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## FOCUS ON HEALTH CARE



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# CMS Proposes Medicare and Medicaid Reimbursement Rules for Earning Incentive Payments for Meaningful Use of Certified Electronic Health Record Technology

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*Electronic health records are viewed by many as representing a potentially invaluable tool with the ability to improve the quality and affordability of health care. This discussion summarizes the Centers for Medicare & Medicaid Services Proposed Rule regarding incentive payments to eligible hospitals and professionals that employ electronic health records.*

## INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) published a proposed rule (Proposed Rule)<sup>1</sup> on January 13, 2010, setting forth the methodology for the calculation of Medicare and Medicaid incentive payments to eligible hospitals and professionals that are “meaningful users” of certified electronic health record (EHR) technology (Certified EHR Technology). The incentives, established by the Health Information Technology for Economic and Clinical Health Act (“HITECH Act”), are part of the federal government’s investment in health information technology to improve the quality and affordability of health care.

Following the HITECH Act, the incentives are structured to encourage early adoption of EHR technology. Thus, the incentives are higher in the earlier years, phase out after a specified number of years, and thereafter convert from enhanced reimbursement to reimbursement reductions.

This discussion summarizes the methodology for calculation and payment of EHR incentives under: (1) Medicare Parts A and B, which is the fee-for-service Medicare program (Medicare FFS); (2) Medicare Part C, commonly known as the Medicare Advantage Program (Medicare Advantage); and (3) state Medicaid programs. For each program, the objective is to assist a provider or Medicare Advantage organization to assess whether it is

eligible for incentive payments and the portion of the expense associated with adoption of an EHR that may be covered with incentive payments.

## EHR INCENTIVES FOR PARTICIPANTS IN MEDICARE FFS

If an eligible physician or hospital demonstrates meaningful use of certified EHR Technology in accordance with requirements established by CMS in the Proposed Rule and the Office of the National Coordinator of Health Information Technology (ONC) in a coordinated administrative rulemaking,<sup>2</sup> the provider (Meaningful EHR User) may earn incentive payments, in the form of enhanced reimbursement, under Medicare FFS.<sup>3</sup> This section discusses the reimbursement methodology in the Proposed Rule for the Medicare FFS incentives. The following sections discuss the methodology for incentives under Medicare Advantage and state Medicaid programs, respectively.

## INCENTIVE PAYMENTS FOR MEDICARE FFS ELIGIBLE PROFESSIONALS

Eligible physicians participating in Medicare FFS who are Meaningful EHR Users may receive

incentive payments of an additional 75 percent of the Medicare allowable charge under the Medicare Physician Fee Schedule (MPFS) for covered professional services, for up to five years beginning as early as calendar year (CY) 2011, subject to an annual cap.<sup>4</sup> The annual cap may be higher under certain circumstances for physicians who practice in a Medicare health professional shortage area.

## Medicare Eligible Professionals

The Proposed Rule defines an eligible professional for the Medicare FFS EHR incentives as doctors in five specialty areas:

1. medicine or osteopathy
2. dental surgery or dental medicine
3. podiatric medicine
4. optometry
5. chiropractics

These doctors must be legally authorized to practice under applicable state law.<sup>5</sup> Hospital-based physicians are not eligible for incentives.<sup>6</sup> The Proposed Rule defines hospital-based physicians as eligible professionals who provide 90 percent or more of their covered professional services in an inpatient and/or outpatient hospital setting.<sup>7</sup>

Whether the 90 percent test is met will depend on the place of service (POS) codes reported on the eligible professional's claims for Medicare reimbursement. POS codes 21 (Inpatient Hospital), 22 (Outpatient Hospital) and 23 (Emergency Department) describe a hospital setting.<sup>8</sup>

The classification of hospital-based physicians as ineligible to receive the Medicare FFS EHR incentives has been particularly controversial in academic medical centers and other hospital settings where physicians provide ambulatory services in clinics that are hospital-based outpatient department loca-

tions for Medicare reimbursement purposes. Such hospital-based clinics often utilize ambulatory EHR technology that has different modules (e.g., appointment scheduling) from the hospital's inpatient EHR and requires an additional investment by the hospital.

## Maximum Annual Incentive Payments

The Proposed Rule caps annual Medicare FFS incentive payments to eligible professionals. If the first year the eligible professional satisfies the meaningful use requirements is 2011 or 2012, then the eligible professional can earn up to a total of \$44,000 over the five-year incentive period, including an \$18,000 maximum annual incentive payment in the first year. The maximum annual incentive payments are summarized in Exhibit 1, which comes from Table 22 of the Proposed Rule.<sup>9</sup>

Eligible professionals who furnish more than 50 percent of Medicare covered professional services (based on quantity of services rather than allowed charges) in a geographic area designated as a health professional shortage area by the Department of Health and Human Services are subject to a 10 percent higher cap.

