Potential Opportunities for Healthcare Industry Under the American Recovery and Reinvestment Act of 2009

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NEWS ALERT

The American Recovery and Reinvestment Act of 2009 (the "Act") was signed into law on February 17, 2009 by President Barack Obama. The Act provides for, among other things, federal tax cuts and increased domestic spending in education, technology, health care and infrastructure. We have reviewed the Act and have identified several funding provisions that could be beneficial to those in the healthcare industry, as well as certain changes to Medicare and Medicaid reimbursements of which they should be aware.

I. FUNDING THROUGH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. The Act allocates an additional $2,500,000,000 for distribution by the Department of Health and Human Services to entities that constitute a "health center" under Section 330 of the Public Health Service Act (the "PHS"). Broadly speaking, a "health center" is an entity that provides primary and certain other health services to populations that are medically underserved, or to a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless or residents of public housing. Of these funds: (a) $500,000,000 will be available for grants to health centers; (b) $1,500,000,000 will be available for grants (i) to health centers for construction and renovation of their facilities and acquisition of equipment and (ii) to health centers, as well as health center controlled networks that receive operating grants under Section 330 of the PHS, for the acquisition of health information technology systems; and (c) $500,000,000 will be available to remedy workforce shortages in the healthcare industry, which may be used for scholarships, loan repayment programs and grants to training programs for equipment as permitted under PHS.

a. Process and Timing. The Secretary of Health and Human Services must provide the Committees on Appropriations of the House of Representatives and the Senate with an operating plan detailing the activities to be supported and timelines for expenditures under this section by May 18, 2009, with continuing reports of funding and activity every six months thereafter.

2. National Center for Research Resources. The Act allocates an additional $1,300,000,000 to the National Center for Research Resources, of which $1,000,000,000 will be available for additional grants or contracts under Section 481A of the PHS. Section 481 of the PHS authorizes the National Center for Research Resources to make grants to public and nonprofit private entities to expand, remodel, renovate or alter existing research facilities or construct new research facilities for biomedical and behavioral research and research training.

3. Healthcare Research and Quality. The Act allocates an additional $700,000,000 to carry out the goals set forth in Titles III and IX of the PHS (patient safety evaluation systems), the Social Security Act and Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (research to improve the quality, effectiveness, and efficiency of the Medicare program). Most of this amount will be transferred to the Office of the Director of the National Institutes of Health to conduct or support comparative effectiveness research under Section 301 of the PHS (research and investigations) and Title IV of the PHS. An additional $400,000,000 is available for distribution at the discretion of the Secretary of Health and Human Services for the development of research assessing the comparative effectiveness of healthcare treatments and strategies through efforts that: (a) conduct research that compares the clinical outcomes, effectiveness, and appropriateness of services and procedures used to prevent, diagnose, or treat diseases, disorders, and other health conditions; and (b) 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 outcome data.

4. Creation of a Prevention and Wellness Fund. The Act has created a Prevention and Wellness Fund, which will be administered by the Secretary of the Department of Health and Human Services. Of the $1,000,000,000 allocated to the fund: (i) $300,000,000 is allocated to the Centers for Disease Control and Prevention to carry out certain immunization programs; (ii) $650,000,000 is allocated to carry out certain PHS clinical studies on chronic disease rates and community-

based prevention; and (iii) $50,000,000 will be provided to the States to carry out activities to reduce healthcare associated infections. The Secretary has the authority to engage public or private entities to evaluate the quality and effectiveness of these programs.

II. HEALTH INFORMATION TECHNOLOGY

1. Background. The Act creates the Health Information Technology for Economic and Clinical Health Act ("HITECH") to advance the use of shared health information technology between healthcare providers, health plans, the government and others. Broadly speaking, HITECH requires the federal government to implement a national electronic exchange for health information in order to improve the quality and coordination of healthcare and to expand existing initiatives, such as the Federal Health IT Strategic Plan. HITECH encourages doctors and hospitals to use electronic record-keeping and ordering systems by offering financial incentives through Medicare reimbursements. The ultimate goal of HITECH is to have an electronic health record for each person in the United States by 2014.

2. Office of the National Coordinator for Health Information Technology. The Office of the National Coordinator for Health Information Technology (within the Department of Health and Human Services) (the "National Coordinator") has been created to review the standards, implementations and certification criteria for the electronic exchange and use of health information. Among other things, the National Coordinator will be responsible for estimating and publishing the annual resources it deems necessary to reach the goal of utilization of an electronic health record for each person in the United States by 2014, including: (a) the required level of federal funding; (b) expectations for regional, state, and private investments; (c) the expected contributions by volunteers for the utilization of such records; and (d) the resources needed to establish a health information technology workforce sufficient to support this effort (including education programs in medical informatics and health information management). The National Coordinator will be a leading member of the HIT Policy and the HIT Standards Committees and will act as a liaison between these two committees and the federal government.

