



## CMS MEANINGFUL USE INCENTIVES FOR MICHIGAN PROVIDERS

The American Recovery and Reinvestment Act of 2009 (Recovery Act) was signed into law by President Obama on February 17, 2009. The law includes the Health Information Technology for Economic and Clinical Health Act, or the "HITECH Act," which established Centers for Medicare and Medicaid Services (CMS) programs to provide incentive payments for the "meaningful use" of certified electronic health records (EHR) technology. The payments are not direct reimbursement for the purchase and acquisition of such technology, but rather are intended to serve as incentives for eligible professionals (EPs) and eligible hospitals to adopt and meaningfully use certified EHR technology.

Details establishing eligibility and payment vary by patient population, provider and organization type and state. Incentives apply differently to EPs, eligible hospitals and certified Critical Access Hospitals (CAHs). For example, EPs may participate in either Medicare or Medicaid's incentive program, while most eligible hospitals may participate in both. EPs, except those practicing in Federally Qualified Health Centers or certified Rural Health Clinics (FQHCs/RHCs), cannot be hospital-based. For the Medicaid EHR Incentive Program, states can request CMS approval to implement additional meaningful use measures.

### MEANINGFUL USE

Congress specified three types of requirements for meaningful use:

1. Use of certified EHR technology in a meaningful manner;
2. Use of certified EHR technology connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and
3. Submission of clinical quality measures and such other measures selected by the Secretary of HHS.

A draft definition of meaningful use of an EHR, along with the requirements to demonstrate meaningful use, was issued by CMS at the end of 2009. This draft definition included 25 objectives for EPs and 23 objectives for hospitals that range from electronic eligibility verification to use of computerized physician order entry (CPOE).

CMS has planned a phased approach to "meaningful use", consisting of the following stages:

**Stage 1:** Capture data in a coded format.

**Stage 2:** Expand upon the Stage 1 criteria in the areas of disease management, clinical decision support, medication management, support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies.

**Stage 3:** Achieve improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data, and improving population health outcomes.

### MEDICARE

#### **I. Eligibility**

**EPs** include a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, who is legally authorized to practice under state law. **Eligible hospitals** include Medicare "subsection (d)" hospitals paid under the hospital inpatient prospective payment system (IPPS), and CAHs. A "subsection (d) hospital" is a general, acute care, short-term hospital.

**Medicare Advantage** incentive payments will be made to qualifying Medicare Advantage (MA) organizations for the adoption and meaningful use of EHR technology by their affiliated EPs. MA-affiliated EPs are EPs who are employed or subcontracted by an MA organization and on average provide at least 20 hours of patient care services per week. For a subcontracted EP, at least 80% of his/her professional services must be furnished to enrollees of the MA organization.

## II. Payment

EPs can receive EHR incentive payments for up to five years with payments beginning as early as 2011. The maximum amount of total incentive payments that an EP can receive under the Medicare program is \$44,000. A qualifying EP can receive an annual incentive payment as high as \$18,000 if their first payment year is 2011 or 2012. Otherwise, the annual incentive payment limits in the first, second, third, fourth, and fifth years are \$15,000, \$12,000, \$8,000, \$4,000, and \$2,000 respectively. The maximum total amount of EHR incentive payments that may be received by a Medicare EP is outlined in the adjacent table.

Incentive Payments	1st Calendar Yr of Eligible Participation			
	2011	2012	2013	2014
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
2016		\$2,000	\$4,000	\$4,000
<b>Total</b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>

**Subsection (d) hospitals** may receive incentive payments for up to four years, beginning FY 2011, provided they meet the requirements for demonstrating meaningful use. The incentive payment for each eligible hospital will be calculated based on (1) an initial amount which is the sum of a \$2 million base amount and the product of a per discharge amount and the number of discharges; (2) the Medicare share which is the proportion of Medicare fee-for-service and managed care inpatient bed-days to the product of total inpatient days and by the hospital's total charges that are not attributed to charity care; and (3) a transition factor which phases down the incentive payments over the four year period.

**CAHs** may receive incentive payments if they meet the definition of a meaningful EHR user for an eligible subsection (d) hospital. Qualifying CAHs can receive incentive payments for the reasonable costs incurred for the purchase of depreciable assets like computers and associated hardware and software, necessary to administer certified EHR technology, excluding any depreciation and interest expenses associated with the acquisition. A qualifying CAH will receive an incentive payment amount equal to the product of its reasonable costs incurred for the purchase of certified EHR technology and its Medicare share percentage. The Medicare share percentage equals the lesser of (1) 100 %; or (2) the sum of the Medicare share fraction for the CAH and 20 percentage points.