## Form and Timing of Payments to Qualifying Eligible Professionals

The Proposed Rule calls for Part B Medicare administrative contractors (f/k/a carriers) (MACs) to make a single, lump sum, annual incentive payment to an eligible professional as soon as the MAC determines that the eligible professional has demonstrated meaningful use for the applicable reporting period and earned the maximum annual incentive payment. The reporting period for an eligible professional is any 90-day period in the first calendar year of meaningful use or the calendar year for the subsequent four years.

For example, if a MAC has determined that an eligible professional has demonstrated meaningful use in 2011 and has \$24,000 of allowable charges for covered professional services that year, the MAC would pay the eligible professional the \$18,000 maximum annual incentive amount. The MAC will make the payment to the eligible professional or a single employer or other entity which is a valid reassignee under the Medicare reassignment rules.<sup>10</sup>

CMS does not permit an eligible professional to allocate the incentive payments among valid re-assignees (such as multiple part-time employers or contracting parties). Thus, physician groups, hospitals and other facilities that engage physicians on a part-time basis should review current and template employment and professional service agreements and consider amending them to specify

**Exhibit 1**  
**Table 22—Maximum Total Amount of EHR Incentive Payments for a Medicare EP Who Does Not Predominantly Furnish Services in a HPSA**

Calendar Year	First CY in which the EP receives an incentive payment				
	2011	2012	2013	2014	2015—subsequent years
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

that the group or facility is entitled to receive the incentive payment rather than other part-time employers or contractors.

## Program Election and Coordination

Physicians who meet the eligibility requirements for both the Medicare and Medicaid incentive programs must elect to receive payments from only one program or the other, but they may change their program election once from 2012 to 2014.

## Payment Adjustments Beginning CY 2015

Beginning in 2015, the MPFS amount payable to eligible professionals who do not satisfy the then-current meaningful use requirements will be reduced by one, two and three percent in years 2015, 2016, and 2017 and each subsequent calendar year, respectively, unless CMS exempts an eligible professional due to a significant hardship.<sup>11</sup> The HITECH Act also authorizes CMS to further reduce the reimbursement rate beginning in 2018 if the proportion of eligible professionals who are Meaningful EHR Users is less than 75 percent.<sup>12</sup>

CMS also indicated that it would make specific proposals for further reductions prior to 2015. CMS did not propose a definition of significant hardship, but stated that one example would be an eligible professional who practices in a rural area without sufficient Internet access.<sup>13</sup> CMS also solicits comments on the possible circumstances for which CMS should allow an eligible professional to qualify for the significant hardship exception.<sup>14</sup>

## INCENTIVE PAYMENTS FOR ELIGIBLE HOSPITALS

### Medicare Eligible Hospitals

A hospital that meaningfully uses Certified EHR Technology is eligible for Medicare FFS incentives beginning Medicare Fiscal Year (FY) 2011 (i.e., October 1, 2010 through September 30, 2011). A Medicare eligible hospital is a hospital located in one of the 50 states or the District of Columbia that participates in the Medicare Inpatient Prospective Payment System (IPPS).<sup>15</sup>

Hospitals and distinct part hospital units excluded from IPPS, such as psychiatric, rehabilitation, long-term care, children's and cancer hospitals and units, are not eligible for incentives.<sup>16</sup> CAHs are also eligible for Medicare FFS incentives under separate provisions discussed below.

## Incentive Payment Calculation for Eligible Hospitals

During Medicare FY 2011 through FY 2016, CMS will pay Medicare FFS EHR incentives to eligible hospitals during the EHR reporting period based on the proportion of discharges attributable to Medicare patients.<sup>17</sup> The EHR reporting period for an eligible hospital is any continuous 90-day period within the first payment year (i.e., a Medicare FY) and the entire payment year thereafter. An eligible hospital that maintains compliance with meaningful use requirements may receive Medicare FFS incentive payments for up to four Medicare FYs.

The formula is equal to the product of the following: (1) initial amount, (2) Medicare share, and (3) transition factor. Each is defined as follows:

- The "initial amount" means the sum of \$2,000,000 plus the discharge-related amount for the hospital's cost reporting year.<sup>18</sup> The "discharge-related amount" means the sum of the amount for each discharge during the cost reporting year up to the 23,000<sup>th</sup> discharge as follows: (a) first through 1,149<sup>th</sup> discharge, \$0, (b) 1,150<sup>th</sup> through 23,000<sup>th</sup> discharge, \$200, plus (c) for any discharge greater than the 23,000<sup>th</sup>, \$0.
- Because the Initial Amount includes a \$2,000,000 base for each eligible hospital, the formula disfavors health systems that have consolidated two or more state-licensed inpatient hospitals into a multi-campus hospital with a single CMS certification number (formerly known as a Medicare provider number) for Medicare reimbursement purposes. Many systems have created such multi-campus hospitals (in accordance with the Medicare Provider-Based Status Rule) in order to maximize disproportionate share hospital and other add-on payments.
- The "Medicare share" means the fraction, where:<sup>19</sup>
  - the numerator is the sum of (1) inpatient-bed days that are attributable to individuals with respect to whom payment may be made under Medicare Part A; plus (2) the number of inpatient-bed-days that are attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C;
  - the denominator is the product determined by multiplying (1) the total number of inpatient bed days and (2) the total amount of the hospital's charges during the cost reporting period, not

including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during the period.

