

**H.R. 1 American Recovery and Reinvestment Act
As Signed into Law
Summary of Health Related Provisions**

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OVERVIEW

The Conference Agreement for H.R. 1, the American Recovery and Reinvestment Act, was agreed to by the House and Senate on February 13, 2009 and signed into law by President Obama on February 17th. The Act has two major sections. Division A- Appropriations Provisions, which includes new funding for the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) as well as part of the funding for new health information technology and comparative effectiveness initiatives. Division B – Tax, Unemployment, Health, State Fiscal Relief and Other Provisions, includes new COBRA continuation premium subsidies and increased and liberalized Health Coverage Tax Credits, increased funding for Medicaid, and miscellaneous Medicare changes. According to the Congressional Budget Office (CBO), the Act will increase federal budget deficits by \$787 billion over the 2009-2019 period. Of that amount, health-related provisions account for roughly \$150 billion. CBO estimates that the Act will increase employment by 1.2 million to 3.6 million by the fourth quarter of 2010.

DIVISION A – APPROPRIATIONS PROVISIONS

Title VIII— HHS Health-Related Appropriations

Health Resources and Services Administration (HRSA)

The Act appropriates \$2.5 billion for programs and activities administered by HRSA. Of this amount, \$500 million is available for grants to community health centers; \$1.5 billion for grants for construction, renovation, and equipment including acquisition of health information technology systems for community health centers and health center controlled networks of providers; and \$500 million to address health professions workforce shortages, of which \$75 million is set aside for the National Health Service Corps for scholarships and loan repayments and for other operational needs of the Corps. The Secretary is required to submit to Congress within 90 days a detailed plan for the use of the funds and a report on use of the funds every six months beginning November 1, 2009.

National Institutes of Health (NIH)

The Act provides an additional \$1.3 billion to the NIH Center for Research Resources of which \$1 billion is reserved for grants or contracts to construct, renovate, or repair non-Federal research facilities, and \$300 million to support shared instrumentation and other capital research equipment for entities receiving grants or contracts. The Center is required to submit an annual report to Congress identifying the grant and contract awardees and the amounts and purposes for use of these funds.

The Office of the Director of NIH is appropriated an additional \$8.2 billion, of which \$7.4 billion is required to be transferred to the various Institutes, Centers, and the Common Fund to support scientific research and support activities including equipment for the clinical center and centralized information support systems. Up to \$400 million of this amount may be used to support research projects under the flexible research authority provisions.

In addition, the Act provides \$500 million for construction, improvement, and repair of NIH buildings and facilities.

Agency for Healthcare Research and Quality (AHRQ)

The Act includes \$1.1 billion for comparative effectiveness research, of which \$300 million is for use by AHRQ, \$400 million must be transferred to NIH, and \$400 million will be available for discretionary use by the Secretary of HHS. The bill requires that funds be appropriated to the Secretary of HHS. *(See Comparative Effectiveness Research below.)*

Public Health and Social Services Emergency Fund

The Act includes \$50,000,000 for the Public Health and Social Services Emergency Fund (PHSSEF) to improve information system security at HHS. It does not include the \$430 million for pandemic influenza preparedness and biomedical research and development that was in the House-passed bill.

Prevention and Wellness Fund

The Act appropriates \$1 billion for the Prevention and Wellness Fund which may be transferred to appropriate agencies within HHS. Within the total, \$300 million is designated for transfer to the Centers for Disease Control and Prevention (CDC) to carry out an immunization program. An additional \$650 million is set aside for evidence-based clinical and community-based prevention and wellness strategies that deliver specific, measurable health outcomes that address chronic disease rates. In addition, \$50 million is reserved for grants to the states to implement healthcare-associated infection reduction strategies. No more than 0.5% of these funds may be used for administration or oversight of these initiatives. The Secretary is required to furnish Congress an operating plan for these funds within 90 days and subsequent reports detailing the use of the funds and any related evaluations.

Comparative Effectiveness Research

Agency for Healthcare Research and Quality

\$700,000,000 is appropriated to the Agency for Healthcare Research and Quality for comparative effectiveness research under the Public Health Service Act, title XI of the Social Security Act, and under section 1013 of the MMA.

National Institutes for Health

Of the \$700,000,000 appropriation to the Agency for Healthcare Research and Quality, \$400,000,000 is transferred to the National Institutes of Health to conduct or support comparative effectiveness research under the Public Health Service Act.

Department of Health and Human Services

An additional \$400,000,000 is appropriated to the Department of Health and Human Services for comparative effectiveness research allocated at the discretion of the Secretary for accelerated development and dissemination of research that assesses

comparative effectiveness of health care treatments and strategies through efforts that—

- (1) conduct, support, or synthesize research that compares the clinical outcomes, effectiveness, and appropriateness of items, services, and procedures used to prevent, diagnose, or treat diseases, disorders, and other health conditions; and
- (2) encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data.

Of the \$400,000,000 appropriated to the Department, \$1,500,000 is allocated for an Institute of Medicine (IoM) report to Congress to recommend national priorities for comparative effectiveness research conducted or supported under this funding provision with input from stakeholders.

Conditions of Funding:

Generally: The Secretary must publish information on grants and contracts awarded under the funding, and disseminate research findings to clinicians, patients, and the public. The Secretary shall prepare annual reports for the congressional authorizing committees of jurisdiction on research conducted or supported with this funding. The Secretary and the Directors of the AHRQ and the NIH shall submit to the congressional appropriations committees operating plans for fiscal years 2009 and 2010 detailing types of research conducted, including priority conditions addressed, and specifying allocation of resources and shall submit a report on actual obligations, expenditures, and unobligated balances.

Specific to HHS grants funding: In designating activities for funding comparative effectiveness research, the Secretary shall consider recommendations from the IoM report and from the Federal Coordinating Council for Comparative Effectiveness Research established in this Act. The Secretary may make grants or enter into contracts with appropriate qualified public or private entities to carry out comparative effectiveness research. With respect to grants and contracts awarded from the \$400,000,000 appropriation to the Secretary, in addition to requirements applicable under this appropriation for grants and contracts, recipients of grants and contracts under the appropriation line must afford the public an opportunity to comment on the research, and the conduct of research must be consistent with HHS Department policies on inclusion of women and minorities in research.

Statement of managers:

The Statement of Managers indicates that the comparative effectiveness research funding in the Act is not to be used to mandate coverage, reimbursement, or other policies for any public or private payer. It further clarifies that the research is for the purpose of evaluating and comparing the clinical outcomes, effectiveness, risk, and benefits of two or more medical treatments and services that address a particular medical condition. No mention of cost effectiveness is included in the Statement of Managers.

Federal Coordinating Council for Comparative Effectiveness Research

Section 804 establishes the Federal Coordinating Council for Comparative Effectiveness Research to foster coordination of comparative effectiveness and related health services research by federal departments and agencies. The duties of the Council are to 1) assist departments and agencies to coordinate such research efforts, 2) advise the President and Congress on infrastructure needs and organizational expenditures in the federal government for such research, and 3) submit annual reports on recommendations for those infrastructure needs and organizational expenditures. The Council is composed of 15 members who are senior officials of various federal health departments and agencies and who must be appointed with 30 days of enactment of the Act. The Council is prohibited from mandating coverage, reimbursement or other policies for any public or private payer and reports of the Council may not be construed as mandates or clinical guidelines for payment, coverage, or treatment.

Office of the National Coordinator for Health Information Technology

\$2 billion is appropriated for the Office of the National Coordinator for Health Information Exchange to carry out Title XIII of this Act (see below). Of this amount, \$20 million is to be transferred to the Director of the National Institute of Standards and Technology for continued work on advancing health care information enterprise integration through activities such as technical standards analysis and establishment of conformance testing infrastructure, another \$300 million is to be used to support regional or sub-national efforts toward health information exchange, and 0.25 percent of the funds provided may be used for administration. The funds are contingent upon receipt of an annual operating plan from the Secretary; with the fiscal year 2009 operating plan due not later than 90 days after enactment (subsequent plans must be provided not later than November 1 of each year).

Title XIII—Health Information Technology

Sec. 13001. Short Title; Table of Contents of Title

This title may be cited as the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Subtitle A—Promotion of Health Information

Part 1—Improving Health Care Quality, Safety, and Efficiency

Sec. 13101. ONCHIT; standards development and adoption

The Public Health Service Act is amended to add a new Title XXX, whose sections are summarized below.

Title XXX—Health Information Technology and Quality

Sec. 3000. Definitions

This section defines 14 terms, including certified electronic health record (EHR) technology, health care provider, health information technology (HIT), and qualified EHR.

