The Proposed Pathway for Achieving "Meaningful Use" and EHR Stimulus Payments

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Physicians want to know how to qualify for Medicare and Medicaid inventive payments under the American Recovery and Reinvestment Act of 2009 (ARRA) stimulus legislation passed last year. Two new rules set the stage for how the U.S. Department of Health and Human Services (HHS) expects to roll out the eligibility, standards, and requirements for ARRA incentive payments for adopting and meaningfully using electronic health record (EHR) technologies.

On December 30, 2009, the Centers for Medicare and Medicaid Services (CMS) released proposed rules for what constitutes "meaningful use" of EHRs for hospitals and eligible professionals to qualify for extra Medicare and Medicaid payments. At the same time, the HHS Office of the National Coordinator (ONC) for Health Information Technology (Health IT) issued an interim final rule setting forth the initial set of standards and certification criteria that vendors must meet in order to have their EHR technology certified. Together, these rules set the stage for EHR adoption, use and exchange of health information to meet far-reaching federal health policy goals.

Background

Congress included the Health Information Technology for Economic and Clinical Health (HITECH) provisions in ARRA to establish a framework for HHS to regulate Health IT using objectives for healthcare quality, efficiency and patient safety. The stated goal is the adoption and use of EHR to improve healthcare delivery in a transformative way. ARRA requires CMS to make EHR incentive payments to eligible professionals and hospitals who adopt and begin to meaningfully use EHR technology meeting certification standards adopted by ONC.

Providers must demonstrate they are achieving "Meaningful Use" through three core concepts (1) using a certified EHR technology in a meaningful manner, including e-prescribing for physicians; (2) connecting the certified EHR technology to allow for electronic exchange of health information to improve quality and care coordination; and (3) submitting information, in a form and manner specified by HHS, on clinical quality and other measures selected by HHS.

Incentive payments begin as early as 2011 under Medicare Fee-for-Service, Medicare Advantage (MA) and Medicaid, and those eligible professionals and hospitals who do not establish meaningful use by 2015 face reductions in their Medicare fee schedule. The two new regulations are designed to work together, with the EHR Technology Rule providing a pathway for the technology, closely linked to the Meaningful Use Rule proposing how eligible professionals and hospitals will use it.

Staged Approach

ARRA allows CMS to build up to a more robust definition of Meaningful Use as technology and provider capabilities ramp up over time. CMS has proposed a three-stage approach with the criteria for qualification becoming more stringent as the expectations rise to reduce the gap between today's reality and the desired state of widespread use of EHR. Both rules contemplate that the state of the art of EHR technology and its adoption will evolve to move providers from the initial stages of 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 to later stages where interoperability of EHR technology is possible and providers manage high priority conditions and improve population health with decision support.

The EHR Technology Rule

ARRA requires providers to use EHR technology certified by HHS and set December 31, 2009 as the statutory deadline for HHS to adopt an initial set of standards, implementation specifications and certification criteria for EHRs. ONC organized quickly and obtained input on what should constitute certified EHRs and how to address Meaningful Use in a way to advance HITECH health policies. HITECH federal advisory committees and stakeholders helped ONC craft a framework, definitions and timetables for the implementation of these core concepts in public forums last summer. The initial deliverables focused on four outcome policy priorities and care goals and for the use of EHR technologies: (1) improving quality, safety, and efficiency and reducing health disparities; (2) engaging patients and families in their care; (3) improving care coordination; and (4) improving population and public health.

ONC met the statutory deadline for the initial set of EHR certification standards by publishing an Interim Final Rule. Those standards provide a roadmap for what vendors must do to have their technology certified, either as a complete EHR or as one or more EHR modules. ONC anticipates that vendors will offer a variety of software programs that alone or together with other certified modules will allow providers to assemble the capabilities required under the rule. The minimum standards for an EHR that qualifies for certification is one that (1) includes demographic and medical information such as a history and problem list, and (2) has the capacity to (a) provide clinical decision support, (b) support physician order entry; (c) capture query information relevant to quality; and (d) exchange and integrate health information with and from other sources. What is most important is that the EHR technology not only meet the certification criteria, but actually be certified. The certification process will be addressed in a forthcoming rule.

The Meaningful Use Rule

Medicare and Medicaid are separate and distinct programs with different eligibility requirements for both hospitals and eligible professionals. Whiles hospitals may simultaneously participate in both the Medicare and Medicaid incentive programs, physicians must choose between the two (although that election can be changed once before 2015). This choice is strategic and will need to take into account the differences in eligibility, the different payment amounts, Medicaid volume criteria, and whether the physician has received any support payments (e.g., hospital EHR donations) under the rule as proposed.

