# "American Recovery and Reinvestment Plan (ARRP)" Highlights

**(1/29/09)**

The Stimulus package known as the American Recovery and Reinvestment Plan (ARRP), with approximately $20 billion for health IT, is rapidly making its way through the Congress. In the House last week, Appropriations, Ways and Means and Energy and Commerce Committees approved legislation consistent with their areas of jurisdiction. The full House voted January 28 along near party lines 244-188 to approve the $819 billion Stimulus package. Earlier this week, the Senate Appropriations and Finance Committees approved similar legislation. The funding level for health IT is approximately $3 billion higher in the Senate.

Next steps in the legislative process include preparation of a consolidated bill in the Senate and floor consideration slated for next week. Following the vote, House-Senate Conferees will meet to resolve differences. The Democratic leadership is targeting the February 16 recess as a deadline for a final bill to the President.

CHIME has articulated its advocacy principles for health IT in letters to the Obama Transition team in December and to the Senate Health, Education, Labor and Pensions Committee (HELP) as part of our endorsement of Senator Daschle for Secretary of HHS in early January. The ALT, through monthly webinars, is dialoging with key Congressional staff and CHIME staff continue to meet directly with Member offices on Capitol Hill. The opportunity for major health IT investment is unprecedented. While CHIME may not agree with every detail, it is critical to continue to articulate support for the overall effort.

Below are highlights of the House and Senate bills. Details will obviously change before Members vote on final passage. The highlights below draw on a summary prepared by HIMSS and bill texts for House Energy and Commerce and Ways and Means and Senate Finance bills.

**Effectiveness Research**. Funding of $400 million will be made available to the Agency for Healthcare Research and Quality to accelerate the development and dissemination of research assessing the comparative effectiveness of healthcare treatments and strategies. Provision encourages the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.

**Investment in Health Information Technology.** (1) Infrastructure investment includes architecture for the nationwide electronic exchange and use of health information; (2) integration of health IT, including electronic medical records to the initial and ongoing training of health professionals and others in the healthcare industry to assure accurate electronic use and exchange of health information; (3) training on dissemination of information on best practices to integrate health information technology, including electronic

records, into a provider's delivery of care, including community health centers and providers participating in one or more of the programs under titles XVIII, XIX, and XXI of the Social Security Act (Medicare, Medicaid, and SCHIP); (4) infrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine and; (5) promotion of interoperability of clinical data repositories or registries.

All investments must be for certified products to permit the accurate electronic exchange and use of health information in a medical record that utilizes standards for security, privacy, and quality improvement as adopted by the Office of the National Coordinator for Health IT.

**Promotion of Health Information Technology/Office of the National Coordinator.** Establishes in law the Office of the National Coordinator with various duties, including development of a strategic plan, development of voluntary certification of health IT, establishment of a governance mechanism for the NHIN and other duties. In addition, the Secretary will appoint a Chief Privacy Officer of the ONC to advise on privacy, security and data stewardship.

**HIT Policy Committee.** Establishes a HIT Policy Committee to make recommendations to the National Coordinator regarding the implementation of a nationwide health information technology infrastructure, including implementation of the strategic plan. The Committee is charged with addressing areas in which standards, implementation specifications, and certification criteria are needed for the electronic exchange of health information as well as recommend priority for the development, harmonization, and recognition of such standards, specifications, and certification criteria.

Composition of the Committee should at least include providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant federal agencies, and individuals with technological expertise. The Policy Committee will function as a Federal Advisory Committee.

**HIT Standards Committee.** Establishes an HIT Standards Committee charged with recommending to the National Coordinator standards, implementation specifications, and certification criteria that have been developed, harmonized, or recognized by the HIT Standards Committee. As part of this process, the Standards Committee as appropriate provides for the testing of standards and specifications by NIST.

Like the Policy Committee, the Standards Committee Membership should at least include providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant federal agencies, and individuals with technical expertise on healthcare quality, privacy and security, and on the electronic exchange and use of health information. The Standards Committee serves as a Federal Advisory Committee

**Use of Adopted Standards and Implementation by Federal Agencies.** Requires the applications and use by Federal agencies of the standards and implementation.

**Voluntary Application of Adopted Standards and Implementation by Private Entities.** With exception of Section 4112 (private entities contracting with the Federal government), any standard or implementation specification adopted is voluntary for private entities.

**Federal Health Information Technology.** The National Coordinator is responsible for supporting the development, routine updating and provision of qualified EHR technology

(an electronic record) which (1) consists of health related information on an individual that includes patient demographics and clinical health information, such as medical history and problem lists; and (2) has the capacity to provide clinical decision support, support physician order entry, capture and query information relevant to healthcare quality, and to exchange electronic health information with, and integrate such information from other sources. This function will be eliminated if the Secretary determines these needs and demands are being met through the marketplace.

**Transitions.** All functions, including staff and administrative efforts now associated with National Coordinator appointed under Executive Order 13335 are transferred to the new National Coordinator created under this legislation. This process allows for a smooth transition as well from the AHIC Successor to the newly-created Policy and Standards Committees.