- The “transition factor” is: 1.0 for the first incentive payment year before FY 2014; 0.75 for the second payment year; 0.50 for the third payment year; 0.25 for the fourth payment year; and zero (0) for any succeeding payment year.<sup>20</sup> Hospitals that begin utilizing an EHR after FY 2013 have lower Transition Factors and consequently lower incentive payments than they would have received by becoming Meaningful EHR Users sooner. Hospitals for which the first payment year is after FY 2015 receive no incentive payments. Exhibit 2, which comes from Table 25 of the Proposed Rule, shows how the transition factor phases out incentive payments to eligible hospitals.<sup>21</sup>

reporting period running from July 1, 2010 through June 30, 2011, CMS would employ the relevant data from the hospital's cost reporting period ending June 30, 2010 in order to determine the incentive payment for the hospital during Medicare FY 2011. However, final payments would be based on hospital discharge data from the cost report ending June 30, 2011, and determined at the time of settlement for that cost reporting period.

## Incentive Payment Adjustments Effective FY 2015

Consistent with the HITECH Act,<sup>25</sup> the Proposed Rule reduces the annual market basket adjustment to the IPPS payment rate for inpatient hospital services for hospitals which are not Meaningful EHR Users by one-quarter, one-half and three-quarters of the percentage increase otherwise applicable in FY2015, FY2016, and FY2017 and subsequent Medicare FYs, respectively.<sup>26</sup>

A hospital may be exempted from the payment reduction if CMS determines, on a case-by-case basis, that requiring the hospital to be a Meaningful EHR User would result in a significant hardship, such as the case of a hospital in a rural area without sufficient Internet access.<sup>27</sup>

## INCENTIVE PAYMENTS FOR CRITICAL ACCESS HOSPITALS

### Incentive Payment Calculation for Critical Access Hospitals

The HITECH Act also provides for EHR incentive payments to qualifying CAHs that are Meaningful EHR Users during an EHR reporting period for a CAH's cost reporting period, beginning after FY 2010 but before FY 2016, for up to four fiscal years. The EHR reporting period is a continuous 90-day period in the first payment year and the entire payment year for subsequent years. Consistent with the HITECH Act,<sup>28</sup> CMS proposes to pay EHR incentives to a CAH for a Medicare FY equal to the product determined by multiplying:

- the CAH's reasonable costs incurred for the purchase of Certified EHR Technology (excluding any depreciation and interest expense) during the cost reporting year that begins in the applicable Medicare FY; and
- the lesser of: 100 percent; and the Medicare Share (as defined above in the discussion of Medicare FFS incentives) percentage plus 20 percentage points.<sup>29</sup>

**Exhibit 2**  
**Table 25—Transaction 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	--	--	--	--
2012	0.75	1.00	--	--	--
2013	0.50	0.75	1.00	--	--
2014	0.25	0.50	0.75	0.75	--
2015	--	0.25	0.50	0.50	0.50
2016	--	--	0.25	0.25	0.25

### Process and Timing For Incentive Payments to Eligible Hospitals

The Part A MACs (formerly known as “fiscal intermediaries”) will pay eligible hospitals that are Meaningful EHR Users a preliminary, estimated EHR incentive payment based on the data on hospital discharges from the hospital cost reporting year that ends during the Medicare FY prior to the Medicare FY for which an incentive payment is made.<sup>22</sup> Final payments will be determined at the time of settling the cost report for the hospital cost reporting year that ends during the applicable Medicare FY, and settled on the basis of the hospital discharge data from that cost reporting period.<sup>23</sup>

CMS provides the following example of process and timing for payments<sup>24</sup>

Example: Medicare FY 2011 begins on October 1, 2010 and ends on September 30, 2011. For an eligible hospital with a cost

The EHR incentive payment is made in lieu of the payment for reasonable costs of the purchase of Certified EHR Technology (including depreciation and interest expense) that would have been otherwise made by Medicare under the reasonable cost reimbursement methodology for CAHs.

The Proposed Rule provides the following example:<sup>30</sup>

Example: A CAH first requests an incentive payment for its cost reporting period beginning on January 1, 2012 which is in FY 2012. The CAH incurred reasonable costs of \$500,000 for the purchase of Certified EHR Technology in its previous cost reporting period beginning on January 1, 2011. This CAH is a meaningful user of Certified EHR Technology during the relevant EHR reporting period and thus qualifies for an incentive payment for FY 2012. (For illustrative purposes this example assumes no salvage value of the assets acquired.) The CAH depreciated \$100,000 of the costs of these items in the cost reporting period beginning on January 1, 2011. As a result, the amount used to compute the incentive payment will be the remaining \$400,000 of undepreciated costs. The CAH's Medicare share is 90 percent (its Medicare Share of 70 plus 20 percentage points). Therefore, the CAH's incentive payment for FY 2012 is \$360,000 (\$400,000 times 90 percent). This CAH's first payment year is FY 2012, and it can receive incentive payments through four consecutive payment years which, in this example, would be FYs 2012 through 2015.

