HIT Perspectives

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ePrescribing

Can CMS Align Its Dueling Incentive Programs and Eliminate Provider Confusion?

By Kurt Andrews, Contributor

The General Accountability Office (GAO), the heavy-duty federal watchdog agency, recently issued a report spotlighting a problem that has been causing a lot of confusion for physicians and health information technology (HIT) vendors[1]: the misalignment of ePrescribing incentives and penalties within two federal programs administered by the Centers for Medicare and Medicaid Services (CMS).

The two programs were created under separate pieces of legislation. The first is the Medicare Improvements for Patients and Providers Act (MIPAA). It was enacted before the American Recovery and Reinvestment Act of 2009 (ARRA), which created the meaningful use (MU) requirements. Both incentive programs encourage ePrescribing adoption and use. MIPAA addresses ePrescribing outright, while ePrescribing is included in the criteria for the certified electronic health records that must be used in order to qualify for the MU incentives. There are two real problems: having the “right stuff” technology-wise varies between the two programs, and both programs have established separate reporting requirements related to ePrescribing. Furthermore, unlike MU, MIPAA lacks a software certification entity – this places the burden on the ePrescriber to understand whether or not the software will meet incentive requirements. Unlike MIPAA, MU applies to both Medicare and Medicaid providers.

While both programs initially provide incentives for those meeting requirements and transition to an era when providers will be penalized for not qualifying, their timelines are not aligned. In fact, it is possible that a prescriber could be penalized by MIPAA and incented by Medicare and Medicaid MU in the same year. The mechanics of the two programs’ incentives and penalties have been detailed in previous issues of *HIT Perspectives*. A summary of the MIPAA and Medicare MU incentives and payments are summarized below.

So what to do about the confusion? As matters pertain to Medicare MU, the GAO has four recommendations (it didn’t even address Medicaid MU). Three are fairly obvious and noncontroversial: 1) encourage physicians and others in the MIPAA program to adopt software that has been certified for MU because MU-certified software will qualify as MIPAA software; 2) expedite efforts to align reporting requirements so that successfully qualifying for incentive payments or avoiding penalties under MU would likewise result in meeting the MIPAA requirements or, in essence, having a single ePrescribing criterion; and 3) have CMS leverage its experience with MIPAA with MU and include consideration of such factors in the integration plan that the agency is required to develop by January 1, 2012. The fourth recommendation — have CMS develop a risk-based strategy to audit a sample of providers who received incentive payments from the electronic prescribing program — is not as simple as it sounds. This would be an unfunded mandate for CMS, which likely would have to set up a whole new auditing program. Even if that could be done, it probably would not be received with open arms by provider groups, which are used to complaint-based enforcement on a case-by-case basis.

See Chart on the next page.

[1] Electronic Prescribing: CMS Should Address Inconsistencies in Two Incentive Programs That Encourage Use of HIT, GAO 11-59

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Incentives and Penalties for Eligible Medicare Providers in the MIPAA and Meaningful Use Programs

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
MIPAA ePrescribing Program										
Incentive										
% of Part B Charges	2%	2%	1%	1%	0.5%					
Penalties *% of Part B Charges*				-1%	-1.5%	-2%				
Meaningful Use Program Incentive										
75% of Part B charges, up to a maximum amount			Up to $18k	Up to $18k	Up to $15k	Up to $12k	Up to $8k	Up to $4k		
Penalties % of Part B charges							-1%	-2%	-3%	-3%

Source: GAO, 2011

What is the impact on eligible prescribers, who are predominantly physicians? The GAO recommendations are good as far as they go, but we believe they won't have much impact on the two programs or physicians. It's a case of too little, too late, even if the recommendations can be implemented fairly quickly. And the GAO's recommendations do not even include Medicaid, which adds yet another set of requirements, timelines and penalties into the confusing mix.

The first problem is the overlapping "carrot and stick" requirements. To avoid the MIPAA payment penalties, CMS will require eligible providers to meet that program's reporting requirement for 2011 even if they participate in the MU program, which also begins this year. We understand the American Medical Association has asked CMS to push back the MIPAA penalty dates.

Next, there are the differences in reporting requirements. CMS potentially would require physicians — the largest and only group of providers eligible to earn incentive payments in both programs — to report to both programs from 2011 through 2014. CMS recognizes this duplication places additional burden on physicians and is in the process of developing a strategy to address this.

Then, there's the money. According to the GAO, CMS paid $148 million in 2009 (the first year that MIPAA incentives were available) to about 8% of the roughly 600,000 eligible Medicare providers. That translates to an average payment of about $3,120, and the median payment was around

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$1,700. Medicare providers qualifying for MU in 2012 could receive up to $18,000.The GAO projects that early adopters could earn a total of $45,200 for the two programs through 2016, while providers who are later adopters could earn $24,600 for the two programs for that time.

According to the GAO, Medicare providers who choose not to participate could lose an average $1,080 over three years for MIPAA and $2,400 over four years under MU, for a combined loss of $3,480 between 2012 and 2018.

While the incentives are hardly chump change, they may not drive adoption for several reasons. For one thing, the incentive payments do not fully cover the costs of adopting a stand-alone ePrescribing system or EHR. Moreover, the penalties are hardly very stiff and may not be enough to encourage a changeover among really hard-core, paper-based practices. And then there is the “hassle factor,” which some physicians simply may want to avoid. For many, giving back $3,480 to Medicare is nothing compared to the potentially onerous costs in revenue and office flow disruption for the implementation and use of an ePrescribing/EMR system. That is not to mention the reports the office must submit to CMS, and even then they still may not qualify for the MIPAA incentives. Lastly, for the reasons previously discussed, there is the possibility that these two programs may drive older physicians to consider phasing out their practices in the next few years. “It’s not worth it” is a phrase we commonly hear in the field from a certain physician demographic.

Point-of-Care Partners is closely monitoring how this all plays out. As leaders in the HIT field with long-standing expertise in ePrescribing, we are well positioned to advise our clients about potential impacts of the two incentive programs and actions the government may take to sync up requirements or adjust penalty dates. Let us know if we can put our expertise to work for you.

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