e-health snapshot

August 2009

Federal Support for Health Information Technology in Medicaid: Key Provisions in the American Recovery and Reinvestment Act

Summary

The American Recovery and Reinvestment Act of 2009 (ARRA) includes an unprecedented nearly $47 billion federal investment in health information technology (HIT) initiatives. This brief provides an overview of the HIT provisions in ARRA that have direct implications for Medicaid.

Medicaid Electronic Health Record Incentive Payments

ARRA provides $21.6 billion in Medicaid funding (and $23.1 billion in Medicare funding) to encourage physicians, hospitals, and other health care providers to adopt and "meaningfully use" certified electronic health records (EHRs). Under the Medicaid EHR incentive program:

- ARRA provides 100% federal funding for Medicaid payments to providers and hospitals for the adoption and use of EHRs as well as 90% federal funding to states to administer the incentives and encourage and track use of EHRs. The incentive payments will become available in January 2011 and end in 2021.
- Incentive payments to eligible health care professionals generally will be 85% of the net average allowable costs for EHR technology and support services. With the exception of children's hospitals, which are automatically eligible for payments, the payments are available to providers that serve at least a minimum volume of Medicaid or other low-income patients. Eligible providers could each receive up to $63,750 over six years.
- Providers receiving on-going incentive payments must demonstrate meaningful use of EHRs. HHS plans to develop proposed rules on meaningful use by the end of 2009.

Grants and Technical Assistance

ARRA also provides funding for two competitive grant programs for states to complement the EHR incentive payments and resources to support technical assistance:

- Grants may be made available to states to make loans to providers for technology purchasing and training. States could use these loans to assist providers who are not eligible for EHR incentives. They could also use the loans in conjunction with the EHR incentives. For example, states could make loans to cover up-front EHR costs for providers with insufficient capital to pay costs, in anticipation of repayment with the EHR incentives.
- States also will be offered at least $300 million in grant funds to facilitate secure electronic exchange of health information among organizations. These grants could provide support for Medicaid agencies interested in developing their capacity to support health information exchange among providers and agencies serving Medicaid enrollees.
- Additionally, the Office of the National Coordinator for HIT (ONCHIT) will establish an HIT extension program, including a network of regional extension centers, to provide technical assistance and help providers adopt and effectively use HIT.

Conclusion

ARRA provides important new opportunities to support HIT efforts in Medicaid. States can utilize these resources to move forward with new HIT efforts, build on existing innovations they may already have underway, and better meet the needs of low-income children and other individuals served by Medicaid.

THE HENRY J. KAISER FAMILY FOUNDATION

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The Children's Partnership

Introduction

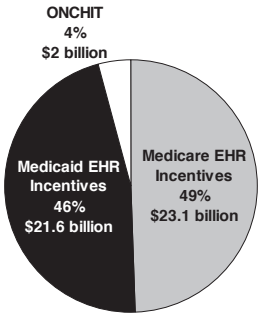
As broad health reform discussions continue, there is an emphasis on expanding the use of health information technology (HIT) to both improve quality of care and reduce costs. Given that Medicaid serves nearly 60 million people, including one in four of our nation's children and many of the nation's poorest and sickest individuals, adoption of HIT within Medicaid will be key to the nation's progress in realizing the full potential of HIT. The American Recovery and Reinvestment Act of 2009 (ARRA) included an unprecedented nearly $47 billion federal investment in HIT. ARRA includes a broad array of HIT initiatives that range from strengthening privacy standards, to developing HIT standards, to supporting HIT research, and providing direct support for new and expanded HIT activities. This brief focuses specifically on the HIT provisions in ARRA that have direct implications for Medicaid, providing an overview of the Medicaid EHR incentive payments and other HIT-related grants for states.[1]

