

**American Hospital Association Summary of
“American Recovery and Reinvestment Act”
February 13, 2009**

Selected Provisions of Interest to Hospitals

Health Care for Newly Unemployed

| | |
|---|------|
| COBRA Premium Assistance | p. 1 |
| Transitional Medical Assistance..... | p. 1 |
| Community Health Centers (CHCs) and CHC Modernization | p. 1 |

Medicaid Funding – Fiscal Relief to States

| | |
|---|------|
| Temporary FMAP Increase | p. 1 |
| Temporary Prompt Payment Requirements for Hospitals and Nursing Facilities (MOE) | p. 1 |
| DSH Allotment Increase..... | p. 1 |
| Funding for OIG for State Relief Oversight..... | p. 2 |
| GAO Study on FMAP and State Economic Needs | p. 2 |

Regulatory Moratoria and Corrections

| | |
|--|------|
| Medicaid Regulations Moratoria Medicaid Regulations Moratoria – Provider Taxes, Case Management, School-based Transportation and Outpatient Services..... | p. 2 |
| Sense of Congress to Withdraw Medicaid Rules – Cost Limit, GME and Rehabilitation Services | p. 2 |
| Medicare Capital IME Rule | p. 2 |
| Long-term Care Hospital (LTCH) Technical Corrections | p. 2 |
| Medicare Payments to Hospice | p. 2 |

Hospital Bonds

| | |
|---|------|
| Bank Deductibility of Tax-Exempt Bonds..... | p. 2 |
|---|------|

Workforce

| | |
|-----------------------------------|------|
| Health Professional Training..... | p. 3 |
|-----------------------------------|------|

Prevention and Wellness

| | |
|------------------------------------|------|
| Prevention and Wellness Fund | p. 3 |
|------------------------------------|------|

Comparative Effectiveness

| | |
|---|------|
| Comparative Effectiveness Research..... | p. 3 |
|---|------|

Broadband

| | |
|---|------|
| Expansion of Broadband Technology | p. 3 |
|---|------|

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Selected Provisions of Interest to Hospitals

Health Information Technology – Promotion of Standards and Certification

| | |
|---|------|
| Defining Health Information Technology (HIT) and Electronic Health Records (EHRs)..... | p. 4 |
| Codification of the Office of the National Coordinator for Health Information Technology (ONCHIT) and Creation of New Committees..... | p. 4 |
| Process for Adoption of Standards and Certification Criteria | p. 5 |
| Adoption Requirements – Private and Federal..... | p. 5 |
| Federal HIT Product Option | p. 5 |
| Studies and Reports..... | p. 5 |
| Research and Development Programs..... | p. 6 |

Health Information Technology – Financial Incentives

| | |
|---|------|
| Immediate Funding to Strengthen the Health Information Technology Infrastructure..... | p. 6 |
| Health Information Technology Implementation Assistance, Grants, and Demonstrations . | p. 6 |
| Medicare Payment Incentives for Hospitals..... | p. 7 |
| Medicare Payment Incentives for Eligible Professionals (Physicians) | p. 8 |
| Study on Payment Incentives for Other Providers..... | p. 9 |
| Medicaid Provider HIT Adoption and Operation Payments; Implementation Funding | p. 9 |
| Expansion of Broadband Technology..... | p. 9 |

Health Information Technology – Privacy

| | |
|---|-------|
| Application of Privacy and Security Provisions and Penalties to Business Associates of Covered Entities..... | p. 9 |
| Definition of a Breach..... | p. 9 |
| Notification in the Case of Breach..... | p. 9 |
| Education on Health Information Privacy..... | p. 10 |
| Restrictions on Use and Disclosure of Electronic Health Information | p. 10 |
| Conditions on Certain Contacts as Part of Health Care Operations (Marketing) | p. 11 |
| Temporary Breach Notification Requirement for Vendors of Personal Health Records and Other Non-HIPAA Covered Entities | p. 11 |
| Business Associate Contracts Required for Certain Entities..... | p. 11 |
| Clarification of Application of Wrongful Disclosures Criminal Penalties | p. 11 |
| Improved Enforcement..... | p. 11 |
| Audits | p. 11 |
| Studies, Reports, Guidance | p. 11 |

