Payout: Reviewing Meaningful Use Payments

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CMS will pay meaningful use bonuses through three programs: Medicare Fee for Service (FFS), Medicare Advantage (MA), and Medicaid programs.

FFS Payments to Providers

For eligible professionals (EPs), understanding the payment system is especially important, because they must choose between receiving incentives through either the Medicare or Medicaid programs. They will have a one-time option to switch.

EPs who qualify for the FFS program beginning in 2011 and 2012 are eligible for $18,000 in the first year, with a maximum incentive payment of $44,000 over five years. CMS will make a 10 percent upward adjustment if the EP serves more than 50 percent in a geographic health professional shortage area, with several other conditions applied.

The maximum first-year payment decreases in 2013 and 2014. EPs who begin the program in 2014 will be eligible for a maximum incentive of $24,000 by the time payments end in 2016.

Once an EP's eligibility is verified, meaningful use demonstrated, and the threshold for payment reached, CMS will make a full payment. How a physician shares the payment in a practice will be determined by the physician and the practice.

Within the final rule CMS lays out its plan for payment adjustments effective in CY 2015 and subsequent years for those EPs who are not meaningful users (beginning on page 44447 of the final rule). This situation applies to all Medicare provider physicians except those who are hospital-based; therefore, even physicians who choose not to apply for incentive funds will be subject to the payment reduction if they do not become meaningful users by the time the adjustments begin.

If an EP does not meet the threshold in the calendar year but is a meaningful user, CMS will use a factor to provide some incentive payment. If the eligible EP is also a qualified MA EP, then the incentive payment would be submitted to the MA where the EP is affiliated. Determining the relationship between an EP and the MA program will determine the method and quantity the EP shall receive.

Medicare Administrative Contractors, fiscal intermediaries, and carriers will facilitate the payment process.

FFS Payments to Hospitals

FFS-based incentive payments apply to eligible hospitals in the 50 states and the District of Columbia; they do not include the territories or hospitals located in Puerto Rico. Hospital incentives currently are based on an initial amount, a Medicare share, and a transition factor applicable to the payment year.

The base amount of the incentive is $2,000,000. To this base is added a "discharge related amount." There is no payment for the first 1,149 discharges or for discharges above 23,000 within the hospital's fiscal year identified in the Medicare hospital cost report period. For each discharge in between, $200 is added.

The initial amount is also multiplied by a Medicare share percentage (which includes FFS and MA bed days), modified by a charity care factor and a transition share. These factors will be worked through a process similar to the cost report. CMS provides the formula on page 44459, and the transaction factor table for Medicare FFS, unchanged from the proposed rule, appears on page 44460.

Like EPs, hospitals will be subject to Medicare payment reductions beginning in 2015 if they are not meaningful users. This will be the case even for hospitals that received incentive payments in prior years. CMS distinguishes differing levels of

payment reductions based on a hospital's progress toward meaningful use.

Critical access hospitals (CAHs) are not paid under the same reimbursement rules as FFS; they are paid on reasonable costs, not DRGs. Hospitals, including CAHs, will be paid on the basis of their cost reports; however, CAHs will have the ability to submit documents for payment once they have incurred actual EHR costs.

MA Payments

MA incentive payments and reductions related to meaningful use are much more complicated due to the nature of the MA program and the fact that contracted physicians and hospitals may also qualify for payments outside of the MA program. The qualifications for payment and the process of attestation through an MA are likewise complicated and will require close consideration by all parties involved.

ARRA prohibits CMS from paying EPs for both MA and FFS services, and the program rules reflect this concern for avoiding duplicate payments. Providers should read the requirements carefully and ensure they and their MA programs are in agreement on the provisions. They must determine how they will seek to qualify for appropriate incentive payments and provide the necessary attestations and reporting.

Medicaid Incentives and Program Policy

Eligibility rules for providers participating in the Medicaid program are very similar to those for Medicare; however, the thresholds are more flexible.

Only acute hospitals and children's hospitals are eligible for Medicaid incentives. These providers must also meet all other program requirements, including Medicaid patient volume thresholds. For acute hospitals, the average length of stay must be below 25 days.

In response to comments received on the proposed rule, CMS amended its definition of acute care hospitals for purposes of the incentive program. The final rule defines acute care hospitals as those hospitals with an average patient length of stay of 25 days or fewer and with a CMS certification number that falls in the range 0001–0879 or 1300–1399. This definition encompasses general short-term hospitals, cancer hospitals, and critical access hospitals that meet the Medicaid patient volume criteria. A children's hospital must be separately certified to qualify; it may not be a part of an acute hospital.

Under the Medicaid incentive program, incentive payments will be based upon whether the EP has already adopted, implemented, or upgraded certified EHR technology or whether the EP begins adopting, implementing, or upgrading certified EHR technology in the first year.

EPs considering either program should consider differences between the Medicare and Medicaid programs, including the patient volume requirements. In addition, they should determine whether their states propose adding unique requirements to those set by CMS. As noted, EPs will have a one-time option to switch between the Medicare and Medicaid programs.

EPs and eligible hospitals may receive payment through one state only. To coordinate both payment and eligibility and avoid duplicate payments, CMS will use a single provider repository that uniquely identifies each participating provider.

For additional review of the payment mechanisms and program requirements, see paper 3 in AHIMA's meaningful use white paper series at http://journal.ahima.org. A detailed overview of the entire final rule, as well as additional ARRA resources, is available on AHIMA's Advocacy and Public Policy Center at www.ahima.org/arrahitech.aspx.

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