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HEALTH INFORMATION TECHNOLOGY FUNDING PROPOSAL

The benefits of health information technology (HIT) are well known. Studies show that use of HIT (e.g., e-prescribing systems, computerized physician order entry, disease registries, electronic medical records, etc.) prevents medical errors, improves communication across care settings (the “hand-off”), and saves money. However, barriers exist that severely hamper the implementation and use of HIT in medical groups, and indeed, in all health care providers. Chief among these barriers may be the high cost to purchase and implement HIT. AMGA’s proposal provides a mechanism to allow health care providers to access capital to fund HIT implementation: The Health Care Provider HIT Loan Program.

The Health Care Provider HIT Loan Program (Program) is based on the federal student loan program’s Direct Loan program. The student loan program provides the ideal model because of its success, wide-spread popularity and familiarity. This familiarity will allow the Program to easily replicate already proven and successful administrative structures, procedures, and policies. Because the Program is based on the student loan program, implementation should be significantly facilitated.

THE HEALTH CARE PROVIDER HIT LOAN PROGRAM – A SUMMARY

Under the Program, the federal government will use funds from the federal treasury to provide capital to health care providers. The government will own the loans. The loans will be either fixed or low-interest variable rate loans with interest caps that limit the cost to the healthcare provider. The U.S. Department of Health and Human Services (HHS) will subcontract with entities that will originate and service the loans. The Program will be an entitlement program and funding will be provided on a permanent indefinite basis and will not be subject to the congressional appropriations process.

In order to increase the use of HIT, the AMGA proposal calls for the government, in partnership with health care providers and other stakeholders, to explore ways to incentivize HIT implementation. The proposal also calls for statutory and/or regulatory exceptions to federal fraud and abuse laws which are current barriers to HIT, and calls for studies to determine the savings resulting from increased HIT implementation due to Program loans.

ADMINISTRATION

Loans to providers will be provided by the federal government and disbursed through a Loan Origination Center (LOC). HHS will contract with private sector entities to serve as LOCs. This public/private partnership combines private sector efficiencies with public sector commitment to help ensure the Program’s success. HHS may contract with one or several entities to serve as LOCs. LOCs will be responsible for assessing the provider’s eligibility for a Program loan; obtaining completed promissory notes from the providers; requesting loan funds from HHS;

performing fund management tasks, including monthly account reconciliation; disbursing approved funds to providers, and notifying HHS of those disbursements.

HHS will also contract with entities to serve as Loan Service Centers (LSC). HHS may contract with one or several entities to serve as LSCs. LSCs will be responsible for monitoring provider eligibility status; billing; collecting loan payments; conducting initial collection services on delinquent loans; and transferring defaulted loans to a debt collection system.

HHS will be responsible for reviewing requests for federal loan capital; transferring funds; monitoring loan servicing and collection activities; ensuring compliance with applicable statutes and Program regulations; and monitoring provider default rates.

FEDERAL COSTS

The Program will have minimal, if not positive, effects on the federal budget. The student loan program's main cost components include interest benefits to students under the subsidized Stafford loan program, a special allowance to lenders, administrative costs of contracts to LOCs and LSCs and defaults. Under the Program, HHS will not subsidize Program loans and there is no need for a special allowance. Moreover, recent data shows that government inflows are greater than government costs in the student loan program's Direct Loan program, even when accounting for administrative costs. It is anticipated that over time, the Program will provide savings to the federal budget.

HIT IMPLEMENTATION INCENTIVES

Under Medicare's current reimbursement system, there is little to no return on investment (ROI) for providers to purchase and implement HIT. With some notable exceptions, the vast majority of commercial payers similarly do not provide any ROI for HIT implementation.

CMS, with input from the Agency for Healthcare Research and Quality (AHRQ), health care providers and other stakeholders, will explore mechanisms to incentivize HIT implementation among health care providers. Such incentives may include prompt claims payment, payment differentials, cost differentials, direct payment for services provided through HIT (e.g., CPT code for on-line visits), bonus payments for meeting quality outcomes, etc. Incentives to purchase and implement HIT shall be in place within 18 months of enactment of the Program.

