Overview of the Final Rule and Clarifications to Meaningful Use

Overview of the final rule defining Meaningful Use of certified Electronic Health Records Issued by Centers for Medicare and Medicaid Services on July 13, 2010
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INTRODUCTION

The Health Information Technology for Economic and Clinical Health Act (HITECH) provision of the American Recovery and Reinvestment Act of 2009 (ARRA) provides billions of dollars in incentives for the adoption and use of Health Information Technology (HIT) by Medicare and Medicaid providers and eligible professionals over the next five years and beyond. To receive the financial incentives, eligible professionals (physicians) and hospitals and critical access hospitals (collectively referred to as “hospitals”) must achieve “meaningful use” of certified electronic health records (EHRs). In support of the HITECH provision, the Centers for Medicare and Medicaid Services (CMS) on July 13, 2010 issued final rules to support the meaningful use of EHRs, titled “Medicare and Medicaid Programs; Electronic Health Record Incentive Program” (Final Rule). The final rule takes affect 60 days after publication in the Federal Register and makes final the proposed rules issued on January 13, 2010.

The final rule retains the intent and structure of the incentive programs established in the proposed rules and includes some modifications to address stakeholder concerns and comments. The most significant change in the final rule is to provide greater flexibility to eligible professionals and hospitals by dividing the Stage 1 objectives into a “core set” of required objectives and a “menu set” of objectives. To qualify for meaningful use incentive payments, eligible professionals and hospitals must satisfy all objectives and measures in the “core set” and any five objectives in the “menu set.”

ARRA specifies that one condition of meaningful use is use of a certified EHR system. It charged the Department of Health and Services (HHS) to determine the certification criteria, which HHS is managing through Office of the National Coordinator for Health Information Technology (ONC). As a result, an interim final rule, or IFR, titled “Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology,” was published in the Federal Register on January 13, 2010. This “interim” rule was effective since February 12, 2010 pending finalization after modifications could be made based on stakeholder comments. On July 13, 2010, ONC

1 The three-stage phased approach to implement and achieve meaningful use of certified EHR technology is explained in the “A Three-Stage Approach to Achieve Meaningful Use” section of this white paper.
issued the final rule with the same title that supersedes the IFR and establishes the required capabilities and related standards and implementation specifications that a certified EHR Technology will need to include in order to support the achievement of meaningful use by eligible healthcare providers under the Medicare and Medicaid EHR Incentive Program regulations.

The final rules issued by CMS and ONC on July 13, 2010 complement two other rules issued by HHS to support the effective implementation of the EHR initiative, namely the June 24, 2010 ONC final rule establishing a temporary certification program for HIT, and the July 8, 2010 proposed rule announced by the Office for Civil Rights that would strengthen and expand privacy, security, and enforcement protections under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This white paper was developed as part of KPMG’s continuing thought leadership support through the KPMG Government Institute in collaboration with the KPMG Healthcare & Pharmaceutical Institute to help healthcare professionals and hospital administrators better understand the goals and provisions of the rules, along with some open issues and possible implications. Included in the review are the definition and what it means to be a “meaningful user,” a discussion of the process for obtaining incentive payments, and what meets the definition of “certified” EHR technology. In preparing to comply with the meaningful use provisions presented in the final rules and other complementing rules issued by the HHS, please refer to counsel to assist with interpreting the requirements.

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OVERVIEW OF MEANINGFUL USE

The meaningful use incentive program is an effort to accelerate the adoption and usage of health information technology and qualified electronic health records. The meaningful use objectives as presented in the proposed January 13, 2010 rule, and confirmed by the final rule are:

- Improve healthcare quality, efficiency, patient safety, and reduce health disparities
- Engage patients and families in their healthcare
- Improve care coordination amongst healthcare providers
- Ensure adequate privacy and security protections for personal health information
- Improve population and public health programs.

