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MEMORANDUM

**To:** PPSV Clients and Friends  
**From:** Powers, Pyles, Sutter & Verville, P.C.  
**Date:** January 6, 2010  
**Re:** Rulemaking Notices on HITECH Act Incentive Payments

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The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) each issued rulemaking notices on December 30 to implement the electronic health record (EHR) incentive program established under the HITECH Act. CMS's proposed rule provides details on how hospitals and eligible professionals (EPs) can qualify for the Medicare and Medicaid incentive payments, including a definition of "meaningful use" of EHR. The interim final rule issued by ONC establishes standards and criteria for EHR technology for hospitals and EPs. Both rules will be published in the Federal Register on January 13, 2010, and comments are due 60 days later.

Some highlights of these rules are:

- CMS proposes to phase-in meaningful use criteria in three stages.
- CMS proposes that hospitals and EPs demonstrate meaningful use through attestation except that, beginning in 2012, hospitals and EPs must demonstrate meaningful use for clinical quality measures by electronic submission.
- Hospital-based professionals, who are neither eligible for incentive payments nor subject to penalties, are defined as individuals who furnish 90% or more of their covered professional services in the preceding calendar year in a hospital inpatient, outpatient or emergency department (Medicare codes 21, 22 and 23).
- The ONC interim final rule establishes criteria for certified EHR technology, but ONC will implement a EHR certification program in a separate rule.

The link to the CMS rule is [http://www.federalregister.gov/OFRUpload/OFRData/2009-31217\\_PI.pdf](http://www.federalregister.gov/OFRUpload/OFRData/2009-31217_PI.pdf) and to the ONC rule is [http://www.federalregister.gov/OFRUpload/OFRData/2009-31216\\_PI.pdf](http://www.federalregister.gov/OFRUpload/OFRData/2009-31216_PI.pdf). A summary of the rules follows.

**I. BACKGROUND ON HITECH ACT**

The HITECH Act provides for Medicare and Medicaid incentive payments to certain hospitals and EPs that demonstrate “meaningful use” of EHR, including “use of certified EHR technology in a meaningful manner.” (One exception to the “meaningful use” requirement is that hospitals and EPs can receive a Medicaid incentive payment for the first payment year if they adopt, implement or upgrade certified EHR.) Hospitals and EPs that do not demonstrate meaningful use of EHR by certain dates are subject to Medicare payment reductions. There are no Medicaid penalties. Neither the incentives nor the penalties are applicable to hospital-based EPs. Qualifying hospitals may receive both Medicare and Medicaid incentive payments; EPs must choose one program (but may make a one-time switch).

**II. CMS’S PROPOSED RULE**

**A. Meaningful Use Criteria**

**1) Three Phases**

As stated above, CMS is proposing a three-stage phase-in of the meaningful use criteria for both the Medicare and Medicaid programs. CMS proposed Stage 1 objectives and measures to demonstrate meaningful use, but not specific Stage 2 and 3 measures. The three stages will be implemented in accordance with the following chart, depending on when a hospital or EP becomes a meaningful user.

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015					Stage 3

CMS is requesting comments on this three-stage plan.

CMS is proposing that, for EPs that practice at more than one location, the meaningful use measures apply only to those locations equipped with certified EHR technology. In addition, an EP must have 50% or more of his or her patient encounters at one or more of these locations to be a meaningful user. CMS is soliciting comments on these criteria.

## **2) Health IT Functionality Measures**

CMS categorizes the Stage 1 measures as 1) health IT functionality measures and 2) clinical quality measures. The health IT functionality measures for both hospitals and EPs are listed in a chart at pages 103-108 of the rule. As one example, hospitals must use computerized provider order entry (CPOE) for at least 10% of all inpatient orders, and EPs must use CPOE for 80% of orders. CPOE is defined as the use of computer assistance to enter medical orders, but not transmittal of the order. (CMS is soliciting comments on whether additional detail is required on the CPOE criteria.) A second example of a health IT functionality measure is that hospitals and EPs must provide patient health information within 48 hours in 80% of the cases in which they receive a request. With regard to health information exchange, the measures require only that EHR have the capacity to exchange information and at least one test of that capacity has been performed, rather than requiring health information exchange on a regular basis. Another example of a health IT functionality measure is that EPs must electronically transmit at least 75% of all prescriptions (other than controlled substances).

