

Congressional Intent for the HITECH Act

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The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009, calls for an unprecedented federal investment in health information technology (IT). Incentive payments will be made available through the Medicare programs and Medicaid to doctors and hospitals that use health IT in a meaningful way (ie, to advance delivery of high-quality healthcare). These IT systems have to be certified as meeting certain technological standards. The Congressional Budget Office has projected that HITECH will reduce federal and private sector spending on health services during the next decade by tens of billions of dollars by increasing efficiency.

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Computer technology is a vital part of both our personal and work lives, and has helped fuel enormous growth in the productivity of the American worker. The glaring exception is the delivery of healthcare. Our healthcare delivery system has largely resisted the digital revolution that occurred almost everywhere else in our society.

Medical technology has grown by leaps and bounds over the past half century. Marcus Welby would be awestruck by the advancements in imaging, surgical, and pharmacologic technologies that have taken place since he put down his stethoscope. But Dr Welby would feel very much at home in the average American doctor's office. Other than electronic billing and computerized scheduling programs, most physician practices still maintain healthcare records and interact with patients the same way they have for decades. Many hospitals and other providers also are far behind in terms of the way they store and use healthcare information.

Many factors discourage investment in health information technology (IT): financial cost, lack of standardized products, disruption of work flow, concerns about privacy and security, and payment policies that do not take health IT costs into consideration. Despite the barriers, it has become increasingly clear that we must modernize our antiquated health IT system.

Ten years ago, the Institute of Medicine estimated that preventable medical errors kill about 100,000 Americans each year.¹ More widespread use of robust health IT would make a serious dent in that number. In addition, as medicine has become increasingly sophisticated, physicians and other providers are finding it difficult to keep up with the myriad of changes and integrate those advancements into patient care. Effective use of health IT can help healthcare providers to better deal with the torrent of information they face every day.

Federal Investment in Health Information Technology

To give credit where credit is due, President George W. Bush recognized the value of getting more providers to use health IT and took steps to break the adoption logjam. One significant turning point was the establishment of the Office of National Coordinator for Health Information Technology (ONCHIT), an acknowledgment that we could not continue to rely solely on the healthcare community to adopt health IT. The federal government needed to step in and take a more active role in spurring adoption.

By the time the 2008 presidential election rolled around, work was un-

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der way in Congress to advance the progress begun during the Bush Administration. In October 2007, the Senate Health Education and Labor Committee had marked up the Wired for Health Care Quality Act (S 1693), and almost a year later the House Energy and Commerce Committee reported out the Protecting Records, Optimizing Treatment, and Easing Communication through Healthcare Technology Act (HR 6357). These 2 bills fully authorized the Office of the National Coordinator, strengthened healthcare information privacy protections, moved to harmonize technology standards, and provided a limited amount of funding to help facilitate adoption.

In September 2008, I introduced the Health-e Information Technology Act (HR 6898). This act built on the policies contained in the above-mentioned 2 bills by adding a key component: making incentive payments available through the Medicare program to doctors and hospitals that use health IT *in a meaningful way*. I was not proposing incentives so that the technology would simply become a digital version of a paper record; rather, providers need to use the technology to advance delivery of high-quality healthcare.

The rationale for looking to Medicare to help drive adoption and use of health IT is 3-fold: (1) The vast majority of American doctors and hospitals take Medicare patients and are familiar with the program; (2) Medicare payments are not subject to annual congressional fights over how much should be appropriated; and (3) Medicare payments to a given provider can be increased but also can be decreased, allowing for a carrot-and-stick approach.

Relying on Medicare to prod providers to reform the healthcare delivery system is not completely new. Medicare already has financial incentives to encourage doctors and hospitals to report certain clinical quality information, and a program to pay doctors for submitting prescriptions electronically was just getting under way. The health IT incentives proposed in my bill were a major expansion of this approach and called for an unprecedented federal investment in health IT.

In November 2008, President-elect Barack Obama called for bold action to address the economic crisis that had started to unfold a year earlier. He proposed an economic stimulus bill that would inject money into the economy. As part of that, he wanted Congress to take action on health IT, including an investment of \$20 billion.

