

# HHS Establishes the Initial Pathway for Qualifying for HITECH Act Incentives Dollars for Meaningful Use of Certified Electronic Health Record Technology

February 4, 2010

## Introduction

On January 13, 2010, the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator of Health Information Technology (ONC), both part of the Department of Health and Human Services (HHS), published two much-anticipated and coordinated sets of regulations establishing the requirements for eligible providers to earn Medicare and Medicaid electronic health record (EHR) incentives. The incentives, established by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), are part of the federal government's decision to make a significant investment to facilitate the adoption of a nationwide health information network.

Under the two sets of regulations, qualified hospitals and professionals earn the incentives, in the form of enhanced Medicare and Medicaid reimbursement, by demonstrating that they are “meaningful users” of “Certified EHR Technology.” The ONC establishes by an interim final rule (the Interim Final Rule)<sup>1</sup> one set of regulations containing the standards, implementation specifications and certification criteria that EHR technology must meet to be Certified EHR Technology. By proposed rule (the Proposed Rule),<sup>2</sup> CMS proposes a second set of regulations containing criteria for demonstrating meaningful use of the certified EHR technology. The Proposed Rule also includes proposed Medicare and Medicaid regulations for the calculation and payment of the HITECH Act's incentives to qualified providers under Medicare Parts A and B, Medicare Advantage organizations under Medicare Part C and state Medicaid programs. Following the structure of the Act itself, the incentives for all eligible providers under the Proposed Rule are structured to encourage early adoption of EHR technology; thus, the incentives are higher in the earlier years, phase out after a specified number of years, and thereafter convert from reimbursement incentives to reimbursement penalties.

The expected flow of incentive dollars available under the Proposed Rule falls short of what Congress intended. CMS' impact analysis<sup>3</sup> estimates that between \$14.1 and \$27.3 billion in Medicare and Medicaid EHR incentive payments will be expended under the program. This is considerably less than the \$34 billion Congress believed CMS would be funding when it enacted the HITECH Act. Efforts are underway on Capitol Hill to urge lawmakers to press for HHS to liberalize the timing and scope of the initial requirements so that eligible hospitals and professionals will more readily be able to draw down the incentive dollars at the level intended by Congress.

Initial health industry reactions are tepid at best. For example, the American Hospital Association stated that the proposed definition of meaningful use “should be a destination point, not a starting point” and advised its members that the new rules will “severely limit hospitals' ability to access federal financing for HIT that is used to improve patient care and that widespread efforts toward adoption will be hindered unless key provisions in the rules are addressed.” Similarly, the American Medical Association has repeatedly “stressed the importance of realistic timeframes for adoption” and the “removal of extraneous requirements that would delay successful adoption [of EHR].”

HHS will accept comments on the two sets of regulations through March 15, 2010. HHS has expressed a keen interest in receiving public input. Sufficient comments from the health sector seeking changes that have political support on Capitol Hill—particularly with respect to the pace at which hospitals, physicians and other eligible professionals must achieve meaningful use—may prompt significant changes to both the Interim Final Rule and the Proposed Rule. Eligible hospitals and professionals, vendors, would-be certifying bodies, and others interested in or affected by the regulations should thus consider submitting comments to HHS. Providers currently using successful EHR technology that will not meet these new certification requirements should consider requesting the “grandfathering” of such systems.

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<sup>1</sup> Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Interim Final Rule, 75 Fed. Reg. 2013 (Jan. 13, 2010) (to be codified at 45 C.F.R. pt. 170), available at

<http://frwebgate6.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=79648995247+3+2+0&WAIAction=retrieve>.

<sup>2</sup> Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule, 75 Fed. Reg. 1843 (proposed January 13, 2010) (to be codified at 42 C.F.R. pts. 412, et al.) , available at <http://frwebgate1.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=796654179042+0+2+0&WAIAction=retrieve>.

<sup>3</sup> 75 Fed. Reg. at 1989.

This White Paper addresses the following topics of the Interim Final Rule and Proposed Rule:

- **Part 1:** The initial set of standards, implementation specifications and certification criteria for EHR technology to become Certified EHR Technology
- **Part 2:** The requirements for demonstrating meaningful use
- **Part 3:** The methodology for calculation and payment of EHR incentives under Medicare Parts A and B
- **Part 4:** The methodology for calculation and payment of EHR incentives under Medicare Part C, commonly known as the Medicare Advantage Program
- **Part 5:** The methodology for calculation and payment of EHR incentives to qualified providers under state Medicaid programs

## Part 1: Interim Final Rule—“Certified EHR Technology”

The HITECH Act set a December 31, 2009, deadline for the Secretary of HHS (Secretary) to adopt an initial set of standards, implementation specifications and certification criteria to enhance the interoperability, functionality, utility and security of health information technology and to support its meaningful use. This deadline prompted ONC to issue the Interim Final Rule on Certified EHR Technology without first issuing a notice of proposed rulemaking. ONC explains that “this initial set of standards begins to define a common language to ensure accurate and secure health information exchange across different EHR systems.” The standards, implementation specifications and certification criteria in the Interim Final Rule are intended, in part, to assure that Certified EHR Technology supports the achievement of meaningful use by eligible professionals and eligible hospitals under the EHR incentive programs. HHS is expected to issue another rule soon that will provide further information about the process for becoming an EHR technology certifying organization.

In particular, the standards, implementation specifications and certification criteria adopted by the Interim Final Rule establish the capabilities a Certified EHR Technology must have to support the achievement of the proposed Stage 1 “meaningful use” criteria established under the Proposed Rule on meaningful use, which are discussed further in Part 2 below. These requirements are effective February 12, 2010.

### Key Definitions Contained in the Interim Final Rule

The Interim Final Rule uses the following defined terms in the standards, implementation specifications and certification criteria that establish the required capabilities for Certified EHR Technology:

“Qualified EHR” means an electronic record of health-related information on an individual that: (1) includes patient demographic and clinical health information, such as medical history and problem lists; 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 health care quality; and (d) to exchange electronic health information with, and integrate such information from, other sources.<sup>4</sup> ONC adopts the statutory definition of Qualified EHR without modification and notes that the capabilities included in the definition of Qualified EHR set the floor, or minimum standard, for the capabilities of Certified EHR Technology.<sup>5</sup>

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<sup>4</sup> *Id.* at 2043 (to be codified at 45 C.F.R. 170.102).

<sup>5</sup> *Id.* at 2023.

“EHR Module” means any service, component or combination thereof that can meet the requirements of at least one certification criterion adopted by the Secretary.<sup>6</sup> The ONC provides the following examples of EHR Modules: (1) an interface or other software program that provides the capability to exchange electronic health information; (2) an open source software program that enables individuals online access to certain health information maintained by EHR technology; (3) a clinical decision-support rules engine; (4) a software program used to submit public health information to public health authorities; and (5) a quality-measure reporting service or software program. ONC notes that the use of EHR Modules may enable an eligible professional or eligible hospital to create a combination of products and services that meets the definition of Certified EHR Technology. However, the eligible professional or eligible hospital bears the responsibility of ensuring that the certified EHR Modules selected are capable of working together to support the achievement of meaningful use and are interoperable.

“Complete EHR” means EHR technology that has been developed to meet all applicable certification criteria adopted by the Secretary.<sup>7</sup> ONC clarifies that the term Complete EHR is meant to encompass EHR technology that can perform all of the applicable capabilities required by certification criteria and to distinguish it from EHR technology that cannot perform those capabilities.<sup>8</sup> The use of the word “applicable” is intended to reflect the fact that some criteria apply to EHR technology used in the ambulatory setting by eligible professionals and other criteria apply to EHR technology used by eligible hospitals in the inpatient setting.