## **3) Clinical Quality Measures**

Hospital clinical quality measures are listed in Table 20 on pages 153-158. Hospitals have the option of reporting on clinical quality measures listed in Table 21 on pages 159-160 for the Medicaid incentive payment if the Table 20 measures are not applicable to the hospital's patient population.

CMS is proposing two sets of clinical quality measures for EPs. One set of measures is a "core" group applicable to all EPs (Table 4 on page 142). The second group of clinical quality measures is divided by clinical specialty, and each EP must select one measure on which to report. The specialty measure groups are: cardiology, pulmonology, endocrinology, oncology, proceduralist/surgery, primary care, pediatrics, obstetrics/gynecology, neurology, psychiatry, ophthalmology, podiatry, radiology, gastroenterology and nephrology. These measures are listed in Tables 5 through 19 on pages 143-151. CMS is requesting comments on whether certain professionals would not have sufficient data to reasonably report on any set of specialty measures.

Hospitals and EPs must report on clinical quality measures for all patients, regardless of payer. The hospital measures related to patient data are applicable to admitted patients only.

## **4) Other issues**

CMS is proposing to deem hospitals that meet the meaningful use criteria for Medicare as meeting the meaningful use criteria for Medicaid, but also giving States the opportunity to add criteria approved by CMS. CMS is requesting comments on whether States should be given added flexibility with regard to meaningful use criteria.

CMS is soliciting comments on whether all providers will be able to meet all of the Stage 1 measures and suggestions for alternative criteria and measures, as well as the inclusion or exclusion of clinical quality measures.

**B. Demonstrating Meaningful Use**

CMS is proposing that, for 2011, hospitals and EPs report meaningful use through attestation for both Medicare and Medicaid, which include an attestation as to the results of the clinical quality measures. For 2012 and subsequent years, CMS is proposing that hospitals and EPs continue to attest to meaningful use for all measures except clinical quality measures, which will be reported electronically (if CMS has the infrastructure in place to accept the data in 2012). CMS is requesting comments on the best method for electronic submission.

The reporting period is any continuous 90-day period during the first payment year and the entire year for subsequent years. CMS is requesting comments on the appropriate length and start date of the reporting period.

CMS plans to conduct compliance reviews to validate eligibility for the incentive payments. Hospitals and EPs must maintain evidence of eligibility for 10 years after they register for payments.

CMS will post online the names of EPs and hospitals who are meaningful users.

**C. Eligible Hospitals and Professionals**

As stated above, hospitals that meet the Medicare and Medicaid criteria may participate in both programs. EPs must pick one program, but can make a one-time switch.

**1) Medicare**

Medicare incentives are available to general, acute care hospitals, including Maryland hospitals (but not Puerto Rico hospitals). Medicare incentives are also available to the following professionals, unless they are hospital-based: physicians, dentists, podiatrists, optometrists and chiropractors.

**2) Medicaid**

Medicaid incentives are available to “acute care hospitals” that meet certain Medicaid patient volume requirements (discussed below). Because the HITECH Act did not define “acute care hospital,” CMS is proposing to define it as a hospital with an average length of stay of 25 days or fewer and with a provider number that has the last four digits in the series 0001-0879 (*i.e.*, general, non-specialty hospitals), as well as the 11 U.S. cancer hospitals.

Children’s hospitals are also eligible for Medicaid incentive payments, but are not subject to Medicaid patient volume requirements. CMS is proposing to define children’s hospitals as

those with a provider number in the 3300-3399 series. CMS is soliciting comments on whether to broaden this definition.

