

Qualifying for Meaningful Use

Preceding papers in the series have reviewed the requirements in the final rule on meaningful use, published July 28, 2010. This paper summarizes the process for qualifying for the program.

CMS intends to open registration for both eligible professional (EPs) and eligible hospitals in January 2011. An exact date had not been announced as of late September.

To be eligible for the program, a professional or hospital must participate in one or more Medicare or Medicaid programs: Medicare Fee-for-Service, Medicare Advantage, or Medicaid. The provider's patient mix and volume will to some extent dictate which program will yield the best incentive. Hospitals may receive payments through both the Medicare and Medicaid incentive programs; EPs must choose between them. However, EPs will have a one-time opportunity to switch programs.

In publishing the final rule CMS clarified its restrictions on switching. Prior to their first successful attempt at qualifying for any program, EPs (and hospitals) may change their registration as many times as they wish. However, once a payment is made, they may switch only once and only for a payment year before 2015 (p. 44439).

Eligibility

EPs participate in the incentive program as individuals, and it will be up to the individual and the practice how the individual will reimburse the organization. For purposes of the program, CMS defines a physician as 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. The volume and mix will be determined by the EP, not the practice.

States will administer the Medicaid incentive program, and they have some discretion in designing their programs. To afford them maximum flexibility in developing policies regarding EPs who practice on state borders, CMS will not dictate how EPs with patients in multiple states will aggregate their patient populations for reporting purposes. States may allow a Medicaid EP to aggregate his or her patients across practice sites, if the state has a way to verify the patient volume attestation when necessary. States will propose their policies and attestation methodologies to CMS for approval in their State Medicaid health IT plans.

Only short-term, acute hospitals are eligible for the Medicare program. Critical access hospitals will be paid under a different reimbursement rules than the Fee-for-Service program. Requirements and payments also vary for EPs and hospitals when services are rendered in a federally qualified health center or a rural health clinic.

Hospital-based physicians practicing in either inpatient or outpatient settings were not eligible for the program under the January 2010 proposed rule. However, in April Congress modified the HITECH definition of hospital-based EPs in the Continuing Extension Act of 2010. The law replaced the original HITECH language “setting (whether inpatient or outpatient)” with the phrase “inpatient or emergency room setting.”

The meaningful use final rule reflects this change. Hospital-based EPs who provide more than 90 percent of their services in hospital inpatient and emergency room settings remain ineligible for the program. Examples of such providers include pathologists, anesthesiologists, and emergency-room physicians.

The exclusion is intended to prevent duplicate payments, since CMS assumes that all of these providers are using the hospital’s EHR system. Of note is the fact that hospital outpatient services are not part of the calculation for hospital incentive payments.

Program qualifications are even more specific with regard to Medicaid, which sets patient volume thresholds for EPs. Five types of professionals are eligible: physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in a federally qualified health center or rural health clinic led by a physician assistant (p. 44483).

To qualify for Medicaid incentives, these professionals cannot be hospital-based, with the exception of EPs practicing predominantly in a federally qualified health center or rural health clinic. The definition for hospital-based is the same for Medicaid as used in the Medicare EHR incentive program.

The Medicaid incentive program also includes additional qualifications for acute hospitals (an average patient stay of 25 days or fewer) and children’s hospitals (separately accredited). In the final rule, CMS amended the definition of acute care hospitals for purposes of the Medicaid EHR incentive program to those hospitals with an average length of stay of 25 days or fewer, and with a CMS certification number that falls into the range 0001-0879 or 1300–1399 (p. 444840).

The incentive program related to Medicare Advantage contains its own set of additional requirements, since some entities may qualify for multiple Advantage programs (pp. 44468).

To avoid duplicate payments among the states and Medicare, CMS will use a single provider election repository that will uniquely identify each participating provider and indicate which incentive program the provider has selected.

Technology Requirements

To qualify as meaningful users, EPs and hospitals must use EHR technology that meets requirements defined in the final rule and the companion regulation on certification and standards published by the Office of the National Coordinator for Health IT. ONC specifies that the standard it describes will be the sole standard to determine meaningful use eligibility.

