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Summary of Electronic Health Record Incentive Program Proposed Rule (CMS-0033-P)

A. Overview

The **American Recovery and Reinvestment Act (ARRA)** authorized Medicare and Medicaid incentive payments to physicians and hospitals that are “meaningful users” of certified electronic health records (EHRs). For physicians and other “eligible professionals” (collectively referred to as “EPs”), the incentive programs begin on January 1, 2011.

For EPs, a total of \$44,000 in Medicare incentive payments can be earned over five years. Physicians that cannot demonstrate meaningful use of EHRs face financial penalties beginning in 2015. The Medicaid incentive program provides greater incentives (maximum of \$63,750 over 6 years) and includes no penalties. To qualify, however, most physicians must have 30 percent of their patients on Medicaid. Physicians must choose between the two programs, although CMS has proposed allowing a one-time switch between the programs before 2014.

The Centers for Medicare and Medicaid Services (CMS) recently released a proposed rule to guide implementation of the EHR incentive programs. The rule, entitled Electronic Health Record (EHR) Incentive Program (CMS-0033-P), was published in the *Federal Register* on January 13, 2010 (Vol. 75, No. 8) and is available at:

<http://www.gpo.gov/fdsys/pkg/FR-2010-01-13/pdf/E9-31217.pdf>.

On the same day, the Office of the National Coordinator for Health Information Technology (ONC) issued an interim final rule that provides direction to vendors on what functionality and standards must be included in certified EHR technology in order to support providers in achieving meaningful use. The interim final rule becomes effective February 12; however, ONC will accept public comments for 60 days (due March 15). This rule includes several definitions important to implementation of the EHR incentive program, including certified EHR. The rule, entitled Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Health Information, is available at:

<http://www.gpo.gov/fdsys/pkg/FR-2010-01-13/pdf/E9-31216.pdf>.

The federal government has yet to release a third regulation that lays out the process for product certification. ONC will likely release that rule in early 2010.

The provisions of these rules will determine, to a great extent, the availability of financial incentives to help oncologists adopt and use electronic health records (EHRs) to support them in providing high-quality, well-coordinated care targeted to the individual needs of individuals with cancer.

This document summarizes the provisions of CMS's proposed rule that affect physicians, and particularly the oncology field. It does not cover provisions related to hospitals, certain Medicare Advantage plans, or states seeking to implement Medicaid programs. Comments on the proposed rule are due by 5 p.m. ET on March 15, 2010, following instructions in the proposed rule.

B. Defining and Demonstrating Meaningful Use

The key to unlocking the EHR incentive payment is to be a meaningful user of "certified EHR technology." Much of the rule explains what that means.

CMS adopts the ONC definition of "certified EHR technology" published in its rule (see Attachment A). Note that ONC has not yet established a certification program and EHRs previously certified (such as those certified by CCHIT) will still likely need to be certified through the federal process to meet the requirements of the EHR incentive program. If an EP successfully meets the meaningful use objectives, but does so through an uncertified EHR, s/he will not be eligible for the incentive payments under the proposed rule.

CMS proposes to create a common definition of meaningful use for the Medicare program that would also serve as the minimum standard for the Medicaid program. CMS proposes to allow states to add additional objectives to the definition or modify existing objectives for their Medicaid programs only if those changes "further promote the use of EHRs and healthcare quality" and do not "require additional functionality beyond that of certified EHR technology."

1. Phased Approach

CMS proposes to define meaningful use of certified EHR technology through three phases, with more stringent criteria applied in each phase:

- **Stage 1 (2011 and 2012)** focuses on electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, implementing some clinical decision support tools, and initiating the reporting of clinical quality measures and public health information.
- **Stage 2 (2013 and 2014)** will expand on the earlier measures to focus on continuous quality improvement at the point of care and the exchange of information in the most structured format possible.

- **Stage 3 (2015 and beyond)** will focus on promoting improvements in quality, safety and efficiency, focusing on decision support, patient access to self-management tools, access to comprehensive patient data, and improving population health.

As described below, CMS proposes specific objectives and measures for Stage 1 in the rule. Requirements for the later stages will be laid out in future rulemaking.

