

# BB BULLETIN

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### CMS ISSUES LONG-AWAITED PROPOSED RULE REGARDING MEDICARE AND MEDICAID INCENTIVE PAYMENTS TO ELIGIBLE PROFESSIONALS AND HOSPITALS

Meeting its deadline, on December 30, 2009, the Centers for Medicare and Medicaid Services (CMS) released its long-awaited proposed rule explaining how eligible professionals and hospitals may “**meaningfully use**” certified electronic health record technology in order to receive governmental incentive payments and how CMS may impose on providers potential penalties for not achieving “meaningful use.” Simultaneously, the Office of the National Coordinator for Health Information Technology (ONC) issued an interim final rule setting forth an initial set of certification standards for electronic health records. Part One of this Health Law Bulletin identifies highlights of the CMS proposed rule regarding the Medicare and Medicaid incentive payments and Part Two of the Bulletin discusses ONC’s initial set of certification standards and specifications for electronic health records.

#### Background

CMS’ proposed rule, published in the Federal Register on January 13, 2010, implements statutory requirements in the American Recovery and Reinvestment Act of 2009 (ARRA), specifically Title IV of Division B, that establishes incentive payments rewarding eligible professionals and hospitals that adopt and meaningfully use interoperable health information technology and qualified electronic health records (EHR). The comment period for the proposed rule ends March 15, 2010.

#### Types of Incentive Programs and Eligible Recipients

ARRA established three governmental incentive programs to encourage the implementation of EHR technology: the Medicare fee for service EHR incentive program, the incentive program for qualifying Medicare Advantage organizations, and the Medicaid EHR incentive program. Professionals eligible to participate in the

Medicare program include (i) doctors of medicine or osteopathy, (ii) doctors of dental surgery or of dental medicine, (iii) doctors of podiatric medicine, (iv) doctors of optometry, and (v) chiropractors. The categories of eligible professionals in the Medicaid program vary somewhat in that the list includes not only physicians (M.D. and D.O.) and dentists but also certified nurse midwives, nurse practitioners, and physician assistants performing services in federally qualified health centers and rural health clinics. As discussed below in more detail, hospital-based physicians are generally ineligible to participate in any of the governmental incentive programs.

A hospital will be eligible for Medicare incentive payments if it is either a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), meaning that Medicare pays the hospital for inpatient services on a prospective payment basis or a critical access hospital. Consequently, children’s, cancer, rehabilitation and long term care hospitals are ineligible. The Medicaid program, on the other hand, allows only acute care and children’s hospitals to be eligible for incentive payments and imposes Medicaid patient volume requirements on potentially eligible hospitals.

While hospitals may participate in both Medicare and Medicaid incentive programs, professionals must select either the Medicare or the Medicaid incentive program.

#### Definition of “Meaningful Use”

To qualify for incentive payments under any of the three incentive programs, eligible professionals and eligible hospitals must “**meaningfully use**” certified EHR technology. The definition of “meaningful use,” common to all governmental incentive programs and the minimum standard for eligible professionals and eligible hospitals participating in the Medicaid incentive program, requires that for an EHR reporting period during a payment year, the provider demonstrate use of certified EHR technology in a form and manner consistent with CMS’ objectives and measuring standards.

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In developing the definition of “meaningful use,” CMS utilized Congress’ requirements: (1) that providers use certified EHR technology in a meaningful manner (e.g., electronic prescribing); (2) that certified EHR technology be connected in order to electronically exchange health information and improve quality of care; and (3) that providers submit clinical quality and other measures selected by the Secretary of the Department of Health and Human Services. CMS attempted to avoid duplicate requirements by using one definition of “meaningful use” for both Medicare and Medicaid payment incentives. Further, CMS also proposed that when a Medicare provider qualifies as a “meaningful user,” it would also be deemed a meaningful EHR user under the Medicaid EHR incentive program.

