

How to Become EHR *Stimulus Ready*[™]

HealthFusion Reviews ARRA, HITECH, and Electronic Health Record Opportunities

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GENERAL QUESTIONS & BACKGROUND

What is the U.S. government's plan to foster Electronic Health Record adoption?

In 2009, the Health Information Technology for Economic and Clinical Health Act (**HITECH**) was passed as part of the American Recovery and Reinvestment Act of 2009 (Recovery Act or **ARRA**). This law mandates that the Centers for Medicare and Medicaid Services (**CMS**) provide incentive payments for the "meaningful use" of certified Electronic Health Record (**EHR**) technology.

HITECH set aside \$19.2 billion to encourage healthcare providers, practitioners, hospitals, and organizations to adopt and "meaningfully use" EHRs (sometimes referred to as Electronic Medical Records or **EMRs**), foster the development of regional health information exchange networks, and to ensure that all systems safeguard protected health information (**PHI**). In reality, an estimated \$14-24 billion will be spent by U.S. federal government from 2011-2016 to incentivize the deployment and use of EHR solutions to improve health care quality through the secure exchange and use of health information.

The Office of the National Coordinator for Health Information Technology (**ONC** or ONCHIT) under the U.S. Department of Health and Human Services (**HHS**) will define the term "**meaningful use**" and establish the certification bodies for "qualified" EHR vendor technology compliance with the programs (**qualified or certified EHR** Vendors offering certified EHR Solutions/Technology). CMS will manage the distribution of incentive payments (and, in some cases, eventual penalties for providers and organizations that do not upgrade to certified EHR solutions by 2015).

What is "meaningful use" of an EHR?

Simply purchasing and deploying a certified EHR solution does not qualify providers and organizations for CMS incentive payments. Beyond acquiring the proper technology, healthcare professionals and organizations are required to demonstrate "meaningful use" of their certified EHR.

While the ONC will precisely define the term in 2010, there will be three main components of “meaningful use”:

- 1. Providers or practitioners must use a certified EHR with e-Prescribing capability that meets current HHS standards.**
- 2. Certified EHRs must support connectivity to other providers for safe, full exchange and reporting on a patient’s medical history.**
- 3. Any certified EHR must be able to report use of the technology to HHS.**

Eligible Professionals (EPs) will need to demonstrate meaningful use of a certified EHR through a means specified by the Secretary of HHS which could include attestation, submission of claims with specific coding, survey responses, submission of clinical quality measures (or other information to be determined), or some future means of meaningful use demonstration to be determined. A **clinical quality measure** is a report on an aspect of patient care based on administrative or medical record data that allows for pattern identification in diagnosis, and treatment related to geography, insurance coverage, race, language, and other segmentation. The HHS Secretary’s adoption of an initial set of standards, implementation specifications, and certification criteria for EHRs should be completed in mid 2010 (please note: the term “Eligible Professional” has different, specific definitions across the two CMS EHR incentive programs which will be explored later in this document).

To allow time for healthcare providers and EHR vendors to prepare for, deploy, and meaningfully use a certified EHR, the process has been broken into stages, each with unique requirements. **Stage 1** is to be applied in 2011-2012, **Stage 2** is 2013-2014, and **Stage 3** is applied in 2015. The proposed Stage 1 criteria for meaningful use are focused on electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information. The proposed criteria for meaningful use are based on a series of specific objectives, each of which is tied to a proposed measure that all EPs and Eligible Hospitals must meet in order to demonstrate that they are meaningful users of certified EHR technology.

For Stage 1, CMS proposed twenty five (25) objectives and measures for EPs and twenty three (23) objectives and measures for eligible hospitals that must be met to be deemed a meaningful EHR user. **In 2011 and 2012 only (the first two years), all of the results for all objectives and measures shall be reported for incentive payments through a process of attestation**, including Medicare clinical quality measures reported by EPs and hospitals to CMS or for Medicaid clinical quality measures reported by EPs and hospitals to the states. Proposed clinical quality measures will focus on these specialties: Cardiology, Pulmonology, Endocrinology, Oncology, Proceduralist/Surgery, Primary Care Physicians, Pediatrics, Obstetrics and Gynecology, Neurology, Psychiatry, Ophthalmology, Podiatry, Radiology, Gastroenterology, and Nephrology. An EP would have to report on the core EHR measures for meaningful use and specialty-specific clinical quality measures to be determined (some exemptions will be considered).

