by David Hartzband, D.Sc.

HIT CONNECTIONS:

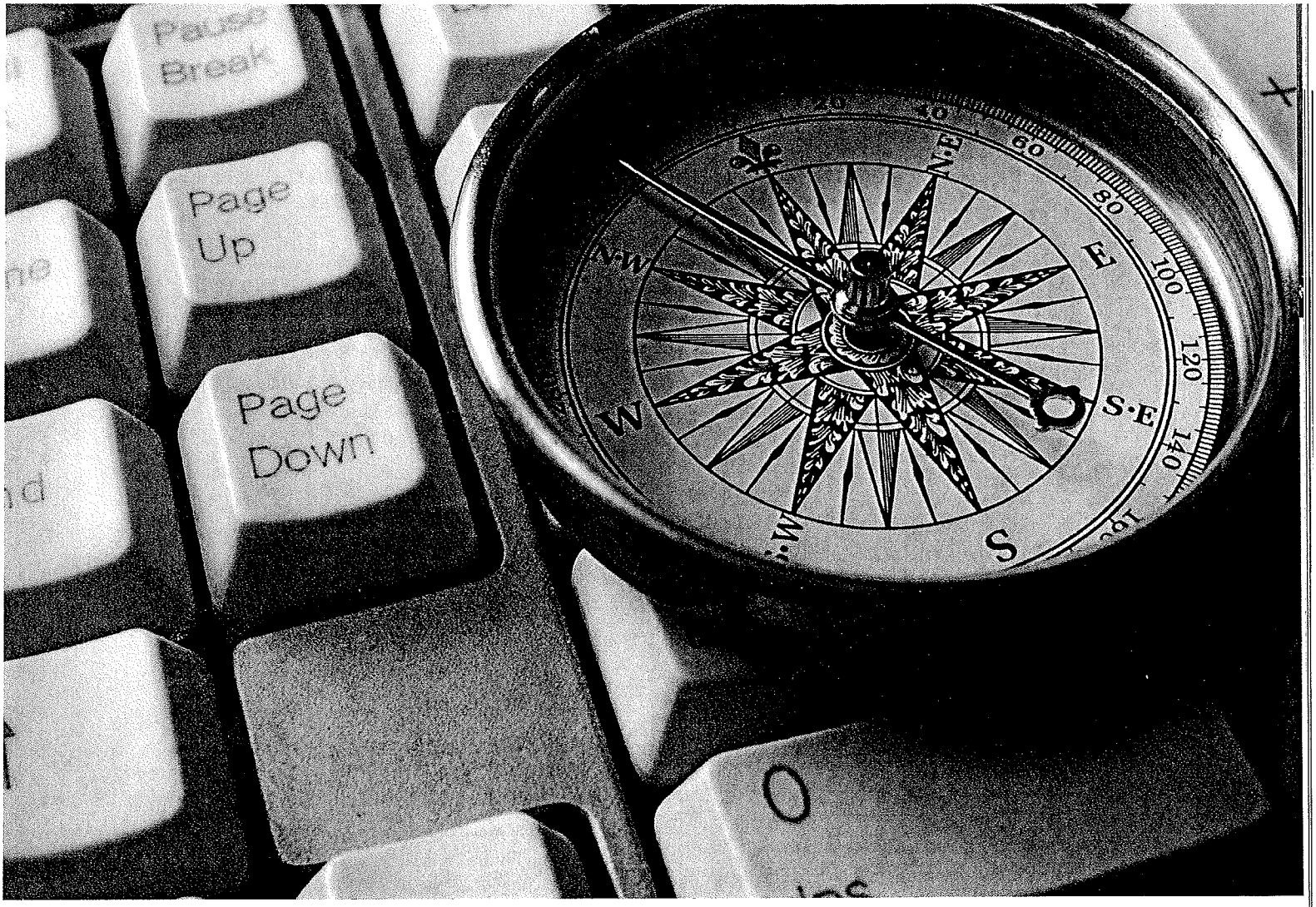
Implications of the ARRA for Health Center HIT

The whole process of acquiring, deploying and maintaining an EHR will now be standards driven.

Passage of the American Recovery and Reinvestment Act (ARRA) last February changed the landscape of health information technology (HIT) overnight. Some people immediately started calling the Act "the HIT stimulus bill." This may not be far from the truth—although the bill is far reaching, with much more in it that is relevant for health centers than just HIT. While there are many provisions in the new law that relate to the acquisition and use of HIT, some are particularly important to health centers. One note: Although the bill uses the term HIT, it is mostly focused on the adoption and use of electronic health record (EHR) systems.

Immediately, the Recovery Act codifies by law the Office of the National Coordinator for Health Information Technology (ONC) within the Department of Health and Human Services (HHS), which is charged with both coordinating national efforts to promote HIT adoption and developing and supporting specific initiatives and programs at the national level. Among the many significant sections concerning the ONC specifically and HIT support generally are:

- *Title VIII, Section 3003* requires the ONC to set up a HIT Standards Committee that will, by the end of this year, produce an initial set of standards to be used in HIT and health information exchange.