## Timing and Process for Payment

The CAH's MAC will pay an incentive payment to a CAH through a prompt interim payment (subject to reconciliation) for the applicable Medicare FY after the CAH submits necessary documentation to support the computation of the incentive payments.

## Incentive Payment Adjustments Effective FY 2015

For cost reporting years beginning in FY 2015, if a CAH is not a qualifying CAH, the reasonable cost payment for inpatient services furnished by a CAH will be reduced from 101 percent of the CAH's reasonable costs in providing CAH services to its inpatients to 100.66 in FY 2015, 100.33 in FY 2016, and 100 percent in FY 2017 and each subsequent FY. A CAH may be exempted from the payment reduction if CMS or the CAH's MAC determines, on a case-by-case basis, that requiring the CAH to be a Meaningful EHR User would result in a significant hardship.<sup>31</sup>

## MEDICARE ADVANTAGE (MA) EHR INCENTIVE PROGRAM

The HITECH Act also provides for incentives under the Medicare Advantage (MA) Program, for certain MA Organizations (Qualifying MA Organizations) with qualifying MA eligible professionals (MA EPs) and Qualifying MA Organization-affiliated eligible hospitals (MA EHs) that are Meaningful EHR Users (all three terms are defined below).<sup>32</sup>

A Qualifying MA Organization with MA EPs and MA EHs that are not Meaningful EHR Users by the CY 2015 benefit year would be subject to a negative adjustment of the MA Organization's capitation payments.<sup>33</sup> Qualifying MA Organizations therefore may want to consider, in deciding whether to adopt Certified EHR Technology, whether future MA Program payments might be at risk of such a reduction.

## Qualifying MA Organizations

The HITECH Act defines a "Qualifying MA Organization" as an MA Organization organized as a health maintenance organization (HMO).<sup>34</sup> The Proposed Rule enhances the definition of qualifying MA Organization to include any MA Organization that meets one of the following criteria:

- a federally qualified HMO
- an entity recognized as an HMO under state law
- a "similar organization regulated for solvency under State law in the same manner and to the same extent as an HMO"



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The Proposed Rule also deems as a Qualifying MA Organization an MA Organization offering an HMO plan under the MA Program “absent evidence to the contrary.”<sup>36</sup> Finally, an MA Organization offering an MA Plan other than an HMO plan (e.g., PPO, PSO, and RPPO MA Plans) would be required to attest to the fact that it is recognized under state law as an HMO or that it meets the “similar organization” standard set out above in order for CMS to consider designating the entity as a Qualifying MA Organization.

## MA Eligible Professionals (MA EP)

A qualifying MA EP is one of two types of physicians who are Meaningful EHR Users: (1) physicians employed by the Qualifying MA Organization and (2) physicians employed by, or a partner in, an entity that furnishes at least 80 percent of its Medicare patient services (both Medicare FFS and MA patients services) to Medicare beneficiaries enrolled in an MA Plan sponsored by the MA Organization.

For both types of physicians, at least 80 percent of professional services provided by the physician to Medicare beneficiaries must be furnished to Medicare beneficiaries enrolled in an MA Plan sponsored by the Qualifying MA Organization, and the physician also must furnish, on average, at least 20 hours of patient care services.<sup>37</sup> Similar to the Medicare FFS EHR incentive program, hospital-based physicians are excluded from the definition of qualifying MA EPs.

A Qualifying MA Organization will have to attest annually that each physician is a Meaningful EHR User and otherwise meets the regulatory requirements for the applicable payment year in order for the physician to be designated as an MA EP.

A physician may not aggregate services furnished to multiple MA Organizations’ Members in order to satisfy the service thresholds, although the Proposed Rule appears to suggest that a physician’s patients who are enrolled in the Qualifying MA Organization’s MA Plans can be aggregated because the Qualifying MA Organization is the required common factor. “[At] least 80 percent of the professional’s total Medicare revenue in a year (that is, total revenue from Medicare FFS as well as from all MA organizations) must be from a single qualifying MA organization. . . .”<sup>38</sup>

As a result, CMS expects that only those physicians employed exclusively by a Qualifying MA Organization and those physicians employed by, or in partnership with, an entity that contracts exclusively with one Qualifying MA Organization will be able to satisfy the criteria to be an MA EP.<sup>39</sup>

## MA-AFFILIATED ELIGIBLE HOSPITAL

A “qualifying MA-affiliated eligible hospital” is an eligible hospital and qualifying MA Organization having a common parent corporation, having a common board of directors, or one of the entities being a subsidiary of the other.<sup>40</sup> The Qualifying MA Organization would have to attest annually that the hospital is a Meaningful EHR User for the applicable payment year.<sup>41</sup> Additionally, of all the Medicare beneficiaries served by the facility, more than two-thirds must be enrolled in an MA Plan.<sup>42</sup>

The Medicare individuals do not have to be enrolled in MA Plans sponsored by the same Qualifying MA Organization, however, as is the case for MA EPs. If, however, for any payment year, one-third or more of the hospital’s discharges (or bed-day patients) who are Medicare beneficiaries are covered under Medicare Part A rather than enrolled in an MA Plan, the hospital may only earn a payment under the Medicare FFS EHR incentive program and the Qualifying MA Organization with whom the hospital is affiliated will not receive any payment under the MA EHR incentive program in connection with the hospital.

