



Answers to frequently asked questions

August 2010

General

1. What is the American Recovery and Reinvestment Act (ARRA)?

ARRA is the legislation that became law last year that established Medicare and Medicaid incentive programs for health care professionals to adopt and use health information technology. The [final regulation](#) was released on July 13, 2010 and defines how the incentive program works.

2. What type of timeline would a typical small practice use to progress through the EHR adoption stages?

There is no standard or typical timeframe. It depends on the structure of the practice and the commitment of the individuals in the practice. A rule of thumb to consider is six months for preparation and selection, and then six months for implementation and to get up to full speed on the EHR. Small practices are usually more nimble and could require less time and larger practices are typically not as nimble and would require more time.

Eligibility/incentive process

3. Who is eligible for the stimulus health information technology (Health IT) incentives?

Medicare and Medicaid professionals, including physicians, are eligible for the health IT incentives. See the American Recovery and Reinvestment Act (ARRA) summary for eligibility details (www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicaid-incentive-summary.pdf).

4. What is the registration process?

CMS plans to open registration in January 2011. According to CMS they will manage a virtual location for registration of both the Medicare and Medicaid incentive programs. At present, the formal registration process has not been finalized.

5. What is a Medicare/Medicaid eligible professional?

For the purposes of the Medicare incentive program, the term eligible professional means a physician as defined in 1861(r) of the Social Security Act below.

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 s/he performs such function or action...

The following are also named as eligible professionals:

- Doctor of dental surgery or medicine
- Doctor of podiatric medicine
- Doctor of optometry
- Chiropractor



Under the Medicaid program (42 USCS § 1396b), the term, eligible professional means a:

- (i) physician;
- (ii) dentist;
- (iii) certified nurse mid-wife;
- (iv) nurse practitioner; and
- (v) physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician assistant or is practicing in a Federally qualified health center that is so led.

6. Do all of the existing Medicare PPO plans count as Medicare or not?

You must be enrolled in Medicare Fee For Service or Medicare Advantage (MA). For the MA incentive program, incentive payments will be made directly to the qualifying MA organizations that function as an HMO for the adoption and meaningful use of EHR technology by their affiliated EPs. For the MA incentive program, incentive payments would be made directly to the qualifying MA organizations that function as an HMO for the adoption and meaningful use of EHR technology by their affiliated EPs.

7. Do the professionals have to service both the Medicare and Medicaid markets?

No. See eligibility requirements in the EHR incentive programs summaries (www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicare-incentive-summary.pdf and www.ama-assn.org/ama1/pub/upload/mm/472/ehr-medicaid-incentive-summary.pdf). In addition, eligible professionals cannot take advantage of incentives under both Medicare and Medicaid incentive programs.

8. What percent of your practice has to be Medicare in order to qualify for incentives?

Physicians (non-hospital based) are eligible for Medicare incentive payments based on an amount equal to 75 percent of the allowed Medicare Part B charges, up to a maximum of \$18,000 for early adopters whose first payment year is 2011 or 2012.

Under the Medicaid incentive program, eligible pediatricians (non-hospital based), with at least 20 percent Medicaid patient volume, could receive up to \$42,500, and other physicians (non-hospital based), with at least 30 percent Medicaid patient volume, could receive up to \$63,750, over a six-year period.

Eligible professionals (EPs) who furnish more than 50 percent of covered services in a geographic Health Professional Shortage Area (HPSA) are eligible for an additional 10 percent incentive on top of the maximum incentive payment amount.

9. How do I notify Medicare or Medicaid that I'm applying for this reimbursement?

Once you submit your attestation for the first payment year with the required information, payments under Medicare will be disbursed through a single payment contractor. to the Tax Identification Number provided by the qualifying eligible professional (EP). The States will administer the Medicaid incentive payments. So we should receive more information from the States on the payment process under the Medicaid program.

10. The stimulus incentive is capped at 75 percent of allowable charges under Medicare. Is this figure strictly that which is paid to the professional or that which is billed to Medicare?

The 75 percent cap pertains to allowable charges. The estimated allowed charges for the qualifying eligible professional (EP's) covered professional services during the payment year are determined based on claims submitted no later than two months after the end of the payment year, and in the case of a



qualifying EP who furnishes covered professional services in more than one practice, are determined based on claims submitted for the EP's covered professional services across all such practices.

11. Is the 75 percent of Medicare allowable charges for all Medicare allowable services or a specific range of CPT codes?

All allowed charges--not those within a specified range of CPT codes--count toward the EHR incentive program. See Question 7 and read the AMA's [Medicare](#) and [Medicaid](#) summaries of the rule for a table of the potential incentive payments throughout the program.