| ISSUE | <p style="text-align: center;">AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009</p> |
|---|---|
| Health Care For Newly Unemployed | |
| COBRA Premium Assistance | Workers (and their families) who have been involuntarily terminated are eligible for a 65 percent subsidy for COBRA health insurance premiums for a 9-month period. The job termination period is from September 1, 2008 through December 31, 2009. Participants must attest that their same-year income will not exceed \$125,000 for individuals and \$250,000 for families. This subsidy also applies to health care continuation coverage if required by states for small employers. This provision is estimated to cost \$24.7 billion. |
| Transitional Medical Assistance | Extends work-related Transitional Medical Assistance (TMA) through December 31, 2010. TMA is available to certain low-income families who are at risk of losing Medicaid benefits because of changes in their income. This provision is estimated to cost \$1.3 billion. |
| Community Health Centers (CHCs) CHCs Modernization | \$500 million is appropriated to community health centers to provide care to uninsured and underserved rural and urban populations. \$1.5 billion for modernization of CHCs to be used toward renovation, construction, equipment, and technology. |
| Medicaid Funding – Fiscal Relief to States | |
| Temporary FMAP Increase | <p>Provides approximately \$86.6 billion in temporary FMAP funding with two thirds of the funds allocated to all states in an across-the-board FMAP increase and one third of the funds allocated to states with high rates of unemployment. Three types of federal assistance to states are available during the period October 1, 2008 through December 31, 2010.</p> <ol style="list-style-type: none"> 1. <u>Hold Harmless</u> – States that are at risk for a decline in their FMAP due to formula issues are held harmless. 2. <u>Uniform FMAP Increase</u> – All states will have their FMAP increased by 6.2 percentage points. (A similar FMAP increase is available to territories.) 3. <u>FMAP + Bonus</u> – States with large increases in unemployment will receive an additional increase in FMAP related to the increase in the state’s unemployment rate. <p><u>Maintenance of Effort (MOE)</u> – state Medicaid eligibility standards cannot be more restrictive than those in effect on July 1, 2008. No MOE on benefits or provider payment levels.</p> <p><u>Temporary FMAP Exclusions</u> – Temporary FMAP does not apply to DSH or CHIP.</p> |
| Temporary Prompt Payment Requirements for Hospitals and Nursing Facilities (MOE) | States cannot access the temporary FMAP increase if they fail to meet Medicaid prompt pay requirements for hospitals and nursing facilities (90 percent of clean claims paid within 30 days and 99 percent of clean claims paid with 90 days). The temporary prompt pay requirements apply to claims after June 1, 2009. States are required to report quarterly on their compliance with this provision. The Secretary has the authority to grant waivers to states for extenuating circumstances. This provision is estimated to cost \$680 million. |
| DSH Allotment Increase | All state Medicaid Disproportionate Share Hospital Payment Program (DSH) allotments would be increased by 2.5 percent. States’ FY 2009 annual DSH allotments increase by 2.5 percent, and states’ FY 2010 increase by 2.5 percent above the new FY 2009 DSH allotment. After FY 2010, states’ annual DSH allotments would return to 100 percent of the annual DSH allotments as determined under current law. The estimated cost of this provision is \$460 million. |

| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
|--|---|
| Funding for OIG for State Relief Oversight | \$31 million is included for the Office of the Inspector General (OIG) and \$5 million for CMS for oversight and implementation of these state fiscal relief provisions. Provision costs \$36 million. |
| GAO Study on FMAP and State Economic Needs | GAO to study and report on pressures faced by state Medicaid programs during periods of economic downturn. The report is due April 1, 2011. |
| Regulatory Moratoria and Corrections | |
| Medicaid Regulations Moratoria – Provider Taxes, Case Management, School-based Transportation and Outpatient Services | The bill extends moratoria for three of the original six Medicaid regulations: 1) provider taxes, 2) targeted case management, and 3) school-based transportation services from March 31, 2009 through June 30, 2009. The bill also <u>adds</u> a moratorium on the Medicaid regulation for hospital outpatient services through June 30, 2009. These provisions are estimated to cost \$105 million. |
| Sense of Congress to Withdraw Medicaid Rules – Cost Limit, GME and Rehabilitation Services | For the remaining three rules that were part of the original moratoria, the bill includes a Sense of Congress that the Secretary of HHS <u>should not</u> promulgate, as final, rules concerning cost-limits for public hospitals, elimination of graduate medical education payments, and coverage of rehabilitation services. |
| Medicare Capital IME Rule | Prevents for FY 2009 CMS' 50 percent reduction in the indirect medical education (IME) adjustment to Medicare capital payments for teaching hospitals. Does not stop the scheduled full elimination of capital IME payments in FY 2010. |
| Long-term Care Hospital (LTCH) Technical Corrections | <p>25% Rule: The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) postponed the full implementation of the 25% Rule by holding <u>most</u> LTCHs to either a 50 percent or 75 percent threshold for three years. This amendment would add those LTCHs that were inadvertently excluded from MMSEA's 25% Rule relief by changing its effective date to cost reporting periods beginning on or after:</p> <ul style="list-style-type: none"> • October 1, 2007 for co-located and satellite LTCHs; and • July 1, 2007 for freestanding, grandfathered, and grandfathered satellite LTCHs (those in existence as of Sept 30, 1999). <p>The bill also clarifies that LTCHs on a general acute hospital campus providing no inpatient services receive the same 25% Rule relief as freestanding LTCHs.</p> <p>LTCH Moratorium: Extends the exceptions to MMSEA's three-year LTCH moratorium to LTCH bed expansions that were approved by state CONs issued between April 1, 2005 and December 29, 2007.</p> <p>The estimated cost of the LTCH provisions is \$13 million.</p> |
| Medicare Payments to Hospice | Blocks FY 2009 Medicare payment cut to Hospice providers related to a wage index payment add-on. This provision is estimated to cost \$134 million. |
| Hospital Bonds | |
| Bank Deductibility of Tax-Exempt Bonds | Increases the tax-exempt bond limit for banks. Banks currently can deduct 80 percent of the cost of buying and carrying the tax-exempt bonds sold by issuers whose annual bond issuance is less than \$10 million. For bonds issued in 2009 and 2010, the bill raises from \$10 million to \$30 million the annual issuance limit. The provision also applies the limit to individual borrowers, rather than the issuer, enabling issuers to provide bank-deductible bond financing to multiple borrowers of up to \$30 million per borrower. |

| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
|---|--|
| Workforce | |
| Health Professional Training | Provides \$500 million to address health professions workforce shortages to fund scholarships, loan repayment and grants to training programs. \$300 million is allocated to the National Health Services Corps program, including \$75 million available through September 30, 2011 for extending contracts. \$200 million is allocated for nurse and physician training. |
| Prevention and Wellness | |
| Prevention and Wellness Fund | Provides \$1 billion to create a "prevention and wellness fund." Among other programs, the fund provides \$650 million to carry out evidence-based clinical and community prevention and wellness strategies to address chronic disease rates, and \$50 million to states to implement health care-acquired infection reduction strategies. |
| Comparative Effectiveness | |
| Comparative Effectiveness Research | <p>Provides \$1.1 billion in funding for comparative effectiveness research. Of these funds, \$400 million is for the NIH and \$300 million to the Agency for Health Care Research and Quality to conduct or support comparative effectiveness research. \$400 million is directed to the Secretary of HHS to accelerate the development and dissemination of comparative effectiveness research.</p> <p>Also establishes a Federal Coordinating Council for Comparative Effectiveness Research, chaired by the Secretary, to ensure optimum coordination of comparative effectiveness and related health services research supported by relevant Federal departments and agencies.</p> <p>The Conference Report language says: "The conferees do not intend for the comparative effectiveness research funding... to be used to mandate coverage, reimbursement, or other policies for any public or private payer. The funding... shall be used to conduct or support research to evaluate and compare the clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition."</p> |
| Broadband | |
| Expansion of Broadband Technology | <p>Establishes the Broadband Technology Opportunities Program that will award grants to States and a variety of corporations, non-profits, foundations and other entities that are found to be in the public interest. Grants are for acquiring equipment, and other technologies related to providing broadband service infrastructure. Services that will enhance the delivery of health care are, among other factors, given consideration in the award. Further consideration in these grants is provided to increasing the availability of broadband services in unserved and underserved areas. \$4.7 billion is authorized for this program.</p> <p>An additional \$2.5 billion is authorized for broadband loans and loan guarantees as authorized by the Rural Electrification Act of 1936 for the Distance Learning, Telemedicine and Broadband Program. Recipients of loans under these programs may not also receive funds under the other program described above.</p> |

| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
|---|---|
| Health Information Technology – Promotion of Standards and Certification | |
| Defining Health Information Technology (HIT) and Electronic Health Records (EHRs) | <p>Defines “Qualified Electronic Health Record” as an electronic record of health-related information on an individual that has patient demographic and clinical health information, such as medical history and problem lists. The system should also have the capacity to provide clinical decision support and to support physician order entry. In addition, it should be able to capture and query quality information and have the capacity to exchange and integrate electronic health information from other sources.</p> <p>Defines “Health Information Technology” as hardware, software, integrated technologies and related licenses, intellectual property, upgrades, and packaged solutions sold as services that are specifically designed for use by health care entities for the electronic creation, maintenance, or exchange of health information.</p> <p>Defines “Certified EHR Technology” as a qualified electronic health record that is certified according to the process developed by the National Institute of Standards and Technology (NIST) and that is applicable to the type of record involved, such as an ambulatory electronic health record or an inpatient hospital electronic health record.</p> |
| Codification of the Office of the National Coordinator for Health Information Technology (ONCHIT) and Creation of New Committees | <p>Codifies the Office of the National Coordinator for Health Information Technology (ONCHIT) to develop, plan and promote HIT adoption. The National Coordinator will be appointed by the Secretary. The National Coordinator is responsible for reviewing and endorsing standards, specifications and certification criteria. The National Coordinator will work with two newly-created committees: the HIT Policy Committee and the HIT Standards Committee. Current functions, personnel and assets of the National Coordinator’s office will be transferred to the new National Coordinator’s office as of the date of enactment of this bill. Within 12 months, the Secretary will appoint a Chief Privacy Officer of the Office of the National Coordinator and the privacy officer will advise the National Coordinator. \$2 billion authorized.</p> <p>Creates a HIT Policy Committee, which will advise the National Coordinator. The HIT Policy Committee will recommend and prioritize areas where standards, implementation specifications and certification criteria are required to implement a nationwide HIT infrastructure and the strategic plan created by the National Coordinator. Requires the HIT Policy Committee to make recommendations regarding electronic collection of demographic data to reduce disparities in services and performance, technologies that address the needs of children and other vulnerable populations, and technologies that render identifiable health information unusable. The Committee should include at least 20 members, with appointments made by leaders of Congress, the Department of Defense, the Department of Veterans Affairs, the Department of Health and Human Services, and the Comptroller General. Outside advisors are also allowed as needed; furthermore, input from the National Committee on Vital and Health Statistics must be considered in all decisions, which must be consensus based.</p> <p>Creates a HIT Standards Committee which, using guidance from the Policy Committee, will recommend to the National Coordinator standards, implementation specifications, and certification criteria that it develops, harmonizes (or recognizes as harmonized by another entity) or recognizes as consistent with the National Coordinator’s strategic plan. Working with the</p> |

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| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
|---|--|
| | <p>National Institute for Standards and Technology (NIST), the Committee will create pilot testing of standards. Membership must represent diversity of health care stakeholders, and meet requirements of the Federal Advisory Committee Act.</p> <p>The National eHealth Collaborative (NeHC), formerly AHIC Successor, Inc., may restructure its charter to become either the HIT Policy Committee or the HIT Standards Committee. Until new recommendations are issued by the HIT Policy Committee, any recent recommendations made by NeHC should be used.</p> |
| Process for Adoption of Standards and Certification Criteria | <p>The Secretary has 90 days to review and decide whether or not to propose regulations for adoption of standards endorsed by the National Coordinator. Initial standards must be adopted by December 31, 2009. Current standards developed through the existing process may be adopted.</p> |
| Adoption Requirements – Private and Federal | <p>Adoption of standards by private entities is voluntary. Private entities will be required under Federal contract to implement, acquire or upgrade HIT systems that meet standards and specifications as set forth in this bill. Entities contracting with Federal government are not required to adopt standards for activities unrelated to the contract. While adoption is voluntary, Medicare providers (professionals and acute care hospitals) will receive payment penalties if they have not adopted certified HIT by FY 2015.</p> <p>Federal agencies must implement, acquire and upgrade HIT systems that meet standards adopted as mandated by this legislation. Federal data collection will remain consistent with standards.</p> |
| Federal HIT Product Option | <p>If the Secretary determines that the needs of the marketplace are not being met, the National Coordinator shall support development and provision of qualified EHR technology, which must meet certification criteria. The National Coordinator may charge a nominal fee for technology and account for financial circumstances when setting fees.</p> |
| Studies and Reports | <p>Within two years of enactment, the Secretary must report to Congress on actions taken to facilitate adoption of a nationwide HIT system, describe barriers, and make recommendations to achieve full implementation.</p> <p>Within two years of enactment, the Secretary must conduct a study on methods to create efficient reimbursement incentives for improving care quality in Federally Qualified Health Centers (FQHCs), rural and free clinics.</p> <p>Within two years, the Secretary must present a report to Congress that studies current and emerging health technologies to meet the needs of seniors, individuals with disabilities, and their caregivers.</p> <p>The Secretary shall report to Congress no later than October 1, 2010 on the availability of open source health information technology systems.</p> |