## EHR INCENTIVE PAYMENTS FOR QUALIFYING MA ORGANIZATIONS

### MA EP Payments

The Proposed Rule provides that, if an MA EP receives the maximum incentive payment under the Medicare FFS EHR incentive program, no payment would be made to the Qualifying MA Organization under the MA EHR incentive program for that same physician. If an MA EP does not earn the maximum incentive payment under the Medicare FFS EHR incentive program, then the only EHR incentive payment made in connection with such physician would be to the Qualifying MA Organization with whom the MA EP is associated.<sup>43</sup>

The incentive payment to the Qualifying MA Organization for each MA EP would equal 75 percent of the physician’s annual revenue attributable to providing Medicare Part B-coverable services to Members enrolled in the Qualifying MA Organization’s MA Plans in the payment year, up to the maximum amount established under the Medicare FFS EHR incentive program for that payment year. Such maximum amounts are discussed above in the Section regarding the Medicare FFS incentives.

For qualifying MA EPs compensated on a salaried basis, the Qualifying MA Organization would develop a methodology (subject to CMS approval)

for calculating an estimate of the portion of the MA EP's salary attributable to providing Part B–coverable services. Overhead costs may be, but are not required to be, included in this estimation. MA EPs paid on a nonsalaried basis (e.g., fee-for-service or capitated payment arrangements) would be required to provide the Qualifying MA Organization with an attestation identifying the compensation received for providing Part B–coverable services.<sup>44</sup>

Over the incentive program's five years (CY 2012–CY 2016), the maximum cumulative incentive payment to a Qualifying MA Organization for each of its MA EPs would be approximately \$44,000—the maximum amount also available under the Medicare FFS EHR incentive program.

## MA EH Payments

CMS appears to anticipate that, based on the definition (and related criteria) of MA EHs, no Qualifying MA Organizations would receive payment under the MA EHR incentive program for MA eligible hospitals. “To the extent data [on discharges and/or bed-day patients necessary to compute payments under the MA EHR incentive program] are available, qualifying MA organizations 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.”<sup>45</sup>

To the extent data are not available to compute payments for MA EHs under the Medicare FFS EHR hospital incentive program, the Qualifying MA Organization would receive an MA EHR incentive program payment equal to the amount that would be paid under Medicare FFS EHR incentive program.<sup>46</sup>

## Avoiding Duplicative Payments

The Proposed Rule specifies that in order to avoid duplicative payments under the Medicare FFS and MA EHR incentive programs, CMS will make payments to Qualifying MA Organizations under the MA EHR incentive program after all payments are made under the Medicare FFS EHR incentive program for the applicable payment year.

## Downward Adjustments

CMS expressly defers to future rulemaking the development of standards related to adjustments to MA Plan payments for Qualified MA Organizations with MA EPs and MA EHs that are not Meaningful EHR Users in CY 2015. The agency anticipates, based on the statutory requirements, that the payment adjustment would be applied to the physician expenditure portion of a bid (with regard to MA

EPs). The payment adjustment would equal 1 percent for 2015, 2 percent for 2016, and 3 percent in 2017 and future years.

The adjustment would be applied to the hospital expenditure portion of a bid (with regard to MA EHs), and the adjustment would affect “three-fourths of the market basket increase related to a hospital” to a tune of 33-1/3 percent reduction in 2015, 66-2/3 reduction in 2016, and 100 percent reduction in 2017 and subsequent years. “Effectively, the reduction is of all but 25 percent of the market basket increase for a specific hospital in years after 2016.”<sup>47</sup> The Proposed Rule does not address how the payment adjustment would be applied for those MA Organizations submitting multiple MA Plan bids.

Note that in anticipation of the payment adjustment, Qualifying MA Organizations will be required to self-report to the agency, effective with the CY 2015 bid submissions, identifying themselves as a Qualifying MA Organization, regardless of whether they have MA EPs and MA EHs for which an incentive payment would be sought.

## STRATEGIC CONSIDERATIONS FOR QUALIFYING MA ORGANIZATIONS

Qualifying MA Organizations seeking an MA EHR incentive payment for CY 2011 will have to make a “preliminary identification” of potential MA EPs and MA EHs in the CY 2011 bid submission, due in June 2010. Identifying information would include the provider's name, address, and NPI. Thus, Qualifying MA Organizations intending to apply for the incentive payment should begin the process of identifying potential MA EPs and MA EHs soon.

