Suggestions for HIT Inclusion in Economic Recovery Package

Privacy and Security
To build public trust in health IT, we need a broad policy framework that is based on fair information practices and that applies to all federal efforts to advance health IT. (One model for such a framework, which has been supported by a wide range of stakeholders, is the "Common Framework" developed by the Markle Foundation's Connecting for Health Initiative.) Such a framework serves as a guide for more detailed statutory and regulatory provisions that are targeted to meet the unique issues raised by different health IT models, as well as industry policies and best practices that inevitably will be needed to ensure an information-sharing environment that also provides comprehensive protections for privacy and security. The attached basic privacy provisions should be included in all funding requirements, procurement activities, regulations, and other administrative processes adopted by HHS related to the advancement of HIT. They are a good first step toward building the foundation of trust that will enable widespread deployment and use of health IT. See Attachment 1, proposed legislative language provided by Deven McGraw, Director of the Health Privacy Project at the Center for Democracy and Technology.

Governance

The Consumer Partnership for eHealth supported language included in the Wired Bll dated 7/30/08 (Sections 3003 and 3004), which establishes 2 entities: one to guide the development of standards, the other to guide the development of policies. A transparent, accountable body is needed to develop policy recommendations on HIT. An existing entity that has already done very good work toward the development of HIT policy and could easily serve as the Policy Committee is the National Committee on Vital and Health Statistics (NCVHS). It is worth considering whether to enhance their role and avoid creating a new advisory body. If NCVHS is designated as the Policy Committee, we recommend that their charter be revised to require at least two consumer/patient representatives on the committee. To strengthen the role of this policy body, we suggest requiring the Secretary to publicly state his reasons if there are any recommendations by this committee that he chooses not to adopt.

To the extent that the AHIC Successor is designated as the standards entity, we strongly support Section 3003(h) of the Wired Bill, which would require AHIC 2.0 to follow policy recommendations adopted by the Secretary.

Priority targets for spending of stimulus funds

1. **Time-limited incentive payments through the Medicare Program**
   Language currently included in the Stark bill (Title III, Subtitle A) is consistent with the goal of improving quality. However, at Section 301, new Section 1848

we would suggest removing the provision allowing self-certification of "meaningful use" of certified health information technology. Allowing the Secretary to establish measures for "meaningful use" in new Section 1848(o)(2)(b) is a good approach, though we would suggest that the Secretary be directed to coordinate with the National Quality Forum (NQF) and other measure endorsement entities when establishing these measures.

We propose that the Secretary be directed to create levels of incentive payments for health IT in order to assure that investments in health IT actually lead to improved quality and affordability of care. The "highest" levels – rewarding actual outcomes – have the most potential for impact, while "lower" levels – assuring core functional capacity of any systems supported – are threshold requirements. Funding could be allocated across levels, providing some portion of funds to each level. We believe that no funding should be provided for IT that does not meet at least the requirements at the lowest level. A middle level of incentives should be provided for the actual use of IT to improve quality and affordability. The highest level (payment for outcomes) is what we should be driving for, but it raises complex relational challenges. CMS should be directed and authorized to implement this payment structure within two years.

2. **Investments in state and local infrastructure to support the achievement of chronic care goals**
   This priority can be implemented by providing money to state Medicaid programs specifically for incentive payments structured in a similar manner to those proposed by the Stark bill. Another provision that would be helpful is re-funding the Medicaid Transformation Grant Program and including FQHCs, community Mental Health Centers and counties, including county-run centers as targeted providers. Lastly, money could also be targeted to state and local exchange efforts working to achieve specified quality goals, such as those found in Massachusetts, New York City, and Vermont. We supported language in the Wired Bill Section 3008(b) that would authorize competitive grants to states, but encourage addition of a provision requiring that in order for states to be eligible for grants to fund HIT adoption, they must establish a set of chronic care goals and have a plan for using HIT to achieve those goals. Funding requirements should be kept flexible, to reduce program silos and encourage coordination across agencies and stakeholders.

3. **Grants and loans**
   Grants and loans are necessary to enable small providers to purchase hardware and software, to participate in local health information exchange networks, and to obtain technical assistance with training and process redesign. We support the language in the Wired Bill (Title II, Section 3008) that ties funding to a strategic plan for implementation of data sharing. We would suggest that Section 3008 (a)(2) be amended to require a plan for how providers receiving grant funding will

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use HIT to improve the quality, safety and efficiency of care. We would also suggest adding a provision allowing funds to be used for training in process redesign, not just for training in the use of the electronic system. Loan forgiveness could be incorporated for achieving specific quality and outcome goals determined by the Secretary.

4. **Expansion of high-speed broadband internet penetration**
   As required by the Telecommunications Act of 1996, the FCC established a program as part of Universal Service policy to subsidize rural healthcare providers' access to and use of the internet for HIE. Beginning in the late 1990s the program has made up to $400 million a year available for this purpose for qualifying healthcare providers. Since its inception, the program has spent only a fraction of the available amount—$50 million or less per year, with a total of fewer than 2500 applicants on an annual basis. Demand has been low in part because other barriers discourage the adoption of HIE, but also because the way the program is structured restricts the extent to which it can support its intended goals. Small modifications will enable funding that has already been allocated to the program but remains unused to be applied effectively. See Attachment 2 for specific suggestions.