2. Pathways to Meaningful Use

CMS assumes that providers may enter the EHR incentive program in different years, depending on when they successfully adopt EHRs. The actual timing of incentive payments for an EP or eligible hospital will depend on when the provider first becomes a meaningful user. To facilitate discussion of the various pathways to meaningful use, CMS defines two terms:

Payment Year: CMS refers to consecutive payment years, such first, second, and third payment years, in describing regulatory provisions. For physicians, a payment year is a calendar year.

EHR Reporting Period: In general, the EHR Reporting Period corresponds to a full calendar year. However, to provide more time for initial implementation, CMS proposes that in an EP's first payment year, the reporting period be shortened to include any continuous 90-day period that falls within the calendar year. CMS invites comments on the appropriate length for the EHR reporting period.

To provide some transition time for providers that first become meaningful users after 2012, CMS proposes to apply the Stage 1 criteria to all physicians and other eligible providers in their first payment year, as long as they become eligible before 2015. Later adopters, however, would need to meet the Stage 2 and Stage 3 criteria on the same schedule as early adopters. For example, EPs that first received an EHR incentive payment in FY 2013 would need to meet only the Stage 1 criteria in that year, but in FY 2014, s/he would need to meet the Stage 2 criteria. In 2015, all EPs would need to meet the Stage 3 criteria to avoid the payment penalties. CMS provides the following chart on which objectives providers must meet in their first payment year:

Table 1: Stage of Meaningful Use Criteria by Payment Year (p. 1854)

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015 and beyond
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 2	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015 and beyond					Stage 3

CMS invites comment on this approach.

3. Criteria and Measures for Meaningful Use

To qualify for the incentive payments in Medicare and in Medicaid (after the first payment year), EPs and eligible hospitals must use certified EHRs to meet specific objectives and report specific measures to CMS, including both HIT functionality measures and clinical quality measures. Although CMS uses the term “objectives,” these are, in fact, requirements of meaningful use.

CMS proposes that oncologists and other EPs must meet **all** of the objectives and their associated measures to be considered meaningful users. In all, CMS proposes 25 objectives and related HIT functionality measures for EPs in Stage 1 (2011 and 2012). Additional quality measures will also need to be submitted and are described below.

The proposed objectives are closely aligned with recommendations made by the HIT Policy Committee. CMS notes, however, that it did NOT include some of the objectives recommended by the HIT Policy Committee, such as recording advanced directives, providing access to patient-specific educational resources, and requiring physicians to document progress notes in the EHR.

In addition, CMS notes that in light of the limited available infrastructure to support information exchange, it either did not include recommended objectives that require electronic exchange of information or set a low bar for them. For example, EPs will only need to demonstrate that they have performed at least one test of the EHR system's capacity to submit electronic data to immunization registries, not that they have submitted the actual data on a regular basis. An important exception to this is in the area of e-prescribing, where EPs are required to generate and transmit at least 75 percent of all prescriptions electronically (with the exception of controlled substances for which the DEA has prohibited e-prescribing).

Regarding privacy and security of health information, CMS proposes that “meaningful use of certified EHR technology supports compliance with HIPAA and the fair data sharing practices outlined in the Nationwide Privacy and Security Framework.” The proposed rule does not include additional regulatory requirements beyond those in the HIPAA Privacy and Security Rules. It does, however, require providers to conduct or review a security risk analysis according to the HIPAA regulations and implement security updates as necessary.

The proposed rule includes some limited requirements for the use of structured data, such as ICD-9 and/or SNOMED for problem lists and LOINC codes for some laboratory data.

CMS summarizes the Phase I Objectives and HIT functionality measures in Table 2 of the proposed rule (p. 1867). Detailed definitions, including numerators and denominators, are also defined for these measures. Some of the denominators will require providers to look across electronic and paper processes (such as the percent of orders placed through CPOE, Measure 1). In addition, many of the measures require EPs to count unique patients, rather than looking across all visits (such as the share of unique patients with a problem list, Measure 3).

The following extract from Table 2 presents the objectives and measures for EPs.

