

# Washington Bulletin

Health care legislative and regulatory update

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## CMS and ONC Issue Rules Regarding Standards, Implementation Specifications and “Meaningful Use” for EHR Incentive Program

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) have issued two inter-related regulations regarding the meaningful use of certified electronic health record (EHR) technology. The regulations are mandated by the ***American Recovery and Reinvestment Act of 2009*** (ARRA).

Copies of both rules are available on-line. The 556 page proposed [CMS rule](#) is titled *Electronic Health Record Incentive Program* and the 136 page interim final [ONC rule](#) is titled *Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology*. Both rules are scheduled to be published in the ***Federal Register*** on January 13<sup>th</sup> and both provide a 60-day comment period. The ONC rule is effective 30 days after publication.

According to the preambles of the rules, the proposed CMS rule would “specify the initial criteria an eligible professional (EP) and eligible hospital must meet in order to qualify for the incentive payment; calculation of the incentive payment amounts; payment adjustments under Medicare for covered professional services and inpatient hospital services provided by EPs and eligible hospitals failing to meaningfully use certified EHR technology; and other program participation requirements.”

The ONC rule “represents the first step in an incremental approach to adopting standards, implementation specifications, and certification criteria to enhance the interoperability, functionality, utility, and security of health information technology and to support its meaningful use. The certification criteria adopted in this initial set establish the capabilities and related standards that certified electronic health record technology will need to include in order to, at a minimum, support the achievement of the proposed meaningful use Stage 1 (beginning in 2011) by eligible professionals and eligible hospitals under the Medicare and Medicaid EHR Incentive Programs.”

Incentive payments may begin as soon as October 2010 to eligible hospitals. Incentive payments to other eligible providers may begin in January 2011.

### Comment

These rules have been expected in as much as the ARRA required the agencies to provide an EHR meaningful use definition by the end of 2009. The material presented is detailed, contains many particulars and requires an in-depth review to understand all the parameters being addressed. While the rules discuss the merits and voluntary incentives of EHRs, they also point out that failure to adopt such will result in reductions in future hospital rates-of-increases and physician payment amounts.

## ONC Rule

The ONC rule provides a section-by-section description of the rule's regulations. Some key items are as follows:

**Definition of Standard** – ONC has chosen to define standard to mean: a technical, functional, or performance-based rule, condition, requirement, or specification that stipulates instructions, fields, codes, data, materials, characteristics, or actions.

**Definition of Implementation Specification** – ONC has adopted the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) regulatory definition of implementation specification without modification.

**Definition of Certification Criteria** – ONC has defined certification criteria to mean criteria that: 1) establish that health information technology meets applicable standards and implementation specifications adopted by the Secretary; or 2) that are used to test and certify that health information technology includes required capabilities.

**Definition of Qualified Electronic Health Record (EHR)** – Qualified EHR is defined at section 3000(13) of the *Public Health Service Act* (PHSA) as “an electronic record of health-related information on an individual that: (A) includes patient demographic and clinical health information, such as medical history and problem lists; and (B) has the capacity: (i) to provide clinical decision support; (ii) to support physician order entry; (iii) to capture and query information relevant to health care quality; and (iv) to exchange electronic health information with, and integrate such information from other sources.”

**Definition of EHR Module** – ONC has defined the term EHR Module to mean any service, component, or combination thereof that can meet the requirements of at least one certification criterion adopted by the Secretary.

**Definition of Complete EHR** – The term complete EHR is used to mean EHR technology that has been developed to meet all applicable certification criteria adopted by the Secretary.

**Definition of Certified EHR Technology** – ONC has defined Certified EHR Technology to mean a complete EHR or a combination of EHR Modules, each of which:

- 1) Meets the requirements included in the definition of a Qualified EHR; and
- 2) Has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary.

**Initial Set of Standards, Implementation Specifications, and Certification Criteria** – These sections describe the initial set of standards, implementation specifications, and certification criteria adopted by the Secretary to support, in part, the achievement of meaningful use Stage 1 (which begins in 2011) (as proposed in the Medicare and Medicaid EHR Incentive Programs proposed rule – see below).

Table 1 below displays the certification criteria ONC has adopted. Tables 2A and 2B include the standards referenced by adopted certification criteria for a particular exchange or privacy or security purpose.

**Table 1 – Certification Criteria**

Proposed Meaningful Use Stage 1 Objectives	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Professionals	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Hospitals
A Complete EHR or EHR Module must include the capability to:		
Use Computerized Provider Order Entry (CPOE) <sup>3</sup>	Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: 1. Medications; 2. Laboratory; 3. Radiology/imaging; and 4. Provider referrals.	Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: 1. Medications; 2. Laboratory; 3. Radiology/imaging; 4. Blood bank; 5. Physical therapy; 6. Occupational therapy; 7. Respiratory therapy; 8. Rehabilitation therapy; 9. Dialysis; 10. Provider consults; and 11. Discharge and transfer.
Implement drug-drug, drug-allergy, drug-formulary checks	1. Automatically and electronically generate and indicate (e.g., pop-up message or sound) in real-time, alerts at the point of care for drug-drug and drug-allergy contraindications based on medication list, medication allergy list, age, and CPOE.  2. Enable a user to electronically check if drugs are in a formulary or preferred drug list in accordance with the standard specified in Table 2A row 2.  3. Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking.  4. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.	
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®	Enable a user to electronically record, modify, and retrieve a patient’s problem list for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standards% specified in Table 2A row 1.	
Generate and transmit permissible prescriptions electronically (eRx)	Enable a user to electronically transmit medication orders (prescriptions) for patients in accordance with the standards specified in Table 2A row 3.	No Associated Proposed Meaningful Use Stage 1 Objective
Maintain active medication list	Enable a user to electronically record, modify, and retrieve a patient’s active medication list as well as medication history for longitudinal care (i.e., over multiple office visits) in accordance with the applicable standard specified in Table 2A row 1.	
Maintain active medication allergy list	Enable a user to electronically record, modify, and retrieve a patient’s active medication allergy list as well as medication allergy history for longitudinal care (i.e., over multiple office visits).	
Record demographics <sup>4,5</sup>	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, and date of birth.	Enable a user to electronically record, modify, and retrieve patient demographic data including preferred language, insurance type, gender, race, ethnicity, date of birth, and date and cause of death in the event of mortality.

