

**Summary of Final Rule
Medicare and Medicaid Programs: Electronic Health Record
Incentive Program**

Revised August 25, 2010

[CMS-0033-F]

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Introduction

CMS-0033-F was put on public display on July 13, 2010, is slated for publication in the July 28, 2010 issue of the *Federal Register*, and is effective September 27, 2010. The final rule would implement the provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5) that provide incentive payments to eligible professionals (EPs) and eligible hospitals participating in the Medicare and Medicaid programs that adopt and meaningfully use certified electronic health record (EHR) technology. The final rule specifies the initial criteria an EP and eligible hospital must meet in order to qualify for the incentive payment; calculation of the incentive payment amounts; payment adjustments under Medicare for covered professional services and inpatient hospital services provided by EPs and eligible hospitals failing to meaningfully use certified EHR technology; and other program participation requirements.

CMS finalizes its proposal to codify ARRA provisions precluding administrative and judicial review under section 1869 or 1878 of the Social Security Act or otherwise of all key aspects of the EHR incentive payment program.

A separate final rule, issued by the Office of the National Coordinator (ONC) for Health Information Technology (HIT), specifies the initial set of standards, implementation specifications, and certification criteria for EHR technology and will be summarized in a separate document. The final rule is effective August 27, 2010 as is the incorporation by reference of certain publications listed in the final rule.

Definitions

CMS finalizes its proposal to use the definitions of certified EHR technology and of a qualified EHR adopted by ONC (at 45 CFR 170.102) in its final rule entitled "Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology".

For purposes of Medicare and Medicaid incentive payments, CMS adopts its proposed definition of a payment year and notes in response to comments that for the Medicare incentive programs, every year subsequent to the first payment year is treated as a payment year without regard to whether an EP, eligible hospital, or eligible critical access hospital (CAH) received an incentive payment, and CMS modifies its proposed definitions of second, third, fourth, and fifth year

accordingly. By contrast, under the Medicaid EHR incentive program, payment years may generally be nonconsecutive and the lack of an incentive payment in a year is not treated as a payment year, except that beginning with FY 2017, payment years for eligible hospitals under the Medicaid EHR incentive program must be consecutive in order to continue participation in the program. The first possible payment year for both Medicare and Medicaid EHR incentive payments is CY 2011 for EPs and FY 2011 for eligible hospitals and eligible CAHs.

In response to a comment on the treatment of an EP who changes practices in the middle of the incentive payment program, CMS notes that the incentive payment is tied to the individual, and the EP may still be eligible if the EP is a meaningful EHR user in the new practice.

CMS adopts its proposal to define the EHR reporting period to be any continuous 90-day period within the first payment year and the entire payment year for all subsequent payment years, and excludes from the final rule, in response to comments, proposed requirements for an EHR reporting period that Medicaid EPs demonstrate adoption, implementation or upgrading of certified EHR technology. Under the Medicaid EHR incentive program, CMS will not require an EHR reporting period for EPs and eligible hospitals to demonstrate adoption, implementation or upgrading of certified EHR technology, and will provide a 90-day EHR reporting period in the second payment year to demonstrate meaningful use.

In future rulemaking, the agency will propose a definition of EHR Reporting Period for purposes of Medicare incentive payment adjustments (reductions), which will accommodate the need to identify meaningful EHR users prior to the application of payment adjustments for those who are not meaningful EHR users. CMS noted that the short EHR reporting period in the first payment year “would provide more flexibility for when an EP or eligible hospital begins to meaningfully use certified EHR technology.” For example, an EP could begin meaningful use of their certified EHR technology as late as October 1, 2011 and still qualify for calendar year (CY) 2011 incentive payments (similarly, eligible hospitals could wait until July 2, 2011 and still qualify for incentive payments in fiscal year (FY) 2011).

CMS finalizes its definition of meaningful EHR user as an EP, an eligible hospital, or an eligible CAH who, for an EHR reporting period for a payment year demonstrates meaningful use of certified EHR technology in the form and manner consistent with CMS standards and declines requests to treat participation in Qualified Health Information Exchange Networks or in the Medicare Electronic Health Record Demonstration Program as meaningful use.

Meaningful Use Criteria

CMS establishes identical definitions for meaningful use under Medicare and Medicaid, arguing that they found no compelling reasons for separate definitions. However, CMS revises its definition by reducing aggregate numbers of objectives and providing more flexibility for EPs, eligible hospitals and CAHs (described below). For purposes of Medicaid, the common definition would be considered the minimum standard, with states free over time to seek CMS approval to add additional objectives to the definition of meaningful use or modify how the existing objectives are measured. However, for 2011 and 2012, CMS will only consider a state's request to tailor a Stage 1 objective for a public health objective or data registry. For example, states could specify standards-based means of transmission and/or destination of data for submission of electronic data on reportable lab results or syndromic surveillance data, but CMS will not approve any request that would require functionality beyond what is included in the ONC EHR certification criteria for Stage 1. CMS indicates that for Stage 2, it may consider states' requests to tailor meaningful use pertaining to health information exchange. Note, too, that CMS explicitly clarifies that hospitals that are meaningful users under the Medicare EHR incentive program are deemed meaningful users under the Medicaid EHR incentive program and do not have to meet any state-specific additional criteria in order to qualify for the Medicaid incentive payment.

CMS adopts its proposed phased approach to defining meaningful use with three stages, but (with one exception) the rule only finalizes meaningful use criteria under Stage 1 for 2011 and 2012. CMS plans to increase the expectations of Stage 1 functionalities over time and to propose that every objective in the Stage 1 menu set (described below) is included in the Stage 2 core set. While acknowledging thresholds under Stage 1 are ambitious, CMS expects technology to evolve and will seek to aggressively advance use of certified EHR technology. CMS will also use data from Stage 1 attestations to redefine and add objectives for Stage 2. While CMS affirms its goal to align the stages of meaningful use across all providers in 2015, they limit discussion to years before 2015, acknowledging concerns about the use of Stage 3 objectives for any provider's first payment year. Table 1 in the final rule (shown below) lists the stage of meaningful use criteria that would apply in various payment years, depending on what an EP's, eligible hospital's or CAH's first payment year might be.

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

Note that Medicaid EPs and eligible hospitals who qualify for an incentive payment for adopting, implementing, or upgrading certified EHR technology in their first payment year (discussed in more detail below) would follow the same meaningful use progression as if their second payment year was their first payment year.

To qualify as a meaningful EHR user for 2011, CMS finalizes its proposal that an EP, determined by unique national provider identifiers (NPIs), or an eligible hospital, as determined by unique CMS certification numbers (CCN), must meet the required number of objectives and their associated measures.

CMS made significant changes in the final rule to the Stage 1 meaningful use criteria for 2011 and 2012 for EPs and eligible hospitals and CAHs and the proposed measures associated with them. In response to comments that the proposed rule requirements for meaningful use established an “all or nothing” approach under which eligible hospitals and EPs who failed to meet any one of the requirements would be ineligible for incentive payments, CMS reduced the aggregate number of and modified objectives; reduced many associated measure thresholds, and established two sets of objectives with associated measures—a core set of 14 objectives for eligible hospitals and CAHs and 15 for EPs, and a menu set of 10 objectives. All objectives in the core set must be met while eligible hospitals and CAHs and EPs may select five objectives from among 10 listed in the menu set with the requirement that at least one selected objective be a population and public health measure.

Additionally, CMS has modified measures to permit an eligible hospital, CAH, or EP to indicate that the objective/measure does not apply to them because, for example, they have no patients or an insufficient number of actions to calculate the measure, and the agency has identified specific exclusions where they exist. CMS will only require attestation to remove the measure from consideration which reduces the number of objectives required to demonstrate meaningful use.

Among the significant changes from the proposed rule, CMS modified the computerized physician order entry (CPOE) objective and measure for stage 1, by limiting it to entry of medication orders (at least one medication order entered electronically) by authorized licensed healthcare professionals and set a threshold of 30 percent of orders for both eligible hospitals and EPs. CMS clarifies that the CPOE criterion also applies to patients admitted to emergency departments, and specifies that to meet the objective and measure, the EP, eligible hospital or CAH must use the capabilities of the certified EHR Technologies as specified. For stage 2, CMS finalizes a threshold for the CPOE measure of 60 percent. While the inclusion of emergency department patients in the CPOE measure came in response to comments, note that CMS has now also chosen to include emergency department patients in the denominator of many of the eligible hospital/CAH meaningful use measures.

In the final rule for Stage 1, CMS also modified the Clinical Decision Support Rule requiring only one clinical decision support rule reduced from the five under the proposed rule. CMS also adopted the “Record Advance directives” criterion recommended by the HIT Policy Committee and the criterion “Provide access to patient-specific education resources upon request” as objectives under the menu set. CMS also dropped several proposed objectives/measures (most notably those related to submitting claims electronically and checking insurance eligibility electronically from public and private payers). In response to comments, the agency also split the drug-drug, drug-allergy, drug formulary check objective and measure into one core objective/measure for clinical checks (drug-drug and drug-allergy) and a second menu set objective/measure for the administrative check (drug-formulary).

CMS adopts as final its proposal that all meaningful use measures be calculated based on the eligible provider’s entire patient population (except where otherwise noted).

Table 2 in the final rule (shown below) lists the Stage 1 criteria of meaningful use for EPs and eligible hospitals and CAHs and the proposed measures associated with them which will be valid for all payment years until updated in future rulemaking.

