

Health Information Technology Provisions in the American Recovery & Reinvestment Act

The American Recovery & Reinvestment Act, signed into law on February 16, 2009, contains provisions which create various financial incentives for health care providers to support the adoption and sustained utilization of health information technology (HIT). The following summary provides detailed information on the grant programs available to states to encourage providers to adopt HIT, as well as Medicare and Medicaid incentive payments to providers for the useful utilization of HIT. Questions? Email Mohini Venkatesh at mohiniv@thenationalcouncil.org.

Note that there are separate fact sheets for the [Medicaid](#) and [Other Key Provisions](#) of the ARRA on our policy page.

FUNDING & ASSISTANCE TO STATES AND HEALTH CARE PROVIDERS (Approx. \$2 Billion)

Sec. 3000 states that the term ‘health care provider’ includes a hospital, skilled nursing facility, nursing facility, home health entity or other long term care facility, health care clinic, community mental health center (as defined in section 1913(b)(1))¹,... federally qualified health center (FQHC), group practice, a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act)², a practitioner (as described in section 1842(b)(18)(C) of the Social Security Act)³,...a rural health clinic...and any other category of health care facility, entity, practitioner, or clinician determined appropriate by the Secretary.

Sec. 3000 allows health care providers to be eligible for the following:

Sec. 3012 states that the Office of the National Coordinator for Health Information Technology and the Secretary will establish several programs to advance the widespread adoption of certified HIT technology:

- The National Coordinator will create a HIT extension program to help health care providers to adopt, implement, and effectively use certified electronic health records (EHR) technology.
- The Secretary will create a Health Information Technology Research Center to provide technical assistance and develop/recognize best practices for the adoption of HIT.

¹ Sec. 1913(b)(1) of the Public Health Service Act: “services under the plan will be provided only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs”.

² Section 1861(r) of the Social Security Act: The term physician...means 1) a doctor of medicine or osteopathy, 2) a doctor of dental surgery or medicine, 3) a doctor of podiatric medicine, 4) a doctor of optometry, 5) a chiropractor.

³ Section 1842(b)(18)(C) of the Social Security Act: A practitioner...is any of the following: 1) a physician assistant, nurse practitioner, or clinical nurse specialist, 2) a certified nurse-midwife, 3) a clinical social worker, 4) a clinical psychologist, 5) a registered dietitian or nutrition professional.

- The Secretary will support the creation of regional centers to provide technical assistance and play a primary role in disseminating best practices learned from the Health Information Technology Research Center. These regional centers should be 1) affiliated to any “U.S.-based nonprofit institution or organization” that applies and is awarded financial assistance and 2) willing to provide technical assistance to all providers in a region (but should prioritize assistance to public/nonprofit hospitals or critical access hospitals, FQHCs, entities located in rural and other areas that serve under/uninsured, individual/small group practices that are focused on primary care.
 - These regional centers may receive financial support for no more 4 years, not to exceed 50% of the capital and annual operating and maintenance funds required to create/maintain the regional center.
 - Within 90 days of enactment, the Secretary must publish in the Federal Register a description of the program to establish regional centers.

Sec. 3013 allows the Secretary to award planning and implementation grants to States/qualified State-designated entities that apply for funding. Such grants are to be used to facilitate and expand the use of HIT among organizations in the state.

- Qualified State-designated entities must be 1) designated by a State to be eligible to receive funds, 2) nonprofit with broad stakeholder representation on governing board, 3) demonstrate that one of its goals is to use HIT to improve quality and efficiency, 4) adopt nondiscrimination and conflict of interest policies that demonstrate commitment to nondiscriminatory participation by stakeholders.
- In carrying out its activities, a State/entity must consider recommendations of health care providers and other entities.
- The Secretary will annually evaluate the activities of the grantee-States/entities and will implement lessons learned such that grants awarded post-evaluation take lessons learned into consideration.
- State must make non-federal contributions available towards the cost of a grant awarded. For FY 2011, State must put no less than \$1 for each \$10 of federal funds, FY 2012, no less than \$1 for every \$7 of federal funds, FY 2013, no less than \$1 for each \$3 of federal funds. For years prior to FY2011, the Secretary may determine the match.

Sec. 3014 allows Secretary to award competitive grants to a State or Indian tribe to establish a HIT loan fund for providers who intend to implement and maintain certified EHR technology. State/entity must be willing to match funds. These awards may not be given before January 1, 2010.

Sec. 3015 allows Secretary to award grants to entities (including graduate programs in behavioral or mental health and other graduate health professions schools) who wish to carry out demonstration projects to develop academic curricula that incorporates EHR technology in the education of health professionals.

Sec. 3016 states that the Secretary may require that entities receiving assistance through the above grant provisions submit to the Secretary, no later than 1 year after first receiving assistance, a report that includes an analysis of the effectiveness of activities being conducted with grant funds and an analysis of the impact of the project on health care quality and safety.

