



UPDATE ON INCENTIVES: THE FINAL RULE

The Final Meaningful Use Rule: Overview of Changes and Clarifications to Incentive Payments

The final rule on meaningful use incentives for payment years 2011 and 2012 was released on July 13, 2010.

- For hospitals the “payment year” is based on the Federal fiscal year (Oct1-Sept 30); for EPs it is the calendar year.
- Unlike the Medicare incentive, a hospital or EP only will need to attest that they have “adopted, implemented, or upgraded” certified EHR technology in order to be eligible for their first Medicaid incentive payment.
- To qualify as a meaningful EHR user for the first time, only 90 consecutive days of meaningful use will be required; a full year will be required for any subsequent year.
- Through at least 2014, providers will be able to qualify for their first payment by meeting Stage 1 requirements, however the current Stage 1 requirements are subject to change through future rulemaking.
- Hospital-based physicians will be determined by place of service (POS) codes 21 and 23; individual hospitals will be distinguished by CMS certification number (CCN).

Introduction

The American Recovery and Reinvestment Act of 2009 includes incentive payments for both hospitals and non hospital-based providers that demonstrate “Meaningful Use” of certified EHRs. On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for determining meaningful use and calculating incentive payments for 2011 and 2012.

CMS intends to phase in meaningful use criteria over time. The final rule that was released on July 13 covers “Stage 1” requirements for payment years 2011 and 2012, and will apply to any subsequent payment years until updated by CMS in future rulemaking. (For more information on meaningful use, see our [Update on Meaningful Use](#) white paper) CMS expects to update meaningful use criteria every two years though, with “Stage 2” requirements finalized by the end of 2011.

Specific meaningful use requirements will be based on the year in which a provider first qualifies. If Stage 2 requirements are finalized as expected by the 2013 payment year, a provider who first demonstrates meaningful use in 2011 would be required to meet Stage 2 criteria in order to receive an incentive payment in 2013; a provider who first achieves meaningful use in 2012 would need to meet Stage 2 requirements in 2014.

Through at least 2014, providers will be able to qualify for their *first* incentive payment by meeting Stage 1 requirements. However, the U.S. Department of Health and Human Resources reserves the right to update Stage 1 meaningful use criteria in future rulemaking. This means it is possible that qualifying for Stage 1 in 2013 or 2014 will be different (and more difficult) than qualifying for Stage 1 in 2011 or 2012.

To qualify as a meaningful EHR user for the first time, only 90 consecutive days of meaningful use will be required. In future years, the reporting period will be the entire payment year. For 2011, meaningful use will be demonstrated through attestation.

Meaningful Use Requirement Sets by Year

First Year of MU*	Payment Year/MU Requirement					
	2011	2012	2013	2014	2015	2016
2011	Stage 1 (90 days)	Stage 1 (90 days)	Stage 2* (365 days)	Stage 2* (365 days)	TBD** (365 days)	TBD** (365 days)
2012	-	Stage 1 (90 days)	Stage 1 (90 days)	Stage 2* (365 days)	TBD** (365 days)	TBD** (365 days)
2013	-	-	Stage 1 (90 days)	Stage 1 (90 days)	TBD** (365 days)	TBD** (365 days)
2014	-	-	-	Stage 1 (90 days)	TBD** (365 days)	TBD** (365 days)

*CMS anticipates updating meaningful use criteria to Stage 2 by the end of 2011

**CMS will address years beyond 2014 in future rulemaking.

Providers will be able to register online for both the Medicare and Medicaid incentive programs starting in January 2011. Meaningful use attestations for 2011 can be made starting in April 2011, with payments beginning in “mid-May.” CMS estimates it will take anywhere from 15 to 46 days from time a provider successfully attests meaningful use to the time when a payment is issued.

Hospitals

Hospital incentive payments are based on the federal fiscal year and paid to individual hospitals. An individual “hospital” will be distinguished by the CMS certification number (CCN) used for cost reporting purposes.

Hospitals can receive both Medicare and Medicaid incentive payments provided they meet the eligibility requirements for each program.

Hospital Medicare Incentives

In order to be eligible for Medicare incentive payments, hospitals must be “subsection (d)” hospitals, which **excludes** any hospital not paid under the Inpatient Prospective Payment System such as rehab hospitals, long-term care facilities, children’s hospitals, psychiatric hospitals and certain cancer centers.