Proposed Meaningful Use Stage 1 Objectives	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Professionals	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Hospitals
A Complete EHR or EHR Module must include the capability to:		
Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• height</li> <li>• weight</li> <li>• blood pressure</li> <li>• calculate and display: BMI</li> <li>• plot and display growth charts for children 2-20 years, including BMI</li> </ul>	<ol style="list-style-type: none"> <li>1. Enable a user to electronically record, modify, and retrieve a patient’s vital signs including, at a minimum, the height, weight, blood pressure, temperature, and pulse.</li> <li>2. Automatically calculate and display body mass index (BMI) based on a patient’s height and weight.</li> <li>3. Plot and electronically display, upon request, growth charts (height, weight, and BMI) for patients 2-20 years old.</li> </ol>	
Record smoking status for patients 13 years old or older	Enable a user to electronically record, modify, and retrieve the smoking status of a patient to: current smoker, former smoker, or never smoked.	
Incorporate clinical lab-test results into EHR as structured data	<ol style="list-style-type: none"> <li>1. Electronically receive clinical laboratory test results in a structured format and display such results in human readable format.</li> <li>2. Electronically display in human readable format any clinical laboratory tests that have been received with LOINC® codes.</li> <li>3. Electronically display all the information for a test report specified at 42 CFR 493.1291(c)(1) through (7).<sup>6</sup></li> <li>4. Enable a user to electronically update a patient’s record based upon received laboratory test results.</li> </ol>	
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Enable a user to electronically select, sort, retrieve, and output a list of patients and patients’ clinical information, based on user-defined demographic data, medication list, and specific conditions.	
Report quality measures to CMS or the States <sup>7,8</sup>	<ol style="list-style-type: none"> <li>1. Calculate and electronically display quality measure results as specified by CMS or states.</li> <li>2. Enable a user to electronically submit calculated quality measures in accordance with the standard specified in Table 2A row 5.</li> </ol>	
Send reminders to patients per patient preference for preventive/ follow up care	Electronically generate, upon request, a patient reminder list for preventive or follow-up care according to patient preferences based on demographic data, specific conditions, and/or medication list.	No Associated Proposed Meaningful Use Stage 1 Objective
Implement 5 clinical decision support Rules <sup>9,10</sup>	<ol style="list-style-type: none"> <li>1. Implement automated, electronic clinical decision support rules (in addition to drug-drug and drug-allergy contraindication checking) according to specialty or clinical priorities that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list.</li> <li>2. Automatically and electronically generate</li> </ol>	<ol style="list-style-type: none"> <li>1. Implement automated, electronic clinical decision Support rules (in addition to drug-drug and drug-allergy contraindication checking) according to a high priority Hospital condition that use demographic data, specific patient diagnoses, conditions, diagnostic test results and/or patient medication list.</li> <li>2. Automatically and electronically generate and Indicate (e.g., pop-up message or sound) in real-time,</li> </ol>

Proposed Meaningful Use Stage 1 Objectives	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Professionals	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Hospitals
	<p>A Complete EHR or EHR Module must include the capability to:</p> <p>and indicate (e.g., pop-up message or sound) in real-time, alerts and care suggestions based upon clinical decision support rules and evidence grade.</p> <p>3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.</p>	<p>alerts and care suggestions based upon clinical decision support rules and evidence grade.</p> <p>3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.</p>
Check insurance eligibility electronically from public and private payers	Enable a user to electronically record and display patients' insurance eligibility, and submit insurance eligibility queries to public or private payers and receive an eligibility response in accordance with the applicable standards specified in Table 2A row 4.	
Submit claims electronically to public and private payers	Enable a user to electronically submit claims to public or private payers in accordance with the applicable standards specified in Table 2A row 4.	
Provide patients with an electronic copy of their health information upon request <sup>11,12</sup>	Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in: 1) human readable format; and 2) accordance with the standards% specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.	Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, discharge summary, and procedures in: 1) human readable format; and 2) accordance with the standards% specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.
Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	No Associated Proposed Meaningful Use Stage 1 Objective	Enable a user to create an electronic copy of the discharge instructions and procedures for a patient, in human readable format, at the time of discharge to provide to a patient on electronic media, or through some other electronic means.
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the eligible professional	Enable a user to provide patients with online access to their clinical information, including, at a minimum, lab test results, problem list, medication list, medication allergy list, immunizations, and procedures.	No Associated Proposed Meaningful Use Stage 1 Objective
Capability to exchange key clinical information among providers of care and patient authorized entities electronically <sup>13,14</sup>	1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard	1. Electronically receive a patient summary record, from other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures and upon receipt of a patient summary record formatted in an alternative standard specified in Table 2A row 1, displaying it in human readable format.