In summary, the incentive program does not focus on the adoption of HIT. The focus instead is on how HIT can be used to further these goals, which is the critical concept behind “meaningful use.” To receive EHR incentive payments, an eligible professional or hospital must demonstrate meaningful use of certified EHR technology. Eligible professionals and providers may adopt a complete, comprehensive, and certified EHR technology solution or a number of technological components or certified EHR modules, each of which:

- Includes patient demographic and clinical health information such as medical history, prescriptions lists, and problem lists
- Has been tested and certified in accordance with the ONC certification program, as having met all applicable certification criteria adopted by the Secretary of Health and Human Services.

Meaningful Use Elements

Eligible professionals and hospitals requesting incentive payments will be considered meaningful EHR users if they meet the following three principal elements specified by HITECH:

- Use certified EHR technology in a variety of functional areas to track, record, and exchange information in a meaningful manner, e.g.:
  - Computer Provider Order Entry (CPOE)
  - ePrescribing
  - Recording of demographics and vital signs
  - Maintaining up-to-date problem lists
  - Verifying insurance eligibility and submitting claims electronically
  - Capability of exchanging key clinical information electronically
  - Implementing specific privacy and security technical capabilities.

- Use certified EHR technology for electronic exchange of health information to improve the quality of healthcare

- Use certified EHR technology to submit clinical quality measures and other measures to CMS (or to the state, for a Medicaid program).
A Three-Stage Approach to Achieve Meaningful Use

The criteria for meaningful use are designed to become increasingly more stringent over three stages. The longer a provider waits to implement EHR technology, the quicker the provider will need to move through the stages to continue receiving incentive payments. A high-level overview of the three stages is as follows:

Stage 1 – Applicable for 2011 and 2012, focuses on capturing and communicating information in a structured format:

- Collect electronic health information in a coded format
- Track key clinical conditions
- Communicate care needs (including provider and patient communication)
- Facilitate disease and medication management
- Implement clinical decision support tools
- Report key quality and public health information

Stage 2 – Starts in 2013, expands on Stage 1, and focuses on improving the care of individual patients:

- Use HIT exchange of information in the most structured format possible, e.g., electronic transmission of orders entered, using CPOE and diagnostic test results.
- Apply more broadly to both the inpatient and outpatient hospital settings.

Stage 3 – Expected to start in 2015, expands on Stages 1 and 2, and focuses on driving improved outcomes:

- Promote improvements in quality, safety, and efficiency.
- Advance decision support for national high-priority conditions.
- Provide patient access to self-management tools.
- Facilitate access to comprehensive patient data.
- Improve population health.

The final rule establishes the meaningful use objectives for both eligible professionals (physicians) and hospitals for Stage 1 and the expected progression of meaningful use requirements for Stage 2.

In Stage 2, the meaningful use objectives are anticipated to heighten quality management requirements and move to the most structured format for information exchange. Stage 3 is expected to target progressively more systemic healthcare improvements as the measures for achieving meaningful use. Although the final rule only finalizes the objectives and associated measure of Stage 1, CMS welcomes comments on the objectives, goals, and assumptions stated with respect to Stage 2.

CMS plans to establish the finalized meaningful use requirements of Stage 2 and Stage 3 by subsequent rulemaking based on lessons learned and input from stakeholders.

STAGE 1: MEANINGFUL USE OBJECTIVES AND MEASURES

Based on the comments received for the proposed rule, CMS reviewed each Stage 1 objective and made changes to the original proposal or finalized them as proposed. Measures associated with each objective have also been updated to be more aligned with the three-stage implementation approach. The final rule also identifies and updates certain measures whose denominator will not be based on all patients, but on a relevant subset of patients or actions, such as number of lab test orders or number of patients requesting an electronic copy of discharge instructions.

The final rule identifies 28 Stage 1 objectives and associated measures that are classified into two groups, as follows:

1. “Core Set” with 16 objectives of which 2 apply only to eligible professionals and 1 applies only to eligible hospitals
2. “Menu Set” with 12 objectives of which 2 each apply only to eligible professionals and eligible hospitals.

