Capturing Incentive Payments: Achieving “Meaningful Use” of Electronic Health Records

Providers have the opportunity to receive a share of $27 billion in government incentive payments over the next six years for the successful adoption and meaningful use of information technology. Although the incentive payments are initially a “carrot” to encourage meaningful use of health technology, the program will eventually become a “stick,” in that providers who are not using electronic health record (“EHR”) technology by 2015 will begin to see reductions in their Medicare reimbursement payment updates.¹

On July 28, 2010, the Department of Health and Human Services (“HHS”) and the Office of the National Coordinator of Health Information Technology (“ONC”) published final rules on how hospitals and physicians must demonstrate “meaningful use” of EHR technology in order to qualify for the incentive payments.² In short, these providers must (i) adopt technology that allows for electronic exchange of data in compliance with federal standards; (ii) demonstrate that they are actually using the technology in a meaningful way; and (iii) use the technology to report clinical quality data to HHS.³

The encouraging news for providers is that the final version of the meaningful use rule contains greater flexibility than the January 2010 proposed rule. This change is likely due, in part, to HHS receiving over 2,000 comments that “almost unanimously” criticized the proposed rule for being too hard to achieve.⁴

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¹ In FY 2015, three-fourths of the percentage change a hospital would otherwise receive under Medicare will be reduced by 33.33%. The reduction percentage will be 66.66% in 2016, and 100% in 2017. 75 Fed. Reg. 44,314, 44,563 (to be codified at 42 C.F.R. § 412.64). Physicians will receive 99% of the applicable charges from the Medicare Physician Fee Schedule if they do not achieve meaningful use by CY 2015 (or 98% if they are also not electronic prescribers), reducing to 98% in 2016 and 97% in 2017. Id. at 44,572 (to be codified at 42 C.F.R. § 495.102).


³ 75 Fed. Reg. 44,324.

⁴ Id. at 44,326.
Eligibility for Incentive Payments

Eligible professionals (“EPs”) may choose to participate in the incentive program under either Medicare or Medicaid, but not both. A Medicare EP is a physician, dentist, podiatrist, optometrist, or chiropractor who is not “hospital-based” (i.e., does not perform more than 90% of his or her professional services in a hospital inpatient or emergency department setting). This definition allows a larger number of EPs to qualify as compared to the proposed rule, which would also have disqualified professionals from receiving incentive payments if they performed 90% of their work in an outpatient hospital-based setting.

The Medicare incentive payment is calculated as 75% of the Medicare estimated allowed charges for professional services provided by the Medicare EP during the payment year, up to $18,000 in calendar year 2011 or 2012, with a cap of $44,000 over five years. The payments are made to individual EPs; however, employers (e.g., group practices or hospitals) may be able to receive these payments and accumulate larger sums if each physician assigns his payments to the employer.

For Medicaid incentive payments, Medicaid EPs include physicians, dentists, certified nurse-midwives, and nurse practitioners who are not “hospital-based” (i.e., do not perform more than 90% of their covered professional services in a hospital inpatient or emergency department setting). Additionally, a physician assistant practicing in either a federally qualified health center (“FQHC”) or a rural health center (“RHC”) that is led by a physician assistant qualifies as a Medicaid EP. In addition, a Medicaid EP must serve a patient population of at least 30% Medicaid patients, or 20% in the case of pediatricians. A Medicaid EP at an FQHC or an RHC, however, must provide at least 30% of his or her services to “needy individuals” and may otherwise be hospital-based. The maximum incentive payment for Medicaid EPs is $63,750 over six years, with a limit of $21,250 in the first year.

Eligible hospitals may receive incentive payments under Medicare and Medicaid, if they qualify under each program’s requirements. Under Medicare, an eligible hospital is either one that is subject to the prospective payment system or a critical access hospital. Under Medicaid, an eligible hospital is either a children’s hospital or an acute care hospital with at least a 10% Medicaid patient volume. The calculation of the incentive payments, which can last for up to four years, is similar under the two programs and is based on a formula that accounts for the percentage of inpatient bed days paid for by the applicable program. Specifically, the Medicare formula is the product of the following three numbers:

Initial Amount = $2 million for up to 1,149 acute care inpatient discharges for the prior 12 months, plus $200 for each additional discharge up to 23,000 (maximum of $6,370,200)

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5 Id. at 44,579 (to be codified at 42 C.F.R. § 495.310). EPs are allowed to switch their program choice once during the period in which they are receiving incentive payments, and those receiving payment under Medicaid can only receive it from one state. Id. States will administer the Medicaid incentive payments with a 100% match from the federal government. Id. at 44,581 (to be codified at 42 C.F.R. § 495.320).

