

WITH THE CHANGES MADE IN THE FINAL RULE, EARNING THE EHR INCENTIVE IS STILL NOT EASY, BUT AT LEAST IT'S EASIER.

A PHYSICIAN'S GUIDE TO THE MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS: THE BASICS

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New laws introduced by Congress and the Obama Administration will greatly change the way most of the health care industry approaches electronic health record (EHR) technology. Their objective is sweeping reform of health care delivery and payment.

The most important elements of the federal health IT agenda are the Medicare and Medicaid EHR incentive programs, the result of passage of the HITECH portion of the American Recovery and Reinvestment Act (ARRA), the economic stimulus bill of 2009. The act gave the Centers for Medicare & Medicaid Services (CMS) and the ONC a broad charter and an original budget of about \$19 billion (now reported to be up to \$27 billion).

This has culminated in the issuance of a complex set of rules and regulations that govern how physicians and hospitals may start to receive incentive payments beginning in 2011 for the "meaningful use of certified EHR technology." The programs are voluntary, but the incentives for participation and the penalties for non-participation warrant a close look by all doctors regardless of practice size, location, specialty or payer mix.

This "physician's guide" is intended to help you learn about the incentive programs. It provides essential information, commentary you may find useful, and references to additional sources of information.

The basics: eligibility, incentives, requirements and the application process

The EHR incentive programs don't provide cash for physicians to buy EHR software. Instead, physicians can collect a year's payments only by demonstrating the

meaningful use of certified EHR technology for the full reporting year. (The exceptions are that, in 2011, Medicare participants need only prove 90 consecutive days of meaningful use starting as late as Oct. 1, and that Medicaid participants don't need to demonstrate meaningful use until the second year, as long as in the first year they adopt or upgrade certified EHR technology.)

Physicians who can demonstrate meaningful use of certified EHR technology and who submit claims to Medicare are eligible for the Medicare incentive. Physicians are eligible for the Medicaid incentive if their case-load includes at least 30 percent Medicaid patients (at least 20 percent for pediatricians). Physicians may switch once from one program to the other during the five years the programs run but can't claim both incentives at once.

Under Medicare, the incentive is 75 percent of the physician's Medicare allowed charges for the year, up to the year's maximum incentive. Under Medicaid, it is 85 percent of the physician's Medicaid allowed charges up to a different maximum. Payments for the Medicare program are spread out over five years and for the Medicaid program over six, with diminishing amounts available to those who start in later years. The tables on page 19 indicate how the maximum incentive payments are to be paid out. For providers in federally designated health professional shortage areas, payments will be 10 percent greater.

Medicare incentive checks will go to individual physicians; physicians who work in group practices or hospitals may assign their payments to their employers. For the Medicaid program, each separate state Medicaid agency will process the incentive payments to physicians or their practices.

Unlike the Medicaid incentive program, the Medicare program incorporates penalties. The Medicare fee sched-

The incentives for participation and the penalties for non-participation warrant a close look.

ule will be *reduced* by 1 percent in 2015, by 2 percent in 2016 and by 3 percent in 2017 for physicians who *aren't* "meaningful users."

Every physician must have a National Provider Identifier (NPI) and be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS) to participate in the Medicare incentive program. Most physicians also need to have an active user account in the National Plan and Provider Enumeration System (NPPES). The Medicaid program is offered and administered voluntarily by states and territories. States can start offering incentives as early as 2011 or as late as 2016. Registration for both programs is expected to open in January 2011. Details of the application process will be posted on the CMS web site at <http://www.cms.gov/ehrincentiveprograms>. (That is, by the way, an excellent source of information about the programs in general.)

Physicians who are "meaningful users of certified EHR technology" can earn CMS bonuses over several years.

For the incentive programs, meaningful use is defined in terms of EHR-derived data that must be reported to CMS.

The EHR technology used must be certified as capable of collecting, manipulating and reporting the data required by specified objectives and measures.

The meaning of 'meaningful use'

Meaningful use requires using the EHR for structured data collection, e-prescribing, health information exchange, clinical decision support, patient engagement, security assurance and quality reporting. The data elements that must be collected in coded format include demographics, vital signs, problems and diagnoses, immunizations, laboratory results, medications, etc.

CMS specifies a "core set" of 15 objectives and measures that must be met to qualify for meaningful use, along with a "menu set" from which the physician must select five for Stage 1 (see "Meaningful use objectives and measures,"

page 20). Meeting the targets for meaningful use requires clear understanding of the new practice workflows needed and the right equipment to report the results of meaningful use.

For 2011, participants will be asked to provide aggregate data for numerators, denominators and exclusions, and to attest that these numbers were arrived at using certified EHR technology. In 2012, CMS will continue accepting attestation for most objectives but plans to require electronic submission of the clinical quality measures and to develop audit systems to protect against fraud. Similarly, state Medicaid programs will support attestation initially and then move to electronic submission of clinical quality measures.