In 2012, CMS proposed requiring the direct submission of clinical quality measures to CMS (or to the states for Medicaid EPs and hospitals) directly through certified EHR technology. CMS recognized that for clinical quality reporting to become routine, the administrative burden of reporting must be reduced. By using certified EHR technology to report

information on clinical quality measures electronically to a health information network, a state, CMS, or a registry, the burden on providers that are gathering the data and transmitting them will be greatly reduced. The burden of generating the necessary information for the provider to then use the information to improve health care quality, efficiency, and patient safety will also be reduced.

What are the Stage 1/2011 or 2012 objectives and measures for EHR meaningful use?

For Stage 1 beginning in 2011 or 2012, CMS proposed twenty five (25) objectives and measures for EPs and twenty three (23) objectives and measures for eligible hospitals that must be met as a meaningful EHR user. The chart below review the objectives, measures, and potential software features related to each objective/measure that will be found in certified EHR solutions (please note: the term “Eligible Professional” has different, specific definitions across the two CMS EHR incentive programs explored later in this document; also, this chart is only focused on Stage 1 for Eligible Professionals, not hospitals):

Stage 1 Meaningful Use Objectives (For Eligible Professionals Only)	Stage 1 Meaningful Use Measures (For Eligible Professionals Only)	Related Features in a Certified EHR
Use CPOE (Computer Provider Order Entry).	CPOE is used for at least 80 percent of all orders in the EP's certified EHR.	Electronically record, store, retrieve, and manage the following order types at a minimum: Medications, Laboratory, Radiology/imaging, Provider referrals, Blood bank, Physical therapy, Occupational therapy, Respiratory therapy, Rehabilitation therapy, Dialysis, Provider consults, and Discharge and transfer information.
Implement drug-drug, drug-allergy, and drug-formulary checks.	Functionality is enabled in the EP's certified EHR.	A) Real-time alerts at the point of care for drug-drug and drug-allergy contraindications, B) Electronically check if drugs are in a formulary or preferred drug list, C) Provide designated users rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking, and D) Track the number of alerts users respond to in the EHR.
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®.	At least 80 percent of all unique patients have at least one entry or an indication of none recorded in the EP's certified EHR (even if a patient is seen multiple times during the EHR reporting period, they are only counted once).	Electronically record, modify, and retrieve a patient's problem list across multiple visits.
Generate and transmit permissible prescriptions electronically (eRx or e-Prescribing).	At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically in the EP's certified EHR.	Electronically create and transmit secure, legal prescriptions.
Maintain active medication list.	At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient is not currently prescribed any medication) recorded as structured data in the EP's certified EHR.	Electronically record, modify, and retrieve a patient's active medication list.

Stage 1 Meaningful Use Objectives (For Eligible Professionals Only)	Stage 1 Meaningful Use Measures (For Eligible Professionals Only)	Related Features in a Certified EHR
Maintain active medication allergy list.	At least 80 percent of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data in the EP's certified EHR.	Electronically record, modify, and retrieve a patient's active medication allergy list.
Record demographics (preferred language, insurance type, gender, race, ethnicity, date of birth).	At least 80 percent of all unique patients seen by the EP have demographics recorded as structured data in their certified EHR.	Electronically record, modify, and retrieve patient demographic data (minimally: preferred language, insurance type, gender, race, ethnicity, date of birth).
Record and chart changes in vital signs (height, weight, blood pressure, calculate and display BMI, plot and display growth charts for children 2-20 years, including BMI).	For at least 80 percent of all unique patients age 2 and over seen by the EP, record blood pressure and BMI in the EP's certified EHR; additionally plot growth chart for children age 2-20.	A) Enable users to electronically record, modify, and retrieve a patient's vital signs, B) Automatically calculate and display body mass index (BMI), and C) Plot and electronically display growth charts for patients 2-20 years old.
Record smoking status for patients 13 years old or older.	At least 80 percent of all unique patients 13 years old or older have "smoking status" recorded in the EP's certified EHR.	Electronically record, modify, and retrieve the smoking status of a patient.
Incorporate clinical lab-test results into EHR as structured data.	At least 50 percent of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	A) Electronically receive clinical laboratory test results and display them in human readable format, B) Electronically display in human readable format any clinical laboratory tests received with LOINC® codes, C) Electronically display all the information for a test report, and D) Electronically update a patient's record based upon received laboratory test results.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach.	Generate at least one report listing patients of the EP with a specific condition in the EP's certified EHR.	Electronically select, sort, retrieve, and output a list of patients and their clinical information related to specific medical conditions.
Report ambulatory quality measures to CMS or the States.	For 2011/Stage 1, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of the proposed rule from the EP's certified EHR (For 2012, electronically submit the measures as discussed in section II(A)(3) of the proposed rule).	A) Calculate and electronically display quality measure results as specified by CMS or the States, and B) Electronically submit calculated quality measures.
Send reminders to patients per patient preference for preventive/follow-up care.	Reminders sent to at least 50 percent of all unique patients seen by the EP that are 50 and over via their certified EHR.	Electronically generate a patient reminder list for preventive or follow-up care per a unique patient's contact preference.