Sec. 3001. Office of the National Coordinator for Health Information Technology

This section codifies an Office of the National Coordinator of Health Information Technology (ONC) and specifies the purpose of the Office and the duties of the National Coordinator. These duties include:

1. Reviewing and determining whether to endorse standards, implementation specifications, and certification criteria for the electronic exchange and use of health information recommended by the HIT Standards Committee.
2. Coordinating HIT policy and programs of the Department with those of other executive branch agencies and being a leading member in the establishment and operations of the HIT Policy and Standards Committees (see below).
3. Updating the Federal Health IT Strategic Plan (developed as of June 3, 2008) to include specific objectives, milestones, and metrics with respect to a range of matters, and measurable outcome goals. Among other things, the plan must address strategies to enhance the use of HIT in improving the quality of health care, reducing medical errors, reducing health disparities, improving public health, increasing prevention and coordination with community resources, and improving the continuity of care among health care settings.
4. Maintaining a website to ensure transparency in promotion of a nationwide HIT infrastructure.
5. In consultation with the Director of the National Institute of Standards and Technology (NIST), keeping or recognizing a program or programs for the voluntary certification of HIT, which shall include, as appropriate, testing of the technology in accordance with section 13201 (see below).
6. Preparing reports and publications, including: (a) a report (not later than 12 months after enactment) on any additional funding or authority needed by the National Coordinator or the HIT Policy and Standards Committees to evaluate and develop standards, implementation specifications, and certification criteria, or to achieve full participation of stakeholders in the adoption of a national HIT infrastructure; (b) a report that identifies lessons learned from major public and private health care systems in their implementation of HIT; (c) an assessment of the impact of HIT on communities with health disparities and uninsured, underinsured, and medically underserved areas, which identifies practices to increase HIT adoption in such communities; (d) an evaluation of benefits and costs of the electronic use and exchange of health information; and (e) an annual estimate of the resources required to reach the goal of utilization of an EHR for each person in the United States by 2014.
7. Providing financial assistance to consumer advocacy groups and not-for-profit entities to defray the costs associated with their participation under the National

Technology Transfer Act of 1995 (Note: such assistance may be provided but is not mandated).

8. Establishing a governance mechanism for the nationwide health information network.

Not later than 12 months after enactment, the Secretary must appoint a Chief Privacy Officer of the Office of the National Coordinator to advise the National Coordinator on privacy, security, and data stewardship of electronic health information, and to coordinate with other Federal agencies, State and regional efforts, and foreign countries on these matters.

Sec. 3002. HIT Policy Committee

An HIT Policy Committee is established to make policy recommendations to the National Coordinator relating to the implementation of a nationwide HIT infrastructure. The Policy Committee must recommend the areas in which standards, implementation specifications, and certification criteria are needed for the electronic exchange and use of health information and an order of priority for the development, harmonization, and recognition of such standards, specifications and criteria. In doing so, the Policy Committee must make recommendations for at least the following areas:

1. Technologies that protect the privacy of health information and promote security in a qualified EHR;
2. A nationwide HIT infrastructure that allows for the electronic use and accurate exchange of health information;
3. The utilization of a certified EHR for each person in the United States by 2014;
4. EHR-related technologies that allow for an accounting of information disclosures made for treatment, payment, and health care operations;
5. The use of certified EHRs to improve the quality of health care;
6. Technologies that allow individually identifiable health information to be rendered unusable, unreadable, or indecipherable to unauthorized individuals;
7. The use of electronic systems to ensure the comprehensive collection of patient demographic data; and
8. Technologies that address the needs of children and other vulnerable populations.

The Policy Committee may also consider a number of other listed topics. It must serve as a forum for broad stakeholder input on all matters considered.

The Policy Committee will have 3 members appointed by the Secretary, 4 members appointed by Senate/House majority/minority leaders, such other members appointed by the President as representatives of other relevant Federal agencies, and 13 members appointed by the Comptroller General to represent specified stakeholder interests or expertise (3 advocates for patients or consumers, 2 representing health care providers, 1 from a labor organization, 1 with expertise in health information privacy and security, 1 with expertise in improving the health of vulnerable populations, 1 from the research community, 1 from third party payers, 1 from IT vendors, 1 from purchasers/employers, and 1 with expertise in quality measurement/reporting). The provision specifies that no single sector must be allowed to unduly influence the recommendations of the Policy Committee. The Committee must also ensure the participation of outside advisers, including individuals with relevant expertise. The Federal Advisory Committee Act, other than section 14 (which relates termination, renewal and continuation of advisory

committees), will apply to the Policy Committee. All recommendations made by the Committee will be posted on the website of the National Coordinator.

Sec. 3003. HIT Standards Committee

An HIT Standards Committee is created to recommend to the National Coordinator Standards Committee-developed, -harmonized, or -recognized standards, implementation specifications, and certification criteria for the electronic exchange and use of health information for purposes of adoption under section 3004 (see below), and its recommendations must be consistent with the latest recommendations made by the HIT Policy Committee. The Standards Committee must, as appropriate, provide for the testing of such standards and specifications by the National Institute for Standards and Technology under section 13201 (see below). The HIT Standards Committee must serve as a forum for the participation of a broad range of stakeholders to provide input on the matters it considers. Not later than 90 days after enactment, the Standards Committee must develop a schedule for the assessment of HIT Policy Committee recommendations (and must update this schedule annually). The schedule must be published in the Federal Register and the Standards Committee must conduct open public meetings and develop a process to allow for public comment on the schedule and the Committee's recommendations.

The membership of the HIT Standards Committee must at least reflect providers, ancillary healthcare workers, consumers, purchasers, health plans, technology vendors, researchers, relevant Federal agencies, and individuals with technical expertise on health care quality, privacy and security, and on the electronic exchange and use of health information, and its members must represent (and its procedures must ensure) a balance among various sectors of the health care system so that no single sector unduly influences its recommendations. The Secretary may provide or ensure that financial assistance is provided by the HIT Standards Committee to defray in whole or in part any membership fees or dues charged by such Committee to those consumer advocacy groups and not-for-profit entities that work in the public interest as a part of their mission. The Federal Advisory Committee Act, other than section 14, will apply to the Standards Committee, and its recommendations will be posted on the web site of the National Coordinator. No other details are specified in this section regarding the appointment or number of HIT Standards Committee members (except that the National Coordinator is expected to take "a leading position in the establishment and operations" of the Committee).

Sec. 3004. Process for adoption of endorsed recommendations; adoption of initial set of standards, implementation specifications, and certification criteria

Not later than 90 days after receiving standards, implementation specifications or certification criteria endorsed by the National Coordinator, the Secretary, in consultation with other relevant Federal agencies, must determine whether or not to propose their adoption. If the Secretary determines to propose adoption, this will be accomplished by regulation. If the Secretary determines not to propose adoption, the Secretary must notify the National Coordinator and the HIT Standards Committee in writing and provide the Secretary's rationale for not proposing adoption. The Secretary must publish all determinations in the Federal Register.

Not later than December 31, 2009, the Secretary must, through the rulemaking process (with an interim final rule specifically permitted), adopt the initial set of standards, implementation specifications, and certification criteria for the areas required for consideration under section 3002 (see above). Standards, implementation specifications, and certification criteria adopted before enactment (under previous procedures) may be applied towards meeting this requirement.

Sec. 3005. Application and use of adopted standards and implementation specifications by Federal agencies

Requirements relating to the application and uses by Federal agencies of the standards and implementation specifications adopted under section 3004 can be found in section 13111 (see below).

Sec. 3006. Voluntary application and use of adopted standards and implementation specifications by private entities

Except as provided in section 13112 (see below), a private entity cannot be required to adopt or comply with a standard or implementation specification adopted under section 3004, and a private entity with a Federal contract cannot be required to apply or use such standards or specifications with respect to activities not related to the contract.

Sec. 3007. Federal health information technology

The National Coordinator must support the development and routine updating of qualified EHR technology and make it available unless the Secretary determines that the needs and demands of providers are being substantially and adequately met through the marketplace. The National Coordinator may impose a nominal fee for the adoption by a health care provider of such technology, taking into account the financial circumstances of smaller providers, low income providers, and providers located in rural or other medically underserved areas. A private or government entity cannot be required to adopt or use technology provided under this section.

Sec. 3008. Transitions

Nothing is intended to prohibit the AHIC Successor, Inc., doing business as the National eHealth Collaborative, from modifying its charter, duties, membership, and any other structure or function in order to allow the Secretary to recognize it as the HIT Policy Committee or the HIT Standards Committee. Until recommendations are made by the new HIT Policy Committee, recommendations of the HIT Standards Committee must be consistent with the most recent recommendations made by the AHIC Successor, Inc.

Sec. 3009. Miscellaneous provisions

Nothing in this title can be construed as having any effect on HIPAA privacy and security provisions. The Secretary is granted the authority to omit certain entities listed in the definition of provider (in section 3000) when applying the definition under this title, where appropriate.

Sec. 13102. Technical amendment

This section makes a minor technical change.

