On July 13, 2010, final rules were issued implementing the electronic health records incentive programs (“EHR Incentives”) authorized by the Health Information Technology for Economic and Clinical Health (“HITECH”) Act. The EHR Incentives reward providers who implement electronic health records and achieve “meaningful use” of the technology with enhanced Medicare and Medicaid rates. Hospitals can begin receiving payments as early as October 2010; other eligible medical professionals (EPs) are eligible as of January 2011. EPs can receive as much as $44,000 over a five-year period through Medicare. For Medicaid, EPs can receive as much as $63,750 over six years.

EPs who meet the eligibility requirements for both the Medicare and Medicaid EHR Incentive Programs may participate in only one program, and must designate the program in which they would like to participate. EPs will be allowed to change their program selection once before 2015. Medicare EHR Incentives will be disbursed through a single payment contractor to the Tax Identification Number (TIN) provided by the qualifying EP. Provided they meet certain conditions, EPs can reassign the entire amount of their incentive payment to one employer or entity. Group practices may want to ensure that each EP is required to assign his or her payments to the employer.

A Medicare EP is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, who is legally authorized to practice under state law. Hospital-based EPs who furnish substantially all (90%) of their services in an inpatient hospital setting or emergency room are not eligible for Medicare meaningful use payments. Medicaid EPs include nurse practitioners, certified nurse midwives and physician assistants who practice in certain federally qualified health centers or rural clinics.

Significantly, physicians who cannot demonstrate meaningful use by 2015 will see reductions in Medicare reimbursement and hospitals will be penalized through reductions in their annual Inpatient Prospective Payment System market basket update. To be able to obtain the EHR Incentives, providers should immediately begin conducting an assessment to determine what technology, staff and other resources are needed to implement an EHR and be able to attest that they have achieved “meaningful use.”

Demonstrating Meaningful Use for Medicare EHR Incentives

Hospitals and EPs are expected to demonstrate meaningful use in three phases; the final rules only address objectives for Phase 1. These focus on (i) capturing health information in a coded format; (ii) using that information to track clinical conditions; (iii) communicating the information to coordinate patient care; and (iv) reporting capability for clinical quality measures and public health information.

In the spirit of other Federal government healthcare regulations, nothing is simple.
All providers must satisfy a “core group” of objectives and then choose five from a menu set. There are 14 core items for hospitals and 15 for EPs.

**Core Group (must meet all 14 or 15)**

1. Use computerized physician order entry (CPOE) for 30% of patients on meds
2. Run drug-drug, drug-allergy, and drug-formulary checks
3. Maintain problem list of diagnoses (80%)
4. Prescribe electronically 40% of all permissible medications (EPs ONLY)
5. Maintain active medication list (80%)
6. Maintain active medication allergy list (80%)
7. Record demographics (50%) (hospitals must include cause of death)
8. Record and chart vital signs (50%)
9. Record smoking status for patients thirteen years and older (50%).
10. Be able to report ambulatory quality measures to CMS
11. Implement and track one clinical decision support rule
12. Supply electronic copy of health information to patients within 3 days (50%)
13. Provide clinical summaries within 3 days of office visit (50%) (Hospitals: 50% get electronic discharge instructions)
14. Able to electronically exchange clinical information with providers and patient-authorized entities
15. Protect electronic health information maintained using certified EHR technology

**A La Carte: 5 from the Menu**

Providers must then satisfy five (5) of the following additional criteria:

- Maintain a drug-formulary check system for entire reporting period
- Incorporate 40% of clinical lab test results into EHR as structured data
- Generate lists of patients by specific condition to use for quality improvement
- Send reminders for preventive/follow-up care to patients 65 years or older or 5 and under (>20%)
- Provide patients with timely electronic access to their health information (>10%)
- Provide patients with education resources and information (>10%)
- Perform medication reconciliation upon transition between care settings (>50%)
- Provide summary care record for each transition of care and referral (>50%)
- Demonstrate ability to submit electronic data to immunization registries (perform at least one test)
- Demonstrate ability to provide electronic syndromic surveillance data to public health agencies (perform at least one test and follow-up)

**Hospitals** can pick from 5 additional “menu” objectives

- Maintain access to at least one formulary for the reporting period
- Record advance directives for patients 65 or older (>50%)
- Record clinical lab test results
- Be capable of providing reportable lab results to public health agencies electronically (perform at least one test and follow-up)

**Specialty EPs: Still Working Out How to Comply**

During the process of developing the meaningful use standards, CMS received a great deal of feedback from specialty physicians who were unhappy with the proposed measures. Radiologists, for instance, do not normally record advance directives, or run drug formularies or medication allergy checks. While it is true that the criteria for Phase 1 meaningful use focus on data collected in primary care practices, and unique objectives were not developed for specialty participation, CMS provided some flexibility in response to criticism from radiologists, psychiatrists and others. Specialty physicians are permitted to exclude several measures as inapplicable to their practice; e.g., a physician who writes < 100 prescriptions will be excluded from the electronic prescription measure. Exclusion criteria also reduce the number of menu set items to be satisfied by an EP: if one measure is excluded, the EP need meet only four instead of five; if two are excluded, the EP must satisfy only three. Flexibility has been built into the quality reporting measures as well. Specialty EP stakeholders are likely to continue demanding that CMS make meaningful use more attainable for their constituencies.

