CMS Meaningful Use Incentives NPRM

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Notice of Proposed Rule Making (NPRM)

- A process used by a government agency (such as the Centers for Medicare and Medicaid Services [CMS]) to solicit comments and concerns from people whom a proposed change to existing regulations will likely affect
  - On January 13, 2010, CMS published an NPRM regarding the Code of Federal Regulations (CFR) Title 42 – Public Health, Parts 412, 413, 422, and 495
- An NPRM usually includes lengthy explanations, sometimes with alternative considerations that the agency is rejecting; and specific requests for comments
- Unlike an Interim Final Rule that carries an effective date, a Final Rule must be published for changes to take effect
  - The comment period is 60 days after publication in the *Federal Register.* Final rule is not expected until after March 2010, with effective date 60 days later. A final rule is not expected until after March 2010, with effective date 60 days later

Topics

- Statutory Basis
- Provisions
- Key Definitions
- Meaningful Use Criteria
- Clinical Quality Measures
- Reporting Methods
- Payments
- Regulatory Impact

Statutory Basis

Health Information Technology for Economic and Clinical Health (**HITECH**) Act; American Recovery and Reinvestment Act (ARRA) of 2009

1. Establishes **Medicare Fee-for-Service (FFS)** incentive payments for the meaningful use **(M.U.)** of certified EHR technology by:
   - **Eligible professionals (EPs)** beginning calendar year (CY) 2011, and if not M.U. less than 100% of fee schedule for their professional services
   - **Hospitals** beginning in Federal fiscal year (FY) 2011, and if not M.U. reduced annual payment beginning in FY 2015
     - **Critical access hospitals (CAHs)** based on the hospitals' reasonable cost beginning in FY 2011, and if not M.U. downward adjustment for hospital services beginning for cost reporting periods in FY 2015
2. Provides for **Medicare Advantage (MA)** organizations certain affiliated hospitals to be provided an incentive (and avoid duplicate payments, and make downward adjustment by FY 2015 if not M.U.
3. Provides 100% Federal financial participation to States for **Medicaid** incentive payments and 90% for associated State administrative expenses

NPRM seeks to create as much commonality between the programs as possible

Provisions

- **Eligible hospitals**
  - Include those receiving reimbursement under Medicare (FFS or MA), critical access hospitals, or Medicaid
  - May receive EHR incentives under both the Medicare and Medicaid program if they meet each program's eligibility requirements
  - A hospital is determined by its unique CMS certification number (CCN)
- **Eligible professionals (EPs)**
  - For **Medicare**: MDs/DOs, dentists, podiatrists, optometrists, chiropractors. For **Medicaid**: physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants in FQHC or rural health clinic
  - Exclude EPs who furnish 90% or more of their covered professional services in an inpatient hospital, outpatient hospital, or emergency room of a hospital. CMS is considering use of HIPAA 837 place of service (POS) codes on physician claims to determine site of service
  - Required to use EHR for ≥ 50% of patient encounters during reporting period; this allows for providers to participate in multiple locations, some of which may not have EHR
  - Are identified by his/her unique National Provider Identifier (NPI)
  - Must choose between Medicare or Medicaid incentives; may switch between Medicare and Medicaid one time during the incentive program
  - May not receive both EHR and e-prescribing incentives
  - May reassign payment to ***one*** employer or entity

Key Definitions

- **Certified Electronic Health Record (EHR) Technology**: see ONC Interim Final Rule; ONC will also be issuing a NPRM on the process for organizations to conduct the certification of EHR technology
- **Qualified EHR**: see ONC Interim Final Rule
- **Payment Year** (Medicare)/Year of Payment (Medicaid):
  - For EPs, calendar year starting in 2011 (or for some Medicaid programs 2010)
  - For eligible hospitals and CAHs, Federal fiscal year (Oct. 1 of prior year through Sept. 30 of relevant year) starting in 2011 (or for some Medicaid programs 2010)
  - First Payment Year is first year for which incentive payment is received; then second, third, fourth, fifth, and sixth payment years follow there from
- **EHR Reporting Period**:
  - For first payment year, any continuous 90-day period, and entire payment year for all subsequent payment years
  - Future rulemaking will define Medicare incentive payment adjustments