**Stage 1 Objectives and Measures for Meaningful Use
(extracted from Table 2 in the proposed rule, p. 1867)**

ELIGIBLE PROFESSIONALS	
Objectives	Measures
1. Use CPOE	1. For EPs, CPOE is used for at least 80% of all orders
2. Implement drug-drug, drug-allergy, drug-formulary checks	2. The EP has enabled this functionality
3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	3. At least 80% of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data
4. Generate and transmit permissible prescriptions electronically (eRx)	4. At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
5. Maintain active medication list	5. At least 80% of all unique patients seen by the EP have at least one entry (or an indication of “none” if the patient is not currently prescribed any medication) recorded as structured data
6. Maintain active medication allergy list	6. At least 80% of all unique patients seen by the EP have at least one entry or (an indication of “none” if the patient has no medication allergies) recorded as structured data
7. Record demographics: <ul style="list-style-type: none"> • preferred language • insurance type • gender • race • ethnicity • date of birth 	7. At least 80% of all unique patients seen by the EP have demographics recorded as structured data
8. Record and chart changes in vital signs: <ul style="list-style-type: none"> • height • weight • blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20 years, including BMI. 	8. For at least 80% of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally plot growth chart for children age 2-20

ELIGIBLE PROFESSIONALS

Objectives	Measures
9. Record smoking status for patients 13 years old or older	9. At least 80% of all unique patients 13 years old or older seen by the EP have “smoking status” recorded
10. Incorporate clinical lab-test results into EHR as structured data	10. At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	11. Generate at least one report listing patients of the EP with a specific condition.
12. Report ambulatory quality measures to CMS or the States	12. For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of the proposed rule For 2012, electronically submit the measures as discussed in section II(A)(3) of the proposed rule
13. Send reminders to patients per patient preference for preventive/ follow up care	13. Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over
14. Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	14. Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP is responsible for as described further in section II(A)(3) of the proposed rule.
15. Check insurance eligibility electronically from public and private payers	15. Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP
16. Submit claims electronically to public and private payers.	16. At least 80% of all claims filed electronically by the EP
17. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	17. At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours
18. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP	18. At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information

ELIGIBLE PROFESSIONALS	
Objectives	Measures
19. Provide clinical summaries for patients for each office visit	19. Clinical summaries are provided for at least 80% of all office visits
20. Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	20. Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
21. Perform medication reconciliation at relevant encounters and each transition of care	21. Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
22. Provide summary care record for each transition of care and referral	22. Provide summary of care record for at least 80% of transitions of care and referrals
23. Capability to submit electronic data to immunization registries and actual submission where required and accepted	23. Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
24. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	24. Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)
25. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	25. Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary

CMS requests comment on the proposed objectives and measures for Phase I, as well as potential objectives and measures for Stage 2 and Stage 3. The agency notes that it plans to increase requirements involving use of structured data and information exchange over time, including actual exchange of information. For example, CMS expects to require the electronic transmission of orders entered by CPOE, the actual submission of data to public health entities, and the incorporation of the full array of diagnostic test data into the EHR as structured data.

4. Reporting on Clinical Quality Measures Using EHRs

One of the meaningful use objectives is reporting on clinical quality measures through certified EHR technology. CMS does not anticipate that it will be able to electronically accept clinical quality measures from EHRs for the 2011 payment year. Therefore, for 2011 and 2012, CMS

proposes that EPs submit summary information (numerator, denominator, and exclusions) via attestation. That data, however, must be generated and calculated by the certified EHR technology. In 2012, quality data would be reported electronically.

Quality Measures for Eligible Providers. CMS proposes that EPs report on both a set of three core measures and a set of measures specific to one of 15 individual specialty groups. In all, 90 physician measures are included in the proposed rule (Table 3, p. 1874).

Specific measures are put forward for the following specialty groups (Tables 5 through 19): Cardiology, Pulmonology, Endocrinology, Oncology (Table 8), Proceduralist/Surgery, Primary Care Physicians, Pediatrics, Obstetrics and Gynecology, Neurology, Psychiatry, Ophthalmology, Podiatry, Radiology, Gastroenterology, and Nephrology. CMS expects to narrow each proposed set to a required subset of 3 to 5 measures based on the availability of electronic measures and comments received.

The vast majority of the proposed measures have been endorsed by the National Quality Forum and are included in the PQRI. However, only nine of them have electronic measure specifications available. CMS is currently conducting a pilot project to test electronic reporting of those measures.

