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Health Information Technology Toolkit for Family Physicians

What Do Federal EHR Incentives and Meaningful Use Mean to You?

By Sandra Newman, M.P.H.

As many family physicians know, the federal government has invested billions of dollars in funding to create a state and federal health information technology infrastructure. One important component of this funding is the creation of financial incentives for providers and hospitals to implement and meaningfully use electronic health records (EHRs). Medicare and Medicaid both have EHR incentive programs; the initiatives are administered separately—Medicare by the Centers for Medicare and Medicaid Services (CMS), Medicaid by the states—but share many of the same criteria. A range of health care providers and hospitals are eligible to receive funding, but the eligibility criteria are very specific. For the purposes of this article, I will focus on eligible provider (EP) incentives in Medicare and Medicaid.

Eligibility for Medicaid incentives

The Medicaid EHR incentive program will provide incentive payments to EPs and eligible hospitals (EHs) for efforts to adopt, implement, upgrade, or meaningfully use certified EHR technology. Many different types of providers are eligible to receive the Medicaid incentives—medical doctors, doctors of osteopathy, nurse practitioners, certified nurse midwives, etc.—provided they meet patient volume threshold requirements as outlined in Table 1. In addition to these thresholds, family physicians and other EPs practicing at federally qualified health centers or rural health centers (FQHCs/RHCs) must demonstrate that more than 50 percent of clinical encounters occurred at an FQHC/RHC over a six-month period, with a minimum 30-percent patient volume from “needy individuals.” And finally, EPs cannot be hospital-based. Hospital-based is defined as 90 percent or more of services performed in an in-patient or emergency department setting.

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Table 1. Medicaid patient volume thresholds

Entity	Minimum 90-Day Medicaid Patient Threshold	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC – 30% "needy individual" patient volume thresholds
Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
Physician Assistants *when practicing at an FQHC or RHC led by a physician assistant*	30%	
Nurse Practitioners	30%	
Acute Care Hospitals	10%	
Children's Hospitals	N/A	

Differences between Medicare and Medicaid

There are no patient-volume thresholds in the Medicare EHR Incentive Program. In terms of eligibility, the rule of thumb is that if you can be paid under the Medicare physician fee schedule, then you can participate. There are a number of key differences, however. First, unlike Medicaid, payment is based on 75 percent of allowed charges, up to a maximum of $44,000. There is a 10-percent payment bonus for those located in a Health Professional Shortage Area (HPSA). In contrast, Medicaid incentives are based on a government calculation of average actual EHR purchase and maintenance costs, to a maximum of $63,750.

Since the Medicaid EHR Incentive Program is implemented at the state level, there is also flexibility for states to add requirements. States are not required to begin programs in 2011, so it will be important to check with Texas Medicaid about when it plans to implement its program. There are also differences in how to qualify for incentives. While the federal meaningful use criteria apply in both programs, those in Medicaid have a special option. In their first year of participation, Medicaid EPs do not need to achieve meaningful use. Instead, they can provide documentation that they have adopted, implemented, or upgraded certified EHR technology.

Demonstrating meaningful use of certified EHR technology

There are three stages of requirements to meet meaningful use. The federal government has only finalized Stage 1; Stages 2 and 3 will be included in future rulemaking. Stage 1 meaningful use focuses on two major areas. The first is demonstrating EHR use for a number of functional criteria. These include, but are not limited to, electronic prescribing, clinical decision support, computerized physician order entry, and patient demographic information. EPs must meet 15 defined functional criteria. EPs (and EHs) must choose five from a menu of 10 additional requirements to meet in the next two years.

The second meaningful use focus area is clinical quality. EPs must meet a defined set of three measures, all of which are from the National Quality Forum. These measures address hypertension, preventive care, and adult weight screening. EPs must also choose an additional three from a menu of 38 measures. Many are measures family physicians already track, such as A1c, smoking use and cessation, diabetes foot exams, etc. Table 2 provides a summary of program requirements, including meaningful use.

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Take-home message

Even if you already have an EHR, funds will be available in 2011 to help offset the costs associated with purchase, implementation, and use. It is important to understand not just the meaningful use criteria outlined in this article, but also the populations to which they apply, how to report to the state and federal government, and TMHP rules. Many of these activities are still being developed, so monitor TAFP's website, TMHP, and the Texas Regional Extension Centers for news and updates.

Table 2. Eligible providers: EHR program in a nutshell

	Medicare	Medicaid
Start Date	Jan. 1, 2011	Varies by state, but cannot begin before Jan. 1, 2011
Payment	Based on actual charges: 75% of allowed charges (capped at $44,000)	Cost calculation: 85% of purchase and maintenance costs (capped at $63,750)
Eligibility	Physicians	Physicians, NPs, certified nurse midwives, dentists and certain PAs 30% Medicaid volume (20% peds)
Clinical Measures	6 total measures: 3 core, 3 menu	6 total measures: 3 core, 3 menu
HIT Functionality Measures	15 core measures Menu of 10 additional measures Choose five for Stage 1 Remainder completed in Stage 2	Same as Medicare, except states may add 4 additional public health and reporting measures States cannot require HIE connectivity
Payment Years	Maximum of 5 payment years	Maximum of 6 payment years
Payments Available	Incentive payments available 2011-2014	Incentive payments available 2011-2021.
Consecutive Payments	Consecutive program years. The "clock starts running" with the first payment year. After receiving payment, EPs must qualify for meaningful use each successive year.	Program years do not have to be consecutive. If an EP (or EH) does not receive an incentive payment in a given year, that year is not counted as a payment year.

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Resources

1. Texas Medicaid and Healthcare Partnership Incentive Program: http://www.tmhp.com/Pages/HealthIT/HIT_EHR.aspx
2. Centers for Medicare and Medicaid Services: https://www.cms.gov/EHRIncentivePrograms/ Federal agency charged with implementing the Medicare EHR Incentive Program.
3. Texas Regional Extension Centers: http://www.txrecs.org/ Federally-funded organization charged with helping certain primary care providers with meeting meaningful use guidelines.

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