12. What is the maximum funding allowed per group?

Under the Medicare incentive program, each eligible professional—no matter what size the practice—could qualify for up to \$44,000 in Medicare incentives over a five-year period, 2011-2016.

Under the Medicaid incentive program, eligible pediatricians (non-hospital based) could receive up to \$42,500, and other physicians (non-hospital based) could receive up to \$63,750, over a six-year period. See Question 14 for more information on eligibility criteria.

13. Is someone who sees Medicare patients but is officially a Medicare "non-participant" still able to get incentive payments through Medicare?

You do not have to be "participating" with Medicare to get incentives. As long as you submit claims to Medicare for treating Medicare patients and meet the other eligibility requirements you qualify for incentives.

14. How do the penalties work?

Physicians who do not adopt/use an EHR system before 2015 will face a reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. The Secretary of HHS has the authority to make exceptions to this reduction on a case-by-case basis for physicians who demonstrate significant hardship (e.g., a physician who practices in rural areas without sufficient Internet access). See the AMA's [Medicare](#) and [Medicaid](#) summaries of the rule for details.

15. It is my understanding that only physicians will be eligible for the incentives. We are a behavioral health practice with licensed clinical social worker professionals. They will have to participate in the EMR but yet not qualify for the incentive. Is this correct?

There is no requirement that social workers use EMRs nor are they among the professionals eligible for the Medicare EHR incentives. See Question 4 for who is considered an eligible professional.

16. Why are pediatricians eligible for fewer incentives than nurse practitioners and physician assistants?

Under the Medicaid incentive program, eligible pediatricians (non-hospital based) could receive up to \$42,500, and other physicians (non-hospital based) could receive up to \$63,750, over a six-year period. Because the required volume of Medicaid patients is less (20 percent) for pediatricians, the incentive amount is lower. Pediatricians could be eligible for the full Medicaid incentive amount should they meet the 30 percent volume requirement of other Medicaid eligible professionals.

The law states that:



- (i) the net average allowable costs under this subsection for the first year of payment (which may not be later than 2016), which is intended to cover the costs described in paragraph (3)(C)(i), exceed \$25,000 (or such lesser amount as the Secretary determines based on studies conducted under subparagraph (C));
- (ii) the net average allowable costs under this subsection for a subsequent year of payment, which is intended to cover costs described in paragraph (3)(C)(ii), exceed \$10,000; and
- (iii) payments be made for costs described in clause (ii) after 2021 or over a period of longer than 5 years. (B) In the case of Medicaid provider described in paragraph (2)(A)(ii), the dollar amounts specified in subparagraph (A) shall be 2/3 of the dollar amounts otherwise specified.

Pediatricians who employ nurse practitioners or physician assistants who bill under their NPI will receive the incentive amounts described.

17. I am a family physician who has a large pediatric Medicaid population. Will my incentive be physician- or pediatrician-based?

Pediatricians could be eligible for the full Medicaid incentive amount should they meet the 20 percent Medicaid patient volume requirement.

If you meet the requirements of an eligible professional for both Medicare and Medicaid, you should review the details of each program and determine which one you prefer to participate in.

18. Ophthalmology practices do not do vitals routinely; will this need to be done to qualify?

Yes. According to the proposed Stage 1 meaningful use health IT functionality criteria, an eligible professional (EP) would have to "record and chart changes in vital signs: height, weight, blood pressure; calculate and display BMI and plot and display growth charts for children 2-20 years, including BMI for at least 50 percent of all unique patients age two and over seen by the EP during the reporting period.

Any EP who either see no patients 2 years or older, or believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice during the EHR reporting period qualifies for an exclusion from this objective/measure.

19. Are all specialties included in the proposed regulation?

Yes. All physician specialties are eligible for the incentive with the exception of most hospital-based EPs (see the AMA's [Medicare](#) and [Medicaid](#) summaries of the rule for more information on hospitalists).

20. Which specialties are covered by the proposed clinical quality measures?

All EPs have to report on the three core measures that apply to their patients or substitute from three alternative core measures. In addition, EPs must report on three additional clinical quality measures that are most appropriate given the physician's specialty. The three additional measures cannot be core or alternate core measures. See the [AMA's clinical quality measure summary](#) for details.

21. I am currently in medical school and will be in residency until 2014, are there plans for incentives for new graduates?

If your first payment year is 2015, you are not eligible for incentives. See the AMA's [Medicare](#) and [Medicaid](#) summaries of the rule for details.

