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# ISSUE BRIEF

## Incentive Payments

### Medicare Fee-for Service Incentives

Eligible Professionals (EP) who are meaningful EHR users during the relevant EHR reporting period are entitled to an incentive payment amount, subject to an annual limit, equal to 75 percent of the Secretary's estimate of the Medicare allowed charges for covered professional services furnished by the EP during the relevant payment year. An EP is entitled to an incentive payment for up to 5 years. There shall be no incentive payments made with respect to a year after 2016.

Since incentive payments are based on the percentage of Medicare allowed charges, it's possible that a physician could receive less than the maximum incentive payment. For example, if a physician's estimated total allowed charges are \$10,000, then the incentive payment for 2011 would 75% of that, which is \$7,500. Incentive payment for an EP for a given payment year shall not exceed the following amounts:

- For the EP's first payment year, for such professional, \$15,000 (or, \$18,000 if the EP's first payment year is 2011 or 2012).
- For the EP's second payment year, \$12,000.
- For the EP's third payment year, \$8,000.
- For the EP's fourth payment year, \$4,000.
- For the EP's fifth payment year, \$2,000.
- For any succeeding year, \$0.

(For EPs who predominantly furnish services in a geographic HPSA (as designated by the Secretary), the incentive payment limitation amounts for each payment year are increased by 10 percent.)

### Maximum Payment

Adopt Year	2011	2012	2013	2014	2015	2016	Total	Penalty*
2011	\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$0	\$44,000	
2012		\$18,000	\$12,000	\$8,000	\$4,000	\$2,000	\$44,000	
2013			\$15,000	\$12,000	\$8,000	\$4,000	\$39,000	
2014				\$12,000	\$8,000	\$4,000	\$24,000	
2015							\$0	1%
2016							\$0	2%
2017							\$0	3%

\*Starting in 2015 and in subsequent years, for physicians who are not meaningful EHR users, fee schedule payments will be reduced by 1 percent in 2015, 2 percent in 2016, and 3 percent in 2017.

An EP is considered to "predominantly" furnishing covered professional services in a geographic HPSA if more than 50% of the EP's Medicare covered professional services are furnished in a geographic HPSA. To determine whether an EP has furnished more than 50% of his/her covered professional services in a geographic HPSA, CMS will use frequency of services provided over a 1-year period from January 1 to December 31, rather than basing it on the percentage of allowed charges.

CMS will make a single, consolidated, annual incentive payment to EPs on a rolling basis. CMS will use the EP's Medicare enrollment information to determine whether an EP belongs to more than one practice (that is, whether the EP's National Provider Identifier (NPI) is associated with more than one practice).

Therefore, EPs are allowed to reassign their incentive payment to their employer or an entity which they have a valid employment agreement or contract providing for such reassignment, consistent with all rules governing reassignments. If the EP has multiple employers/contractual arrangements, the EP must pick one Tax Identification Number to receive payment.

In general, beginning in 2015, if an EP is not a meaningful EHR user for any EHR reporting period for the year, then the Medicare physician fee schedule amount for covered professional services furnished by the EP during the year will be adjusted: 1) for 2015, 99 percent (or, in the case of an EP who was subject to the application of the payment adjustment if the EP is not a successful electronic prescriber for 2014, 98 percent); 2) for 2016, 98 percent; and 3) for 2017 and each subsequent year, 97 percent.

In addition, if for 2018 and subsequent years the Secretary finds that the proportion of EPs who are meaningful EHR users is less than 75 percent, the applicable percent shall be decreased by 1 percentage point from the applicable percent in the preceding year, but in no case shall the applicable percent be less than 95 percent.

CMS will exempt an EP who is not a meaningful EHR user for the year from the application of the payment adjustment if the Secretary determines that compliance with the requirements for being a meaningful EHR user would result in a significant hardship, such as in the case of an EP who practices in a rural area without sufficient Internet access. The exemption is subject to annual renewal, but in no case may an EP be granted a hardship exemption for more than 5 years.

To facilitate funds control, payments will be made through a single payment contractor rather than through the carriers/MACs as was originally proposed. Additionally, the Integrated Data Repository (IDR), rather than the carriers/MACs, will accumulate the allowed charges for each qualified EP's NPI. Payments would be made on a rolling basis, as soon as CMS ascertains that an EP has successfully demonstrated meaningful use for the applicable reporting period (that is, 90 days for the first year or a calendar year for subsequent years) and the EP's allowed charges has reached the threshold that qualifies an EP for maximum incentive payment, for the relevant payment year. Once this determination has been made, the National Level Repository (NLR) will calculate the EP's incentive payment.

The payment will then be made by the single payment contractor. CMS anticipates that it will take anywhere from 15 to 46 days from the time an EP successfully attests to being a meaningful user to the time an incentive payment is made, and that for FY 2011, incentive payments will be made to EPs who successfully demonstrate that they were meaningful EHR users for the EHR reporting period (that is, 90 days) as early as May 2011.

**NOTE:** Administrative or judicial review is prohibited of all of the following:

- The methodology and standards for determining EP incentive payment amounts.
- The methodology and standards for determining the payment adjustments that apply to EPs beginning with 2015.
- The methodology and standards for determining whether an EP is a meaningful EHR user, including: (1) The selection of clinical quality measures; and (2) the means of demonstrating meaningful EHR use.
- The methodology and standards for determining the hardship exception to the payment adjustments.
- The methodology and standards for determining whether an EP is hospital-based.
- The specification of the EHR reporting period, as well as whether payment will be made only once, in a single consolidated payment, or in periodic installments.