The core measures (Table 4, p. 1890) are:

- PQRI 114/NQF 0028 – Preventive care and screening: Inquiry regarding tobacco use
- NQF 0013 – Blood pressure measurement
- NQF 0022 – Drugs to be avoided in the elderly (a. Patients who receive at least one drug to be avoided; b. Patients who receive at least two different drugs to be avoided).

TABLE 8: Measure Group: Oncology (p. 1892)

Measure Number	Clinical Quality Measure Title & Description
PQRI 71 NQF 0387	Title: Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
PQRI 72 NQF 0385	Title: Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
PQRI 102 NQF 0389	Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
PQRI 112 NQF 0031	Title: Preventive Care and Screening: Screening Mammography
PQRI 113 NQF 0034	Title: Preventive Care and Screening: Colorectal Cancer Screening
NQF 0032	Title: Cervical Cancer Screening

CMS proposes to require for 2011 and 2012 that EPs report on all applicable cases for the core measures as well as each measure in a selected specialty group. CMS proposes to require that EPs select the same specialty group in both the first and second payment year. EPs may also attest that none of the measures are applicable to their specialty.

CMS invites comments on the proposed measures, as well as on:

- The clinical utility and state of readiness for electronic reporting of the proposed measures;
- Whether there are EPs who believe no specialty group will be applicable to them; and
- Whether to defer some or all clinical quality measure reporting until 2012.

Quality Reporting Process. CMS proposes attestation of quality measures in 2011 and electronic reporting in 2012. EPs would attest that:

- the measure data were generated as output of a certified EHR;
- the data (including numerators, denominators, and exclusions for each of the applicable measures) are accurate; and
- the data for each measure include all patients to whom it applies.

CMS proposes to require that EPs report numerator, denominator, and exclusion data for each measure by four groupings: all patients, regardless of payer; Medicare FFS patients; Medicare Advantage patients; and Medicaid patients.

CMS proposes a quality reporting period equal to the meaningful use reporting period (90 consecutive days in 2011, and a full calendar/fiscal year thereafter). CMS seeks comment on whether a different reporting period is preferable for quality measures, such as quarterly or twice per year.

EPs participating in the Medicare EHR incentive program would submit data to CMS, while EPs choosing to participate in Medicaid would submit quality measures to the states. Measures included in both the EHR incentive program and another Medicare quality reporting program would only need to be reported through the EHR incentive program.

Looking forward, CMS proposes three methods for direct electronic submission of quality data from the EHR in 2012 and later years: directly to a CMS-designated portal (primary method); through a Health Information Exchange/Health Information Organization; or through a registry. For HIE and registry reporting, however, the data originally submitted by EP or eligible hospital must be generated from a certified EHR. CMS intends to post technical requirements for electronic submission of quality data for EPs on its website before July 1, 2011. CMS invites comment on the proposed reporting methodologies.

5. Program Administration

To administer the program, CMS proposes to collect registration information for both the Medicare and Medicaid programs through a single process that asks for the following information:

- Name, National Provider Identifier (NPI), business address, and business phone of each EP
- Taxpayer Identification Number (TIN) to which the EP wants the incentive payment made
- For EPs, EHR incentive program election (Medicare or Medicaid)

CMS will maintain a single data repository to be used by CMS, its contractors, and the states in administering the program. The single data repository will include the four elements list above, plus information on whether an EP is a meaningful EHR user and the remittance date and amount of any incentive payments made to an EP (Medicare and Medicaid).

The data repository will be used for a number of purposes, including posting the names of meaningful EHR users online and ensuring that EPs do not receive duplicate payments from both the Medicare and Medicaid programs.

EPs must choose between the Medicare and Medicaid incentive programs in their first payment year. CMS proposes that they be allowed to switch between the programs one time before 2014.

CMS will determine meaningful use for oncologists and other EPs by unique NPI. CMS proposes to require that EPs demonstrate meaningful use through attestation via a secure mechanism (such as claims-based reporting or an online portal). Attestation would occur once following completion of the EHR reporting period for a given payment year and include identification of the certified EHR system used, results of HIT functionality measures, and additional reporting of clinical quality measures. As technology matures, alternative mechanisms may be explored in future years.

