EHR Incentive Program: What You Need to Know About Participating in 2015

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Program was authorized under federal law to provide incentive payments to hospitals and physicians who demonstrate meaningful use of certified EHR technology (CEHRT). However, **2014 was the last year to begin qualifying for a Medicare incentive payment under this program.** Starting with the 2015 payment year, eligible professionals (EPs) who have not yet satisfied meaningful use requirements will be subject to an **annual Medicare payment penalty**, which starts at -1.0%, but can climb to as high as -5.0% in later years.

It is important to note that simply replacing or installing a new EHR will not be enough to meet program requirements. As described below, an EP must demonstrate that he/she is using a **federally certified** EHR to meaningfully meet specific objectives and report on specific clinical quality measures (CQMs) that are intended to improve patient care.

As of early 2015, CMS estimated that more than 438,000 health care providers have received a total of $28 billion in Medicare and Medicaid incentive payments under this program. However, CMS also estimated that about 256,000 EPs will be subject to penalties in 2015. About 34% of those EPs will see Medicare payment adjustments between $1 and $250, while another 31% will see adjustments of $2,000 or more.

While the meaningful use penalties might seem relatively small when viewed alone, they are just one of multiple value-based reporting mandates facing physicians at this time. As a result of these and other penalty-driven programs — including the separate Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VM) — 10% or more of a physician’s Medicare payments could be at risk by 2018.¹

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¹ With the passage of H.R. 2, the **Medicare Access and CHIP Reauthorization Act of 2015**, Medicare’s quality programs will transition to a new system called the Merit-based Incentive Payment System (MIPS). The legislation sunsets penalties currently associated with the PQRS, EHR and VM programs at the end of 2018, and combines elements of these programs under a single MIPS, which will provide performance-based payments to EPs beginning in 2019. Unlike the current penalty-only structure of existing programs, EPs will be eligible for both bonuses and penalties under MIPS, which are targeted only towards outliers and are capped at -9% in later years. MIPS also recognizes a broader range of alternative quality improvement activities in which an EP may be engaged. AAHPM will provide additional details about this new program as they become available.
Medicare vs. Medicaid EHR Incentive Program: Which to Choose?

Although most hospitals are eligible to receive an incentive payment from both the Medicare and Medicaid EHR programs, EPs must choose one or the other. Major differences between the two programs are highlighted below:

<table>
<thead>
<tr>
<th>Medicare EHR Incentive Program</th>
<th>Medicaid EHR Incentive Program</th>
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<tbody>
<tr>
<td>Run by CMS</td>
<td>Run by Your State Medicaid Agency</td>
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<tr>
<td>Maximum incentive amount is $44,000</td>
<td>Maximum incentive amount is $63,750</td>
</tr>
<tr>
<td>Payments over 5 consecutive years</td>
<td>Payments over 6 years, does not have to be consecutive</td>
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<tr>
<td>Penalties will begin in 2015 for providers who are eligible, but decide not to participate</td>
<td>No Medicaid penalties*</td>
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<tr>
<td>Providers must demonstrate meaningful use every year to receive incentive payments.</td>
<td>In the first year, providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology. Providers must demonstrate meaningful use in the remaining years to receive incentive payments.</td>
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*EPs who are eligible only for the Medicaid program will not be subject to payment adjustments. However, those who serve both Medicare and Medicaid patients will be subject to payment adjustments if they fail to meet meaningful use requirements.

The information provided on this page focuses on the requirements for EPs participating in the Medicare EHR Incentive Program. Click here for more information about the Medicaid EHR Incentive Program.

Medicare Incentive Payment Timeline

As noted earlier, 2014 was the last year to begin qualifying for an incentive under the Medicare EHR Incentive Program. EPs who began the program in 2011 are eligible for a maximum incentive payment of $44,000 over the course of five sequential years, while those who only first started in 2014 are eligible for a maximum of $24,000 over 3 years.

Each EP is only eligible for one incentive payment per year, regardless of how many practices or locations he or she provides services at. Additional incentives are also available for EPs practicing in predominantly Health Professionals Shortage Areas.
How to Avoid a Penalty

Penalties associated with the EHR Incentive Program begin in calendar year 2015. In general, meaningful use penalties are applied two years after the reporting year. However, current regulations include special reporting periods and deadlines for EPs who are demonstrating meaningful use for the first time in the year immediately preceding a penalty year. These newly participating providers must report for 90 days in the first three quarters of the preceding year, which means they must begin reporting no later than July 1 to meet the October 1 attestation deadline. EPs who have participated in the program in the past must attest for the full calendar year.