The requirements for both eligible professionals and hospitals are largely the same, but there are some differences based on the types of care provided and their corresponding settings. For example, hospitals must record information applicable only to an inpatient setting, including patients’ discharge instructions and summaries and the date and cause of a patient’s death. An example of an outpatient activity only applicable to eligible professionals is sending reminders for preventive or follow-up care.

In order to qualify for EHR incentives, eligible professionals and hospitals will be required to meet all applicable objectives from the core set (15 for eligible professionals and 14 for eligible hospitals) and any 5 objectives from the menu set.

The final rule provides detailed tables listing the meaningful use requirements for both eligible professionals and hospitals for Stage 1, the required EHR technology criteria to accomplish those requirements, and the criteria or measures that will be used to determine meaningful use.
STAGE 1: CLINICAL QUALITY MEASURES

As indicated above, one of the three elements of meaningful use is the use of certified EHR technology to submit clinical quality data to CMS for Medicare programs and to the States for Medicaid programs. The final rule finalizes the clinical quality reporting measures for eligible professionals and hospitals beginning with 2011 and 2012. Several clinical reporting measures listed under the proposed rules for which the electronic transmission specifications could not be finalized were eliminated in the final rule.

It must be noted that clinical quality measures are similar to other Medicare quality reporting measures. Eligible professionals and hospitals are not required to satisfy minimum clinical quality performance levels to qualify for EHR incentive payments. Instead, they will be required to merely report on their ambulatory quality measure results.

The clinical quality measures and the number of measures to be reported vary for eligible professionals and eligible hospitals. The final rule provides greater flexibility by not only reducing the number of clinical measures but also allowing eligible professionals to report from a set of “core” (or “alternate core”) required clinical measures and to select a fixed number of other applicable clinical measures, as explained below.

The final rule provides a listing of 44 clinical measures applicable to eligible professionals for both the Medicare and Medicaid incentive programs. Of these 3 measures, each have been identified as “core measures” and “alternate core measures.” Eligible professionals must report on 6 total measures including 3 core measures (substituting with alternate core measures when necessary) and 3 other applicable measures from the remaining 38 clinical measures.

The number of clinical measures applicable to eligible hospitals for both Medicare and Medicaid programs has been reduced to 15. Only such measures that can be automatically calculated by certified EHR technology have been included in the final rule. Eligible hospitals will be required to report on all 15 measures beginning with 2011.

The final rule requires all eligible professionals and hospitals to self-attest the results calculated by the certified EHR technology and submit the data to CMS (or to the States for a Medicaid program) in the first payment year beginning in 2011. Electronic transmission of such data using the certified EHR technology is not required for the 2011 payment year. It must also be noted that while Medicaid providers can qualify for EHR incentive payments in the first year by having adopted, implemented, or upgraded to certified EHR technology, in lieu of meeting the meaningful use criteria, there is no delayed reporting of clinical quality measures for Medicaid providers. This implies that eligible Medicaid providers will be required to submit self-attested clinical quality measures starting with the first payment year.

Clinical quality reporting is expected to move from self-attestation to direct reporting in 2012 and subsequent years. However, direct reporting of clinical quality measures will depend on the technological capability of CMS to receive such data electronically and the audit strategy to verify the results calculated by the certified EHR technology. It is expected that CMS will have the appropriate technology and supporting processes in place by the beginning of 2012. The process relating to the direct submission of clinical quality measures will be finalized and published by subsequent rulemaking.
MEDICARE AND MEDICAID INCENTIVE CRITERIA

Although the Medicare and Medicaid EHR incentive programs are separate programs, CMS has tried to maintain common definitions of meaningful use for both. There are key differences, however, between the Medicare and Medicaid incentive programs with regard to eligibility, the timing of incentive payments, payment amounts, and payment structures, some of which are discussed in greater detail below. Providers should review these concepts prior to applying for incentive payments.