“Certified EHR Technology” means 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 ONC as having met all applicable certification criteria.<sup>9</sup> This definition differs slightly from the definition in the HITECH Act.<sup>10</sup> The revised definition is intended to ensure consistency with the initial standards, implementation specifications and certification criteria set forth in the Interim Final Rule, and to allow eligible providers both the flexibility to adapt to innovations in a rapidly evolving industry and the ability to choose from a variety of product and service offerings ranging from subscription services, to vendor-based products, to open source products. ONC expects that it will be common in the near future for Certified EHR Technology to be assembled from several interchangeable EHR Modules.

Examples of Certified EHR Technology, include: (1) a Complete EHR that is tested and certified to all applicable certification criteria and (2) the combination of two or more certified EHR Modules that include all of the capabilities required by all certification criteria applicable to those modules.<sup>11</sup> ONC notes that in the circumstance of combined modules it is the user’s responsibility to determine whether the combination of the certified EHR Modules would meet all of the applicable certification criteria necessary to meet the definition of Certified EHR Technology.<sup>12</sup>

In contrast, ONC offers the following examples of what would not meet the definition of Certified EHR Technology: (1) Complete EHRs that have not been tested and certified in accordance with the certification program established by the ONC, even though it may be claimed that such technology provides the capabilities required by adopted certification criteria, and (2) the combination of three certified EHR modules that do not include all of the capabilities required by all applicable certification criteria. For example, if three certified EHR Modules were purchased by an eligible professional and none of them included the capability to electronically prescribe, the combination of the three modules would not meet the definition of Certified EHR Technology.

## EHR Certification Criteria

The certification criteria adopted by ONC are set forth in Table 1 of the Interim Final Rule, which is reproduced in Appendix A of this White Paper.<sup>13</sup> The criteria focus on and describe the required capabilities that EHR technology must include to qualify as Certified EHR Technology. Certain certification criteria apply in either the ambulatory setting or inpatient setting. Others apply in only one or the other setting. In general, the set of criteria in the Interim Final Rule are intended to achieve the capabilities

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<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> *Id.* at 2043 (to be codified at 45 C.F.R. 170.102).

<sup>9</sup> *Id.*

<sup>10</sup> HITECH Act § 3000 (to be codified at 42 U.S.C. § 300jj).

<sup>11</sup> 75 Fed. Reg. at 2043 (to be codified at 45 C.F.R. 170.102).

<sup>12</sup> *Id.* at 2022.

<sup>13</sup> *Id.* at 2025-28.

necessary to support the requirements for Stage 1 meaningful use under the Proposed Rule.<sup>14</sup> Examples of certification criteria include enabling the following: computerized provider order entry for medications, laboratory tests, imaging and provider referrals; maintenance of a patient’s problem list; and maintenance of a patient’s medication allergy list.

To the extent Stage 1 meaningful use objectives under the Proposed Rule objectives are identical for eligible professionals and hospitals, the Interim Final Rule adopts identical, corresponding certification criteria for Complete EHRs or EHR Modules.<sup>15</sup> For Stage 1 meaningful use objectives that differ for eligible professionals and hospitals, or apply to only one or the other, the Interim Final Rule adopts specific certification criteria to assure that Certified EHR Technology includes the capabilities necessary to meet that objective.

## Initial Standards and Implementation Specifications

The EHR certifying bodies will test EHR technology to determine whether the technology meets the standards and implementation specifications associated with the applicable EHR certification criteria. The initial standards focus on increased interoperability and privacy and security. Not all certification criteria adopted by this Interim Final Rule include associated standards and implementation specifications.

Implementation specifications provide specific configuration instructions and constraints for implementing a particular standard or set of standards. ONC states that because some standards can be implemented in many different ways, these specifications are critical in some cases to successfully achieving interoperability.<sup>16</sup> However, ONC recognizes that very few implementation specifications are widely used and most are immature or too architecturally specific for adoption by large segments of the HIT industry before Stage 2 meaningful use. Therefore, with a few exceptions,<sup>17</sup> ONC does not adopt implementation specifications to support Stage 1 meaningful use. ONC will consider adopting implementation specifications for any adopted standard provided that there is convincing evidence submitted in public comment of the specifications’ maturity and widespread usage.

ONC recognizes that certain types of standards, specifically those relating to code sets, must be maintained and frequently updated to serve their intended purpose effectively. For example, CPT codes will need to be updated to reflect the most recent changes in medical practice. Under some circumstances, the new codes must be disseminated and implemented quickly for patient safety and other public health purposes. To address this need, ONC will establish certain types of standards as a floor for certification. References to specific adopted standards that are preceded with the phrase “at a minimum” will require a Complete EHR or EHR Module to comply with the version of the code set that has been adopted through incorporation by reference or any subsequently released version of the code set.

ONC also assures eligible professionals and hospitals that if a code set is modified significantly (*e.g.*, if a code set that uses 7-digit numeric codes is modified to require 9-digit alphanumeric codes), ONC will update the incorporation by reference to reflect the more recent version of the code set prior to requiring or permitting certification according to the newer version.

### CONTENT EXCHANGE AND VOCABULARY STANDARDS AND IMPLEMENTATION SPECIFICATIONS

Table 2A of the Interim Final Rule, which is reproduced in Appendix B, lists the content exchange and vocabulary standards adopted to support Stage 1 meaningful use and associated with Stage 1-related EHR certification criteria.<sup>18</sup> Only a limited number of Stage 1 certification criteria require Certified EHR Technology to be capable of using a specific vocabulary or code set and, in certain instances, these vocabularies and code sets are already required by other HHS regulations such as the HIPAA Transactions and Code Set Rule. The table also lists candidate exchange and vocabulary standards that ONC believes should be adopted and required to support Stage 2 meaningful use. The lack of vocabulary standards indicates that true interoperability among a patient’s providers in separate organizations is likely years away.

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<sup>14</sup> 75 Fed. Reg. at 2024.

<sup>15</sup> *Id.*

<sup>16</sup> 75 Fed. Reg. at 2035.

<sup>17</sup> For example, ONC has adopted the Physician Quality Reporting Initiative Measure Specifications Manual for Claims and Registry as the implementation specification for the CMS PQRI 2008 Registry XML Specification standard for quality reporting.

<sup>18</sup> 75 Fed. Reg. at 2033-34.

## TRANSPORT STANDARDS

The Interim Final Rule adopts Simple Object Access Protocol (SOAP) version 1.2 and Representational State Transfer (REST) to establish standard ways for systems to interact with each other.<sup>19</sup> SOAP is a protocol specification for exchanging structured information in the implementation of web services in computer networks. ONC adopted SOAP because it is widely used and versatile enough to allow for the use of different transport protocols and is both platform and language independent. REST is a style of software architecture for distributed hypermedia systems (such as the internet).<sup>20</sup>

## PRIVACY AND SECURITY STANDARDS

ONC has aligned the EHR certification criteria to applicable HIPAA security rule requirements so that Certified EHR Technology may support the efforts of a HIPAA Covered Entity (Covered Entity) to comply with federal and state privacy and security laws. ONC has adopted the associated privacy and security standards set forth in Table 2B of the Interim Final Rule, which is reproduced in Appendix C of this White Paper.<sup>21</sup> The privacy and security standards address: (1) general encryption and decryption of electronic health information; (2) encryption and decryption of electronic health information for exchange; (3) record actions related to electronic health information (*i.e.*, audit log); (4) verification that electronic health information has not been altered in transit; (5) cross-enterprise authentication; and (6) record treatment, payment and health care operations disclosures.

