

AMGA Summary: Meaningful Use of Electronic Health Records (Electronic Health Record Incentives) Proposed Regulations; Medicare and Medicaid Programs

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.

The entire proposed rule, with instructions for submitting comments, is available at this link:

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

Page numbers mentioned throughout this summary are for the version of the proposed regulations available at this link.

Stages of Implementation

The meaningful use proposals contemplate 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.

Criteria and measures for Stage 1 of meaningful use, beginning in 2011, are outlined as follows:

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.

More detailed criteria for stages 2 (2013) and 3 (2015) will be the subject of future rulemaking.

Table 1 of the proposed rule outlines these stages:

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

*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

Objectives and Goals/Measures

To qualify as a meaningful EHR user for 2011, CMS proposes that an EP or eligible hospital must demonstrate that they meet all of the objectives and the associated measures. EP eligibility will be determined by their unique National Provider Identifier, and individual hospitals by their unique CMS certification numbers (CCNs).

The first health outcomes policy priority specified by the HIT Policy Committee is improving quality, safety, efficiency and reducing health disparities. The objectives that are part of Stage 1 criteria for

meaningful use stem from recommendations of the HIT Policy Committee to group objectives under care goals, which are then grouped under health outcomes. Table 2 of the proposed rule lists all of the health outcomes, objectives, care goals, and measures as follows:

Table 2, Stage 1 Criteria for Meaningful Use

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
Improving quality, safety, efficiency, and reducing health disparities	Provide access to comprehensive patient health data for patient's health care team	Use CPOE	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	For EPs, CPOE is used for at least 80% of all orders For eligible hospitals, CPOE is used for 10% of all orders
		Implement drug-drug, drug-allergy, drug-formulary checks	Implement drug-drug, drug-allergy, drug-formulary checks	The EP/eligible hospital has enabled this functionality
		Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT [®]	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT [®]	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data
		Generate and transmit permissible prescriptions electronically (eRx)		At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified HER

				technology
		Maintain active medication list	Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have a t least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data
		Maintain active medication list	Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have a t least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
		Record demographics <ul style="list-style-type: none"> ○ Preferred language ○ insurance type ○ gender ○ race ○ ethnicity ○ date of birth 	Record demographics <ul style="list-style-type: none"> ○ Preferred language ○ insurance type ○ gender ○ race ○ ethnicity ○ date of birth ○ date and cause of death in the event of mortality 	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data
		Record and chart changes in vital signs: <ul style="list-style-type: none"> ○ height ○ weight ○ blood pressure ○ Calculate and display: BMI ○ Plot and display growth charts for children 2-20 years including BMI 	Record and chart changes in vital signs: <ul style="list-style-type: none"> ○ height ○ weight ○ blood pressure ○ Calculate and display: BMI ○ Plot and display growth charts for children 2-20 years including BMI 	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20
		Record smoking	Record smoking	At least 80% of all

		status for patients 13 years old or older	status for patients 13 years old or older	unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have "smoking status" recorded
		Incorporate clinical lab-test results into EHR as structured data	Incorporate clinical lab-test results into EHR as structured data	At least 50% of all clinical lab tests ordered whose results are 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, and outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP or eligible hospital with specific conditions

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
		Report ambulatory quality measures to CMS or the States	Report hospital quality measures to CMS or the states	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule For 2012 electronically submit the measures as discussed in section II(A)(3) of this proposed rule
		Send reminders to patients per patient preference for preventive/follow up care		Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over
		Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/Eligible Hospital is responsible for, described further in section II(A)(3).
		Check insurance	Check insurance	Insurance

		eligibility electronically from public and private payers	eligibility electronically from public and private payers	eligibility check electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital
		Submit claims electronically to public and private payers.	Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital
Engage patients and families in their health care	Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
			Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it
		Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP		At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information
		Provide clinical summaries for patients for each office visit		Clinical Summaries are provided for at least 80% of all office visits
Improve care coordination	Exchange meaningful clinical information among professional health care team	Capability to exchange key clinical information (for example, problem list, medication list, allegories, diagnostic test	Capability to exchange key clinical information (for example, problem list, medication list, allegories, diagnostic test	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical

		results), among providers of care and patient authorized entities electronically	results), among providers of care and patient authorized entities electronically	information
		Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
		Provide summary care record for each transition of care and referral	Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
Improve population and public health	Communicate with public health agencies	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
			Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)
		Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data

		according to applicable law and practice	according to applicable law and practice	to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)
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Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
Ensure adequate privacy and security protections for personal health information	Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law. Provide transparency to data sharing to patient.	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

