

CMS Proposed Rule on “Meaningful Use” in the Medicare Incentive Program

Executive Summary

Introduction

At the close of 2009, the Centers for Medicare and Medicaid Services (CMS) put on display their initial proposed rules implementing the provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) that provide incentive payments for electronic infrastructure use. The rule interprets the law to define eligible professionals (EPs) and eligible hospitals participating in the Medicare and Medicaid programs that adopt and meaningfully use certified electronic health record (EHR) technology.

A companion interim final rule, also a requirement of ARRA, was issued by the Office of the National Coordinator for Health Information Technology (ONC) addressing the implementation specifications, initial standards, and certification criteria for EHR technology. CMS proposes to use the ONC definition of certified EHRs.

Also a requirement of ARRA, the rules have been shaped by the ongoing deliberations and input of two committees established by the Department of Health and Human Services: the Health Information Technology (HIT) Policy Committee, and the HIT Standards Committees.

Specific requirements must be met by Medicare EPs, Medicaid EPs, hospitals, Critical Access Hospitals (CAHs), and Medicare Advantage (MA) EPs in order to receive incentive payments. **Individual EPs cannot receive incentives from both the Medicare and Medicaid programs, but are allowed a one-time switch from one program to the other if their circumstances change.** Hospitals, however, are eligible to earn incentives from both the Medicare and Medicaid programs. CMS has aligned Medicare and Medicaid definitions for meaningful use, but in the Medicaid program, states can choose to add additional state-specific requirements, with the Medicare requirements being the minimum requirements.

Public comments will be accepted on the provisions of both rules until March 15, 2010, and Public Policy staff is consulting with the ad hoc Regulatory Response Team while comments are being developed.

The display copy of the entire proposed rule, with instructions for submitting comments, is available at this link: <http://www.amga.org/Advocacy/Resources/cmsNoticeRuleMaking.pdf>. To view AMGA’s comprehensive summary, visit this link:

<http://www.amga.org/Advocacy/Resources/meaningfulUseProposals.pdf>.

The proposed rule was also published in the Federal Register on January 13, 2010. CMS is soliciting comments in several areas, which suggests the final rule could contain substantive differences from the proposed rule.

Common Definition of Meaningful Use for both Medicare and Medicaid

CMS proposed one definition of meaningful use for EPs participating in the Medicare Fee for Service and Medicare Advantage incentive programs, as well as Medicaid.

Stages of Implementation

The meaningful use proposals outline a phased-in implementation for meaningful use of EHRs. This is in recognition of the fact that physicians across the country are at various points of readiness, with some medical facilities already using EHRs to the fullest extent (like many AMGA members), and many smaller medical offices not yet having made the investment. Thus, the proposed rule lays out three stages, as follows:

First Payment Year	2011	2012	2013	2014	2015+**
2011	Stage 1	Stage 1	Stage 2	Stage2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015+*					Stage 3

*Avoids payment reductions only for EPs in the Medicare EHR Incentive Program

**Stage 3 criteria of meaningful use or a subsequent update to the criteria if they are established through rulemaking

For the first year that an EP applies for and receives incentives, CMS proposes that the EHR reporting period be any 90 days of continuous use within that calendar year. After this first year, the reporting period would be the entire calendar year.

Stage 1 Criteria

The Stage 1 meaningful use criteria focus on electronically capturing health information in a coded format; using that information to track key clinical conditions, and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible); consistency with other provisions of Medicare and Medicaid law, implementation of clinical decision support tools to facilitate disease and medication management; and the reporting of clinical quality measures and public health information.

HIT Functionality Measures

To qualify as meaningful user for 2011, CMS proposes that an EP or eligible hospital must demonstrate that they meet all of the Stage 1 objectives and associated measures. EP eligibility will be determined by the unique National Provider Identifier, and individual hospitals by their unique CMS certification numbers. Table 2 of the proposed rule outlines the functionality measures for meaningful use associated with Stage 1, including use of computerized provider order entry for at least 80 percent of all orders, implementing 5 clinical decision support rules relevant to specialty or clinical priority, e-prescribing functionality, and providing clinical summaries for patients for each office visit. Initial reaction to the criteria are mixed, with EPs stating that they are presently meeting several of the criteria, and others requiring extensive system changes to capture the required information. The meaningful use criteria can be found in Table 2 of the proposed regulation, and are also available in the AMGA summary.

Quality Measures

EPs will also have to report on a set of core measures that apply to their patients (Table 4 in the proposed rule), as follows: cardiology, endocrinology, gastroenterology, nephrology, neurology, obstetrics and gynecology, oncology, ophthalmology, pediatrics, podiatry, primary care physicians, proceduralist/surgery, psychiatry, pulmonology, and radiology. The core measures are Preventive Care and Screening, Blood Pressure Measurement, and Drugs to be Avoided in the Elderly.

Reporting Method

For 2011, EPs will report using an attestation process.

Incentive Payments for EPs under Medicare Program

Payments will be made to EPs for a payment year in an amount equal to 75 percent of the estimated allowed charges under the physician fee schedule for the covered professional services furnished by the EP during the payment year, up to the maximum amounts stipulated in law. Estimated allowed charges are determined based on claims submitted no later than two months after the end of the payment year. If an EP submitted claims for professional services in more than one practice, the payment is calculated based on the services across all such practices.

A qualifying EP can receive up to the following amounts for each payment year:

- First payment year, \$15,000 (unless the first payment year is 2011 or 2012, in which case the payment is \$18,000)
- Second payment year, \$12,000
- Third payment year, \$8,000

- Fourth payment year, \$4,000
- Fifth payment year, \$2,000
- Succeeding payment years, \$0

EPs that are practicing in Health Profession Shortage Areas (HPSAs) are eligible for an additional 10 percent. **For the first year only, EPs who meet the definition of meaningful use for 90 continuous days are eligible for incentive payments.**