What the American Recovery and Reinvestment Act means for Medical Practitioners

In February of 2009, President Obama signed the American Recovery and Reinvestment Act (ARRA), with the intent to stimulate the economy through investments in infrastructure. ARRA includes significant funding earmarked for the development of information technology for health care and the improvement of the quality of care provided to patients, while bringing down costs. In the hopes of swaying more physicians to adopt and use EMRs, ARRA set aside almost $20 billion under the U.S. Health and Human Services Department (HHS) to help physicians purchase and implement HIT systems. This is a historic opportunity to improve the health of Americans and the performance of the nation's health system through unprecedented investment in HIT. This initiative is expected to be an important part of health reform for health professionals and institutions harnessing the full potential of digital technology to improve the health of the nation.

Two major sections of the stimulus package, Title IV and Title XIII, collectively known as the Health Information Technology for Economic and Clinical Health (HITECH) Act, provide for incentives and aid for physicians who use EMRs meaningfully. The incentive payments in this legislation hopefully will lower a big EMR hurdle that physicians face today — the cost of purchasing software. Reimbursement from the stimulus package will be distributed over a period of time and may be utilized to purchase software, and more important, to pay for implementation and training.

Meaningful Use

Although the incentive payments under HITECH are available to physicians who demonstrate "meaningful use" of an EMR, the act leaves many key questions unanswered, as HHS has yet to define "meaningful use" and clarify other terms of HITECH. What we do know is this: To demonstrate meaningful use, a physician must be able to:

- Use certified EMR technology,
- Engage in e-prescribing (physicians must use an e-prescribing system; computer-generated faxes of prescriptions to pharmacies do not qualify),
- Participate in health information exchange in accordance with law and standards, and
- Produce quality reporting measures according to HHS specifications.

According to ARRA, "certified technology" means that a qualified EMR:

- Includes patient demographic and clinical health information,
- Can provide clinical decision support to physician order entry,
- Has the capacity to capture and query information relevant to health care quality, and
- Exchanges and integrates electronic health information with other sources.

The physician's EMR must be able to exchange health information to achieve several aspects of meaningful use, including improvement in care coordination. While still fairly early in development, health information exchanges already are active in some parts of the country and in development in others. It is expected that the definition of "meaningful use" will initially call for the technology to be capable of participating in an exchange, and in later years, will require actual participation in an exchange.

Reporting and acting on quality measures to improve health outcomes are key factors in the transformation of the health care system that ARRA envisions. The federal policy, as expressed in the law, posits the concept that to improve health care delivery, physicians must be able to generate, analyze, and effectively use quality reports from their EMR data. Physicians who provide quality care may then be rewarded. The Office of National Coordinator for Health Information Technology (ONC) is developing criteria for quality measures around five core areas of health outcomes:

1. Improve quality safety and efficiency while reducing health disparities,
2. Engage patients and families,
3. Improve care coordination,
4. Improve population and public health, and
5. Ensure adequate privacy and security protections for personal health information.

Potential quality measures HHS expects include these reports:

- Percent of hypertensive patients with blood pressure under control,
- Percent of orders entered directly by physicians through computerized order entry,
- Percent of patients with LDL under control,

• Use of high-risk medications in the elderly,
• Percent of smokers offered smoking cessation counseling, and
• Percent of female patients over age 50 receiving an annual mammogram.

In various proposals, ONC indicates that in 2011 and 2012, physicians receiving incentives must first demonstrate the **ability to generate reports on quality measures**, which will reward them for purchasing and implementing EMRs that can **capture quality**. Then in 2013, the proposed definition of "meaningful use" would expand to include a requirement for the **reporting of quality data results**, which will reward the physician for **actual reporting of data**. Lastly, in 2015, the reports must **meet national standards or benchmarks**, which will reward ***effective use of data***, when the systems permit physicians to improve care and meet quality benchmarks. The time waiting for the final definition of "meaningful use" is cause for concern for those physicians who already have adopted an EMR or who are in the process of purchasing one. Physicians currently in the process of purchasing an EMR should request that vendors sign a contract stipulation that ties final payment to the vendor's promise to deliver an EMR, including all of the EMR functionalities needed to enable the physician to meet all meaningful use guidelines by 2011.

Furthermore, physicians may want to consider a contract provision that ties payment of any annual fees for maintenance or updates to be contingent upon the ability of the EMR product to meet the meaningful use requirements each subsequent year. If you already have adopted an EMR system, now is the time to start an ongoing dialogue with your EMR vendor to determine its efforts to provide a product that will allow you to achieve the meaningful use requirement each year, thereby remaining eligible for incentive payments. Definitions continue to evolve, with a final answer expected in early 2010. Check the ONC Web site for updates and developments.