CMS solicits comments on whether Stage 1 criteria for meaningful use objectives are appropriate for the majority of providers or if some measures may be out of reach, and how to best balance the relevant goals, including promoting adoption of EHRs, avoiding excessive or unnecessary burdens, and improving health care.

Meeting the criteria for meaningful use of EHRs also requires reporting on clinical quality measures for electronic submission by Medicare or Medicaid eligible professionals. Quality measures are listed in the proposed rule, beginning on page 123. Proposed clinical quality measures for electronic submission by eligible hospitals for payment year 2011-2012 begin on page 153.

CMS proposes to require each EP to submit information on two measures groups, a core measures group containing Preventive Care and Screening, Blood Pressure Measurement, and Drugs to be Avoided in the Elderly, and a relevant specialty group of measures for 2011 and 2012 (cardiology, endocrinology, gastroenterology, nephrology, neurology, obstetrics and gynecology, oncology, ophthalmology, pediatrics, podiatry, primary care physicians, procedurlist/surgery, psychiatry, pulmonology, and radiology) . These are found on page 142 and 143 of the proposed rule, respectively.

CMS solicits comments on the clinical utility of the measures proposed and their readiness for use in the EHR incentive programs in 2011.

CMS proposes to begin accepting clinical quality measure reporting electronically in 2012, and will accept clinical quality reporting through an attestation process for the 2011 payment year. The attestation process will require that Medicare EPs and hospitals attest to the use of certified EHR system to capture the necessary data elements and calculate the results for the applicable clinical quality measures, including the accuracy and completeness of numerators, denominators, and exclusions submitted for each of the applicable measures, with reporting to CMS for applicable patients irrespective of third party payer or lack thereof; for Medicare FFS patient; for MA patients, and for Medicaid patients. Detailed discussion about the attestation process begins on page 163 of the proposed rule.

CMS solicits comments on the impact of requiring the submission of clinical quality measures data on all patients, not just Medicare and Medicaid beneficiaries.

CMS solicits comments on whether it may be more appropriate to defer some or all clinical quality reporting until the 2012 payment year, and which key measures should be chosen for 2011 and which should be deferred until 2012 and why.

Requirements Specific to the Medicare Program

For purposes of the Medicare program, “eligible professional” is defined as a doctor of medicine or osteopathy, a doctor of dental surgery or medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. An EP qualifies for the incentive payment if he has been a meaningful user of EHRs for the reporting period and is not a hospital-based EP.

A qualifying CAH means an EP who is a meaningful EHR user for the EHR reporting period for a payment year and who is not a hospital-based EP. Additional information on the CAH program begins on page 224 of the proposed rule.

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.

Payment adjustments, made as reductions to physician fee schedule (PFS) reimbursements, become effective in calendar year 2015 and subsequent years for nonqualifying EPs, or EPs that have not adopted, implemented and are not using EHRs meaningfully.

- For 2015, 99 percent of PFS
- For 2016, 98 percent of PFS
- For 2017 and subsequent years, 97 percent of PFS

Incentive payments to eligible hospitals are calculated with a complex equation consisting of a \$2,000,000 base amount, an additional payment based on Medicare discharges (\$200 each for the 1,150th through the 23,000th discharge), and a transition factor for that payment year. Payment years for hospital incentives are based on cost-reporting periods during fiscal years (FYs). The timelines are as follows:

<u>First Payment Year</u>	<u>Can Receive Incentives Through</u>
2011	2014
2012	2015
2013	2016
2014	2016
2015	2017

Payment adjustments for hospitals that do not qualify as meaningful users of EHRs cause incremental reductions in market-basket updates as follows: FY 2015 updates will be reduced by one-quarter, FY

2016 updates will be reduced by one-half, and FY 2017 updates (and beyond) will be reduced by three-quarters.

