PUBLICATION

Financial Incentives for the Adoption and Use of Electronic Health Records

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With the passage of the American Recovery and Reinvestment Act of 2009 (the Stimulus Act), Congress will now offer financial incentives to both hospitals and certain health care professionals to encourage the adoption and use of electronic health records (EHRs). The Stimulus Act, which includes several other provisions designed to promote EHRs and to strengthen the infrastructure for health information technology, creates financial incentives under both the federal Medicare program and state Medicaid funding. These incentives are limited in both amount and duration, and are intended to foster the widespread adoption of EHRs in a relatively short period of time, with the prospect that such mass adoption will result in significant cost savings within the health care industry, along with a concurrent overall increase in the quality of health care delivered to patients.

Medicare Incentives for Eligible Professionals

Section 4101 of the Stimulus Act provides a financial incentive payment from Medicare to certain "eligible professionals" for the adoption and "meaningful use" of a "certified EHR system." "Eligible professionals" are "physicians," as defined under 42 U.S.C. 1395x(r), who participate in the Medicare program and include doctors of medicine, doctors of osteopathy, doctors of dental surgery or of dental medicine, doctors of podiatric medicine, doctors of optometry and chiropractors.[1]

Depending on the year that the eligible professional first adopts an EHR system, he or she may be eligible for five years of financial incentive payments. The Stimulus Act, however, provides no financial incentive after 2016 and an eligible professional adopting a certified EHR system in 2015 or later would receive no financial incentive.

The exact amount of the financial incentive is dependent upon several factors: (i) the amount of Medicare covered services furnished by the eligible professional; (ii) the year in which the eligible professional first adopts an EHR system; and (iii) whether the eligible professional practices predominantly in a health professional shortage area (HPSA). Assuming that an eligible professional furnishes sufficient Medicare covered services to qualify for the annual maximum financial incentive amount, the potential incentive payments (not including HPSA add-on amounts) are as follows:

Maximum Annual Financial Incentive Amounts

First Payment Year	2011	2012	2013	2014	2015	2016	2017	Total
2011	$18,000	$12,000	$8,000	$4,000	$2,000	$0	$0	$44,000
2012	$0	$18,000	$12,000	$8,000	$4,000	$2,000	$0	$44,000
2013	$0	$0	$15,000	$12,00	$8,000	$4,000	$0	$39,000

2014	$0	$0	$0	$12,000	$8,000	$4,000	$0	$24,000
2015	$0	$0	$0	$0	$0	$0	$0	$0

The Secretary of the Department of Health and Human Services (the Secretary) retains discretion whether to pay the financial incentives as a single consolidated amount or in periodic installments.

Certain hospital-based professionals, including pathologists, anesthesiologists and emergency physicians, who furnish substantially all covered services in a hospital setting through the use of the hospital's facilities and equipment, including its EHR system, are not eligible for financial incentive payments. Although the scope of this limitation will not be clear until regulations are issued, the Stimulus Act provides that the determination of whether an eligible professional is hospital-based will be made based on "the site of service and without regard to any employment or billing arrangement between the eligible professional and any other provider."

In order to be deemed a meaningful EHR user, the eligible professional must: (i) demonstrate to the satisfaction of the Secretary, through attestation or other prescribed methods, that during the period in question, the professional is using certified EHR technology in a meaningful manner, which shall include the use of electronic prescribing; (ii) demonstrate to the satisfaction of the Secretary, through attestation or other prescribed methods, that during the period in question, such certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care, such as promoting health care coordination; and (iii) submit information for such period, in a form and manner specified by the Secretary, regarding clinical quality measures and other measures as selected by the Secretary.

Although the Secretary is granted significant discretion as to what constitutes meaningful use, the Stimulus Act gives preference to clinical quality measures developed by consensus-based entities (as required under the Medicare Improvements for Patients and Providers Act of 2008), and requires such measures to be published in the *Federal Register* along with a notice and comment period. Likewise, the Secretary is charged with avoiding duplicative requirements from federal agencies and state governments as to what is required to demonstrate meaningful use of certified EHR technology under the Medicare and Medicaid programs. Importantly, the exact parameters of what constitutes meaningful use of EHR will be developed through the Secretary's rule-making process.