C. Defining Eligible Providers

The rule provides slightly different definitions of EP for the Medicare and Medicaid program:

- Under Medicare, EPs include physicians (MD or DO), dentists, podiatrists, optometrists, and chiropractors that are not hospital-based (see discussion below).
- Medicaid EPs are defined in the proposed rule as: physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in an FQHC or Rural Health Center (RHC) that is so led by a physician assistant.

With one exception, Medicaid EPs cannot be hospital-based (see below). Hospital-based Medicaid EPs practicing predominantly in an FQHC or RHC can qualify for Medicaid incentive payments. CMS interprets this to include Medicaid EPs that provide over 50 percent of their patient encounters over six months in an FQHC or RHC.

Hospital-Based Professionals. Under ARRA, hospital-based professionals are not eligible for EHR incentive payments and are not subject to Medicare penalties. The law refers to hospital-based professionals as EPs who provide "substantially all" of the Medicare-covered professional services in a "hospital setting (whether inpatient or outpatient)."

CMS proposes to define a physician with 90 percent or more of his/her services provided in an inpatient hospital, outpatient hospital, or emergency department setting as hospital-based.

CMS proposes to consider as outpatient hospital settings "all types of outpatient care settings in the main provider, on-campus and off-campus provider-based departments of the hospital, and entities having provider-based status."

CMS estimates that about 30 percent of physicians are hospital-based and will not, therefore, be eligible for EHR incentive payments (32 percent in 2008 claims data and 27 percent in nine months of 2009 claims data). CMS further estimates that 12-13 percent of family practitioners are hospital-based.

For the Medicare program, CMS proposes to determine the hospital-based status of individual EPs annually through analysis of provider claims for the previous calendar year. States would determine hospital-based status for Medicaid programs.

CMS seeks comment on this definition and its possible impact on meaningful use of EHRs for EPs, and particularly primary care physicians, practicing in hospital outpatient settings.

D. Medicare Fee-for-Service Incentives

Under ARRA, EPs can receive up to 5 years of Medicare incentive payments. These payments are equal to the lesser of 75 percent of the physician's allowed charges for the year or a specified maximum amount. The maximum incentive declines from \$18,000 for the first payment year to \$2,000 for the fifth payment year, as outlined in the table below.¹

Schedule of possible payments:

Calendar Year	First Year in which the EP Receives an Incentive Payment				
	2011	2012	2013	2014	2015 and later
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
2016	0	2,000	4,000	4,000	0
Total	44,000	44,000	39,000	24,000	0

¹ However, EPs practicing predominantly in Health Professions Shortage Areas (HPSAs) may receive incentives that are 10 percent higher than the maximum amounts (maximum of \$48,400). CMS defines this as those providing more than 50 percent of their Medicare covered services in a HPSA.

Payments. CMS proposes to make a single, consolidated, annual incentive payment to EPs. Payments will be made as soon as CMS has verified that an EP has demonstrated meaningful use for the reporting period (90 days in 2011 and a calendar year thereafter). Medicare's contractors (carriers and administrative contractors) will calculate and make payments.

CMS will monitor each EP's allowed charges in a payment year to determine whether the EP will receive the maximum payment amount or 75 percent of allowed charges. For a given payment year, charges will be allowed to accumulate for up to two months after the end of the payment year.

Payments for EPs will be based on a single individual taxpayer identification number. Payments will not be made by group practice; however, eligible providers can reassign their incentive payments to a group practice, their employer or to an entity with which they have a contractual arrangement (as they can do for all Medicare payments). CMS proposes to require that EPs providing services in more than one practice choose a single practice to receive incentive payments.

Payment Adjustments (penalties). ARRA applies a downward payment adjustment to EPs who are not meaningful users of certified EHR technology in 2015 and later years. Hospital-based physicians are not subject to the penalties. The payment adjustments will be:

- 1 percent in 2015²
- 2 percent in 2016
- 3 percent in 2017 and later

At the Secretary's discretion, additional penalties of up to five percent may be applied in 2018 and later years if fewer than 75 percent of EPs are meaningful users. The Secretary may also grant a hardship exception to EPs on a case-by-case basis if the penalties would pose a significant hardship.