Proposed Meaningful Use Stage 1 Objectives	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Professionals	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Hospitals
	A Complete EHR or EHR Module must include the capability to:	
Provide summary care record for each transition of care and referral	<p>specified in Table 2A row 1, displaying it in human readable format.</p> <p>2. Enable a user to electronically transmit a patient summary record to other providers and organizations including, at a minimum, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards% specified in Table 2A row 1.</p>	<p>2. Enable a user to electronically transmit a patient summary record, to other providers and organizations including, at a minimum, discharge summary, diagnostic test results, problem list, medication list, medication allergy list, immunizations, and procedures in accordance with the standards% specified in Table 2A row 1.</p>
Perform medication reconciliation at relevant encounters and each transition of care	Electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real-time.	
Capability to submit electronic data to immunization registries and actual submission where required and accepted	Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with the standards% specified in Table 2A row 8 or in accordance with the applicable state-designated standard format.	
Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	No Associated Proposed Meaningful Use Stage 1 Objective	Electronically record, retrieve, and transmit reportable clinical lab results to public health agencies in accordance with the standards% specified in Table 2A row 6.
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Electronically record, retrieve, and transmit syndrome-based (e.g., influenza like illness) public health surveillance information to public health agencies in accordance with the standards specified in Table 2A row 7.	
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	<ol style="list-style-type: none"> <li>1. Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information.</li> <li>2. Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.</li> <li>3. Terminate an electronic session after a predetermined time of inactivity.</li> <li>4. Encrypt and decrypt electronic health information according to user-defined preferences (e.g., backups, removable media, at log-on/off) in accordance with the standard specified in Table 2B row 1.</li> <li>5. Encrypt and decrypt electronic health information when exchanged in accordance with the standard specified in Table 2B row 2.</li> <li>6. Record actions (e.g., deletion) related to electronic health information in accordance with the standard specified in Table 2B row 3 (i.e., audit log), provide alerts based on user-defined events, and electronically display and print all or a specified set of recorded information upon request or at a</li> </ol>	

Proposed Meaningful Use Stage 1 Objectives	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Professionals	Certification Criteria to Support the Achievement of Meaningful Use Stage 1 by Eligible Hospitals
	A Complete EHR or EHR Module must include the capability to:  set period of time. 7. Verify that electronic health information has not been altered in transit and detect the alteration and deletion of electronic health information and audit logs in accordance with the standard specified in Table 2B row 4. 8. Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information. 9. Verify that a person or entity seeking access to electronic health information across a network is the one claimed and is authorized to access such information in accordance with the standard specified in Table 2B row 5. 10. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in Table 2B row 6.	

3 For eligible hospitals the full proposed meaningful use Stage 1 objective is: “Use CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP).”

4 For eligible professionals the full proposed meaningful use Stage 1 objective is: “record demographics: preferred language, insurance type, gender, race, ethnicity, date of birth.”

5 For eligible hospitals the full proposed meaningful use Stage 1 objective is: “record demographics: preferred language, insurance type, gender, race, ethnicity, date of birth, date and cause of death in the event of mortality.”

6 42 CFR 493.1291(b) specifies that “[t]he test report information maintained as part of the patient’s chart or medical record must be readily available to the laboratory and to CMS or a CMS agent upon request.” 42 CFR 493.1291(c) specifies the required test report information.

7 For eligible professionals the full proposed meaningful use Stage 1 objective is “Report ambulatory quality measures to CMS or the States.”

8 For eligible hospitals the full proposed meaningful use Stage 1 objective is “Report hospital quality measures to CMS or the States.”

9 For eligible professionals the full proposed meaningful use Stage 1 objective is “Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules”

10 For eligible hospitals the full proposed meaningful use Stage 1 objective is “Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules”

11 For eligible professionals the full proposed meaningful use Stage 1 objective is “Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request”

12 For eligible hospitals the full proposed meaningful use Stage 1 objective is “Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request”

The initial set of standards and implementation specifications was adopted to support the proposed requirements for meaningful use Stage 1. ONC has added a column in Table 2A to illustrate the standards that it believes Certified EHR Technology should most likely be capable of to support meaningful use Stage 2(although as explained in the Medicare and Medicaid EHR Incentives Program proposed rule, CMS intends to engage in rulemaking to adopt Stage 2 criteria for meaningful use and ONC would adopt standards consistent with this effort).

Table 2A below displays the applicable adopted standards for each exchange purpose specified. ONC has used “Cx” and “V” as shorthand for “content exchange” and “vocabulary,” respectively, to identify which standard category applies to the exchange purpose. Where a cell in table 2A includes the reference “no standard adopted at this time” it means that a Complete EHR or EHR Module would not be required to be tested and certified as including a particular standard. As a result, any local or proprietary standard could be used as well as the standard(s) listed as candidate meaningful use Stage 2 standards. Unless marked with the following superscripts, all of the adopted standards are from the ONC process that took place prior to the enactment of the HITECH Act or are required by other HHS regulations.

