Overview of Meaningful Use Incentive Payments

Note: The following information has been excerpted from the CMS Proposed Final Rule for Meaningful Use. The use of "We" and "us" refers to CMS, not CSRHA. It is for informational use only. For the complete document please visit http://www.cms.gov/ehrincentiveprograms/

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	EP Medi-Cal	EP Medicare	Hospital Medi-Cal	Hospital Medicare	CAHs
Eligibility	Doctors of medicine and osteopathy, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in an FQHC or RHC that is so led by a physician assistant. EP must have at least 30 percent patient encounters attributable to those who are receiving Medicaid. A pediatrician may have at least 20 percent Medicaid patient volume. Medicaid EPs practicing predominantly	Physician = 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. NOT podiatrists, optometrists chiropractor, inpatient or ER POS.	All Hospitals with LOS <25 days– 10% Medi-Cal patient volume	All Hospitals with LOS <25 days– Medicare	Special CAH Medicare program in addition to regular Medicaid Hospital Program if LOS <25 days

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	EP Medi-Cal	EP Medicare	Hospital Medi-Cal	Hospital Medicare	CAHs
	in an FQHC or RHC must have a minimum of 30 percent patient volume attributable to “needy individuals” including sliding scale. Percentage may be individual or clinic calculation. NOT podiatrists, optometrists, chiropractors, inpatient or ER POS.				
Incentive Payment	$63,750 for 85% of net allowable costs, $21,250 for first year AIU (adoption, implementation or upgrade)	$44,000 plus 10% bonus if HPSA, declines if starts after 2012, Max-75% of allowed charges	Medi-Cal share X {($2 million + (#discharges-1,149) X $200)} = Z YR1=Z X 1 YR2= Z X ¾ YR3= Z X ½ YR4= Z X ¼ MAX Z=$6.3702M	Medicare share X {($2 million + (#discharges-1,149) X $200)} = Z YR1=Z X 1 YR2= Z X ¾ YR3= Z X ½ YR4= Z X ¼ MAX Z=$6.3702M	Depreciable costs x Medicare share of inpatient days + 20% for MU, accelerated payments, expensed not depreciated

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	EP Medi-Cal	EP Medicare	Hospital Medi-Cal	Hospital Medicare	CAHs
First Payment Year	Calendar year 2011	Calendar Year 2011	Fiscal Year 2011	Fiscal Year 2011	Fiscal Year 2011
Last Payment Year	CY 2015	CY 2021	FY 2021	FY 2015	
Successive Year Payments Required?	No	Yes, but you can skip and lose the payment unless you switch to Medi-Cal	No	Yes, but you can skip and lose the payment unless you switch to Medi-Cal	No for cost based reimbursement
Which Progam?	Choose Medi-Cal or Medicare	Choose Medi-Cal or Medicare	Both	Both	Special Medicare Program and Regular Medicaid program
One-time switch allowed?	Yes, up to 2014	Yes, up to 2014	Eligibility determined each year	Eligibility determined each year	Eligibility determined each year
Incentive for adopting, implementing or upgrading	Yes, first year up to $21,250	No	Yes, first year up to $21,250	No	Yes, on a cost basis times Medicare Share
EHR Reporting Period	No reporting period for adoption, 90 days in first CY of MU, 12 months in subsequent years	90 days in CY one, 12 months in subsequent years	No reporting period for adoption, 90 days in first FY of MU, 12 months in subsequent years	90 days in FY one, 12 months in subsequent years	Fiscal Year for cost-based reimbursement

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	EP Medi-Cal	EP Medicare	Hospital Medi-Cal	Hospital Medicare	CAHs
Penalties	None	-1%: CY2015 -2%:CY 2016 -3%: CY 2017, up to 5% possible	.None	1/4, 1/2, and 3/4 reductions of their market basket updates in FY 2015, FY 2016, and FY 2017 and subsequent years respectively	FY2015: cost reimbursement = 100.66% FY 2016: cost reimbursement = 100.33% FY 2017: cost reimbursement = 100%
Payment **(maximum of one payment per year, generally within 60 days of acceptance)**		To EP TIN, first year by attestation, 15-46 days later, as early as May 2011, if max is not reached paid the following year.	Beginning in May 2011	Beginning in May 2011	Submit for cost reimbursement as soon actual costs are incurred. Document with invoices, receipts, etc.
					Cost incentive payments must be over 4 consecutive years and end in FY 2015
	50% of pt encounters in RHC or FQHC over 6 months				Non-depreciable costs are treated like other costs (share x 101%)

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NOTES:

DISCHARGES ARE ACUTE CARE INPATIENT ONLY, PRELIMINARY BASED ON MOST RECENTLY FILED COST REPORT, FINAL BASED ON REPORT FILED DURING PAYMENT YEAR.