Part 2—Application and Use of Adopted Health Information Technology Standards; Reports

Sec. 13111. Coordination of Federal activities with adopted standards and implementation specifications

Federal agencies implementing, acquiring, or upgrading HIT systems must utilize, where available, systems and products meeting the standards and implementation specifications adopted under section 3004, as added by section 13101 (see above).

Sec. 13112. Application to private entities

Federal agencies shall require in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements, acquires, or upgrades HIT systems, it utilize, where available, systems and products that meet standards and implementation specifications adopted under section 3004, as added by section 13101.

Sec. 13113. Study and reports

Not later than 2 years after enactment and annually thereafter, the Secretary must submit to Congressional committees of jurisdiction a report on what the Federal government and private sector have done to facilitate HIT adoption, what barriers remain, and what could be done to help achieve full implementation of a nationwide system for the electronic use and exchange of health information.

Not later than 2 years after enactment, the Secretary must submit a report to the Congressional committees of jurisdiction on methods for creating efficient reimbursement incentives for improving health care quality in Federally qualified health centers, rural health clinics, and free clinics.

Not later than 24 months after enactment, the Secretary must submit a report to the Congressional committees of jurisdiction on matters relating to the potential use of new aging services technologies to assist seniors, individuals with disabilities, and their caregivers throughout the aging process, including barriers to innovation in, and adoption of, such technologies and strategies for removing them. Aging services technology is defined as health technology that meets the health care needs of seniors, individuals with disabilities, and the caregivers of such seniors and individuals.

Subtitle B—Testing of Health Information Technology

Sec. 13201. National Institute for Standards and Technology testing

In coordination with the HIT Standards Committee, the Director of the National Institute for Standards and Technology (NIST) shall test HIT-related standards and

implementation specifications, as appropriate, in order to assure the efficient implementation and use of such standards and implementation specifications. The Director shall also support the establishment of a conformance testing infrastructure, including the development of technical test beds. This infrastructure may include a program to accredit independent, non-Federal laboratories to perform testing.

Sec. 13202. Research and development programs

The NIST Director must establish a program of assistance (via competitive grants) to institutions of higher education (or consortia thereof which may include nonprofit entities and Federal Government laboratories) to establish multidisciplinary Centers for Health Care Information Enterprise Integration. The purposes of these Centers are to generate innovative approaches to health care information enterprise integration (defined elsewhere as the electronic linkage of healthcare providers, health plans, the government, and other interested parties, to enable the electronic exchange and use of health information among all the components in the health care infrastructure) by conducting cutting-edge, multidisciplinary research on the systems challenges to health care delivery and the development and use of health information technologies and other complementary fields. Research areas may include such things as interfaces between human information and communications technology systems, voice-recognition systems and software that improves interoperability and connectivity among health information systems. Grant applications must describe the technology transfer activities to demonstrate and diffuse the Center's research results and how the Center will contribute to the education and training of researchers and other professionals in fields relevant to health information enterprise integration.

This section also specifies that the National High-Performance Computing Program must include Federal research and development programs related to HIT.

Subtitle C—Grants and Loans Funding

Sec. 13301. Grant, loan, and demonstration programs

This section adds sections to the new Title XXX of the Public Service Act, which are summarized below.

Sec. 3011. Immediate funding to strengthen the health information technology infrastructure

This section gives the Secretary the authority to use funds appropriated under section 3018 (see below) to promote the electronic exchange and use of health information by investing funds through various Federal agencies to support HIT architecture, development and adoption of appropriate certified EHRs for categories of health care providers not eligible for EHR-related Medicare or Medicaid incentives, training and dissemination of information on best practices to integrate HIT, infrastructure and tools for the promotion of telemedicine, promotion of interoperability of clinical data repositories or registries, promotion of technologies and best practices that enhance the protection of health information, and improvement and expansion of the use of HIT by public health departments.

Sec. 3012. Health information technology implementation assistance

The Secretary must establish a health information technology extension program to assist health care providers to adopt, implement and effectively use certified EHR technology. The Secretary must create an HIT Research Center to provide technical assistance and develop or recognize best practices to support and accelerate efforts to adopt, implement, and effectively use HIT. The Secretary must also provide assistance for the creation and support of regional centers to provide technical assistance and disseminate best practices and other information learned from the HIT Research Center. Regional centers must be affiliated with any United States-based nonprofit institution or organization, or group thereof. Each regional center must aim to provide assistance and education to all providers in a region but must prioritize direct assistance first to public or not-for-profit hospitals or critical access hospitals, Federally qualified health centers, entities located in rural and other areas that serve uninsured, underinsured, and medically underserved individuals, and individual or small group practices (or a consortium thereof) that are primarily focused on primary care. The Secretary may not provide financial assistance to a regional center for more than four years and may not cover more than 50 percent of its capital and annual operating and maintenance costs (except in an instance of national economic conditions which would render this cost-sharing requirement detrimental to the program). Regional centers would be subject to independent biennial evaluations and must receive positive evaluations in order to receive continued funding.

Sec. 3013. State grants to promote health information technology

The Secretary may award HIT planning and implementation grants to States or qualified State-designated entities. Funds are to be used to facilitate and expand the electronic movement and use of health information. To be a qualified State-designated entity, an entity must be a not-for-profit entity with broad stakeholder representation on its governing board, demonstrate that one of its principal goals is to use HIT to improve health care quality and efficiency, and adopt nondiscrimination and conflict of interest policies. States and qualified State-designated entities must consult with relevant stakeholders. States must match Federal grants at not less than \$1 for each \$10 of Federal funds in fiscal year 2011, at not less than \$1 for each \$7 of Federal funds in fiscal year 2012, and at not less than \$1 for each \$3 of Federal funds in fiscal year 2013 and each subsequent fiscal year (the Secretary is authorized to determine an appropriate matching policy for fiscal years prior to 2011).

Sec. 3014. Competitive grants to States and Indian tribes for the development of loan programs to facilitate the widespread adoption of certified EHR technology

The National Coordinator is authorized to award competitive grants to States or Indian tribes for the establishment of programs for loans (or loan guarantees) to health care providers (but such awards may not be made prior to January 1, 2010). Grant recipients must establish a certified EHR technology Loan Fund and develop a strategic plan for the use of the Loan Fund. Loans made by the Loan Funds must be used to facilitate the purchase of certified EHR technology, enhance the utilization of certified EHR technology, train personnel in the use of such technology, or improve the secure electronic exchange of health information. The interest rate for each loan must not exceed the market interest rate, and the principal and interest payments on each loan must commence not later than 1 year after the date the loan was awarded and be fully

amortized not later than 10 years after such date. Each eligible entity may use up to 4 percent of the funds provided to it to pay program administration costs. A Loan Fund may accept private sector contributions but contributors may not specify loan recipients and States/Indian tribes must make publicly available the identity of, and amounts contributed by, private sector entities. The matching requirement under this provision is not less than \$1 for each \$5 of Federal funds.

Sec. 3015. Demonstration program to integrate information technology into clinical education

The Secretary is authorized to award grants, on a competitive basis, to carry out demonstration projects to develop academic curricula integrating certified EHR technology in the clinical education of health professionals. Eligible entities include schools of medicine, osteopathic medicine, dentistry, or pharmacy, graduate programs in behavioral or mental health, or any other graduate health professions schools, and graduate schools of nursing or physician assistant studies (and consortia of two or more of any such schools), and institutions with a graduate medical education program in medicine, osteopathic medicine, dentistry, pharmacy, nursing or physician assistance studies. Grantees must use funds in collaboration with two or more disciplines and to integrate certified EHR into community-based clinical education. The Secretary may not cover more than 50 percent of the costs of any activity for which assistance is provided (except in an instance of national economic conditions which would render such a cost-sharing requirement detrimental to the program). The Secretary must evaluate projects funded under this section and submit annual reports to Congressional committees of jurisdiction on such projects, with recommendations based on their evaluation.

Sec. 3016. Information technology professionals in health care

The Secretary must provide assistance to institutions of higher education (or consortia thereof) to establish or expand medical health informatics education programs.

Sec. 3017. General grant and loan provisions

The Secretary may require grant and loan recipients to submit a report not later than 1 year after receiving assistance, with such report to include an analysis of the effectiveness of the activities supported by such assistance and their impact on health care quality and safety. The National Coordinator must annually evaluate the activities conducted under this subtitle and use the lessons learned to guide future awards.

Sec. 3018. Authorization for appropriations

For carrying out this subtitle, such sums are authorized to be appropriated for fiscal years 2009 through 2013.

Subtitle D—Privacy

Sec. 13400. Definitions

This section defines various terms, including “breach,” which is defined as the unauthorized acquisition, access, use, or disclosure of protected health information

which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. Exceptions are made for certain unintentional or inadvertent actions. The term “personal health record” (PHR) is defined as an electronic record of PHR identifiable information on an individual that can be drawn from multiple sources and that is managed, shared, and controlled by or primarily for the individual. Most other definitions are tied to the existing Privacy Rule.