In addition, processes and procedures will be necessary to collect (and verify) information supporting the Qualifying MA Organization's attestations to CMS regarding the MA EPs' and the MA EHs' status as Meaningful EHR Users as well as to calculate the estimated incentive payment for MA EPs, particularly if the Qualifying MA Organization will have to estimate the portion of a salaried EP's income that is attributable to Part B–coverable services.

MA Organizations that may be Qualifying MA Organizations that do not anticipate seeking MA EHR incentive payments during the initial years of the program nevertheless should consider the potential implications of the downward adjustment for future MA Plan payments. Such an analysis may indicate whether an MA Organization's payments will be adversely affected in CY 2015 and future years, enabling the MA Organization to make a prudent decision to implement Certified EHR Technology in

a time frame that permits the MA Organization to benefit under the MA EHR incentive program.

## MEDICAID EHR INCENTIVE PROGRAM

Under the HITECH Act,<sup>48</sup> state Medicaid programs, at their option, may receive payments from the federal government known as federal financial participation (FFP) for 100 percent of their expenditures for EHR incentive payments to Medicaid eligible professionals and eligible hospitals. Unlike the Medicare incentives, the Medicaid incentive program allows eligible providers to receive an incentive payment even before they have begun to meaningfully use Certified EHR Technology, if they are engaged in efforts to adopt, implement, or upgrade to Certified EHR Technology. The Proposed Rule includes regulations to implement these provisions.

## INCENTIVE PAYMENTS FOR MEDICAID ELIGIBLE PROFESSIONALS

### Qualified Medicaid Eligible Professionals

The following types of Medicaid-participating professionals are eligible for Medicaid incentives: physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in federally qualified health centers (FQHCs) or rural health clinics (RHCs) that are led by a physician assistant. Hospital-based professionals are not eligible for incentives unless the professional practices predominately in a FQHC or RHC.<sup>49</sup>

To qualify for an EHR incentive payment, a Medicaid eligible professional must meet one of the following patient volume thresholds: (1) have a minimum 30 percent patient volume attributable to individuals receiving Medicaid; (2) have a minimum 20 percent Patient Volume (as defined below) attributable to individuals receiving Medicaid, and be a pediatrician; or (3) practice predominantly in a FQHC or RHC and have a minimum 30 percent Patient Volume attributable to Needy Individuals (as defined herein).<sup>50</sup>

Needy Individuals are persons who received medical assistance from Medicaid or the Children's Health Insurance Program, were furnished uncompensated care by the eligible professional, or were furnished services either at no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay.<sup>51</sup>

CMS proposes to define patient volume (Patient Volume) as the fraction where:<sup>52</sup>

- the numerator is the total number of Medicaid (including Medicaid managed care) patients or Needy Individuals treated in any representative 90-day period in the most recent CY preceding the reporting, and
- the denominator is all patient encounters in the same 90-day period.

Medicaid eligible professionals would be required to annually re-attest to meeting the Patient Volume thresholds to continue to qualify for Medicaid incentive payments.<sup>53</sup> A State may propose an alternative Patient Volume measure to CMS for approval.<sup>54</sup>

## Incentive Payment Calculation for Eligible Professionals

Under the Proposed Rule, Medicaid incentive payments to qualified Medicaid eligible professionals are equal to 85 percent of Net Average Allowable Costs (as defined below) for Certified EHR Technology (and support services for the technology), subject to statutory caps of \$21,250 (i.e., 85 percent of \$25,000) in the first payment year and \$8,500 (i.e., 85 percent of \$10,000) in the five subsequent years.<sup>55</sup> The maximum aggregate incentive payment for the six-year period is \$63,750, provided that the first payment year is no later than 2016. The payment years are calendar years.

"Average Allowable Costs" is defined as \$54,000 for the first Medicaid incentive payment year and \$20,610 for the five subsequent years based on data from various studies.<sup>56</sup> To determine Net Average Allowable Costs, Average Allowable Costs must be reduced by any payment to the Medicaid eligible professional that is from a source (other than a state or local government) and directly attributable to payment for Certified EHR Technology or support services.

Since CMS proposes that the Average Allowable Cost for the first year is \$54,000, an eligible professional could receive as much as \$29,000 in funding from sources (other than state or local government) in that year and still receive the maximum \$21,250 Medicaid incentive payment.<sup>57</sup>

In addition, pediatricians who have a minimum of 20 percent of their patient encounters paid by Medicaid, but fall short of the 30 percent Patient Volume threshold, may receive two-thirds of the incentives otherwise available, which equals a maximum first year incentive of \$14,167 and up to \$5,667 in the five subsequent years, for a total maximum six-year payment of \$42,500.<sup>58</sup>

Eligible professionals, assigning Medicaid reimbursement to multiple employers or other assignees, must select one assignee's tax identification number to receive Medicaid incentive disbursements.<sup>59</sup>

Employers and facilities engaging such physicians should consider revising their contracts with the physicians to specify which assignee is entitled to the incentive payments.

