HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

"Touching Lives Every Day"

COMPLIANCE ALERT 10-14

CMS Announces Proposed Rule for Electronic Health Record (EHR) Incentive Program

CMS detailed its proposed regulations for Hospitals to participate in the EHR incentive program as stipulated in the HITECH Act of the American Recovery and Reinvestment Act of 2009 (ARRA) in the January 13, 2010 *Federal Register.* Highlights from the guidance of interest to HHSC facilities include:

- Definitions of technical qualifications for an acceptable electronic health record (EHR)
- Definitions of "meaningful use" that is necessary for qualifying for the incentive
- Qualifications of "eligible professionals" (EP) for incentive payments
- Amounts for incentive payments for eligible professionals
- Formula for eligible acute care hospitals to receive incentive payments
- Formula for eligible critical access hospitals (CAH) to receive incentive payments

Technical Qualifications for an Electronic Health Record (EHR). The regulations are clear that to qualify for an incentive, the EHR technology must meet the definition of a qualified EHR. However, the strict definition was not included in this guidance and will be defined at a later date by the Office of the National Coordinator for Health Information Technology (ONC).

Definition of "Meaningful Use." To be considered a meaningful EHR user, an eligible hospital or EP must meet these requirements;

1. Demonstrate use of certified EHR technology in a meaningful manner;
2. Demonstrate to the satisfaction of the HHS Secretary that certified EHR technology is "connected in a manner that provides for the electronic exchange of health information to improve the quality of health care such as promoting care coordination, in accordance with all laws and standards applicable to the exchange of information;"
3. Submit to the HHS Secretary, using the required forms and manner, information on clinical quality measures and other measures specified by CMS.

CMS proposes using a 3-Stage phased approach to achieve meaningful use that results in "health care that is patient-centered, evidence-based, prevention-oriented, efficient, and equitable." Stage 1 would be implemented immediately. Stage 2 and Stage 3 criteria would be finalized in future rules. CMS is considering updating the meaningful use criteria on a biennial basis with Stage 2 criteria proposed by the end of 2011 and Stage 3 definition proposed by the end of 2013.

The three stages are currently conceptualized are as follows:

- *Stage 1* meaningful use criteria focus on "electronically capturing health information in a coded format; using that information to track key clinical conditions and communicate that information for care coordination purposes." Meaningful use should be "consistent with other provisions of Medicare and Medicaid law, implementing clinical decision support tools to facilitate disease and medication management and reporting clinical quality measures and public health information."
- *Stage 2* meaningful use criteria build on Stage 1 "to encourage the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders entered using computerized provider order entry and the electronic transmission of diagnostic test results."
- *Stage 3* meaningful use criteria are "to focus on promoting 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."

Stage 1 criteria described in depth in this rule will be in place for "all years" of the program until further criteria for Stage 2 and 3 are established in the future. Eligible hospitals and providers applying for the incentive payments must meet Stage 1 if the first incentive payment is in 2012 or 2013. Hospitals applying for incentive payments in later years would meet subsequent stage criteria as published by CMS.

Stage 1 meaningful use criteria were specifically and extensively detailed in the proposed rule. These Stage 1 criteria include a wide variety of objectives such as ability for computerized entry of orders from authorizing providers, maintaining an active medication and allergy list, recording smoking status, recording vital signs, checking insurance eligibility, having the ability to submit claims electronically, providing patients with a copy of the medical record when requested, and ability to maintain an active problem list. Greater detail, explanations, and examples of Stage 1 meaningful use criteria can be found on pages 1854-1904 of the *Federal Register* edition referenced below.

Qualifications for Eligible Professionals (EP) to Receive Incentive Payments. The HITECH Act states that hospital-based providers are NOT eligible for the incentive payments unless they are practicing in a FQHC or a rural health center. Hospital-based providers are providers such as a pathologist, hospitalist, anesthesiologist, radiologist, emergency physician, and other providers who furnish substantially all (defined as 90 percent) of their Medicare-covered professional services in a hospital setting, including provider-based departments of the hospital, using place of service codes, 21, 22, 23.

Payments for EPs. EPs who do qualify for incentive payments (MD, DO, DDS, DDM, DPM, Doctor of Optometry, or Chiropractor) receive the following payments:

- $15,000 for first payment year ($18,000 if first payment year is 2011 or 2012)
- $12,000 for second payment year
- $8,000 for third payment year
- $4,000 for fourth payment year
- $2,000 for fifth payment year

Payments for implementation starting in 2013 and 2014 are less and there are no incentive payments for implementation after 2015. There are additional incentives for EPs that practice in a Health Professional Shortage Area (HPSA).

Formula for eligible acute care hospitals to receive incentive payments. In general, the incentive payment for hospitals for each payment year is a product of an initial amount, the Medicare share, and a transition factor applicable to that payment year.

Initial Amount. The initial amount is a base amount of $2,000,000 plus a discharge related amount. The discharge related amount is defined as "the sum of the amount estimated based upon total discharges for the eligible hospital (regardless of any source of payment) for the period. The sum is derived from an additional amount for each discharge up to the 23,000th discharge." The amount is based on $0 for discharges 0-1,149 and $200 for each discharge from 1,150-23,000.

Then, the initial amount is multiplied by the Medicare share and an applicable transition factor to determine the incentive payment. The Medicare share is a "fraction based on estimated Medicare FFS and managed care inpatient bed days, divided by the estimated total inpatient bed-days, modified by charges for charity care."

Medicare share fraction. The numerator of the Medicare share faction is the sum of the estimated number of inpatient-bed-days which come from individuals paid for under Medicare Part A and the estimated number of inpatient-bed-days that are from individuals enrolled under Medicare

Advantage Part C. The denominator of the Medicare share fraction is the product of the estimated total number of inpatient-bed-days with respect to the eligible hospital during the reporting period and the estimated total amount of the eligible hospital's charges during such period, not including any charges from charity care, divided by the estimated total amount of the hospital's charges during the reporting period.

Transition factor. The transition factor for hospitals that implement EHR beginning in 2011, 2012, and 2013 is "1" for the first payment year, "3/4" for the second payment year, "1/2" for the third payment year,"1/4" for the fourth payment year and "0" after that. Transition Factors for implementation in 2014 or 2015 are reduced.

Formula for eligible critical access hospitals (CAH) to receive incentive payments. CAHs will still be reimbursed for reasonable costs of implementing an EHR. Once a CAH incurs actual EHR costs, it can submit supporting documentation for review and reimbursement. Reasonable costs are costs "for the purchase of certified EHR technology to which purchase depreciation (excluding interest) would otherwise apply" under normal CAH regulations.

Calculating reasonable costs. The reasonable costs will be computed "by expensing such costs in a single payment year and not depreciating these costs over a period of years (and shall include as costs with respect to cost reporting periods beginning during a payment year costs from previous cost reporting periods to the extent they have not been fully depreciated as of the period involved)." Instead of the calculating the Medicare share as defined above, a substitution for the Medicare share will be a percent (not to exceed 100 percent) equal to the sum of: 1) the Medicare share (as would be specified above), plus; 2) 20 percent.

There will be no incentive payments for CAHs after 2015 and there will be reduction in reasonable costs payments in FY2015 and subsequent years for CAHS that are not meaningful EHR users.

Future announcements will update this rule as necessary.

Source: Federal Register, 75, 8, January 13, 2010, 1844-2011. .