Under this structure, EPs who did not satisfy meaningful use in 2013 (or before October 1, 2014 for EPs new to the program) were subject to penalties beginning on January 1, 2015. The penalty is -1.0% of an EP’s Medicare Part B fee-for-service payments in 2015 and increases by -1.0% every year up to a maximum of -5.0% in 2019, as illustrated below.

<table>
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<tr>
<th>% ADJUSTMENT ASSUMING LESS THAN 75% OF EPs ARE MEANINGFUL USERS</th>
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<tbody>
<tr>
<td>Payment Year</td>
</tr>
<tr>
<td>---------------</td>
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<tr>
<td>% Adjustment</td>
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</tbody>
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*Note: if more than 75% of EPs are meaningful users by 2018, the penalty will be capped at -3.0% in 2018 and beyond.

In mid April, CMS released a proposed rule that would make changes to the program’s reporting requirements and timeline for 2015 through 2017. CMS proposes to allow new participants, as well as returning participants, to report for any continuous 90-day period in 2015 to avoid the 2017 penalty (rather than the current requirements of reporting for the full calendar year or reporting for the first three quarters). Reporting for 90-days in 2015 would also allow new participants to avoid the 2016 penalty. The deadline for attestation for both new and existing participants would be February 29, 2016. These rule changes will likely not be finalized until this summer, but AAHPM will continue to post new information on its website as it becomes available.

Payment adjustments are applied to the Medicare physician fee schedule (PFS) amount for covered professional services furnished by the EP during the year. The adjustment amounts are tied to the year that an EP did not demonstrate meaningful use (e.g., if an EP does not demonstrate meaningful use in 2018, he/she will receive a 4.0% penalty regardless if this is his/her first or fourth year not demonstrating meaningful use). EPs must continue to demonstrate meaningful use every year to avoid penalties in subsequent years.

Also note that payment adjustments associated with this program are made at the individual level and not the group practice level. Furthermore, payment adjustments apply to all EPs who treat Medicare patients and do not meet the program requirements, regardless of their Medicare payment “participation” status. Click here for a CMS article detailing how federal quality reporting program penalties will be applied for “non-participating” (Non-Par) Medicare providers.

Hardship Exceptions

CMS may grant a temporary “significant hardship exception” from penalties to an EP on an annual basis for up to 5 years maximum. The following exceptions, which require manual
applications, have an application submission deadline of July 1 of the year before the penalty year.

- **Lacking broadband/infrastructure**: The physician was located in an area without sufficient Internet access to comply for any 90-day period of time from the beginning of the year that is 2 years prior to the penalty year to July 1 of the year before the penalty year.

- **Extreme and uncontrollable circumstances**: a) A previous meaningful use participant faced extreme and uncontrollable circumstances in the year that was 2 years before the penalty year; or b) A physician who has never participated in meaningful use faced extreme and uncontrollable circumstances in the year before the penalty year.

- **Inability to influence availability of CEHRT**: The physician practiced at multiple locations, and lacked control over the availability of CEHRT at one or more locations where he/she had more than 50% of his/her patient encounters.

- **Lack of face-to-face/telemedicine interaction with patients AND lack of need for follow-up**: The physician can demonstrate difficulty in meeting meaningful use on the basis of lack of face-to-face or telemedicine interaction with patients and lack of need for follow up with patients.

EPs who were unable to meet meaningful use in 2014 due to a hardship may still apply for a hardship exception to avoid the 2016 penalty. The hardship exception application will be made available [here](#) in early 2015 and will be due to CMS by July 1, 2015.

**Not All Providers Need to Apply for Hardship Exceptions** Some providers will automatically be granted a hardship exception and do not need to submit a hardship application. CMS will use Medicare data on these providers to determine their hardship exception. These include:

- **Newly Practicing**: EPs who have been practicing for less than 2 years.

- **Hospital-based EPs**: a provider is considered hospital-based if he or she provides more than 90% of their covered professional services in either an inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. These EPs must register in the [CMS Registration & Attestation System](#) to determine hospital-based status).

- **Primary specialty listing in PECOS**: The physician has a primary specialty listed in PECOS as radiology, anesthesiology, or pathology 6 months prior to the penalty year. For radiology, the primary specialty listing would need to be “diagnostic radiology” (30), “nuclear medicine” (36), or “interventional radiology” (94).