Part 1—Improved Privacy Provisions and Security Provisions

Sec. 13401. Application of security provisions and penalties to business associates of covered entities; annual guidance on security provisions

Security provisions that currently apply to HIPAA covered entities (and those being added by this Act) and related civil and criminal penalties are applied to their business associates as well. The Secretary must annually issue guidance on the most effective and appropriate technical safeguards for meeting security requirements.

Sec. 13402. Notification in the case of breach

In case of a breach of unsecured information, the covered entity must notify all affected individuals (or next of kin if an individual is deceased) no later than 60 calendar days after discovery by first-class mail or e-mail if the latter is specified as preferred by an individual (in case of a breach, a business associate must notify the pertinent covered entity). In cases of inadequate or out-of-date contact information for 10 or more affected individuals, the covered entity must post a conspicuous notice on its Web site or place notices in major print or broadcast media (providing a toll-free number where individuals can learn whether their information was affected by the breach). If more than 500 individuals are affected by a breach, the covered entity shall provide notice to prominent media outlets and provide immediate notice to the Secretary (breaches involving fewer individuals may be reported to the Secretary annually). The Secretary will post on the Web site of the Department of Health and Human Services a list of covered entities involved in breaches affecting more than 500 individuals. Required notifications and postings may be delayed for certain law enforcement and national security purposes.

Unsecured protected health information is defined as information not secured through the use of a technology or methodology specified by the Secretary in guidance (or until such guidance is issued, a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards development organization accredited by the American National Standards Institute). The Secretary must issue such guidance not later than 60 days after the date of enactment and annually update the guidance thereafter. The Secretary must annually report to Congress about data breaches. Interim final rules implementing the breach-related requirements must be promulgated no later than 180 days after enactment, and the requirements will apply to breaches that are discovered on or after the date that is 30 days after the publication date of such rules.

Sec. 13403. Education on health information privacy

Not later than 6 months after enactment, the Secretary must designate a privacy advisor in each regional office. Not later than 12 months after enactment, the Office for Civil Rights must develop a national education initiative on uses of health information and the rights of individuals with respect to such uses.

Sec. 13404. Application of privacy provisions and penalties to business associates of covered entities

Privacy requirements and related civil and criminal penalties that currently apply to HIPAA covered entities (and those added by this Act) are applied to the business associates of covered entities.

Sec. 13405. Restrictions on certain disclosures and sales of health information; accounting of certain protected health information disclosures; access to certain information in electronic format

Covered entities must comply with requests to restrict the disclosure of an individual's protected health information if the disclosure is to a health plan for purposes of carrying out payment or health care operations and the information pertains solely to a health care item or service paid for out-of-pocket by the individual.

In using, disclosing or requesting protected health information, covered entities must limit themselves, to the extent practicable, to limited data sets or the minimum necessary information. Not later than 18 months after enactment, the Secretary must issue guidance on what constitutes "minimum necessary."

Electronic health record (EHR) users or maintainers must provide requesting individuals with an accounting of protected health information disclosures made during the three years prior to the request (but only for as much of that three year period during which the EHR was in use). The Secretary must promulgate regulations specifying the information to be collected about each disclosure. EHR users as of January 1, 2009 must comply with the accounting requirement for disclosures made on and after January 1, 2014. For covered entities acquiring EHR after January 1, 2009, the requirements will apply to disclosures made on and after the later of January 1, 2011 or the date it acquires an EHR. The Secretary may specify later effective dates if necessary for both categories of EHR users but no later than 2016 and 2013, respectively.

Covered entities and their business associates may not receive remuneration in exchange for any protected health information of an individual unless the covered entity obtains a valid authorization from the relevant individual or certain exceptions apply. Exceptions include the following: (1) for public health activities; (2) for research as defined in the Privacy Rule and the price charged reflects the costs of preparation and transmittal of the data; (3) for treatment of the individual; (4) the sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity or an entity that will become a covered entity; (5) the activities of a business associate requested by the covered entity; (6) to provide an individual with a copy of the individual's protected health information; and (7) for purposes determined by the Secretary in regulations as being similarly necessary and appropriate as #1-6. Not later than 18 months after

enactment, the Secretary shall promulgate implementing regulations. In doing so, the Secretary must evaluate the impact of restricting the exception under #1 to require that the price charged reflects the costs of the preparation and transmittal of the data on research or public health activities, including those conducted by or for the use of the Food and Drug Administration (the Secretary is authorized to adopt this further restriction if the Secretary finds it will not impede such research or public health activities). The restrictions on sale of protected health information will be effective for information exchanges occurring on or after the date of the promulgation of final implementing regulations.

If a covered entity uses or maintains an EHR with respect to protected health information of an individual, such individual may obtain an electronic copy of such information and request that such copy be transmitted directly to an entity or person designated by the individual (any cost for doing so must not be greater than the entity's labor costs in responding to the request).

Sec. 13406. Conditions on certain contacts as part of health care operations

A communication by a covered entity or business associate about a product or service that encourages recipients of the communication to purchase or use the product or service will no longer be considered a health care operation unless it relates to a health care-related product or service (meaning that an individual's authorization would otherwise be needed to send such communications).

Communications by a covered entity or business associate regarding the marketing of health-related products or services shall not be considered a health care operation if the covered entity receives or has received direct or indirect payment in exchange for making such communications unless one of the following applies: (1) the communications pertain to a drug or biologic currently being prescribed for the recipient of the communication and the payment received by the covered entity is reasonable in amount (as defined by the Secretary); (2) the communications are made by the covered entity and have been authorized by the recipients; or (3) the communications are made by a business associate on behalf of the covered entity and consistent with a written contract or arrangement between the business associate and covered entity.

Fundraising communications sent by covered entities must clearly indicate how recipients may opt out of receiving future communications of this type.

The above requirements are effective 12 months after the date of enactment.

Sec. 13407. Temporary breach notification requirement for vendors of personal health records and other non-HIPAA covered entities

PHR vendors must notify individuals affected by a breach of their unsecured PHR identifiable health information and they must also notify the Federal Trade Commission about such breaches (a vendor's third party service provider must notify the vendor regarding any such breach). The Federal Trade Commission must, in turn, notify the Secretary of Health and Human Services. The breach notification requirements applying to covered entities and business associates (see section 13402 above) will apply to PHR vendors and their third party service providers in a manner to be specified by the Federal Trade Commission. Violations will be treated as an unfair and deceptive act or practice. The definition of unsecured information is the same as they specified under section 13401. Not later than 180 days after enactment, the Federal Trade Commission must promulgate interim final implementing regulations, and the breach-related requirements will apply to breaches discovered on or after the date that is 30 days after the date of

publication of such regulations. Further, these requirements would not apply to breaches discovered on or after the effective date of regulations implementing any new legislation establishing requirements for breach notification that apply to entities that are not HIPAA covered entities or business associates.

Sec. 13408. Business associate contracts required for certain entities

This section requires business associate contracts for certain entities exchanging information with HIPAA covered entities and business associates, including Health Information Exchange Organizations, Regional Health Information Organizations, E-prescribing Gateways, and vendors that contract with a covered entity to allow that covered entity to offer a PHR to patients as part of its EHR.

Sec. 13409. Clarification of application of wrongful disclosures criminal penalties

This section clarifies that wrongful disclosure criminal penalties apply to individual employees of a covered entity and other individuals, not just to the covered entity itself.

Sec. 13410. Improved enforcement

The Secretary must impose civil monetary penalties for noncompliance with security and privacy requirements due to willful neglect and must formally investigate any complaint of a violation if a preliminary investigation indicates a possible violation due to willful neglect. The amounts of such penalties would be transferred to the Office for Civil Rights to support privacy and security enforcement efforts.

Not later than 18 months after enactment, the Government Accountability Office must submit a report to the Secretary including recommendations for a methodology under which an individual harmed by privacy or security violations may receive a portion of any civil monetary penalties or settlements. Not later than 3 years after enactment, the Secretary must establish by regulation such a methodology.

The following tiers of civil monetary penalties are specified for different types of privacy/security violations: (1) \$100 for each violation but no more than \$25,000 for all violations of an identical requirement or prohibition; (2) \$1,000 per violation but no more than \$100,000 in total; (3) \$10,000 per violation but not more than \$250,000 total; and (4) \$50,000 per violation but not more than \$1.5 million total. For violations where it is established that the person did not know (and by exercising reasonable diligence would not have known), the minimum penalty is tier 1. For violations due to reasonable cause and not to willful neglect, the minimum penalty is tier 2. For violations due to willful neglect that are corrected, the minimum penalty is tier 3. The maximum penalty in all three cases is tier 4. For violations due to willful neglect that are not corrected, the minimum penalty is tier 4. These provisions apply to violations occurring after enactment.