6 Id. at 44,572 (to be codified at 42 C.F.R. § 495.100).

7 Id. at 44,566 (to be codified at 42 C.F.R. § 495.4).

8 Id. at 44,572 (to be codified at 42 C.F.R. § 495.102). The limit is increased by 10% for Medicare EPs who perform at least 50% of their professional services in a health professional shortage area.

9 Id. at 44,572 (to be codified at 42 C.F.R. § 495.10).

10 Id. at 44,578 (to be codified at 42 C.F.R. § 495.304).

11 Id. “Needy individuals” are recipients of Medicaid, the Children’s Health Insurance Program, uncompensated care, or care provided at a reduced cost on a sliding scale that is based on the individual’s ability to pay. Id. (to be codified at 42 C.F.R. § 495.302). Although the regulations also specify that EPs practicing at an FQHC or an RHC may be hospital-based, it is not clear how these EPs could be performing 90% of their covered professional services in an inpatient or emergency room setting, as well as practicing predominantly at an FQHC or an RHC (defined to mean that 50% of the EP’s total patient encounters over a six-month period occur in one of these locations). Id. (to be codified at 42 C.F.R. §§ 495.302, 495.304).

12 Id. at 44,579 (to be codified at 42 C.F.R. § 495.310).

13 Id. at 44,317.

14 Id. at 44,572 (to be codified at 42 C.F.R. § 495.100).

15 Id. at 44,578 (to be codified at 42 C.F.R. § 495.304).

16 Id. at 44,573 (to be codified at 42 C.F.R. § 495.104). The Medicaid formula will be codified at 42 C.F.R. § 495.310.
Transition Factor (for hospitals whose first payment year is 2011-2013) = 1.0 in Year 1; 0.75 in Year 2; 0.50 in Year 3; and 0.25 in Year 4.

Therefore, as an example, a hospital that discharges 5,000 inpatients a year and serves a Medicare Share (as described above) of 40% would be eligible to receive $1,108,080 in 2011, and $2,770,200 total over all four years if these inpatient numbers never changed.

Multi-hospital systems that use the same provider number are considered a single hospital for purposes of this program, though discharges from all the affiliates are combined to increase the number generated by the formula. In response to complaints from these hospital systems that their payments are unfairly reduced under this rule, however, Congress is currently considering a bill called “The Electronic Health Records Incentives for Multi-Campus Hospitals Act of 2010,” or H.R. 6072. The bill would allow hospitals with remote inpatient locations to elect an alternate formula calculation where either (i) the base amount of $2 million (from the Initial Amount described above) is multiplied by the number of component facilities of the hospital, or (ii) the additional discharge amount (from the Initial Amount described above) is averaged among all the component facilities and then multiplied by the number of those facilities.

Because HHS does not yet have the capability to receive electronic data submissions, EPs and hospitals will verify their compliance with the criteria described below by attestation in 2011. As soon as HHS has the technological capability to receive information through direct data exchange, however, providers will be required to submit electronically the required data to HHS.

Payment in the first year is based on achieving meaningful use for any continuous 90-day period, while in subsequent payment years, the provider must be in compliance for the entire year in order to receive an incentive payment.

**Technology Specifications**

The first requirement for receiving an incentive payment is that the technology itself must comply with federal standards. Providers may adopt either a complete software package that satisfies all the requirements or a combination of modules that together accomplishes all the required functions. The ONC final rule specifies the information exchange standards for EHRs. For example, providers must be able to use the software to transmit prescriptions to pharmacies, report certain required information to public health agencies and immunization registries, and submit quality data to the government (see below). Therefore, in order to ensure compatibility for these reporting purposes, the rule identifies certain vocabulary standards and code sets that must be incorporated into the software.