**Start Soon—Get Paid More**

Physicians are eligible for incentive payments as early as January 1, 2011. For the first payment year only, physicians
may demonstrate meaningful use of certified-EHR technology over any continuous 90-day period within a calendar year. After the first year, the physician would need to demonstrate meaningful use at all times.

In 2011, providers seeking to demonstrate meaningful use will only need to submit attestation to CMS for all the meaningful use measures. In 2012, attestation will continue for most measures but providers will have to actually submit clinical quality measures electronically. The year 2014 is the last year to initiate participation in the EHR Incentive program, so early participation will maximize the ROI from meaningful use.

A good starting point for reviewing the meaningful use rules is found at: https://www.cms.gov/EHRIncentivePrograms/

STARK IN-OFFICE ANCILLARY SERVICES EXCEPTION GETTING SQUEEZED BY CONGRESS

The Medicare program clearly isn't happy with the in-office ancillary services exception (IOASE). As of 1/1/11, doctors referring their Medicare patients for imaging procedures that can be done in the physicians' offices will be required to (1) provide a list of alternate suppliers in the geographic area and (2) clearly inform patients that they can choose to obtain the services anywhere. The Patient Protection and Affordable Care Act (PPACA) allowed the disclosure requirements to be extended to other services, but CMS has not done so for 2011. The proposed rule requires a written list of at least 10 other suppliers who provide the services located within a 25 mile radius of the referring physician's office. The list must include the supplier's name, address, telephone number, and distance from referring physician's office location. A record of the disclosure notification must be signed by the patient and maintained as part of the patient's record.

PPACA's “disclosure requirement” should please radiologists, who have long campaigned against the quality and medical necessity of in-office imaging referrals. Radiologists have consistently argued that overutilization results from allowing physicians to “self-refer” for sophisticated imaging studies¹. For other physician groups who rely on in-office ancillaries as a significant revenue source, PPACA section 6003 is likely to be a major nuisance.

However, the disclosure requirement may be the least of their worries. CMS has been signaling for some time that the IOASE may have become too much of a good thing, and is now in need of restraints. The Stark law prohibits physicians from making self-referrals for designated health services (DHS) unless an exception applies. The IOASE allows physician groups to order and provide a range of in-office DHS to their own patients. CMS has observed the migration of expensive imaging equipment, pathology services, and therapy services to physicians' offices and specifically noted that many services are not provided on the same day as a patient office visit—one indicator that the DHS being provided in the office are not being used for immediate patient diagnosis and treatment.

The Medicare Payment Advisory Commission (MedPAC) strongly suggests the IOASE needs an overhaul². MedPAC is an independent congressional agency established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program. MedPAC's policy recommendations have historically been a bellwether for regulatory changes.

MedPAC notes that under Medicare's current fee-for-service payment model there is an incentive to over-utilize ancillaries when physicians can self-refer. According to MedPAC, the IOASE was intended to apply primarily to lab tests or x-rays so that sick patients and their physicians would have access to same day diagnostic information for treatment planning. MedPAC’s data analyses show that less than 50% of the DHS were performed on the same day as a patient office visit, with the percentages dropping sharply for ultrasound, advanced imaging and outpatient therapies such as physical therapy.

The report cites a 2008 study showing that acquisition of an MRI scanner led to increases in ordered MRI images of 22% (orthopedic surgeons) and 28% (neurologists). MedPAC suggests that Congress should consider changes to reduce the incentives for physicians to make self referrals that are inconsistent with the original intent of the IOASE. These recommendations include:

- Excluding therapeutic (as opposed to diagnostic) services from the IOASE. This would knock out physical, occupational and speech-language therapy from permissible in-office DHS as well as radiation therapy.
- Excluding diagnostic tests not provided during a patient office visit.

¹ On a related note, more headaches for non-radiologists who provide and bill for advanced diagnostic imaging services: their sites will have to become accredited by a designated organization by 1/1/2012 in order to continue to be reimbursed by Medicare. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the change, which applies to providers of CT, nuclear medicine, PET and MRI that bill under Part B. While it applies to radiologists as well, they are likely already accredited or can easily comply with the process.

• Reducing payment rates for diagnostic tests performed by self-referring physicians.

• Bundling and/or packaging related services under one fee. Bundling covers all services furnished during multiple encounters into one fee—analogous to what is common for global rates for surgical procedures that include some pre- and post-operative office visits. Packaging refers to making a single payment for all services on a single encounter, somewhat like the hospital outpatients prospective payment system. MedPAC points out that bundling and packaging can be combined.

• Requiring preauthorization for advanced imaging (MRI, CT, PET, and nuclear medicine).

• Developing a capitated payment model. A bundled payment covers multiple encounters in connection with one core service—this is analogous to a surgeon’s fee for a procedure that obliges him to provide certain pre- and post-operative patient visits. A packaged fee covers all services on a single encounter date—somewhat like the hospital outpatient prospective payment system. MedPAC points out that bundling and packaging are not mutually exclusive. Medicare might start with packaging single encounter services (such as office visits) and move on to bundling services associated with multiple encounters for the patient’s chronic illness. The goal of course is to encourage physicians to order ancillary services “more prudently.”

If you have any questions about these or related matters, please do not hesitate to contact H. Kennedy Hudner (860-240-6029, khudner@murthalaw.com), Elizabeth M. Neuwirth (203.772.7742, eneuwirth@murthalaw.com), Paul E. Knag (203.653.5407, pknag@murthalaw.com), Heather O. Berchem (203.772.7728, hberchem@murthalaw.com) or Christina Hage (203.772.7704, chage@murthalaw.com).