MEDICARE SHARE NUMERATOR IS ACUTE CARE (NON-NURSERY) MEDICARE INPATIENT DAYS

MEDICARE SHARE DENOMINATOR IS (ALL ACUTE CARE (NON-NURSERY) INPATIENT DAYS) X (TOTAL CHARGES LESS CHARITY CARE AND BAD DEBT DIVIDED BY TOTAL CHARGES)

MEDICARE: HOSPITALS THAT FIRST DEMONSTRATE MEANINGFUL USE IN 2014 ARE ONLY ELIGIBLE FOR YEAR 2, 3 AND 4 PAYMENTS.

MEDICARE: HOSPITALS THAT FIRST DEMONSTRATE MEANINGFUL USE IN 2015 ARE ONLY ELIGIBLE FOR YEAR 3 AND 4 PAYMENTS.

MEDICARE: HOSPITALS THAT FIRST DEMONSTRATE MEANINGFUL USE IN 2016 ARE INELIGIBLE FOR PAYMENTS.

In order to resolve any inconsistencies with the definitions of "encounter," for purposes of EP patient volume, CMS allowed the following to be considered Medicaid encounters:
1) Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service; or
2) Services rendered on any one day to an individual for where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, copayments, and/or cost-sharing.

For purposes of calculating hospital patient volume, CMS allowed the following to be considered Medicaid encounters:
(1) Services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service;
(2) Services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing;
(3) Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or
(4) Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing.

For purposes of calculating needy individuals patient volume, CMS allowed the following to be considered needy patient encounters:
(1) Services rendered on any one day to an individual where Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid for part or all of the service;
(2) Services rendered on any one day to an individual where Medicaid or CHIP or a

Medicaid or CHIP demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing; or
(3) Services rendered to an individual on any one day on a sliding scale or that were uncompensated.

Multiple providers may submit an encounter for the same individual. For example, it may be common for a PA or NP to provide care to a patient, then a physician to also see that patient. It is acceptable in circumstances like this to include the same encounter for multiple providers when it is within the scope of practice.

Clinics and group practices may use the practice or clinic Medicaid patient volume (or needy individual patient volume, insofar as it applies) and apply it to all EPs in their practice under three conditions: 1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation); 2) there is an auditable data source to support the clinic's patient volume determination; and 3) so long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

Physician Assistant Eligibility

1) When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);
2) When a PA is a clinical or medical director at a clinical site of practice; or
3) When a PA is an owner of an RHC.

We agree that FQHCs and RHCs that have PAs in these leadership roles can be considered "PA-led." Furthermore, since RHCs can be practitioner owned (FQHCs cannot), we will allow ownership to be considered "PA-led."

Assignment:

We proposed to preclude an EP from reassigning the incentive payment to more than one employer or entity. To implement this requirement, we proposed to use the EP's Medicare enrollment information to determine whether an EP belongs to more than one practice (that is, whether the EP's National Provider Identifier (NPI) is associated with more than one practice). In cases where the EP was associated with more than one practice, we proposed that EPs would select one tax identification number to receive any applicable EHR incentive payment.

We are taking this opportunity to remind the public that if the EP wishes to reassign his or her incentive payment to the employer or entity with which the EP has a contractual arrangement, the parties should review their existing contract(s) to determine whether the contract(s) currently provides for reassignment of the incentive payment or if the contract(s) needs to be revised. Reassignment of the incentive payment must be consistent with applicable Medicare laws, rules, and regulations, including, without limitation, those related to fraud, waste, and abuse. For Medicaid, a discussion of reassignment of the incentive payment is found in section II.D.3.e of this final rule

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"Entities Promoting the Adoption of Certified EHR technology." We believe that any cost-sharing or subsequent distribution of the incentive payment, such as in the manner described by the commenter, should be resolved between the parties.