22. Does Medicare plan to pay providers for e-visits?



No. The Medicare EHR incentive program authorized under ARRA provides incentives for EPs who successfully demonstrate meaningful use of a certified EHR, does not provide incentives for e-visits or other types of services. It's worth noting that there is a CPT® e-visit code. In addition, the AMA/Specialty Society RVS Update Committee (RUC) has recommended RVUs, but Medicare will not pay for it.

Hospitals and hospital-based professional

23. I am an employed physician with a local hospital. Are the incentive programs the same for me as for privately owned practices?

Hospital-based EPs (i.e., inpatient and emergency room departments) are not eligible for the Medicare incentive payments nor are the majority of hospital-based EPs eligible for Medicaid incentive payments (the only exception to this rule is for those EPs practicing predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)). The Continuing Extension Act of 2010 that was signed into law in April 2010 clarified that the definition of a hospital-based EP does not cover outpatient settings. CMS defines hospital-based EPs as those who furnish at least 90 percent of their professional services in a hospital setting, either inpatient or emergency room, in the year preceding the payment year. CMS will determine non-eligibility based upon site of service codes (code 21 for inpatient hospital and code 23 for emergency room, hospital). EPs providing services in outpatient settings, including ambulatory clinics, are eligible for incentives.

24. Does hospital based include ambulatory practices that are hospital owned, ie. free-standing clinics in the community?

The Medicare EHR incentive program provides incentive payments to eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that are meaningful users of certified EHR technology, not free-standing clinics. See question 23.

25. For providers with Medicare patients in both an outpatient office and a hospital, are the percentages based on charges or volume? Could not having meaningful use in the hospital prevent a provider from qualifying for meaningful use if they have an approved EMR and are using it meaningfully in the office?

The incentives will be based upon 75 percent of the allowed Medicare Part B charges; it does not matter which setting the Part B services were supplied. However, as proposed, physicians who are hospital-based such as pathologist, anesthesiologist, or emergency physician, who provide at least 90 percent of their care in the hospital (based on site of service codes) would not be eligible for the incentives.

26. What happens if a physician who works in multiple ambulatory settings has access to certified EHR technology in only one location?

Medicare and Medicaid EHR incentives are not attached to a location. The incentives are determined on a per provider basis, using the provider's National Provider Identifier (NPI) number. According to the final regulation, a provider may qualify for the incentive program based on their patient panel at the location that provides access to certified EHR technology.

Rural health clinics

27. Are there any differences in the way the meaningful use incentives work for rural health clinics?



Possibly yes under Medicaid. For eligible EPs, states are allowed to add additional objectives and measures.

Meaningful use

28. Did you say that the stages of meaningful use criteria are based on CALENDAR year and not FISCAL year?

Yes. For both Medicare and Medicaid EPs, the payment year is a calendar year beginning Jan. 1, 2011. However, there are some cases when a Medicaid EP could begin reporting in 2010 if CMS has approved a state's request to begin providing incentive payments that year.

For an eligible hospital or critical access hospital, a payment year is the federal fiscal year (October 1 - September 30) starting in fiscal year 2011, which begins Oct. 1, 2010.

29. When do we start the documentation process?

EPs under both the Medicare and Medicaid incentive programs for the first year would be any continuous 90-day period within a calendar year. For the second, third, fourth, and the fifth years, it would be the entire calendar year. The 90-day reporting period may not start before Jan. 1, 2011 or cross over into the next year. For example, a reporting period beginning in November would cross over to January of 2012 and would thus be ineligible. Therefore, the documentation process for demonstration of Stage 1 meaningful use for the first year could begin as soon as Jan. 1, 2011 or as late as Oct. 1, 2011.

Note that in the second, third, fourth, and fifth years, Medicare EPs must report on the entire calendar year.

30. Is 2015 the soonest one can submit for Stage 3?

At this time, only Stage 1 meaningful use criteria have been proposed. Criteria for Stage 2 and 3 meaningful use of EHRs will be defined in future CMS rulemaking.

31. Are the requirements for patient's access to their record different for specialists and primary care physicians?

At this time, the Stage 1 meaningful use criteria are the same for specialists and primary care physicians. This includes the patient access criteria. The core objectives indicate that EP's provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies), upon request (electronic copy must be in an electronic form – patient portal, PHR CD, USB, etc.). According to the CMS website, Stage 2 will expand on multiple criteria, including patient access to their health information.

32. What qualifies as "provide electronic copy of health record" to patients within 48 hours? Fax, email CD?

Currently the method by which you could provide this documentation is flexible. The final regulation says, "Electronic copies may be provided through a number of secure electronic methods (for example, personal health record (PHR), patient portal, CD, USB drive)."