EPs can make a one-time switch from the Medicare incentive program to the Medicaid incentive program. Further details on changing program election are not yet available. If a Medicare FFS (or MA) EP receives an incentive payment from the Medicare EHR incentive program the EP or group practice is not eligible to also receive the incentive payment under the e-prescribing incentive program created by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). (EPs receiving a Medicaid EHR incentive payment would remain eligible for the Medicare MIPPA e-prescribing incentive payment, however).

Hospitals that meet the meaningful use requirements for Medicare would not have to satisfy any additional, state-specific, meaningful use requirements under Medicaid to qualify for the incentive.

Requirements Specific to MA Organizations/EPs

A qualifying MA organization is defined as one that is organized as a health maintenance organization (HMO). This includes 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 as an HMO.

A qualifying MA EP is defined as being employed by a qualifying MA organization, or is a partner (having an ownership stake) of, an entity that through a contract with a qualifying MA organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of such organization; furnishes at least 80 percent of his professional services to enrollees of the qualifying MA organization during the reporting period; and is a meaningful user of certified EHR technology.

The ARRA legislation directs the Secretary of Health and Human Services to study and report on ways that physicians who treat MA patients, but fall outside of this definition, can qualify for incentive payments. A report was due to Congress with the CMS findings early in the summer of 2009, but the report has not been made public. CMS states that this proposed rule does not address these physicians, as it is limited to codifying in regulation existing statutory provisions. Discussion of MA provisions begins on page 240 of the proposed rule.

Hospital-based Eligible Professionals

ARRA states that hospital-based EPs are not eligible for the Medicare incentive payments (similarly, the majority of hospital-based EPs will not be eligible for Medicaid incentive payments either, unless they practice in a Federally Qualified Health Center or Rural Health Clinic). ARRA defines the term hospital-based eligible professional to mean an EP, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all Medicare-covered professional services during the relevant EHR reporting period in a hospital setting (whether inpatient or outpatient) through the use of the facilities and equipment of the hospital, including the hospital's qualified EHRs. The proposed

regulations state that the determination of whether an EP is a hospital-based EP shall be made on the basis of the site-of-service, and without regard to the type of service provided by the EP or any employment or billing arrangement.

The proposed regulation goes on to define another criterion used to determine whether or not an EP is hospital-based. That requirement is that “substantially all”, 90 percent, of all professional services are performed in an inpatient or outpatient hospital setting. CMS proposes to use Place of Service Codes (POS) to determine whether an EP is a hospital-based eligible professional, as follows: 21, for inpatient hospital settings; 22, for outpatient hospital settings; and 23, for emergency rooms. If a physician does not meet the “substantially all” definition and maintains a separate office, they could become eligible to receive incentive payments under the program. Thus, CMS interprets provider-based entities to be hospital-based EPs.

Discussion of hospital-based eligible professionals begins on page 179.

CMS states that it is open to public comments on additional proposals.

Requirements Specific to the Medicaid Program

States may receive 100 percent federal financial participation for providing Medicaid EHR incentive payments to eligible Medicaid providers, and 90 percent federal financial participation for related administrative expenses.

For purposes of the Medicaid program, EPs are defined as physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in a Federal Qualified Health Center (FQHC) or Rural Health Clinical (RHC) that is led by a physician assistant. As with the Medicare program, most Medicaid EPs cannot be hospital-based, though Medicaid EPs practicing predominantly in a FQHC or RHC, are not subject to the hospital-based exclusion. “Practicing predominantly” is defined in the proposed rule as having over 50 percent of the EPs total patient encounters over a period of 6 months taking place at a FQHC or RHC.