- A number sign “#” indicates that the HIT Standards Committee recommended this standard to the National Coordinator but it was not part of the prior ONC process.
- An asterisk “\*” indicates that the standard was neither recommended by the HIT Standards Committee nor part of the prior ONC process.
- A plus sign “+” indicates a standard that is not a voluntary consensus standard.

**Table 2A – Adopted Content Exchange and Vocabulary Standards**

Row #	Purpose	Category	Adopted Standard(s) to Support Meaningful Use Stage 1	Candidate Standard(s) to Support Meaningful Use Stage 2
1	<b>Patient Summary Record</b>	Cx	HL7 CDA R2 CCD Level 2 or ASTM CCR	Alternatives expected to be narrowed based on HIT Standards Committee recommendations
	• Problem List	V	Applicable HIPAA code set required by law (i.e., ICD-9-CM); or SNOMED CT®	Applicable HIPAA code set required by law (e.g., ICD-10-CM) or SNOMED CT®
	• Medication List	V	Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+	RxNorm
	• Medication Allergy List	V	No standard adopted at this time.	UNII
	• Procedures	V	Applicable HIPAA code sets required by law (i.e., ICD-9-CM or CPT-4®)	Applicable HIPAA code sets required by law (i.e., ICD-10-PCS or CPT-4®)
	• Vital Signs	V	No standard adopted at this time.	CDA template
	• Units of Measure	V	No standard adopted at this time	UCUM
	• Lab Order Results	V	LOINC® when LOINC® codes have been received from a laboratory	LOINC®
2	<b>Drug Formulary Check</b>	Cx	Applicable Part D standard required by law (i.e., NCPDP Formulary & Benefits Standard 1.0)	Applicable Part D standard required by law
3	<b>Electronic Prescribing</b>	Cx	Applicable Part D standard required by law (e.g., NCPDP SCRIPT 8.1) or NCPDP SCRIPT 8.1 and NCPDP SCRIPT 10.6	NCPDP SCRIPT 10.6
		V	Any code set by an RxNorm drug data source provider that is identified by the United States National Library of Medicine as being a complete data set integrated within RxNorm+	RxNorm
4	<b>Administrative</b>	Cx	Applicable HIPAA transaction	Applicable HIPAA

Row #	Purpose	Category	Adopted Standard(s) to Support Meaningful Use Stage 1	Candidate Standard(s) to Support Meaningful Use Stage 2
	<i>Transactions</i>		standards required by law	transaction standards required by law
5	<i>Quality Reporting</i>	Cx	CMS PQRI 2008 Registry XML Specification#,+	Potentially newer version(s) or standards based on HIT Standards Committee Input
6	<i>Submission of Lab Results to Public Health Agencies</i>	Cx	HL7 2.5.1	Potentially newer version(s) or standards based on HIT Standards Committee Recommendations
		V	LOINC® when LOINC® codes have been received from a laboratory	LOINC®, UCUM, and SNOMED CT® or Applicable Public Health Agency Requirements
7	<i>Submission to Public Health Agencies for Surveillance or Reporting</i> <i>(excluding adverse event reporting)</i>	Cx	HL7 2.3.1 or HL7 2.5.1	Potentially newer version(s) or standards based on HIT Standards Committee Input
		V	According to Applicable Public Health Agency Requirements	GIPSE or According to Applicable Public Health Agency Requirements
8	<i>Submission to Immunization Registries</i>	Cx	HL7 2.3.1 or HL7 2.5.1	Potentially newer version(s) or standards based on HIT Standards Committee Recommendations
		V	CVX*,+	CVX

Table 2B – Adopted Privacy and Security Standards

Row #	Purpose	Adopted Standard
1	<i>General Encryption and Decryption of Electronic Health Information</i>	A symmetric 128 bit fixed-block cipher algorithm capable of using a 128, 192, or 256 bit encryption key must be used (e.g., FIPS 197 Advanced Encryption Standard, (AES), Nov 2001).+
2	<i>Encryption and Decryption of Electronic Health Information for Exchange</i>	An encrypted and integrity protected link must be implemented (e.g., TLS, IPv6, IPv4 with IPsec). +
3	<i>Record Actions Related to Electronic Health Information (i.e., audit log)</i>	The date, time, patient identification (name or number), and user identification (name or number) must be recorded when electronic health information is created, modified, deleted, or printed. An indication of which action(s) occurred must also be recorded (e.g., modification).+
4	<i>Verification that Electronic Health Information has not been Altered in Transit</i>	A secure hashing algorithm must be used to verify that electronic health information has not been altered in transit. The secure hash algorithm used must be SHA-1 or higher (e.g., Federal Information Processing Standards (FIPS) Publication (PUB) Secure Hash Standard (SHS) FIPS PUB 180-3).+
5	<i>Cross-Enterprise Authentication</i>	Use of a cross-enterprise secure transaction that contains sufficient identity information such that the receiver can make access control decisions and produce detailed and accurate security audit trails (e.g., IHE Cross Enterprise User Assertion (XUA) with SAML identity assertions).+

Row #	Purpose	Adopted Standard
6	<i>Record Treatment, Payment, and Health Care Operations Disclosures</i>	The date, time, patient identification (name or number), user identification (name or number), and a description of the disclosure must be recorded.+

## CMS Proposal

The CMS proposed rule would define the term "meaningful EHR user" as an eligible professional (EP) or eligible hospital that, during the specified reporting period, demonstrates meaningful use of certified EHR technology in a form and manner consistent with certain objectives and measures presented in the regulation.

