GETTING THE MOST OUT OF THE MEDICARE INCENTIVE PROGRAM

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Health Information Technology for Economic and Clinical Health Act (HITECH)

It continues to be clear that physicians are reluctant for multiple reasons to adopt and implement EHR technology. Cost, fear, impact on productivity and comfort with status quo are just some of the reasons. The Health Information Technology for Economic and Clinical Health Act (HITECH) provided $19 billion to encourage the health care industry to adopt information technology. The government is also looking to change the reimbursement system for Medicare to one based on quality (pay for performance). Without appropriate technology, there is no easy way to measure quality. HITECH objectives include promoting the use of EHR technology, electronic exchange of health information and clinical quality and other future measures which will be defined by The Department of Health and Human Services. The ultimate goal of HITECH is the exchange of an individual's health information without regard to where that patient obtains medical services. These could include a hospital or physician's office a lab or surgery center.

Incentives are available to eligible professionals. There are many physicians who think they don't have enough Medicare volume to qualify for incentives, such as physicians specializing in obstetrics and gynecology. In reality, in order to receive the maximum of $18,000 in the first year of the program, you must have Medicare allowable charges of $24,000 ($24,000 x 75% = $18,000). Incentive payments are reduced in subsequent years and end in 2015. There is a Medicare reduction (penalty) for non-participation starting at one percent in year 2015, two percent in 2016 and 3 percent in 2017 and beyond.

Meaningful Use Criteria

The Centers for Medicare and Medicaid Services have developed a three stage process and the timing of compliance with the stages will determine when practices first receive payments. For example, if you want to receive an incentive payment in 2011, you must comply with Stage One Meaningful Use in 2011. The overall vision of stage one is to capture information. Other objectives of stage one are to track key clinical conditions,

THIS ARTICLE WAS PUBLISHED IN THE SPRING 2011 ISSUE OF THE NJAOPS JOURNAL

communication of information, implement clinical decision support tools and report clinical quality measures and public health information. There are also several Meaningful Use Revisions associated with stage one. "Core" criteria have been reduced from 25 to 15 and eligible professionals can choose five additional criteria from a list of ten. All criteria must be met. There are eased minimum requirements of most measures and more narrow but realistic exemptions for some criteria.

The vision of stage two is to report information. The goal is to migrate users from stage one to stage two by executing advanced care processes with decision support. Bi-directional communication with public health agencies is another important objective of this stage. Medication management, support for patient access to health information, transitions in care and quality measurements are put into place during this stage to ensure the highest quality of care for patients.

Stage three is all about leveraging information to improve outcomes; achieving improvements in quality, safety and efficiency. The focus is on decision support for national high priority conditions and improving population health outcomes. Here, the patient will have access to self-management tools and eligible professionals will have access to comprehensive patient data.

E-Prescribing

E-Prescribing was mandated by Medicare Improvements for Patients and Providers Act of 2008. No sign-up or pre-registration is necessary however; eligible professionals require a qualified eRx system. A qualified eRx system generates active medication lists and selects medications, prints and electronically transmits prescriptions. The system provides cost and therapeutic alternatives as well as formulary information.

There were some new changes to e-prescribing in 2010. Eligible professionals must now report eRx measures a minimum of 25 times and only one measure is used for reporting. Code G8553 shows that at least one prescription created during a patient visit was generated and transmitted electronically using a qualified eRx system. At least ten percent of eligible professionals' Medicare charges must be of evaluation and management services and there is a two percent bonus for e-prescribing paid via intermediary.

Physicians have found that utilizing e-prescribing in their practice increases patient satisfaction since pharmacies can have prescriptions ready for pick up by the time patients travel from their physician's office to the pharmacy. Utilizing e-prescribing can also diminish the number of declination by insurers for prescribing drugs that are not on formulary. This information is available to the physician at the time the e-prescribing function is

performed. Lastly, physicians have reported that the process of renewing prescriptions is much more simplified when using an e-prescribing system.

PQRI – Physicians Quality Reporting Initiative

Pay for performance, authorized by the Tax Relief and Health Care Act of 2006, is voluntary and open to eligible professionals. It carries financial incentives if criteria for reporting quality of care are satisfied. Initially a 1.5 percent bonus was put into place if criteria for reporting quality of care were satisfied. Now, the bonus has increased to two percent of total Medicare Part B allowed charges.

PQRI payments in 2007 were $36 million and in 2008 were $92 million. The average incentive increased from $600 per physician in 2007 to $1,000 per physician in 2008. There were new PQRI measure groups established in 2010. There are three reporting options available for PQRI - claims based; registry based and EHR based. There are specific criteria for how many measures must be reported depending upon the option that a physician or practice chooses. Each practice must consider the potential revenue from participation in PQRI and the potential expenses for technology and potential a scribe.

The Future

It is unknown as to how long these incentives will be available to physicians. In some cases, they will be phased out and penalties substituted for non-participation. We urge each practice to consider their options while these incentives can add revenue to their bottom line.

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