Overview of HIT and ARRA

In an effort to boost an ailing economy, Congress passed and President Obama signed ARRA into law on February 17, 2009. The overall package, which the Congressional Budget Office (CBO) estimated would cost $787 billion, includes approximately $46.7 billion in HIT.[2] The bulk of this HIT investment is for new Medicare and Medicaid incentives to encourage the adoption of electronic health records (EHRs) (Figure 1). It also includes $2 billion for the Office of the National Coordinator for Health Information Technology (ONCHIT) to oversee HIT activities and investments and charges ONCHIT with a wide scope of new responsibilities and tasks, including developing a nationwide HIT infrastructure. CBO estimates that the HIT investments will generate $13 billion in federal savings over the 2009 to 2019 period and will result in 90% of doctors and 70% of hospitals adopting HIT by 2019.[3]

Figure 1

Distribution of HIT Funding in the American Recovery and Reinvestment Act



Total = $46.7 billion

SOURCE: Department of Health and Human Services Fiscal Year 2010 Budget in Brief, http://www.hhs.gov/asrt/ob/docbudget/1020budgetinbrief.pdf; and Health Information Technology American Recovery and Reinvestment Act Implementation Plan, http://www.hhs.gov/recovery/reports/plans/onc_hit.pdf

Medicaid Incentives to Promote Adoption of Electronic Health Records

A key goal of the ARRA HIT initiatives is to promote the utilization of an EHR for each person in the United States by 2014. Within ARRA, a certified EHR is defined as an electronic record of health-related information about an individual that has the capacity to support clinical decision making, prescribing, health care quality improvement, and exchange of electronic health information with other sources. ARRA provides funding through Medicare and Medicaid as an incentive to encourage physicians, hospitals, and certain other health care providers to adopt and "meaningfully use" certified EHRs. Providers that serve both Medicare and Medicaid patients may only receive EHR incentives under one program.

Full federal funding is available for the Medicaid incentive payments. ARRA provides 100% federal funding for Medicaid payments to eligible providers and hospitals to encourage adoption and use of certified EHRs. These payments are intended to offset a large portion of

providers' costs of purchasing, implementing, operating, maintaining, and using the technology, as well as the costs for support services such as training.[4] ARRA also provides 90% federal funding for Medicaid payments to states to administer the EHR incentives, including actions to encourage EHR adoption and track "meaningful use" of EHRs.

To qualify for Medicaid incentive payments, providers must serve a minimum level of Medicaid and other low-income patients. With the exception of children's hospitals, which are automatically eligible for payments, the Medicaid EHR incentive payments are generally available to providers that serve at least a minimum volume of Medicaid patients or low-income individuals (Table 1). Pediatricians who do not meet these thresholds can still qualify for incentives by meeting a lower threshold, but they receive lower incentive payments. The Secretary of HHS will establish the methodology for determining whether a provider meets the volume thresholds, but ARRA specifies that the methodology must include individuals enrolled in Medicaid managed care plans and may include adjustments related to uncompensated care.

Table 1:
Minimum Medicaid Patient Volume Thresholds to Qualify for Medicaid EHR Incentives

Provider Type	Volume Threshold	Individuals Who Count toward Threshold
Children's hospitals	None	N/A
Other acute-care hospitals	10%	Medicaid enrollees
Non-hospital-based health care professionals	30%	Medicaid enrollees
Lower threshold non-hospital-based pediatricians	20%	Medicaid enrollees
Health care professionals* who practice predominantly in a rural clinic or FQHC	30%	Medicaid or CHIP enrollees and individuals receiving uncompensated care or reduced charges

Note: Health care professionals include physicians, dentists, certified nurse midwives, and physician assistants who practice at a rural health clinic or Federally qualified health center (FQHC) that is led by a physician assistant.

