Introduction
On March 15, 2010, the public comment period on the proposed federal rules for the “meaningful use” of certified electronic health record (EHR) technology ended with the submission of more than 2,000 comments.

This article examines key aspects of the EHR incentive programs from a hospital’s perspective, including a discussion of several contentious provisions and their likely impact on hospitals seeking to maximize incentive payments. The article concludes with practical tips to help your organization prepare for and achieve meaningful use of EHR-certified technology.

Brief History of the EHR Incentive Programs and Certification Criteria
The American Recovery and Reinvestment Act of 2009, through the Health Information Technology for Economic and Clinical Health Act (HITECH Act), promotes the adoption and meaningful use of interoperable health information technology (HIT) and “qualified EHRs” through a combination of incentive payments and penalties.1 The underlying principle is that such technology, if standardized and widely adopted, will increase administrative efficiency and improve care quality through, among other things, a reduction in medical errors and improved coordination of care.
In January 2010, the Centers for Medicare and Medicaid Services (CMS) published a Notice of Proposed Rulemaking in which it proposed: (1) criteria for determining program eligibility; (2) a definition of meaningful use; and (3) payment rules (EHR Regulations).²

Also in January 2010, the Office of the National Coordinator for Health Information Technology (ONC)³ published an interim final rule setting forth the certification criteria to be used to establish the capabilities and standards that EHR technology must include to support the achievement of meaningful use.⁴ In early March, the ONC also released a Notice of Proposed Rulemaking on the testing and certification process for EHR technology.⁵

Key Aspects of the Incentive Programs

Which Incentive Programs Are Available, and Is My Hospital Eligible?
The HITECH Act established incentive programs under Medicare and Medicaid for both professionals and hospitals. Unlike the incentive programs for eligible professionals, a hospital may be eligible for and receive payments under both the Medicare and Medicaid incentive programs.⁶

Hospitals eligible under the Medicare incentive program are critical access hospitals and hospitals subject to the prospective payment system (PPS)—the latter of which includes most short-term acute care hospitals.⁷ Specialty hospitals such as psychiatric, rehabilitation, long term care, children’s, and cancer hospitals currently are ineligible to participate in the Medicare incentive program.⁸

An acute care hospital also may participate in the Medicaid incentive program if: (1) the average length of patient stay at the hospital is 25 days or fewer; (2) the last four digits of the hospital’s CMS Certification Number (CCN) are in the series 0001 through 0879; and (3) for each year incentive payments are sought, the hospital has at least a 10% Medicaid patient volume.⁹ Children’s hospitals (and units) also are eligible for the Medicaid incentive program.¹⁰ Note that a hospital eligible to participate in the Medicaid incentive program of more than one state may receive payments from a single state only.¹¹

Under the EHR Regulations and with respect to both incentive programs, CMS proposes to further define a hospital by and to calculate a hospital’s incentive payments based on the provider number on the hospital’s cost reports (i.e., the main provider’s CCN).¹² As discussed below, this is controversial and potentially problematic for many large systems because although one CCN can relate to a single hospital, for larger hospital systems, a single CCN typically encompasses multiple hospitals.

My Hospital Is Eligible—How Do I Demonstrate Meaningful Use?
Under each program, an eligible hospital must both become and demonstrate that it has become a “meaningful user” of certified EHR technology to receive incentive payments. The structure and criteria for achieving meaningful use are the same under both the Medicare and Medicaid incentive programs.

HIT Functionality Measures
CMS proposes a three-stage program under which an eligible hospital, in order to achieve meaningful use, must annually satisfy and report on a series of HIT objectives and functionality measures that are designed to evolve with each stage.