Finally, in the event that its use of financial incentives is unsuccessful, the Stimulus Act also requires CMS to utilize financial disincentives to further motivate eligible professionals to adopt and use EHRs by mandating that Medicare physician fee schedule payments be adjusted in 2015 (and subsequent payment years) for eligible professionals who are not meaningful EHR users as follows: a 1% reduction of fee schedule amounts for 2015; a 2% reduction for 2016; and a 3% reduction for 2017 and subsequent years. For year 2018 and each year thereafter, if the Secretary determines that the proportion of eligible professionals who are meaningful EHR users is less than 75%, the applicable discount is to be reduced by an additional percentage point from the prior year's discount to a floor of 95% of the Medicare physician fee schedule amount. These reductions would not apply to hospital-based eligible professionals. The Stimulus Act gives the Secretary the authority to grant exceptions to the payment reduction on a case-by-case basis for significant hardship to eligible professionals who practice in a rural area without significant Internet access. These exceptions, however, may not be granted for more than five years.

Medicare Incentives for Eligible Hospitals

Section 4102 of the Stimulus Act also establishes a financial incentive for eligible hospitals that are meaningful EHR users. Eligible hospitals are generally those included under 42 U.S.C. 1395ww(d) but do not include psychiatric, rehabilitation, children's, long-term care or cancer hospitals.

Incentive payments are available for up to four years depending upon the year an eligible hospital first demonstrates to the Secretary that it is using certified EHR technology in a meaningful manner. Hospitals that implement EHR after 2015 will not receive incentive payments.

The amount of incentive payments for a fiscal year is determined by the following formula:

Incentive Payment = (Base Amount + Discharge Amount) x (Medicare Share) x (Transition Factor)

The base amount is fixed at $2,000,000. The discharge amount is an amount equal to $200 multiplied by the total number of discharges between the 1,150th and the 23,000th discharge. The Medicare share is the ratio of Medicare inpatient bed days to the hospital's total bed days. Stated another way, the Medicare share is the number of Medicare inpatient bed days divided by the hospital's total bed days. The total bed days amount is to be adjusted by the hospital's share of charity care charges at the Secretary's discretion. The transition factor varies depending on when the hospital first becomes a meaningful EHR user and is reduced each successive year it is available. The following chart summarizes applicable transition factors based upon the first year of meaningful EHR use:

	Transition Factor					
First Payment Year	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
2011	100%	75%	50%	25%	X	X
2012	X	100%	75%	50%	25%	X
2013	X	X	100%	75%	50%	25%
2014	X	X	X	75%	50%	25%
2015	X	X	X	X	50%	25%

The incentive for meaningful use of EHR technology by critical access hospitals (CAH) is the ability to expense the cost of certified EHR in a single year's cost report instead of depreciating such costs over a number of years. Beginning in 2011, CAHs that are meaningful EHR users may receive these bonuses for four years. The amount that may be expensed is based on the CAH's Medicare share formula described above plus an additional 20%, not to exceed 100% total.

In order to be treated as a meaningful EHR user, a hospital must (i) demonstrate it is using certified EHR technology in a meaningful manner; (ii) demonstrate that such technology is connected in a manner that provides for the electronic exchange of information to improve the quality of health care; and (iii) submit information for such period on clinical quality measures or other measures selected by the Secretary. Hospitals may demonstrate their compliance with (i) and (ii) above as specified by the Secretary, including any of the following:

a) submitting an attestation to the Secretary;

b) submitting claims with codes indicating that inpatient care was documented using certified EHR technology; or

c) submitting a survey response.

The clinical quality measures referenced in (iii) above will be published for public comment prior to implementation and will not be required until the Secretary has the ability to accept such information electronically. Preference will be given to measures selected for the Reporting Hospital Quality Data for Annual Payment Update program.[2] Similar to the quality reporting measures for eligible professionals, measures that have been endorsed by the National Quality Forum under contract with the Secretary pursuant to the Medicare Improvements for Patients and Providers Act of 2008 may also be used. Also of note, the Secretary may use data from Medicare Part D, despite the restrictions on general use and disclosure of that information.