Medicaid incentive payments are time-limited and capped at maximum amounts. Incentive payments will become available in January 2011 and will end in 2021. The first payment to any eligible provider must occur no later than 2016, and a provider may receive payments for up to six years. The maximum payments available to eligible providers vary by provider type and over time (Table 2). Generally, payments will be 85% of the net average of allowable costs for certified EHR technology and support services, as determined by the Secretary of HHS, with providers responsible for the remaining 15%. ARRA specifies that the net average allowable costs cannot exceed $25,000 in the first year or $10,000 in subsequent years for most eligible providers. Payments to eligible hospitals are based on a statutory formula and will be determined by the Secretary for each individual eligible hospital. For pediatricians who qualify under the lower patient volume thresholds, the maximum payment amount is two-thirds of the maximum amount for other health care professionals.

Table 2:
Maximum Allowable Medicaid EHR Incentive Payments by Provider Type

Provider Type	Year 1	Years 2-6	Total
Non-hospital-based health care professionals	$21,250	$8,500	$63,750
Lower threshold non-hospital-based pediatricians	$14,167	$5,667	$42,500
Health care professionals* who practice predominantly in a rural clinic or FQHC	$21,250	$8,500	$63,750

Table notes: Amounts may not total due to rounding. Health care professionals include physicians, dentists, certified nurse midwives, and physician assistants who practice at a rural health clinic or Federally-qualified health center (FQHC) that is led by a physician assistant. Actual payments may be lower based on the Secretary's determination of net average allowable costs to Medicaid providers for certified EHR technology.

Providers receiving payments must demonstrate meaningful use of EHRs. During the first year of receiving Medicaid EHR incentive payments, providers must demonstrate that they are engaged in efforts to adopt, implement, or upgrade certified EHR technology. In subsequent years, they must demonstrate that they are meaningfully using the certified EHR technology as a condition of receiving EHR incentive payments.[5] The Secretary will determine what is approved as meaningful use. ARRA specifies that the Medicaid meaningful use requirements may be based on the Medicare methodologies, although this is not required. The Medicare provisions specify that meaningful use includes the use of EHRs for electronic prescribing, electronic exchange of health information to improve the quality of health care, and reporting on clinical quality measures. The Medicare provisions also require the Secretary to develop more stringent measures of meaningful use over time. ARRA further requires states and the Secretary to seek to avoid duplicative state and federal requirements for demonstrating meaningful use and requires states to establish methods of demonstrating meaningful use for Medicaid providers to ensure that populations with unique needs, including children, are appropriately addressed. HHS plans to develop proposed rules on meaningful use for the Medicare and Medicaid EHR incentive programs by the end of 2009.[6]

Grants and Technical Assistance to Support EHRs and Health Information Exchange

Beyond the EHR incentive payments, ARRA provides two competitive grant programs to support HIT activities as well as support for technical assistance to aid states or state-designated entities in promoting EHRs and health information exchange:

Under ARRA, ONCHIT may award grants to states to provide loans to providers for technology purchasing or training. For example, these loans could be used for providers' purchasing or upgrading of EHRs**,** training personnel in the use of EHRs, or increasing and improving electronic exchange of health information. States could use these loans to help providers who are not eligible for EHR incentive payments adopt and expand their use of EHRs. They could also use these loans in conjunction with the EHR incentives. For example, states could make loans available to support up-front EHR costs for providers with insufficient capital to cover initial costs, in anticipation of loan repayment using Medicaid EHR incentive funds.

To obtain these grants, states must submit a strategic plan describing how they intend to use the funds and provide $1 in non-federal matching funds for every $5 in federal funds. These matching funds can be paid directly by states or with funds from other public or private entities. ONCHIT has not yet determined the total amount of federal funding to be made available for these grants. Providers who accept these loans must agree to certain federal health care quality requirements, such as reporting on quality measures and using the technology to exchange health information. Interest rates on the loans will be at or below market rates. Providers must begin repayment within one year of receiving the loan and complete repayment within 10 years.