Key Definitions

- **Meaningful EHR user**:
  - "An EP or eligible hospital who, for an EHR reporting period for a payment year, demonstrates meaningful use of certified EHR technology in the form and manner consistent with our standards (discussed below)."
- **Meaningful use** – following HITECH and input from Federal advisory committees, NPRM proposes
  - Common definition for both Medicare and Medicaid
  - Balancing competing considerations:
    - Ensure reform of healthcare and improved healthcare quality,
    - Encourage widespread EHR adoption
    - Promote innovation
    - Avoid imposing excessive or unnecessary burdens on providers
    - While recognizing short time-frame available under HITECH for providers to begin using certified EHR technology
  - **Definition to be based on phased criteria, where subsequent phases (stages) will be updated in future rulemaking**

Meaningful Use Criteria

- **Stage 1**: Criteria applies for all payment years (to 2015) until updated by future rulemaking. They are derived from – and closely align with – recommendations of HIT Policy Committee. Stage 1 criteria also include specific functionality measures
- **Stage 2**: Criteria to be proposed by end of 2011, with goals being to:
  - Expand on Stage 1 to encourage use of HIT for continuous quality improvement at the point of care and exchange of information in the most structured format possible
  - Apply criteria more broadly to inpatient and outpatient hospital settings
- **Stage 3**: Criteria to be proposed by end of 2013, to focus on:
  - Promoting improvements in quality, safety and efficiency
  - Focusing on decision support for national high priority conditions
  - Patient access to self management tools
  - Access to comprehensive patient data
  - Improving population health
- Over time, objectives will include not only capturing of data in electronic format, but also the exchange (transmission and receipt) of data in increasingly structured formats

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
Improving quality, safety, efficiency, and reducing health disparities	Provide access to comprehensive patient health data for patient's health care team Use evidence-based order sets and CPOE Apply clinical decision support at the point of care Generate lists of patients who need care and use them to reach out to patients Report information for quality improvement and public reporting	Use CPOE	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	For EPs, CPOE is used for at least 80% of all orders For eligible hospitals, CPOE is used for 10% of all orders
		Implement drug-drug, drug-allergy, drug-formulary checks	Implement drug-drug, drug-allergy, drug-formulary checks	The EP/eligible hospital has enabled this functionality
		Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data
		Generate and transmit permissible prescriptions electronically (eRx)		At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
		Maintain active medication list	Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data

Stage 1 Criteria

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	**Hospitals**	
		Maintain active medication allergy list	Maintain active medication allergy list	At least 80% of all unique patients seen, by the EP or admitted to the eligible hospital have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data
		Record demographics o preferred language o insurance type o gender o race o ethnicity o date of birth	Record demographics o preferred language o insurance type o gender o race o ethnicity o date of birth o date and cause of death in the event of mortality	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data
		Record and chart changes in vital signs: o height o weight o blood pressure o Calculate and display: BMI o Plot and display growth charts for children 2-20 years, including BMI.	Record and chart changes in vital signs: o height o weight o blood pressure o Calculate and display: BMI o Plot and display growth charts for children 2-20 years, including BMI.	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20
		Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have "smoking status" recorded

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
		Incorporate clinical lab-test results into EHR as structured data	Incorporate clinical lab-test results into EHR as structured data	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
		Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP or eligible hospital with a specific condition.
		Report ambulatory quality measures to CMS or the States	Report hospital quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule
		Send reminders to patients per patient preference for preventive/ follow up care		Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
		Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for as described further in section II(A)(3).
		Check insurance eligibility electronically from public and private payers	Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital
		Submit claims electronically to public and private payers.	Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital
Engage patients and families in their health care	Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
			Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it
		Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP		At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information
		Provide clinical summaries for patients for each office visit		Clinical summaries are provided for at least 80% of all office visits
Improve care coordination	Exchange meaningful clinical information among professional health care team	Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
		Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
		Provide summary care record for each transition of care and referral	Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals
Improve population and public health	Communicate with public health agencies	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
			Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
		Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)
Ensure adequate privacy and security protections for personal health information	Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law. Provide transparency of data sharing to patient.	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary

HIT Functionality Measures

- Requirement for EPs and eligible hospitals to submit numerator and denominator information for each objective (except for “submit quality measures to CMS or the State” in 2012 and beyond)
- In certain measures, reference is made to “unique patient,” which means that even if a patient is seen multiple times during the EHR reporting period they are only counted once. CMS observed that not every measure pertains to every encounter. For example, a problem list would not necessarily have to be updated at every visit