### **Medicare Advantage (MA) Organization Incentive Payments**

A qualifying MA organization may receive an incentive payment only for those eligible professionals who must be either:

- Be employed by the qualifying MA organization; or

- Be employed by, or be a partner of, an entity that through contract with the qualifying MA organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of the qualifying MA organization.

Further, the EP must furnish at least 80 percent of his or her professional services covered under Medicare to enrollees of the qualifying MA organization and must furnish, on average, at least 20 hours per week of patient care services.

CMS interprets “to be a partner of” to mean that the qualifying MA EP has an ownership stake in the entity. Under this interpretation, a professional that contracts with an entity, but has no ownership stake in the entity, is not be considered a qualifying MA EP. CMS interprets “furnishing at least 80 percent” of the entity's “patient care services” to mean at least 80 percent of the qualifying MA EP's total Medicare revenue in a year (that is, total revenue from Medicare FFS as well as from all MA organizations) must be from a single qualifying MA organization. CMS interprets the 20 hours per week requirement to include both Medicare and non-Medicare patient care services.

CMS requires qualifying MA organizations to report the name, practice address, and other identifying information like NPI for all physicians that meet the requirements of the qualifying MA EP for which the qualifying MA organization will be requesting payment under the MA E HR incentive payment program.

Once a qualifying MA organization identifies potential EPs, CMS is required to ensure that such EPs did not receive the maximum EHR incentive payment for the relevant payment year under the Medicare FFS program, before releasing an incentive payment to a qualifying MA organization related to such EP. Therefore, in order to allow CMS time to determine whether an MA EP received the maximum E HR incentive payment under the Medicare FFS program, the agency will not make incentive payments to qualifying MA organizations for the MA EPs for a payment year until after the final computation of EP incentive payments for that year under the Medicare FFS program. Additionally, CMS requires qualifying MA organizations to ensure that all MA EPs are enumerated through the NPI system, in order to detect and prevent duplicate payment for EPs under both the FFS and MA EHR incentive payment programs.

CMS limits payment to an MA organization to only payment for their EPs' services to MA enrollees of plans offered by the MA organization. CMS does not believe it would be appropriate to provide an incentive payment to an MA organization for services provided to individuals covered under Part B.

The incentive payments for MA EPs are similar to the payments for EPs under FFS.

- For the EP's first payment year, \$15,000 (or, if the first payment year is 2011 or 2012, \$18,000).
- For the EP's second payment year, \$12,000.
- For the EP's third payment year, \$8,000.
- For the EP's fourth payment year, \$4,000.
- For the EP's fifth payment year, \$2,000.
- For any succeeding year, \$0.

The maximum cumulative incentive payment over five years to a qualifying MA organization for each of its qualifying MA EPs that meaningfully use certified E HRs beginning on or before 2012 would be \$44,000 per qualifying MA EP. For MA organizations first reporting the meaningful use of certified EHRs by qualifying MA EPs in 2013 or 2014, the maximum potential incentive payment per qualifying EP is, respectively, \$39,000 over 4 years, and \$24,000 over 3 years.

For qualifying MA EPs who are compensated on a salaried basis, CMS requires the qualifying MA organization to develop a methodology for estimating the portion of the qualifying MA EP's salary attributable to providing services that would otherwise be covered as professional services under Part B of Medicare to MA plan enrollees of the MA organization. The methodology, which requires review and approval by the agency, could be based on the relative share of patient care hours spent with MA enrollees of the organization or another reasonable method. So, for instance, if a qualifying MA EP spends

30 percent of his or her time providing covered Part B physician office services to MA plan enrollees, then the qualifying MA organization would report 30 percent of the qualifying MA EP's salary as annual revenue, which would be used to compute the amount of the MA incentive payment due to the qualifying MA EP.

MA organizations should also be permitted to include an amount for overhead related to such costs not directly experienced by salaried qualifying MA EPs. CMS requires qualifying MA organizations to develop a methodology for estimating the additional amount related to overhead attributable to providing services that would otherwise be covered under Part B. Those who are not salaried will have to provide attestation.

For payments to qualifying MA EPs, the time frame for payment will be after the Medicare FFS program computes incentive payments due under the Medicare FFS EHR incentive program – so the first possible incentive payments would be made sometime in early 2012.

To avoid duplicate payments, before payments can be made to qualifying MA organizations for MA EPs, CMS must determine if a maximum incentive payment under Medicare FFS has been previously earned by potential MA EPs. Payment for MA EPs won't be made until claims submissions counted for Medicare FFS incentive payment for CY 2011 have been closed and payment calculations have been completed in the early part of CY 2012.

CMS also will withhold Medicare FFS incentive payments from EPs of less than the maximum to the extent such professionals are also identified as MA EPs. Again, CMS would need to await the computation of payments due EPs under the Medicare FFS EHR incentive program before it can determine whether the EP is entitled to less than the maximum payment amount under the Medicare FFS EHR program, in which case any incentive payment for the EP will only be made to the qualifying MA organization under the MA EHR program, and not to the EP under the Medicare FFS EHR program.

Unlike the Medicare FFS EHR incentive program, where CMS will require the reporting of clinical quality measures, the agency will not require qualifying MA organizations to submit clinical quality measures with respect to EPs. Qualifying MA organizations sponsoring coordinated care MA plans are already required to submit Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcomes Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. Coordinated care MA plans include HMO, PPO and RPPO (Regional PPO) plans. Beginning with CY 2010, PFFS and MSA plans will also be required to begin collecting and submitting administrative HEDIS measures.

For all such EPs of the MA organization that are not meaningful users for such year, the payment adjustment on the proportion of the capitation payment is 1 percent for 2015, 2 percent in 2016, and 3 percent in 2017 and subsequent years.