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| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
|--|---|
| Research and Development Programs | <p>The Director of the National Institute for Standards and Technology (NIST) is directed, in coordination with the HIT Standards Committee, to test standards and implementation specifications and to develop a testing infrastructure that includes test platforms and environments.</p> <p>NIST and the National Science Foundation (NSF) are directed to help higher education institutions establish Centers for Health Care Information Enterprise Integration. The Centers will research and devise new approaches to integration through a wide variety of software, interfaces, and technologies.</p> <p>The National High-Performance Computing Program, which prioritizes goals for Federal computing research and coordinates activities among government agencies, is directed to coordinate Federal research and development on HIT activities related to infrastructure, security, distributed systems, social and economic implications, and other areas.</p> |
| Health Information Technology – Financial Incentives | |
| Immediate Funding to Strengthen the Health Information Technology Infrastructure | <p>The Secretary shall invest in the necessary infrastructure to allow for and promote regional HIT information exchange as outlined in the National Coordinator's strategic plan. Funds will be used for HIT meeting current standards until new standards are adopted. Funds will be distributed through the National Coordinator, Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC) and Indian Health Service (IHS) to support technology architecture, development and adoption of certified EHRs for providers not otherwise eligible, training, infrastructure, and overall expansion and promotion of technology. \$300 million is authorized.</p> |
| Health Information Technology Implementation Assistance, Grants, and Demonstrations | <p>Creates the Health Information Technology Extension Program managed through HHS to assist in adoption and implementation of certified EHRs.</p> <p>The Secretary is directed to create a Health Information Technology Research Center to provide technical assistance, best practices and accelerate efforts to adopt HIT. Input from other agencies, experienced providers and others will be sought.</p> <p>The Secretary will provide assistance to support and accelerate efforts to adopt HIT by creating and supporting regional centers for technical assistance. Regional centers will be associated with any US-based non-profit or group of non-profit institutions or organizations. The Secretary may pay up to 50 percent of the capital, annual operating, and maintenance funds required to create the regional centers for up to four years. The Secretary will publish within 90 days of enactment, a description of the program, criteria for determining qualified applicants, procedures, and maximum support levels available. Regional Centers should give priority to public or non-profit hospitals, critical access hospitals (CAHs), FQHCs and rural entities.</p> <p>The Secretary may award planning and implementation grants to States or State-designated entities to expand electronic exchange and use of health information. State plans must align with the National Coordinator's strategic plan. In order to qualify, entities must be non-profit with broad stakeholder representation, and must exist primarily to improve quality and efficiency through HIT. Entities must consult with a broad group of stakeholders when making recommendations. Beginning in FY 2011, States must contribute \$1 for every \$10 in federal funds; in 2012, \$1 for each \$7; in 2013, \$1 for each \$3. For any grants made prior to FY 2011 the Secretary has the authority to</p> |

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| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
|--|--|
| | <p>require a State match.</p> <p>The National Coordinator may award grants to establish loan programs to States or Indian tribes for the purchase of certified EHR technology used to exchange health information. These funds may also be used for training, improving the exchange of health information, or upgrading systems to meet certification requirements. Grants to create the loan programs require a 20 percent match of non-federal funds, which may come from private sector entities; however, private entities may not specify the recipient of the loan. No awards under this program can be made before Jan. 1, 2010.</p> <p>Creates competitive grants designed for demonstration projects to integrate EHR technology into the clinical education of health professionals. Eligible recipients include schools of medicine, dentistry, pharmacy, graduate programs in behavioral or mental health, nursing, physician assistants or institutions with graduate medical education programs. Schools may create consortia. Software, hardware and services are not covered in the grant. Grants will be limited to 50 percent of the costs of the project except when national economic conditions affect ability to cost-share.</p> <p>The Secretary and the National Science Foundation (NSF) are directed to provide assistance in the creation or expansion of medical health informatics education programs at institutions of higher education or consortia of institutions.</p> <p>All recipients of grants may be required to submit reports within 1 year addressing the effectiveness of the activity and impact on quality and safety.</p> |
| Medicare Payment Incentives for Hospitals | <p>Creates a payment under the Medicare Part A program for hospitals considered “meaningful” users of HIT beginning FY 2011. Inpatient PPS hospitals using certified EHR systems during a reporting year are considered meaningful users for the purposes of the incentive program. Information exchange, certified technology and reporting of quality measures where applicable are required elements of a certified system.</p> <p>A payment for a qualified PPS hospital is calculated as Medicare’s share of the sum of \$2 million plus an additional discharge-related amount. A hospital receives \$200 for each discharge for discharges starting with its 1,150th and continuing through its 23,000th discharge.</p> <p>Medicare share consists of a numerator and denominator. The numerator is the number of inpatient bed days attributable to Part A and Part C (Medicare Advantage). The denominator is the total number of inpatient bed days multiplied by total hospital charges (excluding charity care), divided by the total amount of charges during the period.</p> <p>If charge data on charity care are not available, the uncompensated care data adjusted to eliminate bad debt will be used instead. If data used to construct the charity care factor are not available, the fraction is set to 1.0; if data on Medicare Advantage days are not available, that variable will be set to 0.0.</p> <p>Eligible hospitals receive payments that phase down over four years. A hospital that is a meaningful EHR user starting in Federal FY 2011-2013 receives the full amount in the first year, 75 percent in the second year, 50 percent in the third year, and 25 percent in the fourth year. If a hospital first qualifies in 2014, three years of payments will be made but starting at the 75</p> |