Clinical Quality Measures
To achieve meaningful use, an eligible hospital also must use its certified EHR technology to report information on clinical quality measures that CMS defines as measures of processes, experiences, and/or outcomes of patient care, observations, or treatment that relate to one or more quality aims for care.¹⁴ In all, CMS has proposed 34 clinical quality measures for
hospitals, such as emergency department throughput and central line bundle compliance. For Medicaid-eligible hospitals with patient populations to which these 34 measures are inapplicable (i.e., children’s hospitals), a separate set of measures may be selected.\\(^{15}\) Although the HITECH Act specifies that clinical quality measure reports be made to CMS, hospitals participating in the Medicaid incentive program may be required to submit reports to the applicable state. And, although clinical quality measure reports are supposed to be made electronically, CMS proposes that hospitals can satisfy this reporting requirement in 2011 through written attestation. In addition, clinical quality measures must be reported for all hospital patients—not just those who are Medicare or Medicaid beneficiaries.\\(^{16}\)

**Meaningful Use Caveats**

There are a few timing caveats to these proposed rules worth highlighting. First, statutorily, a hospital may enter an incentive program and be eligible for incentive payments in different years, provided that compliance is first demonstrated between 2011 and 2015. Second, every hospital will be required to satisfy the Stage 1 meaningful use criteria in its first payment year, although CMS proposes that later adopters be required to meet Stage 2 and in some cases Stage 3 requirements at an accelerated pace. Finally, notwithstanding the meaningful use criteria, CMS proposes that any hospital eligible under the Medicaid incentive program may receive an incentive payment in its first payment year according to a relaxed standard; that is, for adopting, implementing, or upgrading certified EHR technology.\\(^{17}\)

**How Do I Know If My EHR Technology Is Certified?**

Under the HITECH Act, an eligible hospital cannot achieve meaningful use if its EHR technology is not “Certified EHR Technology.” Certified EHR Technology is defined as a complete EHR or a combination of EHR modules, each of which: (a) meets the requirements included in the definition of Qualified EHR; and (b) has been tested and certified in accordance with the established certification program.\\(^{18}\) A “Qualified EHR,” in turn, means an electronic record of health-related information on an individual that: (1) includes patient demographic and clinical information; and (2) has the capacity: (a) to provide clinical decision support; (b) to support physician order entry; (c) to capture and query information relevant to healthcare quality; and (d) to exchange electronic health information with and integrate such information from other sources.\\(^{19}\)

In addition to the above, the ONC adopted certain standards intended to conform EHR systems so that they are capable of achieving certification. These standards relate to content exchange, vocabulary, transport, and privacy and security. The ONC also adopted general certification criteria designed to enable EHR systems (whether complete or modular) to perform certain functions electronically and in accord with applicable standards and specifications.\\(^{20}\)

Much like the meaningful use objectives and measures, the ONC’s certification criteria will evolve over time and are now and should in the future be designed to support the achievement of meaningful use across the three stages. The standards and criteria are the same under both incentive programs and for all providers and are consistent with and, in many cases, the same as standards and criteria that are common and widely accepted within the technology and healthcare industries.

**How Much Money Is Available to an Eligible Hospital Under the Incentive Programs?**

**Medicare Incentive Program: General Rule**

For hospitals eligible under the Medicare incentive program, payments may begin in fiscal year (FY) 2011,\\(^{21}\) no hospital may receive more than four years of payments, and the last year that a hospital can begin receiving payments is FY 2015.\\(^{22}\) In addition, although every eligible hospital’s payments will be reduced over the four years by a fixed factor, later adopters will experience an accelerated reduction.\\(^{23}\)

The formula for calculating an eligible hospital’s annual Medicare incentive program payment is as follows:

\[
\text{(Initial Amount)} \times (\text{Transition Factor}) \times (\text{Medicare Share})
\]

**Initial Amount = Base Amount + Discharge Related Amount**

- Base Amount = $2 million
- Discharge Related Amount = $200 per hospital discharge during a payment year beginning with hospital’s 1,150th discharge and ending with hospital’s 23,000th discharge

**Transition Factor**

- 1 in year one; 3/4 in year two; 1/2 in year three; and 1/4 in year four
- Except that if a hospital’s first payment year is 2014, the transition factor in year 1 is 3/4.

**Medicare Share**

\[
\frac{[(\text{Estimated number of Part A inpatient bed days}) + (\text{Estimated number of Medicare Advantage inpatient bed days})] \times (\text{Total number of inpatient bed days})}{(\text{Total charges minus charity care charges})}
\]

1 Much like the meaningful use objectives and measures, the ONC’s certification criteria will evolve over time and are now and should in the future be designed to support the achievement of meaningful use across the three stages.
Medicare Incentive Program: Exception
Because critical access hospitals (CAHs) are normally paid on a cost basis, CMS has proposed that Medicare incentive program payments to CAHs not be based on patient discharges, but on reasonable costs incurred for the purchase of certified EHR technology and the CAH Medicare share percentage. In addition, CMS proposes that no payments be made to CAHs after 2015 and that no CAH receive payment for more than four consecutive payment years.

