Electronic Health Record Incentives in ARRA: What do State Legislatures Need to Know?

The Health Information Technology for Economic and Clinical Health Act (HITECH) within the American Recovery and Reinvestment Act (ARRA) requires quick action from states to ensure that health care providers are eligible to receive Medicare and Medicaid incentive dollars. As new states enter the field and previously active states continue to advance their health information technology (HIT) efforts, it is important that legislatures have a solid understanding of the necessity to quickly establish statewide health information exchange (HIE) capabilities as well as policy options to do so in light of the new environment created by ARRA.

This issue brief addresses key actions state need to take and strategies they can follow to enable HIE and ensure that their providers become eligible for the ARRA Medicare and Medicaid incentives. The brief builds upon the HIT-related work previously performed by NCSL and includes a thorough analysis of recent state ARRA-related legislation along with a discussion of strategies that states with ongoing initiatives are taking to incorporate ARRA into existing activities. Approaches analyzed include:

- **Establishing HIE infrastructure:**
- **Facilitating HIE while ensuring privacy:**
- **Identifying a Structure to Receive ARRA Funds.**

1. **Key ARRA Provisions for States**

ARRA includes a number of important HIT programs. Four programs in particular carry special significance to states:

- **Medicare Incentive Payments to Providers:** Under the Medicare incentive program, providers can only receive funds for operation of certified electronic health record (EHR) technology. To be eligible, providers must already have EHR technology and be meaningful users of EHRs. While the details of meaningful use are left to the Secretary of DHHS to decide, ARRA includes language stating that meaningful use shall include electronic prescribing, quality reporting and health information exchange to improve the quality of care. The maximum payment a provider can receive under Medicare is $44,000 over five years if the provider starts in 2011. While states will not have a role in implementing this program, a vital context to working through the broader issues faced by states in advancing HIT is provided.

- **Medicaid Incentive Payments to Providers:** States have the option of creating an incentive program for eligible Medicaid providers to fund the purchase,
implementation and operation of certified EHR technology. Providers will be able to receive up to $21,500 for the purchase and implementation of an EHR in the first year (until 2016) and up to $8,500 annually over five years if they demonstrate meaningful use, ending after 2021 (for a maximum of $66,000). Under Medicaid, providers will also have to be meaningful users of EHRs to qualify; however, states will be able to create their own definition of the term. States will want to ensure they define meaningful use in a manner complementary with the Medicare definition and with the level of EHR adoption in their state. No state match is required for incentive payments, but states are required to provide 10 percent matching for administrative costs associated with the Medicaid incentives program. Except for hospitals, providers cannot receive incentives payments from both Medicare and Medicaid. To be eligible, 30 percent of the patient population of independent physicians, dentists, nurse midwives, and nurse practitioners must be Medicaid patients. Pediatricians will only need to have a 20 percent Medicaid patient population. Further details of these payments are outlined in CMS’ State Medicaid Directors letter of September 1, 2009 at http://www.cms.hhs.gov/smdl/downloads/SMD090109.pdf.

• **Grants to States to Promote HIT**: Competitive grants will be available to states or state-designated entities for planning or implementation of activities that promote the electronic movement and use of health information. To be eligible for implementation grants, states will need a statewide HIT plan that meets federal requirements. At least $300 million will be made available through this program. State match requirements are as follows:
  
  - before 2011 none
  - 2011 at least 10 percent
  - 2012 at least 14 percent
  - 2013 at least 33 percent.

  More about these grants can be found at [http://healthit.hhs.gov/statehiegrants](http://healthit.hhs.gov/statehiegrants).

• **Optional Competitive Grants to States and Indian Tribes for EHR Loan Programs**: ARRA provides the Federal Government the option to fund competitive grants that can be used to establish loan programs for providers to facilitate the purchase or use of certified EHR, training for the use of EHR and for the exchange of health information. Providers who receive funds must report on certain quality measures, exchange health information and have a plan for continued maintenance of the system. Awards under this program cannot start until January 1, 2010 and require a match of at least $1 for every $5 federal dollars. This match can be state funds or can be met by private sector donations.