**Fee Schedule Reductions** will be applied to EPs and inpatient hospitals who are not meaningful EHR users beginning in 2015. MA organizations will also be subject to payment adjustments if their affiliated EPs or hospitals are not meaningful users of EHR technology beginning in 2015. An exception can be made if the Secretary determines that compliance with the requirements for being a meaningful EHR user would result in a significant hardship.

## MEDICAID

### I. Eligibility

EPs include physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants practicing predominantly in an FQHC/RHC that is directed by a physician assistant. EPs working in more than one state must choose a state from which to receive incentive payments.

\*This document is intended as a summary only. For more details and verification, please consult your organization's leadership or the CMS website [www.cms.hhs.gov](http://www.cms.hhs.gov)\*

**Eligible hospitals** include acute care hospitals and children’s hospitals. An acute care hospital is a primary health care facility where the average length of patient stay is 25 days or fewer. Hospitals with a CMS Certification Number (CCN) that has the last four digits in the series 0001 – 0879 are eligible.

**EPs and hospitals** each must serve a minimum percentage of Medicaid patients according to the following table, or in the case of Medicaid EPs practicing predominantly in an FQHC or certified RHC, a minimum percentage of “needy individuals.” An EP practices predominantly at an FQHC or an RHC when the clinical location for over 50% of his/her total patient encounters over a period of 6 months occurs at an FQHC or a certified RHC. Needy individuals are those meeting any of the following three criteria: (1) Receiving medical assistance from Medicaid or the Children’s Health Insurance Program (CHIP); or (2) Furnished uncompensated care by the provider; or (3) Received services at either no cost or reduced cost based on a sliding scale.

## II. Payment

**EPs** can receive 85% of “net average allowable costs,” capped at \$63,750 per provider over the six year period.

**Hospital payments** may be made up to 100% of an aggregate EHR hospital incentive amount provided over a minimum of a 3-year period and a maximum of a 6-year period for children’s and acute care hospitals. The overall EHR amount is equal to the sum over 4 years of the base amount (\$2,000,000) plus the discharge related amount defined as \$200 for the 1,150<sup>th</sup> through the 23,000<sup>th</sup> discharge for the first payment year, multiplied by the transition factor for each year (equaling 1 in year 1, ¾ in year 2, ½ in year 3, and ¼ in year 4).

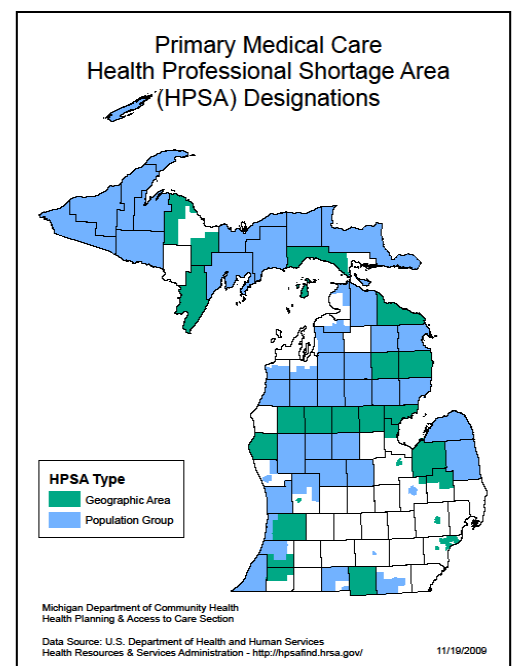
**Fee Schedule Reductions** do not apply to Medicaid providers and hospitals at this time.

## SPECIAL CONSIDERATIONS

EPs who predominantly furnish services in a geographic **Health Professional Shortage Areas (HPSA)** are eligible for a 10% increase in incentive payments.

**Pediatricians** with Medicaid patient volume between 20% to 29% of their total patient volume can receive two-thirds of the maximum amount, while those who reach the 30% threshold qualify to receive the full incentive.

Qualifying Patient Volume Threshold for Medicaid EHR Incentive Program	
Entity	Minimum 90-day Medicaid patient volume threshold (percent)
Physicians	30
Pediatricians	20
Dentists	30
Certified Nurse Midwives	30
Physician Assistants (when practicing at an FQHC/RHC led by a PA)	30
Nurse Practitioners	30
Acute Care Hospitals	10
Children's Hospitals	0



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