Table 2: Stage 1 Meaningful Use Objectives and Associated Measures Sorted by Core and Menu Set

CORE SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
<i>Improving quality, safety, efficiency, and reducing health disparities</i>	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
	Implement drug-drug and drug-allergy interaction checks	Implement drug-drug and drug- allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period

CORE SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
	Generate and transmit permissible prescriptions electronically (eRx)		More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
	Record demographics <ul style="list-style-type: none"> o preferred language o gender o race o ethnicity o date of birth 	Record demographics <ul style="list-style-type: none"> o preferred language o gender o race o ethnicity o date of birth o date and preliminary cause of death in the event of mortality in the eligible hospital or CAH 	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
	Maintain an up-to-date problem list of current and active diagnoses	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data
	Maintain active medication list	Maintain active medication list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data

CORE SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
	Maintain active medication allergy list	Maintain active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) 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 more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data
	Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule

CORE SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
<i>Engage patients and families in their health care</i>	Report ambulatory clinical quality measures to CMS or the states	Report hospital clinical quality measures to CMS or the states	For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of this final rule.
			For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule
	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days
		Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it
	Provide clinical summaries for patients for each office visit		Clinical summaries provided to patients for more than 50% of all office visits within 3 business days

CORE SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
<i>Improve care coordination</i>	Capability to exchange key clinical information (for example, problem list, medication list, medication 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, medication 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
<i>Ensure adequate privacy and security protections for personal health information</i>	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 and correct identified security deficiencies as part of its risk management process

MENU SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
<i>Improving quality, safety, efficiency, and reducing health disparities</i>	Implement drug-formulary checks	Implement drug-formulary checks	The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
		Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded

MENU SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
	Incorporate clinical lab-test results into certified EHR technology as structured data	Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either 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, research or outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition
	Send reminders to patients per patient preference for preventive/ follow up care		More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period
<i>Engage patients and families in their health care</i>	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP		More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information

MENU SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources
<i>Improve care coordination</i>	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)
	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals
	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)

MENU SET			
Health Outcomes Policy Priority	Stage 1 Objectives		Stage 1 Measures
	Eligible Professionals	Eligible Hospitals and CAHs	
		Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)
	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with 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 and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)

CMS does not finalize Stage 2 or 3 requirements in this final rule (except with respect to CPOE), but indicates its intent to increase the expectations of the functionalities in Stage 1 and add new objectives for Stage 2. For Stage 2 meaningful use criteria, CMS announces its intent to propose that every measure in the menu set in Stage 1 be added to the core set. CMS also confirms that it anticipates raising thresholds for Stage 1 objectives in Stages 2 and 3. CMS indicates it will use data from initial attestations of meaningful use to assess thresholds with the goal of aggressively advancing use of certified EHR technology. CMS confirms that it hopes to redefine objectives to include exchange (both transmission and receipt) of data in increasingly structured formats as well as add new objectives to capture new functions that were not ready for Stage 1 use. CMS also notes that future rulemaking might include updates to the Stage 1 criteria. However, the agency also says that the Stage 1

criteria adopted in this final rule would remain valid for all payment years until updated by future rulemaking.

The final rule also provides additional insight into what CMS means by structured data. CMS says that structured data within certified EHR technology merely requires the system to be able to identify the data as providing specific information, which is commonly accomplished by creating fixed fields within a record or file “but not solely accomplished in this manner.” CMS also notes that structured data “is not fully dependent on an established standard.” As an example, CMS states that if a patient is on aspirin, then that information “should be in the system so that it can be automatically identified as a medication and not as an order, note, or anything else” while an example of unstructured data “would be the word aspirin, but no ability of the system to identify it as a medication.”

With respect to the criteria relating to the provision of clinical summaries to patients, note that CMS now adopts the following detailed definition of the term “clinical summary”:

an after-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the patient name, provider’s office contact information, date and location of visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and testing patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit) and symptoms.

For measures involving a test of the capability to exchange information with an entity, such as a public health agency, CMS specifies that the test may involve the exchange of information about a fictional patient, that a failed attempt at such information exchange would meet the measure, that only one test is required for EPs practicing in a group setting that share the same certified EHR technology, and that a yes/no attestation would be sufficient to verify that the requirements of such measures have been met. Note, too, that if a test with an entity is successful, CMS now believes that the relevant EP, eligible hospital, or CAH “should institute regular reporting to that entity in accordance with applicable law and practice.” In addition, CMS notes that more stringent requirements for some of these measures, such as those relating to the submission of electronic data to immunization registries or of electronic syndromic surveillance data to public health agencies (including moving a measure from the menu set to the core set),

may be established under state Medicaid programs where the capability to exchange information exists (subject to CMS approval).

CMS notes the introduction of several new standards and requirements (X12 5010 standards, ICD-10, and other administrative simplification provisions) will require most providers to upgrade their practice management systems or implement new ones. Thus, CMS postpones until Stage 2 formats for the exchange of information among different systems to further the goal of achieving alignment of capabilities and standards for administrative transactions in EHR technologies with the administrative simplification provisions that the Affordable Care Act provides for health plans and health plan clearinghouses.

Clinical Quality Measures

With respect to the meaningful use requirement for using certified EHR technology to report clinical quality measures, CMS finalizes the requirements specified in the proposed rule, with modifications providing for a more limited list of clinical measures required for reporting in 2011 and 2012.

For the 2011 payment year, CMS finalizes its proposal that, to meet the meaningful use requirement, EPs and hospitals must submit to CMS required clinical quality data along with an attestation that certified EHR technology was used to capture the data elements and calculate the results, and that all the data submitted were complete and accurate. Data to be reported for each of the required measures are numerators, denominators, and exclusions. Results are to be reported to CMS for all applicable patients, not just Medicare and Medicaid beneficiaries. The final rule specifies the elements of the attestation, which will use the same system used for other attestations for meaningful use objectives.

For the 2012 payment year, CMS finalizes its proposal that EPs and eligible hospitals begin to report the required data on quality measures electronically. CMS intends to provide one or more alternative options for electronic submission which may include intermediaries. For 2012, electronic submission will be through a CMS-designated portal. CMS plans to test submission through Health Information Exchange/Health Information Organization or through registries for possible future implementation. CMS plans to post the technical requirements for submission on or before July 1, 2011 for Medicare EPs, and on or before April 1, 2011 for Medicare eligible hospitals and CAHs.

Discussion of the required measures and Medicaid requirements adopted in the final rule follows below. For detailed electronic measure specifications, CMS refers readers to its website at http://www.cms.gov/qualitymeasures/03_electronicSpecifications.asp#topofpage. CMS plans to post on its website the specific technical mechanisms and deadlines for attestation and electronic submission and to provide this information through various educational products in development.

Measures Required for 2011 and 2012 -- EPs. Of the 90 measures proposed for reporting by EPs for the 2011 and 2012 payment years under the Medicare and Medicaid EHR incentive programs, the final rule includes 44 measures, which are those that CMS has determined have clearly defined electronic specifications that were finalized by July 13, 2010 (the date of display of the final rule). These measures are listed in Table 6 of the final rule (not reproduced in this summary). In response to many comments received regarding reporting burden, CMS believes the number of measures finalized is a reasonable burden. Table 5 lists 44 additional measures that were proposed but not finalized for 2011 and 2012, and CMS indicates its intent to include all of them in the proposed Stage 2 requirements (expected to apply beginning with the 2013 payment year) or to propose alternative measures which would be identified through a “transparent process that includes appropriate consultation with stakeholders and other interested parties.” CMS also plans to add new measures that have not been proposed, such as in behavioral and mental health.

For the 2011 and 2012 EHR reporting periods, the final rule modifies the proposed requirement for reporting on core measures. The final rule requires that each EP submit information on six measures: three core measures and three others. The three required core measures are shown in Table 7 of the rule, which is reproduced below. If the denominator for one or more of the core measures for an EP is zero, the EP will be required to report results for up to three alternate core measures, also shown in Table 7. If all 6 of these core measures have denominators of zero, the EP will be required to report on 3 measures selected from the 38 measures listed in Table 6 of the final rule that are not identified as core measures or alternate core measures.

Only two of the core measures in the final rule were included as core measures in the proposed rule (relating to blood pressure management and tobacco use). CMS indicates that the others were selected because they have broad applicability, support prevention, were recommended by commenters and had electronic specifications by July 13, 2010.

TABLE 7: Measure Group: Core for All EPs, Medicare and Medicaid	
NQF Measure Number & PQRI Implementation Number	Clinical Quality Measure Title
NQF 0013	Title: Hypertension: Blood Pressure Measurement
NQF 0028	Title: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention
NQF 0421 PQRI 128	Title: Adult Weight Screening and Follow-up
Alternate Core Measures	
NQF 0024	Title: Weight Assessment and Counseling for Children and Adolescents

NQF 0041 PQRI 110	Title: Preventive Care and Screening: Influenza Immunization for Patients \geq 50 Years Old
NQF 0038	Title: Childhood Immunization Status

In addition to the core measures, EPs are required to report on three additional clinical measures selected from the measures listed in Table 6 of the proposed rule. (Thus, in the case of an EP for whom the three core measures and three alternate core measures all have a denominator of zero, the EP will select 6 measures from those listed in Table 6.) To be exempt from reporting the three additional clinical quality measures, the EP must attest that all of the other clinical quality measures calculated by the certified EHR technology have a zero value in the denominator.

The proposal that EPs also report on selected specialty group measures is not included in the final rule. After considering comments, CMS concluded that the proposed specialty groups are not sufficient to have a robust set of specialty measures groups, and that the lack of electronic specifications for many of the measures made the proposed requirement even more impractical. CMS states its intention, however, to reintroduce the proposal for a specialty group reporting requirement in Stage 2 with at least as many clinical quality measures by specialty. It expects electronic specifications will be developed for the proposed measures, and plans to consult with specialty groups and other interested parties as part of a transparent process for clinical quality measure development.

Measures Required for 2011 and 2012 -- Eligible hospitals and CAHs. CMS finalizes 15 of the 35 measures listed in the proposed rule for reporting by eligible hospitals and CAHs for the 2011 and 2012 EHR reporting periods, via attestation and electronic submission, respectively. These measures are those that CMS indicates have electronic specifications as of July 13, 2010, and CMS did not finalize those measures it says have not been fully developed, are only specified for claims-based calculation or did not have complete electronic specifications. The measures are listed in Table 10 of the final rule, which also includes a link to the electronic measures specifications information posted on the CMS website.

Reporting on the 15 measures will be sufficient to qualify for both the Medicare and Medicaid requirements for clinical quality measures. That is, CMS is not finalizing the proposal to have hospitals report alternative measures for Medicaid qualification if the general measures did not apply to their patient population. Under the final rule, if a hospital reports on the required measures (numerators, denominators and exclusions) using a certified EHR, it will meet the clinical quality reporting requirement for Medicare and Medicaid regardless of the measure values – that is, even if the measures do not apply to any of the hospital's patients and have a value of zero.

CMS reports receiving many comments urging delay of reporting requirements including concerns about the readiness of EHR technology for automatic

calculation and reporting of quality measures and the financial and administrative burden associated with the proposed requirements. CMS states that it carefully considered these comments, and has addressed them by limiting the final clinical quality measures to those having existing electronic specifications as of July 13, 2010. CMS notes that hospitals are only required to submit information that can be automatically calculated by their certified EHR technology, no separate data collection is required, and no duplicate reporting requirement is imposed because none of the final measures is required under Medicare's inpatient Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.