Congress could have responded to the incoming president's request by setting up a \$20 billion grant program to hand out money for adoption of health IT. Such an approach would have been easy and would have allowed us to consider our work on health IT finished. Instead, Congress opted for a comprehensive approach to address a wide range of issues re-

lated to health IT and establish a long-term framework that maintains the federal government's commitment to the issue.

Provisions of the HITECH Act

Following the election of President Obama, Congress spent the next 2 months combining the best elements of the 3 health IT bills already introduced in the House and Senate. Enacted as part of the American Recovery and Reinvestment Act of 2009, the final product was dubbed the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act advances adoption and use of health IT in 5 important ways:

Empowerment of the Office of the National Coordinator for Health Information Technology. By authorizing ONCHIT, Congress put its stamp of approval on an office that had been established by an executive order. ONCHIT was tasked with developing a comprehensive strategic plan and was placed at the center of efforts to standardize and harmonize health IT standards in both the public and private sectors. Two advisory committees, consisting of stakeholders from both inside and outside the federal government, were established to provide technical and policy assistance to the national coordinator.

The national coordinator also is required to make a low-cost electronic health record (EHR) system available unless the Secretary of Health and Human Services determines that the needs of providers are being adequately met through the marketplace. Contrary to what some believe, this provision does not represent a federal government takeover of health IT, nor is it intended to dictate a particular type of IT. Rather, it is an insurance policy designed to make sure that a comprehensive health IT system will be available to providers in the event that private-sector health IT developers fail to step up and comply with the largely voluntary provisions in HITECH.

Establishment of Unified Standards and Certification. One of the national coordinator's most important jobs is to harmonize standards that enable effective collection, clinical use, and electronic exchange of digital health information. Congress had long been frustrated by the lack of information exchange between providers, driven in part by different technology standards used by various developers. With the help of the Standards Committee, ONCHIT must issue standards that will eventually be used throughout the federal government to facilitate the collection and electronic exchange of healthcare information. By tying these standards to the data collection and electronic exchange requirements of the Medicare and Medicaid incentive program, Congress made clear its intent that the standards be adopted by the private sector as well.

In order for providers to be eligible for the meaningful-use incentive payments, they must use products that utilize

the technological standards issued by ONCHIT. This will, in turn, encourage private-sector vendors to move away from today's practice of using conflicting technology standards and to make products that are consistent with the standards issued by ONCHIT. In addition, Congress required that ONCHIT and the National Institute of Standards and Technology work together to develop a voluntary testing and certification process to determine whether health IT products comply with the ONCHIT-issued standards.

Building the Infrastructure for Health Information Technology. Congress provided \$2 billion in funding to strengthen and jump-start programs that support provider deployment of health IT and exchange of data. This funding recognizes that most providers are not computer experts and often struggle to adopt and use health IT because they do not have a support network to help them choose and implement the best technology for their needs. More often than not, providers who do successfully adopt a health IT system find themselves on an information island where they cannot exchange clinical data with other providers. This situation severely limits the utility of EHRs, which is why part of the HITECH Act's funding will help build information exchange networks that can carry patient data from one provider to another. The money also is available to fund extension centers to assist providers with implementation of health IT systems, training programs for health informatics professionals, and loan programs to help with implementation costs.

Protection of Privacy and Security of Health Information. A critical part of moving forward on health IT is assuring patients, providers, and others that sensitive information will be kept safe and be shared only with those who are authorized to see it. This challenge takes on even greater importance as more health information is put into digital form where it can be sent around the world in a matter of seconds.

Congress recognized that expanding the use of health IT would be futile if patients and providers came to feel that their information was safer in a paper chart than in electronic format. Therefore, HITECH was seen as the right time to update and strengthen the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules to reflect the greater use of health IT. These steps include clarifying and strengthening rules regarding who may access patient data and where these data can be sent without seeking explicit permission from the patient. The bill also requires providers to notify patients in the event that their medical records are breached by a party who should not see them. It requires providers with health IT systems to make "audit trails" available to patients, so they can see exactly where their health records were sent. Finally, it increases financial penalties for providers that fail to follow the rules designed to protect patient privacy.