As noted above, ONC has not adopted standards for all EHR certification criteria, in part because ONC did not want to preclude innovative approaches to addressing the required capabilities. For example, while the ONC established certification criteria for access control, it did not establish a specific standard or implementation specifications for access control because ONC believes that “the industry will continue to innovate at a rapid pace in this area and better methods to implement this capability will be available faster than we would be able to adopt them via regulation.”<sup>22</sup> In contrast, ONC has adopted certification criteria and standards for encryption because specific industry best practices and requirements exist with respect to encryption and the strength of encryption algorithms,<sup>23</sup> and encryption is one method to “render protected health information unusable, unreadable, or indecipherable to unauthorized individuals” and one that can exempt a Covered Entity from having to report a breach.<sup>24</sup>

## Interaction with HIPAA Administrative Simplification Regulations

ONC cautions that the Interim Final Rule focuses on the capabilities of Certified EHR Technology and does not change HIPAA requirements, guarantee compliance with those requirements or absolve a Covered Entity that adopts Certified EHR Technology from having to comply with HIPAA standards.<sup>25</sup>

## HIPAA SECURITY STANDARDS

ONC plans to look beyond the HIPAA security rule requirements when adopting new certification criteria and standards in the future, to improve the capabilities that Certified EHR Technology can provide to protect health information.

## HIPAA ELECTRONIC TRANSACTIONS AND CODE SET STANDARDS

HHS previously adopted and modified transactions and code sets standards for HIPAA Covered Entities (Covered Entities), including eligible professionals and eligible hospitals. Certified EHR Technology will enable eligible professionals and eligible hospitals to qualify for incentive payments and comply with these transactions and code set standards as well as any timeframes

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<sup>19</sup> 75 Fed. Reg. at 2044 (to be codified at 45 C.F.R. 170.210).

<sup>20</sup> *Id.* at 2031.

<sup>21</sup> *Id.* at 2035.

<sup>22</sup> *Id.* at 2034.

<sup>23</sup> *Id.*

<sup>24</sup> Guidance Specifying the Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification requirements Under Section 13402 of Title XIII (Health Information Technology for Economic and Clinical Health Act) of the American Recovery and Reinvestment Act of 2009; Request for information, 74 Fed. Reg. 19006, 19006 (April 27, 2009).

<sup>25</sup> 75 Fed. Reg. at 2035.

for compliance.<sup>26</sup> ONC's adoption of future standards and implementation specifications for Stage 2 and Stage 3 meaningful use will continue to be consistent with the adoption and modification of HIPAA transactions and code sets standards and their respective timeframes for compliance.

#### CERTIFICATION CRITERION AND STANDARDS REGARDING ACCOUNTING OF DISCLOSURES

The HITECH Act requires Covered Entities with EHRs to produce, upon an individual's request, an accounting of all disclosures of the individual's protected health information over a three-year period, including disclosures made for treatment, payment and health care operations. This expands current law, which limits accounting of disclosures requests to certain non-routine disclosures such as those for research. Covered Entities with EHRs as of January 1, 2009, must have the capacity to comply with this new requirement for disclosures made on and after January 1, 2014. The Secretary has the authority to set a later effective date for such Covered Entities, but the later date may not be after 2016. For Covered Entities that adopt EHRs after January 1, 2009, the Covered Entity must be able to provide for an accounting of disclosures made on or after the later of January 1, 2011, or the date that the Covered Entity acquires an electronic record. The Secretary has the authority to set a later date for Covered Entities acquiring EHRs after January 1, 2009, but the later date may not be later than 2013.

The HITECH Act requires HHS to adopt a certification criterion and standard in this Interim Final Rule regarding technologies that allow for an accounting of these disclosures through an EHR and to promulgate regulations to identify the information that must be collected about each of the disclosures. The Interim Final Rule adopts a basic certification criterion and standard to account for disclosures to provide a technical foundation for the information that HHS will later determine should be collected for treatment, payment and health care operations disclosures. This basic certification criterion requires the capability to record disclosures made for treatment, payment and health care operations in accordance with the standard we have adopted. The standard described in Appendix C requires a recorded disclosure for treatment, payment or health care operations to include the date, time, patient identification (name or number), user identification (name or number) and a description of the disclosure. This first certification criterion and standard for accounting of disclosures is intended as an incremental step that will be refined as the technology develops and regulatory requirements are issued.<sup>27</sup> ONC did go further at this time because it believes several significant technical challenges need to be addressed before it will be possible to record additional information about disclosures in an efficient manner. For example, it notes that the lack of any particular technology solution that is capable of automatically recognizing the difference between a "use" and a "disclosure," as defined by HIPAA, as well as a concern over the amount of electronic storage that will be necessary to record three years of information related to treatment, payment and health care operations disclosures.<sup>28</sup>

Notably, the HITECH Act grants HHS discretion to modify the compliance date for the revised accounting for disclosure regulations, and ONC noted that HHS will address the compliance date for accounting for treatment, payment and health care operations disclosures in a later rulemaking.<sup>29</sup>

## Certification Bodies

#### SEPARATE RULE FOR PROCESS TO SELECT CERTIFICATION BODIES

The HITECH Act requires the ONC, in consultation with the Director of the National Institute of Standards and Technology, to "keep or recognize a program or programs for the voluntary certification of health information technology as being in compliance with applicable certification criteria adopted" by HHS.<sup>30</sup> ONC states that it will soon issue separate regulations to establish the process a certification body will need to follow to become an authorized certification body.

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<sup>26</sup> For example, all Covered Entities are required to comply with ICD-10-CM and ICD-10-PSC on and after October 1, 2013. *See* Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA); Final Rules, 74 Fed. Reg. 3295 (January 16, 2009) (to be codified at 45 CFR part 162).

<sup>27</sup> 75 Fed. Reg. at 2037.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

<sup>30</sup> HITECH Act § 3001 (to be codified at 42 U.S.C. § 300jj-11).

## RELATIONSHIP TO CERTIFYING BODY FOR STARK LAW AND ANTI-KICKBACK STATUTE COMPLIANCE

HHS previously recognized the Certification Commission for Health Information Technology (CCHIT) as the certifying body for purposes certifying software as “interoperable” for compliance with the Stark Law’s self-referral exception<sup>31</sup> and the federal health care program anti-kickback statute’s safe harbor<sup>32</sup> for certain arrangements involving the donation of EHR items and services. ONC declined to designate CCHIT as the sole certifying body for purposes of the Medicare and Medicaid EHR incentive programs. ONC also did not address whether it would recognize CCHIT as one of the certifying bodies for the incentive programs so that EHR vendors and donors and recipients of EHR items and services could rely on a single certifying body for purposes of the incentive programs and compliance with the fraud and abuse laws.

## Part 2: Meaningful Use

### Statutory Requirements

To achieve the stated objectives of increased quality of patient care and heightened efficiency through the implementation of EHR technology, the HITECH Act requires that an eligible professional must be a “meaningful EHR user”<sup>33</sup> of Certified EHR Technology. Such a user is one that meets three requirements:

- “...demonstrates to the satisfaction of the Secretary [in a manner prescribed by the Secretary] that ... the professional is using the certified EHR technology in a meaningful manner...”
- “...demonstrates to the satisfaction of the Secretary [in a manner prescribed by the Secretary] that ... such certified EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to promote the quality of health care...”
- “...using such certified EHR technology, the eligible professional submits information ... [in a manner prescribed by the Secretary] on such clinical quality measures and other such measures as selected by the Secretary...”