Many of the details of these programs remain to be released at time of the writing of this paper. Please see [http://healthit.hhs.gov/](http://healthit.hhs.gov/) for up-to-date information.

ARRA also contains provisions to provide grants to educational institutions to increase the HIT workforce and to provide grants to non-profits for the establishment of regional
implementation centers to assist providers with workflow changes that result from using HIT.

2. Establishing the Infrastructure for the Electronic Exchange of Health Records

A key eligibility requirement for the Medicare and Medicaid incentives is that providers must electronically exchange data to improve the quality of care. The specific details for meeting this requirement have yet to be determined. Despite the lack of details, it is clear that the infrastructure necessary to achieve electronic data exchange does not exist in most states.

The Office of the Coordinator for Health Information Technology within the U.S. Department of Health and Human Services is providing $564 million through the State Health Information Exchange Cooperative Agreement Program to help states establish the necessary infrastructure for electronic data exchange. States can either directly apply for these funds or get the funds through a qualified state designated entity.

A number of states have already established or given responsibility to an entity or entities to create and operate an HIE. These entities—often public-private partnerships—bring together key health care stakeholders to create a common vision and build trust among participants.

The Minnesota e-Health Initiative is an example of such a public-private collaborative. The Initiative aims to accelerate the adoption and use of HIT in order to improve health care quality, increase patient safety, reduce health care costs and improve public health. It is led by a 26-member public-private advisory committee that offers recommendations to the Department of Health, which is running the state's HIT initiatives.¹

State strategies to create a statewide infrastructure for HIE include:

- **Developing a Plan for Statewide Exchange**
  As states work to advance HIT policy, it is important that they have a comprehensive vision of how to utilize HIT to drive improvements in health outcomes. States that have put such plans together have found it very important to have broad stakeholder input and consensus. Through the process of bringing stakeholders together and creating a common vision of HIT in the state, policymakers create buy-in for the plan and build trust among organizations.

  States can use the roadmap as a benchmark to move stakeholders forward. Some states, for example, require any grantee that receives state funds to follow the roadmap. Others have added language to certificate of need laws or other measures that requiring adherence to the plan.
• **Structuring the Infrastructure**

A wide range of approaches can be taken in creating the infrastructure for electronic data exchange. Some states, often smaller ones, are creating a single entity to provide for data exchange across the whole state. Other states, often larger ones, are creating multiple HIEs across the state.

Maryland, for instance, is designating a single exchange for the entire state. To ensure providers use it, the state will on October 1, 2014 prohibit payers from reimbursing providers who do not have an EHR that exchanges data over the designated HIE. Maryland is also requiring payers to include in their provider reimbursement structures the cost of EHR adoption, taking into account any grants or loans that are available to providers from the federal government.2

Large states on the other hand often support the creation of multiple HIEs across the state. Michigan, for example, took a very active role in this process. The state government did an analysis of Medicaid fee-for-service claims data and divided the state into nine medical trading areas based on geographic patterns of service utilization.3 Then, through a competitive process, the state selected a single entity in each of the nine medical trading areas to operate the area’s HIE. In a recent shift, the state has moved to centralize more of the technical infrastructure (for example the master patient index) while still utilizing the regional structure for issues such as governance and technical support. The state expects centralizing the technical infrastructure will reduce costs and make achieving sustainability easier.

**State Legislation Example**

**Designate an entity to serve as the HIE lead**

CT SB 782 2009

"Sec. 2. (NEW) (Effective from passage) (a) Not later than June 1, 2009, the speaker of the House of Representatives and the president pro tempore of the Senate, in consultation with the chairpersons and ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health, the Lieutenant Governor and the Commissioner of Public Health, shall designate an entity to serve, on and after July 1, 2009, as the lead health information exchange organization for the state. The designated entity shall, in consultation with the Department of Public Health, seek private and federal funds, including funds made available pursuant to the federal American Recovery and Reinvestment Act of 2009, for the initial development of a state-wide health information exchange. Any private or federal funds received by such entity may be used for the purpose of establishing health information technology pilot programs."
3. Facilitating HIE While Ensuring Privacy

