

The Road to “Meaningful Use” EHR Stimulus Payments

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On July 28, 2010, the Centers for Medicare and Medicaid Services (CMS) published a final rule regarding what constitutes the “meaningful use” of electronic health records (EHRs) (the “Meaningful Use Rule”) for physicians interested in qualifying for EHR incentive payments from Medicare and Medicaid under the the American Recovery and Reinvestment Act of 2009 (ARRA).¹ The Meaningful Use Rule addresses many of the issues and recommendations from providers and associations on the proposed rule, including comments submitted by the Academy of Medicine of Cleveland & Northern Ohio.²

At the same time, the HHS Office of the National Coordinator (ONC) for Health Information Technology issued a related final rule on the standards EHR vendors must meet in order to have their EHR technology certified for use by physicians to qualify for the EHR incentive payments (the “Certified EHR Technology Rule”). Now, providers and their vendors have a fairly clear picture of what it will take to earn the EHR ARRA stimulus dollars.

Background on the Meaningful Use Rule

Congress established the ARRA EHR incentive program to incentivize providers to use EHR to improve healthcare delivery, quality, efficiency and patient safety in a transformative way. Under this program, CMS will make EHR incentive payments to eligible professionals and hospitals who qualify for extra Medicare and Medicaid payments by (1) demonstrating use of a certified EHR technology in a meaningful manner, including e-prescribing for physicians; (2) connecting the certified EHR technology to exchange health information electronically to improve quality and care coordination; and (3) submitting clinical quality and other measures selected by HHS.

CMS established a three-stage, graduated approach to Meaningful Use. Each biennial stage will include criteria that become more stringent over time. The stages contemplate an evolution from initially just capturing and using health information in a structured format to tracking clinical conditions and using health IT for order entry, result reporting and improving quality at the point of care, and finally to interoperability among EHR technologies with clinical decision support.

The final rule covers the first two (2) years of the incentive program, which begins as early as 2011 under Medicare. CMS will propose the next two stages of criteria for meaningful use through future rulemaking. For the first payment year only, physicians may demonstrate meaningful use of certified EHR technology over any continuous 90-day period within a calendar year - allowing physicians using certified EHR technology in a meaningful manner as late as October 1, 2011 to qualify for incentive payment for 2011. After the first year, however, physicians must demonstrate meaningful for the entire calendar year.

¹This article updates “The Proposed Pathway for Achieving 'Meaningful Use' and EHR Stimulus Payments,” *Northern Ohio Physician* (March/April 2010).

² The Academy of Medicine of Cleveland & Northern Ohio comments on the January 2010 proposed rule are posted on the website.

Medicare EHR Incentive Program

As originally set forth in ARRA and the proposed rule, Medicare EHR incentive payments for eligible professionals will be 75% of Medicare fee-for-service allowable charges up to an annual cap for up to five years beginning in calendar year 2010. (See Medicare Table.) Eligible professionals can receive up to a total of \$44,000 over a five-year consecutive period, including \$18,000 in the first year for early adopters qualifying by calendar year 2012. Eligible professionals must begin by 2014 and the last payment year is 2016. Eligible professionals furnishing more than 50% of their Medicare covered services in a health professional shortage area (HPSA) earn an additional 10%. Eligible professionals who do not establish meaningful use by 2015 will face reductions in their Medicare fee schedule.

Medicare carriers will pay physicians demonstrating Meaningful Use in a single lump sum payment during each annual reporting period. The payments will be made to the physician or to a single employer under a valid Medicare reassignment. Physicians cannot allocate payments among multiple entities. Most health systems and group practices will want to review their employment and professional contractor agreements and determine who is entitled to receive the payments. CMS makes clear that the purpose of the Medicare EHR incentive payments is not to be a reimbursement or cost pass through of software costs to encourage purchasing and adopting EHR technology, but to be an incentive to actually use the EHR technology in a manner that supports the HITECH health policy priorities.

Medicaid EHR Incentive Program

Medicaid payments will be made through the states and states must prepare a health information technology plan to receive the CMS match for their EHR incentive programs. The Medicaid incentive program will allow eligible professionals and hospitals to qualify for initial payments before achieving Meaningful Use. Eligible professionals who adopt, implement, or upgrade their certified EHR technology in the first payment year are still eligible for Medicaid payments during the first participation year only and do not have to meet the Meaningful Use objectives and associated measures of the Stage 1 criteria until the second participation year.

