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MEMORANDUM

To: PPSV Clients and Friends
From: Powers, Pyles, Sutter & Verville, P.C.
Date: January 6, 2010
Re: Rulemaking Notices on HITECH Act Incentive Payments

The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) each issued rulemaking notices on December 30 to implement the electronic health record (EHR) incentive program established under the HITECH Act. CMS's proposed rule provides details on how hospitals and eligible professionals (EPs)(including physicians) can qualify for the Medicare and Medicaid incentive payments, and specifically defines what constitutes "meaningful use" of HER, which is required to receive the payments. The interim final rule issued by ONC establishes standards and criteria for EHR technology for hospitals and EPs. Both rules will be published in the Federal Register on January 13, 2010, and comments are due 60 days later.

Some highlights of these rules are:

- CMS proposes to phase-in meaningful use criteria in three stages.
- CMS proposes that hospitals and EPs demonstrate meaningful use through attestation except that, beginning in 2012, hospitals and EPs must demonstrate meaningful use for clinical quality measures by electronic submission.
- Hospital-based professionals, who are neither eligible for incentive payments nor subject to penalties, are defined as individuals who furnish 90% or more of their covered professional services in the preceding calendar year in a hospital inpatient, outpatient or emergency department (Medicare codes 21, 22 and 23).
- The ONC interim final rule establishes criteria for certified EHR technology, but ONC will implement a EHR certification program in a separate rule.

The link to the CMS rule is http://www.federalregister.gov/OFRUpload/OFRData/2009-31217_PI.pdf and to the ONC rule is http://www.federalregister.gov/OFRUpload/OFRData/2009-31216_PI.pdf. A summary of the rules follows.

I. BACKGROUND ON HITECH ACT

The HITECH Act provides for Medicare and Medicaid incentive payments to certain hospitals and EPs that demonstrate “meaningful use” of EHR, including “use of certified EHR technology in a meaningful manner.” (One exception to the “meaningful use” requirement is that hospitals and EPs can receive a Medicaid incentive payment for the first payment year if they adopt, implement or upgrade certified EHR.) Hospitals and EPs that do not demonstrate meaningful use of EHR by certain dates are subject to Medicare payment reductions. There are no Medicaid penalties. Neither the incentives nor the penalties are applicable to hospital-based EPs. Qualifying hospitals may receive both Medicare and Medicaid incentive payments; EPs must choose one program (but may make a one-time switch).

CMS is proposing to deem hospitals that meet the meaningful use criteria for Medicare as meeting the meaningful use criteria for Medicaid, but also giving States the opportunity to add criteria approved by CMS. CMS is requesting comments on whether States should be given added flexibility with regard to meaningful use criteria.

II. CMS’S PROPOSED RULE

A. Meaningful Use Criteria

1) Three Phases

CMS is proposing a three-stage phase-in of the meaningful use criteria for both the Medicare and Medicaid programs. The proposed rule sets forth Stage 1 objectives and measures to demonstrate meaningful use, but not specific Stage 2 and 3 measures. CMS is requesting comments on this three-stage plan. CMS is also soliciting comments on whether all providers will be able to meet all of the Stage 1 measures and suggestions for alternative criteria and measures, as well as the inclusion or exclusion of clinical quality measures.

CMS is proposing that, for EPs that practice at more than one location, the meaningful use measures apply only to those locations equipped with certified EHR technology. In addition, an EP must have 50% or more of his or her patient encounters at one or more of these locations to be a meaningful user. CMS is soliciting comments on these criteria.

2) Health IT Functionality Measures

CMS categorizes the Stage 1 measures as 1) health IT functionality measures and 2) clinical quality measures. The health IT functionality measures for both hospitals and EPs are listed in the proposed rule.

It is useful to consider a number of examples of health IT functionality measures:

- Hospitals must use computerized provider order entry (CPOE) for at least 10% of all inpatient orders, and EPs must use CPOE for 80% of orders. CPOE is defined as the use of computer assistance to enter medical orders, but not transmittal of the order. (CMS is soliciting comments on whether additional detail is required on the CPOE criteria.)
- Hospitals and EPs must provide patient health information within 48 hours in 80% of the cases in which they receive a request.
- With regard to health information exchange, the measures require that EHR have the capacity to exchange information and at least one test of that capacity has been performed, but do not require health information exchange on a regular basis.
- EPs must electronically transmit at least 75% of all prescriptions (other than controlled substances).
- The CMS rule proposes that hospitals and EPs conduct or review a security risk analysis (required under HIPAA regulation 45 C.F.R. § 164.308(a)(1)) and implement necessary updates as one of the health IT functionality measures.

