



# **The American Recovery and Reinvestment Act: Healthcare IT Provisions and Plans**

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# Medicare Incentives



- “Meaningful Use” of certified EHR technology by community physicians
- Timeframe is 2011-2015 or 2012-2016 with payments of \$18,000, \$12,000, \$8000, \$4000, \$2000
- Consolidated payment or periodic installments to be determined
- 10% increased payment for health professional shortage areas

# Penalties



- Reduced payments if not implemented until 2013 or 2014 - \$15,000, \$12,000, \$8000
- Penalties for non-use by 2015 - 99% of fee schedule in 2015, 98% in 2016, 97% in 2017 and reductions of 1% each year thereafter
- Cap of 95% of fee schedule if EHR adoption is less than 75% by 2018
- Hardship exemption

# Definition of Meaningful Use



- e-Prescribing
- Healthcare Information Exchange that promotes quality improvement such as care coordination
- Submission of quality measures

# Certified EHR Technology



- Meet standards adopted by the National Coordinator
- Must include demographics, medical history, problem lists, quality indicators
- Clinical decision support and provider order entry
- Exchange clinical information to/from other organizations
- Voluntary Certification Program in collaboration with NIST

# Hospital Incentives



- Requires Meaningful Use of EHRs
- Requires Health Information Exchange for improving care quality
- Requires quality measurement data
- Base amount of \$2 million plus \$200 per discharge multiplied by the fraction of Medicare Part A inpatient bed days and multiplied by a “transition factor” resulting in reduced payments over a four-year transition.

# Hospital Penalties



- Four year incentive payment schedule - full incentives for adoption in 2011 and 2012, reduced incentives for 2013 and 2014, no benefit for 2015 or beyond
- 25 reduction in annual Market Basket update for no EHR adoption by 2015  
[www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf](http://www.cms.hhs.gov/MedicareProgramRatesStats/downloads/info.pdf)
- Additional reductions in 2016 and beyond

# Medicaid Incentives



- Expanded funding for pediatricians, federally qualified health clinics, and rural health clinics
- \$63,750 for adoption, implementation, upgrade, and maintenance - \$21,250 to adopt and \$8500/year for 5 years to maintain
- Hospital amounts are similar to those calculations for Medicare and must be spread over 3 years

# Government Leadership



- Office of the National Coordinator (ONCHIT) charged with developing a nationwide HIT infrastructure to improve quality, reduce costs, and protect privacy
- Chief Privacy Officer to be appointed by ONCHIT within 12 months
- Federal Health IT Strategic Plan to be updated and published on a website. Must include a plan for implementation of EHRs for every patient in the US by 2014

# HIT Policy Committee



- Federal Advisory Committee to make recommendations to ONCHIT regarding nationwide infrastructure and Federal Health IT strategic plan
- Includes policies that will address standards, implementation specifications, certification criteria, authentication, and privacy/security

# HIT Standards Committee



- Federal Advisory Committee to recommend standards, implementation specifications and certification criteria needed to achieve interoperability
- Secretary of HHS has until December 31, 2009 to adopt the initial set of standards
- Secretary must submit a report within 2 years (and annually thereafter) describing actions taken to create a nationwide health IT network

# Other Provisions



- Research and Development Funding
- Infrastructure Grants
- HIT Implementation Assistance
- Regional HIT Extension Centers
- State Grants
- Competitive Grants to States and Tribes for Loan programs
- Clinical Education Grants
- Medical Informatics Program Grants

# Summary



- ARRA provides incentives to ambulatory care physicians and hospitals to encourage the adoption of electronic health records.
- Meaningful use must be achieved by 2012 to realize full incentives
- Numerous federal, state and local organizations will be created to assist but institutional planning should begin NOW!