April 2009

Health Information Technology Provisions in the Recovery Act

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The following is an overview of the health information technology (HIT) provisions in H.R. 1, the American Recovery and Reinvestment Act of 2009 (ARRA, or Recovery Act), which President Obama signed into law on February 17, 2009. This document reviews potential funding sources and key decision makers for HIT at the Department of Health and Human Services (HHS) and its agencies. This overview highlights the HIT incentive payments, which are the largest piece of HIT funding in the Recovery Act, how various provisions of the HIT provisions are to be implemented, when they are required or expected to happen, and who the key players will be in the process.

Background on the Recovery Act

- The American Recovery and Reinvestment Act establishes a national framework for developing a nationwide electronic exchange and the development of uniform, interoperable standards for the use of HIT. The HIT provisions of ARRA are found primarily in Division A, the Health Information Technology for Economic and Clinical Health Act (HITECH), and in Title IV of Division B, Medicare and Medicaid Health Information Technology.
- From the total $19.2 billion devoted to HIT adoption, the Office of National Coordinator for HIT (ONCHIT) will receive $2 billion and the Centers for Medicare & Medicaid Services (CMS) will receive approximately $17 billion.
- Other ARRA funds distributed among the HHS agencies which may impact HIT infrastructure include: $10 billion to the National Institutes of Health (NIH) for biomedical research and to improve facilities, $2.5 billion to the Health Resources and Services Administration (HRSA), $1.1 billion to the Agency for Health Research and Quality (AHRQ) for comparative effectiveness research, $1 billion to the Public Health Service for prevention and wellness, and $85 million to the Indian Health Services (IHS).

Additionally, the Veterans Administration, the Department of Defense, and the Social Security Administration will receive funds that could involve and impact the implementation of HIT.

Incentive Payments

A major component of the new national HIT strategy enacted by ARRA, and one of the most significant efforts being made to change the health care system, is the estimated $17 billion in incentive payments created for the adoption of electronic health records (EHRs).

- These incentive payments may include investments in hospital, physician practices, public health infrastructure for EHRs, and telemedicine to ensure interoperability of the new technologies. The $17 billion in incentive payment funds directed to CMS are particularly for certified "meaningful EHR users" and are to begin in 2011. Key to the distribution of these incentive payments will be the way in which regulations further define and clarify the "meaningful user" requirements. Medicare payment rules for fiscal year 2011 will start being drafted in February of 2010 (for the Hospital Inpatient Prospective Payment System) and April of 2010 (for physicians).

- ARRA also imposes penalties on those who do not meet the requirements by the required dates. Physicians lacking certified HIT systems face -1% in 2015, -2% in 2016, and -3% in 2017 penalties, with Secretarial authority for beyond 2019. For hospitals, the market basket update is reduced for any eligible hospital that does not "meaningfully use" EHRs by FY2015. The Secretary may provide a time-limited exemption from the payment reduction to professionals who demonstrate a significant hardship in meeting the meaningful use criteria.

Implementation of HIT Recovery Act Provisions

Another major component of ARRA's HIT provisions is the restructuring and expansion of the federal role in promoting and implementing HIT. In particular, ARRA codifies the Office of National Coordinator for HIT (ONCHIT), establishes the federal role in HIT policy development through federal advisory committees, and it creates the structure and process for developing and implementing official HIT standards and specifications.

- **ONCHIT** is to develop a nationwide HIT infrastructure through the development of standards and certification criteria and coordination of HIT policies through a federal HIT strategic plan. In addition, ONCHIT is required to coordinate with the National Institute of Standards and Technology (NIST) to develop a program to certify HIT as being compliant with the endorsed standards.

- **The HIT Policy Committee** will be established as a federal advisory committee and will make recommendations to the National Coordinator relating to the implementation of a nationwide HIT infrastructure. The Policy Committee will recommend areas in which standards, implementation specifications and certification criteria are needed for the electronic exchange and use of HIT. The GAO is required to appoint 13 of 20 members to the HIT Policy Committee no later than April 3, 2009, and appointments are to be made in a variety of categories to ensure diverse representation.[1]

- **The HIT Standards Committee** will be established as a second federal advisory committee to recommend standards, implementation specifications and certification criteria for the electronic exchange and use of HIT in accordance with policies developed by the HIT Policy Committee. The Secretary will

[1] Members are required to represent the following: patients or consumers; health care providers, one of whom is a physician; labor organization representing health care workers; expertise in health information privacy and security; expertise in improving the health of vulnerable populations; research community; health plans or other third-party payers; information technology vendors; purchasers or employers; and expertise in health care quality measurement and reporting.

appoint members to this committee to reflect designated stakeholders.[2] The Standards Committee is required to conduct open public meetings and to develop a process for public comment.