CMS defines this as requiring eligible professionals to at least (1) acquire, purchase or secure access to certified EHR technology, (2) install or begin utilization of certified EHR technology capable of meeting meaningful use requirements, or (3) upgrade from existing technology to certified EHR technology or add new functionality to meet the definition of certified EHR technology at the practice site, including staffing, maintenance, and training.

The Medicaid EHR incentive program pays eligible professionals up to \$63,750 over a 6-year period for most physicians. (See Medicaid Table.) The maximum Medicaid incentive payment is \$21,250 in the first payment year and \$8,500 annually in five subsequent years, with pediatricians in the 20-29% Medicaid patient volume corridor receiving one-third less. There is no HPSA bonus. Physicians must enter the Medicaid EHR incentive program by 2016 to receive full Medicaid incentive payments available through 2021.

Consistent with the proposed rule, CMS allows that the Medicaid payment amount for any particular professional to be reduced for EHR technology or support service payments received from outside sources other than state or local governments. This reduction can be up to \$29,000 in the first year or \$10,610 in subsequent years. However, technology provided through an employer-employee relationship, vendor discounts, and in-kind contributions do not need to be backed out.

Multiple Programs

Unlike hospitals that may obtain both Medicare and Medicaid incentives, physicians must choose between the Medicare and Medicaid EHR incentive program. However, a one-time switch between programs can be made before 2015. Choosing between the two programs requires an analysis of the different payment amounts, years and whether the physician has received any cash support payments (e.g., hospital EHR donations).

In the final rule, CMS allows eligible professionals to also participate in the Medicare Physician Quality Reporting Initiative (PQRI) and the Medicare EHR Demonstration while participating in the Medicare EHR Incentive Program. However if an eligible professional participates in the Medicare e-prescribing incentive program, they cannot participate in the Medicare EHR Incentive program in the same year, but could choose to participate in the Medicaid EHR Incentive Program. HHS is required under the recent health reform legislation to develop a plan to integrate the EHR incentive programs and PQRI by January 1, 2012.

Eligibility and the Hospital-based Exclusion

The strongest recommendation from the Academy of Medicine of Cleveland and Northern Ohio was that CMS should ensure the broadest possible physician participation allowed by statute. Medicare and Medicaid are separate and distinct programs with differing eligibility requirements, but physicians could qualify under either EHR incentive program. Under the Medicare program, the professionals eligible for the incentives are doctors of medicine or osteopathy, dental surgery and medicine, podiatrists, optometrists, and chiropractors participating in Medicare. Physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who practice predominantly in a federally qualified health center (FQHC) or rural health clinic (RHC) if it is led by PAs are all eligible for the Medicaid EHR program by meeting certain patient volume criteria. The Medicaid EHR program volume requirements are 30% of Medicaid patient encounters, with an allowance for pediatricians having at least 20% of Medicaid patient encounters to qualify at a reduced level, and a special formula allowing professionals who practice predominantly in FQHC and RHCs to meet the 30% threshold by serving needy individuals, such as patients covered by CHIP, sliding scale, and free care.

Hospital-based eligible professionals are not eligible for Medicare or Medicaid incentive payments. Unfortunately the ARRA definition was ambiguous and subject to a broad interpretation. CMS originally proposed to exclude all professionals furnishing 90% or more of their professional services in a hospital inpatient, outpatient or emergency department using place of service codes on the professional claim form to calculate eligibility. AMCNO was very

concerned about the expansive definition of hospital-based physicians in the proposed rule and argued that CMS should interpret the statute considering the goals of ARRA to promote EHR adoption. The Academy of Medicine of Cleveland & Northern Ohio argued that CMS should interpret the statute considering the goals of ARRA to promote EHR adoption and provided CMS with several alternatives consistent with the statute. In conjunction with area academic medical centers and integrated health systems, AMCNO estimated that this proposal would have a devastating effect on the number of local physicians eligible to participate.