The rule proposes a definition that would apply to EPs participating in the Medicare fee-for-service (FFS) and the Medicare Advantage (MA) EHR incentive programs as well as a proposed definition that would apply to eligible hospitals and critical access hospitals.

These definitions also would serve as the minimum standard for eligible professionals and eligible hospitals participating in the Medicaid EHR incentive program. The rule proposes that states could request CMS approval to implement additional meaningful use measures, as appropriate, but could not request approval of fewer or less rigorous meaningful use measures than required by this rule.

This rule proposes a phased approach to implement the proposed requirements for demonstrating meaningful use. This approach would initially establish reasonable criteria for meaningful use based on currently available technological capabilities and providers' practice experience. CMS says it will establish stricter and more extensive criteria for demonstrating meaningful use over-time, as anticipated developments in technology and providers' capabilities occur.

Under all three EHR incentive programs, EPs and eligible hospitals must utilize "certified EHR technology" if they are to be considered eligible for the incentive payments.

For all EPs, CMS is proposing a common definition for both "payment year" and "year of payment," as "any calendar year beginning with 2011"

For purposes of the incentive payments made to eligible hospitals under the Medicare FFS, MA and Medicaid EHR incentive programs, CMS is proposing to define payment year and year of payment as "any fiscal year beginning with 2011".

For the first payment year only, CMS proposes to define the term EHR reporting period to mean any continuous 90-day period within a payment year in which an EP or eligible hospital successfully demonstrates meaningful use of certified EHR technology. Starting with the second payment year and any subsequent payment years for a given EP or eligible hospital, CMS would define the term EHR reporting period to mean the entire payment year.

CMS says that given the strong level of interaction on meaningful use encouraged by the *HITECH Act*, there would need to be a compelling reason to create separate definitions for Medicare and Medicaid. Therefore, CMS is proposing to create a common definition of meaningful use that would serve as the definition for providers participating in the Medicare FFS and MA EHR incentive program, and the minimum standard for EPs and eligible hospitals participating in the Medicaid EHR incentive program.

CMS is proposing to phase-in the criteria for defining “meaningful user.” Over time, the criteria will become more inclusive. The table below outlines CMS’ proposal to apply the respective criteria of meaningful use for each payment year (1st, 2nd, 3rd, etc.) for both EPs and eligible hospitals that become meaningful EHR users before 2015.

**Stage of Meaningful Use Criteria by Payment Year**

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

**Stage 1 Criteria for Meaningful Use**

To qualify as a meaningful EHR user for 2011, CMS proposes that an EP or eligible hospital must demonstrate that they meet all of the (5) objectives and their associated measures as reflected in the table below and also reflected in the ONC criteria:

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible Professionals	Hospitals	
Improving quality, safety, efficiency, and reducing health disparities	Provide access to comprehensive patient health data for patient's health care team	Use CPOE	Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	For EPs, CPOE is used for at least 80% of all orders  For eligible hospitals, CPOE is used for 10% of all orders
	Use evidence-based order sets and CPOE	Implement drug-drug, drug-allergy, drug-formulary checks	Implement drug-drug, drug-allergy, drug-formulary checks	The EP/eligible hospital has enabled this functionality
	Apply clinical decision support at the point of care	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT ®	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data
		Generate and transmit permissible prescriptions electronically (eRx)		At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible		
		Professionals	Hospitals	
	Generate lists of patients who need care and use them to reach out to patients  Report information for quality improvement and public reporting	Maintain active medication list	Maintain active medication list	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data
		Maintain active medication allergy list	Maintain active medication allergy list	At least 80% of all unique patients seen, by the EP or admitted to the eligible hospital have at least one entry or (an indication of "none" if the patient has no medication allergies) recorded as structured data
		Record demographics <ul style="list-style-type: none"> <li>• preferred language</li> <li>• insurance type</li> <li>• gender</li> <li>• race</li> <li>• ethnicity</li> <li>• date of birth</li> </ul>	Record demographics <ul style="list-style-type: none"> <li>• preferred language</li> <li>• insurance type</li> <li>• gender</li> <li>• race</li> <li>• ethnicity</li> <li>• date of birth</li> <li>• date and cause of death in the event of mortality</li> </ul>	At least 80% of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data
		Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• height</li> <li>• weight</li> <li>• blood pressure</li> <li>• Calculate and display: BMI</li> <li>• Plot and display growth charts for children 2-20 years, including BMI.</li> </ul>	Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• height</li> <li>• weight</li> <li>• blood pressure</li> <li>• Calculate and display: BMI</li> <li>• Plot and display growth charts for children 2-20 years, including BMI.</li> </ul>	For at least 80% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital, record blood pressure and BMI; additionally plot growth chart for children age 2-20
		Record smoking status for patients 13 years old or older	Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital have "smoking status" recorded
		Incorporate clinical	Incorporate clinical	At least 50% of all clinical lab