In order to understand the requirements of “meaningful use,” critical terms, such as “payment year,” “EHR reporting period” and “first payment year” require definition. For purposes of the governmental incentive programs, these terms have the following meanings:

- **Payment Year:** CMS proposed a single definition of “payment year” for all eligible professionals as “any calendar year beginning with 2011.” Certain eligible professionals may, however, participate in the Medicaid incentive program beginning calendar year (CY) 2010.

For eligible hospitals, “payment year” will mean any fiscal year (FY) beginning in 2011. As hospitals use the federal fiscal year, “payment years” for eligible hospitals will begin on October 1 and extend to September 30, of any given calendar year. Notably, however, certain eligible hospitals may participate in the Medicaid incentive program beginning with the FY 2010.

- **First Payment Year:** For purposes of receiving incentive payments, the term “first payment year” means the first calendar or federal fiscal year for which an eligible professional or eligible hospital receives an incentive payment period.
- **EHR reporting period:** The EHR reporting period means the time frame during which an eligible professional or eligible hospital must meaningfully use certified EHR technology in order to qualify to receive incentive payments. Eligible professionals and eligible hospitals may demonstrate meaningful use in the first payment year, but they must demonstrate meaningful use in subsequent payment years.

CMS proposes that in the first payment year the “EHR reporting period” may be “any continuous ninety-day period.” In subsequent payment years, the “EHR reporting year” means the entire payment year. CMS plans to propose a separate definition for purposes of Medicare incentive payment adjustments as required by the ARRA statute.

Phased Approach

Reflecting both public and industry input, CMS proposes a phased approach for “meaningful use,” designating the initial “meaningful use” criteria as “Stage One.” Stage Two criteria will be implemented in 2013 and 2014, with more stringent Stage Three criteria implemented in 2015.

The focuses for Stage One “meaningful use” criteria include:

- Capturing health information electronically in a coded format;
- Using gathered information “to track key clinical conditions and [communicate] that information for care coordination purposes”;
- Implementing clinical decision support tools “to facilitate disease and medication management”;
- Reporting both clinical quality measures and public health information.

Eligible hospitals and eligible professionals receiving incentive payments in 2011 as the first payment year must satisfy Stage One criteria during their first and second payment years (2011 and 2012). For the third and fourth payment years (2013 and 2014), Stage Two criteria will be used and CMS proposes using Stage Three criteria during the 2015 payment year.

In structuring both the definition of “meaningful use” and in determining whether an eligible hospital or eligible professionals meet the requirements for being a “meaningful EHR user,” CMS utilized the health outcome policy priorities identified by the HIT Policy Committee, identified “Objectives” to reach the policy priorities, grouped those Objectives under “Care Goals” and proposed Stage One Measures that eligible hospitals and eligible professionals must meet in order to receive payment incentives.

While some Objectives are applicable only to eligible professionals, others are applicable to both eligible professionals and eligible hospitals. An individual eligible professional (determined by his or her unique National Provider Identifier)

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must meet each Objective, as must an individual hospital determined by its CMS certification number.

CMS proposes dividing its measures into two categories: Health IT Functionality Measures and Clinical Quality Measures. The majority of the Measures fall into the category of Health IT Functionality and require that eligible professionals and hospitals obtain a percentage of full compliance. Some Measures for certain Objectives, however, require electronic exchange of information. CMS proposes that eligible hospitals and eligible professionals meet the Objectives requiring an electronic exchange of information by performing at least one test of their certified EHR technology capacity. In general, the Stage One Objectives do not require electronic exchange of "structured data" reflecting CMS's recognition that the necessary infrastructure to support electronic exchange is not available in most areas.

An example of a Health IT Functionality Measure is the Measure for meeting the Objective to use CPOE. "Using CPOE" is one of the Objectives grouped into a Care Goal that supports the Health Outcome Policy Priority of "improving quality, safety, efficiency and reducing health disparities." Five Care Goals address this priority, including using "evidence-based order sets and computerized provider order entry (CPOE)" and providing "access to comprehensive patient health data for [a] patient's health care team." In order to meet this Objective, eligible professionals must use CPOE for 80% of all orders while hospitals must use CPOE for 10% of all orders.

