INCENTIVE PAYMENTS FOR ELECTRONIC HEALTH RECORDS [EHR]
COMMITTEE REPORT SUMMARY FOR AIHC MEMBERS

This summary is provided by Joanne Byron, Board Chair of AIHC

SEC. 4101. INCENTIVES FOR ELIGIBLE PROFESSIONALS.

INCENTIVE PAYMENTS.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

If the eligible professional is a meaningful EHR user for the EHR reporting period with respect to such year, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)), from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an **amount equal to 75 percent** of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) **of the allowed charges** under this part for all such covered professional services furnished by the eligible professional during such year.

NO INCENTIVE PAYMENTS WITH RESPECT TO YEARS AFTER 2016.

No incentive payments may be made under this subsection with respect to a year after 2016.

LIMITATIONS ON AMOUNTS OF INCENTIVE PAYMENTS

In no case shall the amount of the incentive payment provided under this paragraph for an eligible professional for a payment year exceed the applicable amount specified under this subparagraph with respect to such eligible professional and such year.

Subject to clauses (iii) through (v), the applicable amount specified in this subparagraph for an eligible professional is as follows:

First payment year: $15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, $18,000).

Second payment year: $12,000

Third payment year: $8,000

Fourth payment year: $4,000

Fifth payment year: $2,000

For any succeeding payment year for such professional, $0.

PHASE DOWN FOR ELIGIBLE PROFESSIONALS FIRST ADOPTING EHR AFTER 2013.
If the first payment year for an eligible professional is after 2013, then the amount specified in this subparagraph for a payment year for such professional is the same as the amount specified in clause (ii) for such payment year for an eligible professional whose first payment year is 2013.

INCREASE FOR CERTAIN ELIGIBLE PROFESSIONALS.
In the case of an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area, the amount that would otherwise apply for a payment year for such professional under subclauses (I) through (V) of clause (ii) shall be increased by 10 percent. In implementing the preceding sentence, the Secretary may, as determined appropriate, apply provisions of subsections (m) and (u) of section 1833 in a similar manner as such provisions apply under such subsection.

NO INCENTIVE PAYMENT IF FIRST ADOPTING AFTER 2014.
If the first payment year for an eligible professional is after 2014 then the applicable amount specified in this subparagraph for such professional for such year and any subsequent year shall be $0.

NON-APPLICATION TO HOSPITAL-BASED ELIGIBLE PROFESSIONALS.

No incentive payment may be made under this paragraph in the case of a hospital based eligible professional.

ELIGIBLE PROFESSIONAL.

Defining "Eligible Professional" is found in Section 1861(r) of the Social Security Act:

"Physician"

(r) The term "physician", when used in connection with the performance of any function or action, means

(1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)),

(2) A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,

(3) A doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them,

(4) A doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or

(5) A chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Page 736 of the Committee Report states: CMS is administering a number of additional programs to promote EHR adoption. The MMA mandated a three-year pay-for-performance demonstration in four states (AR, CA, MA, UT) to encourage physicians to adopt and use EHR to improve care for chronically ill Medicare patients. Physicians participating in the Medicare Care Management Performance (MCMP) demonstration receive bonus payments for reporting clinical quality data and meeting clinical performance standards for treating patients with certain chronic conditions. They are eligible for an additional incentive payment for using a certified EHR and reporting the clinical performance data electronically.

CMS has developed a second demonstration to promote HER adoption using its Medicare waiver authority. The five-year Medicare EHR demonstration is intended to build on the foundation created by the MCMP program. It will provide financial incentives to as many as 1,200 small- to medium-sized physician practices in 12 communities across the country for using certified EHRs to improve quality, as measured by their performance on specific clinical quality measures. Additional bonus payments will be made based on the number of EHR functionalities a physician group has incorporated into its practice.

The Tax Relief and Health Care Act of 2006 (P.L. 109–432) established a voluntary physician quality reporting system, including an incentive payment for Medicare providers who report data on quality measures. The Medicare Physician Quality Reporting Initiative (PQRI) was expanded by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110–173) and by MIPPA, which authorized the program indefinitely and increased the incentive that eligible physicians can receive for satisfactorily reporting quality measures. In 2009, eligible physicians may earn a bonus payment equivalent to 2.0% of their total allowed charges for covered Medicare physician fee schedule services. The PQRI quality measures include a structural measure that conveys whether a physician has and uses an EHR.

The House bill would add an incentive payment to certain eligible professionals for the adoption and ‘‘meaningful use,’’ defined below, of a certified EHR system. Professionals eligible for the incentive payments are those who participate in Medicare and who are defined under Sec. 1861(r) of the Social Security Act. Incentive payments. The amount of EHR incentive payments that eligible providers could receive would be capped, based on the amount of Medicare-covered professional services furnished during the year in question, and the total possible amount of the incentive payment would decrease over time. The bill permits a rolling implementation period, with cohorts starting in 2011, 2012, and 2013, respectively, being eligible for the entire five years of incentives.

For example, incentives that start in 2011 would continue through 2015, while those that begin in 2012 would run through 2016 and those starting in 2013 would run through 2017.