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible		
		Professionals	Hospitals	
		lab-test results into EHR as structured data	lab-test results into EHR as structured data	tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
		Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP or eligible hospital with a specific condition
		Report ambulatory quality measures to CMS or the States	Report hospital quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule  For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule
		Send reminders to patients per patient preference for preventive/ follow up care		Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over
		Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules related to a high priority hospital condition, including diagnostic test ordering, along with the ability to track compliance with those rules	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP/eligible hospital is responsible for as described further in section II(A)(3).
		Check insurance eligibility electronically from public and private payers	Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital
		Submit claims electronically to public and private payers.	Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP or the eligible hospital
<b>Engage patients and families in their health care</b>	Provide patients and families with timely access to data, knowledge,	Provide patients with an electronic copy of their health information (including	Provide patients with an electronic copy of their health information	At least 80% of all patients who request an electronic copy of their health information are provided it

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible		
		Professionals	Hospitals	
	and tools to make informed decisions and to manage their health	diagnostic test results, problem list, medication lists, allergies), upon request	(including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request	within 48 hours
			Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request	At least 80% of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it
		Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP		At least 10% of all unique patients seen by the EP are provided timely electronic access to their health Information
		Provide clinical summaries for patients for each office visit		Clinical summaries are provided for at least 80% of all office visits
<b>Improve care coordination</b>	Exchange meaningful clinical information among professional health care team	Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible		
		Professionals	Hospitals	
		Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
		Provide summary care record for each transition of care and referral	Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals
Improve population and public health	Communicate with public health agencies	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
			Capability to provide electronic submission of reportable lab results (as required by state or local law) to public health agencies and actual submission where it can be received	Performed at least one test of the EHR system's capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically)
		Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP or eligible hospital submits such information have the capacity to receive the information electronically)

Health Outcomes Policy Priority	Care Goals	Stage 1 Objectives		Stage 1 Measures
		Eligible		
		Professionals	Hospitals	
<b>Ensure adequate privacy and security protections for personal health information</b>	Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law  Provide transparency of data sharing to patient	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary

For 2011, CMS proposes that EPs and eligible hospitals use an attestation methodology to submit summary information to CMS on clinical quality measures as a condition of demonstrating meaningful use of certified EHR technology. CMS proposes to first require the electronic submission of information on clinical quality measures in 2012. Although CMS does not propose to require clinical quality measure reporting electronically until 2012, CMS says it is proposing to begin clinical quality reporting through attestation in the 2011 payment year.

The rules tables 3-20 provide the detailed clinical quality measures that will be required in 2012.

### Medicare Eligible Professionals (EPs)

A Medicare EP is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor, who is legally authorized to practice under state law. A qualifying EP is one who demonstrates meaningful use for the EHR reporting period.

By law, hospital-based EPs who furnish substantially all their services in a “hospital setting” are **not** eligible for incentive payments. CMS proposes that a hospital-based EP be defined as an EP who furnishes 90 percent or more of his/her allowed services in a hospital, including all hospital inpatient, outpatient, and emergency department settings.

A qualifying EP can receive EHR incentive payments for up to five years with payments beginning as early as 2011. A qualifying EP will receive an incentive payment equal to 75 percent of Medicare allowable charges for covered professional services furnished by the EP in a payment year, subject to maximum payments. In general, the maximum amount of total incentive payments that an EP can receive under the Medicare program is \$44,000.

An EP who predominantly furnishes services in a geographic Health Professional Shortage Area is eligible for a 10 percent increase in the maximum incentive payment amount. The maximum amount of total incentive payments that such an EP can receive under the Medicare program is \$48,400.

The following table shows the maximum incentive payment amounts available to EPs under Medicare FFS.

**Maximum Total Amount of EHR Incentive Payments for a Medicare EP who does not Predominantly Furnish Services in a Health Professional Shortage Area**

Calendar Year	First CY in which the EP Receives an Incentive Payment				
	2011	2012	2013	2014	2015 - subsequent years
2011	\$18,000	-----	-----	-----	-----
2012	\$12,000	\$18,000	-----	-----	-----
2013	\$8,000	\$12,000	\$15,000	-----	-----
2014	\$4,000	\$8,000	\$12,000	\$12,000	-----
2015	\$2,000	\$4,000	\$8,000	\$8,000	\$0
2016	-----	\$2,000	\$4,000	\$4,000	\$0
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0

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 (including the fee schedule amount for purposes of determining a payment based on the fee schedule amount) is adjusted to equal the 'applicable percent' of the fee schedule amount (defined below) that would otherwise apply. The payment adjustments will not apply to hospital-based EPs.

The term 'applicable percent' means: “(I) 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 under section 1848(a)(5) for 2014, 98 percent);” “(II) for 2016, 98 percent; and (III) 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.

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 program selection only once during payment years 2012 through 2014.

**Medicare Eligible 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. The statutory definition of a subsection (d) hospital does not apply to hospitals and hospital units excluded under section 1886(d)(1)(B) from the IPPS, such as psychiatric, rehabilitation, long term care, children's, and cancer hospitals. FY 2015 is the last year for which an eligible hospital can begin receiving incentive payments for meaningful EHR use.

Eligible hospitals may receive incentive payments for up to four years for fiscal years beginning October 2010, provided they meet the requirements for demonstrating meaningful use.

Eligible hospitals can qualify to receive payments from both the Medicare and Medicaid EHR incentive programs.

CMS proposes that, for the first year an eligible hospital demonstrates meaningful EHR use, an EHR Reporting Period equals any 90 continuous days 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.