Medicaid Incentive Program: General Rule
Statutory parameters placed on Medicaid incentive payments to eligible hospitals are based on the methodology applied to Medicare incentive payments and the specifications in the EHR Regulations are those to which states must adhere when developing aggregate hospital incentive amounts for eligible hospitals.

Specifically, Medicaid incentive program eligible hospitals may receive up to 100% of an aggregate EHR hospital incentive amount over a minimum of a three-year period and a maximum of a six-year period, where the maximum amount is equal to the sum over four years of the product of the “Overall EHR Amount” and the “Medicaid Share,” where:

\[
\text{Overall EHR Amount} = (\text{Initial Amount}) \times (\text{Transition Factor})
\]

- Initial Amount = Same as Medicare ($2 million + Discharge-Related Amount)
- Transition Factor = Same as Medicare

\[
\text{Medicaid Share} = \frac{A}{B + C}
\]

- \(A\) = (Number of Medicaid inpatient bed days) + (Number of inpatient bed days attributable to individuals enrolled in a managed care organization, prepaid inpatient health plan, or prepaid ambulatory health plan)
- \(B\) = Total number of inpatient bed days for hospital (excluding inpatient bed days attributable to Medicare Part A and Part C patients)
- \(C\) = (Total number of hospital’s charges excluding those attributable to charity care) / (Total amount of hospital’s charges)

Other important aspects regarding Medicaid incentive payments to hospitals are that the last year a hospital may begin receiving payments is FY 2016, and in any payment year, no annual Medicaid payment may exceed 50% of the hospital’s aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment may exceed 90% of the aggregate incentive.

When Do Penalties Kick In?
CMS proposes that any Medicare eligible hospital that, beginning in 2015, is not a meaningful user of certified EHR technology will be subject to a net reduction to 75% of the market basket update applicable to the PPS payment rate that increases over time; specifically, a net reduction in 2015 of 1/4; in 2016 of 1/2; and in 2017 and beyond of 3/4. Also beginning in 2015, a hospital’s applicable PPS percentage increase may be further reduced if the hospital fails to submit data on quality measures.

With respect to CAHs that are ordinarily paid at 101% of reasonable costs, CMS proposes that for cost-reporting periods beginning in 2015, eligible CAHs that are not meaningful users of certified EHR technology be subject to a downward adjustment; specifically, to 100.66% in 2015; to 100.33% in 2016; and to 100% in 2017 and beyond.

CMS has proposed no similar adjustments under the Medicaid incentive program.

Areas of Concern
The EHR Regulations have been the subject of significant debate and more than 2,000 comments were submitted to CMS during the public comment period. This section summarizes those objectives most relevant to hospitals.

Too Much, Too Soon
One common theme is that the proposed rules ask providers for too much, too soon. Many commentators argue that the objectives and criteria captured in Stage 1 represent a system so advanced that it will be difficult, if not impossible, for many providers to achieve within the timeframe allotted. In addition, some argue that obligating later adopters to implement the even more advanced functions of Stages 2 and 3 at an accelerated rate could ultimately discourage some providers from adopting any form of an EHR system.

In response, stakeholders, including the American Hospital Association (AHA), have proposed fixing the number of objectives at the outset, reducing the number of objectives that must be satisfied in Stage 1, and requiring increased levels of use over time as the measure of evolved meaningful use. AHA also suggests that the timeframe for achieving the ultimate vision of meaningful use be extended through 2017.
Wrong Definition of Eligible Hospital—The Problem with Using the CCN

Many commentators have also criticized CMS’ proposed definition of eligible hospital, which looks to the CCN used on cost reports. This is a criticism premised on two facts: (1) a single CCN could encompass one hospital or multiple hospitals within a single system; and (2) incentive payments to hospitals are calculated using a per-hospital base amount plus a capped per-discharge amount per hospital. The concern is that a healthcare system with multiple hospitals, but a single CCN, will be disadvantaged because the system would be eligible for only one base amount and much more likely to reach the discharge cap. Moreover, the entire system would be subject to penalties even if only one of the system's hospitals was not a meaningful user.