3. The HIT Policy Committee. The HIT Policy Committee is responsible for recommending a policy framework to the National Coordinator for the development and adoption of a nationwide health information technology infrastructure that permits the electronic exchange and use of health information. All recommendations to the National Coordinator by the HIT Policy Committee will be published annually in the Federal Register. On or before December 31, 2009, the Secretary must adopt an initial set of standards, implementation specifications and certification criteria based on the recommendations of the HIT Policy Committee. Members of the HIT Policy Committee serve three year terms and are appointed by the President, the Secretary of Human and Health Services, Congress and the Comptroller General of the United States. The members of the HIT Policy Committee should represent a balance among the various sectors of the healthcare industry.

4. The HIT Standards Committee. The HIT Standards Committee is responsible for recommending standards, implementation specifications and certification criteria to the National Coordinator for the electronic exchange and use of health information. By May 18, 2009, the HIT Standards Committee must develop a schedule for the assessment of policy recommendations developed by the HIT Policy Committee, which will be published and revised annually in the Federal Register. Membership of the HIT Standards Committee will consist of providers, ancillary healthcare workers, consumers, health plans, technology vendors, researchers, and individuals with technical expertise on healthcare quality, privacy and security, and on the electronic exchange and use of health information, as to represent a balance among the various sectors of the healthcare industry.

5. Application to Private Entities. Nothing within HITECH will be construed as requiring a private entity to adopt or comply with any of the standards adopted by the Secretary nor may any federal agency, other than by the authority such agency may have under other provisions of the law, require a private entity to comply with the standards and implementations adopted by the Secretary. The exception to this rule applies to private entities that contract with the federal government. Section 13112 of HITECH provides that each federal agency that administers or supports health insurance programs, such as Medicare, or health programs covered by the Department of Defense, the Veterans Affairs Administration and the Federal Health Benefits Program must require in contracts or agreements with healthcare providers, health plans, or health insurance issuers that as each provider, plan, or issuer implements or upgrades its health information technology

systems, it must utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under HITECH.

6. Reimbursement Incentive Study and Report. The Secretary of Health and Human Services will carry out, or contract with a private entity to carry out, (i) studies examining methods to create efficient reimbursement incentives for improving healthcare quality in Federally Qualified Health Centers, rural health clinics, and free clinics and (ii) studies examining the potential use of new aging services technology to assist seniors, individuals with disabilities and their caregivers throughout the aging process.

7. Voluntary Testing Programs. The Director of the National Institute of Standards and Technology will establish a system for testing the standards and implementation specifications developed under HITECH by independent, non-federal laboratories.

8. Health Care Information Enterprise Integration Research Centers. The Director of the National Institute of Standards and Technology will establish a program of assistance to institutions of higher education (or consortia thereof which may include nonprofit entities or federal agencies) to establish multidisciplinary Centers for Health Care Information Enterprise Integration. Grants will be awarded on a merit-reviewed, competitive basis.

9. Immediate Funding to Strengthen the Health Information Technology Infrastructure. The Secretary will invest in the infrastructure necessary to promote the electronic exchange and use of health information by disbursing funds to different agencies, such as the Office of the National Coordinator for Health Information Technology, the Agency for Healthcare Research and Quality and the Centers of Medicare & Medicaid Services, to promote, among other things: (a) technology that will support the nationwide electronic exchange and use of health information; (b) development of appropriate certified electronic health records for healthcare providers not eligible for support under Title XVIII (aged or disabled) or XIX (state funding) of the Social Security Act for the adoption of such records; and (c) the training and dissemination of information on the integration of health information technology into a provider's delivery of care, including health centers defined in the PHS, covered entities under Section 340B of the PHS (drug pricing), and providers participating in one or more of the programs under Titles XVIII, XIX, and XXI of the Social Security Act (relating to Medicare, Medicaid, and the State Children's Health Insurance Program).

10. State Grants to Promote Health Information Technology – Planning Grants. The Secretary may award a grant to a State or a "Qualified State-Designated Entity" for the purpose of, among other things: (a) conducting activities to expand the electronic movement and use of health information; (b) enhancing participation in the authorized and secure nationwide electronic use and exchange of health information; (c) complementing other Federal grants, programs, and efforts towards the promotion of health information technology; (d) assisting patients in utilizing health information technology; and (e) promoting the use of electronic health records for quality improvement including through quality measures reporting.

11. State Grants to Promote Health Information Technology – Implementation Grants. The Secretary may award a grant to the State or Qualified State-Designated Entity that has submitted an approved plan that describes the activities to be carried out by a State or by the Qualified State-Designated Entity to facilitate and expand the electronic movement and use of health information among organizations. Beginning in 2011, the Secretary will not make any Planning Grants or Implementation Grants unless the State agrees to match a certain percentage of the funds provided by Federal grant money.