State Attorneys General are authorized to bring civil actions in a Federal district court if they believe that an interest of one or more residents of their state has been or is threatened or adversely affected by a violation of privacy or security requirements (they cannot do so during the pendency of an action on the same violation brought by the Secretary). Damages of up to \$25,000 (for all violations of an identical requirement or prohibition during a year) and attorney fees may be awarded. The Secretary generally must receive prior written notice of any action brought by a State Attorney General and

has the right to intervene in the action. This provision is effective for violations occurring after enactment.

The Office for Civil Rights retains the right to use corrective action without a penalty in cases where the person did not know (and by exercising reasonable diligence would not have known) of the privacy or security violation involved.

Sec. 13411. Audits

The Secretary must provide for periodic audits to ensure that covered entities and their business associates are complying with privacy and security requirements.

Part 2—Relationship to Other Laws; Regulatory References; Effective Date; Reports

Sec. 13421. Relationship to other laws

The HIPAA State preemption policy applies to all the new privacy and security provisions (meaning, among other things, that more stringent state protections are not preempted). Existing HIPAA privacy and security requirements consistent with the new provisions remain in effect and the Secretary is directed to amend Federal regulations to address any inconsistencies.

Sec. 13422. Regulatory references

References to a provision of the Code of Federal Regulations (for example, provisions of the Privacy Rule) refer to such provision as in effect on the date of enactment (or to the most recent update of such provision).

Sec. 13423. Effective date

Unless otherwise specified, the provisions of Part 1 are effective on the date that is 12 months after the date of enactment.

Sec. 13424. Studies, reports, guidance

The Secretary must submit annual reports regarding complaints of alleged violations of privacy and security requirements, including how they were addressed and resolved, to the Congressional Committees of jurisdiction. These reports will include the Secretary's plan for improving compliance and will be made available on the Department's website.

Not later than 1 year after enactment, the Secretary, in consultation with the Federal Trade Commission, must submit a report to the Congressional Committees of jurisdiction regarding privacy and security requirements that should be applied to entities that are not covered entities or business associates, including vendors of personal health records (PHRs), entities that offer products or services through the website of a PHR vendor or the website of a covered entity that offers PHRs to individuals, entities that access information in a PHR or send information to it, and third party service providers that assist in providing PHR products or services. The report must include a timeframe for implementing needed regulations.

Not later than 12 months after enactment, the Secretary must issue guidance on how best to implement requirements for the de-identification of protected health information.

Not later than 1 year after enactment, the Government Accountability Office (GAO) must submit a report to Congressional Committees of jurisdiction on the best practices related to disclosure among health care providers of protected health information of an individual for purposes of treatment.

Not later than 5 years after enactment, GAO must submit a report to Congress and the Secretary on the impact of the provisions of this Act on health insurance premiums, overall health care costs, adoption of EHRs by providers, and reduction in medical errors and other quality improvements.

The Secretary is directed to study the definition of “psychotherapy notes” in the Privacy Rule with regard to including test data that is related to direct responses, scores, items, forms, protocols, manuals, or other materials that are part of a mental health evaluation, and may, based on this study, issue regulations revising the definition.

DIVISION B – HEALTH, MEDICARE, MEDICAID, STATE FISCAL RELIEF

Title I—Tax Provisions

Sec.1511. Delay in Application of Withholding Tax on Government Contractors

On May 17, 2006, President Bush signed into law the Tax Increase Prevention and Reconciliation Act of 2005 (P.L. 109-222). The primary purpose of the law was to extend the then reduced rates for dividends and capital gains as well as to protect individual tax payers from the alternative minimum tax for tax year 2006.

To offset some of the law’s cost, a number of revenue increasing provisions were included. One of these provisions was Section 511 “Imposition of Withholding on Certain Payments Made by Government Entities.” Under this provision, all governmental entities with expenditures of at least \$100 million are required to withhold three percent of all payments for services or property to certain contractors. The provision was to be effective December 31, 2010. Of particular concern to health care providers, this provision would require the withholding of three percent of Medicare’s payments to tax-paying Medicare contractors, which would include all tax-paying healthcare providers. The provision would exempt Medicaid payments and other payments based on a determination of need or income test. This particular section was credited with increasing Federal revenues about \$7.0 billion during the period 2011 through 2015. Most of this increased revenue would be realized in 2011.

The American Recovery and Reinvestment Act extends the effective date one year from December 31, 2010 to December 31, 2011.

Title III—Health Insurance Premium Assistance

Secs 1899-1999. Trade Adjustment Act Health Coverage Improvement (Health Coverage Tax Credit)

Under the Trade Adjustment Act of 2002, certain individuals who have lost their jobs as a result of foreign trade or who are recipients (55 or over) of pensions through the Pension Benefit Guaranty Corporation are eligible for a refundable tax credit called the

Health Coverage Tax Credit (HCTC) for 65% of their premiums for qualified health insurance coverage for themselves and their families. (A person who has other coverage, such as employer-provided benefits or Medicare or enrolled in Medicaid or SCHIP, is not eligible for the HCTC.) Insurance qualified for the HCTC has to meet specific federal requirements.

The American Recovery and Reinvestment Act increases the HCTC to 80% of the premium for qualified insurance, effective on or after the first day of the month beginning 60 days after enactment. The increased amount does not apply after December 31, 2010. It also modifies the definition of an eligible TAA recipient to eliminate the requirement that an individual be enrolled in training in the case of an individual receiving unemployment compensation. It also provides continued eligibility for the HCTC for family members in the case of certain events, such as if the eligible individual becomes entitled to Medicare or is divorced or dies.

The Act requires the Secretary of Treasury to conduct a biennial survey of HCTC recipients and their coverage and report back to Congress on the findings. Beginning in 2010, the Secretary must also report to Congress on specified information (e.g., number of eligible persons versus HCTC participants, insurance premiums, and cost-sharing features of the insurance) relating to the HCTC program. The Comptroller General (GAO) is required to conduct a study regarding the HCTC to be submitted to Congress no later than March 31, 2010, including an analysis of the administrative costs to the federal government and to providers of insurance of the HCTC; the health status and relative risk of eligible individuals and those who elect the credit; and reasons why people do and do not participate.

Sec. 1899F-1899L. Premium Assistance for COBRA Continuation of Coverage Benefits

The Act provides a 65% subsidy for COBRA continuation premiums for up to 9 months for eligible workers who have been involuntarily terminated and for their families and who fall below a specific income threshold. The premium subsidy is provided with respect to job terminations that occur on or after September 1, 2008 and before January 1, 2010. Workers who were involuntarily terminated between September 1, 2008 and enactment, but failed to initially elect COBRA because it was unaffordable, will be given an additional 60 days to elect COBRA and receive the subsidy. The 65% subsidy terminates upon offer of new employer-sponsored health care coverage (with the exception of limited benefit plans such as dental coverage, flexible spending accounts, or on-site health care that is only first aid or well-care in nature) or Medicare eligibility. Generally, the subsidy will be reimbursed to the employer through a reduction in its payroll taxes. (Any amount in excess of payroll taxes owed will be treated in the same manner as a tax refund).

The income threshold for the COBRA premium subsidy is based on the individual's modified adjusted gross income for the taxable year in which the subsidy is received (either in 2009 or 2010). Participants must attest that their same year income will not exceed \$125,000 for individuals and \$250,000 for families. Under a process specified in the Act, an individual may make a permanent election to waive the right to the premium subsidy to avoid having to make a repayment to the government.

Group health plans are permitted to provide a special enrollment right to premium assistance-eligible individuals to allow them to change coverage options under the plan in conjunction with electing COBRA continuation coverage. In such a situation, the individual can, for example, elect a different plan offered by the employer than he or she had as an active employee if the premium for the different coverage does not exceed the premium for coverage in which the individual was enrolled before the qualifying event (i.e., involuntary termination) occurred.

Employer plans must comply with new requirements relating to providing notice of the new subsidy to all individuals who terminate employment during the applicable time period. An individual determined to be ineligible for the subsidy may appeal that determination to the Secretary of Labor or Health and Human Services (in consultation with the Secretary of the Treasury). Such appeals must be reviewed within 15 business days after receipt of the request for review.

Title IV—Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions

Subtitle A—Medicare Incentives

Sec. 4101. Incentives for eligible professionals

Beginning in 2011, eligible professionals (physicians as defined in section 1861(r) of the Social Security Act) who are “meaningful users” of electronic health records (EHRs) may receive up to \$44,000 of Medicare payment incentives over a five-year period (up to \$18,000, \$12,000, \$8,000, \$4,000 and \$2,000 in years 1 to 5, respectively). Those who predominantly practice in health professional shortage areas may receive up to 10 percent more. Eligible professionals who become meaningful EHR users after 2012 receive reduced incentives, and those who wait until 2015 to first become meaning EHR users, none at all. And no incentive payments will be made after 2016. The financial incentives do not apply to hospital-based professionals, “such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all” of his or her services “in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment of the hospital.” The determination of whether a professional is hospital-based is made on the basis of site of service and “without regard to any employment or billing arrangement between the eligible professional and any other provider.”