CMS defines "Clinical Quality Measures" to consist of "measures of processes, experiences, and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, safe, efficient, patient-centered, equitable and timely care." The proposed rule has a number of tables ([see pp 1874 through 1900 for tables 3 through 21](#)) listing the Clinical Quality Measures that apply to eligible professionals and hospitals. The tables identify 90 potential general Clinical Quality Measures and 15 groups of specialty measures for physicians alone. Hospitals have their own list of 43 Clinical Quality Measures.

In selecting the initial Clinical Quality Measures eligible professionals must report in order to demonstrate "meaningful use" of certified EHR technology, CMS expresses a preference to the clinical quality measures endorsed by the National Quality Forum (NQF), including NQF endorsed measures that have previously been selected for the Physician Quality Reporting Initiative (PQRI) program. The initial Clinical Quality Measures eligible hospitals must report in order to demonstrate "meaningful use" are based on

clinical quality measures endorsed by the NQF or those that have previously been selected for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program.

Starting in 2011, to be a meaningful user, eligible professionals and eligible hospitals will be required to use certified EHR technology to capture the data elements and calculate the results for the applicable Clinical Quality Measures. Eligible professionals and hospitals must demonstrate that they have satisfied this requirement during the EHR reporting period for 2011 through attestation.

CMS has expressed hope that by the 2012 payment year, "we will have completed the necessary steps to have the capacity to receive electronically information on clinical quality measures from EHRs including the promulgation of technical specifications for EHR vendors to use for obtaining certification of their systems." Therefore, for the 2012 payment year, eligible professionals and hospitals are expected to submit information on Clinical Quality Measures electronically.

In enumerating the various Stage One Objectives and Stage One Measures, CMS solicits comments on whether providers might encounter difficulty in meeting the proposed Objectives, whether the percentages identified are achievable and whether the Objectives will interfere with current state law.

## **MEDICARE INCENTIVES**

The HITECH Act grants Medicare incentives to eligible professionals and eligible hospitals that implement and demonstrate meaningful use of certified EHR technology between 2011 and 2016.

### Incentives for Eligible Professionals

The proposed rule now defines an eligible professional (EP) as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a podiatrist, an optometrist or a chiropractor. Hospital based physicians are not separately eligible for incentive payments, and the proposed rule clarifies that a hospital-based EP is one who furnishes 90% or more of his/her allowed services in a hospital, including outpatient departments and emergency departments.

The proposed rule also clarifies that EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs may participate in only one program and must designate the program in which they would like to participate. CMS proposes that, after the initial designation, EPs be allowed to change their

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program selection only once during payment years 2012 through 2014.

For EPs in geographic Health Practitioner Shortage Areas (HPSAs) (including mental health, dental, and primary care HPSAs), the HITECH Act increases the incentive payment by 10%. CMS' proposed rule clarifies that EPs who "predominantly furnish" services in geographic HPSAs are eligible for the 10% increase, and, according to CMS, an EP would be considered to furnish services "predominantly" in a HPSA if more than 50% of the EP's Medicare covered professional services are furnished in a HPSA.

CMS proposes to make single, consolidated, annual incentive payments, as opposed to installment payments, for ease of administration. Payments will be made based on a provider's tax ID number, and providers will be permitted one assignment of the entire payment to an employer or entity.

#### Incentives for Hospitals

An eligible hospital for Medicare incentive payments is a "subsection (d) hospital" that is paid under the hospital inpatient prospective payment system (IPPS). Hospitals must be located in one of the 50 states or the District of Columbia, not including the territories or hospitals located in Puerto Rico. The definition does not include psychiatric, rehabilitation, long term care, children's or cancer hospitals. Eligible hospitals, but not physicians, can qualify to receive payments from both the Medicare and Medicaid EHR incentive programs.