Medicaid incentives are available to the following professionals that meet certain patient volume requirements unless they are hospital-based: physicians, dentists, certified nurse-midwives, nurse practitioners and physician assistants (PAs) practicing in an FQHC or RHC led by a PA.<sup>1</sup>

### **3) Patient Volume Requirements for Medicaid Incentive**

General acute care hospitals must attest that a minimum of 10% of all patient encounters over any continuous 90-day period in the most recent calendar year were covered by Medicaid. An EP must attest that at least 30% of his or her patient encounters over any continuous 90-day period in the most recent calendar year were covered by Medicaid. (Pediatricians with 20% Medicaid patient populations may qualify, but will receive only 2/3 of the Medicaid incentive payment amount. A pediatrician with a 30% Medicaid patient volume receives full payment.) A professional practicing in an FQHC or RHC must attest that at least 30% of his or her patient encounters over any continuous 90-day period in the most recent calendar year were with needy patients. (Needy patients are generally Medicaid, SCHIP, and uncompensated care (other than bad debts) patients or those who pay on a sliding scale based on need.) The proposed rule doesn't specify whether these patient volume requirements are based on inpatient or outpatient patients; presumably both inpatients and outpatients are included. States can submit proposals to CMS for approval of alternative approaches to verify patient volume requirements.

### **4) Hospital-based Professionals**

Under the HITECH Act, a professional who furnishes "substantially all" of his or her professional services in a hospital inpatient or outpatient setting is not eligible for Medicare or Medicaid incentive payments.<sup>2</sup> More specifically, the HITECH Act requires that, for purposes of the Medicare incentive payment, the "substantially all" test be applied to the EP's Medicare covered fee schedule services. The HITECH Act does not define professional services for purposes of the Medicaid incentive payment.

CMS is defining a hospital-based professional as one who furnishes at least 90% of his or her covered professional services in an inpatient, outpatient or emergency department. For purposes of the Medicare incentive payment, CMS will make the determination each year based on claims from the prior year. For purposes of the Medicaid incentive payment, State Medicaid agencies will make the determination by analyzing claims and managed care encounter data. CMS is soliciting comments related to these criteria.

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<sup>1</sup> In addition to the above groups of hospitals and EPs, Medicare incentive payments are available to critical access hospitals on the basis of reasonable cost of EHR. Medicare and Medicaid incentive payments are also available to Medicare Advantage organizations on behalf of affiliated hospitals and physicians. This memo focuses on the hospitals and EPs listed in the text above. Incentive payments are not available to hospitals in Puerto Rico.

<sup>2</sup> The only exception is that hospital-based professionals that practice in a FQHC or RHC are eligible for a Medicaid incentive payment.

There seems to be some ambiguity as to how CMS plans to apply the 90% test. The regulation states that the test applies to “covered professional services,” which are defined as Medicare services in the HITECH Act, but also says that Medicaid agencies will make the determination based on Medicaid data for purposes of the Medicaid incentive payment.

**D. Medicare Payments**

**1) Hospitals**

The HITECH Act establishes the Medicare payment adjustment formula for hospitals and EPs. CMS’s proposed rule defines some terms used in that formula and specifies how it will collect the required data.

The payment calculation for the Medicare incentive payment to hospitals is:  $(\$2,000,000 + \text{Discharge Amount})(\text{Medicare Share})(\text{Transition Percentage})$ .

The “discharge amount” is \$200 per discharge (any payer) beginning with the 1,150<sup>th</sup> discharge through the 23,000<sup>th</sup> discharge. The Medicare share is a fraction defined as:

$$\frac{\text{Inpatient Medicare Part A + Part C Days}}{\text{Total Inpatient Days} \left[ \frac{\text{Total Charges Less Charity}}{\text{Total Charges}} \right]}$$

The transition percentage is 100% for the first payment year, decreasing by 25% in each subsequent year, except that hospitals that begin in 2014 receive a first year transition percentage of 75%, decreasing by 25% in each subsequent year, and hospitals that begin in 2015 receive a first year transition percentage of 50%, decreasing by 25% in each subsequent year.

Data for discharges, Medicare inpatient days and charity care charges will be taken from the hospital’s cost report. More specifically, inpatient days will be counted using the same data that is used to determine direct GME payments, and charity care charges will be based on Worksheet S-10 data. CMS is soliciting comments on the use of charity care financial criteria established by hospitals, collection of this data and other proxies.

Medicare incentive payments to hospitals will be paid for the federal fiscal year (beginning October 1, 2010), and data for the final payment will be based on cost reports for the hospital fiscal year that ends during the federal fiscal year. Preliminary payments will be based on data from the cost report for the prior fiscal year.