Stage 1 Meaningful Use Objectives (For Eligible Professionals Only)	Stage 1 Meaningful Use Measures (For Eligible Professionals Only)	Related Features in a Certified EHR
Implement five clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules.	Implement five clinical decision support rules relevant to the clinical quality metrics the EP is responsible for via the EP's certified EHR as described further in section II(A)(3) of the proposed rule.	A) Implement automated electronic clinical decision support rules according to specialty or clinical priorities, B) Automatically generate electronic real-time alerts and care suggestions based upon clinical decision support rules and evidence grading, and C) Automatically track, record, and generate electronic reports on the number of alerts responded to by a user in the EHR.
Check insurance eligibility electronically from public and private payers.	Insurance eligibility checked electronically for at least 80 percent of all unique patients seen by the EP in the EP's certified EHR.	Electronically record and display patients' insurance eligibility, and submit insurance eligibility checks electronically.
Submit claims electronically to public and private payers.	At least 80 percent of all claims filed electronically in the EP's certified EHR.	Electronically submit insurance claims to public and private payers.
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request.	At least 80 percent of all patients who request an electronic copy of their health information are provided it within 48 hours from the EP's certified EHR.	Create an electronic copy of a patient's clinical information and provide an electronic copy of the information to a patient.
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 96 hours of the information being available to the EP.	At least 10 percent of all unique patients seen by the EP are provided timely electronic access to their health information, managed by the EP's certified EHR.	Provide patients with electronic access to their clinical information.
Provide clinical summaries for patients for each office visit.	Clinical summaries provided for at least 80 percent of all office visits from the EP's certified EHR.	A) Provide clinical summaries to patients (in paper or electronic form) for each office visit, and B) If the clinical summary is provided electronically (not printed), it must be provided in human readable format and on electronic media (or through another method electronically).
Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient-authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	A) Electronically receive a patient clinical information record from other providers and organizations, and B) Electronically transmit a patient clinical information record to other providers and organizations (minimally: problem list, medication list, allergies, and diagnostic test results information).
Perform medication reconciliation at relevant encounters and each transition of care.	Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care within the EP's certified EHR.	Electronically reconcile two or more medication lists into a single medication list that can be electronically displayed.

Stage 1 Meaningful Use Objectives (For Eligible Professionals Only)	Stage 1 Meaningful Use Measures (For Eligible Professionals Only)	Related Features in a Certified EHR
Provide summary care record for each transition of care and referral.	Provide summary of care record for at least 80 percent of transitions of care and referrals in the EP's certified EHR.	Electronically create summary of care record for each unique instance of transition of care or referral.
Capability to submit electronic data to immunization registries and actual submission where required and accepted.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.	Electronically record, retrieve, and transmit immunization information to immunization registries.
Provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).	Electronically record, retrieve, and transmit syndrome-related public health surveillance information to public health agencies (e.g. an H1N1 influenza-like illness).
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary.	A) Enforce unique user names, B) Permit assigned users to access electronic health information (EHI) in emergencies, C) Close a session after a period of user inactivity, D) Encrypt/decrypt any EHI, E) Record history related to EHI, F) Track EHI changes, G) Set up user verification, H) Record disclosures made for treatment, payment, processes, etc., and I) Physical security of EHI.

Which EHR Vendors are currently certified by the ONC as ready for meaningful use demonstration?

Providers and organizations must use certified EHRs to qualify as meaningful users and to receive incentive payments.

Currently, no EHR vendors have been certified by the CMS or ONC whatsoever, as the term "meaningful use" has yet to be fully defined, and the rules and regulations have not been written regarding the organizations that will manage the certification process. There is speculation that the Certification Commission for Health Information Technology (CCHIT) will be one of these future certification bodies, but the ONC has stated that there will be other organizations authorized as certification bodies. Conservative estimates suggest that these certification bodies will be authorized by the ONC and starting to test EHR vendor technologies in mid to late 2010.