A meaningful user of EHR is defined as one who: (1) demonstrates to the satisfaction of the Secretary that the professional is using certified EHR technology in a meaningful manner, which includes the use of electronic prescribing; (2) demonstrates that the technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care; and (3) uses the EHR to submit certain performance measures to the Secretary (but only if the Secretary has the capacity to receive the information electronically). Performance measures to be reported via EHR technology would need to be published in the Federal Register and open for public comment. The Secretary is authorized to use the following means for demonstrating that a professional is a meaningful EHR user: the professional’s submission of an attestation, claims with appropriate coding, or a survey response, the electronic submission of performance measures, or other means specified by the Secretary. The Secretary must post on the website of the Centers of Medicare & Medicaid Services a

list of names, business addresses and business phone numbers of meaningful EHR users.

Eligible professionals (other than hospital-based professionals) who fail to become meaningful EHR users by 2015 will be subject to Medicare payment reductions under the physician fee schedule. For 2015, 2016 and 2017, payment will be set at 99, 98, and 97 percent, respectively, of the otherwise applicable Medicare fee schedule amount (or at 98 percent in 2015 for physicians who are not e-prescribing). After 2017, the Secretary may increase the penalties to 95 percent if less than 75 percent of eligible professionals have become meaningful EHR users. The Secretary may also make case-by-case exceptions to the penalties if they would result in “a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access” (no one may qualify for an exception for more than five years).

Equivalent financial incentives (including penalties) are provided for Medicare Advantage organizations (organized as health maintenance organizations, as defined in section 2791(b)(3) of the Public Health Service Act) whose employed or closely affiliated physicians are (or are not) meaningful EHR users and furnish at least an average of 20 hours per week of patient care services (in this case, incentive payments are made to the Medicare Advantage organization, not the physicians, and penalties are applied to the Medicare physician expenditure portion of the payments made to the Medicare Advantage plan). Close affiliation means that an eligible professional is employed by, or is a partner of, an entity that through contract furnishes at least 80 percent of the entity’s Medicare patient care services to enrollees of the Medicare Advantage Organization (and the professional in question furnishes at least 80 percent of his or her professional services to such enrollees). A qualifying Medicare Advantage organization will demonstrate meaningful EHR use by its eligible professionals by attestation. The Secretary must post on the CMS Web site the names, business addresses and business phone numbers of each Medicare Advantage organization receiving incentive payments (and of each eligible professional for which such incentive payments are based). Within 120 days of enactment, the Secretary must submit a report regarding what might be done to provide incentives to physicians not qualifying for EHR-related incentives provided by this Act (either on their own or through the Medicare Advantage incentives described here) and who receive payments for Medicare patient services nearly-exclusively from Medicare Advantage organizations. The accompanying conference report notes that this provision “reflects the Congress’s intent to provide payment incentives and adjustments towards the meaningful use of certified EHRs with respect to all physicians who treat Medicare patients without regard to practice organization.”

Sec. 4102. Incentives for hospitals

Beginning in 2011, eligible hospitals (subsection (d) hospitals) that are meaningful users of EHR (with respect to inpatient hospital services) qualify for Medicare incentive payments for up to four years. The amount of the incentive payments for a year is based on a base amount (\$2 million), the total number of the hospital’s discharges, and its Medicare share, and phased out over a five-year period (by applying a transition factor). More specifically, a hospital’s Medicare share is applied to the sum of the base amount and a discharge-related amount (\$200 per discharge for the 1,150th through the 23,000th discharge and nothing for discharges outside this range). The Medicare share is based on the estimated number of bed days attributable to individuals covered under Medicare Part A, including individuals enrolled in a Medicare Advantage organization. In calculating the Medicare share, an adjustment to the denominator (the total number of inpatient-bed-days) is adjusted downward to compensate for days relating to charity care

(the Secretary may use data on uncompensated care to develop an estimate of charity care). For years 1-4, an eligible hospital that is a meaningful EHR user will receive 100 percent, 75 percent, 50 percent and 25 percent, respectively, of the calculated amount. Hospitals becoming meaningful EHR users after 2013 will receive reduced incentives and those doing so after 2015 none at all.

A meaningful user of EHR is defined as a hospital that: (1) demonstrates to the satisfaction of the Secretary that it is using certified EHR technology in a meaningful manner; (2) demonstrates that the technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care; and (3) uses the EHR to submit certain performance measures to the Secretary (but only if the Secretary has the capacity to receive the information electronically). Over time, the Secretary is directed to require more stringent measures of meaningful use.

Performance measures to be reported via EHR technology would need to be published in the Federal Register and open for public comment. The Secretary is authorized to use the following means for demonstrating that a hospital is a meaningful EHR user: the hospital's submission of an attestation, claims with appropriate coding, or a survey response, the electronic submission of performance measures, or other means specified by the Secretary. The Secretary must post on the website of the Centers of Medicare & Medicaid Services the names of eligible hospitals that are meaningful EHR users and other relevant data about those hospitals as determined by the Secretary (subject to advance review of such data by the affected hospitals).

Special rules apply to critical access hospitals (since they already qualify for cost-plus reimbursement under Medicare). For these hospitals, Medicare share will be calculated as for subsection (d) hospitals but an additional 20 percentage points will be added (with Medicare share nevertheless capped at 100 percent). Further, special incentive payments are only available related to costs for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would normally apply. Critical access hospitals that are meaningful EHR users will be able to expense these costs in a single year and receive prompt interim payments for them (equal to 101 percent of the calculated incentive amount). A critical access hospital may qualify for up to 4 consecutive years of special incentive payments but no such payments will be made after 2015. Existing cost-plus reimbursement policies will govern payments for other EHR-related costs, such as those for ongoing maintenance.

Beginning in fiscal year 2015, for hospitals that are not meaningful EHR users, three-quarters of the otherwise applicable update factor under the hospital inpatient prospective payment system will be subject to reductions of one-third for fiscal year 2015, two-thirds for fiscal year 2016 and a full reduction for fiscal year 2017 and each subsequent fiscal year. The Secretary may make case-by-case exceptions to the penalties if they would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access, but no hospital may be granted such an exception for more than 5 years. For hospitals paid under section 1814(b)(3) [Maryland], the State would need to apply an equivalent, aggregate penalty to hospitals that are not meaningful EHR users. Similarly, critical access hospitals that are not meaningful EHR users by 2015 will face payment reductions to 100.66 percent of costs for fiscal year 2015 (from 101 percent under current law), 100.33 percent of costs for fiscal year 2016 and 100 percent of costs for fiscal year 2017 and each subsequent year. Critical access hospitals are also eligible for case-by-case exceptions to these penalties.

Equivalent EHR-related financial incentives (including penalties) will apply to hospitals under common corporate governance with qualifying Medicare Advantage organizations

(those organized as health maintenance organizations) and serve individuals enrolled under the Medicare Advantage plan. The Secretary is authorized to use alternative data and methodologies to determine the applicable incentive payments. Hospitals for which at least one-third of their discharges or bed-days of Medicare patients for the year are covered under Part A, incentive payments will be made under the methodology described earlier, not the equivalent one described here (for other hospitals, the Secretary must take steps to avoid duplicate payments). The names, business addresses, and business phone numbers of Medicare Advantage organizations receiving incentive payments will be posted on the CMS Web site (as well as the names of the hospitals for which such incentive payments are based).

Sec. 4103. Treatment of payments and savings; implementation funding

EHR-related incentive payments will not be taken into account in determining beneficiary premiums.

The Medicare Improvement Fund is modified to permit funds to be used to cover reductions in the Medicare physician fee schedule conversion factor for 2014. The amount allocated to the fund for fiscal year 2014 is changed to \$22.29 billion (in lieu of the current \$19.9 billion for fiscal years 2014 through 2017). For fiscal year 2020 and each subsequent year, the Medicare Improvement Fund would be credited with an amount equal to the estimated Medicare expenditure reductions due to the penalties applied to professionals and hospitals that are not meaningful EHR users.

The following amounts are appropriated for CMS implementation of the EHR-related incentive payment provisions and related matters: \$100 million per year for fiscal years 2009 through 2015, and \$45 million for fiscal year 2016.

Sec. 4104. Studies and reports on health information technology

By June 30, 2010, the Secretary must submit a report to Congress regarding health care providers who benefit minimally or not at all from the EHR-related Medicare and Medicaid incentive payments provided under this Act and include the potential costs and benefits of making payment incentives available to such providers.

