The EHR Stimulus: A Complete Primer

How to get Uncle Sam's money, and whether you should

By Ken Terry

Like many physicians, you may have put off purchasing an EHR system because of the cost. Now you've heard the government is offering a chunk of money to physicians who have EHRs. What should you do?

The first step is to understand what the government is and isn't offering. Under the health IT provisions of the American Recovery and Reinvestment Act of 2009, you won't get any cash if you simply buy an EHR; you have to show that you're using it in a "meaningful" way. And, except for a small loan program, the feds aren't providing any money upfront. You still have to go out and purchase or lease a system yourself. But, starting in 2011, Medicare or Medicaid will reimburse you for part of the cost if you can demonstrate "meaningful" use of a qualified EHR.

Here's how the program works: Non-hospital-based physicians who participate in Medicare or derive 30 percent or more of their business from Medicaid (20 percent for pediatricians) are eligible to receive subsidies. The maximum amounts for which you may be eligible range from Medicare payments of $44,000 to nearly $64,000 from Medicaid over a five-year period. You can apply for either of these programs, but not both, and physicians practicing in underserved areas are eligible for an extra 10 percent from Medicare.

Under the Medicare provisions, if you apply in 2011 or 2012, you can receive $18,000 in reimbursements that year, followed by annual payments of $12,000, $8,000, $4,000, and $2,000. Those who apply in 2013 receive $15,000 in the initial year, followed by three years of diminishing payments. The first-year payment in 2014 is $12,000, with lower incentives the following two years. No incentives are available to anyone who applies after that, and no payouts will occur after 2016.

Physicians who are not using qualified EHRs meaningfully by 2015 will lose 1 percent of their Medicare reimbursement; in 2016, they will forfeit 2 percent, and in 2017 and each year thereafter, 3 percent. If less than 75 percent of physicians have met the EHR requirements by 2018, the Secretary of Health and Human Services is empowered to cut Medicare payments to the laggards by up to 5 percent.

Of the $19.2 billion allocated for the health IT program (including subsidies to hospitals), $2 billion has been placed in a discretionary pool that's controlled by the Office of the National Coordinator for Health Information Technology (ONC). About $300 million of that must be spent on health-information exchanges, and another $25 million is earmarked for standards development. Amounts for meeting ONC's other legislated goals have not been specified yet, but a significant percentage will be invested in regional extension centers that will, among other things, help small practices implement EHRs.

Some observers have interpreted "meaningful use" as including the use of electronic prescribing, the exchange of clinical information with other providers, and the reporting of quality data to CMS. But a Senate aide who asked not to be identified said the only thing written in stone is that you have to show you're exchanging data. The HHS Secretary will have to flesh out the details, he says.

What "qualified" means

The Secretary also must define what constitutes a "qualified EHR" that practices must use to qualify for subsidies. Because of the short timeline and other factors, observers believe that certification by the Certification Commission on Health Information Technology (CCHIT), an existing private-sector body, may be required. Dr. Mark Leavitt, chairman of CCHIT, said in a recent webinar that he's "confident" that CCHIT will be recognized as a certifying body for purposes of the financial incentives. He added that it's a "good bet" that either 2008 or 2009 certification (perhaps with some additions to or deletions of CCHIT criteria) will be required. That would mean products that were certified only in 2006 or 2007 wouldn't pass muster.

At press time, only 30 EHRs had been certified under 2008 CCHIT criteria, and of those, 12 are well-established ambulatory-care products. In contrast, about 150 EHRs were certified in 2006 and 2007. The increased requirements for certification are largely responsible for the drop in the number of certified products. Leavitt said that, since the stimulus law's enactment, there had been a "surge" of applications for 2008 certification. The 2009 certification period begins in July.

The government health IT initiative will put a lot of pressure on software vendors to upgrade their programs to meet federal requirements, predicts Robert Doherty, vice president of governmental affairs and public policy for the American College of Physicians. Justin Barnes, chairman of the EHR Vendors Association and vice

president of marketing and government affairs for Greenway Medical Technologies, agrees that more vendors will seek certification, but he doubts that many will be able to clear CCHIT's rising bar, which includes the interoperability functions that the government wants. "I think a handful of companies — perhaps 15 or 16 — can come close to satisfying that requirement today," he says.

The mad rush?

Despite the limited number of choices, Barnes believes that the subsidy program will have a huge impact on EHR sales to physicians. In the next six to nine months, he predicts, between 50,000 and 100,000 physicians will acquire EHRs. In addition, he expects many physicians who now have low-end systems to upgrade to certified products in order to get government cash.

