Meaningful Use White Paper Series
Paper no. 3: Meaningful Use—Incentive Payments and Program Requirements
Published August 26, 2010

Meaningful Use—Incentive Payments and Program Requirements

The second paper in this series began an overview of the provider requirements within the final rule on meaningful use, published by the Centers for Medicare and Medicaid Services on July 28, 2010. This paper continues the overview the meaningful use final rule with a look at the payment and program requirements.

After describing the criteria for the meaningful use of EHRs, the final rule addresses the incentive payments themselves, broken down among the Medicare Fee for Service (FFS), Medicare Advantage (MA), and Medicaid programs.

FFS Payments to Providers

CMS establishes the definition of "physician" to mean one of five types of professionals: a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. In response to comments on the noticed of proposed rulemaking (NPRM), CMS notes that by law this definition cannot be altered or expanded. Hospital-based providers do not qualify for an incentive payment (pp. 44439–42).

The final rule adopts the payment schedule outlined in the NPRM, shown in the table below (the table, however, is not published within the final rule). CMS finalized its proposal of a 10 percent upward adjustment if the eligible professional (EP) serves more than 50 percent in a geographic health professional shortage area (HPSA), with several other conditions applied (pp. 4444–45).

TABLE 22 – MAXIMUM TOTAL AMOUNT OF EHR INCENTIVE PAYMENTS FOR A MEDICARE EP WHO DOES NOT PREDOMINATELY FURNISH SERVICES IN A HPSA

Calendar year	First CY in which the EP receives an incentive payment				
	2011	2012	2013	2014	2015–subsequent years
2011	$18,000	.....	.....	.....	.....
2012	12,000	$18,000	.....	.....	.....
2013	8,000	12,000	$15,000	.....	.....
2014	4,000	8,000	12,000	$12,000	.....
2015	2,000	4,000	8,000	8,000	$0
2016	.....	2,000	4,000	4,000	0
Total	44,000	44,000	39,000	24,000	0

Once an EP's eligibility is verified, meaningful use demonstrated, and the set threshold for maximum payment reached, CMS will make a full payment. How a physician shares the

payment in a practice will be determined between the physician and the practice. CMS provides its rationale for the form and timing of the payment in detail on pages 44445–47.

Within the rule CMS also lays out its plan for payment adjustments effective in CY 2015 and subsequent years for those EPs who are not meaningful users of certified EHR technology (beginning on p. 4447). It should be noted that this situation applies to all Medicare provider physicians except those who are hospital-based; therefore, even physicians who choose not to apply for incentive funds will be subject to the payment reduction if they do not become meaningful users by the time the adjustments begin.

FFS Payments to Hospitals

FFS-based incentive payments apply to eligible hospitals in the fifty states and the District of Columbia; they do not include the territories or hospitals located in Puerto Rico. Hospital incentives currently are based on an initial amount, a Medicare share, and a transition factor applicable to the payment year.

The base amount of the incentive payment is $2,000,000. To this base is added a "discharge related amount." There is no payment for the first 1,149 discharges or for discharges above 23,000 within the hospital's fiscal year identified in the Medicare hospital cost report period. For each discharge in between, $200 is added.

The initial amount is also multiplied by a Medicare share percentage (which includes FFS and MA bed days), modified by a charity care factor and a transition share. These factors will be worked through a process similar to the cost report. CMS provides the formula on page 44459, and the transaction factor table for Medicare FFS, unchanged from the proposed rule, appears on page 44460.

Like EPs, hospitals will be subject to Medicare payment reductions beginning in 2015 if they are not meaningful users. This will be the case even for hospitals that received incentive payments in prior years. CMS distinguishes differing levels of payment reductions based on a hospital's progress toward meaningful use (e.g., a hospital that reports quality data but is not a meaningful user of an EHR). Discussion regarding these adjustments appears on page 44460.

Critical access hospitals (CAHs) are not paid under the same reimbursement rules as FFS; they are paid on reasonable costs, not DRGs. CMS provides detail behind the CAH incentive payment effective with FY 2010 or reimbursement reductions these hospitals after FY 2015 (pp. 44461–44464). The final rule describes the means by which depreciation is calculated as well as the factors for charity care and the "Medicare Share." Unlike FFS hospitals, CAHs will have a prompt interim payment system.

