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Electronic Health Records Incentive Program: the Payment Clock is Ticking!

For Eligible Professionals

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Electronic Health Records (EHRs) are a hot topic in the health care industry.[1] Several studies have suggested that physician practices that implement EHRs will have lower costs, improve the quality of care they offer, and see significant improvement in health outcomes of their patients. However, surveys suggest that only between 20 percent to 40 percent of physician practices in the U.S. are using an EHR system (Simon et al., 2008; Menachemi, 2006). To encourage EHR adoption, the American Recovery and Reinvestment Act (ARRA) of 2009, also known as the "stimulus package," is providing a significant amount of funding as incentives for hospitals and individual physicians to invest in these technologies. In addition to providing incentive payments directly to hospitals and physicians, this legislation also created Regional Extension Centers to support health care providers with technical assistance in selecting a certified EHR product and demonstrating their "Meaningful Use." In Oklahoma, the Oklahoma Foundation for Medical Quality Health Information Technology (OFMQHIT) Regional Extension Center is the designated entity to help health care providers through EHR implementation. The final rules denoting official Meaningful Use definitions were released in July 2010, along with a list of Eligible Professionals (EPs) qualifying for the incentive payments. This report will address the most important aspects regarding the incentive payments for medical professionals, including: those eligible, the components of Meaningful Use, the types and amounts of payments (Medicare and Medicaid) available, the timeline for implementation (particularly the monetary loss associated with waiting), and the next steps for eligible professionals.

1 For more background information about Electronic Health Records, please refer to Oklahoma Cooperative Extension Service current report CR-1013, "Electronic Medical Records: What Are They?"

Inside this report:

Who is Eligible for EHR Incentive Payments?

There are two distinct programs that offer incentive payments for EHR adoption – one under Medicare, and one under Medicaid. It is important to note that both sets of incentives are based on individual physicians, and not practices. Thus, a three-person practice would be eligible for three separate incentive payments – one to each physician. One of the first steps in moving forward, then, is to identify if a medical professional is eligible for the Medicare program, the Medicaid program, or if they are eligible under both programs. If an EP does meet the criteria for both Medicare and Medicaid, they will have to choose from which program to register,

Table 1. Medicare and Medicaid EPs.

	Medicare EP	*Medicaid EP**
Doctor of Medicine	X	X
Doctor of Osteopathy	X	X
Doctor of Dental Surgery	X	X
Doctor of Dental Medicine	X	X
Doctor of Podiatric Medicine	X	
Doctor of Optometry	X	
Chiropractor	X	
Certified Nurse Midwife		X
Nurse Practitioner		X
Physician Assistant- only those practicing in a FQHC or RHC that is led by a PA		X

*Medicaid also specifies that EPs have a minimum Medicaid patient threshold of 30 percent (20 percent for pediatricians), or that the Medicaid EP practices predominantly in an FQHC or RHC with at least a 30% needy individual patient volume threshold.

since EPs can only receive payments from one program per year. If an EP's situation changes, they can switch incentive payment programs – but only once before 2015. Table 1 displays the types of providers eligible for each program, and shows that most doctors are eligible for the Medicare incentive. Eligibility for the Medicaid program also stipulates that EPs must meet a minimum Medicaid patient threshold of 30 percent (20 percent for pediatricians). Additionally, EPs who practice predominantly in a Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) with at least a 30 percent needy individual patient volume threshold qualify for the Medicaid program. Certain types of EPs (certified nurse midwives, nurse practitioners, physician assistants) qualify for the Medicaid program under certain conditions, but do not qualify under Medicare. Hospital based EPs, defined as those with 90 percent or more of their services performed in a hospital inpatient or emergency room setting, are not eligible for either incentive program.

To determine if an EP meets the Medicaid patient minimum threshold, a practice can examine their total Medicaid patient encounters from any 90-day period in the preceding calendar year divided by their total patient encounters during that same 90-day period. This will give the EP an estimate for meeting the minimum patient threshold.

