A lot of physicians have embraced electronic health records (EHR) as a way to improve the care that they provide for their patients. And a lot of them have gotten the nudge that they needed to get from point A to point B with the financial incentives that were made available as a result of the federal stimulus package – aka the Health Information Technology for Economic and Clinical Health Act, or HITECH – that was passed in 2009.

At the same time, there has been a chorus of concerns from physicians who believe that the metrics that they have to meet to qualify for the aforementioned incentives are too aggressive – keeping in mind that the carrot (i.e., the incentive) will ultimately become a stick (i.e., a penalty).

Jim Morrow, M.D., with Morrow Family Medicine in Cumming appreciates those concerns, but he’s one who sees the glass as half full when it comes to EHR.

His optimism stems from his role as an early adopter. He has used an EHR system at his practice since day one – 15 years ago. It’s safe to say that he has a passion for health information technology, which is why he serves on the Medical Association of Georgia’s (MAG) Electronic Health Care Committee (EHCC).

Dr. Morrow, who also represents MAG as the vice chairman of the Board of Directors of the Georgia Health Information Exchange (GaHIN), explains that it can take hundreds of hours to implement an EHR system. He believes that, “If you don’t put the effort into customizing and setting up your EHR, you will never be a satisfied client.”

Eligible providers have been able to offset at least some of the capital that is required to get an EHR up and running by taking advantage of the incentives that are available under Medicare and Medicaid. They have demonstrated that they are using an EHR system in a manner that is consistent with the “meaningful use” criteria that has been established by the federal government, which believes that it can help to improve health care and lower costs by encouraging providers to use EHR in a “meaningful way.”

“Meaningful use” has consequently become the term that is synonymous with the metrics that physicians and other eligible providers have to satisfy with their EHR system to qualify for the financial incentives.

These meaningful use objectives vary by “stage.” Stage 1 providers have to meet 15 core objectives and five out of the 10 objectives from a menu of options to qualify for the incentive payment. What’s more, they have to check off those boxes in full before they can advance to Stage 2 – which will go into effect in 2014.

For Stage 2, the number of core measures will grow by two, to 17, while the number of objectives that are required from the menu will drop from five to three.

Some of the new Stage 2 objectives will build on the Stage 1 objectives. For instance, one Stage 2 objective will call for laboratory and radiology work to be ordered using a computerized provider order entry (CPOE) system. This piggybacks on a Stage 1 objective that requires eligible providers to use computer assistance for medication orders.
It is also worth noting that Stage 2 will call for 10 percent of all patient scans and tests to be incorporated into a certified EHR. Eligible providers will only have to report on three core quality measures to qualify for the Medicare or Medicaid incentives through 2013, but that number will increase to nine for both Stage 1 and Stage 2 beginning in 2014. And the core quality measures must address three of the six health care policy domains that the federal government believes will improve health care quality.

Dr. Morrow doesn’t foresee any problems in meeting the Stage 2 requirements, including one that calls for physicians to be able to communicate with at least five percent of their patients on an electronic basis. “That’s not an issue,” he says. “I have a great portal, and I’m already at five percent or more.”

The Centers for Medicare & Medicaid Services (CMS) is making some exceptions in certain instances. That includes providers who don’t have access to the internet as a result of broadband infrastructure issues. There will also be a two-year exception for physicians who enter the medical profession in 2015, although these “new” physicians will have to meet the Medicare or Medicaid EHR requirements by the end of 2016 to avoid a penalty in 2017. And there is an exception for physicians who work in multiple offices.

Another leading EHR visionary in Georgia is ophthalmologist Jack M. Chapman Jr., M.D., with Gainesville Eye Associates. The former MAG president also does not believe that the Stage 2 requirements will be overly challenging, but he does think that playing catch up could prove tricky for providers who don’t yet have an EHR system in place.

Dr. Chapman, who started using EHR in 1996, says that he was able to put his system into place over an extended, six-month period as an early adopter. The MAG EHCC chair says that today’s providers will have to accelerate that timeline, which could complicate the process.

Dr. Chapman quips that he “got lucky” when he chose his EHR vendor in 1996 – the same vendor his practice, with eight satellite offices, uses today.

“We may be outside the norm when it comes to an EHR vendor, but we feel very fortunate,” he exclaims. “That’s why I encourage physicians to do their homework when it comes to selecting an EHR system or vendor…that’s the only way to ensure that they’ll get matched with a technology partner who can serve their unique needs.”

And he says that, “If a physician is too busy for that, I would suggest they hire a consultant.”

In his various leadership roles, Dr. Chapman has discovered that physicians often buy EHR systems that don’t work for them or their practice, and they end up replacing the system. “Of course,” he states, “that’s costly and frustrating.”

Dr. Morrow and Chapman are unabashed EHR champions, but they do concede that there is a divide within the physician community. Dr. Morrow says that, “The upfront work to establish the EHR, the mandates, and the costs aren’t sitting well with a lot of physicians.”