3) Clinical Quality Measures

Under the proposed rule, hospitals and EPs must report on clinical quality measures for all patients, regardless of payer.

Hospitals must report on clinical quality measures set forth in the proposed rule (Table 20, except that hospitals have the option of reporting on alternative Medicaid clinical quality measures (Table 21) if the Table 20 measures are not applicable to the hospital's patient population.

CMS is proposing two sets of clinical quality measures for EPs. One set of measures is a "core" group applicable to all EPs (Table 4). These include measures on screening for tobacco use, blood pressure measurement, and drugs to be avoided. The second group of clinical quality measures is divided by clinical specialty, and each EP must select one measure on which to report. The specialty measure groups are: cardiology, pulmonology, endocrinology, oncology, proceduralist/surgery, primary care, pediatrics, obstetrics/gynecology, neurology, psychiatry, ophthalmology, podiatry, radiology, gastroenterology and nephrology. While there are no specific oncology measures, especially for screening services, no specific measures are proposed for radiation oncology. CMS is requesting comments on whether certain professionals would have sufficient data to report on any set of specialty measures.

B. Demonstrating Meaningful Use

CMS is proposing that, for 2011, hospitals and EPs report meaningful use through attestation for both Medicare and Medicaid, which include an attestation as to the results of the clinical quality measures. For 2012 and subsequent years, CMS is proposing that hospitals and EPs continue to attest to meaningful use for all measures except clinical quality measures, which will be reported electronically (if CMS has the infrastructure in place to accept the data in 2012). The reporting period is any continuous 90-day period during the first payment year and the entire year for subsequent years. CMS plans to conduct compliance reviews to validate eligibility for the incentive payments. Hospitals and EPs must maintain evidence of eligibility for 10 years after they register for payments. CMS will post online the names of EPs and hospitals who are meaningful users.

B. Payments

1. Medicare

The HITECH Act provides that Medicare incentive payments to EPs are 75% of Medicare allowed charges, subject to caps. The cap is \$44,000 for EPs who demonstrate meaningful use in 2011 or 2012, and decreases thereafter as shown in the following chart:

	2011	2012	2013	2014	2015	2016	Total
Start in 2011	18,000	12,000	8,000	4,000	2,000	0	44,000
Start in 2012		18,000	12,000	8,000	4,000	2,000	44,000
Start in 2013			18,000	12,000	8,000	4,000	39,000
Start in 2014				12,000	8,000	4,000	24,000
Start in 2015					0	0	0

EPs who practice predominately in a designated health professional shortage area (HPSA) receive a 10% add-on. CMS proposes that an EP who provides more than 50% of his or her Medicare services in a HPSA will be considered to be practicing predominantly in the HPSA.

CMS proposes to make a single, consolidated Medicare incentive payment to EPs as soon as the EP demonstrates meaningful use and reaches the minimum threshold of allowed charges.

2. Medicaid Payments

EPs will receive Medicaid payments if they adopt, implement, or upgrade certified EHR in the first year and demonstrate meaningful use in subsequent years in accordance with the following schedule.

Calendar Year	Medicaid Incentive Payments for 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

If the EP has already adopted EHR and is a meaningful user, he or she is eligible for incentive payments of \$8,500 for five years (maximum of \$42,500).

3. Payment Reductions

Hospitals and EPs that are not meaningful users will be subject to Medicare payment reductions beginning in 2015, unless they qualify for a hardship exception. CMS’s proposed rule does not provide much detail on these adjustments, but more guidance should be issued before the adjustments go into effect. There are no Medicaid penalties under the HITECH Act.

III. ONC’s INTERIM FINAL RULE

The ONC’s interim final rule sets out standards, implementation specifications and certification criteria for EHR technology. These provisions were designed to meet the Stage 1 meaningful use criteria proposed by CMS. ONC plans to issue a proposed rule to implement a certification program for EHR and EHR modules. Hospitals and EPs will obviously want to ensure that any EHR system that they consider purchasing has been certified.

IV. PRIVACY AND SECURITY ISSUES

The ONC states that its rule focuses strictly on EHR capabilities and doesn’t change existing HIPAA requirements or guarantee compliance with those requirements. Specifically, the ONC states that “use of Certified EHR Technology alone does not equate to compliance with the HIPAA Privacy or Security rules.”

The ONC standards that focus on privacy and security are listed on page 85 of the ONC rule. The rule requires that EHR technology include access control, but does not include a specific standard for access control as it expects rapid industry innovation in this area. The rule

includes specific criteria and standards for encryption, however. In addition, the rule requires that EHR technology be capable of recording information about disclosures. The ONC is also requiring that EHR technology be capable of using applicable HIPAA transaction standards.

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