Eligible professionals may be eligible to apply for incentive payments from either the Medicare or Medicaid incentive payment program but not both programs. Eligible hospitals on the other hand can qualify for meaningful use incentive payments under both Medicare and Medicaid programs. Under the Medicare program, eligible professionals are individual doctors of medicine, doctors of osteopathy, dental surgeons, doctors of dental medicine, podiatrists, optometrists, and chiropractors. The list of eligible professionals under the Medicaid program is a slightly different group of individuals: physicians, pediatricians, dentists, certified nurse midwives, nurse practitioners, and physician assistants operating at a federally qualified health center (FQHC) or rural health clinic (RHC) led by a physician assistant.

Under the Medicare program, eligible hospitals are “subsection (d) hospitals” that are paid under the hospital inpatient prospective payment system (IPPS); the term applies to hospitals located in the 50 states or the District of Columbia, but not the territories. Hospitals and hospital units are excluded from participation if they are excluded under Section 1886(d)(1)(B) from the IPPS, including psychiatric, rehabilitation, long-term care, children's, and cancer hospitals. Under the Medicare program, an eligible hospital's incentive payments are based on its Medicare share or volume.

By contrast, under Medicaid, eligible hospitals are restricted to acute care hospitals, children's hospitals and general short-term hospitals, cancer hospitals, and critical access hospitals that meet the Medicaid EHR incentive program definition of “hospitals with an average patient length of stay of 25 days or fewer, and with a CMS Certification Number (CCN) that falls in the range 0001–0879 and 1300–1399.” Also, under the Medicaid program, there also are additional requirements based on the professional’s or hospital’s Medicaid patient volume.

“Hospital-based” eligible professionals are excluded from participation under the Medicare incentive payment program. A hospital-based professional is an individual who provides at least 90 percent of his or her covered professional services in an inpatient or outpatient hospital setting. Under Medicaid, hospital-based professionals have the same definition as under Medicare, except that Medicaid professionals practicing predominantly in an RHC or FQHC are not subject to the hospital-based exclusion.
Some of the other major differences between the Medicare and Medicaid EHR incentive programs are summarized in Table 1 below:

### Table 1 – EHR Incentive Payment Criteria Differences between the Medicare and Medicaid Programs

<table>
<thead>
<tr>
<th>EHR Incentive Payment Criteria</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available payment years</td>
<td>• 5 years for eligible professionals</td>
<td>• 6 years for both eligible professionals and hospitals</td>
</tr>
<tr>
<td></td>
<td>• 4 years for eligible hospitals</td>
<td></td>
</tr>
<tr>
<td>Maximum cumulative dollar thresholds</td>
<td>• $44,000 for eligible professionals (fixed annual dollar thresholds)</td>
<td>• $63,750 for eligible professionals (fixed annual dollar thresholds)</td>
</tr>
<tr>
<td></td>
<td>• None for eligible hospitals (formula-based)</td>
<td>• None for eligible hospitals (formula-based)</td>
</tr>
<tr>
<td>First year of payment no later than</td>
<td>• 2014 for eligible professionals</td>
<td>• 2016 for both eligible professionals and hospitals</td>
</tr>
<tr>
<td></td>
<td>• 2015 for eligible hospitals</td>
<td></td>
</tr>
<tr>
<td>Last year of payment</td>
<td>• 2015 for eligible professionals</td>
<td>• 2021 for both eligible professionals and hospitals</td>
</tr>
<tr>
<td></td>
<td>• 2016 for eligible hospitals</td>
<td></td>
</tr>
<tr>
<td>Inconsecutive payment years deducted from the total available</td>
<td>• Yes</td>
<td>• No for eligible professionals</td>
</tr>
<tr>
<td>payment years</td>
<td></td>
<td>• No for eligible hospitals until 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Yes for eligible hospitals after 2017</td>
</tr>
<tr>
<td>Does EHR implementation in lieu of EHR meaningful use qualify</td>
<td>• No</td>
<td>• For both eligible professionals and hospitals:</td>
</tr>
<tr>
<td>for EHR incentives?</td>
<td></td>
<td>• Yes for the first payment year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No for subsequent years</td>
</tr>
<tr>
<td>EHR meaningful use reporting period</td>
<td>• Any continuous 90-day period within the first payment year</td>
<td>• First Year – Proof of EHR adoption, implementation, or upgrade to a</td>
</tr>
<tr>
<td></td>
<td>• Entire payment year starting with the second payment year</td>
<td>certified EHR technology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Any continuous 90-day period within the second payment year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Entire payment year starting with the third payment year</td>
</tr>
</tbody>
</table>
Professionals and providers that qualify for both the Medicare and Medicaid programs should consider the following:

- Eligible professionals may participate in only one program: Medicare or Medicaid. A one-time-only switch between programs is permitted.

- If eligible, hospitals may participate in both programs simultaneously. Hospitals eligible for Medicare incentives will be automatically considered eligible for Medicaid incentives for Stage 1 implementation.

- If a provider serves a multistate population and participates in the Medicaid incentive program, the provider can participate only in the Medicaid incentive program through a single state.

- Multiple campus hospitals under the same CCN will be considered to be one entity for the purpose of EHR incentive payments for both Medicare and Medicaid programs.

**MEDICARE AND MEDICAID INCENTIVE PAYMENTS**

For Medicare, the first payment year has been established as 2011. However, for Medicaid incentive payments, states have the flexibility to establish their first payment year depending on the state’s readiness and plan to support the EHR incentive program, subject to the approval of CMS. The final rule aligns the Medicaid program with the Medicare program to the extent possible, thereby allowing states to initiate Medicaid payments as early as 2011.

The final rule established the definition of the payment year for eligible professionals and hospitals for both the Medicare and Medicaid professionals as follows:

- For eligible professionals, a payment year is a calendar year beginning on the first day of January and ending on the last day of December.

- For eligible hospitals, a payment year is the federal fiscal year beginning with the first day of October and ending on the last day of September.
Medicare Incentive Payments

Medicare incentive payments are available as early as FY 2011 for eligible hospitals, and as early as CY 2011 for eligible professionals. Eligible professionals who qualify can receive an annual incentive payment of up to 75 percent of their allowable charges for Medicare covered services furnished that year. Each year’s incentive payment is limited by a monetary cap and could be further reduced, depending on the year in which the professional first qualified for the incentive payment, and the number of years the professional has earned the incentive. Eligible professionals who furnish services in a geographic Health Professional Shortage Area (HPSA) are eligible for a 10 percent increase to their incentive payments.

As shown in Table 2 below, the incentive payments available to eligible professionals depend on which year they initially achieve meaningful use. Notably, eligible professionals can still achieve the maximum incentive payments if they first reach Stage 1 Meaningful Use in 2012. The incentive payments available to later adopters are reduced.

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Total Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td><strong>$18,000</strong></td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td></td>
<td>$44,000</td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td></td>
<td></td>
<td><strong>$18,000</strong></td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td>$44,000</td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$15,000</strong></td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$39,000</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$12,000</strong></td>
<td>$8,000</td>
<td>$4,000</td>
<td>$24,000</td>
</tr>
<tr>
<td>2015+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$$Penalties$$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2 – Medicare Incentive Payments
A hospital’s Medicare incentive payment is calculated using a complex formula based primarily on hospital discharges. The formula also considers the amount of charity care and the percentage of Medicare covered inpatient days related to the hospital’s total number of inpatient days. Unlike the incentive payment for an eligible professional, the hospital incentive payment is not capped at a specific dollar amount, but the number of hospital discharges used in the calculation of the incentive payment cannot exceed 23,000 annually.

Hospitals may qualify for financial incentive payments for only four consecutive years, and after the first year, the incentive payment will be reduced each year. The first year the hospital is eligible, it will receive 100 percent of the calculated incentive payment. The hospital will receive only 75 percent in the second year, 50 percent in the third year, and 25 percent in the fourth year. Additionally, hospitals that are late implementers (after FY 2013) of EHR technology will either receive reduced payments or be ineligible for any incentives.