Medicare incentive payments are available as early as FY 2011. CMS proposes that, for the first year an eligible hospital demonstrates meaningful EHR use, an EHR Reporting Period equals any 90 continuous day period, beginning and ending within the year. For every year after the first payment year, CMS proposes that the EHR reporting period is the entire year. Hospitals may only qualify for financial incentive payments for four consecutive years.

The incentive payment for each eligible hospital will be calculated based on an initial amount, which is the sum of a \$2 million base amount and the product of a per discharge amount and the number of discharges; the Medicare share, which is the proportion of Medicare fee-for-service and managed care inpatient bed-days to the product of total inpatient days and by the hospital's total charges that are not attributed to charity care; and a transition factor which phases down the incentive payments over the four year period. In calculating discharge amount, CMS will use data on hospital discharges from the fiscal year prior to the qualifying fiscal year.

In calculating inpatient days, CMS proposes to use data in the same manner as calculated by CMS to make direct graduate medical education payments. According to CMS, the methodology and data sources for making these bed day determinations are not only well established, but also well known and understood within the hospital community. To determine charity care, CMS will use the charity care charges that are reported on Medicare cost reports.

#### Incentives for Critical Access Hospitals (CAH)

A qualifying CAH is a certified critical access hospital that meets the definition of a meaningful EHR user for an eligible "subsection (d)" hospital. Incentive payments for CAHs will be calculated based on the provider number used for cost reporting purposes, which is the CCN of the main provider.

Like general eligible hospitals, qualifying CAHs may receive incentive payments for up to four payment years beginning with cost reporting periods that begin in FY 2011. The year with a cost reporting period that begins in FY 2015 is the last payment year for which a qualifying CAH can receive incentive payments as a meaningful EHR user.

Qualifying CAHs can receive incentive payments for the reasonable costs incurred for the purchase of depreciable assets like computers and associated hardware and software, necessary to administer certified EHR technology, excluding any depreciation and interest expenses associated with the acquisition.

A qualifying CAH will receive an incentive payment amount equal to the product of its reasonable costs incurred for the purchase of certified EHR technology and its Medicare share percentage. The Medicare share percentage equals the lesser of: (1) 100%; or (2) the sum of the Medicare share fraction for the CAH and 20 percentage points.

### **MEDICAID INCENTIVES**

Qualifying Medicaid EPs and certain hospitals (acute care and children's hospitals) will be eligible to receive incentive payments from state Medicaid programs for adopting, implementing, or upgrading and meaningfully using certified EHR technology. States, in turn, will be eligible to receive 100% federal financial participation (FFP) for incentives paid to qualifying providers and 90% FFP for state expenditures related to administering the EHR incentive program. In order to receive federal funding, states must administer the EHR incentive program, coordinate with CMS to ensure that there are no duplicate payments, and take responsibility for fraud, waste and abuse oversight. There is no statutory

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implementation deadline for the Medicaid EHR incentive program, and the Rule contemplates that some states may be prepared to implement the program as early as 2010.

EP Eligibility and Incentives

“Medicaid EPs” are eligible to receive Medicaid EHR technology incentives under the Rule. The Rule defines Medicaid EPs as physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants practicing in an FQHC or RHC. Medicaid EPs cannot be hospital-based, except for those practicing predominantly in an FQHC or RHC. To be eligible for incentives, a Medicaid EP must either meet a specified Medicaid patient volume threshold or practice predominantly in an FQHC or RHC. For Medicaid EPs other than obstetricians, a minimum of 30% of total patient encounters must be with Medicaid beneficiaries. For obstetricians, the minimum proportion of Medicaid patients is 20%. As an alternative to the percentage of Medicaid patient threshold, EPs who practice predominantly in an FQHC or RHC (more than 50% of his or her practice) and who provide at least 30% of their services to “needy individuals” will be eligible for incentives. EPs cannot receive both Medicare and Medicaid incentives for EHR technology, but must instead choose one incentive program.