Reporting Obligations Are Burdensome

Many stakeholders also object to the reporting requirements. Specifically, not only will the time required to report on the more than 55 measures significantly exceed the eight hours estimated by CMS, but will further require a new process involving manual chart review and written calculations, especially during the 2011 reporting period. Suggested modifications include delaying implementation of certain reporting requirements and limiting reportable measures to those with the potential to advance patient care.

The Definition of Hospital-Based Eligible Professional Is Overbroad

A fourth objection is related to the HITECH Act’s exclusion of “hospital-based eligible professionals.” Although this objection was the centerpiece of many critical responses to the HITECH Act, the underlying concerns have been assuaged, at least in part, by recent legislative action.

Originally, the HITECH Act defined “hospital-based eligible professional” as “an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of his or her Medicare or Medicaid services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital.” The HITECH Act went on to provide that the determination of whether an eligible professional is a “hospital-based eligible professional” would be made on the basis of the site of service and without regard to any employment or billing arrangement between the eligible professional and any other provider.

In its Notice of Proposed Rulemaking, CMS proposed to further define the term by focusing on the concepts of “substantially all” and “hospital setting” with the result that an eligible professional would be considered a “hospital-based eligible professional” if he or she provided 90% or more of the applicable (i.e., Medicare or Medicaid) covered services in an inpatient and/or outpatient hospital setting based on the reported place of service codes (i.e., 21 (inpatient hospital), 22 (outpatient hospital), or 23 (emergency department)). Thus, an eligible professional who provides 90% or more of his or her professional services in a hospital-based clinic would, under this definition, be ineligible to participate in an EHR incentive program without regard to whether that professional uses (or could use) the hospital’s EHR system.

Many, including CMS, feared that such an overbroad definition of “hospital-based eligible professional” would cause hospitals’ investment in their outpatient primary care EHRs to lag behind their investment in inpatient EHRs. Others also were concerned that the exclusion would limit the benefit of EHR adoption in all communities.

In response to such widespread concern, Congress passed an amendment to the HITECH Act to narrow the definition of “hospital-based eligible professionals” so that physicians who provide substantially all (i.e., 90% or more) of their applicable professional services in a hospital outpatient setting will not be considered a hospital-based eligible professional and so will be able to participate in an EHR incentive program. Of course, such physicians also will be subject to penalties if they fail to achieve meaningful use by the statutory deadline.

Practical Tips

Despite objections to the proposed rules and certain changes that CMS is expected to make in response, the best way to maximize payments under both incentive programs is to get prepared and to start early.

Whether or not your hospital already has an advanced EHR system from an established vendor or no system at all, the first step to achieving and demonstrating meaningful use is to conduct a thorough assessment of what existing capabilities you have, the leadership team you have (or need), physician buy-in to the process, and an assessment of what other resources (whether financial and logistical) your organization requires to achieve meaningful use. Assigning a project leader or designating a committee with authority to make decisions will help streamline the process and allow the project to be divided into discrete and manageable pieces that the leader or committee can identify, track, and manage.

When considering an Electronic Medical Record vendor or an update to an existing system, consider what vendor(s) the hospital currently uses and the vendors used by peer hospitals. Do not settle on mere promises of meaningful use “guarantees,” which some vendors are offering to attract your business.
Instead, review the agreement and focus on the provisions around assurances of meaningful use. Despite initial promises, many agreements will not provide the assurances and obligations you need and that can and often must be obtained through aggressive contract negotiations.

When negotiating the software license and related vendor agreement, also keep in mind that certification standards and related requirements are in flux and will be for some time. So build flexibility, accountability, and the ability to expand product and service offerings into your contract. Also pay special attention to: (a) the timeframe, responsibilities, and system implementation costs; (b) who is responsible for and the level of training provided to new users of the technology; and (c) the interface needs of your organization (i.e., how well your existing systems can “talk to” your vendor’s EHR software)—as interfaces are frequently one of the more time-consuming and expensive elements of any EHR project.