Hospitals that demonstrate meaningful use are eligible for 4 years of Medicare incentive payments — but only over a consecutive 4-year period. For a hospital that qualifies for meaningful use in 2011, this means that 2012 is the “second payment year”, regardless of whether or not an incentive payment was earned. If this hospital is not able to achieve meaningful use in 2012, the organization will only be eligible for the amounts remaining in payment years 3 and 4.

Total Medicare incentive payment amounts available to hospitals phase down over time. In order to receive the maximum, hospitals will need to achieve meaningful use no later than July 2013 and qualify in each subsequent year. The Medicare incentive payment amount for a hospital in any given year is the product of:

$$\begin{aligned}
 &(\$2,000,000 + (\$200 \text{ per discharge for discharges } 1,150 \text{ to } 23,000)) \\
 &\quad \times \\
 &(\text{The hospital's Medicare Share* [i.e., percentage of Medicare and} \\
 &\text{Medicare Advantage patients, but with an adjustment for charity care]}) \\
 &\quad \times \\
 &(\text{A transition factor based on the hospital's current payment year} \\
 &\text{[year one =1.0; year two =0.75; year three =0.50; year four =0.25]})
 \end{aligned}$$

*Medicare Share=[(Medicare + Medicare Advantage bed days) / (total bed days x (total charges – charges for charity care)/(total charges))]

Preliminary or interim payment amounts for a given year will be based on data from the hospital’s most recent cost report once the hospital has qualified as a meaningful user. Final payment amounts for a year will be based on the 12-month cost report that begins after the start of the payment year.

The following chart looks at the payment incentive possibilities for a theoretical 276 bed community hospital.¹ Starting in FY2015, hospitals that do not annually demonstrate meaningful use will be subject to reductions to their annual Medicare market basket update. These penalties will not be insignificant: for a large hospital with a high percentage of Medicare patients, the overall penalty incurred can quickly eclipse the potential incentive payment.

¹ Calculations for the theoretical hospital are based on the following assumptions: total discharges = 19,453; Medicare patient days = 29 percent; Medicaid patient days = 12 percent; charges for charity care = 3.6 percent.

Medicare: Sample Hospital Payment Incentives and Requirement Sets

First Year of MU	Payment Amount/Requirement Set								Total
	2011	2012	2013	2014	2015	2016	2017	2018	
FY2011	\$1,702,903	\$1,277,203	\$851,469	\$425,734	\$0	\$0	\$0	\$0	\$4,257,344
FY2012	-	\$1,702,938	\$1,277,203	\$851,469	\$425,734	\$0	\$0	\$0	\$4,257,344
FY2013	-	-	\$1,702,938	\$1,277,203	\$851,469	\$425,734	\$0	\$0	\$4,257,344
FY2014	-	-	-	\$1,277,203	\$851,469	\$425,734	\$0	\$0	\$2,554,406
FY2015	-	-	-	-	\$851,469	\$425,734	\$0	\$0	\$1,277,203
FY2016	-	-	-	-	-\$269,725	\$0	\$0	\$0	-\$269,725
FY2017	-	-	-	-	-\$269,725	-\$539,450	\$0	\$0	-\$809,175
FY2018	-	-	-	-	-\$269,725	-\$539,450	-\$809,125	\$0	-\$1,618,350
FY2019	-	-	-	-	-\$269,725	-\$539,450	-\$809,125	-\$809,125	-\$2,427,525

Stage 1 Stage 2* TBD** *CMS anticipates updating meaningful use criteria to Stage 2 by the end of 2011

**CMS will address years beyond 2014 in future rulemaking.

Critical access hospitals are eligible for 4 years of Medicare incentive payments starting in FY2011, but their incentive payments are calculated differently and dependent on “reasonable EHR costs.” Critical access hospitals that are unable to achieve meaningful use in any year starting in FY2015 will be subject to a reduction to their Medicare reimbursement.

Hospital Medicaid Incentives

Hospital eligibility under the Medicaid incentive program is slightly different than it is under the Medicare incentive program. In order to receive Medicaid incentive payments, a hospital must be either 1) an “acute care hospital” with 10 percent Medicaid volume or 2) a “children’s hospital” with any Medicaid volume. Acute care hospitals include general short-term hospitals, cancer centers and critical access hospitals.

Medicaid patient volume for hospitals will be based on percentage of patient encounters over any representative continuous 90-day period from the previous calendar year. Unlike the Medicare incentive, hospitals only will need to attest that they have “adopted, implemented, or upgraded” certified EHR functionality in order to be eligible for their first Medicaid incentive payment. Ninety consecutive days of meaningful use would be required in order to receive a second incentive payment, with a full year of meaningful use required for any subsequent Medicaid incentive payments.