AMCNO recommended that CMS eliminate the hospital outpatient department place of service code 22 from the exclusion criteria. On April 15, 2010, President Obama signed the Continuing Extension Act of 2010 to amend the statutory definition of hospital-based EPs. After reviewing public comments and the amendment, CMS revised the definition accordingly. Under the final Meaningful Use Rule, if more than 90% of an eligible professional's services on claim forms are provided in the Inpatient Hospital place of service code 21 or Emergency Department place of service code 23, the professional will not qualify for incentive payments. CMS estimates that the revised definition would exclude only 14% of Medicare eligible professionals, down from 27% in the proposed rule. This revised definition exclude many hospitalists and traditional hospital-based eligible professionals, but allows many primary care physicians and others practicing in a hospital outpatient department setting.

Realistic Objectives and Measures

AMCNO expressed concern in its comments over the breadth and depth of the objectives and measures required under the proposed rule and suggested that CMS scale back the measures to eliminate the "all or nothing" approach to qualification. In particular, the Academy of Medicine of Cleveland & Northern Ohio expressed concern that requiring physicians to directly enter 80% of their orders for ancillaries, obtaining 50% of all lab results in the EHR, and requiring e-prescribing for 75% of permissible prescriptions were too high.

In a welcome relief, CMS lowered the thresholds for most objectives and provided for a core set of objectives and a menu (optional) set of criteria from which to choose. Beginning in Stage 1, eligible professionals must demonstrate that they meet a core set of 15 objectives, and a menu set allowing the professional to choose 5 out of 10 other measures. In Stage 2, all Stage 1 objectives will be core.

CMS also lowered the thresholds for many of the objectives it retained. For example, using computerized physician order entry (CPOE) for at least 80% of all ambulatory EHR orders was lowered to 30% of patients that have medication orders, with at least one medication ordered through CPOE. Eligible professionals will need to transmit more than 40% of all permissible prescriptions electronically. Professionals must implement at least one clinical decision support rule relevant to their specialty or high clinical priority and be able to track compliance with that rule, down from the 5 decision support rules initially proposed.

While lowering thresholds, CMS held the line on requiring health information to be recorded as structured data. The requirement to maintain an active problem list for at least 80% of unique

patients must be recorded as structured data, and eligible professionals must still maintain at least 80% of all active medications and medication allergies as structured data.

Quality Measures

The Academy of Medicine of Cleveland & Northern Ohio commented that the initial list of quality measures should be scaled back to an realistic level with only a few straightforward, achievable measures clearly identified for each specialty. Those measures should be evidence-based measures having full endorsement by the respective medical specialty societies **and** at the level of maturity where implementation specifications have already been developed. In the final rule, CMS limited the Stage 1 measures to those that are already in existence and not under development, but stated that it will seek to align the quality measures for Stage 2 with other quality measures development and reporting related to health care reform and other CMS quality measures programs.

Administrative Burdens

The Academy of Medicine of Cleveland & Northern Ohio commented that CMS should streamline the administrative burden on physicians for easier creation of the compliance documentation, especially considering the technical criteria and the potential for manual calculations. In 2011, eligible professionals must submit aggregate clinical quality measure numerator, denominator, and exclusion data to CMS or the States by attestation, and CMS now estimates about 9 1/2 hours for Eligible Professionals to attest and report objectives and quality measures during the first year. Despite commentator concerns that CMS compliance burden estimates were far too low, CMS says it believes that EHR technology will help reduce the burden as it evolves to calculate the clinical quality measures required for meaningful use incentives. State Medicaid programs will have some flexibility on how they approach provider compliance documentation, although CMS will review the state attestation and provider reporting mechanisms before they are implemented.

The EHR Technology Rule

What is most important is that the EHR technology not only meet the certification criteria, but actually be certified. ARRA requires providers to use EHR technology certified by ONC. The Certified EHR Technology Rule adopted by ONC provides certification standards and a pathway for EHR vendors to have their technology certified, either as a complete EHR or as one or more EHR modules.

Vendors are now gearing up to ensure that their software has the capabilities required or can work with other certified modules to allow providers to meet the minimum standards for an EHR, including the standards for demographics, history and problem list, clinical decision support, physician order entry, quality measures, and exchanging information. Eligible professionals should be working with their vendors to confirm that the vendor can and will pursue certification of the technology under the initial standards and is committed to ramping up over the three stages.

Good luck and stay tuned for more exciting EHR developments!

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