

Increasing Pediatrician Participation in EHR Incentive Programs

Dorothy Miller, JD, MPH^{ab}, Kathleen Noonan, JD^{ab}, Alexander G. Fiks, MD, MSCE^{ab}, Christoph U. Lehmann, MD^{cd}

Although the intent of the federal Meaningful Use (MU) program is to improve the health of children and adults through adoption and use of electronic health records (EHRs), pediatricians face unique obstacles to participation in this program.¹ In addition to known problems with EHR functionality to support pediatric care and the alignment of MU incentives with child health priorities, evidence suggests that the current structure of the MU program puts pediatricians at a disadvantage compared with clinicians caring for adults, leading to wide variability in pediatrician participation in the program across states.² Specifically, despite a national mean participation rate of <20% in 2012, pediatrician registration in the MU program varied considerably across states, from <10% in New Jersey, Georgia, and Hawaii to nearly 70% in North Dakota (Fig 1). By synthesizing participation data with a detailed policy analysis, the present commentary addresses potential causes of this variability and suggests specific solutions to support effective pediatric EHR implementation across all states.

Importantly, pediatric providers have fewer opportunities to participate in the MU incentive program than adult providers.³ Currently, pediatricians seeking MU payments for using EHRs through the MU program must exceed a threshold of 20% of encounters with Medicaid-insured children.¹ In contrast, providers who treat adults can opt to participate through either the Medicare EHR incentive program, which has no patient threshold, or the Medicaid EHR incentive program, which has a 30% threshold.

Qualifying for the MU program through Medicaid is more difficult than through Medicare for 4 major reasons. First, achieving the Medicaid pediatric threshold of 20% of encounters is challenging for many providers because Medicaid panels vary based, in part, on each state's reimbursement rates and policies.^{4,5} For example, in some states (eg, New Jersey, Illinois, Texas, California), the percentage of pediatricians accepting Medicaid payments is low, in part due to small, delayed, or unpredictable reimbursements and varying intrastate market dynamics.^{2,4} In states in which pediatricians have diminished Medicaid panels, fewer providers will be eligible to participate in the pediatric MU program.

Second, by excluding children enrolled in a state's separate Children's Health Insurance Program (CHIP) from the patient encounters used to

^aPolicyLab at The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania; ^bDepartment of Pediatrics, Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania; ^cDepartment of Pediatrics, Vanderbilt University School of Medicine, Vanderbilt University, Nashville, Tennessee; and ^dChild Health Informatics Center, American Academy of Pediatrics, Elk Grove Village, Illinois

Ms Miller drafted the manuscript, researched the legal and policy implications, reviewed and revised the manuscript, and prepared the manuscript for publication. Ms Noonan and Dr Fiks contributed their expertise in policy and practice; they, along with the other authors, conceptualized the article so that it would increase pediatric participation in electronic health record incentive programs; and they contributed to the drafting, reviewing, and revising of the manuscript. Dr Lehmann conducted data collection relative to the manuscript and drafted, reviewed, and revised the manuscript. All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

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Address correspondence to Alexander Fiks, MD, MSCE, The Children's Hospital of Philadelphia, 34th Street and Civic Center Boulevard, CHOP North, 15th Floor, Room 1546, Philadelphia, PA 19104-4399. E-mail: fiks@email.chop.edu