CMS response to additional comments on 2011 and 2012 measures. In the final rule, CMS addresses a variety of issues raised by commenters. For example, in response to comments that measures should be endorsed by the National Quality Forum (NQF), CMS indicates that the statute does not require NQF endorsement, and that while the final rule follows the statutory requirement giving preference to NQF measures, it does not adopt a policy that is more restrictive of the Secretary's discretion than the statute. CMS notes that the NQF endorsement process and the notice and comment rulemaking process provide opportunities for public input regarding measures. CMS indicates its commitment to work with national, state, and local associations to identify or develop additional electronically specified clinical quality measures, particularly for pediatric populations, for later stages of meaningful use.

CMS reports receiving numerous comments raising concerns about overlap between quality measure reporting in the EHR incentive program and quality reporting programs for hospitals and physicians under Medicare, CHIP, and Medicaid. Some comments, for example, suggested that successful reporting under the Physician Quality Reporting Initiative (PQRI) or the RHQDAPU program be considered sufficient for the EHR incentive program. CMS acknowledges overlap and states that the statute requires the Secretary, in selecting clinical quality measures, to avoid duplicative and redundant quality performance reporting. With respect to RHQDAPU in particular, CMS states that the HITECH Act specifically requires the use of certified EHR technology to submit clinical quality measures, which is not a requirement of the RHQDAPU program. CMS indicates its intention to "the align the EHR incentive program and quality reporting programs in future rulemaking." It notes that implementation of requirements under the Children's Health Insurance Program Reauthorization Act (CHIPRA) for a core set of measures for the pediatric population is concurrent with the EHR incentive program implementation, offering an opportunity for aligning these two programs, and points out that four of the final list of clinical quality measures in the final rule are also part of the initial core set of measures for the pediatric population. CMS believes that the adult quality measures requirements enacted in the Accountable Care Act (ACA) will provide a similar opportunity for alignment.

Medicaid Requirements. As proposed, clinical quality measures adopted for the Medicare EHR incentive program will apply to the EPs and hospitals (including CAHs) under the Medicaid EHR incentive program. EPs and hospitals eligible only for the Medicaid EHR incentive program must report their clinical quality measure data to the states. The final rule also requires, as proposed, that states identify to CMS in their state Medicaid HIT Plan how they plan to accept data from Medicaid providers seeking to demonstrate meaningful use by reporting on clinical quality measures. This can be done by attestation or electronic reporting, subject to the prior approval of CMS. If a state uses attestations for clinical quality measures, they must also describe in the HIT Plan how they will inform providers of the timeframe under which they will accept electronic submission. CMS clarifies that while states may not have the capacity to accept electronic reporting of clinical quality measures in 2011 or their first year of implementing their Medicaid EHR incentive program, they are expected to have such capacity by the second implementation year. If they do not, the state would continue to use the attestation method for reporting clinical quality measures, subject to CMS prior approval via an updated state Medicaid HIT Plan. The final rule clarifies that states must include in their Medicaid HIT Plan an environmental scan of existing HIT and quality measure reporting activities related to Medicaid. CMS expects states to include details about how other efforts can be leveraged and supported by the HITECH and how HITECH will not result in duplicative or burdensome reporting by providers.

CMS notes that the statute allows Medicaid providers in their first participation year the choice of receiving the EHR Incentive payment for having adopted, implemented or upgraded to certified EHR technology, in lieu of meeting the meaningful use requirements. CMS expects that most providers will choose this option.

Potential Measures for 2013 and beyond. CMS indicates that it expects the number of clinical quality measures for which EPs, eligible hospitals and CAHs would be able to electronically submit information will expand rapidly in 2013 and beyond. CMS will consider measures from the 2010 PQRI program and measures from the RHQDAPU program which were identified in the FY 2010 IPPS final rule (75 FR 43868-43882). Additional clinical quality measures will be considered for the Medicaid EHR that address quality of care for additional Medicaid and CHIP populations, including measures relating to pediatrics, obstetrics, long-term care, and behavioral and mental health. In addition, Tables 11 and 12 of the final rule contain clinical quality measures and measure topics, respectively, that were proposed to CMS by commenters and which CMS will retain for future consideration. As required by statute, CMS will provide opportunity for public comment prior to including measures in the Medicare EHR incentive payment program. CMS notes that the statute does not require public comment with respect to the Medicaid EHR incentive program, but states that it will consider a process for receiving public input if future stages of meaningful use include clinical quality measures specific to Medicaid providers.

Demonstration of Meaningful Use

To demonstrate meaningful use, CMS adopts a common method for both EHR incentive programs, and provides for attestation in 2011 and 2012, except for clinical quality measures for which CMS will require electronic submission in 2012 if CMS has capabilities to receive that electronic submission. CMS will require a one-time attestation after the end of the EHR reporting period involved which will be done through secure mechanism, such as a secure online portal. CMS will issue further guidance on the secure mechanism. CMS also expects to require demonstration of meaningful use through automated reporting over time.

For exclusion of objectives in 2011 and subsequent years, CMS requires only that the EP, eligible hospital, or eligible CAH report that it meets the criteria for exclusion of the applicable objective.

For 2012 and subsequent years for Stage 1, EPs, eligible hospitals, and eligible CAHs must demonstrate meeting the applicable core and menu set objective and measure requirements other than the objective to report quality measures to CMS or the states.

CMS leaves open the possibility that it, or states, may test options to use existing and emerging HIT products and infrastructure capabilities to meet other objectives—such as use of registries or direct electronic reporting—but would not require participation in a test as a condition for incentive payments.

Hospital-Based Professionals and Other Eligibility Issues

The final rule implements a statutory change made under the Continuing Extension Act of 2010 which defines a hospital-based EP as one who performs substantially all of his or her services in an inpatient hospital setting or emergency room only using hospital facilities and equipment, including EHRs. Substantially all means at least 90% of all the EP's services are furnished in a hospital setting which will be determined annually (in January) based on claims for services furnished during the preceding fiscal year. CMS declined a request to account for services paid under a global fee under this definition. CMS will make the determination for the Medicare EHR incentive program while state Medicaid agencies will make the determination for the Medicaid EHR incentive program.

Under this definition, CMS estimates 14 percent of Medicare EPs would be ineligible for incentive payments. In determining settings, CMS will use the following place of service codes: 21, Inpatient Hospital and 23, Emergency Room, Hospital.

Note that an EP receiving Medicare EHR incentive payments would not be eligible to receive Medicare incentive payments under the E-prescribing Incentive

Program but an EP receiving a Medicaid EHR incentive payment would remain eligible for such e-prescribing-related incentive payments.

CMS will collect the information necessary to post on its website the name, business address and business phone numbers of all EPs, eligible hospitals and critical access hospitals (CAHs) participating in the Medicare fee-for-service EHR incentive program. Additionally, CMS reduced its proposed EP, eligible hospital, and eligible CAH records retention requirement from 10 years to 6 for data necessary for CMS and states to administer the incentive programs.

EPs are required to make a one-time election to participate in either the Medicare or the Medicaid EHR incentives program (since EPs, unlike eligible hospitals, may only receive payments under one or the other of these incentive programs), and allowed to change their election once (as long as this is done for a payment year before 2015).¹ States will be required to provide information to CMS on whether EPs or eligible hospitals are eligible for the Medicaid incentive program, whether they are meaningful EHR users, and when any Medicaid incentive payments are made and the amount of the payment.

Medicare Fee-for-Service Incentives

1. Incentive Payments for EPs

Section 4101(a) of the HITECH Act, provides for incentive payments to EPs who are meaningful users of certified EHR technology during the relevant EHR reporting periods. The incentive payment amount, subject to an annual limit, is equal to 75 percent of the Secretary's estimate of the Medicare allowed charges for covered professional services furnished by the EP during the relevant payment year.

The Medicare EHR incentive program for Eligible professionals (EPs) starts in 2011 and continues through 2016. Eligible professionals can participate for 5 years throughout the duration of the program. The last year to begin participation is 2014.

The incentives are based on individual providers. Each eligible professional in a practice may qualify for an incentive payment, provided they successfully demonstrate meaningful use. Each EP is only eligible for one incentive payment each year, regardless of the number of practices or locations where they provide services.

¹ An EP who switches programs would be placed in the payment year the EP would have been in had the EP not switched. For example, an EP who begins receiving Medicaid incentive payments in 2011 and then switches to the Medicare program in 2012 would be considered in his or her second payment year in 2012.

Under the Medicare EHR Incentive Program, EPs include the following:

- Doctors of Medicine or Osteopathy
- Doctors of Dental Surgery or Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors

Medicare EPs may not be hospital-based. A Medicare EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting.

Physicians who are also eligible as a Medicaid EP must choose between the Medicare and Medicaid incentive programs when they register.

The EHR Incentive Program is separate from other active CMS incentive programs, such as PQRI and the e-Prescribing incentive program. Physicians can participate in PQRI at the same time as the Medicare or Medicaid EHR incentive programs, as long as they meet eligibility requirements for both the PQRI and the applicable EHR incentive program.

However, if a physician participates as a Medicare eligible professional, he/she cannot receive incentive payments from both the Medicare EHR incentive program and the e-Prescribing program in the same year. If a physician participates as a Medicaid EP, he/she may participate in both the Medicaid EHR incentive program and the e-Prescribing program at the same time, as long as he/she meets the eligibility requirements for both programs.

A physician currently participating in the e-Prescribing incentive program who wants to participate in the Medicare EHR incentive program needs to decide in which incentive program to participate. The e-Prescribing incentive program is based on allowable submitted charges during the reporting period, while the EHR incentive program provides a determined incentive payment if the requirements of the program are met. For most physicians, the EHR incentive program will provide the greater monetary value.

To qualify for Medicare incentive payments, Medicare eligible professionals must successfully demonstrate meaningful use for each year of participation in the program. For calendar years 2011-2016, meaningful EHR users generally can receive up to \$44,000 over 5 years under the Medicare incentive program. Incentive payments are made based on the calendar year. To get the maximum incentive payment, Medicare eligible professionals must begin participation by 2012.