And Dr. Chapman notes that, “I’m not sure a lot of my fellow physicians are convinced that the metrics for the Medicare and Medicaid programs have strong enough ties to patient care…they believe that this has evolved into a cost-control initiative.”

With that in mind, MAG’s Board of Directors recently approved the creation of an EHCC work group to develop EHR vendor guidelines that place a greater emphasis on “clinical requirements” that MAG can use in its advocacy efforts.

The aforementioned concerns notwithstanding, the government incentives have had the desired effect from a government perspective. According to a 2012 report from the Centers for Disease Control and Prevention’s National Center for Health Statistics, the number of EHR users in the U.S. jumped from 48 percent in 2009 to 72 percent in 2012.

The prize for Medicare physicians has been a chance to earn $44,000 in incentives over a five-year period, though that total will come down a bit as a result of this year’s “sequester.” Medicaid physicians, meanwhile, have been lured to the EHR table with incentives of up to $63,750 over six years.

CMS reports that nearly 5,700 eligible professionals in Georgia – which includes physicians, dentists, and others – have “successfully achieved the meaningful use incentives for Medicare or Medicaid or have received incentives for adopting, implementing, or upgrading their Medicaid EHR.”

And CMS Atlanta Regional HITECH Specialist Sherri Jones reports that those professionals had received $104 million in incentives as of February 2013. She also says that nearly 45 percent of all eligible professionals in the U.S. have received incentives.

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an incentive payment – adding that more than 126,000 M.D.s and D.O.s have received $2.32 billion for meeting the Medicare or Medicaid EHR meaningful use requirements to date.

Richard E. Wild, M.D., chief medical officer for the CMS Atlanta Regional Office, stresses that it’s not too late for physicians to enroll in the EHR Incentive Program to qualify for the EHR incentive payments that are available.

He says that, “Physicians and other eligible providers can enroll in the program for the first time in 2013, and they can participate in the program under the Stage 1 requirements for two years – followed by two years under Stage 2.” They would, therefore, be eligible to receive up to $39,000 during the four-year, 2013-2016 period.

In turn, Dr. Wild is also advising his fellow physicians that, “Beginning in 2015, physicians who are eligible to participate in the Medicare EHR Incentives Program and who have not achieved meaningful use will be subject to negative Medicare payment adjustments.” That includes a one percent decrease in 2015, followed by a two percent decrease in 2016, and a three percent decrease in 2017 and beyond – though Dr. Wild points out that, “This reduction would not apply to physicians who achieve meaningful use in the Medicaid program.”

Dr. Wild also says that, “The latest date that new participants have to demonstrate meaningful use in order to avoid the 2015 payment adjustment is to begin their first 90-day reporting period no later than July 1, 2014, and to successfully attest to meaningful use no later than October 1, 2014.”

Finally, Dr. Wild emphasizes that, “Those physicians who have successfully demonstrated meaningful use in 2011 and 2012 must also demonstrate meaningful use in 2013, and they must continue to demonstrate meaningful use each year thereafter, to avoid payment reductions beginning in 2015.”

Christine Jordan Sexton is a freelance writer.

Editor’s Note: A health information technology committee that is working under the direction of the U.S. Department of Health and Human Services has drafted preliminary recommendations for the Stage 3 objectives. These preliminary recommendations would reportedly retire some measures, increase the threshold for some measures, and add some new measures. The earliest that Stage 3 would go into effect is 2016.

Stage 1 & 2: Some key points

CMS published a final rule in 2012 that specifies the Stage 2 criteria that eligible professionals, eligible hospitals, and critical access hospitals must meet beginning in 2014 to continue to participate in the Medicare and Medicaid EHR Incentive Programs.

All providers must achieve “meaningful use” under the Stage 1 criteria before they can move to Stage 2.

Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives will continue to be core objectives under Stage 2.

The threshold that providers must meet has been raised for a number of Stage 2 objectives.

Under Stage 2, eligible providers must meet 17 core objectives and three of six menu objectives.

Stage 2 core objectives include...

- Using secure electronic messaging to communicate with patients on relevant health information
- Giving patients the ability to view, download and transmit their health information online within four business days of the information being available to the eligible provider

Stage 2 menu objectives include...

- Recording electronic notes in patient records
- Imaging results that are accessible through “meaningful use” certified EHR technology (CEHRT)
- Recording patient family health history
- Identifying and reporting cancer cases to the state cancer registry
- Identifying and reporting specific cases to a specialized registry (other than a cancer registry)

CMS EHR/Stage 2 resources

Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs: Stage 2 Toolkit  http://go.cms.gov/1a1XPOF

EHR Incentives Programs website
Information about eligibility, registration and attestation, and incentives  www.cms.gov/EHRIncentivePrograms

Questions for CMS?
Questions related to Medicare or Medicaid EHR Incentives Programs Email PartABinquiriesRO4@cms.hhs.gov