Medicaid incentive payments for hospitals are based on the Federal fiscal year and are essentially calculated the same way as they are under Medicare (using Medicaid share in place of Medicare share). Although Medicare hospital incentive amounts are calculated each year based on data from the hospital’s most recent cost report, the Medicaid incentive amount is calculated only once as an aggregate 4-year total, using cost report data from the previous year and projections to account for increases in discharges.

The state has discretion as to the timing and disbursement of payments to the hospital (payment must be made at least over 3 years but within 6 years, starting no sooner than January 2011). Unlike the Medicare program, a hospital does not need to achieve meaningful use in consecutive years in order to receive the maximum Medicaid incentive payment. The example outlined in the following table for the theoretical 276 bed hospital assumes the **fastest** possible payment schedule (50 percent in year one, 40 percent in year two, and 10 percent in year three).¹ If a hospital misses meeting meaningful use criteria after qualifying, they do not lose that year of payment and can still receive the payment in a subsequent year. For any year after FY2016 however, a hospital can only receive an incentive payment if an incentive payment was received in the previous year.

¹ Calculations for the theoretical hospital are based on the following assumptions: total discharges = 19,453; Medicare patient days = 29 percent; Medicaid patient days = 12 percent; charges for charity care = 3.6 percent.

Medicaid: Sample Hospital Payment Incentives and Requirement Sets

First Year of MU	Payment Amount/Requirement Set								Total
	2011	2012	2013	2014	2015	2016	2017	2018	
FY2011	\$880,830	\$704,664	\$176,166	\$0	\$0	\$0	\$0	\$0	\$1,761,660
FY2012	\$880,830	\$704,664	\$176,166	\$0	\$0	\$0	\$0	\$0	\$1,761,660
FY2013	-	\$880,830	\$704,664	\$176,166	\$0	\$0	\$0	\$0	\$1,761,660
FY2014	-	-	\$880,830	\$704,664	\$176,166	\$0	\$0	\$0	\$1,761,660
FY2015	-	-	-	\$880,830	\$704,664	\$176,166	\$0	\$0	\$1,761,660
FY2016	-	-	-	-	\$880,830	\$704,664	\$176,166	\$0	\$1,761,660
FY2017	-	-	-	-	-	\$880,830	\$704,664	\$176,166	\$1,761,660

Stage 1 Stage 2* TBD** *CMS anticipates updating meaningful use criteria to Stage 2 by the end of 2011
 **CMS will address years beyond 2014 in future rulemaking.

There are no penalties for hospitals under the Medicaid incentive program.

Eligible Professionals (EPs)

Incentive payments to eligible professionals (EPs) are based on the calendar year.

In order to be eligible for Medicare or Medicaid incentive payments, an EP **cannot** be a “hospital-based professional.” A “hospital-based” professional is defined as an eligible provider who provides 90 percent or more of his or her services in an inpatient or emergency department setting. Place of service (POS) codes on physician claims will be used to make this determination. Hospital-based visits are those with a POS code of 21 (“Inpatient Hospital”) or 23 (“Emergency Room – Hospital”). EPs who provide services in hospital ambulatory facilities (POS code 22) are eligible for incentive payments.

EPs cannot receive **both** Medicare and Medicaid incentive payments. Before they can receive a payment under either program, an EP must declare which program he or she will participate in. EPs can switch between the Medicare and Medicaid incentive programs **once** before CY2015.

EPs who provide care in more than one practice must have certified EHR technology available for 50 percent or more of their encounters in order to qualify.

Eligible Professional Medicare Incentives

Medicare incentive payments are only available to “physicians.” Physicians are specifically defined as: a doctor of medicine or osteopathy; a doctor of dental surgery or dental medicine; a doctor of pediatric medicine; a doctor of optometry; or a chiropractor.

EPs are eligible for five payment years — and like the Medicare hospital incentive, payment years are consecutive. Medicare payments are based on 75 percent of the EP’s allowable charges to Medicare in the given calendar year, capped at the amounts outlined in the following chart. EPs who furnish more than 50 percent of their covered services in a Health Professional Shortage Area will be eligible to receive a 10 percent additional payment.