CMS also highlights the process for making incentive payments to EPs and eligible hospitals. Medicare Administrative Contractors, fiscal intermediaries, and carriers will facilitate the process. As noted, EPs will be paid on a rolling basis, meaning they will be paid the maximum incentive payment as soon as they meet the threshold set by these regulations. If the threshold is not met in the calendar year but the EP is a meaningful user, CMS will use a factor to provide some incentive payment (p. 44465). If the eligible EP is also a qualified Medicare Advantage

(MA) EP then the incentive payment would be submitted to the MA where the EP is affiliated. Determining the relationship between an EP and the MA program will determine the method and quantity the EP shall receive.

Hospitals, including CAHs, will be paid on the basis of their cost reports; however, CAHs will have the ability to submit documents for payment once they have incurred actual EHR costs. The final rule provides an overview of the timing and process by which the FIs and MACs will issue payment to the CAHs. CAHs will be required to provide documentation to support the costs incurred for EHR implementation and such information could include invoices, receipts, or other comparable materials (p. 44467).

MA Payments

MA incentive payments and reductions related to meaningful use are much more complicated due to the nature of the MA program and the fact that contracted physicians and hospitals may also qualify for payments outside of the MA program. The qualifications for payment and the process of attestation through an MA are likewise complicated and will require close consideration by all parties involved.

ARRA specifically prohibits CMS from making payments to EPs for both MA and FFS services, and CMS's rulemaking addresses this concern for avoiding duplicate payments. Providers or MAs that are part of a Medicare MA program should read these requirements carefully and ensure they and their MA programs are in agreement on the provisions for these situations. They must determine how they will seek to qualify for appropriate incentive payments and provide the necessary attestations and reporting.

Medicaid Incentives and Program Policy

CMS discusses both how states fit within the legislation and qualify for federal administrative assistance, as well as the requirements providers must meet to qualify for a Medicaid incentive payment. The final rule confirms the initial proposal that states may receive 90 percent of their federal financial participation for expenditures related to the administration of an EHR incentive program, as well as 100 percent for expenditures for those incentive payments.

CMS proposes eligibility rules for providers that are very similar to those for Medicare; however, there are "flexible" thresholds for EPs:

- EPs practicing predominantly in a federally qualified health center or a rural health clinic are not subject to the hospital-based exclusion. "Predominately" is defined as more than 50 percent of the professional's total patient encounters in a six-month period (p. 44483).
- At minimum, 30 percent of an EP's patient encounters must be attributable to Medicaid over any continuous 90-day period within the most recent calendar year. For pediatricians, however, this threshold is lowered to 20 percent. A second exception relates to patients seen at federally qualified health centers and rural health clinics (p. 44485).

Only acute hospitals and children's hospitals are eligible for Medicaid incentives (pp. 44484). These providers must also meet all other program requirements, including Medicaid patient volume thresholds. For acute hospitals, the average length of stay must be below 25 days.

In response to comments received, CMs amended its definition of acute care hospitals for purposes of the EHR incentive program. The final rule defines acute care hospitals as those hospitals with an average patient length of stay of 25 days or fewer and with a CCN that falls in the range 0001–0879 or 1300–1399. This definition will now encompass general short-term hospitals, cancer hospitals, and critical access hospitals that meet the Medicaid patient volume criteria. A children's hospital must be separately certified to qualify; it may not be a part of an acute hospital.

The qualifying patient thresholds by provider type appear in table 15 below.

TABLE 15: Qualifying Patient Volume Threshold for Medicaid EHR Incentive Program

Entity	Minimum 90-day Medicaid Patient Volume Threshold	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC - 30% "needy individual" patient volume threshold
Pediatricians	20%	
Dentists	30%	
Certified nurse midwives	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	N/A
Children's hospital	N/A	N/A

States may propose unique requirements to the time frames for patient volume in addition to those set by CMS. They may propose additional requirements to CMS through the State Medicaid HIT Plan.

An EP may assign the Medicaid incentive payment to an associated entity that promotes the adoption of certified EHR technology—"the enabling and oversight of the business, operational and legal issues involved in the adoption and implementation of EHR and/or exchange and use of electronic health information between participating providers, in a secure manner, including maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by EPs" (pp.44491).

CMS encourages states to consider how they will verify on an ongoing basis that the entities that they designate are in fact promoting EHR adoption per the requirements. This does not preclude regional extension centers from being designated by states for this role. The provision permits either a reassignment by an EP or a direct payment from Medicaid to a health information exchange.

