Health Care Bulletin

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HITECH Act Incentives for Certified EHR: Update on Recent Progress Towards Defining "Meaningful Use"

Incentives and Penalties for "Meaningful Use" of Certified EHRs

Within the American Recovery and Reinvestment Act of 2009 (ARRA), signed into law on February 17, 2009, the Health and Information Technology for Economic and Clinical Health Act (HITECH Act) provides $19.2 billion to promote the adoption of health information technology (HIT), including the widespread implementation of electronic health records (EHRs) over the next five years.

As a significant part of the HITECH Act funding for HIT, Medicare and Medicaid will offer financial incentives to both eligible professionals and hospitals that can demonstrate "meaningful use" of certified EHRs. Soon thereafter, however, Medicare will begin imposing penalties in the form of reduced reimbursement on those who fail to use qualifying EHR technology on time.

Medicare Incentives and Penalties for Hospitals. Beginning in federal fiscal year 2010 (October 2010), Medicare will provide incentive payments to general acute care hospitals and critical access hospitals (CAHs) that can demonstrate to the Department of Health and Human Services (HHS) "meaningful use" of certified EHRs. A hospital that is a "meaningful user" can receive up to four years of financial incentive payments. Medicare will determine the amount of incentive payments for each individual hospital using a formula based on the product of (1) a base amount of $2 million, plus $200 for every discharge between 1,150 and 23,000, (2) the Medicare share, and (3) a transition factor that phases payment amounts down over the four years.[1] As a result, hospitals can receive greater incentives if they demonstrate "meaningful use" earlier. However, Medicare will not make any incentive payments to hospitals that become "meaningful users" after 2015.[2]

By contrast, for hospitals that fail to become "meaningful users," beginning in federal fiscal year 2015 (October 2015), Medicare will reduce reimbursement payments. Hospitals that are not "meaningful users" for a fiscal year would receive a net reduction of 25, 50, 75, and 100 percent of the market basket update that would otherwise apply in fiscal years 2015, 2016, 2017, respectively[3], and thereafter.

Medicare Incentives and Penalties for Eligible Professionals. Similarly, physicians[4] and other eligible professionals (EPs), who are "meaningful users" of certified EHRs can receive financial incentives of up to $44,000 (per provider), paid over a five year period beginning in calendar year 2011 (January 2011) and ending in 2016. Medicare will not pay incentives to EPs who first become "meaningful users" in 2015 or later, however. Moreover, for EPs who are late adopters of EHR technology, beginning in 2015 Medicare will impose reimbursement reductions in the Medicare fee schedule amount for professional services for failure to demonstrate "meaningful use" of certified EHRs as follows:

- One percent decrease in 2015
- Two percent decrease in 2016
- Three percent decrease in 2017
- Three to five percent decrease in 2018 and beyond.

How to Qualify for Medicare Incentives. To qualify for Medicare incentives, hospitals and EPs must show that they are "meaningful users" of EHR technology that meets HHS certification standards. However, the HITECH Act failed to include certification standards and a detailed definition of "meaningful use". Instead, it requires the Centers for Medicare & Medicaid Services (CMS) to publish regulations defining these key terms by the end of 2009. In particular, the HITECH Act codified the HHS Office of National Coordinator (ONC), and created within ONC two key advisory committees: the HIT Policy Committee and the HIT Standards Committee. These Committees are performing the critical task of developing the detailed standards for "meaningful use" and EHR certification. As a result, to ensure that they will be aware of requirements to receive financial incentives and avoid reimbursement penalties, hospitals and EPs must closely monitor the ongoing efforts of ONC and these Committees as they work to establish certification standards and define "meaningful use." Recent developments in this area are discussed further below.

Medicaid Incentives. In addition to the Medicare incentives described above, the HITECH Act includes Medicaid incentives for eligible hospitals and EPs[5] to purchase, implement, and operate certified EHR technology. To be eligible for incentive payments, hospitals must have at least a 10 percent Medicaid patient volume and EPs must similarly meet minimum Medicaid patient volumes. As with the Medicare incentives, hospitals and EPs must demonstrate "meaningful use" of EHR technology. However, for the Medicaid incentives, the states will develop standards for meaningful use, subject to HHS approval. Note that unlike hospitals, physicians and other EPs may not receive an incentive under both the Medicare and Medicaid programs in the same year.

HIT Policy Committee Report on Meaningful Use

As indicated above, the HIT Policy Committee will play a critical role in recommending standards for "meaningful use" to assist in the development of CMS regulations by December 31, 2009. Most recently, on June 16, 2009, the HIT Policy Committee forwarded its initial recommended definition of "meaningful use" to ONC.

In its June 16th report, the HIT Policy Committee Meaningful Use Working Group announced its vision for "meaningful use:" "*to enable significant and measurable improvements in population health through a transformed health care delivery system.*" Guided by this vision, it recommended the following five national priorities (using 2008 National Quality Forum priorities) as themes for the definition of "meaningful use":

(1) Improve quality, safety, efficiency, and reduce health disparities;

(2) Engage patients and family;

(3) Improve care coordination;

(4) Improve population and public health; and

(5) Ensure privacy and security protections.