An eligible critical access hospital (CAH) will be reimbursed a percentage of the reasonable costs incurred for the purchase of certified EHR technology (less any depreciation) equal to the percentage of Medicare patients treated at the CAH, plus 20 percent, up to the total cost of the technology. For example, if the CAH incurred reasonable costs of $500,000 for the purchase of certified EHR technology, and the percentage of the CAH’s overall patient population who are Medicare beneficiaries is 70 percent, the CAH will be reimbursed ($500,000 x (70% + 20%)) = $450,000.

Eligible professionals and hospitals that are not meaningful users by 2014 and 2015 respectively will not qualify to receive any EHR incentive payments. A “significant hardship exception” is available for any professional or hospital that is able to demonstrate that the implementation of EHR technology would impose a significant hardship of the person or entity.

**Medicaid Incentive Payments**

The Medicaid eligibility rules for providers are very similar to those of Medicare; however, there are “flexible” thresholds for eligible professionals:

- Eligible professionals are not considered hospital-based if they are practicing predominately in a federally qualified health center or a rural health clinic. “Predominately” is defined as more than 50 percent of the professional’s total patient encounters in a six-month period.
- At minimum, 30 percent of an eligible professional’s (20 percent for pediatricians) patient encounters must be attributable to Medicaid over any continuous 90-day period within the most recent calendar year.

Less technologically advanced eligible professionals and hospitals may qualify to receive a first year Medicaid incentive payment by engaging in efforts to adopt, implement, or upgrade to a certified EHR technology. After the first payment year, Medicaid providers must demonstrate meaningful use to qualify for future Medicaid incentive payments. CMS breaks down the elements of showing sufficient efforts to adopt as follows:

- “Certified EHR Technology” as defined by the ONC
- Actual installation prior to receiving the incentive payment, rather than simply making efforts to install. Researching technology or interviewing vendors does not satisfy the requirements.
- “Implementing” means that the hospital has begun to use the certified EHR technology. Implementation includes staff training, data entry, or establishing data exchange agreements.

A Medicaid provider must certify that it satisfies the applicable standards, and the state must confirm. States are required to establish the process to support the same. Providers may wish to work with their state Medicaid programs to speed up the implementation of the incentive programs.

**State Preparations Required for Medicaid EHR**

To receive and distribute federal funds as EHR incentives, states must prepare a State Medicaid Health Information Technology Plan (SMHP). The purpose of the SMHP is to show CMS that the state is ready to make timely and accurate payments.

Some states will need to upgrade their own electronic systems in order to monitor the disbursement of funds for hospitals to upgrade their electronic systems. At a minimum, a state needs to keep track of:

- The legal entity that receives the money (tax identification and provider number)
- The date that the entity received the funds (which starts the evaluation clock ticking)
- The amount of money that was disbursed to the hospital.

CMS, in turn, will monitor activities to ensure that a hospital receives funds from only one state.

States can receive 90 percent of their federal financial participation for their expenditures related to the administration of an EHR incentive program, as well as 100 percent for expenditure for incentive payments.

Given the amounts involved, CMS is very concerned about potential fraud and abuse and creating an audit trail. Thus, there will be many attestations and certifications among those entities through which the money flows, including fiscal agents and Medicaid HMO plans.
Incentives Time Frames

Table 3 on the following page demonstrates the payment time frames established by CMS to demonstrate and qualify meaningful use of EHR technology across the various stages of EHR implementation. The final rule provides more flexibility for the adoption of EHR technology as compared to the earlier proposed rules that required all eligible EHR users to meet Stage 3 criteria by 2015. The final rule provides eligible professionals and providers two years to implement Stage 1 if their first payment year is 2011, 2012, or 2013. The final rule also provides that eligible EHR users may receive incentives for meeting Stage 1 criteria of meaningful use over a span of four years, i.e. as late as 2014. The final rule removes language regarding the time frames for incentive payments beyond 2014. Payment time frames and implementation Stages beyond 2014 will be addressed by later rulemaking.