Bruce Merlin Fried, a Washington, DC, healthcare attorney who specializes in health IT, agrees that the stimulus will greatly accelerate EHR adoption. For doctors who are reluctant to invest upfront, he believes that the back-end penalties will be a strong incentive. As for the current lack of interoperability standards, he says that's why the incentives don't start until 2011. "The plan is that in the ensuing period, the necessary standards will be met, and the vendors will be required to certify that those standards are employed."

But Mark Anderson, a health IT consultant in Montgomery, Texas, notes that few EHRs today have even a basic ability to exchange information. And he views the requirement that practices buy systems before they can qualify for government subsidies as "a deal breaker" for many physicians.

Even if physicians are willing to pay upfront — and they'd have to buy soon to qualify for maximum Medicare subsidies — some observers point out that the government incentives will cover only a third to a half of the five-year cost of an EHR system. A recent study by Avalere Health concluded that many physicians in small practices may decide they'd be better off taking the hit on Medicare payments after 2014 than investing in an EHR now.

Where physicians stand

Some physicians agree. For example, Will Sawyer, a solo family physician in Cincinnati, hasn't bought an EHR system "because none of them has been effective enough to integrate into a busy family practice. Also, they cost a fortune." Although the government incentives would lower the cost barrier, Sawyer doubts

that an EHR would help him significantly improve the quality of his care, especially in the absence of interoperability among systems.

Family physician Mitchell Cohen, who belongs to a three-doctor practice in rural Elma, Wash., would like to acquire an EHR. His group might even qualify for the $64,000 Medicaid subsidy in the stimulus package. But he and his colleagues are now putting up a new office building to accommodate their growing practice. “We just couldn’t swing the extra cost” of investing in an EHR right now, he notes, adding that that might change in another year.

But other physicians are ready to take advantage of the government subsidy now. Internist Jeff Kagan of Newington, Conn., says, “If someone is going to pay for us to get an EHR, we’re certainly going to be much more interested in doing it.”

Kagan and his partner rejected an offer by a local hospital to pay for 65 percent of the cost of EHR software, because the EHR it offered was unsuitable for ambulatory practices. He says the government offer is more appealing, especially since they can choose among certified EHRs.

Some physicians who already have certified EHRs are happy that the government is finally going to reward them. For example, Ed Bujold, an internist in Granite Falls, N.C., figures he’s spent $150,000 on EHR software and computer equipment since 2000. While his EHR has made his practice more efficient and improved his ability to code appropriately, he’s delighted about the government incentive. “This is a novel concept that you might be rewarded for doing the right thing, and that you might get paid more for practicing quality medicine,” he crows.

Gearing up for the future

Despite everything, many physicians remain skeptical about the value of EHRs and are fearful about what the work flow changes might mean to their practices. Although the regional extension centers are designed to help small practices get over the hump, EHRs represent a formidable technical challenge. And it’s unclear that there are enough qualified technicians available to help physicians implement EHRs and train them and their staffs, notes MGMA consultant Rosemarie Nelson.

Nelson believes that physicians should start shopping for EHRs now. If a product is not yet CCHIT-certified, she recommends getting the vendor to commit to that as a condition of purchase. Anderson says that even if an EHR was certified in the past, the vendor should promise to obtain CCHIT's 2009 seal of approval. Also, you should make sure the EHR and its associated PM system can be upgraded for compliance to the ICD-10 coding system that must be in place by 2013, he says.

Family physician Steven Waldren, director of the American Academy of Family Physicians' Health Information Technology Center, notes that physicians who already have a non-certified EHR will be reluctant to switch to another system, especially if they can show the meaningful use that the government demands. But other experts say it's unlikely that such EHRs will be grandfathered in so that physicians can receive subsidies for them.

Doherty regards the HHS incentive program as "kind of a now-or-never decision for physicians." If doctors don't take advantage of it, he points out, they risk not receiving government subsidies and being penalized later on. On the other hand, he says, physicians have found some systems don't work well, and many don't offer robust quality improvement features.

At some point, if not enough physicians acquire EHRs, Congress may mandate them as a condition of participation in Medicare and Medicaid, Doherty says. Jim Morrow, a family physician in Alpharetta, Ga. who is an experienced EHR user, believes that that could happen within as little as five years. But he suggests that the government might not require the kind of EHR it's talking about now.

"It might be a requirement to share data electronically," he says. "The aim of an EHR is not to create better progress notes, but to be able to access and analyze your patient data. It's the data that's important, not the notes."

Ken Terry *is a New Jersey-based freelance writer and the author of the book "Rx for Health Care Reform." He can be reached at physicianspractice@cmpmedica.com.*

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