

Early Analysis of the Impact of the ARRA on U.S. Healthcare IT

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The American Recovery and Reinvestment Act (ARRA) contain \$19 billion specifically targeted for healthcare IT (HIT) and billions more in other programs that will drive the acquisition of HIT. This first look at how to pursue this funding is directed to CIOs and other executives in grant-receiving organizations, officials in government and nonprofit grant-giving organizations, and product managers and other executives of IT vendors.

Key Findings

- The ARRA largely follows the approach to HIT established by the current and previous national coordinators for HIT, but it ramps up the funding from an "explore it" to a "do it" level.
- The act contains no new thinking on how to ramp up industry implementation bandwidth for electronic health records (EHRs). Because of this limitation, money targeted for infrastructure will be spent more rapidly than that targeted for EHRs.
- The Obama administration faces oxymoronic imperatives to spend money quickly and to spend it wisely. It is unlikely that the red tape associated with grants and contracts will be any less than has been true in the past.
- The act includes modest improvements in the protection of health information under the Health Insurance Portability and Accountability Act (HIPAA) and hints at more to come. It also creates a larger onus on enforcement than has previously been the case.

Recommendations

- Organizations seeking to pursue grants should ramp up their qualifications for dealing with disadvantaged and underserved communities.
- Although incentives go to physicians, there will be substantial opportunities for "physician aggregators." Healthcare organizations, nonprofit health information exchanges, state and local governments, and vendors should all review their capabilities from the point of view of rolling out EHRs to entire communities.
- Healthcare organizations will need to budget for reviewing all business associate agreements for HIPAA compliance. Business associates and personal health record (PHR) vendors all face some compliance issues as a result of the act.

WHAT YOU NEED TO KNOW

In five years, the ARRA will be judged not on whether it was the most efficient at rolling out HIT, or even the most effective. If meaningful EHR and HIT use is up and beginning to turn the corner on improving the quality of care, it will be a success.

EVENT

Event Facts

On 17 February 2009, President Obama signed the \$789 billion ARRA. It includes \$19 billion that is clearly identified for HIT. Of this total, \$17 billion will be used to encourage Medicare and Medicaid providers that are not hospital-based to use HIT through individual incentives that total \$44,000 for those that are making meaningful use of certified EHRs (see Note 1) in 2011 and taper down to zero by 2015. There are higher incentives for health professions in designated health professional shortage areas.

The \$17 billion also includes incentives to hospitals that could be as high as \$6.3 million each during the first year, but scale down by various factors, including the portion of bed days funded under various Medicare programs and the absolute date at which EHR use reaches meaningful levels. In subsequent years after the hospital's first meaningful use of EHR, the incentive tapers down.

Medicaid provider and hospital incentives funds will be disbursed by the states. Generally the incentives apply to providers and hospitals that have a least 30% Medicaid business; however, the percentage can be lower in some cases.

An additional \$2 billion is directed to the Office of the National Coordinator of HIT (ONCHIT). This includes:

- \$300 million to support efforts toward health information exchange
- \$20 million to the National Institute of Standards and Technology (NIST) for continued work on advancing healthcare information enterprise integration
- Competitive grants to states and Indian tribes for the development of loan programs to facilitate the widespread adoption of certified EHR technology
- Development of a plan for "the utilization of a certified electronic health record for each person in the United States by 2014"
- Immediate grants and loans to strengthen the HIT infrastructure
- Support for moderate revisions in privacy and security policy; coordination of federal health IT activities, infrastructure and tools for the promotion of telemedicine, including coordination among federal agencies; development and promulgation of standards: the promotion of a broader HIT workforce: and at least a dozen other activities specified in the language of the bill.