STARK rules *typically require contracts between the parties which set out, among other provisions, that any compensation paid between the parties does not take into account the volume or value of referrals or any other business generated between the parties, is based on fair market value, is set in advance, is in writing, and is for at least a one-year term.*

HPSA Eligibility: We proposed that for an EP to be considered as "predominantly" furnishing covered professional services in a geographic HPSA, more than 50 percent of the EP's covered professional services must be furnished in a geographic HPSA.

The amount of the EHR incentive payment is based on the estimated allowed charges for all covered professional services furnished by an EP during the payment year, subject to the maximum payment amount for the payment year for the EP. For EPs that practice in an RHC, EHR incentive payments are based on the amount of covered professional services that are not part of the RHC package of services and are billed by the EP through the physician fee schedule.

Multiple program Eligibility:
We continue to believe that providers should be able to participate in every program for which they are statutorily eligible and therefore are maintaining our proposal to only limit Medicare EPs from receiving either the Medicare EHR incentive payment or the Medicare E-Prescribing incentive payment.

Thus we will exclude those EPs (or group practices) who accept a Medicare EHR incentive payment for a given year from being eligible for the e-prescribing Incentive Program payment for that same year. EPs receiving a Medicaid EHR incentive payment would remain eligible for the Medicare MIPAA E-Prescribing Incentive Program payment.

An EP will be a hospital based EP and therefore ineligible to receive a Medicare (or Medicaid) EHR incentive payment if more than 90 percent of their Medicare (or Medicaid) services (encounters, not charges) are provided in the following two place of service (POS) codes for HIPAA standard transactions:
21—Inpatient Hospital, 23 – Emergency Room.

Attestation and Reporting:
We will require that an EP, eligible hospital or CAH would, through a one-time attestation following the completion of the EHR reporting period for a given payment year, identify the certified EHR technology they are utilizing and the results of their performance on all the measures associated with the reported objectives of meaningful use.

We would collect the information necessary to post the name, business address and business phone numbers of all EPs, eligible hospitals and CAHs participating in the Medicare FFS and MA EHR incentive programs, and to post this information on our web site. The HITECH Act did not require Medicaid EPs and eligible hospitals to be identified online so we will not do so.

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What Previous Payments Must be Deducted From Net Allowable Costs?
CMS determined average allowable first year cost is 54,000 and $20,610 per year for maintenance. MediCal can pay 85% of net allowable costs,

Since we set the average allowable cost at $54,000 in the first year, EPs could receive as much as $29,000 in funding from sources (other than from State or local governments) as contributions to the certified EHR technology and the incentive payment would still be based on 85 percent of the maximum net average allowable cost of $25,000 (or $21,250). This is appropriate since $54,000 (the average allowable cost) minus $29,000 (contributing sources of funding from other than State or local governments) equals $25,000. Since $25,000 is equal to the level of the maximum net average allowable cost or capped amount discussed above, providers could receive 85 percent of $25,000 or $21,250 in year one as a Medicaid incentive payment.

The same logic would hold true for subsequent years. Specifically, if in the following years an eligible professional received as much as $10,610 in contributing funds from sources other than State or local governments, the maximum incentive payment of $8,500 would be unaffected in such subsequent years. This result is due to the fact that the average allowable costs of $20,610 for maintaining EHR technology minus the $10,610 received would still equal $10,000, the maximum net average allowable costs permitted under the statute.

When States begin to think through the payments that are not considered acceptable and that must be subtracted from the average allowable cost to get to the net average allowable costs and consequently, the incentive payment, we believe that States should consider the situation in which professionals may have been provided with the certified EHR technology through, for example, an employer/employee relationship. We do not believe in this case that there could be any payments directly attributable to the professional for the certified EHR technology; therefore, there are no payments that must be subtracted. This situation would apply in the case of clinics like FQHCs/RHCs or IHS facilities. Additionally, States should consider that any in-kind contributions such as EHR technology or free software provided by vendors are not cash payments and therefore are also not costs that must be subtracted. Further, in the case of grants like the HRSA Capital Improvement Program grants that are used to finance many projects within an organization; for example, research projects, infrastructure, construction or repair and renovation of health centers, health care services, etc., we do not believe these grants are directly attributable as payments for the certified technology but rather are payments for several projects of the organization. Again, we do not believe that these costs are directly attributable to payment costs for the certified technology and therefore must be subtracted. These are just some examples but the clarifying point is that any costs that are subtracted from the average allowable cost to get to the net average allowable cost have to be cash payment that is “directly attributable to the professional for the certified EHR technology.” Aside from specific costs related to computer hardware, software, staff training, and/or upgrades of the technology, we believe there are limited situations that exist in which cash payment has been made that is directly attributable to the professional solely for the purpose of certified EHR technology. In those cases in which the professional himself must satisfy the responsibility for the 15 percent net average allowable costs, we believe in determining the calculation, States should consider costs related to the providers’ efforts to address workflow redesign and training to
facilitate meaningful use of EHRs as contributing to the providers’ 15 percent share.