For the first calendar year of the designated period described above, the limit would be $15,000. Over the next four calendar years, the total possible amount would decrease respectively by year to $12,000, $8,000, $4,000, and $2,000. The phase-down is different

for eligible professionals first adopting EHR after 2013. For these eligible providers, the limit on the amount of the incentive payment would equal the limit in the first payment year for someone whose first payment year is 2013. For example, if the first payment year is after 2014 then the limit on the incentive payments for that year would be $12,000 rather than $15,000. The EHR incentive payments for professionals would not be available to a hospital-based eligible physician, such as a pathologist, anesthesiologist or emergency physician who furnishes substantially all such services in a hospital setting using the hospital's facilities and equipment, including computer equipment. However, health IT incentive payments are made available to hospitals in Sec. 4312.

The payments could be in the form of a single consolidated payment or in periodic installments, as determined by the Secretary. The Secretary would establish rules to coordinate the limits on the incentive payments for eligible professionals who provide covered professional services in more than one practice. The Secretary would seek to avoid duplicative requirements from federal and state governments to demonstrate meaningful use of certified EHR technology under the Medicare and Medicaid programs. The Secretary would be allowed to adjust the reporting periods in order to carry out this clause.

Meaningful use.

For purposes of the EHR incentive payment, an eligible professional would be treated as a ''meaningful user'' of EHR technology if the eligible professional meets the following three criteria:

(1) the eligible professional demonstrates to the satisfaction of the Secretary that during the period the professional is using a certified EHR technology in a meaningful manner, which would include the use of electronic prescribing as determined to be appropriate by the Secretary;

(2) the eligible professional demonstrates to the satisfaction of the Secretary that during such period such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination; and

(3) the eligible professional submits information on clinical quality measures.

The Secretary could provide for the use of alternative means for meeting the above requirements in the case of an eligible professional furnishing covered professional services in a group practice (as defined by the Secretary). The Secretary would seek to improve the use of electronic health records and health care quality by requiring more stringent measures of meaningful use over time.

Clinical quality measures.

The Secretary would select the clinical quality measures and other measures but must be consistent with the following:

(1) the Secretary would provide preference to clinical quality measures that have been endorsed by the consensus-based entity regarding performance measurement with which the Secretary has a contract under Sec. 1890(a) of the Social Security Act; and

(2) prior to any measure being selected for the purposes of this provision, the Secretary would publish the measure in the Federal Register and provide for a period of public comment.

The Secretary could not require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis. In selecting the measures and in establishing the form and manner for reporting these measures, the Secretary would seek to avoid redundant or duplicative reporting otherwise required, including reporting under the physician quality reporting initiative.

A professional could satisfy the demonstration requirement above through means specified by the Secretary, which may include the following:

(1) an attestation;

(2) the submission of claims with appropriate coding (such as a code indicating that a patient encounter was documented using certified EHR technology);

(3) a survey response;

(4) reporting the clinical quality and other measures mentioned above; and

(5) other means specified by the Secretary.
Notwithstanding other provisions of law that place restrictions on the use of Part D data, the Secretary could use data regarding drug claims submitted for purposes of determining payment under Part D for purposes of determining the EHR incentive payments under this legislation.

Payment adjustments.

Fee schedule payments to eligible professionals would be adjusted under certain conditions. For covered professional services furnished by an eligible professional during 2016 or any subsequent payment year, if the professional is not a meaningful EHR user during the previous year's reporting period, the fee schedule amount would be reduced to 99% in 2016, 98% in 2017, and 97% in 2018 and in each subsequent year.

For 2019 and each subsequent year, if the Secretary finds that the proportion of eligible professionals who are meaningful HER users is less than 75%, the applicable fee

schedule amount would be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case would the applicable percent be less than 95%.

Hardship exemption.

The Secretary could, on a case-by-case basis, exempt an eligible professional from the application of the payment adjustment above if the Secretary determines, subject to annual renewal, that being a meaningful EHR user would result in a significant hardship, such as in the case of an eligible professional who practices in a rural area without sufficient Internet access. In no case would an eligible professional be granted such an exemption for more than five years.

Medicare Advantage.

In general, Medicare incentives created under this section are not available to Medicare Advantage (MA) plans, and both the payments and penalties made under this section are exempt from the MA benchmark determinations. However, the legislation establishes conditions under which the EHR bonus payments and penalties for the adoption and meaningful use of certified EHR technology would apply to certain HMO-affiliated eligible professionals. In general, with respect to eligible professionals in a qualifying MA organization for whom the organization attests to the Secretary as meaningful users of EHR, the incentive payments and adjustments would apply in a similar manner as they apply to other eligible professionals.

Incentive payments would be made to, and payment adjustments would apply to, the qualifying organizations. With respect to a qualifying MA organization, an eligible professional would be an eligible professional who (i) is employed by the organization or is employed by or is a partner of an entity that through contract furnishes at least 80% of the entity's patient care services to enrollees of the organization; and furnishes at least 80% of the professional services of the eligible professional to enrollees of the organization; and (ii) furnishes, on average, at least 20 hours per week of patient care services. For these MA-affiliated eligible professionals, the Secretary would determine the incentive payments which should be similar to the payments that would have been available to the professionals under FFS.