    - Both the HIT Policy and HIT Standards Committees are to serve as forums for stakeholders to participate and provide input on the development, harmonization and recognition of standards necessary for the development and adoption of HIT nationwide.

- **Certification** is a critical component to the implementation of ARRA's HIT provisions. Certified EHR technology means that it qualifies as meeting standards adopted for that particular record. See timeline below for further explanation of the dates and process for adoption of HIT standards and recommendations.

Timeline for Implementation

ARRA sets out a number of dates and deadlines for the HIT provisions, such as the establishment of programs and standards, appointment of committee members and officers, publishing of rules, implementation of regulations, and submission of reports to Congress. Some key dates and deadlines are listed below.

- By April 3, 2009, HIT Policy Committee members are to be appointed by specified officials authorized under ARRA. If after this date, the officials have not appointed the full number of members, the Secretary may appoint such members to the Committee.

- By May 18, 2009, HIT Standards Committee is to develop a schedule for the assessment of policy recommendations received from the HIT Policy Committee.

[2] These stakeholder areas include: 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, and on the electronic exchange and use of health information.

- By Dec. 31, 2009, HHS must adopt an initial set of standards through the notice and comment rule-making process regarding the areas that the HIT Policy Committee should address. Already approved standards, such as those established by the Certification Commission for Healthcare Information Technology (CCHIT) or by the Healthcare Information Technology Standards Panel (HITSP), may be used to meet the requirement.

- Within 90 days of the receipt of standards, the HHS Secretary, "in consultation with representatives of other relevant Federal agencies, shall jointly review such standards, implementation specifications, or certification criteria and shall determine whether or not to propose adoption of such standards, implementation specifications, or certification criteria."

- January 1, 2010 is the earliest date on which the Secretary may make an award to eligible entities under Sec. 3014, Competitive Grants to States and Indian Tribes for the Development of Loan Programs to Facilitate the Widespread Adoption of Certified EHR Technology.

- By February 16, 2010, the national coordinator is to submit a report to Congress regarding the need for any additional funding or authority for the National Coordinator, HIT Policy and HIT Standards Committees.

Key Players

There will be key players in each of the agencies of HHS overseeing the process of implementing these HIT provisions. Below is a brief summary of several key players and positions.

Office of the Secretary: Current advisors include Rima Cohen and Dr. Dora Hughes. Additional appointments and decisions on how to utilize advisors, however, will likely be made by Governor Sebelius after her confirmation as HHS Secretary. The Assistant Secretary for Planning and Evaluation is likely to play an important role as will the Assistant Secretary for Resources and Technology (ASRT), who is responsible for the budget for the Department and for spending Agency funds. Richard Turman is currently the Acting ASRT.

Office of the National Coordinator for HIT (ONCHIT):
David Blumenthal, M.D. was recently named the National Coordinator of HIT. Current key career staff includes Jodi Daniel. ONCHIT will play a lead role in the Department in terms of the HIT initiative as it will oversee interoperability standards.

Centers for Medicare & Medicaid Services (CMS):
Charlene Frizzera is the Acting Administrator. The Administrator and Deputy Administrator are expected to be announced in April.

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Regarded as one of the top food and drug lawyers in Washington, Paul Kim draws on his extensive governmental experience to advise clients on legal, legislative and regulatory issues in food, drug and device law, Medicare and Medicaid coverage and reimbursement, and the conduct of clinical research. He represents leading biotechnology, pharmaceutical and medical device companies before the Food and Drug Administration (FDA), the Centers for Medicare and Medicaid Services (CMS), and Congress.

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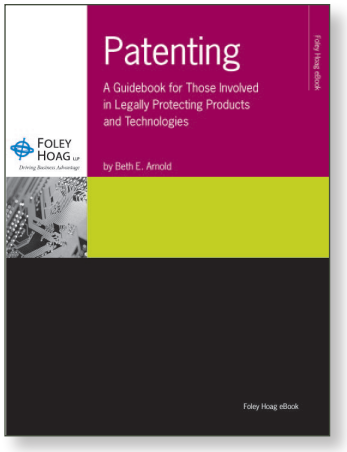

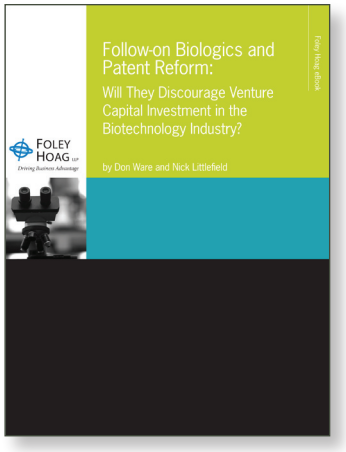

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