Compliance Reviews. CMS will conduct select compliance reviews of EPs who receive EHR incentive payments. The reviews will look at both attestations of meaningful use and payment calculations. CMS will identify and recoup overpayments that result from incorrect or fraudulent attestations, quality measures, cost data, patient data, or any other submission required to establish eligibility or to qualify for a payment.

Medicare FFS EPs will need to maintain evidence of qualification to receive incentive payments for 10 years after the date they register for the incentive program.

²An EP who is neither a meaningful user nor a successful electronic e-prescriber under the E-prescribing incentive program will be subject to a 2 percent penalty in 2015.

E. Medicaid Incentives

EPs with sufficient Medicaid volume may be eligible for more generous incentive payments under Medicaid. The Medicaid volume threshold is 30 percent for EPs (20% for pediatricians),³ calculated as the share of all patient encounters over any continuous 90-day period in the recent calendar year prior to the reporting year covered by Medicaid (both fee-for-service and managed care).

Medicaid payments for eligible EPs will be \$21,250 in Year 1 and \$8,500 in each of Year 2 through Year 6. The maximum total benefit over six years is capped at \$63,750 for most Medicaid EPs. Medicaid EPs may begin receiving incentive payments as late as 2016 and still receive up to the maximum payments under the program. Medicaid EPs are not required to participate on a consecutive annual basis.

In addition to a greater possible total payment, there are no penalties for failing to demonstrate meaningful use under Medicaid. Furthermore, in their first year of eligibility for Medicaid incentives, EPs do not have to meet the meaningful use criteria – they can qualify by adopting, implementing, or upgrading to certified EHR technology. In their second and later years of Medicaid incentive payments, all EPs and eligible hospitals must demonstrate meaningful use of EHRs to the states in order to receive Medicaid incentive payments.

According to CMS:

- Adoption requires evidence that a provider demonstrate actual installation of certified EHR technology (as opposed to efforts to install).
- Implementation means that the provider has started using the certified EHR technology in his or her clinical practice. Implementation activities include staff training, data entry of patients' information, or establishing data exchange agreements with other health care entities (such as labs, pharmacies, or HIEs).
- Upgrade means the expansion of the functionality of the certified EHR technology, such as the addition of clinical decision support, e-prescribing, or CPOE.

CMS proposes that Medicaid EPs attest to having adopted, implemented, or upgraded their certified EHR technologies. States would be responsible for verifying that provider attestations are true, establishing appeals processes, and implementing fraud and abuse controls. CMS encourages states to consider the submission of a vendor contract from providers to ensure the existence of EHR technology.

Eligible providers may only receive Medicaid incentive payments from one state, even if they are licensed to practice in multiple states.

States will generally make payments directly to Medicaid EPs. CMS, however, proposes to allow states to also make payments to state-designated entities promoting the adoption of

³ However, for EPs practicing predominantly in a FQHC or RHC (per the definition noted above), the threshold is defined as 30 percent of patient volume attributable to needy individuals, which includes Medicaid, SCHIP, uncompensated care, and those furnished services at either no cost or reduced cost based on ability to pay.

certified EHR technology, such as a health information exchange, if directed to do so by a Medicaid EP.

It is important to note that the Medicaid programs are voluntary for the state and some states may not establish them. In general, CMS proposes that states use the Medicare meaningful use definition, including objectives and measures, as a “minimum standard” for their Medicaid programs. However, CMS proposes to allow states to add additional objectives to the definition or modify existing objectives if those changes “further promote the use of EHRs and healthcare quality” and do not “require additional functionality beyond that of certified EHR technology.” Examples of additional criteria in the proposed rule include requiring providers to participate in HIEs and requiring that providers link to immunization, lead screening, or newborn screening registries. CMS notes that, to be approved, these information exchange mechanisms must be readily available to providers and not represent a financial burden.

F. Estimates of Reporting Burden

As required by law, CMS estimated the expected burden of complying with this regulation. Within that estimate, CMS looked at the costs of adopting EHR technology and the likely time needed to report on the HIT functionality measures and the new clinical quality measures.