Are there separate Medicare and Medicaid EHR Incentive Programs?

Yes. However, eligible medical providers and organizations can **only participate in one of the programs, not both**, and they must designate the program in which they would like to participate. CMS proposes that, after the initial designation, providers and organizations be allowed to change their program selection only once during the incentive payment years

2012-2014 (however, if two years were completed in the Medicaid program, but a provider no longer met the 30% patient volume threshold, they could switch to the Medicare program in the third year payment of that program; read further for program details).

Please note: CMS will **require recoupment of monies if overpayments or erroneous payments** are found to have been paid across the two Medicare and Medicaid programs. There will be a concerted, ongoing effort to discover and prosecute fraudulent activity in these stimulus incentive programs.

The **Medicare EHR Incentive Program** will provide incentive payments to Eligible Professionals (EP), Eligible Hospitals, and Critical Access Hospitals (CAHs) that demonstrate meaningful user of certified EHR technology.

The **Medicaid EHR Incentive Program** will provide incentive payments to EPs and hospitals for efforts to adopt, implement, upgrade, or meaningfully use certified EHR technology or for meaningful use, and also incentive payments in subsequent years for meaningful use. ARRA and HITECH amended the Medicaid statute to provide 100 percent Federal Financial Participation (FFP) for state expenditures for provider incentive payments to encourage Medicaid healthcare providers to adopt, implement, and operate certified EHR technology. It also established a 90 percent FFP match for state expenses for administration of the incentive payments and for promoting EHR adoption. Planning activities for which the 90 percent match is available are related to administering the incentive payments to providers, auditing and monitoring of payments, and participating in statewide efforts to promote interoperability and meaningful use of EHR technology. Within the Medicaid program, states may request CMS approval to implement meaningful use measures above the minimum requirements of HITECH, as appropriate, but may not request approval of meaningful use measures below the minimum requirements.

What about existing CMS incentive programs for e-Prescribing and the Physician Quality Reporting Initiative?

Electronic Prescriptions or **e-Prescribing** incentives are currently available through the Medicare Improvements for Patients and Providers Acts of 2008 (**MIPPA**) and provide for a 2 percent Medicare reimbursement for the use of a qualified e-Prescribing system. Additionally, under the Physician Quality Reporting Initiative (**PQRI**), Medicare will pay a 2 percent bonus incentives to eligible professionals that report on a designated set of "Quality Measures" for patient encounters. Under these two programs, an eligible professional can earn around **\$7,000/year** on average prior to participating in the Medicare and Medicaid EHR Incentive Programs. There has been speculation that the PQRI incentive may not apply to providers who participate in the Medicare and Medicaid EHR Incentive Programs, but this has not been confirmed.

What changes to HIPAA and related privacy laws are included in HITECH?

As an aside to the EHR adoption incentives, HITECH boosts the Health Insurance Portability and Accountability Act (**HIPAA**) of 1996 requires notification to individuals in the event of a breach of the security or the privacy of unsecured protected health information (unsecured protected health information is defined as protected health information that is not secured through a technology or methodology specified in guidance by HHS). According to the guidance, electronic protected health information can be secured by encryption, and traditional paper protected health information can be secured by destruction. No means are

described for securing oral protected health information within HITECH. Also, Business Associates are required to provide notification of a breach to covered entities, and covered entities are required to provide the notification to the affected individuals and to HHS. Finally, HITECH also authorizes increased civil monetary penalties for HIPAA violations and grants the authority to enforce HIPAA to the states' attorney generals.

QUESTIONS ON THE *MEDICARE* EHR INCENTIVE PROGRAM

Who is eligible for the Medicare EHR Incentive Program in general?

The Medicare EHR Incentive Program will provide incentive payments to Eligible Professionals (EP), Eligible Hospitals, and Critical Access Hospitals (CAHs) that demonstrate meaningful use of certified EHR technology.

Geographically, an EP or hospital must be in one of the fifty U.S. states, American Samoa, Guam, Puerto Rico, the District of Columbia, the Northern Mariana Islands, or the Virgin Islands to be eligible.