Medicaid eligible hospitals are acute care hospitals, defined as a health care facility where the average length of patient stay is 25 days or fewer. The definition excludes specialty providers and long-term care facilities where the average patients’ length of stay exceeds 25 days. To further refine the definition, CMS will use information embedded in the CCN to determine eligible acute care hospitals. Separately certified children’s hospitals are included in the Medicaid EHR incentive program only. A proposed alternative would include those hospitals with Medicare provider numbers in the following series: short-term hospitals, rehabilitation hospitals (excluded from prospective payment systems), children’s hospitals (excluded from prospective payment systems), psychiatric hospitals (excluded from prospective payment systems). For the purposes of Medicaid payments, this definition would apply only to those freestanding hospitals within the above categories that exclusively furnish services to individuals under age 21.

CMS is soliciting comments on the proposed definitions of “children’s hospital” as it applies to the Medicaid EHR incentive program.

The general rule for Medicaid EPs is that the EP has at least 30 percent patient volume attributable to those who are receiving Medicaid over any continuous 90-day period within the most recent calendar year prior to reporting, with two exceptions. The first exception is that a pediatrician may have at least 20 percent patient volume attributable to Medicaid patients. The second exception is that Medicaid EPs that practice predominantly in a FQHC or RHC must have a minimum of 30 percent patient volume attributable to “needy individuals.” Needy individuals must meet one of three criteria 1) they are receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP); 2) they are furnished uncompensated care by the provider; or 3) they are furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

For a Medicaid EP that has already adopted, implemented, or upgraded certified EHR technology and can meaningfully use this technology in the first incentive payment year, CMS proposes that the EP be permitted to receive the same maximum payments, for the same period of time, as the Medicaid EP who merely adopted, implemented or upgraded certified EHR technology in the first year.

Payments are based on 85 percent of net average allowable costs (with a cap on costs statutorily set at \$25,000 for the first year and \$10,000 for each of five subsequent years, based on data that assume \$54,000 for the purchase, initial implementation, and upgrade of certified EHR technology, including support services and training). Using these assumptions, the table below shows the maximum incentive payment amounts for Medicaid professionals:

Cap on Net Average Allowable Costs, per the HITECH Act	85 percent Allowed for Eligible Professionals	Maximum Cumulative Incentive over 6-year Period
\$25,000 in Year 1 for most professionals	\$21,250	\$63,750
\$10,000 in Years 2-6 for most professionals	\$8,500	
\$16,667 in Year 1 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$14,167	\$42,500
\$6,667 in Years 2-6 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$5,667	

Unlike the Medicare program, the last year that a hospital may *begin* receiving Medicaid incentive payments is FY 2016, as shown in this table.

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

For Medicaid hospitals, the formula is similar to the Medicare formula, except that payments would be calculated with the Medicaid share, based on Medicaid inpatient-bed-days plus estimated Medicaid managed care inpatient-bed-days. Hospitals, but not EPs, may receive both Medicare and Medicaid EHR incentive payments. States can require that Medicaid EPs and hospitals report on additional, state-specific, quality measures, with the Medicare measures being the “floor.”

The proposed regulations include detailed requirements that states must meet in order to receive federal financial participation fund. A detailed discussion of the Medicaid requirements begins on page 275 of the proposed rule.

Information Collection Requirements

The discussion on Information Collection Requirements (ICRs) begins on page 347 of the proposed rule. Table 33 of the proposed rule outlines the ICRs. This table can be found on page 350 of the proposed rule.

CMS estimates that the total burden for attestation to EHR technology and quality measures would be 8 hours for each hospital and 9 hours for each EP.

CMS invites public comment on the burden associated with reporting and the assumptions used in making their calculations under this section.

Regulatory Impact Analysis

This rulemaking meets the definition of a major rulemaking, one that will have an annual effect on the economy of \$100 million or more, and has therefore prepared a Regulatory Impact Analysis (RIA).

CMS cautions that those reading the rule should understand that there is uncertainty on the assumptions and forecasts that CMS has made because several variables will affect the adoption of EHR systems and demonstration of meaningful use. This discussion begins on page 405 of the proposed rule.

CMS is asking for comments of what a qualified EHR system would cost for EPs and hospitals (one that can collect and store patient demographic data and support CPOE, clinical decision support and registry functions).