System certification

33. Are certifications required for the modular approach?

Yes. The Office of the National Coordinator (ONC) issued a [final rule](#) on July 13, 2010 establishing an initial set of standards, implementation specifications, and certification criteria for electronic health record (EHR) technology. The regulation included definitions for "Complete EHRs" and "EHR Modules," both of which eligible professionals can use to receive incentives. Both technology types must be certified, including the individual EHR modules. Click [here](#) to read more about the final rule and meaningful use. Keep in mind however, that vendors are responsible for obtaining product certification whereas physicians are required to ensure the module they purchase together meet the requirements for obtaining the incentives.

34. Many of the programs boast of Certification Commission for Health Information Technology (CCHIT) certification, but the government has not stated that that certification means anything regarding the meaningful use criteria, is that right?

ONC issued a final rule detailing the certification program in June 2010. It is believed that the CCHIT will be one of the accredited certifying bodies. However, others will also seek accreditation. In early July, ONC had already received 14 requests for applications. Last fall, CCHIT released two new certifications-- Certified® 2011 program and Preliminary ARRA 2011--specifically addressing meaningful use. Click [here](#) to read more about the certification program. Visit www.cchit.org for updates about their application to become an ONC-Authorized Testing and Certification Body.

Regional extension centers

35. Doesn't some of the ARRA money pay for consultants to help practices with EHR implementation and meaningful use reporting?

No. However, ARRA appropriates a total of \$2 billion in discretionary funding, in addition to incentive payments under the Medicare and Medicaid programs for EPs' and other providers' adoption and meaningful use of certified EHR technology. This funding will go to Health Information Technology Regional Extension Centers (Regional Centers) that will offer technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of EHRs.

In March and April 2010, ONC awarded cooperative agreements to 60 Regional Extension Centers representing all the states and U.S. territories. Locate your local REC at www.ama-assn.org/go/hit. For more information on the Regional Extension Centers visit <http://www.hhs.gov/recovery/programs/hitech/factsheet.html> and <http://www.hhs.gov/news/press/2010pres/02/20100212a.html>.

Payment/reporting

36. How will Medicare incentives be given to doctors? Will it be checks, additional payments, or other?

Incentive payments are tied to the individual EP, and not his/her place of practice. According to the regulation, both Medicare and Medicaid eligible professionals would receive a single, consolidated, annual incentive payment. Medicare EPs would be paid electronically via their Medicare contractor.



Medicaid EPs would receive payment from either the State Medicaid agency or their designated intermediary (i.e., a Medicaid HMO).

The payments would be distributed on a rolling basis, as soon as you have: 1) demonstrated meaningful use for the applicable reporting period (90 consecutive days for the first year or the calendar year for subsequent years); and 2) reached the threshold for maximum payment.

37. How do we report our progress in meaningful use to CMS in order to get the ARRA funds? What is in this for any practices that have already implemented an EHR and are doing "meaningful use" prior to 2011?

For both EPs who are already using EHRs and for those who have newly implemented an EHR—to the extent that they are using one that has been certified as meeting the criteria for the Medicare and Medicaid EHR incentive programs and are meeting the requirements outlined by the government—the attestation period for Medicare EHR incentive program begins on April 1, 2011. As stated earlier, payments will be made on a rolling basis.

38. How will they track participation?

Tracking will be done at the unique National Provider Identifier (NPI) level. Both Medicare and Medicaid eligible professionals will need to furnish the following information to be paid accurately and quickly:

- Name;
- NPI;
- Business address and business phone; and
- Taxpayer Identification Number (TIN) to which you want the incentive payment made

CMS has proposed that Medicare and the states use a single program data repository to track participation in both Medicare and Medicaid.

39. How will the state count whether I've hit the threshold to participate in the Medicaid incentives?

Thirty percent of all your patient encounters must be attributable to Medicaid over any continuous 90-day period within the most recent calendar year. They will apply a plain meaning test. Short-term temporary Medicaid outreach programs do not count. Medicaid EPs are also required to annually re-attest to patient volume thresholds.

Pediatricians can qualify with 20 percent, but note that the maximum incentive amount is 33 percent less, or \$42,502, versus the \$63,750 cap for other Medicaid EPs. See Question 5 for Medicaid EP definition.

40. Do you have to accomplish these measures for all patients or only Medicare patients?

You will need to accomplish these measures for all patients, the Stage 1 meaningful use criteria specify that an EP will need to report on all "unique patients" seen by the EP. Please note, a "unique patient" means that even if a patient is seen multiple times during the EHR reporting period they are only counted once. See the AMA's [Medicare](#) and [Medicaid](#) summaries of the rule for details.