## Program Election and Coordination

Eligible professionals who meet the eligibility requirements for both the Medicare and Medicaid incentive programs must elect to receive payments from one program or the other, but may change their program election once from 2012 to 2014.<sup>60</sup> In addition, a Medicaid eligible professional may receive an incentive payment from only one state Medicaid program in a payment year.<sup>61</sup>

## INCENTIVE PAYMENTS FOR MEDICAID ELIGIBLE HOSPITALS

### Qualifying Medicaid Eligible Hospitals

The HITECH Act also provides for 100 percent FFP for Medicaid incentives to “acute care hospitals” and “children’s hospitals.”<sup>62</sup>

The Proposed Rule defines an “acute care hospital” for purposes of the incentives as a health care facility where the average length of stay is 25 days or fewer and a CMS certification number (previously known as a Medicare provider number) that has the last four digits in the series 0001-0879.<sup>63</sup> That range of certification numbers includes short-term general hospitals and the 11 cancer hospitals in the United States, but excludes long-term acute care hospitals. In addition, to qualify for an EHR incentive payment, an acute care hospital must have a minimum 30 percent Patient Volume attributable to individuals receiving Medicaid.<sup>64</sup>

“Children’s hospital” is defined as a separately certified children’s hospital, either free-standing or hospital-within-hospital that has a CMS certification number that has the last four digits in the series 3300-3399 and predominately treats individuals under 21 years of age.<sup>65</sup> CMS assigns that range of certification numbers to the country’s 78 certified children’s hospitals.

### Incentive Payment Calculation for Qualifying Eligible Hospitals

The Proposed Rule includes new regulations implementing Medicaid incentive payments to Qualifying Medicaid eligible hospitals that equal the product of the Overall EHR Amount and the Medicaid Share, payable over three to six years beginning before 2017. Each term is defined below:

- The “Overall EHR Amount” is equal to the sum over four years of (1)(a) \$2,000,000 plus (b) the discharge related amount defined as \$200 for the 1,150th through the

23,000th discharge for the first payment year (for subsequent payments years, state Medicaid programs must assume discharges increase by the hospital’s average annual rate of growth for the most recent three years for which data are available per year), multiplied by (2) the transition factor applicable for each year, which is one in year 1,  $\frac{3}{4}$  in year 2,  $\frac{1}{2}$  in year 3, and  $\frac{1}{4}$  in year 4.<sup>66</sup>

- The “Medicaid Share” means the fraction where:
  - the numerator is the sum (for the 12-month period selected by the State Medicaid program and with respect to the eligible hospital) of (1) the estimated number of inpatient-bed-days that are attributable to Medicaid individuals plus (2) the estimated number of inpatient-bed-days that are attributable to individuals who are enrolled in certain Medicaid managed care plans, and
  - the denominator is the product of (1) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period and (2)(a) the estimated total amount of the eligible hospital’s charges during such period, not including any charges that are attributable to charity care, divided by (b) the estimated total amount of the hospital’s charges during such period.<sup>67</sup>

### Dual Eligibility For Incentives

A hospital may receive incentive payments from both Medicare and a state Medicaid program if it meets all eligibility requirements of both incentive programs.<sup>68</sup> A hospital may only receive an incentive payment from one state Medicaid program in a payment year.<sup>69</sup>

## SUMMARY AND CONCLUSION

Since incentives will begin to flow to eligible providers as early as 2011, providers with EHRs should evaluate their ability to satisfy the requirements for “meaningful use” and the impact of incentive payments on their health information technology budgets. Likewise, providers that are considering an investment in EHR technology should reevaluate their project budgets in light of the demands of meaningful use and assess the extent to which they can fund part of the budget through incentive payments.

#### Notes:

1. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule, 75 Fed. Reg. 1843 (proposed January 13, 2010) (to be