**What Are the Program Requirements?**

Once an EP starts the Medicare EHR Incentive Program, he/she is required to continue to meet higher stages of meaningful use over time, each of which have their own set of requirements:

<table>
<thead>
<tr>
<th>Stage of Meaningful Use</th>
<th>Focus of Requirements</th>
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<tr>
<td>Stage 1</td>
<td>Data capture/sharing, using EHR to track key conditions</td>
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*Prepared by Hart Health Strategies, 4/16/15, [www.hhs.com](http://www.hhs.com)*
Stage 2
Advanced clinical processes, more rigorous information exchange, increased requirements for e-Rx and incorporating lab results, more patient engagement

Stage 3
Improved outcomes, use of decision support tools, patient access to self-management tools, improving population health

Under the current program, each stage requires that EPs report on a set of core (i.e., required) objectives; a set of optional menu objectives; and a set of clinical quality measures (CQMs). Each objective includes specific quality measures to which an EP must attest. Some of these measures require the reporting of a numerator and denominator and include a minimum performance percentage that EPs must meet to satisfy the measure, while others only require that the EP attest to taking a certain action or enabling a specific EHR functionality over the reporting period. CQMs, on the other hand, do not require that an EP achieve a threshold, but do require that the EP report numerator, denominator and performance rate data calculated by the EHR to CMS.

However, in April, CMS proposed to overturn the existing structure of this program by merging Stage 1 and 2 requirements and ultimately aiming to move everyone to a single set of Stage 3 requirements by 2018. As such, starting in 2015, all EPs would be required to attest to a single set of objectives and measures that represent a modified version of objectives previously finalized for Stage 2. As part of this process, CMS would remove redundant, duplicative, and topped-out measures previously finalized for Stage 1; make modifications to other measures, such as minimizing EP accountability for measures that require patient actions (e.g., Patient Action to View, Download, or Transmit Health Information to a Third Party); and eliminate the core versus menu structure so that all retained objectives would be required.

To accommodate EPs already scheduled to demonstrate Stage 1 in 2015, CMS proposes OPTIONAL ALTERNATIVE MEASURES that align more closely with Stage 1, as well as EXCLUSIONS, which may provide additional flexibility to certain specialists who do not perform the actions specified in the objective as a normal scope of practice.

CMS does not propose changes to the CQM reporting requirement. Therefore, EPs would still be required to report on at least 9 CQMs that cross 3 National Quality Strategy domains, in addition to the newly proposed objectives/measures.

More information about this newly proposed structure and the objectives and measures to which EPs would have to attest in 2015 is available here.

For more information about CQM reporting options and a link to CMS' CQM library, click here.

How to Get Started

1. Determine your eligibility

Professionals eligible for the Medicare EHR Incentive Program include:
- Doctor of medicine or osteopathy
- Doctor of podiatry
- Doctor of dental surgery or dental medicine
- Doctor of optometry
- Chiropractor

*Note: the Medicaid EHR Incentive Program defines EPs differently and includes certain nurses and PAs.

As noted above, hospital-based EPs are not eligible for the program.

2. Register

The EHR Incentive Program Registration site, as well as useful Registration User Guides, can be accessed here. EPs may register before having installed a certified EHR. Registering does not mean that you have to participate in the program. You can cancel your registration at any time.

3. Adopt Certified Electronic Health Record Technology

To be considered a meaningful user and avoid penalties, an EP must use federally CEHRT. In 2015, both EPs seeking to meet Stage 1 requirements and EPs moving to Stage 2 of the program must use a 2014 certified product. The most up-to-date list of Certified EHR Technology products can be found on the Office of National Coordinator for Health Information Technology’s Certified Health IT Product List (CHPL). To view the complete list of EHR products certified for the 2014 Edition EHR Certification Criteria, you must first select the 2014 edition, choose the option to browse all products, and then limit the results by ambulatory vendors and complete products only.

Please note that EHRs certified or qualified for other Medicare incentive programs may not be certified for this program. Also, if you already own an EHR, it may not be certified for use in the EHR Incentive Programs.

4. Attest to Demonstrating Meaningful Use

EPs must attest to meaningful use through the EHR Incentive Program Registration and Attestation website, which is accessible here. The website also includes links to Attestation User Guides that walk EPs through the attestation process.

As soon as you submit your attestation, you will find out immediately whether or not you have successfully achieved the core and menu objectives of the program.

If you are not successful, you can edit any information that was entered incorrectly and resubmit your attestation. Or you can resubmit for a different 90-day reporting period with new information.

As noted above, CMS recently proposed a new attestation deadline of February 29, 2016 for both new and existing participants in 2015.

Note that CMS has the authority to audit meaningful use attestations. CMS details the audit process, what to expect, and what documentation will be needed to pass an audit in this FAQ. One of the leading causes for failing a meaningful use audit is insufficient documentation of a security risk assessment. Even if you have received a bonus payment and have moved ahead in the meaningful use program, you are strongly encouraged to
retain all supporting documentation in case of a future audit.

**Additional Information**

Click [here](#) for additional information about the EHR Incentive Program, including attestation worksheets and other decision tools to help you determine which program and start date is most appropriate for you. This site also will continue to be updated as CMS finalizes changes to the program for 2015 through 2017.