To be a **Medicare Eligible Professional or EP**, the provider must be licensed under state or local law in one of the following specialties:

- Doctor of Medicine or Osteopathy (M.D. or D.O.)
- Doctor of Dental Surgery or Medicine (D.D.S. or D.D.M.)
- Doctor of Podiatric Medicine (D.P.M.)
- Doctor of Optometry (O.D.)
- Chiropractor (D.C.)

Hospital-based EPs who furnish substantially all their services in a "hospital setting" are not eligible for incentive payments. CMS proposed that a hospital-based EP be defined as an EP who furnishes 90 percent or more of their allowed services in a hospital, including all hospital inpatient, outpatient, and emergency department settings.

A **Qualifying EP** that meets the above criteria and demonstrates meaningful use of a certified EHR solution can receive EHR incentive payments for up to five years with payments beginning as early as 2011. Incentives are paid per provider individually, not to groups of providers.

How much can an Eligible Professional earn in the Medicare EHR Incentive Program – and how is this calculated?

In general, the maximum amount of total incentive payments that an EP can receive under the Medicare program is **\$44,000** from 2011-2016 if they start to deploy and meaningfully use their certified EHR in 2011 or 2012 (there is a \$3,000 early adopter bonus for EPs who demonstrate meaningful use in 2011 or 2012 included in this overall \$44,000 incentive opportunity). The Medicare EHR Incentive Program formula states that a qualifying EP will receive an incentive payment equal to **75 percent** of Medicare Part B allowable charges for covered professional services furnished by the EP in a payment year, subject to maximum payments (Part B claims for the Fee for Service program, items in the Medicare Physician's

Fee Schedule, and only the “professional”, not the “technical”, components).

For example, to receive the maximum payment in 2011 or 2012, a provider would need to bill **\$24,000** to Medicare to receive the maximum 75 percent of Medicare Part B allowable charges for that year or \$18,000 in incentives payments under the Medicare program (put another way, an EP with \$14,000 in allowable Medicare charges would only be eligible for \$10,500 in incentive payments in 2011 or 2012). Continuing the example in 2012, the same provider would only have to bill \$16,000 to Medicare to receive the maximum 75 percent of Medicare Part B allowable charges for that year or \$12,000 in incentives payments under program.

A Payment Year equals a Calendar Year (CY). For EPs who begin meaningful EHR use in 2014, their payment calculations will be made as if they began meaningful use in 2013. To clarify, if an EP were to begin meaningful use in 2014, the EP would receive \$12,000 for that year, the second year’s amount as if they had begun in 2013. Thus, Stage 1 requirements will apply to the EPs’ first year of meaningful use, even if in 2014, but the stage requirements will leap forward to the stage matching the calendar year after that (i.e. Stage 3 in 2015). 2014 is the last year for which an EP can begin receiving incentive payments for meaningful use, and incentive payments for meaningful EHR use ends after 2016 under the Medicare program.

The chart below offers a detailed breakdown of the payment opportunity in the **Maximum Total Amount of EHR Incentive Payments for a Medicare EP:**

Calendar Year	First CY in which the EP Receives an Incentive Payment				2015 (and subsequent years)
	2011	2012	2013	2014	
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

If a medical group has ten providers, would it receive one payment or ten payments if all ten providers were Eligible Professionals in the Medicare EHR Incentive Program?

Incentives are paid per provider individually, not to groups of providers. In this example, a medical group with ten EPs would receive a payment for each EP, not one payment for the group as a whole, in the Medicare program. To clarify, the medical group would receive a potential \$44,000 over the course of the program for each EP or a potential to earn \$440,000 in incentive payments overall.

How long must an Eligible Professional demonstrate meaningful use to receive a payment in the Medicare EHR Incentive Program?

The Medicare program starts January 11, 2011, although this is not a deadline. For the first year an EP applies for the Medicare program to receive an incentive payment, CMS proposed that an EHR Reporting Period is **ninety (90) days** for any continuous period beginning and ending within the year. For every year after the first payment year, CMS proposed that the EHR reporting period is **the entire year**. CMS proposed there are considerations that distinguish the first payment year from the remaining payment years. The foremost being that once an EP begins to meaningfully use certified EHR technology, they are unlikely to stop. A shorter EHR reporting period in the first payment year provides more flexibility for when an EP begins to meaningfully use certified EHR technology and still qualify for the incentive in the same year. However, in subsequent years, CMS did not see that that flexibility was still required. This is the rationale behind the difference in the length of the EHR reporting period for the first payment year when compared to all other payment years.