**State Grants to Promote Health Information Technology.** Matching grants will be made available to States to facilitate and expand electronic movement and use of health information in the State using nationally recognized standards beginning in FY 11 with diminishing federal support through 2013.

**Competitive Grants to States and Indian Tribes for the Development of Loan Programs to Facilitate the Widespread Adoption of Certified EHR Technology.** The National Coordinator may award competitive grants to eligible entities for the establishment of programs for loans to healthcare providers. Funding is allocated only for certified EHR technology. An eligible entity shall establish a certified EHR technology loan fund and specify the intent for use of funds.

**Demonstration Program to Integrate Information Technology into Clinical Education.** Grants will be made available to develop academic curricula integrating certified EHR technology in the clinical education of health professionals. Grants will be made on a competitive basis.

**Information Technology Professionals on Health Care.** In consultation with the Director of the NSF, the Secretary will provide assistance to institutions of higher education to establish or expand medical health informatics education programs, including certification, undergraduate, and masters degree programs, for both healthcare and IT students to ensure the rapid and effective utilization and development of health IT.

**Medicare**
**Incentives**. To encourage adoption of information technology, funding will be available for those providers using certified EHR technology, including the use of e-prescribing. For physicians, payment is authorized from the Federal Supplementary Medical Insurance Trust Fund in an amount equal to 75 percent of the Secretary's estimate of the allowed charges under this part. Physicians are also required to report on clinical quality measures as specified by the Secretary. None of these incentives shall be made to a hospital-based physician.

Incentive payments shall be made to hospitals deemed a meaningful EHR user. The amount for an eligible hospital is determined on a base amount, the discharge specifications for a 12 month period, Medicare Share, and Transition Factor. In addition, the eligible hospital must report clinical quality measures and other measures as specified by the Secretary.

**Medicaid**

**Incentives.** To encourage the use of certified EHR technology among Medicaid providers, physicians and hospitals are to receive incentive payments through an increase in reimbursement payments for the meaningful use of certified EHR technology. Allowable costs for physicians should not exceed $25,000 or include costs over a period of longer than five years. Costs related to the operations, maintenance, or use of a certified EHR technology, should not exceed $10,000. The aggregate allowable costs with respect to a Medicaid provider (physician) should not exceed $75,000.

Hospital payments are subject to specified formulas. As such, the Medicaid share is calculated in the same manner as the Medicare share except that there is substituted for the numerator an amount that is equal to the number of inpatient-bed-days which are attributable to individuals who are receiving medical assistance. For Medicaid providers other than hospitals, the Secretary will facilitate coordination of the different programs to encourage adoption or use of health information technology and avoid duplication of funding.

**Privacy**

**Breach.** In cases of breached patient health information (PHI) by covered entities and their business associates, notification is required no later than 60 days after the discovery. Methods of notice can occur through written notification by first class mail, posting on an internet site or telephone.

**Education.** Each Regional HHS office will designate an individual responsible for educating covered entities, business associates, and individuals on their rights and responsibilities related to Federal privacy and security requirements for PHI. At the national level, the Office for Civil Rights will develop a multi-faced national education initiative to enhance public transparency regarding the uses of PHI, including programs to educate individuals about potential uses of their PHI.

**Business Associates of Covered Entities:** In the case of a business associate of a covered entity that obtains or creates PHI regarding a written contract with a covered entity, the business associate may use and disclose such PHI only if such use or disclosure is in compliance with HIPAA.

**Restrictions on Certain Disclosures.** A covered entity is prohibited from disclosing PHI to a health plan if the disclosure is not for treatment, and when a healthcare provider has been paid out-of-pocket for a service that pertains to the PHI.

**Accounting for Disclosures**. If a covered entity uses or maintains an EHR with respect to PHI, an individual has a right to receive an accounting of disclosures only in the three years prior to the date on which the accounting is requested.

**Remuneration.** A covered entity or business associate shall not directly or indirectly receive remuneration in exchange for any PHI of an individual unless the covered entity obtained a valid authorization from the individuals in accordance with HIPAA. Exceptions include research or public health activities and the fee reflects the actual cost of preparation and transmittal of the data.

**Marketing.** A communication by a covered entity or business associate that is about a product or service that encourages recipients of the communication to purchase or use the product or service is not considered a healthcare operation.

**Enforcement.** New enforcement penalties are applied for unauthorized access, use, and disclosure of PHI, ranging from $100 to $1.5 million. State attorneys general are authorized to bring a civil action on behalf of State residents who have been threatened or adversely affected by privacy violations in a district court of the U.S. of appropriate jurisdiction.

**HIPAA**. HIPAA standards and regulations will remain, unless otherwise indicated in the ARRP. Implementation also includes yearly reports by the Secretary
to appropriate Congressional Committees regarding complaints of alleged violations of law and a GAO report on best practices related to the disclosure among healthcare providers of PHI for treatment purposes.