At bottom, "meaningful use" requires physicians to collect a designated set of data about patients and encounters, to store those data in a computer database and to perform a number of computations with those data. As the stages of the incentive programs progress, the required operations become more complex. In Stages 2 and 3, the plan is to require additional capabilities and more sophisticated uses of the data for decision support and population reporting.

Why "EHR technology" is not the same as an EHR

Physicians need to grasp the difference between *certified EHR technology* as used in these incentive programs and terms such as *electronic medical record (EMR)* and *electronic health record (EHR)*. The new regulations define certified EHR technology with specific reference to the capabilities needed for meaningful use, and they also subdivide EHR technology into two new categories:

1) A *complete EHR* is one that equips a physician to attain all of the objectives of meaningful use.

2) An *EHR module* is defined as any EHR technology that equips a physician to attain at least one of the objectives.

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MAXIMUM INCENTIVE PAYMENT AMOUNTS

Physicians who use a qualified EHR could receive up to \$44,000 over five years from the Centers for Medicare & Medicaid Services, assuming they have at least \$24,000 in Medicare allowed charges per year and use the qualified EHR from 2011 on. Under Medicare, the incentive amount is based on 75 percent of the physician's Medicare allowed charges, up to the year's maximum incentive amount.

Alternatively, a physician may choose the Medicaid incentive, which pays up to \$21,250 in year one (85 percent of a maximum of \$25,000 in Medicaid allowed charges) for health information technology adoption and implementation and up to \$8,500 over the next four years (85 percent of a \$10,000 maximum) for operation and maintenance. To qualify for the Medicaid incentives a physician's case-load must include at least 30 percent Medicaid patients.

Physicians may not receive both Medicaid and Medicare incentives.

Note: For providers in federally designated health professional shortage areas, incentive payments will be 10 percent greater.

Medicare incentive max per year:

Year EHR use is first demonstrated	2011	2012	2013	2014	2015	Total maximum incentive
2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$44,000
2012		\$18,000	\$12,000	\$8,000	\$4,000	\$42,000
2013			\$15,000	\$12,000	\$8,000	\$35,000
2014				\$12,000	\$8,000	\$20,000

Medicaid incentive max per year:

Year 1 (no later than 2016)	Year 2	Year 3	Year 4	Year 5	Year 6	Total maximum incentive
\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$63,750

An e-prescribing application, for example, is an EHR module that could meet several meaningful use objectives. E-prescribing integrated with other modules – a patient registry, a module for providing patients with clinical summaries, etc. – might meet all of the criteria of meaningful use. Modular EHRs, open-source and home-grown software programs are specifically cited in the regulations as being allowable EHR technologies provided, of course, that they undergo certification.

The important notion here is that EHR products now on the market may not qualify as certified EHR technology even if they were certified by the Certification Commission for Health Information Technology (CCHIT). For example, most legacy EHR systems are not equipped to report out specific quality measures or to offer patients a clinical summary in electronic form, which are capabilities included in the meaningful use criteria.

At the same time, many legacy EHR products have functions that lie outside the definition of meaningful use. Automated calculation of evaluation and management (E/M) codes to justify billing levels is a staple of many legacy EHRs, for instance, but not one of the meaningful use criteria.

As you evaluate products with one of the EHR incentive programs in mind, you will want to be sure you purchase neither too little to qualify for the incentive nor too much for the needs of your practice. Mistakes in this area could be costly.

The new rules regarding certification

An important aspect of the incentive programs is the requirement that only *certified* EHR technology may be used to qualify for meaningful use incentives. Under the new rules, the ONC will accredit “testing and certifying bod-

Previously certified EHR systems will need to be recertified under new rules to qualify as certified for meaningful use, and most will likely require upgrade.

Medicare-associated incentives can be as much as \$44,000, and Medicaid-associated incentives as much as \$63,750.

To qualify for incentive payments, a physician must meet 15 specified objectives plus five the physician can choose from a list of 10.

ies” starting in early fall 2010. There is to be no grandfathering in of either certification bodies such as CCHIT or of products certified by them. Legacy EHR technology must go through the new certification process along with newer technology. To receive incentive payments, most users of older EHRs will need to upgrade their systems to versions that have met the new certification criteria.

The first products certified under the new system will reach the market in late 2010 or early 2011. CMS and ONC will maintain a web site for products and services that have been tested and certified.

Quality reporting requirements

All physicians seeking incentive payments will have to report data on three core quality measures in 2011 and 2012: blood-pressure level, tobacco status and adult weight screening and follow-up, or alternates if these do not apply.

Alternates include influenza immunizations for patients older than 50, weight assessment and counseling for children and adolescents, and childhood immunizations. Physicians must also report three more clinical quality measures chosen from 44 familiar National Quality Forum and/or Physician Quality Reporting Initiative (PQRI) measures. A complete list is available through the online version of this article at <http://www.aafp.org/fpm/2010/0900/p17>.

According to recent announcements from ONC and CMS, the PQRI program may be consolidated with the Medicare EHR incentive program to avoid redundant reporting requirements. And by 2012, CMS intends to create a single reporting infrastructure for electronic submission of clinical quality data.