CMS proposes different approaches toward Medicaid incentives payments based upon whether the EP has already adopted, implemented, or upgraded certified EHR technology or whether the EP begins adopting, implementing, or upgrading certified EHR technology in the first year (pp. 44495–96).

Under Medicaid an EP is not required to participate on a consecutive annual basis; however, the last year an EP may begin receiving payments is 2016 and the last year the EP can receive payments is 2021. In this area, Medicare and Medicaid differ, allowing Medicaid more flexibility in its participation.

EPs considering either program should consider differences between the Medicare and Medicaid programs, their patient volume requirements, and potential additional requirements that states could develop. EPs will have a one-time option to switch between the Medicare and Medicaid programs.

The description of payments to acute and children's hospitals also provides alternate payment scenarios that states may consider, including means to gather data for determining eligibility and payment (pp. 44497–501). It should be noted that unlike Medicaid EPs, hospitals may receive incentive payment from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements.

After 2016 eligible hospitals may not receive an incentive payment unless payment was received the previous year. States can make no more than 50 percent of the hospital's aggregate incentive payment in any one year. In addition, over a two-year period, the state cannot pay more than 90 percent of the aggregate incentive. Finally, no more than six years of payment may be made and may not be made to a hospital for any year beginning after 2016, unless the hospital was provided an incentive payment for the preceding year.

The final rule supports the proposed approached for establishing a coordinated set of proposals to both harmonize payments from the Medicare and Medicaid programs (with the exception of payments Medicaid may be making from ONC grants) and avoid duplicate payments. To coordinate both payment and eligibility, CMS proposes a single provider repository that would uniquely identify each participating provider and indicate which incentive program the provider has selected.

States will have access to the repository to prevent duplicating payments with other states or with the Medicare program. Cross-checks for potential duplicative payments will be based upon provider NPI.

EPs and eligible hospitals may receive payment through one state only. EPs, as noted, must choose between the Medicare and Medicaid incentive programs. CMS recognizes the impact on EPs and hospitals that see patients in multiple states and through multiple programs, but it writes that it could not determine a plan that permitted coordination among more than one Medicaid program and the Medicare programs.

CMS did not feel that aggregating patient volume across states would be an issue once EPs actually began tallying up patient volume as this is calculated based upon a percentage, not an absolute number.

Under the Medicaid program eligible providers may receive incentive payments before they have begun to meaningfully use certified EHR technology, a provision of the NPRM that remains unchanged in the final rule (pp. 44503–4). Providers may receive a first year of payment if they are engaged in efforts to "adopt, implement, or upgrade" to certified EHR technology.

Of particular interest to HIM professionals are CMS's comments that the Medicaid Transformation Grants have demonstrated the importance of staff training and workflow redesign in EHR implementation.

CMS writes, "EHR system availability is not the same as EHR system utilization. It is for that reason that we propose to include staff training and efforts to redesign provider workflow under the definition of implementing certified EHR technology. Success is not simply defined by the acquisition and installation of new or upgraded certified EHR technology, but more importantly by providers demonstrating progress towards the integration of EHRs into their routine health care practices to improve patient safety, care and outcomes" (p. 44504).

The final rule also addresses the requirements for Medicaid to receive federal financial participation reimbursement for administering the meaningful use program (pp. 44507–16).

Information Collection Requirements

Given the applications and other forms necessary to run the incentive program, CMS describes the information collection requirements (pp. 44516–44). The first requirement, related to demonstration of meaningful use, lays out in a series of tables the projected burden and potential capital cost associated with meaningful use objectives and associated measures.

Regulatory Impact Analysis

This paper will not review the final rule's regulatory impact analysis (pp. 44544–63), which is a requirement of all final rules. However, it should be noted that CMS expresses several times to the difficulty of estimating the impact, because participation in the incentive program is voluntary and those who do participate will begin from varying starting points.

In addition, CMS notes in the final rule that they anticipate that the "short-term costs to demonstrate meaningful use of certified EHR technology will be outweighed by the long-term benefits, including practice efficiencies and improvements in medical outcomes."

Paper 4 in the series will take a look at meaningful use and certification.

Additional ARRA resources are available on the AHIMA Advocacy and Public Policy Web site, www.ahima.org/advocacy/arrameaningfuluse.aspx, and the Journal of AHIMA *Web site, http://journal.ahima.org.*

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