If Medicare EPs are currently participating in the e-Prescribing programs, they will not be eligible to receive payments for both programs (i.e. Medicare EHR incentive and e-Prescribing). However, if they are a Medicaid EP, they may participate in both the Medicaid EHR incentive program and e-Prescribing (providing all criteria are met for both programs). Participation in other programs such as the Medicare Physician Quality Reporting Initiative (PQRI) or Medicare EHR Demonstration does not interfere with the ability to receive payments under the Medicare EHR incentive program.

What is "Meaningful Use?"

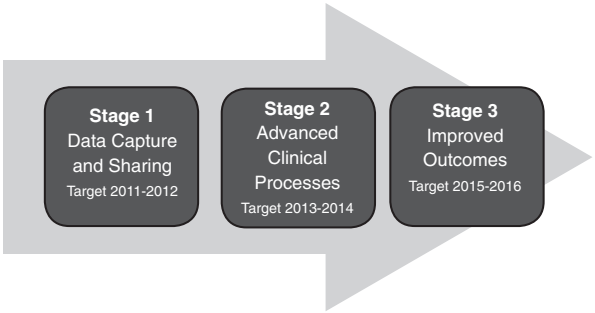
To receive Medicare or Medicaid incentive payments, EPs are required to document that they are "meaningfully using" the EHR technology adopted during a staggered timeframe. There are three primary components of Meaningful Use:

1. Use of a certified EHR in a meaningful manner (such as e-prescribing).
2. Use of a certified EHR for electronic exchange of health information with other healthcare entities.
3. Use of a certified EHR to submit clinical quality measures (CQMs).

Source: Centers for Medicare and Medicaid Services (www.cms.gov

These components are then linked to three stages of "Meaningful Use" (Figure 1), with the requirements for reporting each component becoming more stringent each time. For example, to meet specific requirements under Stage 1, 80 percent of patients must have records in the certified EHR technology. While concrete rules for Stage 2 and Stage 3 have not been finalized, it is certain that requirements will become more rigorous as the stages progress.

Figure 1. The three stages of EHR "Meaningful Use"



To meet the Meaningful Use requirements for Stage 1, EPs must complete 15 core objectives, 5 out of 10 objectives from a "menu" set, and 6 out of 44 Clinical Quality Measures (CQMs). More detail into these objectives can be found in Tables 2 through 4. In Oklahoma, Meaningful Use requirements for Medicare and Medicaid incentive payments are exactly the same.

Table 2. Meaningful Use Core Set- All 15 must be met.

1. Computerized Provider Order Entry (CPOE).
2. Report ambulatory clinical quality measures to CMS/ States.
3. Provide patients with an electronic copy of their health information, upon request.
4. Drug-drug and drug-allergy interaction checks.
5. Maintain an up-to-date problem list of current and active diagnoses.
6. Maintain active medication allergy list.
7. Record smoking status for patients 13 years or older.
8. Protect electronic health information.
9. ePrescribing (eRx).
10. Implement one clinical decision support rule.
11. Provide clinical summaries for patients for each office visit.
12. Record demographics.
13. Maintain active medication list.
14. Record and chart changes in vital signs.
15. Capability to exchange key clinical information among providers of care and patient-authorized entities electronically.

Source: Centers for Medicare and Medicaid Services (www.cms.gov)

Table 3. Meaningful Use Menu Set- 5 of the 10 must be met.

1. Drug- formulary checks.
2. Incorporate clinical lab test results as structured data.
3. Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate.
4. Medication reconciliation.
5. Send reminders to patients per patient preference for preventative/follow up care.
6. Generate lists of patients by specific conditions.
7. Provide patients with timely electronic access to their health information.
8. Summary of care record for each transition of care/referrals.

*9. Capability to submit electronic data to immunization registries/systems.

*10. Capability to provide electronic syndromic surveillance data to public health agencies.