Eligible Medicaid EPs can receive incentive payments for up to 6 years beginning in 2011 and ending in 2021. The payment formula for the first year, in which the EP adopts, implements, or upgrades certified EHR technology is: 85% x Net Average Allowable Costs up to \$25,000, or a maximum payment of \$21,500. For subsequent years, in which the EP demonstrates meaningful use of the certified EHR technology, the incentive formula is: 85% x Net Average Allowable Costs up to \$10,000, or a maximum payment of \$8,500. For EPs who adopt certified EHR technology before 2011, the first year cap on Net Average Allowable Costs is \$10,000 instead of \$25,000. Thus, the maximum payment for EPs who qualify to receive incentives for a six year period between 2011 and 2021 is \$42,500 for early adopters (\$8,500 x 6) and \$63,750 for new adopters/implementers/upgraders (\$21,500 + (\$8,500 x 5)).

Hospital Eligibility and Incentives

Acute care hospitals with average lengths of stay less than 25 days and children’s hospitals are the only two types of institutions eligible to receive Medicaid incentive payments. Qualifying acute care hospitals must meet a minimum Medicaid patient threshold of 10%, calculated based on patient encounters (i.e., Medicaid Patient Encounters / Total Patient Encounters). There is no Medicaid patient volume requirement for children’s hospitals.

In contrast to EPs, hospitals may receive EHR incentive payments from both Medicare and Medicaid. The aggregate incentive payment for hospitals is determined according to the following formula, summed over a four year period: Overall EHR Amount x Medicaid Share. The Overall EHR Amount is calculated as follows: Base Amount (\$2,000,000) + Discharge Related Amount (\$200 x each discharge over 1,150 up to 23,000). The Medicaid Share is calculated using the following formula: (Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Bed Days) ÷ [(Total Inpatient Bed Days) x (Estimated Total Charges – Charity Care Charges) ÷ (Estimated Total Charges)].

For each of the four years used to calculate the incentive payment, a “transition factor” is applied to account for greater initial costs of EHR implementation, and diminishing costs over time. Thus, in years one through four, the total incentive amount calculated according to the formula above is stepped down using the transition factors as follows: 100% in year 1, 75% in year 2, 50% in year 3, and 25% in year 4. States may, based on their discretion, pay the aggregate incentive amount to hospitals over a minimum of three years and a maximum of six years.

Following is an example calculation of a hospital incentive payment provided in the Rule:

Overall EHR amount = Sum (Year 1, Year 2, Year 3, Year 4) = \$14,655,050

Year 1: {\$2,000,000 + ((20,000-1,149) x 200)} x 1 x 1 = \$5,770,200

Year 2: {\$2,000,000 + ((20,454-1,149) x 200)} x 1 x .75 = \$4,395,750

Year 3: {\$2,000,000 + ((20,918-1,149) x 200)} x 1 x .50 = \$2,976,900

Year 4: {\$2,000,000 + ((21,393-1,149) x 200)} x 1 x .25 = \$1,512,200

Medicaid Share: 34,000 / (100,000 x ((\$1,000,000,000 – \$200,000,000) / 1,000,000,000)) = 0.425

Overall EHR Amount x Medicaid Share = Medicaid aggregate EHR incentive amount  
\$14,655,050 x 0.425 = \$6,228,396.

**DEMONSTRATION OF  
MEANINGFUL USE**

The HITECH Act requires that as a condition of eligibility for the incentive payment, EPs and hospitals must demonstrate meaningful use of certified EHR technology. CMS proposes to

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create a common method for demonstrating meaningful use in both the Medicare and Medicaid EHR programs such as a one-time attestation through a secure mechanism such as claims based reporting or an online portal. EPs and hospitals would be required to identify the certified EHR technology used and the results of performance on all measures associated with the objectives of meaningful use.

### **HOSPITAL-BASED ELIGIBLE PROFESSIONALS**

Hospital-based EPs are not eligible for the Medicare incentive payments, nor are the majority eligible for Medicaid incentive payments. "Hospital-based eligible professional" means an EP, such as a pathologist, anesthesiologist, or emergency physician who furnishes substantially all of his or her Medicare-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or outpatient, through the use of facilities and equipment of the hospital. The determination is made on the basis of the site of service and without regard to the type of service provided or any employment or billing arrangement between the EP and any other provider.

