 373 (National Center for Health Statistics 2006).

[3] *See generally* DAVID M. CUTLER, YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA'S HEALTH CARE SYSTEM (2004); MAGGIE MAHAR, MONEY-DRIVEN MEDICINE: THE REAL REASON HEALTH CARE COSTS SO MUCH (2006).

[4] DEPARTMENT OF HEALTH AND HUMAN SERVICES, *supra* note 2, at 173 (ranking the United States twenty-eighth in infant mortality).

[5] *Id.* at 174 (ranking the United States twenty-sixth in life expectancy).

[6] *See* NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS, INFORMATION FOR HEALTH: A STRATEGY FOR BUILDING THE NATIONAL HEALTH INFORMATION INFRASTRUCTURE (Nov. 2001), *available at* http://www.ncvhs.hhs.gov/nhilayo.pdf (last accessed June 2, 2007).