Clinical Quality Measures

- Summary information (i.e., not personally identifiable) for all patients to whom clinical quality measure applies, whether or not Medicare or Medicaid beneficiary
  - Intent is to report on all cases in order to accurately assess quality of care rendered by particular provider generally. Otherwise it would only be possible to evaluate care being rendered for a portion of patients and lessen ability to improve quality generally.
- In selecting measures for 2011 and 2012,
  - Preference was given measures endorsed by National Quality Forum, including those previously selected for:
    - Physician Quality Reporting Initiative (PQRI)
    - Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)
- Redundant or duplicative reporting will be avoided:
  - Measures reported under Medicare EHR incentive program will have satisfied parallel reporting requirements under other applicable programs
- No changes (i.e., additions or deletions) will be made except through further rulemaking, although administrative and/or technical modifications or refinements may be made

Quality Measures for EPs

- Table 3 lists applicable PQRI and NQF measure specifications where available
- Tables 4 through 19 describe further reporting requirements of Core and Specialty measure groups

TABLE 3: Proposed Clinical Quality Measures for Electronic Submission by Medicare or Medicaid Eligible Professionals for the 2011 and 2012 Payment Year

Measure Number	Clinical Quality Measure Title & Description	Clinical Quality Measure Developer & Contact Information	Electronic Measure Specifications Information	Core/Specialty Measure Group
PQRI 1 NQF 0059	**Title:** Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus **Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%	**National Committee for Quality Assurance (NCQA)** **Contact Information:** www.ncqa.org	http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage	Endocrinology, Primary Care
PQRI 2 NQF 0064	**Title:** Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus **Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl)	**NCQA** **Contact Information:** www.ncqa.org	http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage	Endocrinology
PQRI 3 NQF 0061	**Title:** Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus **Description:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)	**NCQA** **Contact Information:** www.ncqa.org	http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage	Endocrinology
PQRI 5 NQF 0081	**Title:** Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD who were prescribed ACE inhibitor or ARB therapy	**American Medical Association-sponsored Physician Consortium for Performance Improvement (AMA-PCPI)** **Contact Information:** cpe@ama-assn.org	http://www.cms.hhs.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage	Cardiology

Part of List

TABLE 20: Proposed Clinical Quality Measures for Electronic Submission by Eligible Hospitals for Payment Year 2011-2012

Measure Number Identifier	Measure Title, Description & Measure Developer	Electronic Measure Specifications Information
ED-1 NQF 0495	**Title:** Emergency Department Throughput – admitted patients Median time from ED arrival to ED departure for admitted patients **Description:** Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department **Measure Developer:** CMS/Oklahoma Foundation for Medical Quality (OFMQC)	http://www.hitsp.org/ConstructSet_Details.aspx?&PrefixAlpha=5&PrefixNumeric=906
ED-2 NQF 0497	**Title:** Emergency Department Throughput – admitted patients Admission decision time to ED departure time for admitted patients **Description:** Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status **Measure Developer:** CMS/OFMQ	http://www.hitsp.org/ConstructSet_Details.aspx?&PrefixAlpha=5&PrefixNumeric=906
ED-3 NQF 0496	**Title:** Emergency Department Throughput – discharged patients Median Time from ED Arrival to ED Departure for Discharged ED Patients Description: Median Time from ED arrival to time of departure from the ED for patients discharged from the ED **Measure Developer**: CMS/OFMQ	
Stroke-2 NQF 0435	**Title:** Ischemic stroke – Discharge on anti-thrombotics **Description:** Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge **Measure Developer:** The Joint Commission	http://www.hitsp.org/ConstructSet_Details.aspx?&PrefixAlpha=5&PrefixNumeric=906

Part of List

TABLE 21: Proposed Alternative Medicaid Clinical Quality Measures for Medicaid Eligible Hospitals

