Common Questions from Employed Physicians about the “Meaningful Use” Program
By Kelly Hagan and Jennifer Franks

At the end of 2011, the Centers for Disease Control and Prevention (CDC) released a report showing that doctors’ adoption of health information technology (HIT) had doubled in the past two years.¹ To encourage HIT adoption, the Centers for Medicare and Medicaid Services (CMS) offers incentives for “meaningful use” of electronic health records (EHR) in the Medicare and Medicaid programs. Employed physicians, full-time and part-time, have some common questions about their relationship to EHR incentives (and penalties).

Who is eligible to participate in EHR Meaningful Use Incentive Program?

“Eligible professionals” (EPs) who are meaningful users of certified EHR technology may participate in the EHR Incentive Programs. The definition of EP depends on the program to which the doctor is applying. Under the Medicare program, hospital-based EPs are not eligible to participate. An EP is hospital-based if the EP furnishes 90 percent of his or her services in a hospital inpatient or emergency room setting. Traditionally hospital-based physicians – pathologists, ER physicians, anesthesiologists, and radiologists – will generally be ineligible, as will many other physicians who provide “substantially all” their covered services in the inpatient setting: hospitalists, surgeons, nephrologists, neonatologists, ICU physicians, and hospital psychiatrists. However, some of these specialists may provide substantial outpatient services and therefore qualify. Indeed, it is possible that the eligibility of members of the same physician group will vary, depending on their practice site. For example, an anesthesiology group may be populated by members doing substantially all of their services in the OR, while others in the group perform substantially all their covered services in an outpatient pain clinic.

Although no guidance discusses the application of the 90 percent formula to part-time employed physicians, the denominator of the calculation would appear to be total services rendered by each individual physician. Thus, for example, the question would be whether 90 percent of a physician’s half-time practice is devoted to hospital inpatient or emergency room patients.

Under the Medicaid program, EPs must meet one of the following three criteria: have a minimum 30 percent Medicaid patient volume;² have a minimum 20 percent Medicaid patient volume and be a pediatrician;³ or practice predominantly in an FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals.⁴ Again, the guidance does not discuss part-time practices, but under the logic used above, these percentages will be applied to the total service levels of each individual physician, whether full-time or part-time.

EPs who qualify for both programs in the same year must elect to receive payments from one program. But EPs who have received an incentive payment from one program may switch programs once before 2015.

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2. Children’s Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.
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What happens if an Eligible Provider does not demonstrate meaningful use of certified EHR technology?

Nothing – for now. However, beginning in 2015, CMS will “adjust” the EP’s Medicare physician fee schedule amount for covered services. They payment for an EP’s covered services not involving meaningful use of HIT will be decreased by 1 percent in 2015, 2 percent in 2016, and by 3 percent in 2017. At this time, there are no Medicaid payment reductions if an EP chooses not to participate in the Medicaid Incentive Program.

Are employed physicians at risk for reductions in their employer’s reimbursement or other liabilities?

Generally not. An employed EP’s eligibility can affect reimbursement to the employer for covered services, as can the employed EP’s meaningful use (or not) of EHR technology. Thus, the incentive program may create variation in the value of covered services between eligible and ineligible employed physicians, and those meaningfully using HIT and those not. But the billing entity, not the employed physician, reaps the benefit or detriment. Moreover, bona fide employees of billing entities need not fear Stark or Anti-Kickback liability for EHR hardware and software provided by the employer. While this may be an issue for independent physicians receiving capital assistance from hospitals or others, employees will enjoy employment or personal services protections under the Stark and Anti-Kickback Laws.

One area of potential liability would be the employed provider who “attests” to information provided to Medicare or Medicaid during Phase 1 of the program. Attesting to false information may give rise to personal liability under the False Claims Act.

May a practice that employs a physician utilize the incentive funds that accrue to the employed physician to support an EHR that serves the entire practice?

If we assume that a physician is eligible for the subsidies, we necessarily assume the physician has invested in and possesses a qualifying HIT system. Once the incentives have reached the physician, we know of no restriction on their use as part of the meaningful use rules. That money becomes fungible so far as we perceive the meaningful use regulatory scheme. Thus, if for whatever reason the physician wants to pass those dollars to the clinic, we assume he or she is free to do so.