The table below shows the maximum total amount of EHR incentive payments for a Medicare EP who does not predominantly furnish services in a primary medical care, dental or mental health professional shortage area (HPSA). Note

that to receive the maximum incentive payments for CY 2011, an EP would need to have at least \$24,000 in Medicare-allowed charges that year (that is $\$24,000 \times .75 = \$18,000$).

Calendar Year	First Calendar Year in which the EP receives an Incentive Payment				
	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later
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

The amount of the annual EHR incentive payment limit for each payment year will be increased by 10% for Medicare eligible professionals who predominantly furnish services in an area that is designated as a HPSA. “Predominantly” is defined to mean that more than 50 percent of the EP’s covered professional services are furnished in a HPSA. HPSA bonuses are not available for eligible professionals in the Medicaid EHR incentive program.

EPs are allowed to reassign their incentive payment to no more than one employer or an entity with which they have a valid employment agreement or contract providing for such reassignment (CMS argues it would be difficult operationally to allocate incentive payments among two or more individuals or entities). CMS proposed that when an EP is associated with more than one practice, the EP would be required to select one tax identification number (TIN) to receive any applicable EHR incentive payment. As described below, this was modified in the final rule to permit the use of Social Security Numbers.

For 2015 and later, Medicare eligible professionals who do not successfully demonstrate meaningful use will have a payment reduction in their Medicare reimbursement. The payment reduction starts at 1% and increases up to 5% for every year that a Medicare eligible professional does not demonstrate meaningful use. Hospital-based physicians and Medicaid eligible professionals are not subject to possible payment reductions.

Medicare EPs who cannot successfully demonstrate meaningful use will have a payment reduction in their Medicare reimbursement starting in 2015, even if they never received an incentive payment or only participate in the Medicaid EHR incentive program.

In the final rule, CMS responds to public comments as follows:

- Citing a lack of statutory authority, CMS rejects requests to expand the definition of EPs to include non-physician and other health care

practitioners, rural health clinics (RHCs), Federally qualified health centers (FQHCs), ambulatory surgical centers (ASCs), dialysis facilities and outpatient clinics.

- Clarifies that the EHR incentive payments for EPs that practice in an RHC 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.
- Rejects requests to modify the definition of “predominantly” for the purpose of determining eligibility for the 10 percent HPSA bonus.
- Rejects requests that FQHCs and RHCs receive the 10 percent HPSA bonus, citing the statutory definition of an EP – which does not include FQHCs and RHCs.
- Finalizes the proposal to pay the 10 percent HPSA bonus to physicians who furnish Medicare-covered professional services in an area that is designated as a geographic HPSA as of December 31 of the prior year, even if the area loses its designation as a geographic HPSA during the current year. Physicians furnishing Medicare-covered professional services in an area that is not designated as a geographic HPSA as of December 31 of the prior year are not eligible to receive the HPSA bonus for the current year, even if the area is subsequently designated as a geographic HPSA during the current year.
- Finalizes the proposal to permit EPs to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement, rejecting comments that the EP’s EHR incentive payments must be paid to an employer or other entity to which the EP has reassigned payments for his/her services.
- Rejects requests to allow EPs to reassign their incentive payments to more than one employer or entity.
- Declines to issue any statement regarding application of the physician self-referral law or the federal anti-kickback statute to the issue of reassignment.
- Revises the proposal that an EP must submit the TIN to which the EP’s incentive payment should be made by providing that the TIN may be the EP’s Social Security Number (SSN).
- Rejects concerns that an EP who is not a meaningful EHR user will face reduced payments beginning in 2015, citing the requirements of the statute.
- Notes that the Secretary may, on a case-by-case basis, exempt an EP who is not a meaningful EHR user for the year from the application of the payment adjustment if the Secretary determines that compliance with the requirements for being a meaningful EHR user would result in a significant hardship, such as in the case of an EP who practices in a rural area without sufficient Internet access. The exemption is subject to annual renewal, but in no case may an EP be granted a hardship exemption for more than 5 years.

2. Incentive Payments for Hospitals

- a. Definition of Eligible Hospital for Medicare.** The new law provides incentive payments, beginning in FY 2011, for eligible hospitals that are meaningful users of certified EHR technology during the EHR reporting period for the payment year. CMS proposed that incentive payments would be calculated based on the CMS certification number (CNN) of the main provider.

CMS received numerous comments objecting to this proposed policy on various grounds. These objection included that there was no standard policy that defines the specific types of facilities to which a single CNN applies, identifying hospitals solely by the CNN would result in distributing payments in a manner that does not foster widespread EHR adoption and use, linking the incentive payment only to a single CCN would not accurately reflect the pattern of costs required for deploying EHR systems across all sites in a hospital system, and that the proposed policy ran counter to the intent of the EHR incentive provision, which is to promote broader adoption of EHR systems.

Notwithstanding these and other objections, CMS finalizes the policy as proposed. Thus, for purposes of this provision, CMS says that it would provide incentive payments to hospitals as they are distinguished by their unique provider number in hospital cost reports.

- b. Incentive Payment Calculation for Eligible Hospitals: Initial Amount.** In general, the law requires the incentive payment for each payment year to be calculated as the product of: (1) an initial amount; (2) the Medicare share; and (3) a transition factor applicable to that payment year. The law defines the initial amount as the sum of a “base amount” and a “discharge related amount.” The base amount is \$2,000,000. The discharge related amount is \$200 for the 1,150th through the 23,000th discharge.

Commenters generally argued that the law provides for the inclusion of all patient discharges within the inpatient area of the hospital. This would include not only discharges from the acute care hospital but also from excluded units and nurseries. CMS, however, disagrees and says that the law clearly restricts the discharges to those from the acute care portion of the hospital.

The law also provides that a “12-month period selected by the Secretary” may be employed for purposes of determining the discharge related amount. The law also specifies that the payment year is determined based on a Federal fiscal year. CMS had proposed to use data on the hospital discharges from the hospital fiscal year that ends during the FY that is prior to the FY that serves as the payment year as the basis for making preliminary incentive

payments. CMS had also proposed to determine final payments at the time of settling the cost report for the hospital FY that ends during the payment year, and settled on the basis of the hospital discharge data from the cost reporting period.

In response to the various commenters on these proposals, CMS adopted the following policies:

- For purposes of determining preliminary incentive payments, CMS will use discharge and other relevant data from a hospital's most recently submitted 12-month cost report once the hospital has qualified as a meaningful user.
- For purposes of determining final incentive payments, CMS will use the first 12-month cost reporting period that begins after the start of the payment year, in order to settle payments on the basis of the hospital discharge and other data from the cost reporting period.

c. Incentive Payment Calculation for Eligible Hospitals: Medicare Share.

The law defines the Medicare share as a fraction based on estimated Medicare fee-for-service (FFS) and managed care inpatient bed days, divided by estimated total inpatient bed-days, modified by charges for charity care.

To remain consistent with the immediately above finalized policy, CMS adopts the following policies:

- For purposes of determining preliminary incentive payments, CMS will use data on the hospital's/CAH's Medicare fee-for-service and managed care bed days, total inpatient bed-days, and charges for charity care from the hospital's/CAH's most recently submitted 12-month cost report once the hospital has qualified as a meaningful user.
- For purposes of determining final incentive payments, CMS will use the first 12-month cost reporting period that begins after the start of the payment, in order to settle payments on basis of the hospital's/CAH's Medicare fee-for-service and managed care inpatient bed days, total inpatient bed-days, and charges for charity care from the cost reporting period.

The law defines the numerator and denominator of the Medicare share fraction for an eligible hospital in terms of estimated Medicare FFS and managed care bed-days, estimated total inpatient bed-days, and charity care charges. Accordingly, CMS proposed to determine the numbers of Medicare Part A and Part C inpatient bed-days using the same data sources and methods for counting these days as is used in determining Medicare's share for direct graduate medical education costs.

In responses to the various comments on this section; CMS:

- Affirms the exclusion of nursery days from the count of Medicare inpatient bed days saying that the agency was following the precedent of not counting such days for purposes of the direct medical education, indirect medical education and disproportionate share adjustments under the Medicare IPPS.
- Affirms the exclusion of swing bed days from the count of Medicare inpatient days because of precedent and the absence of clear direction from the law.
- Affirms the exclusion of “unpaid” Medicare days (for non-covered services and in the situation where the beneficiary has exhausted coverage of inpatient hospital services).
- Finalizes the proposal with regard to the data to be used to determine the “inpatient bed-days . . . attributable to individuals with respect to whom payment may be made under Part A” and the “estimated number of inpatient bed-days attributable . . . to individuals who are enrolled with a MA organization under Part C” in the numerator of the Medicare share fraction.
- Finalizes the proposal for determining the count of total inpatient bed-days in the denominator of the Medicare share fraction as including all patient days attributable to inpatients, excluding those units not paid under the IPPS.

d. Incentive Payment Calculation for Eligible Hospitals: Charity Care and Charges. In determining the denominator of the Medicare share fraction, CMS said it must determine any charges that are attributable to charity care furnished by an eligible hospital or CAH. In the proposed rule, CMS defined charity care as part of uncompensated and indigent care described for Medicare cost reporting purposes. CMS finalizes the proposed definition of charity care. CMS goes on to say that the charity care charges used to calculate the final Medicare share would be reported on line 20 of the pending final OMB approved Worksheet S-10.

e. Incentive Payment Calculation for Eligible Hospitals: Transition Factor. As noted above, the initial amount must be multiplied not only by the Medicare share fraction, but also by an applicable transition factor in order to determine the incentive payment to an eligible hospital. The law designates that the applicable transition factor equals one (1) for the first payment year, three-fourths ($3/4^{\text{th}}$) for the second payment year, one-half ($1/2$) for the third payment year, one-fourth ($1/4^{\text{th}}$) for the fourth payment year, and zero thereafter. However, the law penalizes hospitals whose first incentive payment year is after 2013 (see below for details). The law provides that the transition factor for a hospital for which the first payment year is after 2015 equals zero for all years. In other words, 2015 is the last year for which

eligible hospitals may begin participation in the Medicare EHR Incentive Program.

The final rule includes the following figure and table.