41. How is the reporting for 90 days going to be accomplished? Do we know?

In the first payment year, a Medicare eligible professional will report any continuous 90-day period within the calendar year. For the second, third, fourth and fifth payment years, the reporting period is the whole calendar year.

42. How many health IT functionality objectives/measures must a physician meet to be eligible for funding? Is funding pro-rated if a physician meets only some of the objectives/measures?

For receipt of incentives for 2011 and 2012, the eligible professional (EP) must meet 20 health IT functionality objectives/measures outlined in the final regulation. The final rule includes two sets of objectives - core and menu. The core set includes 15 measures/objectives that comprise basic functions of EHRs. An EP must meet all 15 core measures/objectives to qualify for incentives. One of these objectives requires a physician to report ambulatory clinical quality measures - three core measures and three additional measures relevant to the practice.

In addition to the core set, an eligible professional must also meet five of 10 objectives/measures off of a menu set.

The rule does not include the option of pro-rated incentive amounts for partial compliance. However, the rule does account for exceptions to certain objectives/measures. For example, an EP who writes fewer than 100 prescriptions during the EHR reporting period qualifies for an exclusion for the medication ordering objective. For an exclusion to apply, the EP must meet all of the following requirements:

- Must ensure that the objectives list under the core and menu sets include an option for the EP to attest that the objective is not applicable;
- Meets the criteria in the applicable objective that would permit the attestation; and
- Attests that the exclusion applies.

See the AMA's table of the Stage 1 meaningful use criteria and clinical quality summary for details.

43. Could you explain how the 20 proposed health IT functionality measures and objectives for the first year will be reported?

For 2011 and for 2012 EPs will be required to "attest" to meeting the criteria for being a meaningful user of an EHR. CMS has said EPs would have to conduct a one-time attestation through a "secure mechanism" following the completion of the EHR reporting period for a given payment year. See the AMA's table of the Stage 1 meaningful use criteria for more information about the reporting method for each objective measure. CMS plans to announce more details about the attestation process in the future.

44. Is it true that CMS will not be able to receive required reports electronically in 2011 and possibly not in 2012?

Yes. For 2011, reporting quality will be done through attestation. If CMS is not ready to accept electronic measures/reports electronically by 2012, they will reassess. However, the plan for 2012, for quality reporting, is electronic.

Privacy and security

45. Do you have any recommendations with respect to privacy and implementing electronic health records?



Currently, privacy and security standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require physicians to protect the privacy of patients' medical information. Physicians are required to control the ways in which they use and disclose patients' "protected health information."

For more information on the HIPAA Privacy and Security Rules please check our website:

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act.shtml>

And the Office of Civil Rights website: <http://www.hhs.gov/ocr/privacy/index.html>

Personal health records and e-visits

46. What is the liability for reviewing and answering information placed on email that you might not get to until the next day?

Practices that want to offer e-visits should 1) establish written guidelines for physicians, practice staff and patients and 2) determine appropriate reporting before the patient initiates a visit. To develop guidelines, practices should complete the following:

- Check local state law, as some states may require the physician to obtain a special/specific license for conduction of e-visits.
- Contact his/her participating contracted health plans to determine coverage, restriction and payment for these services.
- Contact online vendors to establish an account. This will ensure use of secure, encrypted and HIPAA-compliant secure messaging.
- Implement both practice and patient policies and guidelines for conducting e-visits.

Perhaps most important is that the guidelines set realistic expectations for both physicians and patients. AMA members can read more about establishing e-visit policy [here](#).

Governance

47. Which federal government body audits the meaningful use requirements?

While audits were not discussed in the proposed regulation, since CMS has oversight of the meaningful use of EHR requirements, it is likely they would oversee any audits associated with the Medicare incentive program. It is also possible that states would engage in this function for Medicaid. However, these details have not yet been announced. Regardless, EPs are required to maintain evidence of qualifications to receive incentive payments for 10 years after the date they register for the incentive program.

Also, as stated earlier, some states may begin their Medicaid incentive program in 2010. Further, unlike the Medicare incentive program, the Medicaid program allows eligible providers to receive an incentive payment even before they have begun to meaningfully use certified EHR technology. These EPs may receive a first year of payment if they are engaged in efforts to "adopt, implement, or upgrade" to certified EHR technology. EPs would have to attest to this.

ADDITIONAL RESOURCES:

- **AMA Web site on EHR incentive programs – www.ama-assn.org/go/hit.**
- **CMS Web site on the EHR incentive programs – http://www.cms.hhs.gov/Recovery/11_HealthIT.asp.**
- **HHS Web site on health IT - <http://healthit.hhs.gov/portal/server.pt>.**