After reviewing the literature, CMS estimated that, for EPs, the costs for installing and maintaining certified EHR technology include \$54,000 in capital costs and annual maintenance and training costs of \$10,000. CMS solicits comment and additional information on these costs.

Regarding the burden of reporting for specific measures, CMS divided the meaningful use measures into 2 groups (see table below for placement by measure):

- Set A, which includes those objectives and measures where “the certified EHR technology adopted by the [provider] will capture ... and generate automated numerator and denominator information, where required, or automated summary reports.” All of the quality reporting is assumed to fall into Set A as a single item. CMS estimates that 17 of the objectives/measures for EPs belong in Set A.
- Set B, which will includes objectives and measures where reporting may require providers to manually gather the information necessary to report. CMS estimates that Set B includes 8 objectives/measures for EPs.

CMS estimates a combined reporting burden of 9 hours per reporting period for EPs, as follows:

- Use of certified EHR technology and objectives/measures in Set A – 30 minutes
- Quality measures – 30 minutes
- Objectives in set B – 8 hours

Table 33 in the proposed rule (p. 1949) includes the estimated reporting burden for each required measure. CMS invites comment on its estimates of reporting burden.

G. Impact Analysis

Due to uncertain knowledge of provider costs and other factors affecting EHR adoption, CMS provides high and low estimates of spending under the proposed rule for the period from 2011 to 2019. In its analysis, the agency assumes that:

- Between 10 and 36 percent of Medicare EPs will qualify for incentive payments in 2011
- Between 36 and 70 percent of Medicare EPs will be meaningful users in 2019
- Between 25.4 and 46.5 percent of Medicaid EPs will receive incentive payments in 2011
- Between 56.2 and 92.7 percent of Medicaid EPs will have received incentive payments by 2019

Since the agency projects that not all Medicare EPs will qualify as meaningful users by 2015, total estimated penalties paid by EPs range from to \$1.4 to \$3.2 billion. In its low scenario, CMS anticipates Medicare receiving \$600 million more in penalties than it pays in incentives over the nine-year period. In its high scenario, the net payout by Medicare (incentives minus penalties) would be \$5.4 billion (Tables 51 and 52).

The agency seeks comment and information on many aspects of the impact analysis, such as the costs of adopting and using certified EHR technology and other factors such as reduced staff productivity, the likely costs of reporting, and the benefits of EHRs for EPs and hospitals.

Estimated Cost of the EHR Incentive Payments for Eligible Professionals, in Billions (from Tables 51 and 52, p. 1989)

	<i>Time Period</i>	<i>Medicare</i>	<i>Medicaid</i>	<i>Total</i>
Low Scenario	2011	0.1	0.6	3.1
	2011-2019	-0.6	3.5	14.1
High Scenario	2011	0.3	1.2	5.0
	2011-2019	5.4	6.6	27.3

Attachment 1. ONC Definitions.

Certified EHR Technology. CMS proposes to use the ONC definition of “certified EHR technology.” In its interim final rule (IFR), ONC lays out a multi-stage definition of “certified EHR technology” to mean: “A Complete EHR or a combination of EHR Modules, each of which: 1) meets the requirements included in the [statutory] definition of a Qualified EHR; and 2) has been tested and certified in accordance with the certification program established by the National Coordinator as having met all application certification criteria adopted by the Secretary.”

ONC specifies that a “**Complete EHR**,” has been developed to meet all of the applicable certification criteria adopted by the HHS Secretary, while a combination of “**EHR Modules**,” can be “any service, component, or combination thereof that can meet the requirements of at least one” of the certification criteria adopted by the Secretary.

ARRA defined a “**Qualified EHR**” as: “an electronic record of health-related information on an individual that: (A) includes patient demographic and clinical health information, such as medical history and problem list, and (B) has the capacity:

- (i) to provide clinical decision support;
- (ii) to support physician order entry;
- (iii) to capture and query information relevant to health care quality; and
- (iv) to exchange electronic health information with, and integrate such information from other sources.”

ONC states that providers who choose to combine multiple EHR modules must ensure that the modules work together and that, together, they meet all of the certification criteria. In most instances, physicians will likely purchase and install a complete EHR.