For example, if an EP deployed a certified EHR in mid 2011, they would have to meaningfully use the EHR for 90 days or three months consecutively in 2011 to receive the full incentive payment for that year. An EHR reporting period of March 13, 2011 to June 11, 2011 would be just as valid as an EHR reporting period of January 1, 2011 to April 1, 2011. An example of an unallowable EHR reporting period would be for an EP to begin on November 1, 2011 and finish on January 31, 2012 (as this crosses over two calendar years). Continuing this example in 2012, the EP would have to meaningfully use their EHR for the whole year to receive payment – and every year after that until the program ends in 2016 to continue to receive all possible incentive payments. The EP can start in 2012 to still receive the maximum potential incentive in the Medicare program.

How are earned incentive payments distributed in the Medicare EHR Incentive Program?

Payments under the Medicare program will be disbursed through Medicare Administrative Contractors (**MAC**) or carriers to the **Tax Identification Number** provided by the qualifying Eligible Professional (EP). These will be single, consolidated, annual incentive payments.

If an Eligible Professional practices in a Health Professional Shortage Area, are there any additional incentives in the Medicare EHR Incentive Program?

Yes. An EP who predominantly furnishes services in a geographic Health Professional Shortage Area is eligible for a **10 percent increase in the maximum incentive** payment amount under the Medicare program. The maximum amount of total incentive payments that such an EP can receive is \$48,400. Explore designated Health Professional Shortage Areas (**HPSA**) online at <http://hpsafind.hrsa.gov> to determine eligibility for this additional incentive.

Can Eligible Providers reassign their incentive payments from the Medicare EHR Incentive Program to another organization?

Provided they meet certain conditions to be determined, EPs can reassign the entire amount of their incentive payment to one employer or entity under the Medicare program. Incentive payments can be reassigned, for instance, if the EP has a valid employment arrangement. Please note: an EP cannot reassign payment to more than one employer or entity. It is unclear in the proposed rules if an EP could assign a portion of the incentive money to a hospital or organization that was not their employer, and the ONC may clarify this matter in the future. Reassignment could entail only the allowable charges for an EPs' professional services to the employer or entity but not the incentive payment, or the reverse (this is of course dependent on the details of the EPs' contract).

What about incentive payments when the Eligible Provider is employed or subcontracted by a Medicare Advantage organization in the Medicare EHR Incentive Program?

Incentive payments under the Medicare program will be made to qualifying Medicare Advantage (MA) organizations organized as health maintenance organizations for the adoption and meaningful use of EHR technology by their affiliated EPs. For clarification, incentive payments will not go to the qualifying EPs directly, but instead to the MA organization. As defined by the ONC, MA-affiliated EPs are EPs who are employed or subcontracted by an MA organization must provide at least 80% of their services (based on at least 20 hours per week providing physician services) to the MA organization to become a qualifying EP for incentive payments that will be paid directly to the MA organization.

Is there a penalty for not deploying and meaningfully using a certified EHR under the Medicare EHR Incentive Program?

Yes. EPs who are not meaningful, certified EHR users will be **subject to future lower Medicare payment updates** for their covered professional services beginning in 2015 under the Medicare program. In addition, Medicare Advantage (MA) organizations will also be subject to payment adjustments if their affiliated EPs are not meaningful users of certified EHR technology beginning in 2015. Specifically, the Medicare fee schedule for non-participating providers will be reduced by 1% in 2015, 2% in 2016, and 3% in 2017 and subsequent years. Starting in 2018, the Secretary of HHS may reduce payments by 5% at their discretion. On a case-by-case basis, the Secretary may exempt eligible providers from payment reductions for failure to adopt a certified solution under the Medicare EHR Incentive Program, if the requirement would result in significant hardship (the example used most often is a rural provider with limited access to the Internet). However, this exemption can only be granted for five years, so all providers with Medicare patients would have to be using a certified EHR by 2021 to avoid any payment reductions based on the program rules.

QUESTIONS ON THE *MEDICAID* EHR INCENTIVE PROGRAM

Who is eligible for the Medicaid EHR Incentive Program in general?

The Medicaid EHR Incentive Program will provide initial incentive payments to Eligible Professionals (EP) and Eligible Hospitals for efforts to adopt, implement, upgrade or meaningfully use certified EHR technology or for meaningful use, and incentive payments in subsequent years for meaningful use.

Geographically, an EP or hospital must be in one of the fifty U.S. states, American Samoa, Guam, Puerto Rico, the District of Columbia, the Northern Mariana Islands, or the Virgin Islands to be eligible.