Provision of Incentives Through Medicare and Medicaid. HITECH made doctors, hospitals, and certain other providers eligible for incentive payments through Medicare and Medicaid for the meaningful use of EHRs certified by the process set up by ONCHIT and the National Institute of Standards and Technology. The incentives were not meant to cover the entire cost of adoption of health IT, but rather to improve a provider's business case for doing so. More money is made available through Medicaid because Congress recognized that providers who care for underserved populations would need more resources. The incentive payments are time-limited and decrease over time. In Medicare, payments will eventually be adjusted downward for providers who do not demonstrate that they are using a certified EHR system. The legislation takes a carrot-and-stick approach, with incentives structured to provide a reasonable amount of time for providers to adopt and start using health IT systems. However, the legislation does not encourage providers to procrastinate indefinitely.

HITECH Incentive Program

Because I authored the Medicare incentive provision on which HITECH's incentives are based and was most involved with developing that part of the final bill, I want to provide a little more detail about the thinking behind that part of the legislation.

I have long been convinced that health IT has the potential to transform American medicine for the better. A robust health IT system—used correctly—can improve the quality of care, facilitate care coordination, reduce redundancy and improve efficiency, increase patient safety, give patients tools to improve their own health, and provide data that can be used to better track public health and fuel clinical research. That is why I admire the health IT system used by the Veterans Administration, known as VistA. I have visited several VA facilities and believe that VistA is an example of a well-deployed health IT system that has been effectively used to improve the health of patients and provide data for important clinical research.

I am not the only member of Congress who thinks highly of VistA, and for years I thought the best way to ensure that every American had access to a good health IT system was to simply provide a free version of VistA to every doctor and hospital in America and mandate that they use it. I still think that is not a bad idea, but I also recognize that many providers have now invested enormous amounts of time and money into their health IT systems and it would be disruptive to require them to use an entirely different system.

One important lesson from the VistA experience is that we needed to find a way around the balkanized maze of standards

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and protocols used by different health IT systems. We had to push the private sector to start speaking the same IT language, or at least get them to speak in a way that could be easily translated and understood by other health IT systems.

Another important lesson is that healthcare will not improve just because a health IT system is in place. Health IT is simply a tool, like a stethoscope or an X-ray machine. What is most important is how that tool is used.

Too often I heard from doctors who installed a health IT system, but its use was limited to a fancy scheduling program or digitizing paper records as a way of clearing space in the practice's records room. I realized that simply handing out money to help providers pay for a health IT system was not good enough. Incentives should be provided only to those who use health IT in ways that markedly improve patient care.

These lessons formed the genesis of the Medicare incentive program I proposed in the fall of 2008. Under my bill, doctors and inpatient hospitals would be eligible for payments from Medicare as long as they demonstrated that they were meaningfully using a health IT system that was certified as meeting certain technological standards.

This proposal, in turn, became the core of the Medicare and Medicaid incentive program in the economic stimulus bill that was drafted in the months immediately after Obama's election. Tweaks were made, most of which worked to improve the original proposal. For instance, in spelling out what it means to be a meaningful user, the final legislation places more emphasis on information exchange and reporting clinical quality measures.

The stimulus bill also clarifies that the meaningful-use criterion should be seen as an "elevator," continuously adapting to changes in technology and raising the bar by challenging providers to become more sophisticated users of health IT. In the end, Congress wisely resisted the urge to spell out the meaningful-use criterion in detail, instead leaving that up to those with more expertise in medicine and technology.

Another important change to my proposal was the time frame for incentives. My original bill envisioned the first incentive payments going out the door in 2013 and penalties for providers who did not use health IT in meaningful ways starting in 2016. Although Obama indicated that the health IT provisions in the stimulus bill were more of a first step toward health reform than an economic stimulus, the incoming administration insisted incentive payments go out the door as soon as possible. Therefore, HITECH will make incentive payments available in 2011; penalties for nonusers will begin in 2015.