Other programs not included in the \$19 billion that are likely to include some funding for HIT projects:

- \$2.5 billion through the Department of Agriculture for a distance learning, telemedicine and broadband program; this program is not entirely limited to rural areas

- \$7.4 billion to the National Institutes of Health (NIH) to fund research, some portion of which may result in IT expenditures by NIH or grantees
- \$1.5 billion in grants to health centers that includes a portion for HIT and health-center-controlled networks
- \$1.1 billion to support clinical effective research of therapies and devices, including an additional \$400 million for programs under the NIH and \$400 million to the Department of Health and Human Services (DHHS)
- A \$1 billion Prevention and Wellness Fund that includes \$650 million to carry out evidence-based clinical and community-based prevention and wellness strategies
- \$65 million to the Indian Health Services for telehealth services development and related infrastructure requirements
- \$50 million provided to states for an additional amount to carry out activities to implement healthcare-associated infection-reduction strategies
- \$40 million to the Social Security Administration to facilitate the adoption of electronic medical records in disability claims

Numerous specifications in the ARRA are not associated directly with budgetary amounts but will, nonetheless, affect healthcare organizations and governmental organizations. Some examples include:

- Each agency of the federal government is required to use federally recognized HIT standards in purchasing and upgrading systems. Agencies must require contractors to use these standards for information exchanges related to their contracts.
- The president must ensure that federal activities involving the broad collection and submission of health information are consistent with federally recognized HIT standards.
- HIPAA is strengthened and applied to previously noncovered entities:
 - An individual will now have the right to get an electronic copy of his protected health information; previously, providing paper copies would fulfill the disclosure requirement.
 - Security and privacy provisions, and the associated penalties, now apply directly to business associates and must be included in business associate agreements.
 - Limits on multiple HIPAA monetary penalties in a single year are substantially raised if the violation is willful or the entity subject to the penalty fails to make corrections; some penalties could exceed \$1 million.
 - The requirements are extended to include notification of breaches to the affected consumer, the Federal Trade Commission (FTC) and third-party suppliers; penalties will be exacted by the FTC as for other unfair trade practices.
 - The DHHS secretary is required to pursue investigations of willful violations.
 - Civilian monetary penalties that are collected will go to the Office for Civil Rights to fund enforcement activities.
 - Within three years, some portion of monetary penalties collected under HIPAA should go to the harmed individual.

- HIPAA compliance may be pursued by actions of state attorneys general.
- The DHHS may pursue monetary penalties if the Department of Justice does not.
- Vendors of PHRs and their business associates must also provide notification of breaches, as described here.

Analysis

As with any law, the ARRA sets the broad strokes of federal approaches to the use of HIT. It must be read closely, not to find exact detail but to estimate how it will be interpreted by various federal agencies and, in extreme situations, by the courts. Agency interpretations will become clear in regulations, requests for proposals and grant offerings.

Nothing in the ARRA represents a fundamental shift in directions already set to increase the use of interoperable HIT. Instead, it largely encodes in law the approach established administratively by President Bush, former DHHS Secretary Leavitt and the national coordinators for HIT. At the same time, it aggressively ramps up funding for the approaches, moving them from the "prove it" to the "do it" stages.

The only tools government has to change things are blunt instruments. We should not judge these programs by expecting them to have exactly the intended consequence and be free of unintended consequences. The measure of success will be if interoperable HIT is better off than it is now in five years.

For healthcare organizations and government agencies interested in HIT, the choices are to participate or not, but there is no option to seek a better program for the government.

Gartner has been discussing probable impacts of the ARRA for some time with clients that want to participate. Our working assumption in those discussions is that ARRA would mirror and extend the approach of the past five years, and this has been borne out. In this analysis, we recap the advice that is widely applicable.

Prepare for Ramped Up Security and Privacy Enforcement

Support has been gathering in the DHHS for increased security enforcement. Although Congress tinkered with HIPAA in minor ways, the primary thrust of the legislation is to clarify the authority and establish funding mechanism for HIPAA enforcement.

The legislation extends HIPAA to cover entities other than healthcare providers, payers and clearinghouses, partially closing a substantial HIPAA loophole. Because the previous limits on covered entities were thought to be sacrosanct, this extension probably signals future action by Congress to apply the principles of HIPAA to a broader community.

Expect the Roll Out of Grants, Loans and Other Programs to Be Hectic

The Obama administration has embraced the oxymoronic goals of spending money rapidly and wisely. Government agencies devising programs will not be able to substantially reduce the red tape associated with fulfilling such grants and, indeed, may be obligated to add red tape. A laid-back approach of watching the Commerce Business Daily will not suffice. Use all available sources of intelligence, including professional societies, analysts and the mainstream press. Don't assume that the final RFP will be substantially the same as the one initially issued. Clarifications during the open period will probably be more numerous and substantive than usual.