It must be however noted that in order to meet the ultimate goals of meaningful use of certified EHR technology and to maximize the potential of EHR technology, all users will need to converge to a common stage at some point after 2014. As a result, it would be fair to assume that the later a provider first meets the Stage 1 criteria, the shorter will be the time frame to advance through the stages and a more aggressive progression may be required to meet the common stage after 2014, when and as determined by CMS.

Table 3 – Time Frames for Incentive Payments Under Meaningful Use

<table>
<thead>
<tr>
<th>First Payment Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 2</td>
<td>TBD</td>
</tr>
<tr>
<td>2012</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>TBD</td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>TBD</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>TBD</td>
</tr>
</tbody>
</table>

* – Avoids payment adjustments only for eligible professionals in the Medicare EHR incentive program.

– CMS will establish the Stage of meaningful use implementation and associated requirements by later rulemaking.
Incentive payments also depend on the implementation timeline and meaningful use of certified EHR technology (outlined in greater detail under “Medicare and Medicaid Incentives” section of this white paper). Eligible professionals are eligible to receive Medicare incentive payments for up to five years starting with calendar year 2010 (subject to annual caps). In addition, eligible professionals also qualify for an additional incentive of $3,000 for 2011 and 2012, if their first payment year is 2011 or 2012. The Medicare incentive payment eligibility for eligible professionals terminates after 2015.

Eligible hospitals are eligible to receive Medicare incentive payments for up to four years starting with fiscal year 2011 based on a complex formula that uses a “transition factor” to compute the annual incentive payments. The higher the transition factor, the higher the incentive payment. The transition factor reduces each payment year based on the first payment year as indicated in Table 4 below:

<table>
<thead>
<tr>
<th>First Payment Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>0.75</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>0.50</td>
<td>0.75</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>0.25</td>
<td>0.50</td>
<td>0.75</td>
<td>0.75</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td>0.25</td>
<td>0.50</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td>0.25</td>
<td>0.25</td>
<td>0.25</td>
</tr>
</tbody>
</table>

Table 4 – Meaningful Use Incentive Transition Factor for Medicare Eligible Hospitals
The Medicare incentive payment eligibility for eligible hospitals terminates after 2016. In other words, an eligible professional or hospital that does not qualify to receive an EHR Medicare incentive payment by 2014 or 2015, respectively, will not receive any incentive payments at all. In addition, such eligible professionals and hospitals that have not met the meaningful use requirements will also be subject to financial penalties.

The Medicaid incentive program for eligible professionals and hospitals varies from that of Medicare and such incentive payments can be received until 2021. However, an eligible professional or hospital that does not qualify to receive an EHR Medicaid incentive payment by 2016 will not receive any incentive payments at all. Hence the impact on eligible incentive payments should also be considered when planning for the implementation and meaningful use of EHR technology.

TECHNOLOGY WILL BE THE MAIN PLATFORM FOR ACHIEVING MEANINGFUL USE

Essential to becoming a meaningful user of EHR technology, of course, is the technology itself. The ONC has described the initial set of standards, implementation specifications, and certification criteria for EHR technology that eligible professionals and hospitals must adopt and use to become meaningful users. These standards, specifications, and criteria are requirements that an EHR will need to include in order to support the achievement of the proposed Meaningful Use Stage 1. Following the same phased approach, the ONC anticipates the requirements for a certified EHR also will become more stringent over time, with the objective to incrementally improve the interoperability, functionality, and utility of health information technology.

Defining "certified EHR technology"

To qualify as certified EHR technology, the technology must:

- Meet the requirements for a qualified EHR, by having the following capabilities:
  - Includes patient demographic and clinical health information (e.g., medical history and problem lists)
  - Provides clinical decision support
  - Supports CPOE
  - Captures and queries information relevant to healthcare quality
  - Exchanges electronic health information with—and integrates such information from—other sources
  - Have been tested and certified in accordance with the certification program established by the ONC as having met all applicable certification criteria.
The criteria for certification are designed to support the various measures for meaningful use specified in the CMS rule so that the eligible professional or hospital acquiring EHR technology has the technological capabilities to become a meaningful user and to track and report its use automatically and electronically.