*At least one public health objective must be selected.
Source: Centers for Medicare and Medicaid Services (www.cms.gov)

To achieve the quality and safety component, six total CQMs must be met. Three of these should be from a set of core measures; however, if any of the three core measures are not applicable, there are three alternative core measures available for replacement (Table 4). The remaining three CQMs can be achieved through any of the 38 menu set of CQMs.

Table 4. Meaningful Use Clinical Quality Measures.

Core Quality Measures	*Alternative Core Quality Measures*
1. Blood Pressure	1. Children and Adolescent Weight
2. Tobacco Status	2. Influenza Screening for patients over 50
3. Adult Weight Screening and Follow up	3. Childhood immunization status

Source: Centers for Medicare and Medicaid Services (www.cms.gov)

A complete list of the 38 additional CQMs can be found at: http://www.cms.gov/EHRIncentivePrograms/Downloads/MU_Stage1_ReqSummary.pdf.

EPs demonstrate these Meaningful Use measures in various ways, including attestation that certain elements are available, submission of claims with applicable data, and reporting of clinical quality measures. It is essential for an EP to discuss the Meaningful Use measures it plans to achieve with potential EHR vendors. This can help determine the system that best fits individual needs and will also meet the requirements for Meaningful Use at the same time. OFMQHIT can help EPs through this decision by providing a list of certified vendors and discussing the merits of each option.

Medicare and Medicaid Incentive Program Payment Amounts and Schedules

As previously indicated, Medicare and Medicaid have different incentive payment programs. If an EP is eligible for both, the payment amount and structure will likely be a major factor when considering which program to choose. Once the EP meets the criteria for Meaningful Use and registers with a selected program, the payments will begin. These payments are incentives, and are therefore, not tied to the cost of the EHR system being implemented. With typical costs for physician office EHR systems ranging from $16,000 to $36,000 per physician (Miller and Sim, 2004), the payments under each program can offset a sizable portion of total costs – or even pay for more than the entire system. Table 5 displays the maximum payment schedule under the Medicare incentive program. Payments are made once per year. The maximum incentive payment under the Medicare program is $44,000 and occurs over five years. Note that in order to receive the maximum incentive payment, an EP must reach Meaningful Use prior to the end of 2012. Additionally, 2014 is the last year to register to start receiving incentive payments with Medicare. Table 6 displays the maximum incentive payments under the Medicaid program. The Medicaid program has a larger maximum incentive payment ($63,750) and permits a longer time period for implementation (EPs can register as late as 2016). The Medicaid program also pays the same incentive regardless of the time of registration (anytime between 2011 and 2016).

EPs practicing in Health Professional Shortage Areas (HPSAs) are eligible for an additional 10 percent increase in incentive payments under the Medicare program, resulting in a total maximum payment of $48,400. There are no additional HPSA increases under the Medicaid program.

Medicaid also has a single-year program known as Adopt / Implement / Upgrade (A/I/U) where only the first participation year payment of $21,250 is given for accomplishing any of the following:

- Adoption: Evidence of EHR installation prior to the incentive program
- Implementation: Commenced utilization of EHR
- Upgrade: Upgraded to certified EHR system or added new functionality needed to meet definition of certified EHR technology.

While there is no requirement to meet Meaningful Use with the A/I/U option, providers who meet Meaningful Use objectives will be eligible for subsequent payments, up to the maximum $63,750. The A/I/U option is not available under the Medicare incentive program.

Timeline of Implementation

Since the exact specifications of Meaningful Use were not released until July 2010, EHR vendors have had to make recent adjustments to their products in order for Meaningful Use to be achieved. In addition, a certification process established for health care information and technology has been set up by the Office of the National Coordinator for Health Information Technology (ONC). A list of certified EHR products is now available on the ONC website: http://onc-chpl.force.com/ehrcert. Figure 2 displays the timeline of registration, payments, and milestones defined by CMS.

The dates are quickly approaching with registration for the incentive programs starting promptly in January 2011. For EPs to receive the maximum incentive payment from Medicare, Meaningful Use must be reached by the end of 2012. Thus, the timeline is short for going through the vendor selection process and achieving Meaningful Use. This process can take approximately 18 months (see Table 7). Thus, it is essential for EPs to start moving quickly to meet these tasks in a timely manner and receive the maximum incentive payments.