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Considering the costs of training, preparing for, and installing or upgrading EHR technology, we believe the vast majority of EPs will spend, or receive funding from other sources in the amount of 15 percent of the maximum net average allowable cost (or $3,750 in the first year and $1,500 in subsequent years). We also believe that for providers' first payment for having adopted, implemented or upgraded certified EHR technology, States should take into consideration providers' verifiable contributions up through the date of attestation.

Pediatricians:
Since pediatricians are qualified to participate in the Medicaid EHR incentive program as physicians, and therefore classified as Medicaid EPs, they may qualify to receive the full incentive (that is, the 85 percent threshold applied to the net average allowable cost) if the pediatrician is not hospital-based and can demonstrate that they meet the minimum 30 percent. This means pediatricians with a minimum 20 percent patient volume may qualify for up to a maximum of $14,167 in the first incentive payment year and to up a maximum of $5,667 in the 5 subsequent incentive payment years, or no more than $42,500 over the maximum 6 year period.

Medi-Cal Payments to Hospitals
States may pay children's hospitals and acute care hospitals up to 100 percent of an aggregate EHR hospital incentive amount provided over a minimum of a 3-year period and a maximum of a 6-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider have been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive six years of payments on a nonconsecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. Prior to 2016, Medicaid incentive payments to hospitals can be made on a non-consecutive, annual basis.

Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a 2-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

Meaningful Use:
In order to qualify as a meaningful EHR user, an EP, eligible hospital, or CAH must successfully meet the measure for each objective in the core set and all but five of the objectives in the menu set (See companion document "CMS Final Rule Objectives and Measures". With one limitation, an EP, eligible hospital, or CAH may select any five objectives from the menu set to be removed from consideration for the determination of qualifying as a meaningful EHR user. With an option for an EP, eligible hospital, or CAH to report that the objective/measure is inapplicable to them, because they have no patients or no or insufficient number of actions that would allow calculation of the meaningful use measure. This will allow an EP, eligible hospital, or CAH to qualify as a meaningful EHR user without being required to meet objectives we have specified as potentially inapplicable. In other words, the EP, eligible hospital, or CAH could satisfy the core set objectives by satisfying all remaining objectives included in the core set. For objectives in the menu set, such an attestation would also remove the objective from consideration when determining whether an EP, eligible hospital, or CAH is a meaningful EHR user. For example, if for one objective included in the menu set an EP attests that

he or she did not have any patients or insufficient actions during the EHR reporting period on which to base a measurement of a meaningful use objective, rather than satisfy 5 of the 10 meaningful use objectives included in the menu set for EPs, the EP need only satisfy 4 of the 9 remaining meaningful use objectives included in the menu set for EPs

The first payment year for EPs is any calendar year (CY) beginning with
CY 2011 and for eligible hospitals and CAHs is any fiscal year (FY) beginning with 2011.

Patient Volume for Meaningful Use

To be a meaningful EHR user an EP must have 50 percent or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. An EP for who does not conduct 50 percent of their patient encounters in any one practice/location would have to meet the 50 percent threshold through a combination of practices/locations equipped with certified EHR technology. For example, if the EP practices at both a Federally Qualified Health Center (FQHC) and within his or her individual practice, we would include in our review both of these locations and certified EHR technology would have to be available at the location where the EP has at least 50 percent of their patient encounters.

If EP has multiple practices, must have 50% on CEHR, and only reports those patients in the denominator for MU. System downtime doesn't count and is subtracted.

The number of unique patients seen in a reporting period must be tracked by the entity and used as the denominator for the following measures:

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