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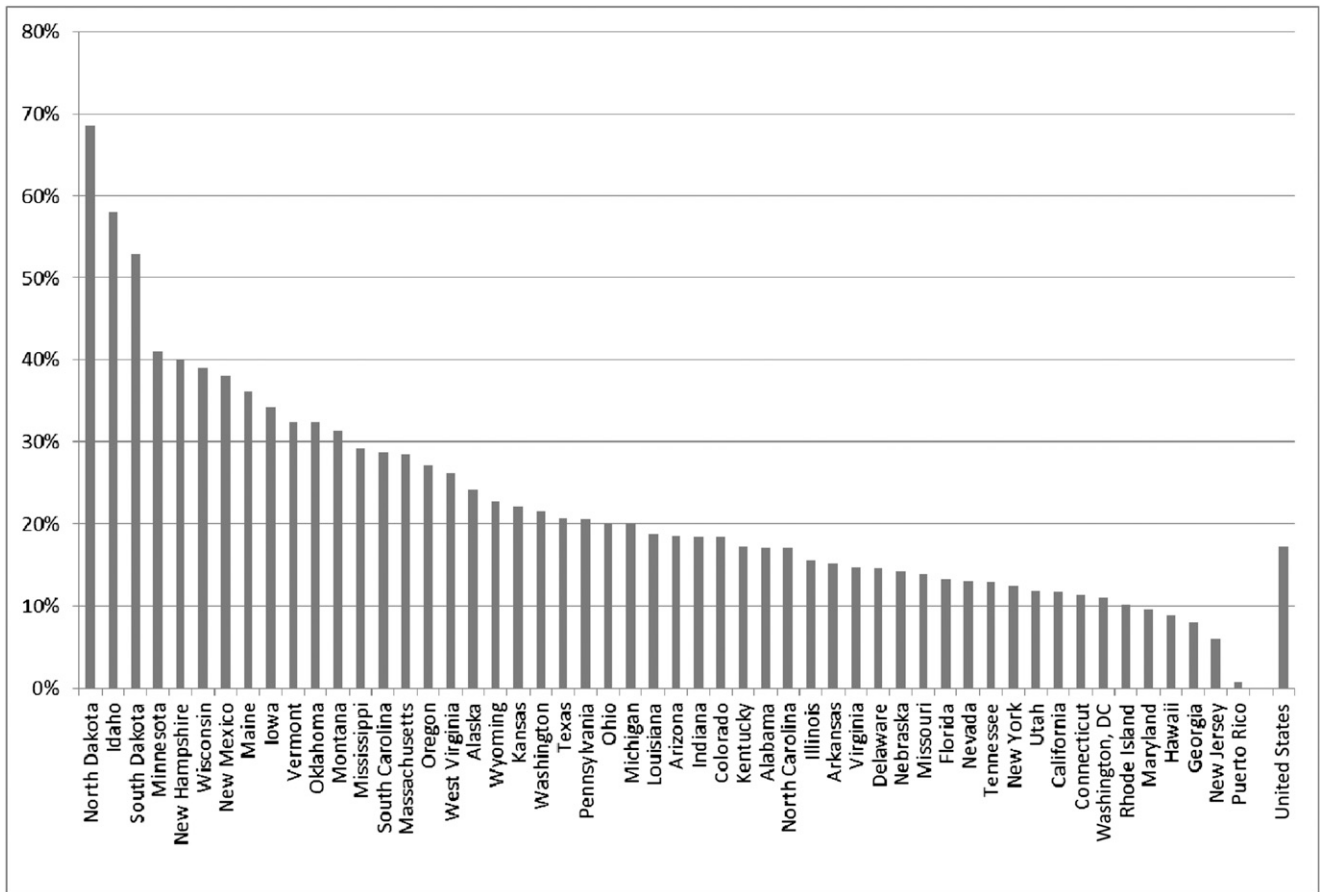


FIGURE 1 Pediatricians registered (by state) in the federal MU EHR adoption program, 2012. The graphic was created by using data from the AAP and the Centers for Medicare & Medicaid Services. Percentages were calculated from a denominator representing all AAP members in each state; the numerator is the number of pediatricians registered for the MU program in each state. The data have not been previously published but were presented at the 2013 CMS Multi-State Medicaid HITECH Conference (<http://www.medicaidhitechconference.com/index.php/resources1/conference-materials-2013/>).

calculate eligibility, a critical group of providers serving lower income children are being excluded from receiving MU incentives. Because some states are using CHIP funds to expand Medicaid, those patients are counted toward the total percentage of Medicaid patients served. However, in states in which CHIP is operated as a separate insurance program (eg, New Jersey, Tennessee), those children are excluded from the 20% threshold, meaning that pediatricians (and by extension, the children they serve) are disadvantaged by the policy and program structure choices that the states have made.