- *Title VIII, Section 3007* directs the ONC to support the development of qualified EHR systems and make it available to health care providers at a nominal fee.
- *Title VIII, Section 3014* provides that the ONC may award competitive grants to states and Indian tribes for the purpose of establishing loan funds that could be used by health care providers toward the purchase of certified EHRs.
- *Title IV, Section 4201* directs the Secretary of HHS to offer payment incentives to providers for "meaningful use" of EHRs.

HIT Standards

Why are standards important enough to be covered in this bill? The answer depends not so much on standards themselves but on their *enforcement and common use*. Standards can be defined simply as agreed-upon guidelines referring to interoperability among information systems and applications, and there are many entities currently issuing HIT standards.

The Recovery Act sets up an **HIT Standards Panel** reporting to the National Coordinator for HIT at the ONC. This panel is directed to recommend implementation standards and certification criteria to the National Coordinator, including those that they have developed independently or evaluated and vetted from other sources.

The first set of standards is to be adopted by December 31, 2009. This is important because the specification of a set of interoperability standards and certification criteria for electronic health record systems by an HHS entity will carry more weight than any standards body currently has. While the panel is unlikely to change any of the major standards currently in use (Health Level 7, for instance) the whole process of acquiring, deploying and maintaining an EHR will now be standards driven, and HIT standards could finally become effective in providing the basis for the adoption of systems as well as the exchange of health care data. This is an area to watch.

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Access to the Technology

There are two provisions that might make acquiring and maintaining an electronic health record system more possible for health centers. The first of these (Title VIII, Section 3007) is the section that directs the National Coordinator to make a certified EHR available to health care providers. It is too early to speculate as to whether the ONC will, in fact, directly make an EHR available, especially because the provision provides that the HHS Secretary must first determine if the marketplace is meeting the needs for certified EHRs.

An important aspect of this provision, though, is that while the National Coordinator may charge a nominal fee for any EHR offered, "such fee shall take into account the financial circumstances of smaller providers, low-income providers, and providers located in rural or other medically underserved areas." This first provision doesn't take into account the maintenance, training, support and other costs that go into the adoption of an EHR, but we know that these aspects are critical to the successful adoption of a technology.

The second provision (Title VIII, Section 3014) states that the National Coordinator may make grants to states' Indian tribes for the purpose of establishing a loan fund for health care providers that could be used for the purchase of a certified EHR, enhancements or upgrades to an existing EHR, training of personnel, and general improvements to the secure electronic exchange of health care information.

This provision carries a 20 percent funds match, so it may not be viable for some health centers without other support. However, it acknowledges the lack of a level playing field that today prevents some providers, including health centers, from acquiring appropriate HIT. It also begins to provide a mechanism for bridging an all-important gap.

Reimbursement Incentives

Starting in 2011 (this date is important) incentive payments can be made to eligible providers who demonstrate "meaningful use" of EHR technology. These incentives have been described in detail elsewhere, but suffice it to say that the incentives are potentially significant—that no first-year payments will be made after 2016, and that no payments at all will be made after 2021.

Several things are important about these incentives. First, in order to get these incentives, which will be made available through Medicaid incentive payments, health cente must first demonstrate that they qualify as eligible providers and that they are "engage in efforts to adopt, implement or upgrade EHR technology." Adoption—not just acquisition—is the key here.

Second, providers must, after the initial year, demonstrate "meaningful use." But what is meaningful use? This has not been fully determined, but considerable discussion is going on now, and participation in this discussion will be essential so that the viewpoint of health centers is incorporated into this critical definition. Capacity for health information exchange is likely to be a requirement.

Finally, what are the chances that a health center will receive these incentives if it is not already well down the path tc meaningful use of an EHR? We know from experience that it is a time-consuming process to select, acquire, adopt and use any new health care technology.

We also know that this process is especially difficult for EHR adoption and use, as this requires changes to both operational and clinical workflows. The process of EHR adoptio can often take two to three years, which means that if you started now, you might first qualify for incentives in 2012.

While much depends on how HHS ultimately defines "meaningful use," it is clear that providers have little time to waste. Centers that have not yet begun the process of EHR adoption must start right now, and all providers must select certified applications, remain mindful of the pending determination of meaningful use definitions, and make note of key milestone dates in order to qualify for incentive payments.

Opportunities to Improve Quality of Care

The American Recovery and Reinvestment Act provides huge potential in the realm of information technology. The HIT Standards Panel may finally bring some much-needed clarity to the standards area. Health centers may be able to acquire certified EHRs through the Office of the National Coordinator and may also qualify for loans to acquire this technology, as well as to upgrade, train staff and improve information exchange.

Finally, providers at health centers may be eligible for financial incentives through the meaningful use of EHR technology. This will accelerate the real use of EHRs and may also facilitate the use of electronic information exchange to improve quality of care for health center patients.

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