### The Proposed Rule

It also sets forth concrete parameters that define when use of EHR technology is sufficient to meet the statutory meaningful use standards.

### Phased Roll-Out Of Meaningful Use Criteria

The Proposed Rule issued by CMS sets forth three “stages” of objectives and measures for demonstrating “meaningful use.” This phased approach to giving form and definition to meaningful use will enable eligible professionals, eligible hospitals and critical access hospitals (CAHs) to incrementally improve and expand their adoption and implementation of EHR technology<sup>34</sup> and reflects CMS’ recognition that existing technology and interoperability made certain of the more ambitious (and critical) goals of EHR adoption difficult to achieve immediately.<sup>35</sup> CMS provides a roadmap to the broad themes and goals of each Stage so that eligible professionals can understand and anticipate the phased expectations of the agency.

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<sup>31</sup> 42 C.F.R. § 411.357(w).

<sup>32</sup> 42 C.F.R. § 1001.952(y).

<sup>33</sup> *Id.* §§ 4101 and 4102 (to be codified at 42 U.S.C. § 1395w-4 and 1395ww).

<sup>34</sup> CMS has specifically solicited comments on the phased approach and possible alternatives. *See id.* at 1572.

<sup>35</sup> *See, e.g., id.* at 1853 (“...the primary reasoning for developing different stages of meaningful use is the current lack of HIT infrastructure and penetration of qualified EHRs necessary to support the ambitious goals of the Stage 3 criteria of meaningful use.”).

While the Stage 1 meaningful use criteria concentrate on electronically recording patient data to facilitate coordination of care, implementation of clinical decision support, and the reporting of clinical quality measures,<sup>36</sup> Stage 2 and Stage 3 will focus more on the interoperability of EHR technology, an increase in efficiency and an improvement in population health. Depending on when a provider elects to begin implementing meaningful use of EHRs, the provider will establish as its base Stage 1, 2 or 3 meaningful use criteria.<sup>37</sup> A summary of these timing instructions is set forth in Table 1 of the Proposed Rule, which is reproduced below.<sup>38</sup>

**TABLE 1—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.

\* Avoids payment adjustments only for Eligible Professionals in the Medicare EHR Incentive Program.

\*\* Stage 3 criteria of meaningful use or a subsequent update to the criteria if one is established through rulemaking.

Only the Stage 1 criteria are currently proposed and include 23 different objectives and associated functionality measures, including computerized provider order entry for 10 percent of all hospital orders and 80 percent of all eligible professional orders. The Proposed Rule does not contain any objectives or measures that will be required in the second or third stages of meaningful use. CMS indicates that it expects to provide Stage 2 and 3 guidance beginning in 2013.<sup>39</sup> This phased approach, which will become more robust over time, is meant to result in patient-centered, evidence-based, prevention-oriented, efficient and equitable health care.<sup>40</sup>

The Proposed Rule seeks to strike a balance between setting high and aggressive standards that will achieve appreciable and measurable progress in EHR adoption (and its intended quality and cost benefits) and setting preferred but unrealistic and unattainable goals that might have the unintended effect of discouraging adoption. Nonetheless, many hospital and physician organizations have stated publicly that HHS has not struck the right balance and instead proposed meaningful use criteria that are not attainable in the proposed time frames for most providers.

## Stage 1 Meaningful Use Objectives and Measures

The Proposed Rule includes 31 objectives and corresponding measures of EHR functionality and adoption for providers to demonstrate meaningful use for Stage 1 and receive incentive payments for the 2011 payment year. The objectives elaborate on the four general goals or “outcomes policy priorities” of EHR adoption identified by the HIT Policy Committee: (1) improving quality, safety, efficiency and reducing health disparities; (2) engaging patients and families in their healthcare; (3) improving care coordination; and (4) improving population and public health.<sup>41</sup> CMS organizes its discussion of the objectives around these

<sup>36</sup> *Id.* at 1852.

<sup>37</sup> *Id.* at 1852-53.

<sup>38</sup> *Id.* at 1854.

<sup>39</sup> *Id.* at 1870.

<sup>40</sup> *Id.* at 1852.

<sup>41</sup> *Id.* at 1854-58.

four policy priorities; however, the priorities are not, themselves, enumerated requirements. Certain of the objectives and measures apply to all eligible providers while others only apply to a subset of providers.

The 31 objectives focus on care coordination and overall public health and build upon, but are not identical to, the recommendations by the HIT Policy Committee. For example, CMS did not adopt the HIT Policy Committee's recommendation to require recording of advance directives because it would be "relevant to a limited and undefined patient population when compared to the patient populations to which other objectives" apply.<sup>42</sup> Similarly, the HIT Policy Committee recommended recording Body Mass Index (BMI) for all patients; instead, the Proposed Rule requires BMI for children over the age of two as well as growth charts because "BMI itself does not provide adequate information for children."<sup>43</sup> The modifications and departures also reflect CMS' recognition of the gap between what is preferred and what is possible based on existing technologies. For example, the HIT Policy Committee recommended requiring that eligible professionals "provide access to patient-specific education resources upon request."<sup>44</sup> While recognizing that providing such resources is a "critical component of patient engagement and empowerment," CMS did not include it in the proposed objectives because of the "paucity of knowledge resources that are integrated into EHRs that are widely available and that meet these criteria."<sup>45</sup> A summary of the interplay between the HIT Policy Committee policy priorities and the corresponding objectives and measures in the Proposed Rule are set forth in Table 2 of the Proposed Rule, which is reproduced in Appendix D.<sup>46</sup>

For each selected objective, CMS proposes a corresponding "measure." The measure is the numerical calculation that the provider uses to demonstrate to CMS that the provider has met the objective. The majority of the measures are calculated on a percentage basis in order to ensure that differences in patient volume do not affect whether a provider meets each measure.<sup>47</sup> In many cases, CMS provides detailed instructions for calculating the fractions that constitute a majority of the measures. Generally, the numerator of the fraction is the total number of the provider's unique patients whose information was recorded for purposes of the measure. The denominator is the total number of unique patients who fall under the measure. For example, one objective requires eligible providers to maintain an active medication allergy list. The corresponding measure requires that this requirement is met if such a list is maintained for at least 80 percent of unique patients seen by the eligible provider or admitted to the eligible hospital.<sup>48</sup> In general, the threshold percentage that providers must meet for objectives and measures that focus on information exclusive to the provider is higher than for objectives and measures that require interoperability with other providers' EHR technology.<sup>49</sup> For example, the Proposed Rule sets the measure for incorporating clinical lab-test results into a structured data format at only fifty percent in recognition that many lab test results will be from unaffiliated third parties. We expect a significant proportion of the comments received by CMS during notice and comment will endorse or challenge this balancing act.

## Clinical Quality Measures

CMS proposes clinical quality measures and procedures for the reporting of such measures required by the HITECH Act's definition of a Meaningful EHR User discussed above. Clinical quality measures "consist of measures of processes, experience and/or outcomes of patient care, observations or treatment that relate to one or more quality aims for health care such as effective, patient-centered, equitable and timely care."<sup>50</sup> The Act indicates that preference should be given to clinical quality standards that have been previously endorsed by National Quality Forum (NQF). Accordingly, the Proposed Rule elects to give preference to the quality measures endorsed by NQF and the Physician Quality Reporting Initiative (PQRI) program.<sup>51</sup>

The proposed quality measures fall into three categories: core measures applicable to all eligible professionals; measures relevant to specialties of eligible professionals; and measures relevant to eligible hospitals. These measures are outlined in a series of

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<sup>42</sup> *Id.* at 1855-56.