Professionals eligible for the Medicare EHR

program are doctors of medicine or osteopathy, dental surgery and medicine, podiatrists, optometrists, and chiropractors participating in Medicare. Under the Medicaid EHR program, physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who practice predominantly in a federally qualified health center or rural health clinic led by PAs are eligible by meeting certain patient volume criteria. The Medicaid EHR program volume requirements are generally 30% of Medicaid patient encounters, although pediatricians with at least 20% of Medicaid patient encounters would qualify at a reduced level, and a special formula allows professionals who practice predominantly in FQHC and RHCs to meet the 30% threshold by considering needy individuals receiving Medicaid, SCHIP, or services at no cost or reduced cost based on payment ability.

Medicare EHR payments for eligible professions are 75% of Medicare allowable charges up to an annual cap for up to five years beginning in calendar year 2010. This means that eligible professionals can receive a total of up to $44,000 over a five-year period, including $18,000 in the first year for early adopters that qualify in calendar year 2011 or 2012. Eligible professionals furnishing more than 50% of Medicare covered services in a health professional shortage area (HPSA) earn an additional 10%.

Medicare carriers would pay out incentive payments in a single lump sum payment once determining that a physician demonstrated meaningful use for that annual period. CMS has proposed that the payments be made to the physician or to a single employer under a valid Medicare reassignment and would not allow physicians to allocate payments among multiple entities. Most hospitals and group practices will want to amend employment and professional contractor agreements to outline who is entitled to receive the payments.

Under the Medicaid EHR incentive program, the amount payable to eligible professionals is set at 85% of "net average allowable costs" capped by statute at $25,000 for the first year and $10,000 for five subsequent years. CMS proposes to set average allowable costs at $54,000 per physician in the first year and $10,000 per physician in annual maintenance costs for subsequent years. That amount for any particular professional would be reduced for any EHR technology or support service payments received from sources other than state or local governments, so if the eligible professional received more than $29,000 in the first year or $10,610 in subsequent years from hospitals or private payors, those subsidies would be backed out. As a result, the maximum Medicaid incentive payment would be $21,250 in the first payment year and $8,500 annually in five subsequent years or $63,750 over a six-year period for most physicians, with pediatricians in the 20-29% Medicaid patient volume corridor receiving one-third less.

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. Unlike hospitals that are deemed to be meaningful users under Medicaid by meeting the Medicare criteria, eligible professionals seeking Medicaid incentive payments must meet the Medicare "floor" and additional state requirements that CMS approves. CMS would restrict states from adding required functionality to the EHR, but allow states to add additional objectives for eligible professionals and hospitals or measure their achievement in a different way.

Caps on Medicare EHR Incentive Payments (HPSA add 10%)

Calendar Year	First CY in which Physician receives Incentive Payment				
	2011	2012	2013	2014	2015 +
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	$0
2016		$2,000	$4,000	$4,000	$0
TOTAL	$44,000	$44,000	$39,000	$24,000	$0

Medicaid Maximum Incentive Payment Amount for Eligible Professionals

Net Avg. Allowable Costs, Cap	85% EP Allowable	6 yr Max
$25,000 in Year 1 for most professionals	$21,250	$63,750
$10,000 in Years 2-6 for most professionals	$8,500	
$16,667 in Year 1 for pediatricians with minimum 20% patient Medicaid volume, but < 30%	$14,167	$42,500
$6,667 in Years 2-6 for pediatricians with minimum 20% patient Medicaid volume, but < 30%	$5,667	

Another distinctive provision of the Medicaid incentive program allows eligible professionals and hospitals to qualify for payments before achieving meaningful use during the first year only by adopting, implementing or upgrading EHR technologies. CMS would define this to mean that the EHR technology has at least been installed or use of it has begun, or for upgrades, that the available functionality of the certified EHR technology has been expanded at the practice site, including staffing, maintenance, and training.

The Hospital-based Exclusion

Hospital-based physicians are excluded from both programs. While the ARRA language contains this exclusion, CMS would define the term expansively to include not only pathologists, anesthesiologists and emergency physicians, but any other professional furnishing 90% or more of his or her professional services within a hospital inpatient, outpatient or emergency department setting. CMS proposes to use place of service codes on the professional claim form to determine who becomes ineligible under the 90% test.