Some of us had reservations that the time frame was overly optimistic given the steep mountain that had to be climbed before any incentive payment could be made: agreeing on standards, implementing a certification process, vendors

adapting their products to meet those standards, and getting those products into doctors' offices and hospitals. Thus, HITECH builds in rolling start dates so that providers that need an extra year or two to get started still are eligible for some incentive payments. The Obama Administration has worked tirelessly to meet the ambitious time line established by HITECH, and I am now optimistic that providers will have a fair shot at getting the incentives if they are committed to doing so.

Debate Over HITECH

HITECH has been criticized by some as being an inefficient use of money because it makes payments available to providers who already have adopted sophisticated health IT systems. Frankly, I believe this is not a fair criticism. Providers should not be shut out of the incentives simply because they did the right thing by being early adopters of health IT. Kaiser-Permanente, for example, has spent billions of dollars on its health IT system and used that system to improve patient care. Presumably they will need to spend more to bring their existing system into compliance with the standards issued by ONCHIT. It should not make any difference whether a provider invested in a health IT system 10 years ago or 2 weeks ago. As long as that provider demonstrates that it is meeting the meaningful-use criterion, the policy goal has been achieved and the incentive payments should be available.

The legislation also has been criticized because it does not make money available up front to help pay for the initial installation of an EHR, and because the incentive payments do not cover total adoption costs. Again, I disagree. As stated earlier, the incentive payments are not meant to go toward adoption of an EHR system. Congress intended these payments to reward providers who meaningfully use an EHR to improve patient care.

Some have suggested that incentive payments could be made in advance to providers who promise to meaningfully use whatever system they purchase, and the government could recoup the money later if the provider failed to meet that promise. But such an arrangement would inevitably end up with thousands of pay-and-chase situations, turning Medicare into the healthcare version of the Internal Revenue Service.

Congress never intended for the payments to cover all costs associated with using a health IT system. Rather, the incentives are designed to offset a portion of the costs involved with adopting and using an EHR. As economies of scale grow because more providers are adopting the technology, it is also likely that prices for certified EHR systems will fall and the incentive payments will go further toward covering those costs.

Finally, some have faulted HITECH for not making incentive payments available to more providers, including nurses

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and physician assistants, nonphysician mental health professionals, facilities such as nursing homes, and other providers who do not currently qualify. Spending on health IT in the stimulus bill was limited to a total of \$20 billion. Congress decided to focus first on physicians, because they drive the bulk of decisions about care, and hospitals, because they are where the largest share of healthcare dollars are spent. Furthermore, providing sizable incentive payments to a limited number of providers has a greater impact than spreading payments more thinly to a larger number of providers.

There are also legitimate questions about whether it is currently possible to establish a clear and effective meaningful-use standard for all these other providers. To the extent that patients could benefit from use of health IT in those settings, Congress should give consideration to providing incentives to additional providers.

Conclusion

The HITECH Act is a landmark law that will be seen as a turning point in the effort to modernize the nation's healthcare system. In its estimate of the bill's effects, the Congressional Budget Office projected that HITECH would reduce federal and private sector spending on health services during the next decade by tens of billions of dollars by increasing efficiency.² The Congressional Budget Office also said that 90% of physicians and 70% of hospitals will be meaningfully using

a comprehensive EHR system by 2019. In addition to its other benefits, health IT will help to maximize the effect of the payment and delivery reforms that are part of the health reform bill enacted earlier this year. Congress will continue to monitor progress toward these ambitious goals, but there is little doubt among my colleagues and myself that the HITECH Act is a monumental step forward in the effort to improve the way healthcare is delivered in the United States.

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REFERENCES

1. Kohn LT, Corrigan JM, Donaldson MS, eds; Committee on Quality of Health Care in America, Institute of Medicine. *To Err is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 1999.
2. Congressional Budget Office. *Letter to the Honorable Charles B. Rangel, Chairman, Committee on Ways and Means, U.S. House of Representatives*. January 21, 2009. <http://www.cbo.gov/ftpdocs/99xx/doc9966/HITECHRangelLtr.pdf>. Accessed November 22, 2010. ■