ARRA also requires ONCHIT to establish a grant program to facilitate and expand health information exchange among organizations. Under this program, states or state-designated entities can apply for planning or implementation grants to support activities such as expanding participation in health information exchange; providing technical assistance to facilitate health information exchange; promoting strategies for the adoption and use of HIT in medically underserved communities; and supporting public health agencies' authorized use and access to electronic health information. These grants are not Medicaid-specific, but they could provide support for Medicaid agencies interested in developing their capacity to support health information exchange among providers and agencies serving Medicaid enrollees. Given that

many Medicaid enrollees have complex health needs, increased use of health information exchange could significantly improve the coordination of their care. The state matching requirements for the grants increase over time, from $1 in non-federal contributions for every $10 in federal funds in fiscal year 2011 to $1 for every $3 in fiscal year 2013 and beyond. ONCHIT intends to spend at least $300 million on regional health information exchange, as required by ARRA. However, the exact amount and timing for these grants has not yet been determined.[7]

ONCHIT is also required to establish an HIT extension program to assist health care providers in adopting and using EHRs and participating in health information exchange. This extension program includes two components. First, ONCHIT will create an HIT Research Center to provide technical assistance, disseminate evidence, and accelerate the transfer of lessons learned on EHRs and health information exchange. Second, ONCHIT will provide assistance for the creation of regional extension centers to assist providers in the region adopt and effectively use HIT. ONCHIT has released a draft description of this program that anticipates two-year grant awards averaging $1 million to $2 million per extension center, and no greater than $10 million to any one center, during fiscal year 2010.[8] The total number of grants to be awarded and the number and size of the regions have yet to be determined, but the program is intended to provide at least a minimum level of technical assistance across the nation and each geographic area will be served by only one extension center.

Related Medicaid and CHIP HIT Efforts

Prior to the passage of ARRA and its significant federal investment in HIT, states were already taking steps forward to implement HIT in their Medicaid and CHIP programs. Further, other federal initiatives were already in place to encourage adoption of HIT in Medicaid and CHIP. As such, some states will be able to leverage the ARRA resources to build on existing efforts, and states will have opportunities to coordinate ARRA resources with other federal HIT initiatives.

For example, utilizing federal Medicaid Transformation Grants, a number of states have already moved forward with HIT innovations in areas of outreach, enrollment and renewal; quality improvement; communication with families; and program evaluation, improvement, and modernization.[9] Further, the CHIP Reauthorization Act of 2009 (CHIPRA) provides $20 million to support demonstration projects in up to ten states to test the use of HIT to improve the quality of children's health care in Medicaid and CHIP programs, and an additional $5 million to develop and disseminate a model EHR for children in Medicaid and CHIP. CHIPRA also calls for the development of quality measures for children enrolled in Medicaid or CHIP, which should be useful in state efforts to evaluate the “meaningful use” of HIT efforts.

HHS is also working with state Medicaid programs on the Medicaid Information Technology Architecture (MITA) initiative, which is intended to help states improve systems development and healthcare management by allowing for greater data sharing across agency organizational boundaries. When approved as a Medicaid Management Information System project (that is, addressing the Medicaid claims processing and information retrieval system), MITA efforts receive an enhanced federal matching rate of 90% for development and 75% for operation of the system. These improvements offer an opportunity to design and deploy service-oriented architecture, which can then be a key driver of a state's health information exchange effort as well as create claims processing and administrative efficiencies.[10] HHS has indicated that it may use administrative funds available under ARRA to harmonize EHR technology with the MITA initiative.

Using HIT to Address the Specific Needs of Children

Across the full range of HIT activities and investments under the ARRA and related initiatives, it will be important to give specific attention to the unique needs of children. Children have different health needs, are often served by different caregivers and in different care settings, and in some cases require HIT with different functionality than adults. In recognition of these concerns, ARRA specifically requires both ONCHIT and states to address children and other populations with unique needs in developing their HIT strategies.