CMS proposes to consider the place of service (POS) codes on physician claims to determine whether an EP furnishes substantially all of his or her professional services in a hospital setting and is, therefore, hospital-based. Generally, POS codes 21 (Inpatient Hospital), 22 (Outpatient Hospital), and 23 (Emergency Room, Hospital) will be used to determine whether an EP is hospital-based. An EP's claims history from the prior year will be annually analyzed.

The Stage 1 meaningful use criteria for eligible hospitals will apply only to a hospital's inpatient setting. Concerned that hospitals' investment in outpatient primary care sites will likely lag behind investment in inpatient EHR systems, CMS plans to consider ways to realign the meaningful use objectives and criteria to include a broader definition of hospital care to include outpatient services.

### **INFORMATION COLLECTION REQUIREMENTS**

CMS estimates there to be approximately 442,600 EPs, 5,011 eligible hospitals and CAHs, and 12 MAs from whom certain information will be required. The below projections are based on such numbers and take into account the mean hourly rate for the individuals compiling required information, such as physicians, secretaries, and attorneys.

### ICRs Regarding Demonstration of Meaningful Use Criteria

CMS proposes that to demonstrate meaningful use EPs, eligible hospitals, and CAHs must attest that: (1) certified EHR technology was used and specify the technology used; and (2) each of the applicable objectives and associated measures was satisfied. CMS estimates it will take each EP approximately one hour to provide the attestations for Meaningful Use Set A at an estimated cost burden of \$79.33 per EP or \$35,111,458 or all EPs, and approximately eight hours for Meaningful Use Set B at an estimated cost burden of \$644.64 or \$280,891,664 for all eligible EPs. CMS estimates the total cost burden to attest to EHR technology used and Meaningful Use Set A is \$29.99 per hospital or \$150,310 total, while the estimated cost burden for Meaningful Use Set B is estimated at \$419.86 per hospital or \$2,103,918 for all hospitals.

### ICRs Regarding Participation Requirements for EPs, Eligible Hospitals, and CAHs

In order for an EP, eligible hospital, or CAH to participate in the Medicare or Medicaid EHR incentive program, they must submit (1) their name; (2) the National Provider Identifier; (3) business address and phone; (4) Taxpayer Identification Number to which incentive payment should be made; and (5) CMS certification number for hospitals. CMS estimates it will take 0.5 hour to register, with an estimated cost burden of \$7.41 or \$37,106 for all hospitals, and \$39.67 or \$17,555,729 for all EPs. CMS proposes that EPs may switch from Medicare to Medicaid EHR incentive program or vice versa once, and only for payment year 2014 or before.

### ICRs Regarding Identification of Qualifying MA Organizations, MA-EPs and MA-affiliated Eligible Hospitals

Beginning with bids due in June 2010, MA organizations seeking reimbursement for qualifying MA EPs and qualifying MA-affiliated eligible hospitals under the MA EHR incentive program are required to identify themselves to CMS as part of submissions of initial bids. CMS estimates the total burden hours for all MA organizations to do so is three hours at a total cost burden of \$46.32. Additionally, qualifying MAs, starting in 2011, must make preliminary identification of potentially qualifying EPs and MA-affiliated eligible hospitals for which the organization is seeking incentive payment. The total burden hours for compliance is estimated at six at a total cost burden of \$359.88.

## Address Change . . .

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## ICRs Regarding Incentive Payments to Qualifying MA Organizations for MA-EPs and Hospitals

Qualifying MAOs must report to CMS within 30 days of the close of the calendar year the aggregate amount of revenue attributable to providing services that would otherwise be covered as professional services under Part B received by each qualifying MA EP for enrollees in MA plans or the MAO in the payment year. CMS believes it will take an MAO 40 hours annually to comply at a cost burden of \$617.60, or 480 hours for all MAOs with a total annual cost burden of \$7,411.