Similar to the hospital program, Medicare incentive payment amounts for EPs phase down over time, and in order to receive the maximum an EP must achieve meaningful use no later than October 2012. EPs who are not meaningful EHR users by CY2015 will be subject to reductions in their Medicare reimbursement (1 percent in CY2015, 2 percent in CY2016, etc.).

Medicare: Example EP Payment Incentives and Penalties

(Note: The EP in the example below has annual allowable Part B charges of \$50,000)

First Year of MU	Payment Amount/Requirement Set								Total
	2011	2012	2013	2014	2015	2016	2017	2018	
FY2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$0	\$0	\$44,000
FY2012	-	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$0	\$44,000
FY2013	-	-	\$15,000	\$12,000	\$8,000	\$4,000	\$0	\$0	\$39,000
FY2014	-	-	-	\$12,000	\$8,000	\$4,000	\$0	\$0	\$24,000
FY2015	-	-	-	-	\$0	\$0	\$0	\$0	\$0
FY2016	-	-	-	-	-\$500	\$0	\$0	\$0	-\$500
FY2017	-	-	-	-	-\$500	-\$1,000	\$0	\$0	-\$1,500
FY2018	-	-	-	-	-\$500	-\$1,000	-\$1,500	\$0	-\$3,000
FY2019	-	-	-	-	-\$500	-\$1,000	-\$1,500	-\$2,000	-\$5,000

Stage 1 Stage 2* TBD** *CMS anticipates updating meaningful use criteria to Stage 2 by the end of 2011

**CMS will address years beyond 2014 in future rulemaking.

Eligible Professional Medicaid Incentives

Medicaid incentive payments are available to the following types of professionals, provided that they have Medicaid patient volume of more than 30 percent: physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants practicing in a federally-qualified health center or rural health clinic that is led by a physician assistant. Pediatricians only need 20 percent Medicaid patient volume in order to qualify.

Medicaid patient volume will be based on the EP's percentage of Medicaid patient encounters. An EP will be able to use "any representative continuous 90-day period" from the previous calendar year in order to qualify.

EPs can receive up to six years of Medicaid incentive payments for meaningful use, which will be based on calendar year and dispersed by the states. As with the hospital Medicaid incentive payments, eligible professionals only need to attest that they are engaged in efforts to "adopt, implement or upgrade" certified EHR technology in order to qualify for their first payment.

The Medicaid incentive payment amounts for EPs are based on "net average allowable costs," or the "allowable" EHR costs minus any payment the EP receives (aside from money received from the state or federal government) that is directly attributable to EHR implementation and support.

Note that "allowable costs" is not the amount an EP spends on an EHR; rather it is a standard amount established by CMS that applies to all eligible Medicaid professionals, regardless of the certified EHR being used. The "allowable cost" amounts defined by CMS are \$54,000 for initial implementation and \$20,610 in subsequent years for maintenance and support. Given the threshold established by the final rule, an EP could receive up to \$29,000 in funding from outside sources for an EHR in the first payment year and \$10,610 in subsequent payment years and still be eligible for the maximum Medicaid incentive payment.

Medicaid: Maximum EP Payment Amounts and Requirement Sets

First Year of MU	Payment Amount/Requirement Set											Total
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	
FY2011	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$0	\$0	\$0	\$0	\$0	\$63,750
FY2012	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$0	\$0	\$0	\$0	\$0	\$63,750
FY2013	-	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$0	\$0	\$0	\$0	\$63,750
FY2014	-	-	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$0	\$0	\$0	\$63,750
FY2015	-	-	-	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$0	\$0	\$63,750
FY2016	-	-	-	-	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$0	\$63,750
FY2017	-	-	-	-	-	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$63,750

Stage 1 Stage 2* TBD** *CMS anticipates updating meaningful use criteria to Stage 2 by the end of 2011

**CMS will address years beyond 2014 in future rulemaking.

There are no penalties under the Medicaid program, but participation does not exempt EPs from Medicare penalties if they do not demonstrate meaningful use by CY2015.

Recommendations

- Maximize efforts to meet Stage 1 criteria in 2011 and 2012. In order to receive the maximum incentive payment, hospitals must achieve meaningful use no later than July 2013; eligible professionals only have until October 2012. This is an extremely short time frame given all the work required to achieve — and sustain — meaningful use.
- Work towards the Stage 1 criteria with an eye to likely future requirements. Meaningful use is not a one-time event and requirements will become more difficult over time, so in order to maximize incentive payments and avoid penalties, hospitals and physician practices will need to ensure the right foundation exists to demonstrate meaningful use annually.

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