- codified at 42 C.F.R. pts. 412, et al.), available at <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=796654179042+0+2+0&WAISSaction=retrieve>.
2. Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Interim Final Rule, 75 Fed. Reg. 2013 (Jan. 13, 2010) (to be codified at 45 C.F.R. pt. 170), available at a <http://frwebgate6.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=79648995247+3+2+0&WAISSaction=retrieve>.
  3. HITECH Act, §§ 4101 and 4102 (to be codified at 42 U.S.C. § 1395w-4 and 1395ww).
  4. HITECH Act, § 4101 (to be codified at 42 U.S.C. § 1395w-4(o)(1)(A)(i)).
  5. *Ibid.*, at 1996 (to be codified at 42 C.F.R. § 495.100).
  6. *Ibid.*
  7. *Ibid.*, at 1993 (to be codified at 42 C.F.R. § 495.4).
  8. *Ibid.*
  9. *Ibid.*, at 1908.
  10. *Ibid.*, at 1910.
  11. 75 Fed. Reg. at 1996 (to be codified at 42 C.F.R. §495.102(d)).
  12. HITECH § 4101(b) (to be codified at 42 U.S.C. § 1395w-4(a)(7)(A)(iii)).
  13. 75 Fed Reg. at 1911.
  14. HITECH § 4101(b) (to be codified at 42 U.S.C. § 1395w-4(a)(7)(B)); 75 Fed Reg. at 1911.
  15. 75 Fed Reg. at 1996 (to be codified at 42 C.F.R. § 495.100); See also 42 U.S.C. §1395ww(d)(1)(B) (defining subsection (d) hospital).
  16. 75 Fed Reg. at 1996 (to be codified at 42 CFR 495.100).
  17. HITECH § 4102(a); 75 Fed Reg. at 1997 (to be codified at 42 C.F.R. § 495.104).
  18. 75 Fed Reg. at 1997 (to be codified at 42 C.F.R. § 495.104(c)(3)).
  19. *Ibid.* (to be codified at 42 C.F.R. § 495.104(c)(4)).
  20. *Ibid.* (to be codified at 42 C.F.R. § 495.104(c)(5)).
  21. *Ibid.*, at 1915.
  22. 75 Fed Reg. 1997 (to be codified at 42 C.F.R. § 495.104(c)(2)).
  23. *Ibid.*
  24. *Ibid.*, at 1912.
  25. HITECH Act § 4102(b)(1) (to be codified at 42 U.S.C. §1395ww(b)(3)(B)).
  26. 75 Fed Reg. at 1990 (to be codified at 42 C.F.R. § 412.64(d)(3)).
  27. HITECH Act § 4102(b)(1) (to be codified at 42 U.S.C. § 1395ww(b)(3)(B)).
  28. HITECH Act § 4102(b)(2) (to be codified at 42 U.S.C. §1395(f)(1)).
  29. 75 Fed Reg. at 1997-98 (to be codified at 42 CFR 495.106)).
  30. *Ibid.*, at 1918.
  31. HITECH Act § 4102(b)(2)(C) (to be codified at 42 U.S.C. § 1395(f)(1)).
  32. HITECH Act § 4101(c) (to be codified at 42 U.S.C. § 1395w-23).
  33. *Ibid.*, at § 4101(c) (to be codified at 42 U.S.C. § 1395w-23); 75 Fed. Reg. at 1923.
  34. HITECH Act § 4101(c) (to be codified at 42 U.S.C. § 1395w-23).
  35. 75 Fed. Reg. at 1921, 1999 (to be codified at 42 C.F.R. § 495.200).
  36. *Ibid.*
  37. *Ibid.*, at 1998.
  38. *Ibid.*, at 1921.
  39. *Ibid.*
  40. *Ibid.*, at 1998 (to be codified at 42 C.F.R. § 495.200).
  41. *Ibid.*
  42. *Ibid.*
  43. 75 Fed. Reg. at 2000 (to be codified at § 495.208(a)).
  44. *Ibid.*, at 1999-2000 (to be codified at § 495.204(b)). The payment year would be defined as a calendar year.
  45. *Ibid.*, at 1999 (to be codified at 42 C.F.R. § 495.204(c)(2)).
  46. *Ibid.*, at 1999-2000 (to be codified at § 495.204(c)). The payment year would be defined as the federal fiscal year, rather than the MA Program benefit year (i.e., the calendar year).
  47. *Ibid.*, at 1928.
  48. HITECH § 4201(a)(1) (to be codified at 42 C.F.R. § 1396b(a)(3)).
  49. 75 Fed. Reg. at 2001 (to be codified at 42 C.F.R. § 495.304(d)).
  50. *Ibid.*, at 2001 (to be codified at 42 C.F.R. § 495.304(c)).
  51. *Ibid.*, at 2001 (to be codified at 42 C.F.R. § 495.302).
  52. *Ibid.*
  53. *Ibid.*, at 2002 (to be codified at 42 C.F.R. § 495.306(a)).
  54. *Ibid.*, at 2002 (to be codified at 42 C.F.R. § 495.306(b)).
  55. *Ibid.*, at 2002 (to be codified at 42 C.F.R. § 495.310(a)).
  56. *Ibid.*, at 1933-1934.
  57. *Ibid.*, at 1934.
  58. *Ibid.*, at 2002 (to be codified at 42 C.F.R. § 495.310(b)).
  59. *Ibid.*, at 2006 (to be codified at 42 C.F.R. § 495.332(c)(9)(i)).
  60. *Ibid.*, at 2002 (to be codified at 42 C.F.R. § 495.310(c)).
  61. *Ibid.*, at 2002 (to be codified at 42 C.F.R. § 495.310(e)).
  62. HITECH Act § 4201 (to be codified at 42 U.S.C. §1396b).
  63. 75 Fed. Reg. at 2000 (to be codified at 42 CFR 495.302).
  64. *Ibid.*, at 2001 (to be codified at 42 CFR 495.304(e)(1)).
  65. *Ibid.*, at 2001 (to be codified at 42 CFR 495.302).
  66. *Ibid.*, at 2002-2003 (to be codified at 42 CFR 495.310(g)(1)).
  67. *Ibid.*, at 2003 (to be codified at 42 CFR 495.310(g)(2)).
  68. *Ibid.*, at 2003 (to be codified at 42 CFR 495.310(j)).
  69. *Ibid.*, at 2003 (to be codified at 42 C.F.R. § 495.310(e)).

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