Eligible hospitals that do not become meaningful EHR users by 2015 will be penalized under the Stimulus Act. Failure to submit required quality data will result in a 25% reduction in the annual market basket update. Prior law allowed for a reduction of only 2%. Further, the remaining 75% of the market basket update is subject to reduction over a three-year period beginning in 2015 for hospitals that fail to become meaningful EHR users. Specifically, in 2015, the market basket update related to EHR use would be reduced by one-third; in 2016, by two-thirds; and in 2017 the update would be eliminated. For CAHs that are not meaningful EHR users by 2015, their Medicare reimbursement would be reduced from 101% to 100.66% in 2015, 100.33% in 2016 and 100% from 2017 forward.

Medicaid Incentives for Eligible Professionals

The Stimulus Act also provides federal matching funds for Medicaid incentives to encourage the use of certified EHR technology. Prior law did not allow for federal financial participation for such expenditures by states. The Stimulus Act provides for federal financial participation of 100% for state payments to encourage the adoption and use of certified EHR technology. Federal financial participation of 90% is available for sums expended by states that are attributable to reasonable administrative expenses related to the promotion of EHR technology use.

The incentives are available to the following eligible professionals who are not hospital-based: physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants (PA) in PA-led Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC). Incentives are available to those professionals whose patient volume mix is at least 30% individuals who are Medicaid recipients. Pediatricians are eligible for expanded incentives. Pediatricians whose patient volumes are between 20 – 30% Medicaid recipients are also eligible to receive two-thirds of the full incentive payment amounts until they reach the 30% threshold and full payment. FQHCs and RHCs are also eligible for expanded incentive payments. When determining whether the 30% threshold is satisfied, in addition to Medicaid recipients, FQHCs and RHCs are permitted to count (i) Children's Health Insurance Program (CHIP) recipients, (ii) charity care recipients and (iii) those paying for care on a sliding-scale based on their ability to pay.

Incentive payments are 85% of an eligible professional's "net average allowable costs" capped at $63,750 per eligible professional.[3] Medicaid providers are responsible for the remaining 15% of the net average allowable cost. The "net average allowable costs" reduces the average allowable cost for the purchase, implementation and maintenance of certified EHR technology by any payments made for that technology to the eligible professional from any source. As a result, eligible professionals must choose incentives under either Medicare or Medicaid.

The federal government caps the net average allowable cost for the first year at $25,000, and for subsequent years the cap is $10,000. Accordingly, up to $21,250 (or 85% of $25,000) is available in the first year to professionals who adopt, implement and upgrade certified EHR technology. Over the next five years, up to $8,500 (85% of $10,000) is available for ongoing operation and maintenance of such technology. Payments under this program are not available after the year 2021. Eligible professionals who do not adopt EHR technology by 2016 are not eligible to receive any incentives.

Medicaid Incentives for Hospitals

Acute care hospitals whose patient volumes are at least 10% Medicaid recipients are also eligible for Medicaid incentive payments under the Stimulus Act. Children's hospitals, regardless of Medicaid patient volumes, are also eligible for incentive payments. For hospitals, Medicaid incentive payments are structured in a manner similar to those available from Medicare under Section 4102 discussed above. That is, the incentive payment is based upon the following formula:

Medicaid Incentive Payment = (Base Amount + Discharge Amount) x (Medicaid Share)

In any given year, federal financial participation is limited to a maximum of 50% of the Medicaid Incentive Payment. For any two-year period such payment is limited to 90% of the Medicaid Incentive Payment. As a result, states are encouraged to spread incentive payments over at least a three-year period. Incentive payments are available to a provider for a maximum of six years. In order to participate, providers must be eligible for the incentive payments no later than 2016.

1. Eligible professionals who may receive financial incentive payments also include certain eligible professionals associated with qualified Medicare Advantage organizations. Stimulus Act, § 4101(c) (*see* new 42 U.S.C. §§ 1395w-23(l)(2)(A)-(B)).

2. Such measures were established under 42 U.S.C. § 1395ww(b)(3)(B)(viii).

3For pediatricians with a patient mix of 20 – 30% Medicaid recipients, the cap amount is $42,500 (or 2/3 of $63,750).