However, if there is some suggestion of impermissible remuneration or disguised payment for referrals, obviously that is a problem. We see Stark as less likely a problem so long as the physician qualifies as a “member” of the group/clinic. That is a certainty for employees of a qualifying group practice, but not for independent contractors. In the latter case, while potentially a “physician in the group practice,” the contracted physician is not a “member” such that the ancillary services exception is available. Thus, more care would be needed in the relationship of the clinic to independent contractors, assuming there were referrals passing between the parties for DHS.

Where can physicians find more information about EHR Incentives?

CMS’s official website for the Medicare and Medicaid EHR Incentive Programs provides a wealth of information and education materials at www.cms.gov/EHRIncentivePrograms/01_Overview.asp.

The Oregon Health Authority’s Medicaid Electronic Health Records Incentive Program provides information about Oregon’s Medicaid EHR Incentive Program at http://medicaidehrincentives.oregon.gov.

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Improving Efficiency with Standards and Electronic Administrative Transactions

Oregon is working to simplify the way providers interact with other health care entities through an initiative known as Administrative Simplification that works to streamline administrative processes by moving toward electronic transaction systems and standardized electronic transactions. The Department of Consumer and Business Services has already begun mandating standards as part of this initiative; compliance to these standards is important, as many have already taken effect.

Compliance with new standards for eligibility transactions (270/271) is mandated as of Jan. 1, 2012 for health care entities already using electronic transactions. These standards are outlined in the 270/271 Oregon Companion Guide for Eligibility Transactions. By Oct. 1, 2012, all health care entities in Oregon are required to use electronic transactions to verify eligibility and follow the standards outlined in the 270/271 Oregon Companion Guide for Eligibility Transactions. New standards have also been developed for claims and encounter transactions (837) and the compliance period begins Oct. 1, 2012. Providers and health care entities, such as health insurers, third-party administrators and clearinghouses are all subject to these transaction standards in Oregon.

Ongoing work will continue to streamline administrative and financial transactions in Oregon. Analysis and standard development is underway, and OMA will continue to inform you on upcoming developments.

**Transition to 5010 Causing Cash Flow Concerns**

*The OMA is here to help!*

To date, Medicare's data does not indicate widespread problems regarding the 5010 transition. However, the AMA has raised concerns to CMS about issues that physicians are reporting and has indicated they will monitor the implementation process closely both with medical associations and Medicare to ensure that all goes as smoothly as possible.

The AMA has stated that it is aware of cash flow issues resulting from claims rejections due to the 5010 transition and is urging physicians and practice management staff to work closely with their billing services and clearinghouses to help resolve them.

The AMA has also indicated that it remains deeply concerned about the impact of the 5010 transition on physicians despite CMS having postponed enforcement of the new transaction standards until April 1, 2012. The AMA is urging CMS to look into an advance payment policy that would help alleviate the burden for physicians who are experiencing cash flow issues due to the 5010 transition.

The OMA has received many calls and e-mails from practices that are having cash flow troubles due to 5010 and is helping them resolve those issues. If you are experiencing claims/cash flow interruptions with payers related to the 5010 transition, please e-mail Gabriella Tagliacozzo at gabriella@theOMA.org. For important 5010 clarification information from CMS, visit [http://go.cms.gov/zfMrRJ](http://go.cms.gov/zfMrRJ).

**O-HITEC Exceeds Recruitment Goals through Partnership with the OMA**

In a state where technology is dominant, Oregon health care providers are rapidly adopting EHRs and advancing both state and national health reform initiatives. In December of 2011, OCHIN and O-HITEC reported that they'd surpassed the goal of their 2009 federal grant award by signing on more than 2700 Oregon primary care providers to receive help selecting, implementing and effectively using EHR technology to improve patient care and reduce costs. This ranks O-HITEC in the top 10 out of 62 regional extension centers in the nation.