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| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
|--|--|
| | <p>percent level. In the second year, 50 percent will be paid, and in the third year, 25 percent. If 2015 is the first year a hospital qualifies, only two years of payments are made, starting at the 50 percent level. Hospitals that are not meaningful users by 2016 will receive no incentive payments.</p> <p>The Secretary will determine an alternate but equitable method to determine payments to hospitals under common corporate governance with Medicare Advantage organizations.</p> <p>Penalty for non-users: Unless significant hardship is demonstrated, hospitals that are not meaningful users by FY 2015 will see three quarters of their market basket update reduced by 33.33 percent and for FY 2016, 66.66 percent, and FY 2017 and subsequent years, 100 percent.</p> <p>For Critical Access Hospitals (CAHs) the costs of certified EHR can be fully depreciated beginning in FY 2011. In addition, the Medicare share, for purposes of determining cost-based payment, is increased by 20 percentage points (not to exceed 100 percent). No payments will be made after 2015, and payments cannot be made using this formula for more than 4 consecutive years.</p> <p>Medicare payments are reduced for CAHs that are not meaningful users of EHR starting FY 2015. Payment is reduced to 100.66 percent of cost in FY 2015, 100.33 percent of cost in FY 2016, and 100 percent of cost in FY 2017 and thereafter. CAHs demonstrating hardship as determined by the Secretary are eligible for exemption from penalties for a maximum 5 years.</p> |
| Medicare Payment Incentives for Eligible Professionals (Physicians) | <p>Physicians using certified EHR technology with e-prescribing, information exchange, and reporting on certain quality measures, are considered meaningful users and will receive from the Part B Trust Fund, 75 percent of estimated allowed charges for all covered professional services during the year but limited to the following maximums over a five-year period: Year 1: \$15,000; Year 2: \$12,000; Year 3: \$8,000; Year 4: \$4,000; Year 5: \$2,000; subsequent years: \$0. First eligible year is 2011.</p> <p>If first adopting in 2011 or 2012, the maximum yearly incentive is increased to \$18,000. For example, if adopting in 2011, the maximum amount available over 5 years is \$44,000. If adopting in 2014, the maximum amount available over 5 years is \$26,000.</p> <p>If a professional is serving in a designated rural health professional shortage area, payments are increased 10 percent.</p> <p>The Secretary has discretion to pay in a lump sum or in installments.</p> <p>Physicians not implementing by 2015 are not eligible to receive funds. If not using EHRs by 2015, fee schedule amounts are reduced 1 percent, 2 percent in 2016 and 3 percent in 2017. In 2018 and after, the Secretary may further reduce payments up to 2 percent if less than 75 percent of professionals have adopted HIT. If the first payment year is 2014, the payment for that year will be the same as if the first year had been 2013. No payments will be made after 2016.</p> <p>Hospital-based physicians who furnish substantially all services in a hospital setting and use the facilities of the hospital and equipment, including computer equipment, are ineligible to receive funds under this section. The definition of</p> |