Table 5. Maximum Medicare Incentive Payments.

		Year Meaningful Use is Reached			
		2011	*2012*	*2013*	*2014*
Year of Payout	2011	$18,000			
	2012	$12,000	$18,000		
	2013	$8,000	$12,000	$15,000	
	2014	$4,000	$8,000	$12,000	$12,000
	2015	$2,000	$4,000	$8,000	$8,000
	2016		$2,000	$4,000	$4,000
	Total	**$44,000**	**$44,000**	**$39,000**	**$24,000**

Note: EPs who practice at least 50 percent of their services in a geographic health professional shortage area (HPSA) are eligible for a 10% increase in incentive payments (not included in above).

Source: Centers for Medicare and Medicaid Services (www.cms.gov)

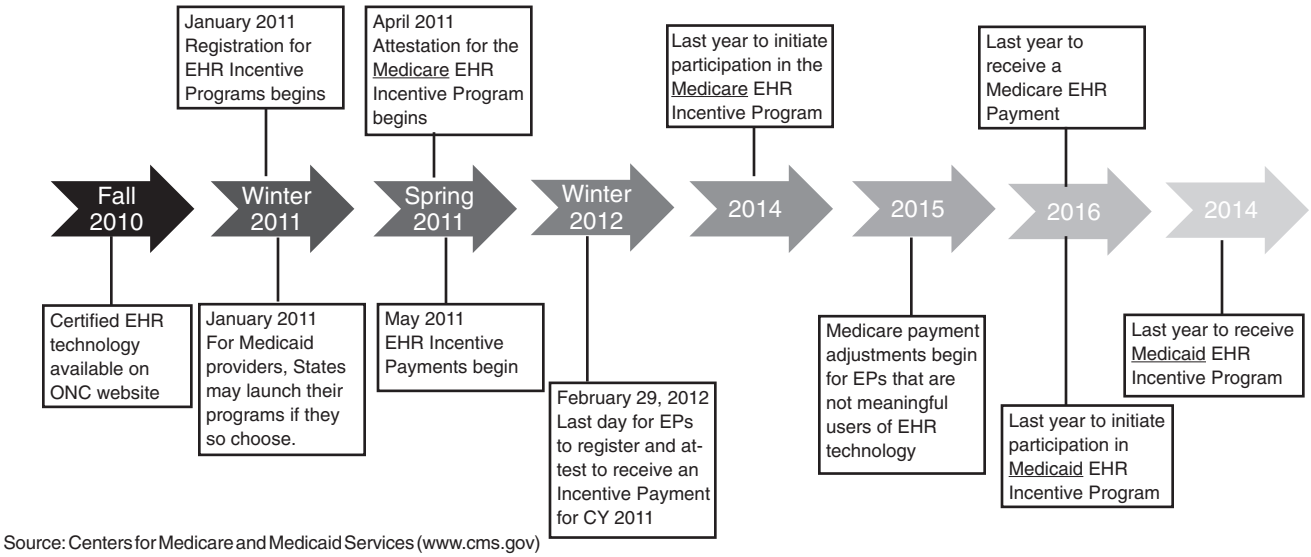
Table 6. Maximum Medicaid Incentive Payments.

		Year Meaningful Use is Reached					
		2011	*2012*	*2013*	*2014*	*2015*	*2016*
Year of Payout	2011	$21,250					
	2012	$8,500	$21,250				
	2013	$8,500	$8,500	$21,250			
	2014	$8,500	$8,500	$8,500	$21,250		
	2015	$8,500	$8,500	$8,500	$8,500	$21,250	
	2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
	2017		$8,500	$8,500	$8,500	$8,500	$8,500
	2018			$8,500	$8,500	$8,500	$8,500
	2019				$8,500	$8,500	$8,500
	2020					$8,500	$8,500
	2021						$8,500
	Total	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**	**$63,750**

*Pediatricians that only meet the 20% Medicaid patient threshold will receive $14,167 the first year and $5,667 for years following. The maximum that can be received is $42,500 over the 6 years in this case.