<sup>43</sup> *Id.* at 1855.

<sup>44</sup> *Id.* at 1857.

<sup>45</sup> *Id.*

<sup>46</sup> *Id.* at 1867-70.

<sup>47</sup> *Id.* at 1859.

<sup>48</sup> 75 Fed. Reg. at 1855 (to be codified at 42 C.F.R. § 495.6(c)(4)(i)).

<sup>49</sup> *Id.* at 1862.

<sup>50</sup> *Id.* at 1871.

<sup>51</sup> *Id.* at 1872.

tables in the preamble to the Proposed Rule.<sup>52</sup> The clinical quality measures will be effective 60 days after CMS publishes a final rule in the Federal Register.

The core clinical quality measures required for all eligible professionals focus on basic preventive care and patient screening, including considerations regarding tobacco use, blood pressure measurement and drugs to be avoided in the elderly.<sup>53</sup> Although the quality measures under the different core specialty groups vary greatly, they reflect a central theme focused on preventive care and disease management unique to the specialty.<sup>54</sup> For example, the gastroenterology specialty group focuses primarily on preventive screenings and vaccinations for colon illnesses.<sup>55</sup> In contrast, the clinical quality measures for eligible hospitals focus more on efficiency, procedure upon discharge and reporting medical errors.<sup>56</sup>

## Reporting Methodology for Quality Measures

The HITECH Act provides that CMS may not require electronic reporting of clinical quality measures to CMS unless it has the technological ability and capacity to receive the information.<sup>57</sup> CMS has indicated that HHS will not complete steps necessary for CMS to electronically accept data on clinical quality measures from EHRs for the 2011 payment year. Accordingly, CMS proposes that eligible professionals and hospitals use an attestation methodology to submit aggregated summary information.<sup>58</sup> Further, eligible hospitals (but not eligible professionals) will be required to report on clinical quality measures for all applicable patients, regardless of payor, even though the HITECH Act incentive payments are payable by Medicare, state Medicaid programs and Medicare Advantage organizations.<sup>59</sup>

## Demonstration of Stage 1 Meaningful Use

Finally, the Proposed Rule requires providers to “demonstrate” satisfaction of the applicable meaningful use measures. The precise demonstration methodologies differ for professionals and hospitals and there are exceptions for certain Medicaid providers that merely adopt Certified EHR Technology, but are not Meaningful EHR Users. However, in all cases, CMS proposes that the attestation methodology will be the manner of demonstrating the Stage 1 meaningful use.

## Part 3: EHR Incentives for Participants in the Medicare Fee-for-Service Program

If an eligible professional or hospital demonstrates meaningful use of certified EHR Technology in accordance with requirements discussed in Parts 1 and 2, above, the provider may earn incentive payments, in the form of enhanced reimbursement, under the original Medicare fee-for-service program, commonly known as Medicare Parts A and B (Medicare FFS).<sup>60</sup> This Part discusses the reimbursement methodology in the Proposed Rule for the Medicare FFS incentives. Parts 4 and 5, below, discuss the methodology in the Proposed Rule for incentives under Medicare Part C (Medicare Advantage) and state Medicaid programs, respectively.

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<sup>52</sup> *Id.* at 1874-1900 (see Tables 3-21).

<sup>53</sup> *Id.* at 1890-91.

<sup>54</sup> *Id.* at 1891-95.

<sup>55</sup> *Id.* at 1895.

<sup>56</sup> *Id.* at 1896-99 (explaining clinical quality measures for eligible hospitals such as median time for emergency arrival and departure, whether aspirin is prescribed at discharge, and the presence of urinary tract infections for intensive care unit patients).

<sup>57</sup> *Id.* at 1871.

<sup>58</sup> *Id.* at 1870.

<sup>59</sup> *Id.* at 1900.

<sup>60</sup> HITECH Act, §§ 4101 and 4102 (to be codified as 42 U.S.C. § 1395w-4 and 1395ww).

## Incentive Payments for Medicare FFS Eligible Professionals

Eligible professionals participating in Medicare FFS who are meaningful users of Certified EHR Technology may receive incentive payments of an additional 75 percent of the Medicare allowable charge under the Medicare Physician Fee Schedule (MPFS) for covered professional services, for up to five years beginning as early as calendar year (CY) 2011, subject to an annual cap.<sup>61</sup> The annual cap may be higher under certain circumstances for professionals who practice in a Medicare health professional shortage area.

### MEDICARE ELIGIBLE PROFESSIONALS

The Proposed Rule defines an eligible professional for the Medicare FFS EHR incentives as doctors in five specialty areas—medicine or osteopathy, dental surgery or dental medicine, podiatric medicine, optometry, or chiropractic—each of whom must be legally authorized to practice under applicable state law.<sup>62</sup> Hospital-based professionals are not eligible for incentives.<sup>63</sup> The Proposed Rule defines hospital-based professionals as eligible professionals who provide 90 percent or more of their covered professional services in an inpatient and/or outpatient hospital setting.<sup>64</sup> Whether the 90 percent test is met will depend on the place of service (POS) codes reported on the eligible professional’s claims for Medicare reimbursement. POS codes 21 (Inpatient Hospital), 22 (Outpatient Hospital) and 23 (Emergency Department) describe a hospital setting.<sup>65</sup>

The ineligibility of hospital-based professionals has been particularly controversial in academic medical centers and other hospitals where physicians and other professionals provide ambulatory services in clinics that are hospital-based outpatient department locations for Medicare reimbursement purposes. Such hospital-based clinics often utilize ambulatory EHR technology that has different modules (*e.g.*, appointment scheduling) from the hospital’s inpatient EHR and requires additional expense.

### MAXIMUM ANNUAL INCENTIVE PAYMENTS

The Proposed Rule caps annual Medicare FFS incentive payments to eligible professionals. If the first year the eligible professional becomes a Meaningful EHR User is 2011 or 2012, the eligible professional can earn up to a total of \$44,000 over the five-year incentive period, including an \$18,000 maximum annual incentive payment in the first year. The maximum annual incentive payments are summarized in Table 22 of the Proposed Rule, which is reproduced below<sup>66</sup>:

**TABLE 22—MAXIMUM TOTAL AMOUNT OF EHR INCENTIVE PAYMENTS FOR A MEDICARE EP WHO DOES NOT PREDOMINANTLY FURNISH SERVICES IN AN HPSA**

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
<b>TOTAL</b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>	<b>\$0</b>

<sup>61</sup> HITECH Act, § 4101 (to be codified at 42 U.S.C. § 1395w-4(o)(1)(A)(i)).

<sup>62</sup> *Id.* at 1996 (to be codified at 42 C.F.R. § 495.100).

<sup>63</sup> *Id.*

<sup>64</sup> *Id.* at 1993 (to be codified at 42 C.F.R. § 495.4).

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* at 1908.

Eligible professionals who furnish more than 50 percent of Medicare covered professional services (based on quantity of services rather than allowed charges) in a geographic area designated as a health professional shortage area by HHS are subject to a 10 percent higher cap.