ARRA provides many opportunities to address children's unique needs. For example, the Medicaid EHR incentive program, combined with the assistance made available through the loan program and regional extension centers, can be designed to reach a broad range of providers that treat children and support their adoption and increasingly meaningful use of HIT over time. Meaningful use can be defined to include communications that support parents in meeting their children's needs, as well as children and adolescents in meeting their own needs. The standards and infrastructure for health information exchange can enable sharing of appropriate information among the array of professionals, programs, and settings that serve children to ensure better coordinated and more child-centered care. Federal and state privacy protections can be clarified to foster a common understanding and standards for protecting children's health information while supporting the communication that can lead to more effective, better coordinated care. Outcomes measures for these HIT investments can include metrics specifically designed to assess progress in meeting children's health needs. With comprehensive attention to children's health needs throughout the implementation of the HIT provisions of the ARRA, there is tremendous potential for achieving improvements in their quality of care as well as gains in efficiency.

Conclusion

HIT offers the promise of potential improvements in quality of care as well as increased efficiencies in care and cost savings. However, to reap the full potential benefits of HIT, it will be key for HIT efforts to be adopted across different insurers and by a growing number of providers. Given that Medicaid covers nearly 60 million people, including nearly a quarter of the nation's children and some of the sickest and poorest individuals in the nation, it can serve as a key leader HIT developments and expansions. ARRA provides important new opportunities to support HIT efforts in Medicaid, most notably through its Medicaid EHR incentive program and the loan and grant programs for states. States can utilize these resources to move forward with new HIT efforts as well as to build on existing innovations they may already have underway. Moving forward it will be important for states to also consider how to coordinate the HIT opportunities available through ARRA with other HIT initiatives and resources.

This brief was prepared by Terri Shaw of The Children's Partnership in partnership with Samantha Artiga of the Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured.

ENDNOTES

[1] For more information about other Medicaid and health care provisions in the ARRA, please refer to *American Recovery and Reinvestment Act (ARRA): Medicaid and Health Care Provisions*, Medicaid Facts, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, March 2009, publication # 7872, available at www.kff.org.

[2] Congressional Budget Office, *Cost Estimate for the Conference Agreement for H.R. 1, American Recovery and Reinvestment Act of 2009* (Washington, D.C.: CBO, February 13, 2009). Available at http://www.cbo.gov/doc.cfm?index=9989; U. S. Department of Health and Human Services, *Fiscal Year 2010 Budget in Brief* (Washington, D.C.: U.S. Dept. of Health and Human Services, May 2009) 16. Available at http://www.hhs.gov/asrt/ob/docbudget/2010budgetinbrief.pdf.

[3] Douglas W. Elmendorf, *Options for Controlling the Cost and Increasing the Efficiency of Health Care*, Testimony before the House Committee on Energy and Commerce, Subcommittee on Health (Washington, D.C.: CBO, March 2009). Available at http://www.cbo.gov/ftpdocs/100xx/doc10016/Testimony.1.1.shtml.

[4] The incentive payments generally must be paid directly to providers. However, payments may be made to state-designated entities that promote the adoption of EHRs if the provider voluntarily agrees to that arrangement and no more than 5% of the payments to the entity are for costs unrelated to EHR technology or support services.

[5] Medicare providers must also demonstrate meaningful use of EHRs under the Medicare EHR incentives. Unlike the Medicare EHR incentive program, however, ARRA does not create financial penalties for Medicaid health care professionals that fail to meaningfully use EHRs in later years.

[6] Center for Medicare and Medicaid Services, U.S. Department of Health and Human Services, *Fact Sheet: Medicare and Medicaid Health Information Technology: Title IV of the American Recovery and Reinvestment Act* (Washington, D.C.: U.S. Dept. of Health and Human Services, June 2009). Available at https://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3466&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

[7] ONCHIT, *Health Information Technology: American Recovery and Reinvestment Act (Recovery Act) Implementation Plan* (Washington, D.C.: U.S. Dept. of Health and Human Services, May 2009). Available at http://www.hhs.gov/recovery/reports/plans/onc_hit.pdf

[8] Federal Register, Vol. 74, No. 101, Thursday May 28, 2009.