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CMS says it believes that since Medicare already pays hospitals for hospital outpatient and provider-based overhead, including an integrated medical record system, and physicians using these systems should not benefit under the new program. This despite the fact that throughout the Medicare rule, CMS makes clear the basis for incentive payments is not simply purchasing technology but going beyond EHR adoption to actually using it in a manner to support the HITECH health policy priorities. Medicare payments are not designed to be a reimbursement or pass through for software costs, rather incentive payments for using it as set forth in the statute.

While CMS acknowledges that there is an interest in assuring nearly all primary care physicians qualify for EHR incentive payments, it estimates that 27% of physicians would be considered hospital-based under this definition and ineligible for EHR incentive payments. For areas like northeast Ohio with several academic medical centers and integrated health systems, this proposal would have a devastating effect on the number of physicians eligible to participate in the program.

Fortunately, CMS seeks public comment on whether it should use a different method and any associated complexities and implementation issues resulting from including integrated health settings. **The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is preparing comments on this particular proposal.**

Achieving Meaningful Use for Physicians

Physicians could be eligible for incentive payments as early as January 1, 2011. For the first payment year only, CMS proposes that physicians may demonstrate meaningful use of certified EHR technology over any continuous 90-day period within a calendar year. This flexibility would mean that a physician may begin using certified EHR technology in a meaningful manner as late as October 1, 2011 and still receive an incentive payment for 2011. However, after the first year, the physician would need to demonstrate meaningful use at all times. This requirement could pose challenges for physicians experiencing problems with a vendor keeping up with the EHR certification standards or desiring to change EHR systems over the three stages of the incentive program. Expect commentators to request that CMS provide for some type of relief for these extraordinary or uncontrollable events. Eligible professionals and hospitals 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.

Beginning in Stage 1, eligible professionals must demonstrate that they meet all of the Stage 1 objectives and associated measures. Examples of some of these initial measures for physicians include directly entering orders using CPOE for at least 80% of all orders, maintaining an active problem list in ICD-9 for at least 80% of unique patients, transmitting 75% of all permissible prescriptions electronically, and maintaining at least 80% of all active medications and medication allergies as structured data. Measures for hospitals to demonstrate meaningful use are separate and distinct but achievement obviously impacts or is dependent on physicians. For example, hospitals must demonstrate that 10% of all orders are entered directly by an authorizing provider on the inpatient EHR. In an effort to interface the physician with EHR decision support, CMS proposes that these orders be entered directly by the authorizing practitioner, triggering industry debate over the appropriate use of "scribes" or other members of the clinical team for order entry.

CMS will require substantiation through both data reporting and physician attestations as to the achievement of objectives. Surprisingly, CMS estimates only 9 hours for the physician burden in making these reports. Since many proposed measures require manual tracking and calculation of orders and encounters to compute percentages, one of the early criticisms of the rule has been the administrative burden in collecting and reporting performance.

Another big area of concern for physicians and hospitals is how they are to share health information with patients. Several of the measures address the care goal of patient information sharing and providing patients with health information, sometimes electronically and sometimes on paper, at least initially. Hospitals and physicians would be required to provide patients an electronic copy of their health information (including diagnostic test results, problem list, medication lists and allergies) on request and within 48 hours at least 80% of the time. In addition, physicians would be required to provide patients with timely electronic access to that same set of health information within 96 hours of it being available to the physician for at least 10% of all unique patients. Hospitals would be required to provide patients with an electronic copy of discharge instructions and procedures at the time of discharge to at least 80% of patients requesting this information. Likewise, physicians would be required to provide clinical summaries for at least 80% of all office visits, although this information could be provided on paper.

There is also concern over the vast scope of the objectives and measures required under the rule. Many provider organizations have expressed concern that an "all or nothing" approach to qualification makes the programs unattractive, especially for those providers who have little or no experience with EHR adoption and are a bit overwhelmed with the breadth and depth of measures involved. Some of the quality measures for physician reporting follow PQRI and are in their infancy in terms of implementation guidance and acceptance by the medical community. Providers are also understandably concerned with making certifications to the government of compliance on technical criteria. Scaling these expectations and providing for the concept of substantial compliance and good faith certifications would help alleviate these concerns.

Comments are due March 15, 2010, and the AMCNO intends to comment on some of these challenging aspects of the rule. CMS does not anticipate publishing a final rule until after the first quarter of 2010, with an effective date 60 days thereafter. Stay tuned for further updates and join us at the AMCNO legal issues seminar in April for further discussion.

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