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| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
|--|--|
| | <p>hospital-based is dependent on site of service as defined by the Secretary and independent of employment or billing arrangements with other providers.</p> <p>Physicians under common corporate governance with a Medicare Advantage organization who are eligible for the maximum incentive under Part B will receive payments under that program; otherwise, payments determined by the Secretary to be of a similar amount will be paid under a formula adjusted for Medicare Advantage. Qualifying Medicare Advantage organizations and professions will be posted on the Internet.</p> <p>The Secretary will also determine meaningful use as it applies to group practices.</p> <p>The Secretary may not require electronic reporting of quality measures until those reports can be received electronically.</p> |
| Study on Payment Incentives for Other Providers | <p>No later than June 30, 2010, the Secretary is required to submit to Congress a report identifying additional incentives that should be created for other providers who receive minimal or no payment or funding under this Act.</p> |
| Medicaid Provider HIT Adoption and Operation Payments; Implementation Funding | <p>States will be paid a 100 percent match for up to 85 percent of allowable costs of EHR technology, support services, maintenance and training for the adoption and operation of systems by Medicaid eligible hospitals, and 90 percent of the cost of administrative expenses related to paying for that technology.</p> <p>Children's hospitals and acute-care hospitals with at least 10 percent Medicaid volume are eligible.</p> <p>Payment is calculated in the same way as under the Medicare section but bed-days are calculated using Medicaid patient data. The Secretary will publish the HIT amount for each hospital eligible for incentive payments. No payments will be made after 2016 or for more than 6 consecutive years.</p> <p>Appropriates \$40 million for each fiscal year from 2009 through 2015 and \$20 million for fiscal year 2016.</p> |
| Expansion of Broadband Technology | <p>Significant spending for the expansion of broadband technology.</p> <p>See above (page 3).</p> |
| Health Information Technology – Privacy | |
| Application of Privacy and Security Provisions and Penalties to Business Associates of Covered Entities | <p>HIPAA privacy and security provisions would apply to a business associate (BA) in the same manner that they apply to a covered entity (CE) and must be incorporated into BA agreements. Civil and criminal penalties would apply in same manner to BAs. Secretary shall, with stakeholder consultation, issue annual guidance on appropriate technical safeguards to carry out this section.</p> |
| Definition of a Breach | <p>Breach is defined as the unauthorized acquisition, access, use, or disclosure of Protected Health Information (PHI) that compromises the security, privacy, or integrity of such PHI. Unintentional acquisition, access, or use [not disclosure] by an employee of a CE or BA, made in good faith and within the scope of employment, and without further acquisition, access, use or disclosure, is not considered to be a breach. In addition, inadvertent disclosure between authorized individuals within a CE's facility is not a breach if the information is not further disclosed.</p> |
| Notification in the Case of Breach | <p>CEs must notify individuals within 60 days if unsecured PHI has been disclosed as result of a breach. BAs must notify CE's following a breach, and include identification of each individual compromised. If written notification</p> |

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| ISSUE | AMERICAN RECOVERY AND REINVESTMENT ACT Summary of Key Provisions February 13, 2009 |
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| | <p>cannot be made to an individual by mail, substitute notification can be made on the CE's web site or by public notice, including a toll free number.</p> <p>With breaches affecting more than 500 individuals, CE must immediately notify the Secretary of HHS. HHS will post the CE's identity on HHS website. Smaller breaches must be submitted and reported to HHS annually. This information will be reported to Congress annually.</p> <p>Notification can be delayed for law enforcement purposes. Unsecured information is that which has not been made unusable, unreadable or indecipherable to unauthorized individuals. Interim final regulations are due within 180 days of enactment; breaches are covered beginning 30 days after regulations published.</p> |
| Education on Health Information Privacy | <p>Secretary will designate Regional Office Privacy Advisors, one per HHS regional office. Within 12 months of enactment, the Office of Civil Rights will create a national education initiative.</p> |
| Restrictions on Use and Disclosure of Electronic Health Information | <p>Patients who pay for health care in full with out-of-pocket funds can request the CE not to disclose their PHI to the health plan for the plan's health care operations.</p> <p>CEs must limit use or disclosure of PHI to "limited data set," or, if needed, to minimum necessary to accomplish intended purpose. Secretary will issue guidance within 18 months on what constitutes "minimum necessary." Provisions sunset upon publication of guidance.</p> <p>CEs using an Electronic Health Record (EHR) must account for past three years of disclosures of PHI to any individual requesting such disclosure. CEs may elect to account for their own disclosures and those of all their BAs, or CEs may provide the patient with a list of all BAs acting on behalf of the CE. The Secretary must issue regulations on what information will be collected about each disclosure. Such regulations must be issued no later than 6 months after adoption of standards. The regulations must take into account the interests of the individual and the administrative burden on the CEs. The effective date for CEs with an EHR in place on 01/01/09 is 2014. The effective date for CEs who adopt an EHR after 01/01/09 is the date of EHR adoption or 2011, whichever comes later. The Secretary may delay effective dates for this section by up to 2 years.</p> <p>Individuals must explicitly authorize having their PHI sold by CE or BA. Exceptions are made for public health, treatment, exchanges that are part of a BA contract, exchanges that are involved in the sale or merger of a CE, or providing an individual with a copy of his PHI. An exception is also made for research, and in this case the CE may charge for the preparation and transmittal of such information. Within 18 months of enactment, the Secretary must issue rules implementing this section and must determine if allowing entities to charge a similar fee for public health could impede such public purposes health activities.</p> <p>An individual has a right to a copy or explanation of PHI held by CE in electronic format, and to have the CE transmit such copy to an entity or person of the individual's choice. Any fee imposed by CE should not exceed labor cost of providing copy or explanation.</p> |