#### FORM AND TIMING OF PAYMENTS TO QUALIFYING ELIGIBLE PROFESSIONALS

The Proposed Rule calls for Part B Medicare administrative contractors (f/k/a carriers) (MACs) to make a single, lump sum, annual incentive payment to an eligible professional as soon as the MAC determines that the eligible professional has demonstrated meaningful use for the applicable reporting period and earned the maximum annual incentive payment. The reporting period for an eligible professional is any 90-day period in the first calendar year of meaningful use or the calendar year for the subsequent four years. For example, if a MAC has determined that an eligible professional has demonstrated meaningful use in 2011 and has \$24,000 of allowable charges for covered professional services that year, the MAC would pay the eligible professional the \$18,000 maximum annual incentive amount. The MAC will make the payment to the eligible professional or a single employer or other entity that is a valid reassignee under the Medicare reassignment rules.<sup>67</sup>

CMS does not permit an eligible professional to allocate the incentive payments among valid reassignees (such as multiple part-time employers or contracting parties). Thus, physician groups, hospitals and other facilities that engage physicians and other eligible professionals on a part-time basis should review current and template employment and professional service agreements and consider amending them to specify that the group or facility is entitled to receive the incentive payment rather than other part-time employers or contractors.

#### PROGRAM ELECTION AND COORDINATION

Professionals who meet the eligibility requirements for both the Medicare and Medicaid incentive programs must elect to receive payments from only one program or the other, but they may change their program election once from 2012 to 2014.

#### PAYMENT ADJUSTMENTS BEGINNING CY 2015

Beginning in 2015, the MPFS amount payable to eligible professionals who are not Meaningful EHR Users will be reduced by one, two and three percent in 2015, 2016 and 2017 and each subsequent calendar year, respectively, unless CMS exempts an eligible professional due to a significant hardship.<sup>68</sup> The HITECH Act also authorizes CMS to further reduce the reimbursement rate beginning in 2018 if the proportion of eligible professionals who are Meaningful EHR Users is less than 75 percent.<sup>69</sup> CMS also indicated that it would make specific proposals for further reductions prior to 2015. CMS did not propose a definition of significant hardship, but stated that one example would be an eligible professional who practices in a rural area without sufficient internet access.<sup>70</sup> CMS also solicits comments on the possible circumstances for which CMS should allow an eligible professional to qualify for the significant hardship exception.<sup>71</sup>

## Incentive Payments for Eligible Hospitals

#### MEDICARE ELIGIBLE HOSPITALS

A hospital that is a Meaningful EHR User is eligible for Medicare FFS incentives beginning Medicare fiscal year (FY) 2011 (*i.e.*, October 1, 2010, through September 30, 2011). A Medicare eligible hospital is a hospital located in one of the 50 states or the District of Columbia that participates in the Medicare Inpatient Prospective Payment System (IPPS).<sup>72</sup> Hospitals and distinct part

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<sup>67</sup> *Id.* at 1910.

<sup>68</sup> 75 Fed. Reg. at 1996 (to be codified at 42 C.F.R. §495.102(d)).

<sup>69</sup> HITECH § 4101(b) (to be codified at 42 U.S.C. § 1395w-4(a)(7)(A)(iii)).

<sup>70</sup> 75 Fed Reg. at 1911.

<sup>71</sup> HITECH § 4101(b) (to be codified at 42 U.S.C. § 1395w-4(a)(7)(B)); 75 Fed Reg. at 1911.

<sup>72</sup> 75 Fed Reg. at 1996 (to be codified at 42 C.F.R. § 495.100); *See also* 42 U.S.C. §1395ww(d)(1)(B) (defining subsection (d) hospital).

hospital units excluded from IPPS, such as psychiatric, rehabilitation, long-term care, children's and cancer hospitals and units, are not eligible for incentives.<sup>73</sup> CAHs are also eligible for Medicare FFS incentives under separate provisions discussed below.

#### INCENTIVE PAYMENT CALCULATION FOR ELIGIBLE HOSPITALS

During Medicare FY 2011 through FY 2016, CMS will pay Medicare FFS EHR incentives to eligible hospitals that are Meaningful EHR Users of Certified EHR Technology during the EHR reporting period based on the proportion of discharges attributable to Medicare patients.<sup>74</sup> The EHR reporting period for an eligible hospital is any continuous 90-day period within the first payment year (*i.e.*, a Medicare fiscal year) and the entire payment year thereafter. An eligible hospital that is a Meaningful EHR User may receive Medicare FFS incentive payments for up to four Medicare FYs. The formula is equal to the product of the following: (a) Initial Amount; (b) Medicare Share; and (c) Transition Factor. Each is defined as follows:

- The "Initial Amount" means the sum of \$2,000,000 plus the Discharge-Related Amount for the hospital's cost reporting year.<sup>75</sup> The "Discharge-Related Amount" means the sum of the amount for each discharge during the cost reporting year up to the 23,000<sup>th</sup> discharge as follows: (i) first through 1,149<sup>th</sup> discharge, \$0; (ii) 1,150<sup>th</sup> through 23,000<sup>th</sup> discharge, \$200; plus (iii) for any discharge greater than the 23,000<sup>th</sup>, \$0.
- The "Medicare Share" means the fraction, where:<sup>76</sup>
  - The *numerator* is the *sum* of (A) inpatient-bed-days which are attributable to individuals with respect to whom payment may be made under Medicare Part A; plus (B) the number of inpatient-bed-days which are attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C
  - The *denominator* is the *product* determined by multiplying (A) the total number of inpatient-bed-days; and (B) the total amount of the hospital's charges during the cost reporting period, not including any charges that are attributable to charity care divided by the estimated total amount of the hospital's charges during the period
- The "Transition Factor" is based on the incentive payment year: 1.0 for the first incentive payment year before FY 2014; 0.75 for the second payment year; 0.50 for the third payment year; 0.25 for the fourth payment year; and zero (0) for any succeeding payment year.<sup>77</sup> Hospitals that begin utilizing an EHR after FY 2013 have lower Transition Factors and consequently lower incentive payments than they would have received by becoming Meaningful EHR Users sooner. Hospitals for which the first payment year is after FY 2015 receive no incentive payments. Table 25 of the Proposed Rule, which is reproduced below, shows how the Transition Factor phases out incentive payments to eligible hospitals<sup>78</sup>:

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<sup>73</sup> 75 Fed Reg. at 1996 (to be codified at 42 CFR 495.100).

<sup>74</sup> HITECH § 4102(a); 75 Fed Reg. at 1997 (to be codified at 42 C.F.R. § 495.104).

<sup>75</sup> 75 Fed Reg. at 1997 (to be codified at 42 C.F.R. § 495.104(c)(3)).

<sup>76</sup> *Id.* (to be codified at 42 C.F.R. § 495.104(c)(4)).

<sup>77</sup> *Id.* (to be codified at 42 C.F.R. § 495.104(c)(5)).

<sup>78</sup> *Id.* at 1915.

TABLE 25—TRANSITION 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

PROCESS AND TIMING FOR INCENTIVE PAYMENTS TO ELIGIBLE HOSPITALS

The Part A MACs (formerly known as “fiscal intermediaries”) will pay eligible hospitals that are Meaningful EHR Users of certified EHR technology a preliminary, estimated EHR incentive payment based on the data on hospital discharges from the hospital cost reporting year that ends during the Medicare fiscal year prior to the Medicare fiscal year for which an incentive payment is made.<sup>79</sup> Final payments will be determined at the time of settling the cost report for the hospital cost reporting year that ends during the applicable Medicare fiscal year, and settled on the basis of the hospital discharge data from that cost reporting period.<sup>80</sup> CMS provides the following example of process and timing for payments:<sup>81</sup>

Example: Medicare FY 2011 begins on October 1, 2010, and ends on September 30, 2011. For an eligible hospital with a cost reporting period running from July 1, 2010, through June 30, 2011, CMS would employ the relevant data from the hospital’s cost reporting period ending June 30, 2010, in order to determine the incentive payment for the hospital during Medicare FY 2011. However, final payments would be based on hospital discharge data from the cost report ending June 30, 2011, and determined at the time of settlement for that cost reporting period.