By October 1, 2010, the Secretary (in consultation with several Federal departments and agencies) must submit a report to Congress regarding the current availability of open source health information technology systems to Federal safety net providers (including small, rural providers). This report is to include the Secretary's recommendations for appropriate legislation and administrative action.

Subtitle B—Medicaid Incentives

Sec. 4201. Medicaid provider HIT adoption and operation payments; implementation funding

The Federal government would cover 100 percent of the costs for EHR-related Medicaid incentive payments made to Medicaid providers and 90 percent of the related State administrative costs.

For qualifying health professionals, these incentive payments would equal up to 85 percent of the net average allowable costs for adoption and operation of EHR technology (including related maintenance and training). To qualify, at least 30 percent

of a health professional's patient volume must be made up of Medicaid patients (for pediatricians, at least 20 percent of such volume), which includes patients enrolled in Medicaid managed care plans. For health professionals predominantly practicing in a Federally qualified health center or rural health clinic, at least 30 percent of their patient volume must be made up of "needy" individuals (that is, individuals covered under Medicaid or SCHIP, those furnished uncompensated care, and those for whom charges are reduced based on ability to pay). To qualify, health professionals must further waive their rights to receive Medicare EHR-related incentives. Qualifying health professionals include physicians, dentists, certified nurse mid-wives, nurse practitioners and physician assistants (if the physician assistants are practicing in a federally qualified health center or rural health clinic led by a physician assistant); they cannot be hospital-based. Qualifying providers are children's hospitals and any other hospital with at least 10 percent of its patient volume attributable to Medicaid patients.

For health professionals, the net average allowable costs (that is, costs reduced by payments received from other sources, other than a State or local government) for the first year of payment (for purchase and initial implementation or upgrade of EHR technology and related support services, including training) cannot exceed \$25,000 (the Secretary is authorized to specify a lower amount if the Secretary determines based on studies that such lower amount is sufficient, and the first year may not be later than 2016). For up to the following five years, the net average allowable costs (for operation, maintenance and use of EHR technology) cannot exceed \$10,000, provided the professional is determined to be a meaningful EHR user (no such payments may be made after 2021). For qualifying pediatricians, the allowable costs are two-thirds of the amounts applicable to other qualifying professionals. Average allowable costs for health professionals will be determined by the Secretary based on studies (which may include studies submitted by States).

For hospitals, incentives will be based, in part, on the formula used to calculate the Medicare EHR-related incentive payments (see section 4102 above), assuming the Medicare share to be 1 and further assuming that a hospital's discharges increase at the average annual rate of growth of the most recent 3 years for which discharge data are available. This amount will be multiplied by a hospital's Medicaid share, and incentive payments in any year may not exceed 50 percent of the resulting amount or 90 percent of such amount in any 2-year period. Incentive payments may not be made for more than 6 years or begin after 2016.

For CMS administration of the Medicaid incentive program, \$40 million is appropriated annually for fiscal years 2009 through 2015 and \$20 million for fiscal year 2016.

Miscellaneous Medicare

Sec. 4301. Moratoria on Certain Medicare Regulations

Delay in Phase-out of Medicare Hospice Budget Neutrality Adjustment Factor during FY 2009

When CMS switched from using Bureau of Labor Statistics (BLS) data to hospital wage data in 1997 to adjust hospice payments for differences in the labor costs across geographic areas, CMS added a budget neutrality adjustment factor (BNAF). The BNAF prevented participating hospices from experiencing reductions in total payments as a

result of the wage data change. On August 8, 2008, CMS, effective October 1, 2008, began a three-year phase-out of this BNAF. In the final rule, CMS listed five reasons why the agency felt that the BNAF was outdated.

The Act postpones the phase-out or elimination before October 1, 2009. The conference report said, “[t]he Conferees do not anticipate extending this provision as they expect the hospice community to seek a permanent fix in the annual rulemaking cycle for Medicare hospice payments.”

Non-Application of Phased-out Indirect Medical Education (IME) Adjustment Factor for Fiscal Year 2009

In the FY 2008 final hospital inpatient prospective payment system rule, CMS began eliminating, over a three-year transition period, the capital payment adjustment for teaching hospitals. CMS acted because the agency felt that such an adjustment was contributing to excessive payment levels for teaching hospitals. Accordingly, in FY 2008 CMS maintained the current teaching hospital capital payment adjustment. In FY 2009 the adjustment was to cut in half and then beginning in FY 2010 would be eliminated.

The Act stops implementation of the FY 2009 reduction in the capital IME payment. The conference report said, “[t]he Conferees do not anticipate extending this provision as they expect the hospital community to seek a permanent fix in the annual IPPS rulemaking cycle.”

Sec. 4302. Long-term Care Hospital Technical Corrections

Long-term care hospitals (LTCHs) are generally defined as hospitals that have an average length-of-stay greater than 25 days. Such hospitals are designed to provide extended medical and rehabilitative care for patients who are clinically complex and have multiple acute or chronic conditions. LTCHs can exist as Medicare participating providers as a long term care hospital within an acute care hospital (hospital-within-hospital (“LTCH HwH”)), a satellite LTCH of an acute care hospital (“satellite LTCH”), or a freestanding LTCH.

Starting October 1, 2004 CMS imposed limits (generally 25 percent) on the number of Medicare patients a LTCH HwH or satellite LTCH could admit from a co-located host hospital. In general, CMS paid less for discharges in excess of the threshold. And while certain LTCH HwHs and satellite LTCHs were initially exempted from these limits as “grandfathered” facilities (those in existence as of September 30, 1999), CMS extended the limits to such hospitals starting October 1, 2007. At the same time, CMS extended these limits to LTCH discharges admitted from hospitals with which the LTCH or satellite facility was not co-located.

The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) provided for a three-year delay in the imposition of the above limits for grandfathered LTCH HwHs for discharges admitted from a co-located host hospital and a three-year delay of this limit for LTCH HwHs and freestanding LTCHs for referrals from non-co-located hospitals. These MMSEA provisions were effective on or after December 29, 2007.

MMSEA also doubled the above limit (from 25 percent to 50 percent) for certain LTCH HwHs’ and non-grandfathered satellite LTCHs’ discharges admitted from a co-located

hospital and from 50 percent to 75 percent for certain other LTCH HwHs and satellite LTCHs.

Finally, the MMSEA provided a three-year moratorium on new LTCHs or satellite LTCHs with certain exceptions, one of them for an approved certificate of need (CON) from a State where one is required.

The conference agreement would add those LTCHs that were inadvertently excluded from the MMSEA 25 percent rule relief by aligning:

- The start dates of the three-year delay in the implementation of the 25 percent limit for referrals from non-co-located facilities for freestanding LTCHs and grandfathered HwHs with the original effective date for the phase-in of this regulatory policy. This new effective date is July 1, 2007.
- The start date of the three-year delay in the implementation of the 25 percent limit for referrals from co-located hospitals with the original effective date for the phase-in of this regulatory policy. This new effective date is October 1, 2007. For grandfathered satellite LTCHs, the effective date is July 1, 2007.

The conference agreement also included several clarifications as regards the application of the discharge limits as well as the application of the certificate-of-need exception to the LTCH moratorium for certain LTCHs and satellite LTCHs.

Title V. State Fiscal Relief

Sec. 5001. Temporary Increase of Medicaid FMAP

The conference agreement includes a temporary increase in the share of the Medicaid program paid by the federal government over nine calendar quarters (October 1, 2008 through December 31, 2010). Reportedly, this provision would increase federal Medicaid outlays by about \$87 billion over the 2009-2019 period, mostly in fiscal years 2009 and 2010. The provision separates this temporary increase Medicaid funding into three parts.

- First, all states would be “held harmless” for drops in the Federal Medical Assistance Percentage — known as FMAP¹ — that some states would otherwise automatically experience this year (federal fiscal year 2009) and into FFY 2011. This is necessary to prevent states from losing federal funding as a result of much stronger economic conditions that may have prevailed in a state three years ago, since FMAP is calculated based on a state’s per capita income and has a substantial lag. According to the Federal Funds Information for States (FFIS), 16 states would qualify for this protection.
- Second, all states would receive a “base” 6.2 percentage point increase in the share of the Medicaid program the federal government pays.

¹ The Medicaid FMAP is the share of the total cost of Medicaid-covered medical services that the federal government pays and is based on a formula that assigns a higher federal matching rate to states that have lower income per capita (and vice versa) relative to the national average. The average FMAP that the federal government pays is 57 percent nationwide; states contribute the remaining 43 percent of the cost of services. Under current law, each state’s FMAP is updated annually to reflect changes in per capita incomes.