Figure 1--Incentive Payment Calculation for Subsection D Hospitals

$$\text{Incentive Amount} = [\text{Initial Amount}] \times [\text{Medicare Share}] \times [\text{Transition Factor}]$$

$$\text{Initial Amount} = \$2,000,000 + [\$200 \text{ per discharge for the } 1,150^{\text{th}} - 23,000^{\text{th}} \text{ discharge}]$$

$$\text{Medicare Share} = \text{Medicare} / (\text{Total} * \text{Charity Care}) = [M / (T * C)]$$

$$M = [\# \text{ of Inpatient Bed Days for Part A Beneficiaries}] + [\# \text{ of Inpatient Bed Days for MA Beneficiaries}]$$

$$T = [\# \text{ of Total Inpatient Bed Days}]$$

$$C = [\text{Total Charges} - \text{Charges for Charity Care}^*] / [\text{Total Charges}]$$

*If data on charity care is not available, then the Secretary would use data on uncompensated care as a proxy. If the proxy data is not also available, then "C" would be equal to 1.

Table13: Transition Factor

Consecutive Payment Year	Transition Factor
1	1
2	3/4
3	1/2
4	1/4

- f. **Duration and Timing of Incentive Payments.** The law provides that an eligible hospital could receive up to 4 years of financial incentive payments. The transition factor phases down the incentive payments for the 4-year period. The first incentive payment year would be FY 2011. The last year, as noted above, is FY 2015.

Table 14 in the final rule (reproduced below) shows the possible years an eligible hospital could receive an incentive payment and the transition factor applicable to each year.

TABLE 14: Transition Factor for Medicare FFS Eligible Hospitals

Fiscal Year	Fiscal Year that Eligible Hospital First Receives the Incentive Payment				
	2011	2012	2013	2014	2015
2011	1.00	NA	NA	NA	NA
2012	0.75	1.00	NA	NA	NA
2013	0.50	0.75	1.00	NA	NA
2014	0.25	0.50	0.75	0.75	NA
2015	NA	0.25	0.50	0.50	0.50
2016	NA	NA	0.25	0.25	0.25

- g. Incentive Payment Adjustment Effective in FY 2015 and Subsequent Years for Eligible Hospitals who are not Meaningful EHR users.** CMS notes that the law provides for an adjustment to the market basket update to the IPPS payment rate for those eligible hospitals that are not meaningful EHR users for the EHR reporting period for a payment year, beginning in FY 2015. Essentially, the law requires that the respective annual market basket update for eligible hospitals who are not meaningful EHR users would be reduced 33 1/3 percent for FY 2015, 66 2/3 percent for FY 2016, and 100 percent for FY 2017 and beyond.

CMS notes that this provision establishes a continuing incentive for hospitals to become meaningful EHR users.

CMS asks for comments on this provision and says that any such comments would be considered in developing future proposals to implement these provisions.

3. Incentive Payments for Critical Access Hospitals (CAHs)

- a. Definitions of CAHs for Medicare.** The law defines a CAH as a facility that has been certified as a critical access hospital. CMS proposed that incentive payments to CAHs would be calculated based on the provider number used for cost reporting purposes, which is the CCN of the main provider. CMS finalizes this proposal despite receiving many opposing comments.
- b. Current Medicare Payment of Reasonable Cost for CAHs.** CMS describes current law as regards how Medicare pays CAHs for most inpatient and outpatient services provided to Medicare beneficiaries. Specifically Medicare pays CAHs on the basis of reasonable cost. Effective January 1, 2004 Medicare pays CAHs for inpatient services, other than services of a distinct part of a CAH, 101 percent of the reasonable cost of the CAH in providing CAH services.

- c. Changes made by the HITECH Act.** In this section, CMS describes the payment changes for inpatient CAH services made by the HITECH Act. The Act did not change the payment policies for outpatient CAH services.
- d. Incentive Payment Calculations for CAHs.** CMS adopts as final its proposed methodology for calculating EHR incentive payments for CAHs. This means that CAHs determined to be meaningful EHR users during an EHR reporting period for a cost reporting period beginning during a payment year after FY 2010 but before FY 2016 will be paid an amount equal to the product of—(1) the reasonable costs incurred for the purchase of depreciable assets, such as computers and associated hardware and software, necessary to administer certified EHR technology in that cost reporting period and any similarly incurred costs from previous cost reporting periods to the extent they have not been fully depreciated as of the cost reporting period involved and (2) the CAH's Medicare share, which equals the Medicare share as computed for eligible hospitals, including the adjustment for charity care, plus 20 percentage points (but not to exceed 100 percent). This percentage adjustment will be used in place of the 101 percent typically applied to a CAH's reasonable costs, and the incentive payments would be in lieu of payments that would otherwise be made. In response to commenters concerned that certain expenses, such as staff training, associated with an EHR system may not be included in the CAH's incentive payment, CMS notes that any non-depreciable reasonable costs incurred in a payment year that are associated with an EHR system may be paid for under the current Medicare reasonable cost payment system at 101 percent.
- e. Reduction of Reasonable Cost Payment in FY 2015 and Subsequent Years for CAHs that are not Meaningful EHR Users.** CMS proposed that if a CAH has not demonstrated meaningful use of certified EHR technology for FY 2015, its reimbursement would be reduced from 101 percent of its reasonable costs to 100.66 percent. For FY 2016, its reimbursement would be reduced from to 100.33 percent of its reasonable costs. For FY 2017 and each subsequent fiscal year, its reimbursement would be reduced to 100 percent of reasonable costs. CMS also proposed that a CAH may on a case-by-case basis be exempted from this adjustment. However, in no case may a CAH be granted such a "significant hardship" exemption for more than 5 years.

CMS adopts the proposed policy as final. Further, in response to some comments, CMS says that a CAH may appeal the statistical and financial amounts from the Medicare cost report used to determine the CAH incentive payment.

4. Process for Making Incentive Payments under the Medicare FFS Program.

- a. **Incentive Payments to EPs.** CMS proposed that the carrier/MACs calculate incentive payment amounts for qualifying EPs, where incentive payments would be disbursed on a rolling basis, as soon as it was ascertained that an EP demonstrated meaningful use for the applicable reporting period.

CMS finalizes this proposal but notes that payments will be made through a single payment contractor with the Integrated Data Repository (IDR) accumulating the allowed charges for each qualified EP's National Provider Identifier (NPI).

- b. **Incentive Payments to Eligible Hospitals.** CMS proposed that the Fiscal Intermediary (FIs)/MACs would calculate incentive payments for qualifying hospitals, and would disburse such payments on an interim basis once the hospital has demonstrated it is a meaningful EHR user.

CMS says that hospital incentive payments will be calculated by the FIs/MACs; however, to facilitate funds control, payments will be made through a single payment contractor. CMS will direct the payment contractor to issue a qualifying hospital a single initial payment for the year. CMS said it expects payments will be made beginning in May 2011. No payment will be made prior to an eligible Medicare hospital successfully demonstrating that it is a meaningful user during the EHR period for the relevant payment year.

The exact timing of when a qualifying hospital receives its initial incentive payment will depend on when the hospital successfully demonstrates that it is a meaningful EHR user. For a Medicare hospital's second and subsequent participation years, after a hospital successfully demonstrates that it was a meaningful user during the reporting period for the payment year, the hospital will receive the interim payment in the following year; the initial incentive payment will be made on a monthly payment cycle beginning shortly after the hospital is determined to be a meaningful user.

- c. **Incentive payment to CAHs.** CMS finalizes its proposed policy that CAH payments will be calculated by the FIs/MACs; however, to facilitate funds control, payments will be made through a single payment contractor. Once the FIs/MACs review the documentation and the allowable amount is determined, CMS will direct the payment contractor to release to the CAH a single incentive payment in the next HITECH payment cycle. Payment cycles will begin in May 2011.
- d. **Payment Accounting under Medicare.** CMS says it will conduct selected compliance review of EPs, eligible hospitals and qualified CAHs and of

recipients of incentive payments for the meaningful use of certified EHR technology. The agency says it will identify and recoup overpayments made under the incentive payment programs that result from incorrect or fraudulent attestations, quality measures, cost data, patient data, or any other submission required to establish eligibility or to qualify for a payment

- e. **Preclusion of Administrative and Judicial Review.** While CMS says that the preclusion of administrative and judicial review in the proposed rule was not discussed, the agency believes that the statutory provisions on preclusion of review are self-implementing. Nonetheless, in the final rule, CMS identifies the provisions for which administrative and judicial review is precluded.

Medicare Advantage Organization (MAO) Incentive Payments

Under ARRA, EHR incentive payments are available to qualifying Medicare Advantage Organizations (MAOs) for certain of their affiliated eligible professionals and hospitals who are meaningful EHR users during the relevant EHR reporting period for a payment year. In this section of the final rule, CMS defines qualifying MAOs and affiliated eligible professionals and hospitals, establishes the process MAOs are to use for identifying meaningful EHR persons and entities to CMS so that incentive payments may be provided, and specifies other related requirements.

1. Definitions

Qualifying MA Organization. CMS has adopted as final its proposed definitions for a qualifying MAO. A qualifying MAO is one that is organized as a health maintenance organization (HMO) as defined in section 2791(b)(3) of the Public Health Service (PHS) Act (i.e., a federally qualified HMO, an organization recognized as an HMO under state law, or a similar organization regulated for solvency under state law in the same manner and to the same extent as an HMO). CMS again notes that since there are few federally qualified HMOs, it expects MAOs to primarily qualify for incentive payments as state-licensed HMOs, or as organizations regulated for solvency under state law in the same manner and to the same extent as HMOs. CMS will deem MAOs offering MA HMO plans to meet the definition of HMO in section 2791(b)(3) of the PHS Act. For other plan types, such as preferred provider organization plans (PPOs) and private fee-for-service plans, CMS will require the sponsoring MAO to attest that it meets one of the qualifying criteria.

Qualifying MA Eligible Professional (EP). CMS has largely adopted as final its proposed rules relating to qualifications to be an MA EP, although it has added one additional item to the definition of a qualifying MA EP. A qualifying MAO may only receive incentive payments for EPs who are either: (1) employed by the MAO (under the usual common law rules); or (2) employed by, or a partner of

(that is, have an ownership stake in), an entity that through contract with the qualifying MAO furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of the qualifying MAO. The EP must also furnish at least 80 percent of his or her professional services covered under Medicare to enrollees of the qualifying MAO and must furnish, on average, at least 20 hours per week of patient care services (during the relevant EHR reporting period). (Such services can include both Medicare and non-Medicare services and patients.) CMS further notes that at least 80 percent of the qualifying MAO EP's total Medicare revenue in a year (that is, total revenue from Medicare FFS as well as from all MAOs) must be from a single qualifying MAO. Finally, CMS has added that a qualifying MA EP "is not a 'hospital-based EP' as that term is defined in §495.4 of this Part."