To qualify for Medicare’s 2011 meaningful use incentive, participating physicians must send CMS summary clinical quality data gathered from *all* patients, not just Medicare beneficiaries. After 2012, Medicare assumes that it will

MEANINGFUL USE OBJECTIVES AND MEASURES

CORE SET	
Stage 1 Objectives	Stage 1 Measures
Use computerized physician order entry (CPOE) for medication orders.	> 30 percent of patients with at least one medication in their medication list have at least one medication order entered using CPOE.
Implement drug-drug and drug-allergy interaction checks.	Enable this functionality for the entire reporting period.
Use e-prescribing.	> 40 percent of all permissible prescriptions are transmitted electronically.
Record patient demographics.	> 50 percent of patients have demographics recorded as structured data.
Maintain an up-to-date problem list.	> 80 percent of patients have at least one entry, or an indication that no problems are known for the patient, recorded as structured data.
Maintain an active medication list.	> 80 percent of patients have at least one entry recorded as structured data.
Maintain an active medication allergy list.	> 80 percent of patients have at least one entry recorded as structured data.
Record and chart changes in vital signs.	> 50 percent of patients age 2 or older have height, weight and blood pressure recorded as structured data.
Record smoking status for patients 13 years old or older.	> 50 percent of patients age 13 or older have smoking status recorded as structured data.
Implement one clinical-decision-support rule.	Implement one clinical-decision-support rule.
Report ambulatory clinical quality measures to CMS or the states.	For 2011, provide aggregate numerator, denominator and exclusions through attestation.
	For 2012, submit the clinical quality measures electronically.
Give patients an electronic copy of their health information upon request.	> 50 percent of patients who request an electronic copy of their health information get it within 3 business days.
Provide clinical summaries for patients for each office visit.	Provide clinical summaries to patients for > 50 percent of all office visits within three business days.
Be able to exchange key clinical information with other providers and patient-authorized entities electronically.	Conduct at least one test of the EHR’s ability to exchange key clinical information electronically.
Protect electronic health information created or maintained by the certified EHR technology.	Conduct or review a security risk analysis, implement security updates as necessary and correct identified security deficiencies.


CMS specifies a “core set” of 15 objectives and measures along with a “menu set” from which a physician must select five.

be able to receive the raw, de-identified data directly from EHR technologies via electronic data formats not yet specified. The states will be able to decide their own methodology for Medicaid data collection starting in 2012, although they must validate this with CMS.

Getting help: RECs and other resources

A provision in ARRA/HITECH establishes a set of regional health IT extension centers (RECs) modeled after the agricultural extension programs of the 1930s. The RECs are intended to help eligible professionals earn the meaningful use incentives. They are to give priority to primary care professionals in small

and rural practices. Each must assist at least 1,000 such professionals in the next two years to retain funding. About 60 RECs are funded as of August 2010, with most being state-level organizations. For more information and to locate the REC in your region, consult the ONC web site at http://bit.ly/REC_program.

To stay up-to-date on all aspects of meaningful use, visit the AAFP’s Center for Health IT (CHIT) web site at <http://www.centerforhit.org/meaningfuluse> and follow the new *FPM* blog, “Making Health IT Meaningful,” written by the staff of CHIT. You’ll find it at <http://blogs.aafp.org/fpm/healthit>. 

Send comments to fpmedit@aafp.org.

To begin with, participants need only attest that the results they report were derived from EHR technology.

Regional health IT extension centers are being set up to help physicians achieve the objectives specified by the incentive programs.

MENU SET	
Stage 1 Objectives	Stage 1 Measures
Implement drug-formulary checks.	Implement this functionality and have access to at least one drug formulary for the entire reporting period.
Incorporate test results as structured data.	> 40 percent of all lab test results reported in a positive/negative or numerical format are incorporated in the EHR as structured data.
Generate lists of patients by specific conditions.	Generate at least one report listing patients with a specific condition.
Send reminders to patients per patient preference for preventive/follow-up care.	> 20 percent of all patients 65 or older or 5 or younger were sent an appropriate reminder during the reporting period.
Give patients timely electronic access to their health information.	> 10 percent of all patients seen are provided electronic access to their health information within four business days of its updating in the EHR, subject to the physician’s discretion to withhold certain information.
Provide patient-specific education resources to the patient as appropriate.	Use the EHR to give > 10 percent of all patients seen patient-specific education resources.
Perform medication reconciliation whenever appropriate.	Perform medication reconciliation for > 50 percent of patients arriving from another setting.
Provide summary-of-care records.	Provide a summary-of-care record more than half the time when referring patients to other providers or settings of care.
Be able to submit electronic data to immunization registries or immunization information systems.	Perform at least one test of the EHR’s ability to submit electronic data to immunization registries and make a follow-up submission if the test is successful (if the registries to which the physician submits such information can receive it electronically).
Be able to submit electronic syndromic surveillance data to public health agencies.	Perform at least one test of the EHR’s ability to provide electronic syndromic surveillance data to public health agencies and make a follow-up submission if the test is successful (if the agencies to which the physician submits such information can receive it electronically).