Medicare Incentives

Those physicians who utilize EMRs and meet the meaningful use criteria can take advantage of thousands of dollars of incentives over the next few years. The proposed incentives do not include payments to long-term care physicians or hospital-based physicians (e.g., pathologists, emergency room physicians, and anesthesiologists), if those hospital-based physicians provide care almost exclusively in the hospital and using the hospital's facilities and equipment, including qualified electronic health records. The incentives also may exclude physicians who use hospital-based EMRs in hospital-based clinics. Funding amounts vary depending on mathematical formulas and the year in which the physician is first able to demonstrate meaningful use. **To receive the maximum amount over five years, physicians must demonstrate meaningful use by 2011 or 2012**. Prepare now so that you are positioned to receive maximum levels of incentives offered.

Depending on the amount of Medicare services provided, physicians who accept Medicare patients could earn up to $44,000 in incentives over five years. For those who meet the requirements by 2011 or 2012, the first Medicare incentive payment is $18,000. The annual payment amounts decrease after that.

Medicare Incentive Schedule

First Payment year	2011	2012	2013	2014	2015	2016	Max
2011	$18,000	$12,000	$8,000	$4,000	$2,000	-	$44,000
2012		$18,000	$12,000	$8,000	$4,000	$2,000	$44,000
2013			$15,000	$12,000	$8,000	$4,000	$39,000
2014				$12,000	$8,000	$4,000	$24,000

Eligible physicians who work in health professional shortage areas will receive a 10-percent increase in incentive payments as compared with physicians in other areas. Please note that these funding amounts are per physician; therefore, practices with multiple physicians would multiply the amounts by the number of physicians in the practice achieving meaningful use. However, where an eligible professional is providing covered professional services in more than one practice, the incentive payment shall be modified to "coordinate" the incentive payments. This aspect of the law will be subject to future rulemaking. While ARRA offers quite a large carrot to physicians, be aware that there is a stick involved as well. Physicians who have not become "meaningful users" will be subject to reduced Medicare payments, beginning with a 1-percent cut in 2015. The penalties increase to 2 percent by 2016 and 3 percent by 2017. HHS

may continue to decrease 1 percent per year to a maximum of 5 percent, if 75 percent of office based physicians do not achieve meaningful use by 2018. All incentive payments end in 2016. ARRA does place some caveats on eligibility to receive incentive payments. Physicians who report using an EMR with e-prescribing capabilities forfeit their eligibility for the e-prescribing bonuses established by the 2008 Medicare Improvements for Patients and Providers Act if they seek incentive payments under ARRA. In addition, physicians may qualify for payments for using HIT under Medicare or Medicaid, but not both.

The potential success of the incentives is debatable, but any funding is likely to be of assistance to physicians planning to adopt technology, as cost is frequently cited as a major barrier. Opportunities for incentive payments and threats of penalties related to adoption and use of EMRs make it tempting to rush into implementing a system. Physicians should proceed with caution and tap into available resources to make wise decisions.

Medicaid Incentives

The Medicaid incentives and definitions for "meaningful use" of certified EMR technologies are vaguer than those for Medicare. Nevertheless, the stimulus legislation stipulates that the following health care professionals are eligible for incentive payments:

- Nonhospital-based pediatricians and other professionals with at least a 30-percent Medicaid patient volume;
- Nonhospital-based pediatricians with at least a 20-percent Medicaid patient volume are eligible for two-thirds of the dollar amounts specified for the maximum;
- Eligible professionals who practice predominantly in federally qualified health centers or rural health clinics and have at least 30 percent of the patient volume attributable to needy individuals. Needy patients are those covered by Medicaid, receiving services under Title XXI, unable to pay, or receiving services on a sliding scale due to inability to pay.

The Medicaid incentive program will be administered by the states, and has a more complex funding schedule based on EMR costs. Medicaid will pay up to 85 percent of costs related to EMR adoption and operation. Physicians can receive a one-time incentive payment for 85 percent of the allowable cost for the purchase and implementation of a certified EMR in the first year.

For example, in the first year, physicians can receive up to $21,250 (85 percent of a $25,000 maximum) for an EMR implementation or upgrade. Medicaid professionals who achieve meaningful use can receive up to $8,500 (85 percent of a $10,000 maximum) for five years for operating and maintaining an EMR. Physicians who already have an EMR can receive the one-time payment the first year and the yearly payments thereafter by achieving meaningful use in those years. Remember, physicians may qualify for payments for meaningfully using HIT under Medicare or Medicaid, but not both. The maximum amount an eligible physician can receive through Medicaid incentives is $63,750 over a five-year period.

The legislation does not penalize Medicaid physicians for failing to adopt a certified technology. Unlike Medicare penalties, no reductions in Medicaid payments are to be made if the physician does not adopt EMR technology.