CMS observes in the preamble to the final rule that it lacks the statutory authority to combine original FFS Medicare claims-payment data and MA services provided by EPs in order to arrive at a single combined EHR payment, or to eliminate the requirement that an EP provide 80 percent of Medicare services to enrollees of an MAO. These were changes sought in comment letters.

Qualifying MA-Affiliated Eligible Hospitals. Under ARRA, Medicare EHR incentive payments will also be made to a qualifying MAO (as defined above) for qualifying MA-affiliated eligible hospitals determined to be meaningful EHR users. No comments were received on CMS' proposed definitions relating to such entities and CMS has finalized them as proposed without modification. An eligible hospital is a subsection (d) hospital under common corporate governance with a qualifying MAO (that is, where a qualifying MAO and a qualifying MA-affiliated hospital have a common parent corporation, where one is a subsidiary of the other, or where the organization and the hospital have a common board of directors). However, as required by ARRA, if for a payment year at least one third (33 percent) of a MA eligible hospital's discharges (or bed-days) of Medicare patients are covered under Part A (rather than under Part C), the hospital may only receive an incentive payment under the Medicare FFS incentive program. For purposes of simplicity, all incentive payments for MA-affiliated hospitals will be made through the Medicare FFS EHR incentive program.

Identification of Qualifying MAOs, MA EPs, and MA-Affiliated Eligible Hospitals. Under the proposed rule, qualifying MAOs, as part of their initial bids starting with plan year 2011, would have been required to make a preliminary identification of potentially qualifying MA EPs and MA-affiliated eligible hospitals for which the organizations sought EHR incentive payments. These MAOs would also be expected to submit an attestation that these EPs and hospitals meet the criteria to be considered eligible. Such attestations would be required within 30 days of the close of the applicable EHR incentive payment year (that is, by October 30 for hospitals and by January 30 for EPs). These requirements have been retained in the final rule with the exception that CMS has delayed the requirement for a full year. Thus, MAOs will be required to submit preliminary

lists in June of 2011 (when bids are due for 2012) of potential MA EPs for incentive payment year 2011 and not by June 2010. This delay was in response to concerns expressed in comment letters that the June 2010 deadline was impractical. CMS also agreed with comments that the time permitted for final identification of potentially qualifying MA EPs and MA-affiliated eligible hospitals should be extended from 30 to 60 days after the close of the payment year. Conforming changes in deadlines have also been made in the final rule.

In the final rule, CMS has also finalized as proposed a requirement that qualifying MAOs report the name, practice address, and other identifying information, like NPI, for all physicians that meet the requirements of a qualifying MA EP for which the qualifying MAO will be requesting payment under the MA EHR incentive payment program at the time of the initial bid beginning in June 2014 (for bids related to plan year 2015), in anticipation of the statutory requirement to negatively adjust capitation payments to qualifying MAOs for MA EPs and MA-affiliated eligible hospitals that are not meaningful EHR users for years beginning with 2015. No comments were received on these provisions.

Computation of Incentives to Qualifying MAOs for MA EPs and Hospitals. CMS has adopted as final without modification its proposed rule related to the services upon which the incentive payments are based. Thus, incentive payments will be limited to an MAO to their EPs' services to MA enrollees of plans offered by the MAO (and not for services covered under Part B). Although annual payment limits for incentive payments will be the same as those described for fee-for-service EPs, these limits will be applied to a qualifying MAO's entire MA EP population in any specific payment year relative to that MAO, regardless of the length of employment/partnership of or between that specific MA EP and that specific MAO. Further, incentive payments relating to MA EPs will only be made if the EP has not earned the maximum EHR incentive payment under the Medicare FFS incentive payment program. CMS will, therefore, need to make a determination about this prior to paying MAOs for their MA EPs (and CMS plans to withhold Medicare FFS incentive payments from EPs of less than the maximum to the extent such professionals are also identified as MA EPs—in this case incentive payments will only be made under the MA EHR incentive payment program).

CMS' proposed approach to determining the *amount of EP incentive payments* has largely been adopted as final with some modifications to address concerns about provider privacy and the need to develop a consistent and verifiable method of computing payment amounts. CMS will use revenue received by the EP for services provided to enrollees of the qualifying MAO as a proxy for amounts that would have been paid under Medicare Part B. Thus, qualifying MAOs will need to report to CMS the aggregate annual amount of revenue received by each qualifying MA EP.

For EPs compensated on a salaried basis, each MAO will need to develop a methodology for estimating the portion of the salary attributable to providing services otherwise covered under Medicare Part B. Such methodology can be based on the relative share of patient care hours spent with MA enrollees of the MAO or another reasonable method. CMS will permit the MAO to identify, where appropriate, an additional amount related to overhead that will be added to the qualifying MA EP's estimated Part B compensation. The proposed methodology must be reviewed and approved by CMS, and (newly added by the final rule), must be auditable by an independent third-party. The final rule also adds that CMS will review and approve or disapprove the proposed methodology in a timely manner.

For qualifying MA EPs who are not salaried, qualifying MAOs may (the proposed rule said "must") obtain attestations from such qualifying MA EPs as to the amount of compensation received by such EPs for MA plan enrollees of the MAO. The organizations may (the proposed rule said "must") submit to CMS compensation information for each such MA EP based on such attestations. In another change from the proposed rule, CMS will allow the physician group or other payer to provide EP reimbursement information directly to CMS. In addition, CMS has in the final rule added assurance that it will use the EP reimbursement data only to compute the MA EP incentive payment due the MAO.

For *qualifying MA-affiliated eligible hospitals*, CMS proposed and has finalized the following provisions. (No comments were received on these provisions.) To the extent data are not available to compute payments for qualifying MA-affiliated eligible hospitals under the Medicare FFS EHR hospital incentive program, CMS will substitute an amount determined to be equivalent to the amount computed if hospitals' services were made under Medicare FFS instead of Part C. It will use the same methodology and defines "inpatient-bed-days" and other terms as used under the Medicare FFS EHR hospital incentive program in computing amounts due qualifying MAOs for MA-affiliated eligible hospitals. To the extent data are available, qualifying MAOs must receive hospital incentive payments through their affiliated hospitals under the Medicare FFS EHR hospital incentive program, rather than through the MA EHR hospital incentive program.

As in the proposed rule, the final rule also includes selected compliance reviews to ensure EPs and eligible hospitals for which MAOs receive incentive payments are actually meaningful users of certified EHR technology.

Timeline for Payment and Avoidance of Duplicate payments. The final rule adopts unchanged proposed provisions related to the timeline for incentive payments. CMS will make payment to qualifying MAOs for qualifying MA EPs after computing incentive payments due under the Medicare FFS EHR incentive program. For qualifying MA-affiliated eligible hospitals, the general rule is that MAOs will be paid according to the timeline specified for FFS Medicare.

Safeguards are also included in the final rule to avoid duplicate payments. Unless a qualifying MA EP is entitled to a maximum payment for a year under the Medicare FFS EHR incentive program, payment only will be made under the MA incentive program to a qualifying MAO. Payment to qualifying MAOs for a qualifying MA-affiliated eligible hospital under common governance only will occur under the MA incentive program to the extent that sufficient data do not exist to pay the hospital under the Medicare FFS hospital incentive program.

Meaningful User Attestation. CMS proposed and has finalized requirements that each MA EP and MA-affiliated hospital for which a qualified MAO seeks an incentive payment attest that they are meaningful EHR users, adopting the same definition of meaningful user as under the Medicare FFS program. CMS has modified the timeline for submitting attestations to the agency from its proposed 30 to 60 days after the close of the payment year.

Although MA EPs and MA-affiliated hospitals will generally be required to meet the same meaningful use criteria that apply to EPs and hospitals under the FFS incentive payment program, a notable exception is that CMS will not require qualifying MAOs to submit clinical quality measures with respect to MA EPs and MA-affiliated hospitals. In part, this is due to the fact that MAOs already submit the Healthcare Effectiveness Data and Information Set (HEDIS), and other data. Under the final rule, MAOs will be able to establish meaningful use through attestation and continued HEDIS reporting.

In the rule's preamble, CMS includes comments from health plans that responded (largely unfavorably) to two alternative requirements that CMS was considering. Under the first alternative, CMS would have required qualifying MAOs that receive an EHR incentive payment to report to CMS data for any "meaningful use" quality measures not otherwise being reported (to the extent that such measures are appropriate for the MA program). Under the second, CMS would have required such MAOs to report all of the "meaningful use" quality measures directly to CMS while reporting other measures under the existing MA quality program.

Posting information on the CMS website. CMS has adopted as final its proposal to post on its website the names, business addresses and business phone numbers of each qualifying MAO receiving an EHR incentive payment as well as the same information for each of the qualifying MA EPs and MA-affiliated hospitals for which an incentive payment has been made. No comments were submitted on this issue.

Limitation on Review. CMS is adopting as final its proposed rule relating to the limitation on review. Consistent with statute, no administrative or judicial review will be available with respect to the methodology and standards for determining payment amounts and payment adjustments under the MA EHR EP or MA EHR hospital incentive programs. CMS received no comments on this issue.

Payment Adjustment and Future Rulemaking. Under the law, in the case of a qualifying MAO that attests that not all of its MA EPs are meaningful EHR users with respect to years beginning with 2015, CMS must apply the payment adjustment on the proportion of the capitation payment with respect to all such EPs of the MAO that are not meaningful users for such year. The adjustment amount is 1 percent for 2015, 2 percent in 2016, and 3 percent in 2017 and subsequent years. In the case of a qualifying MAO that attests that not all of its affiliated eligible hospitals are meaningful EHR users with respect to years beginning with 2015, CMS must apply the payment adjustment on the proportion of all such MA-affiliated eligible hospitals of the organization that are not meaningful users for such year. The adjustment reduces three-fourths of the market basket increase related to a hospital by 33 1/3 percent in 2015, by 66 2/3 percent in 2016, and by 100 percent in 2017 and all subsequent years. Effectively, the reduction is of all but 25 percent of the market basket increase for a specific hospital in years after 2016. In the NPRM, CMS had asked for comments on how the agency could most effectively and efficiently apply payment adjustments to such MAOs but comments were very limited.