In addition, the Working Group developed a matrix of objectives and care processes to define what measures will be required for "meaningful use." For each of the priorities, the Working Group set multiple care goals. For each care goal, the matrix includes a list of objectives and measures beginning in 2011 and increasing in scope and complexity in 2013 and 2015. For example, in the year 2011, under the priority "improve quality, safety, efficiency, etc." providers would need to:

- Use computerized physician order entry (CPOE) for all order types
- Implement drug-drug, drug-allergy, drug-formulary checks;
- Maintain up-to-date problem lists;
- Maintain active medication lists;
- Maintain active medication allergy lists;
- Record primary languages, insurance type, gender, race, ethnicity;
- Record patient vital signs;
- Incorporate lab tests into EHRs;
- Generate patient lists by condition; and
- Send reminders to patients.

Measures would include, for example, reporting the percentage of hypertensive patients with blood pressure under control. Future objectives and measures effective in 2013 and 2015 will be more challenging. For example, 2013 objectives include use of evidence-based order sets and clinical decision support at the point of care. Many details remain yet to be clarified by CMS. In fact, on the same day that the HIT Policy Committee reported its recommendations, the National Coordinator, David Blumenthal, M.D., sent the Working Group back to develop a new set of less stringent standards. As a result, the definition of "meaningful use" ultimately remains uncertain. What is clear, however, is that meeting these objectives and measures will likely be a daunting task requiring not only advances in EHR technology, but high levels of hospital and EP implementation of EHR systems, all within a few short years.

Public comment on the HIT Policy Committee's initial draft recommended definition of "meaningful use" closed on June 26, 2009. The HIT Policy Committee is expected to provide an updated draft

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definition of "meaningful use" at its upcoming meeting on July 16, 2009. ONC and HHS leadership will consider the HIT Policy Committee's final recommendation, along with the public comments received by June 26, to determine which recommendations to forward to ONC, and thereafter the HIT Standards Committee for its consideration. After receipt, the HIT Standards Committee is charged with making specific recommendations to HHS about which standards to accept. At the conclusion of this process, the final definition of "meaningful use" is expected to be proposed by the CMS before the end of 2009 and made final in early 2010.

HIT Standards Committee Update

The HIT Standards Committee, which will consider the HIT Policy Committee's recommendations and make recommendations to HHS about which standards for "meaningful use" CMS should accept, also recently met on June 23, 2009, to discuss the HIT Policy Committee's recommended definition of "meaningful use." At the June 23rd meeting, several Standards Committee Working Groups reported on their progress to date and future plans. In particular, these Working Groups will focus on clinical operations, quality measures using the National Quality Forum's Health Information Technology Panel, and specific privacy and security safeguards. The three Working Groups expect to be finished with their assignments by the next HIT Standards Committee meeting on July 21, 2009, followed by a meeting on August 20, 2009. The finished product of the HIT Standards Committee will be a matrix of standards, an estimate of the readiness for deployment of each standard, quality measures, and privacy/security best practices for each meaningful use objective. These will be forwarded to ONC for its approval and recommendation to CMS.

As indicated above, as the HIT Committees and ONC continue their work to define "meaningful use" and develop certification standards for EHR, many important concepts remain uncertain. During this period, hospitals and EPs should continue to watch developments closely, participate in future opportunities to comment on proposed CMS regulations, and prepare to meet fast-approaching deadlines to be eligible to obtain financial incentives.

For up-to-date information on the HIT Policy and Standards Committee see:

Policy

Standards

Footnotes

1 The Medicare share is a fraction based on estimated Medicare fee-for-service and managed care inpatient bed days, divided by estimated total inpatient bed-days and modified by charges for charity care. The transition factor phases down the incentive payments over the four-year period. The transition factor equals one for the first payment year, ¾ for the second payment year, ½ for the third payment year, ¼ for the fourth payment year, and zero thereafter.

2 CAHs that are meaningful EHR users can receive their reasonable costs for the purchase of certified EHR technology, which will be computed by expensing such costs in a single payment year, rather than depreciating them over time. In addition, CAHs can receive incentive payments based on the Medicare share formula used for hospitals, plus 20 percentage points (not to exceed a total of 100 percent). Medicare will not make payments with respect to a cost reporting period beginning during a payment year after 2015. In addition, no CAH can receive payment with respect to more than four consecutive payment years.

3 HHS may, on a case-by-case basis, exempt a hospital from reduced reimbursement payments if requiring the hospital to be a "meaningful EHR user" would result in an undue hardship. CAHs are also subject to payment reductions for failure to become "meaningful users" as follows: in FY2015, reimbursement for inpatient services at 100.66 percent of reasonable costs; in FY2016, reimbursement for inpatient services at 100.33 percent of reasonable costs; and in FY2017 and each subsequent year, 100 percent of reasonable costs.

4 Hospital-based physicians who substantially furnish their services in a hospital setting are not eligible for incentives. Until CMS provides further guidance, it is unclear if this exclusion may apply to physicians who furnish significant services in the hospital, such as surgeons, in addition to traditional hospital-based physicians.

5 Eligible Medicaid providers include physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants who are practicing in Federally Qualified Health Centers or Rural Health Clinics led by a physician assistant.

This Health Care Client Bulletin was prepared by Claire Turcotte with assistance from summer intern, John C. Bunch. Please contact any member of the Bricker & Eckler LLP Health Care Group for more information.