## ICRs Regarding Meaningful User Attestation

CMS proposes to require qualifying MA organizations to attest within thirty (30) days after the close of a calendar year whether each qualifying MA EP is a meaningful EHR user. The attestation is estimated to take 40 hours per year at a cost burden of \$2,399 or 480 hours and \$28,790 for all MA organizations.

## **CERTIFICATION STANDARDS**

On January 13, 2010, the Department of Health and Human Services (HHS) issued an interim final rule setting forth certification standards under the HITECH Act to support the achievement of meaningful use in Stage 1 (which begins in 2011) by eligible professionals and eligible hospitals under Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. This interim rule is effective in 30 days and public comment on the rule is permitted for 60 days.

Under HITECH, in order to qualify for the EHR incentives, an eligible professional or eligible hospital must (1) adopt Certified EHR Technology and (2) demonstrate meaningful use of such technology. The HHS issued this interim final rule to establish the certification standards for achieving Stage 1 meaningful use, which “focuses on electronically capturing health information in a coded format; using that information to track key clinical conditions and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible); consistent with other provisions of Medicare and Medicaid law, implementing clinical decision support tools to facilitate disease and medication management; and reporting clinical quality measures and public health information.”

In developing the interim final rule, the HHS has adopted definitions from pre-existing rules, such as HIPAA and the Public Health Service Act (PHSA), while recognizing that technology is a fluid industry that may progress faster than rule-

making. Additionally, the HHS is mindful that the technology field may allow market participants to develop full EHR systems or only parts thereof, referred to in the interim final rule as “EHR Modules”. Consequently, the HHS has defined Certified EHR Technology as “a Complete EHR or a combination of EHR Modules, each of which: 1) meets the requirements included in the definition of a Qualified EHR [as defined in 3000(13) of the PHSA]; and 2) has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary.”

Recognizing that eligible professionals and eligible hospitals may require different EHR Technology capabilities, the certification standards vary slightly for each (for example, eligible hospitals will need to have the capability of maintaining discharge records electronically, while such records are not applicable to eligible professionals). Using the proposed meaningful use Stage 1 objectives from the Medicare and Medicaid EHR Incentive Programs, the HHS developed certification criteria in a matrix, which depicts graphically the differences between those criteria specific to eligible professionals, eligible hospitals, or both. [See Table 1- Certification Criteria.](#)

These criteria generally require that Certified EHR Technology enable users to electronically record, store, retrieve and manage orders, generate drug checks against other drugs the patient may be taking and patient allergies, track care and medications over multiple office visits, record demographics, insurance information, vital signs, and smoking status of patients, incorporate test results, generate patient reminders for appointments for follow-up care, provide reports to applicable health agencies, and provide patients with access to their electronic health records.

Additionally, the certification standards adopt certain coding languages to promote standardization of the records across eligible providers and eligible hospitals; nonetheless, because the EHR also must be human readable, certain translation tools will be required to convert coding to its human-readable description. Finally, the certification standards prescribe that certain security measures be taken (e.g., user authentication, encryption, password protection, automatic log-off, access and revision logs, and disclosure logs) to ensure the integrity of the record and the security of the information contained therein.

This interim final rule provides a list of specifications that must be met in order to achieve Certified EHR Technology and in turn, achieve meaningful use in Stage 1 under the Medicare and

Medicaid EHR Incentive Programs and in doing so, assists not only eligible professionals and eligible hospitals in standardizing processes for achieving meaningful use, but also technology companies who will be developing the EHR Technology for such health care providers. These certification standards prescribe specific protocols and functionalities for such EHR Technology and should be closely followed by health care providers who wish to qualify for Medicare and Medicaid EHR Incentive Programs and software developers and service providers who wish to provide services to health care providers. Should you have specific questions about the certification standards or should you wish to provide public comment to this interim final rule, please feel free to contact us.

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