CONGRESSIONAL STUDIES

The government (e.g., GAO, MedPAC, CMS, CBO) shall study the Program to determine the savings to Federal health care programs resulting from implementation of HIT due to Program loan funding.

FRAUD AND ABUSE

Because federal monies will be disbursed to health care providers under the Program, federal fraud and abuse statutes will be implicated, including the Stark II law (Stark law), the Anti-Kickback Statute (AKS), and the False Claims Act (FCA). These statutes currently serve as a barrier to HIT implementation because they prohibit certain financial relationships between health care providers. To encourage HIT implementation, providers must be assured that their

lawful participating in the Program will not result in increased governmental scrutiny and investigation.

To address these concerns, CMS shall create an exception to the Stark law for providers that participate in the Program and adhere to Program rules and regulations. Additionally, the OIG shall create a safe harbor to the AKS for providers that participate in the Program and adhere to Program rules and regulations.

To ensure that the Program is not used as a vehicle to commit fraud, the FCA will be amended, if appropriate, to clarify that false representations to the LOC, LSC, or HHS regarding the Program (e.g., knowing misstatements on the loan application or knowing misuse of loan funds) will be covered conduct under the FCA. Additionally, the Civil Money Penalties Law (CMPL) will be amended, if appropriate, to clarify that fraudulent conduct related to the Program is covered conduct under the CMPL.

REGULATORY MANDATES

The government shall not mandate any additional condition of participation that is not directly related to the application for, and disbursement of, Program loans to eligible providers.

ELIGIBILITY

To be eligible to participate in the Program, providers must be licensed by an appropriate state agency, participate in the Medicare program, attest that Program loans will be used to purchase, implement, and/or improve HIT, and certify that the HIT is interoperable with a medical group, hospital or health system in the community. Interoperability will help to ensure that providers do not spend federal funds to purchase HIT systems that can not be linked to other community providers.

The provider must not be in default on an existing federal loan. There will be no analysis to determine a provider's financial need because the government will not subsidize Program loans, although the government may, on a case by case basis, opt to defer, forbear, discharge, or forgive the loan based on defined factors.

LOAN LIMITS

The Program loan amount that may be borrowed will be fixed by statute and based upon cost of the HIT and provider size.

INTEREST RATES

The formula used to calculate Program loan interest rates will be fixed by statute and shall stay in effect for the life of the loan. The rate for Program loans will be adjusted annually and will be determined every June 1 to be effective on July 1. (These dates are the same as used in the student loan program and fixing the Program's rate adjustment date on the same schedule will promote efficiency and familiarity). The formula will also establish a statutory maximum rate that can be charged. Interest rate discounts are permissible to provide incentives for on-time repayment, use of electronic fund transfer, etc., provided that the reduction is cost-neutral to the government.

BORROWER FEES

Providers will be responsible for paying origination and, where applicable, loan insurance fees. Currently, the student loan program charges a 3% origination fee to its Direct Loan borrowers.

REPAYMENT TERMS

Providers will be able to choose among payments plans. Under a Standard Plan, providers will pay a fixed monthly amount. Under a Graduated Payment Plan, repayment amounts increase as the provider's income increases over time. Additionally, the Secretary may agree to an Alternative Payment Plan on a case-by-case basis to accommodate a provider's unique situation. There will be no penalty for pre-payment of the loan.

REPAYMENT RELIEF

The Secretary may provide repayment relief to providers including: deferments, forbearance, loan consolidation, and loan discharge and forgiveness.

LOAN DEFAULT

Default will be defined when a health care provider has failed to make a required payment, or otherwise violated the terms of the borrower's promissory note for 180 days. Consequences of default shall include: reports to the major credit bureaus; offset of tax refund due to the provider; wage garnishment; ineligibility for further Program loans (though providers that make re-payment for 6 consecutive months on defaulted loans will retain their eligibility); and litigation.