Medicaid Incentives

Overview

CMS is adopting as proposed the general rule under HITECH that provides state Medicaid programs, at state option:

- 100 percent federal financial participation (FFP) for providing incentive payments to eligible Medicaid providers to adopt, implement, upgrade and meaningfully use certified EHR technology;
- 90 percent FFP for administrative expenses related to carrying out the requirements associated with the incentive payments.

Identification of Qualifying Medicaid EPs and Eligible Hospitals

Qualifying Medicaid EPs: the definition of a qualifying EP includes five types of professional:

- physicians;
- dentists;
- certified nurse-midwives;
- nurse practitioners; and
- physician assistants (PAs) practicing in a federally qualified health center (FQHC) or rural health center (RHC) that is led by a physician assistant.

CMS clarifies in its response to comments the definition of physician assistant (PA) led entity. That definition can include:

- when a PA is the primary provider in a clinic (if there is a part-time physician and a full-time PA, CMS would consider that clinic PA led);
- when a PA is a clinical or medical director at a clinical site of practice; or

- when a PA is an owner of an RHC.

A Medicaid EP, to qualify for incentive payments, cannot be "hospital-based." That hospital-based exclusion is defined in the same manner as under Medicare. The hospital-based exclusion does not apply to Medicaid EPs practicing predominantly in an FQHC or RHC, which CMS defines as when the clinical location for more than 50 percent of the EP's patient encounters over a period of 6 months occurs at an FQHC or RHC.

CMS also responded to comments about the definition of "physician" for purposes of Medicaid and other provider qualification questions. CMS notes that for purposes of Medicaid, a "physician" is limited to doctors of medicine or osteopathy legally authorized to practice, and, at state option, optometrists. Further, CMS clarifies that states need to refer to current CMS regulations and their own scope of practice laws to determine qualification for providing services.

Qualifying Medicaid Hospitals: acute care and children's hospitals are the only two types of institutional providers potentially eligible for Medicaid incentive payments.

Acute Care Hospitals: CMS defines an acute care hospital as a health care facility where the average length of stay is 25 days or fewer and with a CCN that has the last four digits in the series 0001-0879 (short-term general hospitals and the 11 cancer hospitals). In response to comments, CMS in the final rule has added Critical Access Hospitals (CAHs), which have a CCN that falls in the range of 1300-1399. CAHs will have to meet the same requirements for receiving a Medicaid incentive payment as acute care hospitals.

In determining the average length of stay, CMS is leaving to states whether to use a fiscal year or calendar year basis. CMS rejects comments that outliers with long lengths of stay be excluded from the calculation, noting that both long and short stay outliers are included in length of stay calculations for other purposes.

Children's Hospitals: CMS is retaining its proposed definition of children's hospitals. That definition includes only separately certified children's hospitals, with CCNs in the 3300-3399 series, that predominantly treat individuals under the age of 21. It does not include the pediatric wing of larger institutions (the entire institution would need to qualify as a Medicaid eligible hospital).

A number of commenters proposed to expand the definition of those qualifying for incentive payments to include other facilities, but CMS made no changes from the proposed rules because these definitions are identified by statute. CMS has however, provided clarifying language that a Medicaid EP may qualify if practicing at such a facility (such as a behavioral health facility). If EPs qualify for the incentive payment, they can choose voluntarily to reassign the incentive

payment to a TIN associated with the facility, so long as that reassignment complies with other rules.

Adoption, implementation, upgrading and meaningful use of EHRs

In the first payment year, a Medicaid EP or eligible hospital must:

- demonstrate that, during the payment year, it has adopted, implemented or upgraded certified EHR technology; or
- Demonstrate that during the EHR reporting period for a payment year it is a meaningful EHR user as defined elsewhere in these regulations.

In subsequent payment years:

- A Medicaid EP or eligible hospital must demonstrate that it is a meaningful EHR user, as defined elsewhere in these regulations.
- The automated reporting of clinical quality measures will be accomplished using certified EHR technology interoperable with the system designated by the state to receive the data.

Volume thresholds

Medicaid EPs must have at least 30 percent of their patient volume attributable to those who are receiving Medicaid. CMS defines this as 30 percent of all patient encounters attributable to Medicaid over any continuous, representative 90 day period in the most recent calendar year. There are two exceptions to the 30 percent rule:

- A pediatrician may have 20 percent of their patient encounters attributable to Medicaid;
- Medicaid EPs practicing predominantly in an FQHC or RHC must have a minimum of 30 percent patient volume attributable to "needy individuals"; this includes those receiving Medicaid or CHIP, those receiving uncompensated care, or those receiving care at no cost or on a sliding scale, based on ability to pay.

Qualifying Medicaid hospitals must have a minimum of 10 percent of patient encounters attributable to Medicaid. There is no volume standard for children's hospitals. For purposes of meeting the volume thresholds, individuals enrolled in a Medicaid managed care plan are included in the calculation.

In response to comments about the volume thresholds, CMS is providing two options for states in the final rule for computing the percentage volume thresholds:

- Defining patient encounters within the representative 90-day period. Under this method, which was set out in the proposed rule, the numerator is the hospital's or EP's total number of Medicaid patient encounters in

that 90 day period, and the denominator is total patient encounters in that period. For those meeting the 30 percent "needy individual" test, the numerator would be the total number of needy individual patient encounters in the representative 90 day period, and the denominator is the total patient encounters in that period.

- Alternatively, defining panel enrollees. For situations where Medicaid enrollees are assigned to a panel, the numerator would be the EP's or hospital's total number of Medicaid patients assigned through a Medicaid managed care panel or similar provider structure with case assignment during the representative 90 day period, with at least one encounter during the preceding calendar year, PLUS all other Medicaid encounters with other, non-panel enrollees. The denominator is all patients assigned to the provider in that same 90 day period, with at least one encounter during the preceding calendar year, PLUS all other Medicaid encounters with other, non-panel enrollees. For those meeting the 30 percent "needy individual" test, the number of "needy individuals" would replace Medicaid in the numerator.

Definition of "encounter":

- For Medicaid EPs: services rendered to an individual per inpatient discharge where Medicaid or a Medicaid section 1115 demonstration project paid for part or all of the service, or paid all or part of the individual's premiums, co-payments and/or cost-sharing.
- For hospitals:
 - services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project paid for part or all of the service, or paid all or part of the individual's premiums, co-payments and/or cost-sharing; and
 - services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid section 1115 demonstration project paid for part or all of the service, or paid all or part of the individual's premiums, co-payments and/or cost-sharing.
- For needy individual patient volume:
 - services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project paid for part or all of the service, or paid all or part of the individual's premiums, co-payments and/or cost-sharing; and
 - Services rendered to an individual on any one day on a sliding scale or that were uncompensated.

In response to comments, CMS in the final rule is providing states flexibility to propose alternative methodologies for the timeframe and all of the other

elements for establishing patient volume (with the exception of the statutory percentage thresholds). If CMS approves an alternative methodology, it would make that approval public and allow other states to adopt the alternative methodology.

The statute includes only Medicaid (and not CHIP) encounters in the definition, with one exception noted above: those practicing in an FQHC or RHC may include CHIP volume within the definition of "needy individuals." CMS responded to commenters suggesting a broader inclusion of CHIP encounters. CMS notes the specific statutory language and their inability to move beyond it. However, CMS did note that it will work on a case-by-case basis with individual states that have seamless eligibility systems, and in some cases one enrollment card, which may make it more difficult for beneficiaries and providers to separately identify Medicaid, CHIP, or state-only patients. CMS will work with those states to find appropriate data sources.

Practice or clinic level encounter data: CMS agrees with commenters who requested that group practice- or clinic-level Medicaid (or needy individual) patient volume be allowed for all EPs in the practice. CMS revises the proposed regulations to allow the use of practice- or clinic-level data, subject to three conditions:

- The clinic or practice volume is an appropriate methodology for the EP (for example, if an EP within a practice only sees Medicare, commercial or self-pay patients, this is not an appropriate calculation for that EP or clinic).
- There is an auditable data source).
- The practice and its EPs all use one methodology in each year (for example, some EPs in a practice cannot use their own patient volume data, while others use the practice-level data).

Entities Promoting the Adoption of Certified EHR Technology

The statute and proposed rule permits payment of incentive payments to "entities promoting the adoption of certified EHR technology" as designated by the state (such as health information exchanges (HIEs)). The state must assure that the Medicaid EP voluntarily assigns the payment, and the entity must not retain more than 5 percent of the payments for costs unrelated to certified EHR technology and support services including maintenance and training that is necessary for the operation of the technology.

CMS defines "promoting" the adoption of certified EHR technology to mean 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 among participating providers in a secure manner. This includes maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by EPs. CMS clarifies in response to

comments that Regional Extension Centers funded by ONC are not precluded from being designated by the states as entities promoting the adoption of certified EHR technology. .

CMS clarifies in the final rule that states must consider how they will verify on an on-going basis that the entities they designate are in fact promoting adoption of EHRs.

Computation of amounts payable for Medicaid EPs

In general, payments for Medicaid EPs are set at 85 percent of "net average allowable costs" as estimated by the Secretary. The net average is subject to a cap for purposes of payment of \$25,000 in the first year and \$10,000 in each of five subsequent years. In the case of pediatricians with under 30 percent Medicaid patient volume (pediatricians may qualify with just 20 percent Medicaid volume), the cap is two-thirds of these amounts. Pediatricians meeting the 30 percent volume standard would not have this lower cap. EPs may begin receiving incentive payments in 2011, and must begin in 2016 if they are to qualify for any incentive payments.

There are several steps for the calculations, summarized in the table below.

First, the Secretary has to estimate the "average allowable cost" in two parts:

- For purchase, initial implementation and upgrade of certified EHR technology for purposes of the initial year's payment: CMS estimates that to be \$54,000.
- For operating, maintaining and using certified EHR technology for purposes of payments for five additional years: CMS estimates that to be \$20,610 per year.

Second, the statute sets a cap on the "net average allowable costs" for purposes of payment. That is \$25,000 for the initial year and \$10,000 for each of the five additional years.

The difference between the "average allowable cost" and the "net average allowable cost" is the "maximum allowed from other sources." This is the maximum allowable cash payments to the provider that can be received from other sources for its EHR: \$29,000 for the initial year and \$10,610 for each of the five additional years. If more is received from other sources, the net average allowable cost is reduced below the statutory maximums for purposes of Medicaid payment.