Third, a lack of centralized reporting creates barriers and inconsistencies for pediatricians interested in receiving incentives. There are 56

different systems through which pediatricians report their MU participation to their respective state or territory, a much less consistent approach than the single, central federal repository under Medicare.⁶ Under the Medicare EHR incentives, providers could begin reporting at the same time and to the same system.¹ In contrast, because states developed their own MU reporting sites for their Medicaid programs, registration with the MU program became available in different dates depending on state readiness and was also associated with distinct requirements and documentation burdens.⁶ Furthermore, for any of the MU reporting tools, states may require additional information not found in any of the federal guidelines.

Fourth, as with other health reform efforts, most notably the Patient Protection and Affordable Care Act's Medicaid expansion option, states vary widely in their response to and support of new federal initiatives.⁷ Thus, some states have embraced efforts by the federal government to move toward EHRs (including the MU program), and others, whether for political, fiscal, or policy reasons, have hesitated or moved more slowly to prioritize their MU reporting systems. For example, Florida had elected not to request additional spending authority for the Medicaid "flow-through" MU dollars in 2014. As a result, pediatricians and children's hospitals in Florida who were eligible for federal dollars did not receive their MU incentive payments,

representing approximately \$20 million in incentive payments for hospitals and \$50 million for eligible providers. Only with a recent appropriations act did Florida make it again possible for pediatricians to participate in the federal program. Adult providers who are eligible under Medicare had remained able to participate all along.

As the Centers for Medicare & Medicaid Services (including the Office of the National Coordinator) reassess the timeline for implementation of the MU policies, pediatricians have several ways to work toward improving this program. Locally, pediatricians can contact their state and local legislators to educate them about the effects of these MU policies, as well as contact their state American Academy of Pediatrics (AAP) chapter (which are connected to the work of the AAP Department of Federal Affairs) about ongoing MU education efforts.³ The Office of the National Coordinator also supports regional extension centers in every federal region of the country; these centers can assist pediatricians in MU implementation. At the national policy level, there are also several solutions for consideration by policy makers and children's health advocates to increase participation in the pediatric MU program.

As a first step, universally allowing providers to include patients enrolled in CHIP toward their MU incentive threshold would substantially increase the number of pediatricians eligible for MU participation. This solution has been endorsed by the AAP.² Although implementing this policy would require a statutory change, the change could be prioritized and incorporated into broader efforts to review and reauthorize CHIP over the next year.

An expansion of the MU incentive structure could also create opportunities for pediatric providers who do not currently meet the Medicaid threshold to participate in the MU program. An obvious option is to establish a route to MU participation more comparable to what exists for adult providers participating through Medicare. For example, while both pediatricians and adult providers face patient thresholds (20% and 30% respectively) to participate in the Medicaid MU program, there is no patient threshold for adult providers to participate in the Medicare MU program.¹ Creating an alternative similar to Medicare MU, but targeted to pediatricians, could bridge the gap between qualifying and nonqualifying providers, promote greater equity in

program participation across states, and expand the number of providers implementing and optimizing their EHRs. Finally, government (federal or state) could work with private market payers and health systems to implement different incentive options for pediatric providers who do not meet the current Medicaid MU criteria. With an array of market options, such as tax credits or payment incentives, efforts toward moving more of the population onto EHRs could have far-reaching benefits.

MU incentives are intended to build on the goals of the Patient Protection and Affordable Care Act that include more insured Americans, reduced health care disparities, and improved population health. Unfortunately, the benefits of these incentives are unnecessarily constrained for pediatricians and the children they serve. Implementing our proposed solutions would support pediatricians' use of EHRs, with an ultimate goal of improving child health.

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