To avoid duplication of payments, if an eligible professional is both an MA-affiliated professional and eligible for the maximum payment under the fee-for-service program (FFS), the payment incentive would be made only under FFS. Otherwise, the incentive payment would be made to the plan. The Secretary would develop a process to ensurethat duplicate payments are not made. A qualifying MA organization would specify a year (not earlier than 2011) that would be treated as the first payment year for all eligible professionals with respect to the MA organization. In applying the applicable percentage payment adjustment to MA-affiliated eligible professionals, instead of the payment adjustment being an applicable percent of the fee schedule amount for a year, the payment adjustment to the payment to the MA organization would be a proportional

amount based on the payment adjustment applicable to FFS providers and the fraction of the organization's eligible professionals who are not meaningfully using EHRs.

SENATE BILL

The Senate bill is mostly the same as the House bill, but with the following exceptions.

The Senate bill does not provide for any incentive payments to eligible professionals who first adopt EHR in 2014 or in subsequent years but does provide a greater incentive for early adoption of EHR, with payments of $18,000 if the first payment year under the EHR incentive program is 2011 or 2012. Certain rural eligible providers would receive larger incentive payments in the Senate bill. The incentive payment would be increased by 25% if the provider predominantly serves beneficiaries in a rural area designated as a health professional shortage area.

Under the Senate bill, the Secretary would also be given the authority to deem providers who satisfy state requirements for demonstrating meaningful use of EHR technology as meeting the criteria for meaningful use under the Medicare EHR incentive program. No similar authority or provision is included in the House bill.

The incentive adjustment (penalty) would begin a year earlier in 2015 under the Senate bill as opposed to 2016 in the House bill. The schedule of reductions over time in the applicable percentage also reflects this difference, so that the applicable percent under the Senate bill would be 99% in 2015, 98% in 2016, and 97% in 2017.

With respect to the application of the incentive payment program to managed care organizations, the Senate bill differs from the House bill in two areas. First, the Senate bill applies a slightly different requirement to determine an eligible professional. Under the Senate bill, a professional who furnishes at least 75% (vs. 80% in the House bill) of his or her professional services to enrollees of the managed care organization and who also met the additional criteria noted above would be eligible for this incentive program. Second, the Senate bill includes a cap on large managed care organizations that limits incentive payments to no more than 5,000 eligible professionals of the organization in recognition of economies of scale in such organizations. This difference is also reflected in the payment adjustment penalty calculation in the Senate bill. The Senate bill would require that the names, business addresses, and business phone numbers of each qualifying managed care organization and the associated eligible professionals receiving EHR incentive payments be posted on the CMS website in an easily understandable format.

Finally, the Senate bill would require the HHS Secretary to provide assistance to eligible professionals, Medicaid providers, and eligible hospitals located in rural or other medically underserved areas to successfully choose, implement, and use certified EHR technology. To the extent practicable, the assistance would be through entities that have expertise in this area.

CONFERENCE AGREEMENT

With regard to eligible professionals, the conference agreement includes provisions from the House and Senate bills. The conference agreement provides eligible professionals who show meaningful use of an EHR in 2011 or 2012 with incentive payments of $18,000 in the first year; provides no payment incentives after 2016; and does not provide incentive payments to eligible professionals who first adopt an EHR in 2015 or subsequent years.

Incentive payments would be increased by 10% if the provider predominately serves beneficiaries in any area designated as a health professional shortage area. The conference agreement mirrors the Senate bill in that payment adjustments for eligible professionals not demonstrating meaningful use of an EHR would begin in 2015.

The conference agreement, like the House and Senate-passed bills, prohibits payments to hospital-based professionals (because such professionals are generally expected to use the EHR system of that hospital). This policy does not disqualify otherwise eligible professionals merely on the basis of some association or business relationship with a hospital. Common examples of such arrangements include professionals who are employed by a hospital to work in an ambulatory care clinic or billing arrangements in which physicians submit claims to Medicare together with hospitals or other entities. The change in the conference agreement clarifies that this test will be based on the setting in which a provider furnishes services rather than any billing or employment arrangement between a provider and hospital or other provider entity. For MA organizations, the conference agreement reflects the Senate bill with the following exceptions. The agreement requires MA-affiliated professionals to provide 80 percent of their Medicare services to the enrollees of the qualifying MA organization and removes the payment incentive cap on eligible professionals affiliated with health maintenance organizations. It also extends the language of limitations on review for eligible professionals to professionals eligible under the managed care section and makes several technical corrections.

In addition, the conference report requires the Secretary to report to Congress on methods of making payment incentives and adjustments with respect to eligible professionals who (1) contract with one or more MA organizations or with intermediary organizations that contracts with one or more MA organizations and (2) are not eligible for incentive payments under this legislation.

The report is due to Congress within 120 days of enactment and shall include recommendations for legislation as appropriate. The agreement reflects the Congress's intent to provide payment incentives and adjustments towards the meaningful use of certified EHRs with respect to all physicians who treat Medicare patients without regard to practice organization.