- Third, states that are experiencing particularly poor economic conditions, as indicated by a significant increase in unemployment, would receive additional assistance. The formula would compare the lowest average for any 3-consecutive month period beginning after January 1, 2006 with the average for the most recent 3-consecutive month period.^{2,3} Depending on the extent of the percentage point increase in the state's unemployment rate, a state could receive a 5.5 percent, 8.5 percent, or 11.5 percent reduction in the share of Medicaid that the state pays. The calculation is made after application of the hold harmless provision and an across-the-board increase of 3.1 percentage points.

Each territory (Puerto Rico, the Virgin Island, Guam, the Northern Mariana Islands, and American Samoa) would be allowed to choose between an FMAP increase of 6.2 percentage points along with a 15 percent increase in its spending cap, or its regular FMAP along with a 30 percent increase in its spending cap.

According to the conference report, it is estimated that the conference agreement would provide about 65 percent of its spending via the hold harmless and across-the-board increases, and about 35 percent via the unemployment-related increase.

The higher FMAP increase would apply to the costs of Medicaid benefits and Title IV-E foster care and adoption assistance, but not to Medicaid disproportionate share hospital payments, SCHIP and other Title IV programs that have federal matching rates based on the FMAP.

The qualification of each state for a higher level of assistance because of unemployment rate increases would be evaluated each quarter, and states would receive the additional assistance if their economic situation worsens. While a state's additional assistance could be increased, no state's additional assistance would be reduced as a result of dropping unemployment before July 1, 2010.

To receive any increased FMAP, a state must not have Medicaid eligibility levels that are more restrictive than were in effect on July 1, 2008. Restrictions on eligibility include changes that make it more difficult for recipients to meet procedural requirements for enrollment or periodic renewal of their coverage. It is important to note that this provision does not limit a state's ability to restrict provider payments levels or optional benefits. With certain exceptions, states that restrict eligibility would be allowed to reverse their actions and still qualify for an increased FMAP in the first calendar quarter in which they have restored their Medicaid eligibility.

The bill also requires the respective state to comply with prompt pay requirements⁴ in order to be eligible for the FMAP increase. Such a requirement is only applicable to

² The bill's provision requires the use of the BLS data for such determinations.

³ The bill's provision requires that for the first two calendar quarters during the recession adjustment period, (October 1, 2008 through March 31, 2009), the most recent previous 3-consecutive-month period shall be the calendar quarter starting October 1, 2008. There is a similar requirement for the last 2 calendar quarters of the recession adjustment period – the state can either use the calendar quarter starting January 1, 2009 or January 1, 2010 depending on the higher applicable unemployment adjustment percent.

⁴ The Social Security Act's prompt pay provision requires a state to pay at least 90 percent of Medicaid claims (for which no further written information or substantiation is required in order to

claims submitted after enactment of this bill by practitioners, skilled nursing facilities and hospitals (but only temporarily) and would be effective after June 1, 2009.

States that require local governments to finance a portion of the state's share of the cost of Medicaid would be prohibited from raising the effective proportion paid by local governments compared to the levels prior to any temporary FMAP increase. In addition, state would not be permitted to deposit any federal funds provided through the temporary FMAP increase into their rainy day funds.

States that receive such FMAP increases are required to file a report no later than September 30, 2011 regarding how the additional Federal funds were expended.

Additional Medicaid and Other Provisions

Sec. 5002. Temporary Increase in DSH Allotments During Recession

This section increases states' FY2009 Disproportionate Share Hospital (DSH) allotments 2.5% above their current allotments. In addition, states' DSH allotments in FY2010 would be increased by another 2.5% over their FY2009 DSH allotments (including the increase to their FY2009 DSH allotment). After FY2010, states' annual DSH allotments would be determined under current law. However, if for any state, its adjusted DSH allotment under this section in either FY 2009 or FY2010 is less than what they would have received under current law, those states would receive the higher DSH allotment.

Sec. 5003. Extension of Moratoria on Certain Medicaid Final Regulations

CMS issued seven Medicaid regulations during 2007 and 2008, six of which are subject to a congressional moratorium preventing them from being implemented prior to April 1, 2009. The seventh regulation affecting hospital outpatient services was issued in final November 7, 2008. The Act extends the current moratoria for four of these regulations that were issued in final form until July 1, 2009. The affected final regulations are: (1) Targeted Case Management; (2) School-Based Services; (3) Provider Taxes; and (4) Outpatient Hospital Services. No enforcement actions are permitted with respect to the final outpatient hospital rule prior to July 1, 2009. With respect to the three regulations that have not been issued in final form – (1) graduate medical education, (2) cost limits for public providers, and (3) rehabilitation services – the Act includes an expression of congressional intent that these proposed regulations should not be finalized.

Sec. 5004. Extension of Transitional Medical Assistance (TMA)

Under current law, states are required to provide Medicaid coverage for certain low-income families who would otherwise lose eligibility because of increases in family income. Coverage is extended for at least 6 months and may, at the state's option be extended for 12 months. Eligible families must have been enrolled in Medicaid in three of the six months prior to losing eligibility. Current statutory provisions authorizing this coverage are set to expire June 30, 2009.

make payment) within 30 days of submission and pay 99 percent of such claims within 90 days of submission.

The Act extends TMA coverage through December 31, 2010 and gives states the option to waive the requirement for prior Medicaid enrollment. In addition, eligible families can retain coverage for the initial 6 month period with a state option for an additional 6 months provided for under current law or, at the state's option, eligible families can be offered an initial coverage period of 12 months (without the option to extend coverage for another 6 months).

States are required to submit data to the Secretary on average monthly enrollment and whether children losing TMA coverage are enrolled in Medicaid or SCHIP. The Secretary is required to make annual reports to Congress based on state reported data.

Sec. 5005. Extension of the Qualifying Individual (QI) Program

Under current law, certain low income beneficiaries of the Medicare program are eligible for assistance from Medicaid for their Medicare premiums. Qualified Individuals (QIs) include beneficiaries who have incomes between 120% and 135% of the Federal Poverty Level and assets no greater than \$4,000 for individuals and \$6,000 for couples. The costs of this premium assistance are borne 100% from Medicare Part B funds that are appropriated annually. States are only required to cover eligible beneficiaries up to the extent of their annual allotments. Authority for the QI program is scheduled to expire on December 31, 2009.

The Act extends the QI program through December 31, 2010 and authorizes funding at \$412.5 million for January 1, 2010 through September 30, 2010 and \$150 million for October 1, 2010 through December 31, 2010.

Sec. 5006. Protections for Indians under Medicaid and CHIP

A series of changes are made regarding Indians receiving services under Medicaid and the State Children's Health Insurance Program (CHIP), effective July 1, 2009. No premiums or cost sharing may be required for services provided to Indians through Indian Health Service programs, including services provided directly or by contract. Asset tests used in determining Medicaid or CHIP eligibility must disregard certain reservation property and ownership rights. Estate recovery exemptions provided to Indians under Medicaid are extended.

In addition, managed care entities (including managed care organizations and primary care case management programs) must permit eligible Indian enrollees to select a participating Indian health provider (Indian Health Program or Urban Indian Organization) as a primary care provider; must demonstrate sufficient access to Indian health providers by Indian enrollees; must pay Indian health providers for services at least the rate paid to other providers or a negotiated rate, and prompt pay rules apply. Managed care entities must also pay Indian health providers that are federally qualified health centers the same rate whether or not they are participating providers, and the state must make supplemental payments to certain Indian providers.

A state with one or more Indian health providers must include in its Medicaid plan and for CHIP, a process for seeking regular ongoing advice from Indian health providers on matters likely to affect them. A Tribal Technical Advisory Group established in 2003 is codified.

Sec. 5007. Funding for Oversight and Implementation

Funding of \$31.25 million is appropriated to the HHS Office of the Inspector General (OIG) for the purpose of ensuring proper expenditure of federal Medicaid funds. This amount is appropriated for FY 2009 in addition to any other appropriation made to the OIG, and will remain available through FY 2011. In addition, \$5 million is appropriated for FY 2009 to the Secretary for the implementation of the FMAP increase provided under Section 5001, with funds available through FY 2011.

Sec. 5008. GAO Study and Report Regarding State Needs During Periods of National Economic Downturn

The Government Accountability Office (GAO) is required to study the current economic downturn along with others that have occurred since 1974, including past and projected effects of temporary FMAP increases. By April 1, 2011, the GAO must report to appropriate committees of Congress with recommendations on the needs of states during such downturns.

The report is to include recommendations for improving the countercyclical FMAP formula described in a 1997 GAO report (GAO-07-97), including the economic factors that would begin and end the application of the countercyclical FMAP, reflection of state and regional economic variations, and reflection of actual Medicaid costs incurred by states. In addition, the report is to assess the effect on states of decreased private insurance coverage, decreased state revenue, and caseload maintenance and growth under Medicaid, CHIP and other publicly funded health insurance programs.