INCENTIVE PAYMENT ADJUSTMENTS EFFECTIVE FY 2015

Consistent with the HITECH Act,<sup>82</sup> the Proposed Rule reduces the annual market basket adjustment to the IPPS payment rate for inpatient hospital services for hospitals that are not Meaningful EHR Users by one-quarter, one-half and three-quarters of the percentage increase otherwise applicable in FY 2015, FY 2016, and FY 2017 and subsequent Medicare FYs, respectively.<sup>83</sup> A hospital may be exempted from the payment reduction if CMS determines, on a case-by-case basis, that requiring the hospital to be a Meaningful EHR User would result in a significant hardship, such as the case of a hospital in a rural area without sufficient internet access.<sup>84</sup>

<sup>79</sup> 75 Fed Reg. 1997 (to be codified at 42 C.F.R. § 495.104(c)(2)).

<sup>80</sup> *Id.*

<sup>81</sup> *Id.* at 1912.

<sup>82</sup> HITECH Act § 4102(b)(1) (to be codified at 42 U.S.C §1395ww(b)(3)(B)).

<sup>83</sup> 75 Fed Reg. at 1990 (to be codified at 42 C.F.R. § 412.64(d)(3)).

<sup>84</sup> HITECH Act § 4102(b)(1) (to be codified at 42 U.S.C. § 1395ww(b)(3)(B)).

## Incentive Payments for Critical Access Hospitals

### INCENTIVE PAYMENT CALCULATION FOR CRITICAL ACCESS HOSPITALS

The HITECH Act also provides for EHR incentive payments to qualifying CAHs that are Meaningful EHR Users during an EHR reporting period for a CAH's cost reporting period, beginning after FY 2010 but before FY 2016, for up to four fiscal years. The EHR reporting period is a continuous 90-day period in the first payment year and the entire payment year for subsequent years. Consistent with the HITECH Act,<sup>85</sup> CMS proposes to pay EHR incentives to a CAH for a Medicare fiscal year equal to the product determined by multiplying the following two items:

- The CAH's reasonable costs incurred for the purchase of Certified EHR Technology (excluding any depreciation and interest expense) during the cost reporting year that begins in the applicable Medicare fiscal year
- The lesser of: 100%; and the Medicare Share (as defined above) percentage plus 20 percentage points<sup>86</sup>

The EHR incentive payment is made in lieu of the payment for reasonable costs of the purchase of Certified EHR Technology (including depreciation and interest expense) that would have been otherwise made by Medicare under the reasonable cost reimbursement methodology for CAHs. The Proposed Rule provides the following example:<sup>87</sup>

Example: A CAH first requests an incentive payment for its cost reporting period beginning on January 1, 2012, which is in FY 2012. The CAH incurred reasonable costs of \$500,000 for the purchase of Certified EHR Technology in its previous cost reporting period beginning on January 1, 2011. This CAH is a meaningful user of Certified EHR Technology during the relevant EHR reporting period and thus qualifies for an incentive payment for FY 2012. (For illustrative purposes, this example assumes no salvage value of the assets acquired.) The CAH depreciated \$100,000 of the costs of these items in the cost reporting period beginning on January 1, 2011. As a result, the amount used to compute the incentive payment will be the remaining \$400,000 of undepreciated costs. The CAH's Medicare share is 90 percent (its Medicare Share of 70 plus 20 percentage points). Therefore, the CAH's incentive payment for FY 2012 is \$360,000 (\$400,000 times 90 percent). This CAH's first payment year is FY 2012, and it can receive incentive payments through four consecutive payment years which, in this example, would be FYs 2012 through 2015.

### TIMING AND PROCESS FOR PAYMENT

The CAH's MAC will pay an incentive payment to a CAH through a prompt interim payment (subject to reconciliation) for the applicable Medicare fiscal year after the CAH submits necessary documentation to support the computation of the incentive payments.

### INCENTIVE PAYMENT ADJUSTMENTS EFFECTIVE FY 2015

For cost reporting years beginning in FY 2015, if a CAH is not a qualifying CAH, the reasonable cost payment for inpatient services furnished by a CAH will be reduced from 101 percent of the CAH's reasonable costs in providing CAH services to its inpatients to 100.66, 100.33 and 100 percent in FY 2015, FY 2016 and FY 2017 and each subsequent Medicare fiscal year, respectively. A CAH may be exempted from the payment reduction if CMS or the CAH's MAC determines, on a case-by-case basis, that requiring the CAH to be a Meaningful EHR User would result in a significant hardship.<sup>88</sup>

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<sup>85</sup> HITECH Act § 4102(b)(2) (to be codified at 42 U.S.C. §1395(f)(1)).

<sup>86</sup> 75 Fed Reg. at 1997-98 (to be codified at 42 CFR 495.106)).

<sup>87</sup> *Id.* at 1918.

<sup>88</sup> HITECH Act § 4102(b)(2)(C) (to be codified at 42 U.S.C. § 1395(f)(1)).

## Part 4: Medicare Advantage (MA) EHR Incentive Program

The HITECH Act also provides for incentives under the Medicare Advantage (MA) Program, for certain MA Organizations (Qualifying MA Organizations) with qualifying MA eligible professionals (MA EPs) and Qualifying MA Organization-affiliated eligible hospitals (MA EHs) that are Meaningful EHR Users (all three terms are defined below).<sup>89</sup> A Qualifying MA Organization with MA EPs and MA EHs that are not Meaningful EHR Users by the CY 2015 benefit year would be subject to a negative adjustment of the MA Organization's capitation payments.<sup>90</sup> Qualifying MA Organizations, therefore, may want to consider, in deciding whether to adopt Certified EHR Technology, whether future MA Program payments might be at risk of such a reduction.

### QUALIFYING MA ORGANIZATIONS

The HITECH Act defines a “qualifying MA Organization” as an MA Organization organized as a health maintenance organization (HMO).<sup>91</sup> The Proposed Rule enhances the definition of qualifying MA Organization to include any MA Organization that is one of the following:

- A federally qualified HMO
- An entity recognized as an HMO under state law
- A “similar organization regulated for solvency under State law in the same manner and to the same extent as an HMO”<sup>92</sup>

The Proposed Rule also deems as a Qualifying MA Organization an MA Organization offering an HMO plan under the MA Program “absent evidence to the contrary.”<sup>93</sup> Finally, an MA Organization offering an MA Plan *other than* an HMO plan (*e.g.*, PPO, PSO and RPP0 MA Plans) would be required to attest to the fact that it is recognized under state law as an HMO or that it meets the “similar organization” standard set out above in order for CMS to consider designating the entity as a Qualifying MA Organization.