5. **Workforce development for training direct care providers**
   We support the language in the Wired Bill (Title II, Section 3009) that provides funding for integrating information technology into clinical education for health professionals. We suggest adding community colleges that have health informatics curriculums to the list of eligible entities.

If you have any questions about this document, please contact Eva Powell, HIT Project Director at (202)248-4834 or by email at epowell@nationalpartnership.org.

ATTACHMENT 1

‘‘SEC. 3015. NOTIFICATION OF PRIVACY BREACH.

‘‘Not later than 1 year after the date of enactment of this title, and after notice and comment, the Secretary shall promulgate regulations providing for notification by an entity responsible for protected health information to an individual whose protected health information has been lost, stolen, or otherwise accessed or acquired on an unauthorized basis or for an unauthorized purpose. Such regulations shall include an appropriate trigger for notification, as well as the timing, methods, and content of such notification. The Secretary shall also consider appropriate accommodations for law enforcement and national security needs. [The Secretary shall determine penalties to be imposed on entities that fail to comply with this section in accordance with sections 1176 and 1177 of the Social Security Act.] [alternative: The Secretary shall consider whether penalties should be imposed on entities that fail to comply with this section; any such penalties shall be in accordance with sections 1176 and 1177 of the Social Security Act.]

Original version:

‘‘SEC. 3015. NOTIFICATION OF PRIVACY BREACH.

‘‘Not later than 1 year after the date of enactment of this title, and after notice and comment, the Secretary shall provide for the development of standards and protections and determine appropriate protocols regarding the notification trigger, methods, and contents of the notification by the entity responsible for the protected health information to an individual whose protected health information has been lost, stolen, or otherwise disclosed for an unauthorized purpose. Such notification shall be made within 60 days of the discovery that such information has been lost, stolen, or otherwise disclosed. The Secretary shall include exemptions to such standards and protection for law enforcement and national security purposes. The Secretary shall determine penalties to be imposed on entities that fail to comply with this section in accordance with sections 1176 and 1177 of the Social Security Act.

III. Tasking the Secretary to Examine HIPAA Privacy Regulations and Consider Modifications in a Number of Areas

The Secretary shall examine the regulations in subparts C and E of part 164 of title 45 of the Code of Federal Regulations to ensure they provide appropriate protections for an individual’s health information, focusing in particular on privacy and security issues

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newly raised, or exacerbated, by the increased use of electronic health records and the electronic exchange of health information, as well as increasing demand for health data for research, public health, and quality improvement purposes. The Secretary shall report to Congress recommendations for any changes in legislation he deems necessary in order to provide better protections for health data. In particular, the Secretary should examine whether:

-New participants in the health care system, including but not limited to so-called health information exchanges or regional health information organizations, are providing appropriate protections for privacy and security;

-Current rules regarding the use of protected health information for marketing and other commercial purposes provide sufficient protection for an individual's personal information without creating obstacles to important health-related communications;

-With respect to uses and disclosures of health information that has been stripped of information identifying the patient, (i) there should be additional options beyond the limited data set and de-identified data that should be made available, as well as incentives or requirements for greater use of such anonymized data, including for purposes that today may be accomplished with fully identifiable data; and (ii) whether there are sufficient protections against re-identification by recipients of anonymized data;

-Individuals should be provided with greater options regarding how their health information is accessed, used and disclosed, particularly with respect to health information exchange networks and consumer-based tools like personal health records, as well as a greater ability to monitor access to and disclosures from their medical records;

-There is sufficient accountability for complying with privacy and security rules for covered entities and their business associates;

- The current rules are sufficient to ensure that individuals can access, and receive an electronic copy of, their records held in electronic form, without undue delay and at a cost that appropriately reflects the ease of providing electronic access or an electronic copy.

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ATTACHMENT 2

Suggested modifications to the Universal Service policy:

- Currently infrastructure supported by the program must be used for health purposes only. It should also be usable for other purposes. Most healthcare providers are (and should be) using the same Internet services that the rest of society uses – in other words, there isn't a separate "health Internet," and deployment of broadband services that facilitate HIE will also be beneficial for all kinds of other purposes. In the vast majority of cases, building duplicate networks is wasteful and provides little or no benefit.

- Rewrite the funding guidelines based on rural/urban definitions. The current rules are very complex, and also preclude worthwhile subsidies of urban programs that need but cannot afford broadband services. Subsidies should be awarded based on need, not geography alone, and the complex rules for determining subsidy levels should be simplified.

- Relax restrictions on subsidizing internet service fees. Currently the "Pilot Program" primarily invests in developing new infrastructure. It is also able to subsidize service fees for the use of existing infrastructure, but only up to 25% of the total cost of those fees. This sometimes creates a perverse incentive for health care facilities to build new networks because it is cheaper for them to do so than to use adequate existing ones. To eliminate this problem, the fund should be allowed to cover a much higher proportion of usage or service fees.

- Make sure health experts are integrated into the fabric of the program. Currently the program has little or no integration with HHS or the other HIE programs supported by the federal government. The program should be explicitly linked to HHS (in addition to the FCC) in its oversight or in an advisory capacity.

- The definition of "broadband" used by the program should be reexamined, and a careful assessment of what kinds of services are appropriate in specific circumstances should be made. One of the reasons to include health experts in the program's oversight is to make sure that funds are not needlessly spent on services that provide much greater bandwidth than is likely to be used for most health applications.

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