



## **H.R. 1, the “American Recovery and Reinvestment Act of 2009” Explanation of Health Information Technology (HIT) Provisions<sup>1</sup>**

The “American Recovery and Reinvestment Act of 2009” (ARRA) provides substantial financial incentives (\$19 billion over a specified five-year period) that will help physicians purchase and implement HIT systems. Beyond adequate financing, a key element to the widespread adoption and use of HIT is the development of uniform electronic standards that allow various HIT systems to communicate with each other. ARRA requires the Department of Health and Human Services (HHS) to develop such standards by December 31, 2009. Beginning in 2011, Medicare physicians who implement and report meaningful use of electronic health records (EHR) will be eligible for an initial incentive payment up to \$18,000. While ARRA includes a provision that will reduce Medicare payments (starting at 1%) for physicians who do not use EHR systems, this does not take effect until 2015, and there are exceptions for significant hardship cases. As noted below, some of the details on the implementation of ARRA’s HIT incentive provisions will be worked out through the regulatory rule-making process in the coming months. The AMA will be closely monitoring and providing input to ensure that the HIT provisions are implemented in a manner consistent with the intent of ARRA.

### **HIT Incentive and Penalty Program**

ARRA provides financial incentives through the Medicare Part B program to encourage physicians to adopt and use qualifying EHRs in a meaningful way. Meaningful use of EHRs will be defined by HHS during the rulemaking process and may include reporting requirements on quality measures. ARRA also authorizes HHS to provide competitive grants to states to make loans available to health care providers to assist them with HIT acquisition and implementation costs.

Physicians (non-hospital based) are eligible for Medicare incentive payments based on an amount equal to 75% of the allowed Medicare Part B charges, up to a maximum of \$18,000 for early adopters whose first payment year is 2011 or 2012. The Secretary of HHS will define the reporting period(s) with respect to a payment year. Incentive payments would be reduced in subsequent payment years, eventually phasing out in 2016. Physicians who do not adopt/use an EHR system before 2015 will face a reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. The Secretary of HHS has the authority to make exceptions to this reduction on a case-by-case basis for physicians who demonstrate significant hardship (e.g., a physician who practices in rural areas without sufficient Internet access).

The following table shows how the incentives and potential reductions are expected to work from 2010-2017:

First Payment Year	First Payment Year Amount, and Subsequent Payment Amounts in Following Years	Reduction in Fee Schedule for Non-Adoption/Use
2011	\$18k, \$12k, \$8k, \$4k, and \$2k	\$0
2012	\$18k, \$12k, \$8k, \$4k, and \$2k	\$0
2013	\$15k, \$12k, \$8k, and \$4k	\$0
2014	\$12k, \$8k, and \$4k	\$0
2015	\$0	-1% of Medicare fee schedule
2016	\$0	-2% of Medicare fee schedule
2017 and thereafter	\$0	-3% of Medicare fee schedule

Note: Physicians in rural health professional shortage areas who adopt/use EHRs are eligible to receive a 10% increase on the incentive payment amounts described above.

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<sup>1</sup> This summary will be updated when additional details become available during the rule-making process.

Note: Physicians who report using an EHR system that is also capable of e-prescribing will no longer be eligible for the e-prescribing bonuses established by the “Medicare Improvements for Patients and Providers Act” (MIPPA); they will be eligible for HIT incentives only to avoid “double-dipping.” Also, e-prescribing penalties sunset after 2014, so that no physician will be subject to penalties for failing to both e-prescribe and use an EHR.

Incentives under the Medicaid program are also available for physicians, hospitals, federally-qualified health centers, rural health clinics, and other providers; however, physicians cannot take advantage of the incentive payment programs under both the Medicare and Medicaid programs. Eligible pediatricians (non-hospital based), with at least 20 percent Medicaid patient volume, could receive up to \$42,500, and other physicians (non-hospital based), with at least 30 percent Medicaid patient volume, could receive up to \$63,750, over a six year period.

In the event that the Secretary of HHS finds that the proportion of health care providers who are meaningful users of EHRs is less than 75%, the Secretary is authorized to increase penalties beginning in 2018, but penalties cannot exceed -5%.

#### ARRA Will Establish HIT Policy and Electronic Standards

ARRA formally establishes the role and functions of the Office of the National Coordinator for Health Information Technology (ONCHIT) within HHS, which is to promote the development of a nationwide interoperable HIT infrastructure. (ONCHIT was already created by Executive Order in 2004).

ARRA establishes the HIT Policy and Standards Committees, which are comprised of public and private stakeholders (e.g., physicians) to provide recommendations on the HIT policy framework, standards, implementation specifications, and certification criteria for EHRs.

HHS is required to adopt, through the regulatory rule-making process, an initial set of standards, implementation specifications, and certification criteria by December 31, 2009, for qualifying EHRs.

ONCHIT is authorized to make available a qualifying EHR system to health care providers for a nominal fee. The AMA will be seeking clarification from HHS on the cost of such a system and the date it will be available. Physicians do not need to purchase the government’s EHR system; they can purchase any qualifying system (i.e., meets certain standards, including interoperability) from a vendor of their choice.

AMA Policy strongly supports positive financial incentives for physicians to acquire and implement HIT. Throughout the legislative process, the AMA urged flexibility in the timeline for HIT adoption and use, given the uncertainties surrounding the readiness of standards, the availability of EHR systems that are interoperable, secure, and affordable, and the rule-making process. The AMA will continue with efforts to ensure that physicians obtain the funds and assistance they need to transition their practices from paper to electronic-based systems.