The initial amount of the incentive is the sum of a “base amount,” – \$2,000,000 and a sum based upon total discharges up to the 23,000th discharge adjusted for the portion of Medicare as follows:

- (i) For the first through the 1,149<sup>th</sup> discharge, \$0.
- (ii) For the 1,150<sup>th</sup> through the 23,000<sup>th</sup> discharge, \$200.
- (iii) For any discharge greater than the 23,000<sup>th</sup>, \$0.

CMS provides the following formula:

### **Incentive Payment Calculation for Subsection D Hospitals**

Incentive Amount = [Initial Amount] x [Medicare Share] x [Transition Factor]

**Initial Amount** = \$2,000,000 + [\$200 per discharge for the 1,150<sup>th</sup> – 23,000<sup>th</sup> discharge]

Medicare Share =  $Medicare / (Total * Charity\ Care) = [M / (T * C)]$

**M** = [# of Inpatient Bed Days for Part A Beneficiaries] + [# of Inpatient Bed Days for MA Beneficiaries]

**T** = [# of Total Inpatient Bed Days]

**C** = [Total Charges – Charges for Charity Care\*] / [Total Charges]

\*If data on charity care is not available, then the Secretary would use data on uncompensated care as a proxy. If the proxy data is not also available, then “C” would be equal to 1.

CMS would define charity care as part of uncompensated and indigent care described for Medicare cost reporting purposes in the Medicare cost report instructions at section 4012 of the Provider Reimbursement Manual (PRM), Part 2; Worksheet S-10; Hospital Uncompensated and Indigent Care Data.

The revised instructions for line 19 of Worksheet S-10 state the following:

Enter the total initial payment obligation of patients who are given a full or partial discount, based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), this is the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

The initial amount must be multiplied not only by the Medicare share fraction, but also by an applicable transition factor in order to determine the incentive payment to an eligible hospital for an incentive payment

year. The applicable transition factor equals 1 for the first payment year, three-fourths for the second payment year, one-half for the third payment year, one-fourth for the fourth payment year, and zero thereafter.

The following table shows the possible years an eligible hospital could receive an incentive payment and the transition factor applicable to each year.

**Transaction Factor for Medicare FFS Eligible Hospitals**

Fiscal Year	Fiscal Year that Eligible Hospital First Receives the Incentive Payment				
	2011	2012	2013	2014	2015
2011	1.00	-----	-----	-----	-----
2012	0.75	1.00	-----	-----	-----
2013	0.50	0.75	1.00	-----	-----
2014	0.25	0.50	0.75	0.75	-----
2015	-----	0.25	0.50	0.50	0.50
2016	-----	-----	0.25	0.25	0.25

The current reduction of 2.0 percent to the IPPS annual update for failure to report quality data is modified. Beginning in FY 2015, the failure to report quality data information becomes 0.5 percent and 1.5 percent will become subject to being a meaning full EHR user.

For FY 2015 and each subsequent FY, an eligible hospital that is not “a meaningful EHR user for an EHR reporting period will receive a reduced update to the IPPS standardized amount.

For FY 2015 and each subsequent FY, the reduction to three-quarters of the applicable update will be 33 1/3 percent for FY 2015, 66 2/3 percent for FY 2016, and 100 percent for FY 2017 and each subsequent FY.

**Critical Access Hospitals (CAHs)**

A qualifying CAH is a certified critical access hospital that meets the definition of a meaningful EHR user.

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.

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 percent; or (2) the sum of the Medicare share fraction for the CAH and 20 percentage points.

If a CAH is not a meaningful EHR user during the cost reporting period beginning in FY 2015, its reimbursement will be reduced from 101 percent of its reasonable costs to 100.66 percent. For FY 2016, the percentage is reduced to 100.33 percent. For FY 2017 and each subsequent FY, the percentage of reimbursement is reduced to 100 percent of reasonable costs

The amount of the incentive payment made to a qualifying CAH represents the expensing and payment of the reasonable costs of certified EHR technology computed in a single payment year. The Medicare contractor will review the CAH's current year and each subsequent year's cost report to ensure that the assets associated with the acquisition of certified EHR technology are expensed in a single period and that depreciation and interest expenses associated with the acquisition are not allowed.

## Medicaid Incentives

CMS would provide to States (1) 90 percent Federal Financial Participation (FFP) for State expenditures related to the administration of an EHR incentive program for certain Medicaid providers that are adopting, implementing, or upgrading and meaningfully using certified EHR technology; and (2) 100 percent FFP for State expenditures for those incentive payments.

Only certain Medicaid providers will be eligible for EHR incentive payments.

The following Medicaid providers are eligible to participate in the incentives program:

(1) Medicaid EPs which are limited to the following individuals.

A physician

A dentist

A certified nurse-midwife

A nurse practitioner

A physician assistant practicing in a Federally Qualified Health Center or Rural Health Clinic, which is so led by a physician assistant

(2) Acute care hospitals.

(3) Children's hospitals.

EPs

To qualify for an EHR incentive payment, a Medicaid EP must not be hospital-based. Have a minimum 30 percent patient volume attributable to individuals receiving Medicaid; or, if a pediatrician have a minimum 20 percent patient volume attributable to individuals receiving Medicaid; or practice predominantly in a Federally Qualified Health Center or Rural Health Clinic and have a minimum 30 percent patient volume attributable to needy individuals.

