



Meaningful Use White Paper Series
 Paper no. 3: Meaningful Use—Incentive
 Payments and Program Requirements
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Meaningful Use—Incentive Payments and Program Requirements

The second paper in this series began an overview of the provider requirements within the notice of proposed rulemaking on meaningful use, published by the Centers for Medicare and Medicaid Services on January 13, 2010. This paper continues that overview with a look at the proposed payment methods and program requirements.

After describing the criteria for the meaningful use of EHRs, the NPRM 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 takes 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. Hospital-based physicians do not qualify for an incentive payment (pp. 1904–7).

The payment schedule is shown in table 22 (below). There is a 10 percent upward adjustment if the eligible professional (EP) serves more than 50 percent in a geographic health professional shortage area (HPSA, pp. 1908-10), with several other conditions applied.

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 is reached, CMS will make a full payment. How a physician might share 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 1910–11.

CMS also lays out its plan for payment adjustments effective in CY 2015 and subsequent years for EPs who are not meaningful users of certified EHR technology. It should be noted that this situation applies to all Medicare provider physicians except those who are hospital-based; therefore, even physicians that 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 apply in Puerto Rico. Hospital incentives currently are based on an initial amount, plus 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 and 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 (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 1914, and the transaction factor table for Medicare FFS appears on page 1915.

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; for instance, a hospital that reports quality data but is not a meaningful user of an EHR. This example and others appear on page 1916.

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. 1916–20). The NPRM 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. 1919). The EP’s relationship to the MA program will also impact payment and the payment process.

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. Medicare Administrative Contractors and others can be expected to release information describing their processes for each category of payee once CMS issues its final rule.

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 need careful consideration by all parties involved.

CMS is concerned with the potential for duplicate payments. Any provider or MA that is part of a Medicare MA program should read these requirements carefully and ensure they and the MA program are in agreement on the provisions for these situations and how they might qualify for appropriate incentive payments and provide the necessary attestations and reporting.

Medicaid Incentives and Program Policy

Within this section 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. States can receive 90 percent of their federal financial participation for their 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 are not considered hospital-based unless they are practicing predominately in a federally qualified health center or a rural health clinic. “Predominately” is defined as more than 50 percent of the professional’s total patient encounters in a six-month period (p. 1930).
- 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. 1931).

Only acute hospitals and children’s hospitals are eligible for Medicaid incentives (pp. 1930–31). For acute hospitals, the average length of stay must be below 25 days. A children’s hospital must be separately certified to qualify (not just part of an acute hospital).

The qualifying patient thresholds by provider type appear in table 26 (shown on the next page).

TABLE 26—QUALIFYING PATIENT VOLUME THRESHOLD FOR MEDICAID EHR INCENTIVE PROGRAM

Entity	Minimum 90-day Medicaid patient volume threshold (percent)	
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	
Children’s hospital .....	.....

States may propose unique requirements in addition to those set by CMS.

An EP may reassign the Medicaid incentive payment to an associated entity that promotes the adoption of certified EHR technology—“enabling an 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...” (pp.1932–33). The provision permits either a reassignment by an EP or a direct payment from Medicaid to a health information exchange.

CMS proposes a number of alternative methods for Medicaid incentives payments, including consideration of EPs that have already adopted, implemented, or upgraded certified EHR technology (pp. 1933–37). Under the Medicaid proposed rules an EP is not required to participate on a consecutive annual basis.

Under the proposed rule EPs will be able to participate in one program only—either Medicare or Medicaid. Accordingly, in commenting on the NPRM or in applying for the program, potential EPs should take into account the differences between the Medicare and Medicaid programs, their patient volume requirements, and other potential requirements that states could develop beyond these. 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 and the means to gather data for determining eligibility and payment (pp. 1937–39). Those commenting on the NPRM again must consider how these criteria might meet their state’s approach. It should be noted that unlike Medicaid EPs, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements.

States do have the capability to make payments over six years and begin payments in 2010; however, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital’s aggregate incentive payment.

The NPRM also lays out 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 would have access to the repository to prevent duplicating payments with other states or with the Medicare program.

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.

Another difference in the proposed Medicaid program is the ability for eligible providers to receive incentive payments before they have begun to meaningfully use certified EHR technology (pp. 1941–42). 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 is CMS’s comments that the Medicaid Transformation Grants have demonstrated the importance of staff training and workflow redesign in EHR implementation.

CMS notes, “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. 1943)

Other Requirements Related to Medicaid

The NPRM also includes the requirements for Medicaid to receive federal financial participation reimbursement for administering the meaningful use program (pp. 1945–48).

Information Collection Requirements

Given the applications and other forms necessary to run the incentive program, CMS lays out the information collection requirements (pp. 1948–72). Normally, these requirements would be published in individual notices in the *Federal Register*, but including them in the NPRM saves time once the program is final and implementation begins. The first requirement, related to demonstration of meaningful use, lays out in a series of tables the projected burden and potent capital cost associated with meaningful use objectives and associated measures (pp. 1949–61).

Regulatory Impact Analysis

This white paper series will not cover the NPRM’s regulatory impact analysis (pp. 1972–90), which is a requirement of all NPRMs. However, it should be noted that CMS alludes 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, the final rule could change significantly from the proposed rule depending on the feedback received during the public comment period.

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

References

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