In addition, the software must be able to accomplish a specified set of clinical functions, such as generating automatic real-time notifications when a provider is prescribing a drug that conflicts with a patient’s other medications or allergies. There are also additional certification criteria based on whether the EHR is designed to be used in either an ambulatory or an inpatient setting. For example, ambulatory software must be able to generate patient reminders for follow-up or preventive care, while inpatient software must be capable of providing electronic discharge instructions. Finally, patient data must be encrypted according to one of the specified security algorithms identified by the National Institute of Standards and Technology.

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17 Id. at 44,448.
18 Id. at 44,570 (to be codified at 42 C.F.R. § 495.8).
19 Id. at 44,380.
20 Id. at 44,566 (to be codified at 42 C.F.R. § 495.4). EP payment periods are defined based on the calendar year, while hospital payments are measured based on the federal fiscal year.
21 Id. at 44,596.
22 Id. at 44,650 (to be codified at 45 C.F.R. § 170.205).
23 Id. at 44,651 (to be codified at 45 C.F.R. § 170.302).
24 Id. at 44,652-653 (to be codified at 45 C.F.R. § 170.304 and § 170.306, respectively).
25 Id. at 44,650 (to be codified at 45 C.F.R. § 170.210).
Pursuant to a separate final rule, ONC is currently accepting applications from organizations that ONC will authorize to test and certify the compliance of providers’ technology. ONC considers its current certification program to be “temporary,” because it is being put in place quickly to allow providers to begin receiving incentive payments in 2011. The temporary program is expected to sunset on December 31, 2011. ONC contemplates that the certification standards of the permanent program will be “more rigorous” than those of the temporary program.

**Meaningful Use**

The second requirement for receiving an incentive payment, and the one that has received the most attention from providers, is to make “meaningful use” of the technology. The final list of requirements for demonstrating meaningful use of technology includes a “core set” of 15 objectives for EPs and 14 objectives for eligible hospitals, along with a list of 10 additional objectives from which 5 must be chosen. These requirements will likely be a welcome change from the proposed rule, which had included 25 proposed objectives for EPs and 23 for hospitals.

HHS has also added flexibility by allowing Medicaid EPs and hospitals participating under the Medicaid incentive program to receive their first payment in the year they “adopt, implement or upgrade” an EHR system, without having to demonstrate meaningful use until Year 2. In addition, HHS has reduced many of the thresholds for meeting the objectives. For example, while the proposed rule required that 80% of patient records include an entry about the smoking status of patients over age thirteen, the final rule only requires that 50% of the provider’s records contain this information in order to show meaningful use.

Finally, HHS has crafted exceptions to a number of the requirements in recognition that not all of the objectives are relevant or possible for all providers. For example, an EP who writes fewer than one hundred prescriptions in a ninety-day period does not have to meet the requirement for computerized order entry of medication orders.

It is important to remember that this rule only represents “Stage 1” of meaningful use. HHS currently plans to issue Stage 2 criteria by the end of 2011 and Stage 3 criteria by the end of 2013. As part of this phased-in approach, the main goals of Stage 1 are to implement the technology and begin using it to engage with patients and accomplish certain required reporting functions. After achieving Stage 1 goals, increasing use of information technology will be required in order to continue receiving incentive payments. Among other things, HHS anticipates that optional Stage 1 criteria will be required in Stage 2, meaning that more electronic transmission of clinical orders and test results will be expected.

**Quality Reporting**

The final requirement for receiving an incentive payment is that providers must use their EHRs to submit quality data to HHS. HHS emphasizes in the final rule that providers do not have to meet any specified quality thresholds in order to qualify for an incentive payment; they just need to report their quality data as generated by their software:

- EPs must report on three core quality measures and three additional measures that they select from a list of 44 measures. The core measures

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26 75 Fed. Reg. 36,158 (June 24, 2010).
27 Id. at 36,164.
28 Id. at 36,175.
29 Id. at 36,184.
31 Id. at 44,566-567 (to be codified at 42 C.F.R. § 495.6).
are blood pressure measurement, tobacco use assessment and cessation intervention, and adult weight screening and follow-up, though alternate core measures are available for providers with patients for whom these measures are not applicable.