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|--|--|
| Conditions on Certain Contacts as Part of Health Care Operations (Marketing) | <p>Communications by CE or BA intended to market a product or service are not considered health care operations unless communication is made to describe plan or service changes, treat the individual, or recommend alternative treatments, providers or treatment settings.</p> <p>The CE or BA cannot receive payment for making such communications unless such communication is specifically authorized by individual, is part of existing BA contract, or describes a drug or biologic already prescribed for the recipient of the communication.</p> <p>Recipients of a hospital's fundraising solicitations must be given – in a clear and conspicuous manner – the opportunity to opt out of receiving further fundraising communications from that hospital.</p> |
| Temporary Breach Notification Requirement for Vendors of Personal Health Records and Other Non-HIPAA Covered Entities | <p>Personal Health Records (PHR) vendors, and third parties that provide services to such vendors, must notify individuals and the Federal Trade Commission (FTC) of breaches of unsecured PHR identifiable health information. Such vendors must follow all steps prescribed for CEs and BAs (see p. 9) until such time as Congress enacts new legislation establishing requirements for breach notification by non-CEs or -BAs. Failure to follow notification procedures will be treated as an unfair and deceptive practice under the Federal Trade Commission Act. Within 180 days, the Federal Trade Commission must promulgate interim final regulations.</p> |
| Business Associate Contracts Required for Certain Entities | <p>Organizations that access PHI from CEs – like Health Information Exchange Organizations, Regional Health Information Organizations, E-prescribing Gateways or vendors that contract with a CE to offer PHRs as part of the CE's EHR – must have written contracts with the CEs and be treated like BAs.</p> |
| Clarification of Application of Wrongful Disclosures Criminal Penalties | <p>Clarifies that criminal penalties may apply to an employee of a CE who obtains PHI without authorization.</p> |
| Improved Enforcement | <p>Secretary must investigate and can apply civil penalties if HIPAA violation is due to willful neglect.</p> <p>Civil monetary penalties (CMPs) collected for HIPAA violations shall be used to fund enforcement efforts of the Office of Civil Rights; within 3 years, Secretary must establish a method to distribute a percentage of CMPs to harmed individuals.</p> <p>Creates a tiered increase in CMPs ranging from a low of \$100 per violation to total amount per year of \$1.5 million; criteria for imposition of CMPs range from lack of knowledge to willful neglect.</p> <p>Regulations must be issued within 18 months and become effective within 24 months.</p> <p>Authorizes state Attorneys General to bring civil suits to enforce HIPAA privacy violations on behalf of residents of their states. The HHS Secretary shall be notified of any such action and have the right to intervene.</p> |
| Audits | <p>Secretary shall provide for periodic audits to ensure CE and BAs are in compliance.</p> |
| Studies, Reports, Guidance | <p>Secretary will report annually to Congress on compliance, complaints, resolutions, audits, etc., and such reports will be publicly available on the HHS website.</p> |

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| | <p>Secretary will conduct study with FTC and report on privacy and security requirements for, among others, vendors of personal health records. Within 12 months, Secretary shall consult with stakeholders and issue guidance on how best to implement requirements on de-identification of PHI.</p> <p>Within 12 months, GAO shall report on best practices relating to PHI disclosure among providers for purposes of treatment, as well as an examination of the use of electronic informed consent for disclosing PHI for treatment, payment, and health care operations.</p> <p>Within 12 months, GAO shall report to Congress and HHS Secretary on impact of this title on health insurance premiums, overall health care costs, adoption of EHRs by providers, and reduction in medical errors and other quality improvements.</p> <p>The HHS Secretary shall study the definition of psychotherapy notes and may, based on such study, issue a regulation to revise such definition.</p> |

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