Acute Care Hospitals

CMS is proposing that for purposes of Medicaid incentive payments, an "acute care hospital" is defined as: a health care facility where the average length of patient stay is 25 days or fewer. This definition also includes some specialty hospitals where the average length of stay is 25 days or fewer. This definition of acute care hospitals will exclude specialty providers and long-term care facilities where the average patients' length of stay exceeds 25 days.

CMS is using CMS Certification Numbers (CCNs) to define acute care Medicaid hospitals. CCNs are structured such that the first two digits represent the State in which the hospital is located, and the next four digits identify the type of facility and are assigned sequentially from the appropriate block of numbers. Short-stay general hospitals receive CCNs whose number range is 0001-through 0879. The 11 cancer hospitals in the United States also are issued CCNs within this number range.

An acute care hospital must have at least a 10 percent Medicaid patient volume for each year for which the hospital seeks an EHR incentive payment. A children's hospital is exempt from meeting a patient volume threshold.

Children's Hospitals

CMS notes that while the Act specifically includes children’s hospitals as eligible for the Medicaid incentive, it does not provide a definition of a children’s hospital.

CMS is defining a children's hospital as a separately certified children's hospital, either freestanding or hospital-within-hospital that—

- (1) Has a CNN that has the last 4 digits in the series 3300-3399; and
- (2) Predominantly treats individuals under 21 years of age.

The following table demonstrates the various maximum incentive payment amounts for Medicaid professionals.

**Maximum Incentive Payment Amount for Medicaid Professionals**

Cap on Net Average Allowable Costs, per the HITECH Act	85 percent Allowed for Eligible Professionals	Maximum Cumulative Incentive over 6-year Period
\$25,000 in Year 1 for most professionals	\$21,250	\$63,750
\$10,000 in Years 2-6 for most professionals	\$8,500	
\$16,667 in Year 1 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$14,167	\$42,500
\$6,667 in Years 2-6 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$5,667	

The following table demonstrates the payment scenarios available to a Medicaid EP who begins in their first year by adopting, implementing, or upgrading certified EHR technology.

**Payment Scenarios for Medicaid EPs Who Begin Adoption in the First Year**

Calendar Year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	\$21,250					
2012	\$8,500	\$21,250				
2013	\$8,500	\$8,500	\$21,250			
2014	\$8,500	\$8,500	\$8,500	\$21,250		
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018			\$8,500	\$8,500	\$8,500	\$8,500
2019				\$8,500	\$8,500	\$8,500
2020					\$8,500	\$8,500
2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

The two tables above do not represent EPs whose incentive payments may be reduced because their net average allowable costs may actually be lower than \$25,000 in the first year, or \$10,000 in subsequent years ( $\$25,000 * 0.85 = \$21,250$ ;  $\$10,000 * 0.85 = \$8,500$ ).

States may pay children's hospitals and acute care hospitals up to 100 percent of an aggregate EHR hospital incentive amount provided over a minimum of a 3-year period and a maximum of a 6-year period. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share. The aggregate EHR hospital incentive amount is the total amount the hospital could receive in Medicaid payments over 4 years of the program.

The Medicaid EHR incentive program is equal to the sum over 4 years of (I)(a) the base amount (defined by statute as \$2,000,000); plus (b) the discharge related amount defined as \$200 for the 1,150<sup>th</sup> through the 23,000<sup>th</sup> discharge for the first payment year (for subsequent payments years, States must assume discharges increase by the provider's average annual rate of growth for the most recent 3 years for which data are available per year): multiplied by (II) the transition factor for each year equals 1 in year 1,  $\frac{3}{4}$  in year 2,  $\frac{1}{2}$  in year 3, and  $\frac{1}{4}$  in year 4.

The statute specifies that the payment year is determined based on a Federal fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the payment year.

The aggregate EHR incentive calculation for Medicaid eligible hospitals is represented mathematically as follows:

(Overall EHR Amount) \* (Medicaid Share)

or

{Sum over 4 year of [(Base Amount+ Discharge Related Amount Applicable for Each Year)  
\* Transition Factor Applicable for Each Year]}  
\* {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) / [(total inpatient-bed days) \*  
(estimated total charges – charity care charges)/(estimated total charges)]}

CMS has provided the following sample calculation of the aggregate EHR hospital amount.

Assume the following as constant over four years except where noted:

20,000 discharges (Assumes growth rates of .0227 for year 2, .0227 for year 3, and .0227 for year 4)

- 34,000 inpatient Medicaid bed-days (including fee-for-service and managed care days)
- 100,000 total inpatient bed-days
- \$1,000,000,000 in total charges
- \$200,000,000 in charity care
- Overall EHR amount = Sum (Year 1, Year 2, Year 3, Year 4) = \$14,655,050

Year 1:  $\{\$2,000,000 + ((20,000-1,149) \times \$200)\} \times 1 \times 1.0 = \$5,770,200$

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

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

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

Medicaid Share:  $34,000 / (100,000 \times ((\$1,000,000,000 - \$200,000,000) / 1,000,000,000)) = 0.425$   
Overall EHR Amount x Medicaid Share = Medicaid aggregate EHR incentive amount  $\$14,655,050 \times 0.425 =$   
 $\$6,228,396$

Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

CMS is proposing that for EPs and hospitals with multi-state Medicaid practice locations, that the provider may annually pick only one State from which to receive incentive payments.

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