Medicaid pays 85% of this final "net average allowable cost." Unless the provider has received more than the maximum allowed from outside sources, that payment amount is \$21,250 in the initial year (85% of \$25,000) and \$8,500

for each of the five additional years (85% of \$10,000). The remaining 15% is the responsibility of the Medicaid EP.

Maximum Incentive Payment for Medicaid Professionals		
	Initial Year	Each of 5 additional years
1. Average Allowable Cost	\$54,000	\$20,610
2. Statutory maximum Net Average Allowable Cost	\$25,000	\$10,000
3. Maximum allowed from other sources (line 1- line 2)	\$29,000	\$10,610
4. Actual incentive payment (85% of line 2)	\$21,250	\$8,500
5. Remaining responsibility of Medicaid EP (line 2- line 4)	\$3,750	\$1,500
6. Maximum payment (line 4: \$21,250 + 5 x \$8,500)	\$63,750	
Assumes that the provider has not exceeded the maximum allowed from other sources (line 3). If the provider received more from other sources, the incentive payment would be 85% of the actual net allowable cost.		
In the case of pediatricians who qualify based on the lower Medicaid volume standard of 20% (rather than the 30 percent standard), the statutory maximum net allowable cost and actual incentive payment is 2/3 of the amounts shown.		

Unlike the Medicare incentive payments, the Medicaid EPs do not have to receive the payments for six consecutive years (initial year plus five additional years). The constraints are that incentive payments can start no later than 2016, and 2021 is the last year in which a payment can be made.

Medicaid eligible EPs must choose between getting the Medicaid incentive payment or the Medicare payment. They may make a one-time election to switch between the two programs.

A Medicaid EP who has already adopted, implemented or upgraded certified EHR technology and can meaningfully use it in year one can still qualify for the full initial year payment and five additional years. CMS had requested comments on an alternative approach, to limit payments to such EPs to exclude the initial year payment, but chose not to adopt that alternative because it would have punished early adopters.

Payment methodology for eligible hospitals

Medicaid eligible hospitals are eligible for an incentive payment that is calculated as the product of the "overall EHR amount" times the "Medicaid Share."

Computation of overall EHR amount for hospitals: The overall EHR amount is computed based on a theoretical four years of payment, but the state can actually pay the overall amount over a 3- 6 year period. The overall amount is computed for each of the four years as follows:

- Base amount: \$2 million; plus
- Discharge related amount: \$200 for each discharge from discharge 1,150 through 23,000 in a 12 month period ending in the FY before the first payment year. That amount is used for purposes of payment for year 1; for years 2-4, the number of discharges is changed (up or down) based on the hospital's average annual rate of change in discharges over the most recent three year period.

That base amount plus discharge related amount is multiplied by a "transition factor" that declines over the four year period. It is 1.0 in year one, .75 in year two, .5 in year 3, and .25 in year four.

Finally, that amount is multiplied by the "Medicaid share" which is computed as a fraction for a twelve month period selected by the state:

- The numerator is the sum of:
 - estimated inpatient days attributable to Medicaid individuals (subject to exception below), plus
 - estimated inpatient days attributable to Medicaid enrolled individuals in managed care organizations and prepaid health plans
- The denominator is the product of:
 - estimated total inpatient days; times
 - total charges, excluding charity care charges, divided by total charges.

Exception: In computing the Medicaid share, the final regulations clarify that Medicaid days may not include days that can be paid under Medicare part A or Medicare Part C.

Actual annual payments: the overall payment is the sum of the payments above over the four year period. However, states can spread that four year total over a time period that ranges from 3 to 6 years, subject to several constraints:

- The final rule clarifies that FY 2011 is the first year of eligibility for payment, and FY 2016 is the last year in which payments may begin;
- Prior to FY 2016, payments can be made on a non-consecutive basis; the final regulations clarify that after 2016, a hospital may not receive a payment unless it received a payment in the prior year.
- No payment for any one year may exceed 50 percent of the overall total; and no payment for a two year period may exceed 90 percent of the overall total.

Hospitals may receive incentive payments under both Medicare and Medicaid.

Hospitals and Medicaid EPs with multi-state practice locations will be required to choose only one state from which to receive incentive payments.

State requirements

The final rule confirms a number of requirements for states to receive the higher federal financial participation under this section. This includes standards set out in the regulations for:

- State monitoring and reporting requirements;
- State submission of a state Medicaid HIT Plan to CMS, and the requirements for such Plans, including systems requirements, processes for determining eligibility of providers, monitoring and validation, provider payment processes, and provisions for combating fraud and abuse;
- State responsibilities for tracking use of the incentive funds, oversight of the program, and initiatives to encourage the adoption of HIT technology;
- Prior approval requirements;
- Disallowance of FFP, termination of FFP, and procedures for reconsideration of adverse determinations by CMS;
- Access to systems and records;
- Procurement standards;
- Financial oversight and monitoring of expenditures;
- Appeals processes for providers.

Information Collection Requirements

Table 20 of the final rule lists the burden and capital costs associated with EHR meaningful use objectives and associated measures. In sum, for 2011 CMS' estimate of the total burden for attestation to EHR technology and attestation and reporting of quality measures would equal 9 hours 12 minutes for each hospital and 9 hours 22 minutes for each EP, and the associated cost burden is \$743.08 for EPs and \$551.82 for eligible hospitals. CMS believes eligible hospitals or CAHs may use an attorney to attest on their behalf and estimates total costs using a mean hourly rate for attorneys. Due to options available under the menu set, CMS notes the difficulty of estimating burden associated given the range of possible choices among selected menu set objectives and therefore averaged estimates of high and low burden scenarios.

Further, the agency estimates that the capital cost for hospitals would be about \$5 million for EHR installation and \$1 million for annual maintenance/training costs. For EPs, the equivalent estimates are \$54,000 and \$10,000, respectively.

Due to the change in the definition of hospital-based EPs, for CY 2011 CMS now estimates that there are about 521,600 non-hospital-based Medicare and Medicaid EPs (382,000 Medicare EPs, 95,500 dual Medicare/Medicaid EPs and 44,100 Medicaid-eligibility-only EPs) and expects that to increase to 527,254 for

CY 2012. Since the standard full amount of Medicaid incentive payments for EPs is greater than the comparable Medicare incentive payments (\$63,750 vs. \$44,000), CMS assumes that all of the 95,500 dual Medicare/Medicaid EPs may elect to receive EHR incentive payments through the Medicaid incentive program (since they can only receive payments through one of the two programs).

CMS further estimates that in FY 2011, there will be about 5,011 Medicare and Medicaid eligible hospitals and CAHs (including 3,620 acute care hospitals, 1,302 CAHs, 78 Medicaid children's hospitals, and 11 Medicaid cancer hospitals).

Finally, CMS makes no changes to the estimates in the proposed rule relating to MAOs. There are 12 qualifying MAOs with 29 MA-affiliated eligible hospitals and 28,000 MA EPs. CMS does not believe that any MAO that sponsors a non-HMO type plan will request reimbursement before 2014 for qualifying EPs or Medicare-affiliated eligible hospitals under the MA EHR incentive program). CMS believes it will take an MAO 40 hours annually to report the required aggregate revenue data for all its salaried MA EPs, 1.5 hours to develop the required methodology for estimating the portion of each qualifying MA EP's salary that is attributable to providing services that would otherwise be covered under Medicare Part B, up to 0.25 hours to electronically obtain and compile each attestation from qualifying MA EPs who are not salaried, and about 40 hours annually to attest whether its qualifying MA EPs are meaningful users.

CMS will accept comments regarding its information collection and recordkeeping requirements through September 13, 2010. These comments, which must reference the information collection request identifier (CMS-10336), may be submitted electronically to <http://www.regulations.gov> or by regular mail to CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Room C4-26-05, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Regulatory Impact Analysis

CMS expects spending under the EHR incentive program for transfer payments to Medicare and Medicaid providers to be between \$9.7 and \$27.4 billion over 10 years (these estimates include net payment adjustments for Medicare providers who do not achieve meaningful use in 2015 and beyond in the amount of -\$3.9 billion to -\$8.1 billion). The changes in the final rule estimates are attributable to the revised definitions of hospital-based EP and Medicaid acute care hospital, as well as updated data on discharges and adoption costs among hospitals.

Under the "low scenario," Medicare payments would be \$4.6 billion for hospitals and -\$2.5 billion for professionals (because incentive payments would be more than offset by payment adjustments beginning in 2015 for EPs who are not meaningful EHR users), and Medicaid payments would be \$3.8 billion for

hospitals and \$3.8 billion for professionals. Under CMS' "high scenario," Medicare payments would be \$10.1 billion for hospitals and \$5.0 billion for professionals and the Medicaid payments would be \$4.3 billion for hospitals and \$8.0 billion for professionals. Both low and high scenario costs are based on current law which includes a scheduled 23 percent cut in physician payments on December 1, 2010. CMS believes that the revisions to meaningful use criteria under the final rule and the nationwide implementation of the Regional Extension Center Program increase the likelihood of reaching the "high scenario" but also notes that adoption trends could significantly differ from their assumptions.

CMS described four studies used to estimate costs of implementation, including purchase and installation of hardware and software, and associated costs, including ongoing operating costs, which while not taking into account standards and the meaningful use concept, prompted CMS to conclude that EPs will likely receive the maximum incentive permitted due to those costs. Using a 2008 AHA Survey, CMS observed significantly higher costs in 2008 than 2007 and posits that the increase may reflect costs of implementing additional functionalities. CMS also updates discharge estimates based on more recent data. This survey indicated EHR costs among hospitals ranging from \$20 to \$100 million. CMS developed cost ranges by hospital size and level of EHR sophistication.

CMS acknowledges that it has not been able to quantify certain EHR-related effects, such as reduced staff productivity related to learning how to use the EHR technology, the need to add additional staff to work with HIT issues, and administrative costs related to reporting, and invites comments and information about these matters. CMS is also unable to quantify certain expected, EHR-related benefits, such as improved quality of care, better health outcomes, and reduced errors.

CMS estimates the percent of EPs who will be meaningful EHR users by 2019 and the number of such meaningful users. Under its "high scenario," that would be 70 percent of EPs (288,800). Under its "low scenario," it would be 36 percent of EPs (148,100). The comparable hospital estimates under CMS' "high" and "low" scenarios are 100 percent and 95.6 percent, respectively.

CMS notes that the Part B beneficiary premium will not be affected by the EP payment incentives.