**2) EPs**

The HITECH Act provides that Medicare incentive payments to EPs are 75% of Medicare allowed charges, subject to caps. The cap is \$44,000 for EPs who demonstrate meaningful use in 2011 or 2012, and decreases thereafter as shown in the following chart:

	2011	2012	2013	2014	2015	2016	Total
Start in 2011	18,000	12,000	8,000	4,000	2,000	0	44,000
Start in 2012		18,000	12,000	8,000	4,000	2,000	44,000
Start in 2013			18,000	12,000	8,000	4,000	39,000
Start in 2014				12,000	8,000	4,000	24,000
Start in 2015					0	0	0

EPs that practice predominately in a designated health professional shortage area (HPSA) receive a 10% add-on. CMS proposes that an EP who provides more than 50% of his or her Medicare services in a HPSA will be considered to be practicing predominantly in the HPSA.

CMS proposes to make a single, consolidated Medicare incentive payment to EPs as soon as the EP demonstrates meaningful use and reaches the minimum threshold of allowed charges.

#### **E. Medicaid Payments**

The Medicaid incentive payment to hospitals is calculated using the same formula as the Medicare incentive payment, except that Medicaid inpatient days are substituted for Medicare inpatient days. In addition, Medicaid payments may begin as late as 2016 and continue through 2021. States can spread the Medicaid payments over 3 to 6 years.

EPs will receive Medicaid payments if they adopt, implement, or upgrade certified EHR in the first year and demonstrate meaningful use in subsequent years in accordance with the following schedule.

Calendar Year	Medicaid Incentive Payments for EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	-----	-----	-----	-----	-----
2012	\$8,500	\$21,250	-----	-----	-----	-----
2013	\$8,500	\$8,500	\$21,250	-----	-----	-----
2014	\$8,500	\$8,500	\$8,500	\$21,250	-----	-----
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	-----
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	-----	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	-----	-----	\$8,500	\$8,500	\$8,500	\$8,500
2019	-----	-----	-----	\$8,500	\$8,500	\$8,500
2020	-----	-----	-----	-----	\$8,500	\$8,500
2021	-----	-----	-----	-----	-----	\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

If the EP has already adopted EHR and is a meaningful user, he or she is eligible for incentive payments of \$8,500 for five years (maximum of \$42,500).

EPs may only participate in either the Medicare or Medicaid incentive program and may make a one-time switch between programs.

States may begin making payments to hospitals and EPs in 2010 for adopting, implementing or upgrading certified EHR technology (not for meaningful use). The State must demonstrate to CMS that it is ready to implement the incentive payment program.

States must implement an appeals process for providers to contest eligibility for payments, payment amounts and related issues. (The HITECH prohibits appeals related to Medicare incentive payments.)

#### **F. Payment Reductions**

Hospitals and EPs that are not meaningful users will be subject to Medicare payment reductions beginning in 2015, unless they qualify for a hardship exception. CMS's proposed rule does not provide much detail on these adjustments, but more guidance should be issued before the adjustments go into effect. There are no Medicaid penalties under the HITECH Act.

### **III. ONC's INTERIM FINAL RULE**

The ONC's interim final rule sets out standards, implementation specifications and certification criteria for EHR technology. These provisions were designed to meet the Stage 1 meaningful use criteria proposed by CMS. ONC plans to issue a proposed rule to implement a certification program for EHR and EHR modules. Hospitals and EPs will obviously want to ensure that any EHR system that they consider purchasing has been certified.

### **IV. PRIVACY AND SECURITY ISSUES**

The CMS rule proposes that hospitals and EPs conduct or review a security risk analysis (required under HIPAA regulation 45 C.F.R. § 164.308(a)(1)) and implement necessary updates as one of the health IT functionality measures. It does not include any other Stage 1 measures related to privacy or security.

The ONC states that its rule focuses strictly on EHR capabilities and doesn't change existing HIPAA requirements or guarantee compliance with those requirements. Specifically, the ONC states that "use of Certified EHR Technology alone does not equate to compliance with the HIPAA Privacy or Security rules."

The ONC standards that focus on privacy and security are listed on page 85 of the ONC rule. The rule requires that EHR technology include access control, but does not include a specific standard for access control as it expects rapid industry innovation in this area. The rule includes specific criteria and standards for encryption, however. In addition, the rule requires

that EHR technology be capable of recording information about disclosures. The ONC is also requiring that EHR technology be capable of using applicable HIPAA transaction standards.

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