Be a "Competent Grantee"

The executives in granting agencies are very aware that many otherwise valuable and competent firms and nonprofit organizations have not built the infrastructures necessary to respond well to RFPs and financially control the execution of grants. Grant programs are likely to be designed to verify the competence of applicants in meeting the requirements of the government. Be prepared to partner or acquire recognized competence in managing federal contracts and grants.

Expect the Absorption of HIT to Be Prioritized by Industry Capacity

There will be a substantial increase in funding for EHRs. The expansion will stretch the ability of software providers to implement their products almost to the breaking point. On the other hand, grants for enhancing IT infrastructure, in general, will be easier to award because of the capacity of infrastructure vendors to ramp up. (In other words, some HIT money will be programmed for programs to increase broadband access to rural communities and rural hospitals with only nominal tie-in to specific healthcare deliverables.)

The explicit goal of "the utilization of a certified electronic health record for each person in the United States by 2014" is no clearer than it was under the Bush administration. If you interpret it as every provider using an EHR for every patient, then the goal is patently unreachable, unless the criteria for certifying EHRs are substantially softened. It is more likely that the slogan will be honored by measuring progress toward EHR adoption and celebrating substantial progress.

When Seeking Grants, Focus on Disadvantaged Populations and Community Physicians

Grant applications that focus on support for Indian tribes, rural medicine, and enhancing the proliferation and acceptance of interoperable electronic medical records (EMRs) among community physicians will generally have a higher probability of winning than before.

Focus on Projects to Improve HIT Outcomes

Ideally, a program such as this would award grants and incentive payments to programs that demonstrate improved health outcomes. There is, however, a multiyear lag time associated with measuring health outcomes. It will not be practical to spend all the stimulus money with such a long-term focus. To the extent that the programs for EHR adoption promote "outcomes" at all, it will be by measuring meaningful use of the EMR by physicians. There is specific language in the law to support that view.

States and healthcare organizations that seek to assist physicians in installing EHRs should incorporate objective measurements of meaningful use and interoperability into their concepts of operation. HIT vendors expecting to sell products under such programs should incorporate the necessary measurement features into their products.

Academic Medical Centers Should Focus on Practical Projects to Improve Healthcare Outcomes and Measure Clinical Effectiveness

The previous section notwithstanding, the act embodies a vision for how aggregate information can be used to improve healthcare. Programs that have explicit goals of using HIT to create measurable change in the quality, safety and efficiency of delivering care will be key to seeing that vision realized in the future. As a practical matter, these grants are likely to emphasize achieving actual success with limited scope. That is, they will focus on achieving an outcome in a matter of a year for a specific disease or condition in a given locale. Creativity in making do with information that is already online will be rewarded.

Emphasize "Community Physician Aggregation"

Although some of the money will be channeled directly to community physicians in the form of positive and negative incentives for deploying and using EMRs and other HIT, as a practical matter, community physician practices are rather feckless at choosing and implementing IT. Acceleration of adoption will depend on active programs by larger healthcare organizations to create aggregate programs supporting physicians by limiting their choices to a few reliable products and providing actual support in implementation. Activities might include grants in support of programs previously funded entirely by Stark relief — grants for programs modeled on the Massachusetts eHealth Collaborative and the New York City department of health, and state-directed programs.

RECOMMENDED READING

"Ten Questions U.S. Hospitals Should Answer Before Subsidizing EMRs for Physicians"

"The Cloud-Based Personal Health Record"

"Refresh HIPAA Security Assessments to Prepare for More-Proactive Audits"

"The U.S. Nationwide Health Information Network Will Be a 'Network of Networks'"

"2007 CPR Generation Criteria: Interoperability"

Note 1

"EHR" Defined

In this research, we use the term "EHR" consistent with its use by the U.S. federal government, as described in "Global Definitions of EHR, PHR, E-Prescribing and Other Terms for Healthcare Providers."

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