To be a **Medicaid Eligible Professional or EP**, the provider or practitioner must be licensed under state or local law and/or certified in one of the following specialties:

- Doctor of Medicine or Osteopathy (M.D. or D.O.)
- Doctor of Dental Surgery or Medicine (D.D.S. or D.D.M.)
- Nurse Practitioner
- Certified Nurse Midwife
- Physician Assistants (practicing predominantly in a Federally Qualified Health Center or Rural Health Clinic (FQHC/RHC) that is directed by a physician assistant)

EPs must also not be hospital-based, meaning they do not provide “substantially all of his or her professional services in a hospital setting.” “Substantially all” is defined to mean that 90 percent or more of the services are performed in the hospital setting. The proposed rule aligns the definition of hospital-based with the Medicare definition.

A **Qualifying EP** that meets the above criteria and demonstrates meaningful use of a certified EHR solution can receive EHR incentive payments for up to six years with payments beginning as early as 2011. Incentives are paid per provider individually, not to groups of providers.

How much can an Eligible Professional earn in the Medicaid EHR Incentive Program – and how is this calculated?

In general, the maximum amount of total incentive payments that an EP can receive under the Medicaid program is **\$63,750** (or **\$42,500** for pediatricians, two thirds (2/3) the maximum amount) from 2011-2018, depending on when they start to deploy and meaningfully use their certified EHR.

Unlike the Medicare program, the incentive payments in the Medicaid program are flat payments intended to cover the “net average allowable” cost of purchasing, implementing and maintaining a certified EHR. In the first payment year, this payment is capped at **\$21,500 (85 percent)** of an ONC-set \$25,000 average allowable cost for an EHR), with the second through the sixth possible year of incentive payments capped at **\$8,500/year (85 percent)** of an ONC-set \$10,000 average allowable maintenance cost for an EHR).

Any outside funds received by an EP that can be directly tracked to an EHR purchase other than allowed State or local funds, such as outside funds provided through a Stark program,

will be subtracted from the Medicaid program incentive. However, with overall average allowable costs for maintenance set at \$54,000 for an EHR purchase and \$20,610 for EHR yearly maintenance, EPs can accept up to **\$29,000** in external EHR funding to still receive the first year capped incentive payment of again \$21,500. Such EPs can then receive up to **\$10,610/year** in external EHR maintenance funding and yet still receive the second through the sixth possible year of incentive payments of again \$8,500/year. EPs receiving outside funds for EHR purchase and maintenance should consider this calculation careful.

The Medicaid EHR Incentive Program formula then is broken into two groups and is based on patient volume. The “General EP” group is an EP with at least **30 percent of patient volume** attributable to Medicaid patients. The “Pediatrician EP” group is a pediatrician EP with **at least 20 percent and up to 29 percent of patient volume** attributable to Medicaid patients (please note: the terms “General EP” and “Pediatrician EP” are not official, but this is how the program is organized). In the case of EPs practicing predominately at a Federally Qualified Health Center or Rural Health Clinic (defined as having more than 50 percent of their encounters over a six-month period in the most recent calendar year occurring at an FQHC/RHC), needy individual encounters can be used to account for the patient volume levels (needy individuals are defined as those receiving medical assistance from Medicaid or the Children’s Health Insurance Program, individuals furnished uncompensated care by the provider, or individuals furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay). Please note: different states may have an alternative approach to the established timeframe for measuring patient volume (but those states must submit the approach to CMS for review and prior approval). Both the General and Pediatrician EP group formulas are subject to the same maximum payment levels. A Payment Year equals a Calendar Year (CY).

Here is a detailed breakdown of the payment opportunity in the **Maximum Total Amount of EHR Incentive Payments for a Medicaid EP (the “General EP” group)**:

Calendar Year	First CY in which the EP Receives an Incentive Payment					
	2011	2012	2013	2014	2015	2016
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	\$8,000	\$21,250	-
2016	\$8,500	\$8,500	\$8,500	\$4,000	\$8,500	\$21,250
2017	\$0	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	\$0	\$0	\$8,500	\$8,500	\$8,500	\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$55,250	\$46,750	\$38,250

Here is a detailed breakdown of the payment opportunity in the **Maximum Total Amount of EHR Incentive Payments for a Medicaid EP (the “Pediatrician EP” group)**:

Calendar Year	First CY in which the EP Receives an Incentive Payment					
	2011	2012	2013	2014	2015	2016
2011	\$14,167	-	-	-	-	-
2012	\$5,667	\$14,167	-	-	-	-
2013	\$5,667	\$5,667	\$14,167	-	-	-
2014	\$5,667	\$5,667	\$5,667	\$14,167	-	-
2015	\$5,667	\$5,667	\$5,667	\$5,333	\$14,167	-
2016	\$5,667	\$5,667	\$5,667	\$2,667	\$5,667	\$14,167
2017	\$0	\$5,667	\$5,667	\$5,667	\$5,667	\$5,667
2018	\$0	\$0	\$5,667	\$5,667	\$5,667	\$5,667
TOTAL	\$42,500	\$42,500	\$42,500	\$33,500	\$31,167	\$25,500

If a medical group has ten providers/professionals, would it receive one payment or ten payments if all ten providers/professionals were Eligible Professionals in the Medicaid EHR Incentive Program?

Incentives are paid per provider/professional individually, not to groups of providers/professionals. In this example, a medical group with ten EPs would receive a payment for each EP, not one payment for the group as a whole, in the Medicaid program. To clarify, the medical group would receive a potential \$65,000 over the course of the program for each EP or a potential to earn \$650,000 in incentive payments overall (please account for any pediatricians in this example, as they would individually receive two thirds (2/3) of this potential incentive in the Medicaid program).

How long must an Eligible Professional demonstrate meaningful use to receive a payment in the Medicaid EHR Incentive Program?

The Medicaid program starts in **2011** (although some states may offer 2010 payments if their systems are ready to monitor the Medicaid program, but there is not much concrete information on this topic, so 2011 start date is more likely). For an EP to receive an incentive payment under the Medicaid program, CMS proposed that an EHR Reporting Period is 90 days for any continuous period beginning and ending within a Calendar year. This is for the duration of the program (unlike the Medicare program, which calls for 90 days in the first year, followed by a period of an entire year of reporting in year two and afterwards). To clarify, an EHR reporting period of March 13, 2011 to June 11, 2011 would be just as valid as an EHR reporting period of January 1, 2011 to April 1, 2011. An example of an unallowable EHR reporting period would be for an EP to begin on November 1, 2011 and finish on January 31, 2012 (as this crosses over two calendar years). The EP can start in 2012 to still receive the maximum potential incentive in the Medicaid program.

How are earned incentive payments distributed in the Medicaid EHR Incentive Program?

Payments under the Medicaid program will be **disbursed by individual states**, which will be required to verify the eligibility of and disburse payments to Medicaid EPs, including developing and managing a system capable of coordinating with a national database to

verify provider eligibility and identity and also collecting data necessary to incentive program administration and coordination. States must have processes in place to report estimated and actual expenditures for the Medicaid program using the Medicaid Budget and Expenditure System. These will be single, consolidated, annual incentive payments.

If an Eligible Professional practices in a Health Professional Shortage Area, are there any additional incentives in the Medicaid EHR Incentive Program?

No. Geographic Health Professional Shortage Areas (HPSAs) not mentioned by CMS or ONC in relationship to the Medicaid program. As there are significant incentives for EPs in Health Professional Shortage Areas under the Medicare program, providers in these areas may want to consider the Medicare versus the Medicaid program to maximize their incentive for deploying and meaningfully using a certified EHR.

Can Eligible Providers reassign their payments from the Medicaid EHR Incentive Program to another organization?

ONC specifies that entities promoting the adoption of certified EHR technology may be designated by states for EPs to voluntarily assign their incentive payments. The statute allows EPs to assign their incentive payments to their employers or to state-designated "entities that promote the adoption of certified EHR technology." The regulation's definition of such an entity requires the entity to enable oversight of the business, operational, and legal issues involved in the adoption and implementation of EHRs and/or the exchange and use of electronic health information between participating providers in a secure manner.

What if an Eligible Provider has Medicaid patients in more than one state?

If an EP practices in multiple states or Medicaid patients from several states visit their office, such EPs will be required to choose **only one state** from which to receive Medicaid incentive payments under the program. The EP can change their choice of reporting state annually when they attest to their demonstration of meaningful EHR use, but cannot report in two states within one calendar year.

Is there a penalty for not deploying and meaningfully using a certified EHR under the Medicaid EHR Incentive Program?

No. Unlike in the Medicare program, ARRA, HITECH, and the ONC made **no mention of Medicaid payment reductions** if an EP does not become a meaningful, certified EHR user.