HIGHLIGHTS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) PROPOSED RULE ON MEANINGFUL USE

Proposed Rule: This summary of CMS' proposed rule on the Medicare and Medicaid Electronic Health Record Incentive Programs is subject to change given that this rule is not yet final. Public comments to this proposed rule are due by March 15, 2010. The proposed rule can be found at: http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf.

Common Meaningful Use Definition for Medicare and Medicaid incentives: CMS proposes a common definition for meaningful use (MU) that would apply to eligible professionals (EPs), including physicians, participating in the Medicare Fee For Service (FFS) and Medicare Advantage (MA) electronic health record (EHR) incentive program, and would be the minimum standard for those participating in the Medicaid incentive program.

One-Time Switch Policy: EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs would be able to participate in only one program, and would have to designate which one they would like to participate in. After their initial designation, EPs are allowed to change their program selection only once during payment years 2012 through 2014.

Medicare FFS Incentives: EPs who are meaningful EHR users, are eligible for incentives based on an amount equal to 75 percent of their allowed Medicare Part B charges for covered professional services subject to the annual maximum limits specified below:

Calendar Year (CY) Note: A Payment Year equals a Calendar Year (CY)	**First CY in which the EP Receives an Incentive Payment**				
	2011	**2012**	**2013**	**2014**	**2015 and 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; - 1% of Medicare fee schedule (penalty)
2016		$2,000	$4,000	$4,000	$0; -2% of Medicare fee schedule (penalty)
TOTAL	$44,000	$44,000	$39,000	$24,000	$0

Payment Process: For EPs, the payment year would be based on the calendar year starting in 2011. Incentive payments would be made on a rolling basis by Medicare contractors as soon as they ascertain that an EP has demonstrated meaningful use for the applicable reporting period, and has reached the threshold for maximum payment. The contractors would also track the incentive payments using the qualifying EP's Tax Identification Number (TIN).

Reporting Period: For the first year an EP applies for and receives an incentive payment, CMS proposes that the EHR reporting period be 90 days for any continuous period beginning and ending within the calendar year (i.e., EHR reporting period can be January 1, 2011 to April 1, 2011, March 13, 2011 to June 11, 2011, etc.). For every year after the first payment year, CMS proposes that the EHR reporting period be for the entire calendar year.

Three Stages for Meeting Meaningful Use Criteria: In general, Stage 1 criteria would require: 1) electronically capturing health information in a coded format; 2) 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); 3) implementing clinical decision support tools to facilitate disease and medication management; and 4) reporting clinical quality measures and public health information. The reporting requirements vary based on when a physician begins reporting. Stages 2 and 3 will be defined in future rulemaking.

	1st Payment Year	**2nd Payment Year**	**3rd Payment Year**	**4th Payment Year**	**5th Payment Year**
2011	Stage 1	-	-	-	-
2012	Stage 1	Stage 1	-	-	-
2013	Stage 2	Stage 1	Stage 1	-	-
2014	Stage 2	Stage 2	Stage 2	Stage 1	-
2015	Stage 3	Stage 3	Stage 3	Stage 3	Stage 3
2016	Stage 3+	Stage 3+	Stage 3+	Stage 3+	Stage 3+

Two Categories of Measures for Reporting: CMS proposes two categories of measures to be reported on: health IT functionality measures and clinical quality measures.

Health IT Functionality Measures: Some of the proposed functionality measures include: using computerized provider order entry (CPOE) for at least 80 percent of all orders (i.e., medications, laboratory services, imaging studies); transmitting at least 75 percent of all permissible prescriptions electronically using certified EHR technology; maintaining active medication and medication allergy lists for at least 80 percent of patients seen by the EP; requiring at least 50 percent of all clinical lab test results ordered by the EP to be incorporated in certified EHR technology as structured data; checking insurance eligibility electronically from public and private payers for at least 80 percent of patients seen; providing at least 80 percent of patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, allergies list) within 48 hours upon request; and performing medication reconciliation for at least 80 percent of relevant encounters and transitions of care. (for the complete list see Table 2 in the regulation)

Reporting Method for 2011: Attestation
Reporting Method for 2012: Attestation

Quality Measures: All EPs would have to report on: 1) all core measures that apply to their patients (see Table 4 in the regulation); and 2) a subset of clinical measures (see Tables 5-19 in the regulation) that are most appropriate given the physician's specialty. Core measures include: 1) preventive care and screening regarding tobacco use; 2) blood pressure measurement; 3) drugs to be avoided in the elderly. There are a total number of 93 proposed quality measures (90 clinical measures and 3 core measures) and several of the 90 clinical measures are used in multiple specialty groups. The specialty groups, and number of measures that comprise each, include: Cardiology (10); Pulmonology (8); Endocrinology (9); Oncology (6); Proceduralist/Surgery (6); Primary Care Physicians (29); Pediatrics (9); Obstetrics and Gynecology (9); Neurology (5); Psychiatry (6); Ophthalmology (3); Podiatry (3); Radiology (7); Gastroenterology (6); and Nephrology (6).

For 2011 and 2012, EPs would select a specialty measures group on which to report on all applicable cases for each of the measures in the specialty group. The same specialty measures group selected for the first payment

year would be required for reporting in the second payment year. In the final rule, CMS will indicate which EP specialties will be exempt for 2011 and 2012 from selecting and reporting on a specialty measures group, however these physicians would still have to report on core measures. It is anticipated that EPs would report on up to five clinical quality measures.

Reporting Method for 2011: Attestation
Reporting Method for 2012: Using certified EHR technology

Demonstration of Meaningful Use: For 2011, EPs would be required to demonstrate that they satisfy each of the proposed meaningful use objectives through a one-time attestation following the reporting period, which would also cover identification of the certified EHR technology they are utilizing, and the results of their performance on all the measures associated with the objectives of meaningful use.

Hospital-Based Professionals: Hospital-based EPs (includes all outpatient settings where hospital care is furnished to registered hospital outpatients) are not eligible for the Medicare incentive payments nor would the majority of hospital-based EPs be eligible for Medicaid incentive payments (the only exception to this rule is for those practicing predominantly in an Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)). CMS proposes to define hospital-based EPs as those who furnish at least 90 percent of these services in a hospital setting, either inpatient, outpatient or emergency department. CMS would determine non-eligibility based upon site of service codes.

Additional Incentives for Providing Services in Health Professional Shortage Areas: An EP who furnishes more than 50 percent of covered services in a geographic Health Professional Shortage Area (HPSA) would be eligible for an additional 10 percent incentive on top of the maximum incentive payment amount. CMS would determine eligibility by reviewing the frequency of services provided over a 1-year period (January 1 through December 31).

Medicaid Incentives: The maximum incentive payment an EP would receive from Medicaid equals 85 percent of $75,000, or $63,750, over a period of 6 years. To receive a Medicaid incentive payment during the first payment year, through attestation an EP would only have to demonstrate engagement in efforts to "adopt, implement, or upgrade certified EHR technology," without having to demonstrate meaningful use. See below for details on the Medicaid incentives:

Cap on Net Average Allowable Costs under Medicaid Incentive Program	85 percent Allowed for Medicaid Eligible Professionals	Maximum Cumulative Medicaid Incentive over 6-year Period
$25,000 in Year 1 for most Medicaid eligible professionals	$21,250	$63,750
$10,000 in Years 2-6 for most Medicaid eligible 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	