

HITECH Act Inequality: Lobbying for Technology Funding Critical for Rehab and LTACH

by:

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Introduction

When President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009, he took an important initial step toward fulfilling campaign promises to reform the American health care system. During his campaign and in his inaugural address, President Obama vowed to improve quality and reduce inefficiencies in the health care system by dedicating significant federal funds to health information technology. The President proposed a \$10 billion investment in health care IT over five years, but Congress increased this amount significantly, nearly doubling that amount in the final ARRA legislation.

The HITECH Act – Background

Two separate sections of the Recovery Act comprise what is referred to collectively as the "HITECH Act" (Health Information Technology for Economic and Clinical Health Act). The purpose of the HITECH Act is to promote the use of health information technology with a goal of utilization of an electronic health record for each person in the United States by 2014. The HITECH Act authorizes an investment in health care IT that is expected to top \$20 billion. The bulk of this funding is allocated to direct financial incentives intended to encourage hospitals and other health care providers to invest in IT infrastructure, training, and electronic health records.

HITECH Funding for Healthcare IT Infrastructure Includes:

- **Health care IT architecture to support the electronic exchange of health information**
- **Adoption of certified electronic health records (EHRs)**
- **EHRs for providers not eligible for such funding under Medicare and Medicaid**
- **Training on best practices for integrating health care IT**
- **Infrastructure and tools for telemedicine**
- **Promoting interoperability of clinical data repositories**
- **Promoting technologies and best practices to ensure the protection of health information**
- **Improving the use of health care IT by public health departments**

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Other provisions in the HITECH Act fund a greatly expanded Federal role in regulating health care information technology. The legislation also provides funds for programs run by states, state contractors and academic institutions to promote the use and exchange of electronic health information.

Most notably, the HITECH Act provides financial incentives to physicians and hospitals to adopt and use certified electronic health records (or EHR) technology. Providers that participate in the Medicare and Medicaid program stand to receive between \$43,000 and \$64,000 (for individuals) and up to \$11 million (for hospitals) in cash incentives over four to six years. These

incentives come with attached conditions – the provider must be considered a “meaningful HER user.”

In order to be considered a meaningful EHR user, the eligible physician or eligible hospital will need to meet the following three requirements:

1. **CERTIFIED TECHNOLOGY** – Demonstrate that the physician or hospital is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing
2. **INTEROPERABILITY** – Demonstrate that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care in accordance with the standards and criteria adopted under the Act
3. **QUALITY MEASURES** – Submit information on clinical quality measures and other measures in a form and manner that will later be specified by the HHS Secretary

Additionally, the HITECH Act's economic incentives phase out over time, and become penalties beginning in 2015. Providers that cannot demonstrate "meaningful use" of an electronic health record by 2015 will see their reimbursement reduced by a percentage that begins at 1% and increases in subsequent years.

A problematic issue lies in what exactly “certified” EHR technology means. Currently the Office of National Coordination for HIT (ONC) and National Institute of Standards & Technology (NIST) are working on this very issue. The ONC will turn over \$20 million to NIST who will define the test standards, implementation specifications, and testing infrastructure for a “certified EHR.” The HITECH legislation also includes language regarding the testing NIST will manage referencing “including a program to accredit independent, non-Federal labs to perform testing.” This backdrop for defining “certified” technology creates a slippery slope for a monopoly of electronic record vendors. Competition is important in an evolving market and limiting EHR technology to only “certified vendors” may quash innovativeness. However, it is critical that we have national universality of systems to assure uniformity of compatibility of technology.

The HITECH Act – Inequality of Application

While the HITECH Act has well placed goals, the incentives described above have inequitable applicability throughout the healthcare delivery system. The financial incentives are only available for “eligible hospitals.” Section 4102(a)(6)(B) of the HITECH Act defines an “eligible hospital” as a “subsection (d) hospital.” Subsection (d) hospitals are only short term acute care hospitals. Long-term care facilities, rehabilitation hospitals, psychiatric hospitals childrens’ hospitals, and cancer centers are not “subsection (d)” hospitals per 42 U.S.C. 1395ww(d)(1)(B). ***Therefore, as written the HITECH Act incentive provisions for the adoption of certified electronic health records are not applicable to rehabilitation hospitals or LTACHs.***

Since one of the purposes of the HITECH Act is to help develop a uniform technological infrastructure that will ultimately support personal electronic health records, it is important for

all venues of care to be afforded the incentives to adopt an electronic system. The post-acute continuum of care is a vital component of the healthcare delivery system that the aging population utilizes on a regular basis, including both rehabilitation hospitals and LTACHs. Unfortunately, these smaller hospitals have been specifically excluded from receiving any of the financial incentives under the HITECH Act.

Thus, it is important for non-eligible hospitals to lobby for change and inclusion in the HITECH Act incentives. Notably, critical access hospitals were originally going to be exempt from receiving the financial incentives for adoption of EHR due to size concerns. After strong lobbying, provisions for critical access hospitals to be eligible for these incentives were included in the HITECH Act.

Two Important Studies within the ARRA

Despite the apparent inequality for all healthcare providers in the HITECH Act, the Recovery Act also includes two relevant studies for excluded providers: a technology study related to aging service providers and a study on need for incentives for the excluded providers discussed above.

The ARRA contains a study on aging services technology proposed by The Center for Aging Services Technology (CAST). This study by HHS will examine “matters relating to the potential use of new aging services technology to assist seniors, individuals with disabilities, and their caregivers throughout the aging process.” The study shall include evaluation of technology methods and identification of barriers to innovation and adoption of technology within aging services.

The second study is a study on need by health care providers for incentive payments. This study specifically focuses on those providers that are excluded from the incentive payments in the HITECH Act. This study will specifically focus on whether other providers have a need to receive the same or similar incentive payments to invest in electronic health record technology (hardware and software). The study will examine adoption rates, clinical utility and potential costs for these providers among other issues. The HHS Secretary must submit a report to Congress on the findings and conclusions of this study no later than June 30, 2010.

Study on Aging Services Technology

Evaluation of:

- (i) **methods for identifying current, emerging, and future health technology that can be used to meet the needs of seniors and individuals with disabilities and their caregivers across all aging services settings, as specified by the Secretary;**
- (ii) **methods for fostering scientific innovation with respect to aging services technology within the business and academic communities; and**
- (iii) **developments in aging services technology in other countries that may be applied in the United States.**

Identification of:

- (i) **barriers to innovation in aging services technology and devising strategies for removing such barriers; and**
- (ii) **barriers to the adoption of aging services technology by health care providers and consumers and devising strategies to removing such barriers.**

Study on Need of Incentives for Other Providers

Examination of:

- (i) the adoption rates of certified HER technology by such health care providers;
- (ii) the clinical utility of such technology by such health care providers;
- (iii) whether the services furnished by such health care providers are appropriate or would benefit from the use of such technology;
- (iv) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act;
- (v) the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and
- (vi) any other issues the Secretary deems to be appropriate.

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Conclusion

Bringing 21st technology to the United States health care delivery system is a valid and important goal. With the ultimate goal for each individual in this country to have an electronic health record by 2014, it is imperative for all venues of care to be afforded the opportunity to invest in an electronic medical record system. The promises of more than \$20 billion for health-information technology investment specifically excluded many smaller hospital settings, like rehabilitation hospitals and LTACHs, both of which are an integral post-acute component in this country's healthcare system. While there are studies underway to determine if funds should be allocated for the investment of healthcare IT in these venues, it is critical for providers to immediately become involved in the legislative lobbying for an end to the current incentive inequality.

About the Author:

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