12. Information Technology Professionals in Health Care. The Secretary will provide assistance to institutions of higher education (or consortia thereof) to establish or expand medical health information education programs, including certification, undergraduate, and masters degree programs, for both healthcare and information technology students.

13. Privacy and Security Provisions. The Act addresses the liability and civil and criminal penalties in connection with the unauthorized acquisition, access, use, or disclosure of protected health information for business associates and covered entities. The Act also establishes mandatory notification procedures to the Secretary of Health and Human Services and to affected individuals for certain breaches of disclosed protected health information.

III. MEDICARE AND MEDICAID HEALTH INFORMATION TECHNOLOGY

1. Incentives for Non-Hospital Based Physicians. Beginning in 2011, if a non-hospital based physician is a "meaningful user" of electronic health records ("EHR") for the fiscal year, the physician shall receive an amount equal to 75% of the

Secretary's estimate of the allowed charges for all such covered professional services furnished by the physician during such year.

a. This payment may be made by the Federal Supplementary Medical Insurance Trust to the physician's employer if (i) the physician is required as a condition of its employment to turn over its fee for such service to its employer, or (ii) if the service was provided under a contractual arrangement between the physician and an entity if the entity submits the bill for the service.

b. The incentive payments are capped at $15,000 for the physician's first payment year, unless the first payment year is 2011 or 2012. In such cases, the incentive payment could be as much as $18,000, thereby encouraging early participation of EHR use. The incentive payments are gradually phased out over a five year period and no incentives will be provided to physicians who fail to use EHR's by 2014.

2. Penalties for Non-Hospital Based Physicians. If a physician is not a meaningful EHR user by 2015 or during any subsequent payment year, the fee schedule amount for covered professional services during the year will be decreased by 1% in 2015, 2% in 2016, and 3% in 2017. Thereafter, if the Secretary determines that less than 75% of physicians are meaningful EHR uses, the Secretary may continue to decrease fee schedule payments up to 5%. The Secretary may make exceptions in cases of hardship.

3. Qualifying MA Organizations. The incentives and penalties described in Sections 1 and 2 above are applicable to physicians employed by a "qualifying MA Organization", although the amounts of the incentives and penalties are calculated differently. A physician is deemed to be employed with a qualifying MA Organization if: (a)(i) the physician is actually employed by the organization; or (ii) is employed by, or is a partner of, an entity that through contract with the organization furnishes at least 80% of the entity's Medicare patient care services to enrollees of such organization and (iii) furnishes at least 80% of the professional services of the physician to enrollees of the organization; and (b) furnishes, on average, at least 20 hours per week of patient care. A "qualifying MA Organization" is a Medicare Advantage organization that is organized as an HMO.

4. Incentives for Hospitals (Generally). With respect to inpatient hospital services, if an eligible hospital is a meaningful EHR user, the hospital may receive financial incentives based on a formula that calculates the amount incurred for hospital discharges in a year, plus a share by Medicare and a transition factor. The Medicare share is based on the number of inpatient bed days and the number of inpatient bed days by Medicare Advantage patients. There is a phase down of incentives for eligible hospitals first adopting EHR after 2013. Provisions of Section 1886 of the Social Security Act addressing market basket adjustments have been amended and are beyond the scope of this memorandum.

5. Incentives for Critical Access Hospitals. Critical access hospitals are entitled to incentives for use of EHR's and penalties for failure to be a meaningful EHR user by 2015. The amounts of the incentives and the penalties are calculated using a unique formula.

6. Certain MA-Affiliated Eligible Hospitals. With respect to a qualifying MA Organization, an "eligible hospital" is a hospital that is under common corporate governance with a qualifying MA Organization and serves individuals enrolled under an MA plan offered by the qualifying MA Organization. Financial incentives are available to qualifying MA Organizations, largely based on payments for services. Eventually, a qualifying MA Organization will be penalized if it is not a meaningful EHR user but the time period is not specified.

7. Medicaid Health Information Technology. In addition to the amounts currently payable by the Secretary to states with an approved Medicaid plan, the Secretary will pay 100% of the payments made by a state to certain Medicaid providers for the use of certified EHR technology.

IV. BROADBAND TECHNOLOGY OPPORTUNITIES PROGRAM

Grants. The Assistant Secretary of Commerce for Communications and Information must establish a national broadband service development and expansion program, known as The Broadband Technology Opportunities Program (the "Program"). One of the goals of the Program is to provide broadband access, equipment and support to medical and healthcare providers and community support organizations and entities to facilitate greater use of broadband service by these organizations. A nonprofit corporation is eligible for a grant under the Program if it can, among other things, provide a detailed explanation of how the funds will be used to carry out the purposes of the Program with a showing that the project would not have been implemented during the grant period without federal grant assistance.

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