Without public trust in the privacy and security of electronic medical data, an infrastructure to exchange that data will be of little use. States and the Federal Government have been actively working over the past years to ensure this needed public trust develops. In ARRA, Congress included significant additions and expansions to federal privacy laws that:

- Expand the HIPAA privacy and security rules to cover new e-health entities such as HIEs;
- Add a breach notification requirement for covered entities, business associates and personal health record vendors (See HHS Office for Civil Rights final rule on this topic at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/breachnotificationfr.html);
- Require entities using EHRs to provide patients with access to a more robust audit trail than previously required. The audit trail must now include disclosures for treatment payment and healthcare operations; and
- Along with other strengthening of enforcement provisions, provide state attorneys general with the power to enforce HIPAA.

HIPAA continues to set a privacy floor upon which states can build. Moving forward, states will continue to actively work to address the key issues around privacy and security in this new context. As before, lawmakers are taking differing paths as they attempt to capture the benefits of mobile health data and temper the associated risks. State strategies include:

- **Examining the Current Privacy Landscape**
  In light of the expansion of HIPAA, some states are proposing studies to understand the new privacy environment created by these changes.

2009 CA AB 1011

By April 1, 2010, the Office of Health Information Integrity shall report to the appropriate policy and fiscal committees of the Legislature on the impact of federal changes related to health care technology and the privacy of health and medical information. The office shall evaluate and make recommendations for statutory changes to ensure that California's medical privacy laws are minimally compliant with or exceed federal privacy laws, including, but not limited to, compliance with changes to the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg) enacted through the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and that California law is updated to reflect and promote the development and expansion of health information technology while safeguarding confidential medical information.
• **Educating Patients and Providers**
  To help broaden patient and provider awareness and understanding of HIT, some states are creating and disseminating educational materials for these audiences. Educating patients and providers can ease potential privacy and liability concerns and encourage the adoption of these important tools. Washington, for instance, created a website to educate patients about the value of electronically exchanging health data and address privacy concerns ([www.accessmyhealth.org/](http://www.accessmyhealth.org/)).

The federally funded Health Information Security and Privacy Collaborative, made up of 42 states and the territories, has been working to address key privacy and security issues that states are facing. The Collaborative created a variety of educational materials targeted at providers and consumers that other states can adapt for their own use. One example of the resources produced by the project is an FAQ targeted at consumers that address key privacy issues such as what is consent. The project just released a guide to help other states access these resources at [http://healthit.hhs.gov/html/hispc/AIMReport.pdf](http://healthit.hhs.gov/html/hispc/AIMReport.pdf).

• **Updating Laws to Facilitate the Secure Digital Exchange of Health Data**
  As states look at their current privacy laws, some have found them outdated and inadequate for the digital age. Laws created for a paper era often fail to address some of the key new challenges presented in a digital world. Digitizing records raises patient concerns that sensitive health data will be breached and potentially used against them by employers or in insurance coverage decisions. Providers must be able to use the system without fear they will be liable for treatment decisions based on misinformation in the system. States are taking varying actions as they seek to update privacy provisions to remove any unnecessary barriers.

  State efforts to facilitate the exchange of health data often fall in one of two categories:

  o Updating existing laws for the digital age; or
  o Creating comprehensive measures which often define key terms, address consent, provide for access to data in an emergency, and establish penalties.

  Strategies to modify existing statutes are generally limited in scope and often serve to clarify existing statutes to remove provisions that prevent or limit HIE. A simple example of a required change of law for the digital age comes from the prescribing process. Prescribing laws enacted prior to the digital era required that prescriptions have wet signatures. To allow electronic prescribing, laws had to be changed to allow for digital signatures.