In addition, it is important not to lose track of other related requirements that are scheduled to become effective in the near future. For example, full compliance with new electronic transaction standards is required by January 1, 2012, and full compliance with (i.e., use of) new ICD-10 codes is required by October 1, 2013.

Finally, as part of the planning and development process, consider whether your hospital wants to avail itself of the exceptions under the federal physician Anti-Self Referral and Anti-Kickback Statutes for EHR software and technology services. These exceptions, which enable a hospital to donate certain software and services to physicians meeting approved criteria, are scheduled to sunset on December 31, 2013.

Conclusion
The Medicare and Medicaid incentive programs provide much-needed financial incentives to hospitals and other key stakeholders to encourage the widespread use and adoption of interoperable EHR technology. Although it is likely that CMS will modify some of the proposed standards in the final rule, CMS has set a clear vision for the future and devised a detailed roadmap with aggressive timelines. Accordingly, it is vital that hospitals begin the implementation process now, starting with the development of a coordinated and comprehensive plan for achieving meaningful use.

Michael D. Beauvais (mbeauvais@ropesgray.com) is a partner in the Corporate Department at Ropes & Gray and a member of the firm’s Health Care and Life Sciences Practice Groups. Mr. Beauvais regularly counsels academic medical centers, health systems, community hospitals and other healthcare providers on a wide range of matters, including strategic affiliations, joint ventures, IT licensing, and general regulatory and compliance matters. He has specific expertise in the area of licensing and implementing interoperable health information Technology (HIT) and electronic health record (EHR) systems. In addition to representing healthcare providers, Michael represents healthcare companies and investors in connection with financings, acquisitions, collaborations, licensing, and all aspects of securities law compliance and corporate governance issues.

The author would like to thank his colleague, Joanna Bergmann, for her significant contributions to this article.

Endnotes
2 See Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule, 75 Fed. Reg. 1844 (Jan. 13, 2010).
3 Exec. Order No. 13335 established the ONC on April 24, 2004. In collaboration with the National Health Information Technology Coordinator and CMS, ONC has been working to develop and adopt standards, implementation specifications, and certification criteria to support achievement of meaningful use under the Recovery Act.
7 See id. at 1916-17.
8 See id. at 1911.
9 See id. at 1930.
10 See id. at 1930-31.
11 See id. at 1941.
12 See id. at 1911.
13 The HIT functionality measures and objectives are one of the more complicated and detailed of the proposed EHR rules. A helpful overview is set forth in “Table 2” at 75 Fed. Reg. 1844, 1867-70 (Jan. 13, 2010).
14 See id. at 1895-1900.
15 See id. at 1895.
16 See id. at 1871. Note that with respect to both the clinical quality measures and the functionality measures, CMS intends that a hospital’s electronic reporting requirements will be satisfied (and capable of satisfaction) by 2012. Until then, CMS proposes that hospitals report such measures in summary form through written attestation. See id. at 1871.
19 See id.
20 See id. at 2045.
22 See id. at 1914.
23 See id. at 1914.
24 See id. at 1911-16.
25 See id. at 1916-18.
26 See id.
27 See id. at 1937.
28 See id.
29 See id. at 1919-39.
30 See id. at 1915-16.
31 See id.
32 See id. at 1918-19.
33 See id. at 1905.
34 See 42 C.F.R. § 411.357(w) and 42 C.F.R. § 1001.952(y).

Thanks go to the leadership of AHLA’s In-House Counsel Practice Group for sponsoring this feature: Teresa A. Williams, In House Legal Counsel, Integris Health Inc. (Chair); Susan Feigin Harris, Baker & Hostetler LLP (Vice Chair – Membership); Richard G. Korman, General Counsel/Organizational Integrity Officer, Saint Joseph Regional Medical Center (Vice Chair – Web-Based Activities); Jonathan J. Oviatt, Chief Legal Officer, Mayo Clinic (Vice Chair – Educational Programs); Davis W. Turner, Vice President & Assistant General Counsel, Vanguard Health Systems Inc. (Vice Chair – Strategic Activities); and Charles R. Whipple, General Counsel, Hallmark Health System (Vice Chair – Publications).