- Eligible hospitals must report on 15 quality measures, including median emergency department wait time, certain readmission rates, and certain infection rates. HHS plans to increase the number of quality measures that must be reported in Stage 2 of the incentive payment program.

**Next Steps**

Providers should assess their current eligibility for incentive payments based on the adoption of EHR technology and required next steps to attain or ensure such eligibility. For example, providers should engage their information technology departments or contractors to ensure that the EHR software they have chosen (or will choose) provides all the required functionalities as described above. EHR technology is likely to play an increasing role in the new payment models and reporting requirements associated with health care reform. This new importance on health information technology may be an important consideration in a provider’s decision about whether, and how fast, to implement EHR.

Entities who employ physicians and bill based on physician reassignment may also want to review their contractual relationships to clarify who is entitled to retain the individual physician’s incentive payment, if applicable. Even if the entity has incurred the cost of EHR implementation, the incentive payment may still be directed to the physician unless the parties have agreed otherwise.

Finally, providers should consider putting in place certain processes and procedures, through their compliance departments, to monitor and ensure that they are accurately attesting and reporting compliance with these meaningful use requirements. Providers are subject to audits by the government to determine whether their reporting is accurate, and any improper receipt of governmental payments could lead to liability under the federal False Claims Act (and/or applicable state False Claims Act statutes), including via whistleblower action. In addition, as states implement the Medicaid incentive program, they will be required to have monitoring systems in place to detect fraud and abuse related to the receipt of incentive payments, and providers receiving Medicaid incentive payments should watch for those programs as they are developed.

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38 *Id.* at 44,412. Table 10 (hospital measures) starts on 44,418.

39 *Id.* at 44,386.

40 *Id.* at 44,588 (to be codified at 42 C.F.R. § 495.368).
## Summary of the Who, What, How, and How Much of Meaningful Use

<table>
<thead>
<tr>
<th>Eligible Hospital</th>
<th>Eligible Professional (‘EP’)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>May I receive payment from Medicare and Medicaid?</strong></td>
<td>Yes, if the hospital meets the criteria under each program.</td>
</tr>
<tr>
<td><strong>What is the payment formula?</strong></td>
<td>Initial Amount (x) Medicare or Medicaid Share Fraction, as applicable (x) Transition Factor</td>
</tr>
<tr>
<td><strong>When can payments begin?</strong></td>
<td>Fiscal year beginning October 2010</td>
</tr>
<tr>
<td><strong>How much money can I receive in the aggregate?</strong></td>
<td>Varies based on the number of inpatient discharges per year and the portion of those discharges paid for by Medicare or Medicaid; the formula is designed to produce decreasing incentive payments over four years.</td>
</tr>
<tr>
<td><strong>How many years may I participate in the program?</strong></td>
<td>4 years</td>
</tr>
<tr>
<td></td>
<td>No Medicare payments may be made after 2016. The first payment year under Medicaid must be in 2016 or earlier.</td>
</tr>
<tr>
<td>When will I be paid?</td>
<td>After cost report reconciliation under Medicare(^{41})</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Rolling basis under Medicaid</td>
</tr>
<tr>
<td>Who will determine how much I will be paid?</td>
<td>Fiscal intermediary or Medicare administrative contractor(^{42})</td>
</tr>
<tr>
<td>How will I be paid?</td>
<td>Annual lump sum</td>
</tr>
<tr>
<td>What reductions do I face for failure to adopt an EHR system?</td>
<td>Market basket decrease: Three-fourths of the applicable percentage change is decreased by 33.3% in 2015; 66.6% in 2016; and 100% in 2017 and subsequent years.</td>
</tr>
<tr>
<td></td>
<td>2016: 98% of rates on Physician Fee Schedule</td>
</tr>
</tbody>
</table>

\(^{41}\) *Id.* at 44,450.

\(^{42}\) *Id.* at 44,467.

\(^{43}\) *Id.* at 44,501.

\(^{44}\) *Id.* at 44,465.