  Comprehensive measures differ by their broad scope and creation of entirely new sections of statute to enable electronic data exchange. Two examples of recent comprehensive privacy overhauls follow.
**FLS 162 2009 (enacted)**

The bill defines key terms related to HIT. It permits the release of a patient's health record without consent for treatment in an emergency situation. It permits clinical laboratories to disclose a patient's test results, without the patient's consent, to a health care practitioner or provider who did not request that the test be performed but who is involved in the care or treatment of the patient.

The bill also requires the Agency for Health Care Administration to develop a universal patient authorization form for the use or release of a patient's identifiable health record and provides immunity from liability for release of an identifiable health record in reliance on the information provided on the authorization form. The bill establishes penalties for forging or altering a signature on an authorization form or for obtaining an authorization form or an identifiable health record of another person under false pretenses.

**NM New Mexico Statutes Annotated Chapter 24. Health and Safety Article 14B. Electronic Medical Records Act**

This statute establishes that an electronic medical record or electronic signature is the legal equivalent of a paper record or wet signature. The law also prohibits the use or disclosure of information in an electronic medical record unless the patient consents or:

a) it is required for emergency treatment;
b) it is necessary for the development or operation of a record locator service or health information exchange; or
c) is otherwise permitted by state or federal law.

Record locator services are now required to maintain an audit log of access to electronic medical records. The audit log shall be made available to an individual health care consumer provided that it only includes information related to that person.

Patients can choose not to participate in a record locator service. Providers, health care institutions, or health information exchanges shall not be liable for any harm caused to an individual by the individual's decision to exclude his or her information.

**4. Identifying a Structure to Receive ARRA Funds**

States are actively preparing to receive federal funds for HIT projects. They are establishing structures to coordinate efforts across the state, appropriating matching funds, and establishing the necessary administrative function to plan, distribute and monitor the Medicaid incentive payments under HITECH.
• **Preparing to Lead**

As states prepare for the rapid expansion of their HIT efforts, many are finding it important to have a single point of leadership and coordination within the state. To this end, states have designated a single agency to serve as the state government lead. In addition to providing a single point of accountability and coordination, the agency can serve as a liaison with other HIT initiatives in the state.

For states that do not already have this structure in place, the HIE grants would require them to appoint a high-level government official to serve as the HIT coordinator. The purpose of the coordinator is to have an official with decision making authority to coordinate HIT policy with other state officials, representatives from other states, and public and private stakeholders in order to foster the flow of health information across different sectors of the healthcare system. The HIE grants have funding for states to hire an FTE as the HIT Coordinator.

The structure, placement, purpose and level of influence of these offices vary widely across states. Commonly, the responsibility is given to a health agency. Less often, the responsibility is invested in the CIO or Governor's office. The best way to structure this effort will depend on the number of health agencies in the state and their respective function and areas of staff strength. A lead agency is particularly important in states where the state employee health plan, public health and Medicaid reside under different agencies making coordination and collaboration across public programs particularly difficult.5

• **Matching Funds**

Multiple potential funding streams could emerge from HITECH for states. All of them require matching funds at some point. As states prepare to apply for and draw down these funds, some are appropriating dollars to meet matching requirements. With the dire condition of almost every state budget, locating matching funds will be very difficult. States are already setting aside dollars for this purpose.

A few states are looking at establishing dedicated revenue streams for HIT initiatives that could be drawn from to cover the required match. In 2008, Vermont established a dedicated revenue source for HIT initiatives. The funding comes from a 0.199 percent fee on all health care claims of health insurers (including third-party administrators) in the state. West Virginia is currently considering a similar fee. Other sources of revenue considered by states include dues, bonds, insurer assessments and user fees.

• **State Oversight Strategies for ARRA**

ARRA money comes with a heightened expectation of oversight and transparency from the Federal Government. In response, almost every state has created or
proposed methods to track and provide oversight for and distribution of information relating to ARRA funds. Legislatures are forming commissions or committees to oversee ARRA and are enacting legislation necessary to access certain funding streams. Governors are issuing executive orders and creating new entities made up of agency officials, legislators and others to provide for oversight and accountability. State agencies are documenting projects. Many states are establishing websites to track state implementation and spending of ARRA funds. A short summary of state initiatives has been compiled by NCSL at http://www.ncsl.org/programs/fiscal/stimulusoversight.htm. Dollars received from ARRA for HIT will also be subject to these newly established oversight processes.