The criteria cover:

- Twenty-one functional areas generally applicable to all EHR
- Nine areas with specific criteria for ambulatory EHR
- Five areas with specific criteria for inpatient EHR.

The differences between the ambulatory and inpatient EHR specific certification criteria are based on the nature of the settings and track the different requirements for meaningful use for eligible professionals and hospitals. The certification process and the process to become a certifying body will be the subject of a separate rule.

The ONC rule establishes specific standards in four general areas: vocabularies, content exchange, transporting information, and privacy and security. The rule does not create new technology standards but adopts existing standards, specifications, and protocols promulgated by the technology industry generally (with respect to information transport) and the healthcare industry (with respect to vocabularies, content, and privacy/security).

**Complete EHR versus Collection of Modules**

The various criteria for certified EHR technology may be met by a single, complete EHR system that has been certified, or by a collection of various EHR modules each of which has been certified. EHR modules may include, as a few possibilities, software installed on site, software as a service, health information exchange interface or program, a clinical decision support rules engine, or a quality measure reporting service.

Under the complete EHR approach, a provider would have the peace of mind of knowing that all criteria have been certified in a single system. If a provider elects to utilize certified EHR technology through a variety of EHR modules, then it is the responsibility of the eligible professional or hospital to ensure that the combination of EHR modules collectively satisfies all criteria specified in the rule, meaning that collectively, each and every criterion is certified.

**HIPAA or Other Legal Requirements**

The certification criteria include standards and implementation specifications with regard to technical aspects designed to protect the privacy and security of health information, but they do not guarantee compliance with HIPAA. The comments are explicit in this regard; the ONC rule does not change existing HIPAA privacy or security requirements, does not guarantee compliance, and does not absolve any provider from compliance with HIPAA privacy or security requirements.

The same is true of any other legal requirements. That is, certified EHR technology may assist a user in compliance, but does not waive, alter, or guarantee compliance with those requirements.

**HEALTHCARE TRANSFORMATION**

The American healthcare system across all segments—providers, payors, pharmaceuticals, life sciences, and government—is undergoing an unprecedented transformation, which is only further accelerated by the new healthcare reform laws. Employers and individuals across the country will all be affected by the changes.

Solving the complex equation for healthcare that balances cost, quality, and access is growing ever more difficult as the industry faces reductions in government reimbursement, an unknown demand curve from the newly insured, new intersections among the segments, and employers’ insistence on moderating healthcare premiums.

This environment for business planning and operational execution has never been more dynamic or challenging. From the perspective of KPMG Healthcare, the industry should both acknowledge that this is a transformative time and that executing exceptionally against immediate mandates isn’t discretionary. For example, meeting the meaningful use of healthcare IT standards and converting to ICD-10 are complex, multiyear programs that cannot be delayed nor denied.

At the same time, the industry needs to ensure that the deep business changes accompanying such mandates are institutionalized in a sustainable fashion. This is what we call “transformation sustainability”—a fundamental principle that informs today’s healthcare landscape.
At this critical time, the professionals of KPMG Healthcare offer our clients and other industry leaders this distinct and deceptively simple point of view that shapes our approach to helping them develop and maintain transformation sustainability — that healthcare is ultimately about the patient — a person who is at the center of an emerging healthcare ecosystem, which is increasingly integrated in new ways and defined by important intersection points among the key players in the industry.

With deep experience in technical matters and full commitment to understanding this emerging environment in all its complexity, KPMG Healthcare now brings together more than 1,500 partners and professionals from our provider, payor, pharmaceutical, life sciences, and government practices, to serve the business of healthcare.

Importantly, KPMG Healthcare’s services are informed by our view of this increasingly integrated ecosystem and its challenge to achieve sustainable transformation. The KPMG approach not only adds value to the industry dialogue but also links all of our industry-based services in end-to-end fashion — from independent audit, to tax compliance and consulting, in a broad continuum of healthcare advisory services.
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