NQF #	Measure Title, Description & Measure Developer	Electronic Measure Specifications Information
0341	**Title:** PICU Pain Assessment on Admission **Description:** Percentage of PICU patients receiving: a. Pain assessment on admission b. Periodic pain assessment. **Measure Developer:** Vermont Oxford Network	
0348	**Title:** Iotrogenic pneumothorax in non-neonates (pediatric up to 17 years of age) **Description:** Percent of medical and surgical discharges, age under 18 years, with ICD-9-CM code of iatrogenic pneumothorax in any secondary diagnosis field. **Measure Developer:** AHRQ	
0362	**Title:** Foreign body left after procedure, age under 18 years **Description:** Discharges with foreign body accidentally left in during procedure per 1,000 discharges **Measure Developer:** AHRQ	
0151	**Title:** Pneumonia Care PNE-5c Antibiotic **Description:** Percentage of pneumonia patients 18 years of age and older who receive their first dose of antibiotics within 6 hours after arrival at the hospital **Measure Developer:** CMS/OFMQ	
0147	**Title:** Pneumonia Care PN-6 Antibiotic selection **Description:** Percentage of pneumonia patients 18 years of age or older selected for initial receipts of antibiotics for community-acquired pneumonia (CAP). **Measure Developer:** CMS/OFMQ	
0356	**Title:** Pneumonia Care PN-3a Blood culture **Description:** Percent of pneumonia patients, age 18 years or older, transferred or admitted to the ICU within 24 hours of hospital arrival who had blood cultures performed within 24 hours prior to or 24 hours after arrival at the hospital. **Measure Developer:** CMS/OFMQ	

TABLE 21: Proposed Alternative Medicaid Clinical Quality Measures for Medicaid Eligible Hospitals

NQF #	Measure Title, Description & Measure Developer	Electronic Measure Specifications Information
0527	**Title:** Infection SCIP Inf-1 Prophylactic antibiotic received within 1 hour prior to surgical incision **Description:** Surgical patients with prophylactic antibiotics initiated within 1 hour prior to surgical incision. Patients who received vancomycin or a fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within 2 hours prior to surgical incision. Due to the longer infusion time required for vancomycin or a fluoroquinolone, it is acceptable to start these antibiotics within 2 hours prior to incision time. **Measure Developer:** CMS/OFMQ	
0529	**Title:** Infection SCIP Inf-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time **Description:** Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after *Anesthesia End Time.* **Measure Developer:** CMS/OFMQ	

Reporting Methods

- **Demonstration of M.U. measures**
  - For CY 2011 and FY 2011, providers demonstrate through attestation
  - For payment years CY and FY 2012 and subsequent years, providers demonstrate M.U. through attestation, except for objective to "submit quality measures to CMS or the State," which must be demonstrated through electronic reporting
  - Medicaid providers will qualify for 2011 incentive payment by adopting, implementing, or upgrading to certified EHR technology, and therefore will not need to attest to M.U. of EHR
- **Electronic reporting of clinical quality measures** may be performed via:
  1. Upload into CMS-designated portal using specified structures, such as Clinical Document Architecture (CDA) and templates produced as output from EHR
  2. Use of health information exchange (HIE)/health information organization (HIO)
  3. Submission through registries
- Technical requirements will be published for Medicare EPs by July 1, 2011 and for Medicare hospitals by April 1, 2011
- Because CMS does not anticipate that HHS will complete necessary steps for it to have the capacity to electronically accept data or for HHS to have provided vendors technical specifications that they can code into EHRs for reporting measures from EHRs for the 2011 payment year, for 2011, Medicare and Medicaid providers must:
  - Use EHR to capture data and calculate results for applicable clinical quality measures
  - Attest to accuracy and completeness of numerators and denominators for each applicable measure

Attestation for Quality Measures

- Information submitted was generated as output of an identified certified EHR
- Information is accurate to best of knowledge and belief
- Information submitted includes information on all patients to whom measure applies
- Identifying information, including NPI and TIN
- Attestation with respect to any exemption or inapplicability of certain measures
- Numerators, denominators, and exclusions for each measure result reported, including for all patients irrespective of payer or lack thereof
- Beginning and end dates for which data apply

Further instructions will be published through established outreach venues

Online Posting

- ARRA requires HHS to list the names, business addresses, and business phone numbers of Medicare EPs, hospitals and CAH, and MA programs who are M.U. of EHR
  - CMS does not propose to post information on group practices because they do not propose to base incentive payments at the group practice level
- CMS will provide States with information on whether an EP or eligible hospital is a Medicare M.U., and the remittance date and amount of any incentive payments in order to