In addition to these general oversight procedures, to access the 90 percent federal matching funds for administration of the Medicaid Incentives program, states will need to demonstrate the following:

- "Appropriate use of funds including tracking of meaningful use by Medicaid providers;
- Adequate oversight of the program is being conducted, including routine tracking of meaningful use attestations and reporting mechanisms; and
- Other initiatives are being pursued to encourage the adoption of certified EHR technology for the promotion of health care quality and the exchange of health care information."

Meeting these requirements will require significant effort from Medicaid agencies. Among other things, they will need to: establish systems to pay incentives; identify participating providers and ensure their compliance with program requirements; define meaningful use and create measurable goals and quality outcomes consistent with it; and educate providers about the incentive program.

In some states, additional authority will be required for the Medicaid agency to meet these requirements. In Minnesota, for instance, to meet certain reporting requirements under ARRA, the commissioner of health would be given the ability to require various health care entities to submit data to assess the status of adoption, effective use, and interoperability of EHR systems.

• **Defining Meaningful Use**

States and the federal government have a very important task ahead of them in establishing the definition of meaningful use. How this term is defined will determine what benchmarks providers need to achieve each year to be eligible for the incentive payments under Medicaid and Medicare. In creating the definition, policymakers will have to carefully balance the desire to quickly reach the end goal of driving improvement of health and transforming health care with the on-the-ground challenges for stakeholders. If the bar is set too high in early years, few providers will be able to qualify for the incentives.
In addition, phasing in the requirements will allow sufficient lead time for the lengthy process of EHR vendors incorporating new requirements in their products and for providers to subsequently implement these new products. During recent hearings before a federal advisory board, vendors stated it takes as much as 18 to 24 months to roll out product enhancements and providers stated they often require 18 to 24 months to implement new technology. For the Medicare incentives a national definition will be created.

The core difference between the two incentive programs is that under Medicaid, providers can receive funds for the purchase and operation of certified EHR technology. Under Medicare, providers can only receive funds for the operation of certified EHR technology. Providers can only receive incentive payments from one program. It is likely any provider who does not have EHR technology and meets the requirements of both programs will choose the Medicaid incentives because they can receive a higher total incentive payment that includes funds to assist with purchase of an EHR. As a result, many providers participating under Medicaid will be struggling through the difficult and time consuming task of implementing EHR technology.

In addition, it is important states have solid data on the current adoption rate of EHR in the provider community. States can draw on the 90 percent federal match to undertake an environmental scan of provider EHR adoption. This data will be very useful in targeting outreach efforts and in crafting a state's definition of meaningful use. This recent report from Wisconsin documents one state's approach to surveying provider adoption [http://dhs.wisconsin.gov/eHealth/EHR/2008EHRsurveyfinal.pdf](http://dhs.wisconsin.gov/eHealth/EHR/2008EHRsurveyfinal.pdf).

The Department of Health and Human Services must issue its final rule defining meaningful use by the end of 2009. A committee tasked with working on the issue recently issued a draft of its proposed definition at [http://healthit.hhs.gov/meaningfuluse](http://healthit.hhs.gov/meaningfuluse). A wide range of stakeholders have provided input as the federal government has worked on this issue. A summary of stakeholder views presented at a federal advisory body hearing on defining meaningful use may be found at [http://www.ncvhs.hhs.gov/090518rpt.pdf](http://www.ncvhs.hhs.gov/090518rpt.pdf) and observations from the advisory body may be found at [http://www.ncvhs.hhs.gov/090428rpt.pdf](http://www.ncvhs.hhs.gov/090428rpt.pdf).

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2. 2009 Md. Laws, Chap. 689
3. For more information on the Michigan medical trading area analysis please see [http://www.michigan.gov/mihin/0,1607,7-235--156995--00.html](http://www.michigan.gov/mihin/0,1607,7-235--156995--00.html)