[9] Beth Morrow, *Emerging Health Information Technology for Children in Medicaid and CHIP Programs* (Washington, D.C.: Kaiser Family Foundation, November 2008). Available at http://www.kff.org/medicaid/7837.cfm.

[10] U.S. Department of Health and Human Services, *HHS Recovery and Reinvestment Act (Recovery Act) Implementation Plan: Health Information Technology – Medicare and Medicaid Incentives and Administrative Funding* (Washington, D.C.: U.S. Dept. of Health and Human Services May 2009). Available at http://www.hhs.gov/recovery/reports/plans/hit_implementation.pdf

Additional Resources

Blumenthal, D. "Stimulating the Adoption of Health Information Technology," *New England Journal of Medicine*, Vol. 360, No. 15, April 9, 2009, pp. 1477-79, at http://content.nejm.org/cgi/content/full/NEJMp0901592.

The Children's Partnership and the Kaiser Commission on Medicaid and the Uninsured, *E-Health Snapshot: Emerging Health Information Technology for Children in Medicaid and SCHIP Programs* (Kaiser Family Foundation, Nov. 2008) at http://www.kff.org/medicaid/7837.cfm.

The Children's Partnership, *Letter to the Office of the National Coordinator*, "Promoting Children's Health through Meaningful Use of HIT," (May 26, 2009) at www.childrenspartnership.org.

The Commonwealth Fund, *States in Action: Early Federal Action on Health Policy: The Impact on States* (Feb/March 2009) at www.commonwealthfund.org.

Kaiser Commission on Medicaid and the Uninsured, *Medicaid Facts, American Recovery and Reinvestment Act (ARRA): Medicaid and Health Care Provisions* (Kaiser Family Foundation, March 2009) publication # 7872 at www.kff.org.

Markle Foundation, Connecting for Health, *Achieving the Health IT Objectives of the American Recovery and Reinvestment Act: A Framework for 'Meaningful Use' and 'Certified or Qualified' EHR* (April 2009) at www.connectingforhealth.org.

Brad Finnegan, et. al., *Boosting Health Information Technology in Medicaid: The Potential Effect of the American Recovery and Reinvestment Act* (Geiger Gibson/RCHN Community Health Foundation Research Collaborative, July 2009) at http://www.rchnfoundation.org/.

Patricia MacTaggart and Bruce Bagley, *Policy and System Strategies in Promoting Child Health Information Systems, Including the Role of Medicaid, the State Children's Health Insurance Program, and Public Financing*, Pediatrics 2009; 123: S111-S115.

Marie Mann, Michele Lloyd-Puryear, and Deborah Linzer, *Enhancing Communication in the 21st Century*, Pediatrics 2009; 117: S315-S319.

Richard Shiffman, et. al., *Information Technology for Children's Health and Health Care*, JAMIA, v. 8(6): Nov.-Dev. 2001: 546-551.

Andrew Spooner and the Council on Clinical Information Technology, "Special Requirements of Electronic Health Record Systems in Pediatrics," Pediatrics 2007, 119: 631-637.

Web Resources

Federal website for monitoring the implementation of ARRA: http://www.recovery.gov

U.S. Department of Health and Human Services, Health Information Technology website: http://healthit.hhs.gov:

National Governors Association, Center for Best Practices, State Alliance for e-Health: http://www.nga.org/portal/site/nga/menuitem.1f41d49be2d3d33eacdcbeeb501010a0/?vgnextoid=5066b5bd2b991110VgnVCM1000001a01010aRCRD

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The Henry J. Kaiser Family Foundation
The Kaiser Commission on Medicaid and the Uninsured
1330 G Street, NW • Washington, DC 20005
phone: (202) 347-5270 • www.kff.org

The Children's Partnership
1351 3rd Street Promenade, Suite 206 • Santa Monica, CA 90401
phone: (310) 260-1220 • www.childrenspartnership.org