Medicare Payments to EPs

Payment Year	Amount of Incentive or Adjustment subject to per EP cap of 75% of Medicare allowed charges in any year
First year if 2011 or 2012	$18,000
First year if before 2013	$15,000
Second year	$12,000
Third year	$8,000
Fourth year	$4,000
Fifth year	$2,000
Succeeding payment years	$0
If EP in health provider shortage area	Above increases by 10%

$44,000

- Payments to be distributed within 2 months of payment year end
- CMS considering safeguards to limit risk that an allocation or reassignment of incentive payments received by an EP may implicate certain fraud, waste, and abuse laws or regulations
- Adjustments on reimbursement are provided in ARRA

Medicare Payment to Eligible Hospitals

- Calculated as a product of three elements:
  - An initial amount including:
    - Base amount of $2 million, plus
    - Discharge related amount of $200 for each hospital discharge during a payment year, beginning with a hospital's 1,150th discharge of the payment year, and ending with a hospital's 23,000th discharge of the payment year.
  - Medicare share:

    $$\frac{\text{Medicare days [including MA days]}}{\text{Total inpatient days [not including charity days]}}$$

  - Transition factor:
    - 1 for first year,
    - ¾ for second year
    - ½ for third year
    - ¼ for fourth year
    - The transition factor is modified for eligible hospitals that first become meaningful users of certified EHR technology beginning in 2014 or 2015
- Adjustments in subsequent years

Medicaid Payments

- To EPs
  - 85% of average allowable costs for EHR, capped at $25,000 for first year and $10,000 for subsequent years
  - Maximum of $63,750 over 6 years for [est. 45,000] EPs
  - EPs with at least a 30% Medicaid patient load; pediatricians who are not provider-based with at least a 20% Medicaid patient load
  - EPs practicing in a FQHC or rural health clinic with at least 30% load of patients classified as “needy”
  - Average allowable cost of purchasing, implementing, and maintaining an EHR estimated by CMS is $54,000
- To Eligible Hospitals
  - Up to 100% for hospitals, capped at 50% of actual costs for year one and 90% for the first two years combined. Allowable costs are adjusted to reflect the Medicaid load for the provider. EH include children’s hospitals and acute care hospitals with at least a 10% Medicaid load

Other Incentives and Adjustments

- Critical access hospitals
  - Eligible for reasonable costs incurred for purchase of certified EHR technology in a cost reporting period beginning during a payment year after FY 2010 but before FY 2016.
- Medicare Advantage (MA) organization
  - A qualifying MA organization may receive an incentive payment for **EPs** either employed by the qualifying MA organization; or employed by or a partner of an MA contractor that furnishes at least 80 percent of the entity's Medicare services to enrollees of the qualifying MA. Further, the EP must furnish at least 80% of services under Medicare to enrollees of the qualifying MA organization and must furnish, on average, at least 20 hours per week of patient care services
  - MA-affiliated eligible **hospitals** are those under common corporate governance with a qualifying MA organization where more than two-thirds of patients are Medicare

Regulatory Impact

- Federal agencies are required to prepare a regulatory impact analysis (RIA) for rules with economically significant effects ($100 million or more in any 1 year)
- In this RIA, all costs and benefits must be considered in selecting regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity
- In this NPRM CMS describes that:
  - Many factors affect adoption and demonstration of M.U., including a "bandwagon" effect, impact of current physician payment reductions, and inability to accurately estimate current adoption rates or costs of EHR for either physicians or hospitals
  - Benefits estimates are even more difficult to quantify and the NPRM explicitly states CMS has not quantified the overall benefits, but believes in the first 5 years of the incentive program they may be better able to do so. In addition, references are provided to some reference material of interest

10 Steps To Take Today To M.U.

1. Organize to fully understand your options, keep up to date on new regulations, and coordinate with all stakeholders
2. Assess existing HIT environment
   – at the macro level (applications)
   -- at the micro level (data collection, quality reporting)
3. Determine what your vendor will do sand when
4. Get better value from what you have today by establishing goals and expectations for use
5. Plot a migration path that fits your environment, considering needed software, hardware, people, policy, and process needs
6. Acquire and implement what is needed for M.U.
7. Gain adoption through early engagement, workflow and process improvement, change management, cultural adaptation
8. Report measures to CMS and to the stakeholders
9. Monitor results of any third party reporting services to ensure they are accurate
10. Use information on measures to establish goals and strategies for improvement