Sec. 3018 authorizes, for the purposes of carrying out Sections 3012-3015, for appropriation as much funding as may be necessary for each of FY09-13. (**Sec. 3011** establishes that this funding will be invested in various agencies with appropriate expertise; naming the National Coordinator, HRSA, AHRQ, CMS, CDC and IHS as such agencies).

INCENTIVE PAYMENTS (Approx. \$17 Billion)

Medicare

Sec. 4101 establishes Medicare incentive payments for meaningful use of certified Electronic Health Record (EHR) technology, beginning in 2011. “Eligible professional” is defined as a physician, as defined in Section 1861(r) of the Social Security Act: 1) a doctor of medicine or osteopathy, 2) a doctor of dental surgery or medicine, 3) a doctor of podiatric medicine, 4) a doctor of optometry, 5) a chiropractor.

Incentive Payments

- Incentive payments should equal 75% of allowed charges (based on submitted claims from eligible providers).
- Incentive payments should not exceed \$15,000 (1st yr), \$12,000 (2nd yr), \$8,000 (3rd yr), \$4,000 (4th yr), \$2,000 (5th yr), \$0 for subsequent years. Also identifies that the incentive payment for early adopters (first payment years are in 2011 or 2012) is increased to \$18,000.
- Eligible professionals must adopt EHR technology before 2015; otherwise, they will not receive an incentive payment.
- Beginning in 2015 and continuing in subsequent years, if an eligible provider is found to not be a meaningful EHR user for the previous year, the ARRA states that their incentive payments identified in the above schedule would be reduced to 99% in 2015, 98% in 2016, and 97% in 2017 and subsequent years.
- If, beginning in 2018 and each subsequent, the Secretary finds that less than 75% of eligible providers are meaningful EHR users, the ARRA identifies that the incentive payment for that schedule year will decrease by 1%, but should never be less than 95% of the incentive payment identified according to the schedule named above.
- Payments may be made to an eligible professional, the professional’s employer, or facility.

Payment Coordination

- In the case of an eligible professional who provides services in multiple practices, the Secretary must establish rules to coordinate incentive payments.
- The Secretary must make efforts to ensure that State and Federal requirements to demonstrate meaningful use of EHR technology for Medicare incentive payments is not duplicative of requirements for Medicaid incentive payments, and vice versa.

Medicaid

Sec. 4201 provides for Medicaid incentives for the adoption of health information technology, and details the eligibility standards for Medicaid incentive payments for the adoption of certified HIT technology. “Eligible

professional” defined as 1) a physician, 2) dentist, 3) certified nurse mid-wife, 4) nurse practitioner, 5) physician assistant practicing in a rural health clinic or FQHC.

Additional Eligibility Requirements

- A Medicaid provider **must meet one** of the following qualifications: 1) cannot be hospital-based⁴ and has a patient volume comprised of at least 30% Medicaid beneficiaries; 2) a pediatrician, who is not hospital-based, with a patient volume comprised of at least 20% Medicaid beneficiaries; 3) a children’s hospital or an acute-care hospital with a patient volume comprised of at least 10% Medicaid beneficiaries (Medicaid managed care included); 4) a federally-qualified health center (FQHC) or rural health clinic (RHC) which has a patient volume comprised of at least 30% Medicaid beneficiaries (Medicaid managed care included); AND
- Eligible providers must show meaningful usage of EHR technology (criteria established by State and accepted by Secretary).

Incentive Payments

- Payments for certified EHR technology are made by the State.
- Payments are to equal 85% of the net allowable costs of eligible Medicaid providers for such technology (and support services). Allowable costs for purchase and initial implementation of certified EHR technology (and maintenance/training costs) cannot exceed \$25,000 and must be paid no later than 2016. For other costs not previously mentioned that are related to the use of EHR technology, allowable costs are not to exceed \$10,000/year and cannot be disbursed after 2021 or for more than five years.
 - For pediatricians who qualify as an eligible provider, they may receive up to two-thirds the amount of these payments.

Payment Coordination

- The Secretary will ensure that eligible providers, who are also eligible for incentive payments through Medicare or other programs, are not receiving duplicate payments.
- The Secretary must make efforts to ensure that State and Federal requirements to demonstrate meaningful use of EHR technology for Medicaid incentive payments are not duplicative of requirements for Medicare incentive payments, and vice versa.

State Obligation

- In order for a State to receive federal participation in incentive payments, it must demonstrate that it is 1) using the funds for administering incentive payments for meaningful EHR usage, 2) conducting adequate oversight of the program, and 3) pursuing initiatives that encourage the adoption of certified EHR technology to promote health care quality.

⁴ Hospital-based professionals’ are defined as those that furnish a substantial amount of services in inpatient/outpatient hospital setting, or use hospital facilities or equipment