There is some exception to the certification requirement in the Medicaid program, which allows payment to “certain Medicaid providers to adopt, implement, upgrade, and meaningfully use

certified EHR technology.” Participants will have to attest that the technology—which can be either a single EHR system or a collection of EHR modules—is certified. Providers will have to work with their vendors to determine if their systems meet the requirements.

The reporting methods vary over the initial two years of the program, given the capabilities of CMS and the states to receive electronic reporting (see papers 5a and 6a for EPs and papers 5b and 6b for hospitals). Initially participants will demonstrate that they meet the functional and clinical quality measures requirements through attestation. Specific reporting requirements are detailed beginning on page 44380.

As technology advances, the requirements for meaningful use and clinical quality reporting will increase in stages 2 and 3 of the incentive program. EHR systems thus must be capable of adapting to future changes, which is one requirement for certification.

In the first year of the program, eligible participants may qualify by meeting the requirements during any 90-day period. In subsequent years they must meet the requirements for the entire year.

Payment

State Medicaid programs have the option of starting payments in 2010; however, few states will likely be ready, given the number of processes to establish and test. CMS expects to make its first incentive payments for the Medicare program in May 2011.

Payments will vary across each of the programs, but CMS proposes they be the same across state Medicaid programs. Payments will vary by the type of provider and when the provider enters the program. It should be noted that for the most part payments are made after the provider has invested in an EHR and its implementation.

Descriptions of the eligibility and payment processes by program and provider type appear on the following pages within the rule:

Incentive Program	Type of Provider	Requirements (page no.)	Administrative Processes (page no.)
Medicare Fee-for-Service	EP	44442–48	44464–65
	Hospital	44448–60	44466–67
	Critical Access Hosp.	44460–61	44467–68
Medicare Advantage	EP	44469–71	44473–82
	Hospital	44471	44473–82
	MA Organization	44472–73	44473–82
Medicaid	EP	44483–91	44491–505
	Acute Hospital	44483–91	44491–505
	Children’s Hospital	44483–91	44491–505

The American Recovery and Reinvestment Act provides additional state grant and loan payments for EHR adoption, and the Department of Health and Human Services and ONC have already announced some funding to the states and Indian tribes for this purpose. Providers can follow up with their states to determine what additional funding might be available.

The Medicare program also includes an option for payment through “Entities Promoting the Adoption of Certified EHR Technology,” described on pages 44491, and as noted above, limited potential for payment in 2010. CMS emphasizes in the final rule that the language in the proposed rule is adopted as written; however, states are encouraged to consider how they will verify on an ongoing basis that the entities they designate are in fact promoting EHR adoption per the requirements.

CMS suggests that some of the current reporting required under Medicare and Medicaid, such as the cost report, be used in determining payment amounts. However, a number of the volume reports required for eligibility and for describing meaningful use are new, and they will require changes to internal processes.

In determining payments CMS also notes that its calculations include the cost of hardware, software, and workforce training associated with system implementations. This is described throughout the document and especially in section IV, “Regulatory Impact Analysis” (p. 44544). However, as CMS notes, the forecasts are subject to substantial uncertainty because demonstration of meaningful use will depend on standards and future rulemakings.

In February ONC announced funding for additional programs designed to assist providers in their EHR implementation, including contract awards to regional extension centers for health IT. It is too early to identify how these resources will be made available to providers. For more information on the extension program and their contacts, go to <http://healthit.hhs.gov>.

The next and final paper in the series offers providers recommendations for getting started on the meaningful use program.

References

Centers for Medicare and Medicaid Services. “Medicare and Medicaid Programs Electronic Health Record Incentive Program.” *Federal Register* 75, no. 144 (July 28, 2010): 44314–4588. Available online at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Continuing Extension Act of 2010. Public Law 111-157. Available online at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4851enr.txt.pdf.

Office of the National Coordinator for Health Information Technology, Department of Health and Human Services. “Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Final Rule.” *Federal Register* 75, no. 144 (July 28, 2010): 44590–654. Available online at <http://edocket.access.gpo.gov/2010/pdf/2010-17210.pdf>.