Source: Centers for Medicare and Medicaid Services (www.cms.gov)

Figure 2. EHR Incentive Programs Timeline for Eligible Professionals (EPs) (Medicare and Medicaid)



Source: Centers for Medicare and Medicaid Services (www.cms.gov)

Table 7. Timeframe for EHR Implementation and Reaching Meaningful Use

Task	*Time to Accomplish**
Vendor Programming and Testing	90 to 120 days
Vendor Certification	30 to 60 days
Vendor Capacity to Implement	60 to 240 days
Vendor EHR Implementation and Testing	120 to 240 days
90 day Meaningful Use Qualification Period	90 days

"Typical" time from vendor selection to meaningful use: 550 days (18 months).

Penalties for Failure to Achieve Meaningful Use by 2015

If an EP has not successfully demonstrated Meaningful Use with a certified EHR by 2015, the EP will experience payment adjustments for Medicare reimbursements. The adjustments for 2015-2017 are:

Year	*Medicare physician fee schedule covered amount*
2015	99%
2016	98%
2017	97%

In addition, if less than 75 percent of EPs are meaningful users by 2018, payment reductions of 1 percent annually are probable until the reimbursement rate is 95 percent. At this time, there are no penalties in place for Medicaid payments.

Next Steps

The push to implement EHRs has been accompanied by the fears and speculations of many small-practice physicians. It is likely that EHRs will generally slow doctors down while a system is being implemented. It is true that an EHR may change the way a practice operates. However, these changes are part of an overall improvement in the quality of care provided. The short-lived deceleration in everyday tasks will quickly lead to a more efficient way of running a practice, and these efficiencies and commonalities with EHR systems in other locations (pharmacies, hospitals) will improve the quality of life for both patients and physicians. In short, EHRs are here to stay – so physicians should embrace the change and take advantage of the incentive payments provided by Medicare and Medicaid as they implement an EHR that will ultimately benefit their patients' health.

To move forward, medical providers should first determine whether or not they are eligible for incentive payments under the Medicare or Medicaid programs. EPs should also become familiar with the list of certified EHR vendors provided by ONC, since each EHR must meet certification standards before any payments can be administered. EPs should also consider which elements of Meaningful Use are relevant to their practice and potential EHR system. EPs should also review the requirements to register at the national EHR incentive program website (https://www.cms.gov/EHRIncentivePrograms/50_Registration.asp), including the need for a National Provider Number (NPI) and enrollment in the CMS Provider Enrollment, Chain and Ownership System (PECOS). Registration on this national site should become available in early 2011.

Fortunately, there is an entity in Oklahoma specifically tasked with helping providers through this process. OFMQHIT is Oklahoma's certified Regional Extension Center for EHR

implementation and is focused on individual and small group practices (less than 10 clinicians). They can provide expertise on which system is appropriate for a particular practice and can also help practices reach Meaningful Use status. The vast majority of the cost of this program is subsidized via the federal government; however, practices can generally expect to pay around $700 to OFMQHIT in order to participate. Given that the process can take 10 months to 18 months, the result can be $40,000 to $60,000 in incentive payments, and provides access to EHR technology specialists; this represents an exceptional value for practices seeking consulting expertise for EHRs, Meaningful Use, and ARRA funding.

OFMQHIT has a goal of assisting 1,000 primary care providers to achieve Meaningful Use by February 2012, and currently has about 300 signed up across the state. If your practice does not yet have an EHR system or wants to know more about upgrading their current one, please contact OFMQHIT at (405) 302-3318 as soon as possible. OFMQHIT's website is http://www.ofmqhit.com, which has contact and interest forms for the EHR incentive program. Keep an eye out for additional current reports on this topic, as OFMQHIT, Oklahoma Cooperative Extension Service, and the Center for Rural Health will continue to provide information as it becomes available.

Additional Information / References

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