A key to O-HITEC's success is their education grant partner Oregon Health and Sciences University and statewide partnerships with organizations such as the Oregon Medical Association, Oregon Association of Family Physicians, the Oregon Rural Health Association, many Independent Physicians Associations and the state of Oregon. "I could not be prouder," said Abby Sears, OCHIN's CEO. "Strategic partnerships and dedicated, mission-driven staff members made our success possible," she said.

**Telemedicine Licensure at Issue in Oregon**

OMA President Carla McKelvey spoke at the Telehealth Alliance of Oregon’s meeting in February in Portland; OMA general counsel Gwen Dayton also participated in the discussion of health reform. At the conference they heard from many present that help in modernizing the regulations for telemedicine licensure was urgently needed. That information, combined with the potential for proposed legislation from Sen. Tom Udall (D-Utah) to make it easier for physicians to practice telemedicine in many states instead of applying for a separate license for each state, may hasten changes in Oregon. For more information, visit [http://govhealthit.com/news/udall-drafting-bill-remove-telemedicine-barrier](http://govhealthit.com/news/udall-drafting-bill-remove-telemedicine-barrier).

**New Electronic Funds Transfer Standards Projected to Save Time and Money**

New rules published by the U.S. Department of Health and Human Services on Jan. 5 adopt streamlined standards for the format and data content of the transmissions a health plan sends to its bank when it wants to pay a claim through an electronic funds transfer and to issue a Remittance Advice notice. The standards build upon regulations published earlier this year that set industry-wide standards for how health care providers use electronic systems to quickly and easily determine a patient’s eligibility for health coverage and check on the status of a health claim.
A new tracking system will eliminate inefficient and costly manual processes by using a trace number to automatically match EFT payments with their corresponding Remittance Advice. According to HHS estimates, these new standards required by the Affordable Care Act will reduce up to $4.5 billion off administrative costs for physicians and hospitals, private health plans, states, and other government health plans over the next ten years.

The regulation is effective Jan. 1, 2012, and all health plans covered under HIPAA must comply by Jan. 1, 2014. Future HHS administrative simplification rules will address adoption of a standard unique identifier for health plans; a standard for claims attachments; and requirements that health plans certify compliance with all HIPAA standards and operating rules.

A fact sheet from CMS with more information is available at www.theOMA.org/EFTstandards. To view the Interim Final Regulation with comment period, visit www.regulations.gov.

### Upcoming Education and Events

#### Don’t Miss the OMA’s Downstream IT Workshop for the Medical Practice

**Shifting from Chaos to Control**  
March 6, 8:00 am - 10:00 am, OMEF Conference Center, Portland

This workshop will look at best practices for planning and managing IT resources (either internal or outsourced) for small, medium and large-sized practice groups. It will also look at resource management planning including help desk staff, hosting vs. on-site server applications, disaster recovery planning and other current technologies that can help streamline medical practices and lower the cost of IT management. Learn more and register at www.theOMA.org/workshops/HIT.

#### OMA General Membership Meeting

**Promoting Patient Health in a Transformed World**  
April 20–21, Portland

We are excited to announce the first General Membership Meeting of the Oregon Medical Association. All OMA members, their spouses/partners and special guests are invited to join OMA for a weekend of exceptional educational offerings, networking opportunities and exciting social events. This new meeting format offers OMA members the opportunity to gather annually for educational programs and forums to discuss the work of our association. Don't miss this opportunity to engage with your peers through the OMA.

This year's theme is "Promoting Patient Health in a Transformed World." Highlights include:

- Free Basic Disaster Life Support CME Training on Friday
- Welcome Reception sponsored by The Partners Group
- Keynote address from Patrick House, season 10 winner of NBC's “The Biggest Loser”
- Educational sessions focused on community health and wellness on Saturday
- Saturday evening "Party in the Pearl" to benefit medical and PA students
- OMA Alliance Silent Basket Auction
- Installation of the 138th OMA President, William "Bud" Pierce, MD

Take advantage of our Early Bird Prices and register today at www.theOMA.org/2012meeting.

#### Have you filled out the survey? The OMA needs your feedback on our publications

Visit www.theOMA.org/ReadershipSurvey to complete the short series of questions. You will need to be logged in to the OMA website to access the survey.