### MA ELIGIBLE PROFESSIONALS

A qualifying MA EP is one of two types of physicians who are Meaningful EHR Users: (1) physicians employed by the Qualifying MA Organization; and (2) physicians employed by, or a partner in, an entity that furnishes at least 80 percent of its Medicare patient services (both Medicare FFS and MA patients services) to Medicare beneficiaries enrolled in an MA Plan sponsored by the MA Organization. For both types of physicians, at least 80 percent of professional services provided by the physician to Medicare beneficiaries must be furnished to Medicare beneficiaries enrolled in an MA Plan sponsored by the Qualifying MA Organization, and the physician also must furnish, on average, at least 20 hours of patient care services.<sup>94</sup> Similar to the Medicare FFS EHR incentive program, hospital-based physicians are excluded from the definition of qualifying MA EPs. A Qualifying MA Organization will be required to attest annually that *each* physician is a Meaningful EHR User and otherwise meets the regulatory requirements for the applicable payment year in order for the physician to be designated as an MA EP.

A physician may not aggregate services furnished to multiple MA Organizations' Members in order to satisfy the service thresholds, although the Proposed Rule appears to suggest that a physician's patients who are enrolled in the Qualifying MA Organization's MA Plans can be aggregated because the Qualifying MA Organization is the required common factor. “[At] least 80 percent of the professional's total Medicare revenue in a year (that is, total revenue from Medicare FFS as well as from all MA organizations) must be from a single qualifying MA organization....”<sup>95</sup> As a result, CMS expects that only those physicians

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<sup>89</sup> HITECH Act § 4101(c) (to be codified at 42 U.S.C. § 1395w-23).

<sup>90</sup> *Id.* at § 4101(c) (to be codified at 42 U.S.C. § 1395w-23); 75 Fed. Reg. at 1923.

<sup>91</sup> HITECH Act § 4101(c) (to be codified at 42 U.S.C. § 1395w-23).

<sup>92</sup> 75 Fed. Reg. at 1921, 1999 (to be codified at 42 C.F.R. § 495.200).

<sup>93</sup> *Id.*

<sup>94</sup> *Id.* at 1998.

<sup>95</sup> *Id.* at 1921.

employed exclusively by a Qualifying MA Organization and those physicians employed by, or in partnership with, an entity that contracts exclusively with one Qualifying MA Organization will be able to satisfy the criteria to be an MA EP.<sup>96</sup>

#### MA-AFFILIATED ELIGIBLE HOSPITAL

A “qualifying MA-affiliated eligible hospital” is an eligible hospital and qualifying MA Organization having a common parent corporation, having a common board of directors, or one of the entities being a subsidiary of the other.<sup>97</sup> The Qualifying MA Organization would be required to attest annually that the hospital is a Meaningful EHR User for the applicable payment year.<sup>98</sup> Additionally, of all the Medicare beneficiaries served by the facility, *more than two thirds* must be enrolled in an MA Plan.<sup>99</sup> The Medicare individuals do not need to be enrolled in MA Plans sponsored by the same Qualifying MA Organization, however, as is the case for MA EPs. If, however, for any payment year, one third or more of the hospital’s discharges (or bed-day patients) who are Medicare beneficiaries are covered under Medicare Part A rather than enrolled in an MA Plan, the hospital may only earn a payment under the Medicare FFS EHR incentive program and the Qualifying MA Organization with whom the hospital is affiliated will not receive any payment under the MA EHR incentive program in connection with the hospital.

## EHR Incentive Payments for Qualifying MA Organizations

#### MA EP PAYMENTS

The Proposed Rule provides that, if an MA EP receives the maximum incentive payment under the Medicare FFS EHR incentive program, no payment would be made to the Qualifying MA Organization under the MA EHR incentive program for that same physician. If an MA EP does not earn the maximum incentive payment under the Medicare FFS EHR incentive program, then the *only* EHR incentive payment made in connection with such physician would be to the Qualifying MA Organization with whom the MA EP is associated.<sup>100</sup>

The incentive payment to the Qualifying MA Organization for each MA EP would equal 75 percent of the physician’s annual revenue attributable to providing Medicare Part B-coverable services to Members enrolled in the Qualifying MA Organization’s MA Plans in the payment year, up to the maximum amount established under the Medicare FFS EHR incentive program for that payment year. Such maximum amounts are discussed in Part 3, above. For qualifying MA EPs compensated on a salaried basis, the Qualifying MA Organization would develop a methodology (subject to CMS approval) for calculating an estimate of the portion of the MA EP’s salary attributable to providing Part B-coverable services. Overhead costs may be, but are not required to be, included in this estimation. MA EPs paid on a non-salaried basis (*e.g.*, fee-for-service or capitated payment arrangements) would be required to provide the Qualifying MA Organization with an attestation identifying the compensation received for providing Part B-coverable services.<sup>101</sup>

Over the incentive program’s five years (CY 2012 through CY 2016), the maximum cumulative incentive payment to a Qualifying MA Organization for each of its MA EPs would be approximately \$44,000.00, the maximum amount also available under the Medicare FFS EHR incentive program.

#### MA EH PAYMENTS

CMS appears to anticipate that, based on the definition (and related criteria) of MA EHs, no Qualifying MA Organizations would receive payment under the MA EHR incentive program for MA eligible hospitals. “To the extent data [on discharges and/or bed-day patients necessary to compute payments under the MA EHR incentive program] are available, qualifying MA organizations must receive hospital incentive payments through their affiliated hospitals under the Medicare FFS EHR hospital incentive program, rather than through the MA EHR hospital incentive program.”<sup>102</sup> To the extent data is not available to compute payments for MA EHs under the Medicare FFS EHR hospital incentive program, the Qualifying MA Organization would receive

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<sup>96</sup> *Id.*

<sup>97</sup> *Id.* at 1998 (to be codified at 42 C.F.R. § 495.200).

<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> 75 Fed. Reg. at 2000 (to be codified at § 495.208(a)).

<sup>101</sup> *Id.* at 1999-2000 (to be codified at § 495.204(b)). The payment year would be defined as a calendar year.

<sup>102</sup> *Id.* at 1999 (to be codified at 42 C.F.R. § 495.204(c)(2)).

an MA EHR incentive program payment equal to the amount that would be paid under the Medicare FFS EHR incentive program.<sup>103</sup>

#### AVOIDING DUPLICATIVE PAYMENTS

The Proposed Rule specifies that in order to avoid duplicative payments under the Medicare FFS and MA EHR incentive programs, CMS will make payments to Qualifying MA Organizations under the MA EHR incentive program after all payments are made under the Medicare FFS EHR incentive program for the applicable payment year.

#### DOWNWARD ADJUSTMENTS

CMS expressly defers to future rulemaking the development of standards related to adjustments to MA Plan payments for Qualified MA Organizations with MA EPs and MA EHs that are not Meaningful EHR Users in CY 2015. The agency anticipates, based on the statutory requirements, that the payment adjustment would be applied to the physician expenditure portion of a bid (with regard to MA EPs), and would equal 1 percent for 2015, 2 percent for 2016 and 3 percent in 2017 and future years. The payment adjustment would be applied to the hospital expenditure portion of a bid (with regard to MA EHs), and the adjustment would affect “three-fourths of the market basket increase related to a hospital” by a 33 and 1/3 percent reduction in 2015, a 66 and 2/3 reduction in 2016, and a 100 percent reduction in 2017 and subsequent years. “Effectively, the reduction is of all but 25 percent of the market basket increase for a specific hospital in years after 2016.”<sup>104</sup> The Proposed Rule does not address how the payment adjustment would be applied for those MA Organizations submitting multiple MA Plan bids.

Note that in anticipation of the payment adjustment, Qualifying MA Organizations will be required to self-report to the agency, effective with the CY 2015 bid submissions, identifying themselves as a Qualifying MA Organization, regardless of whether they have MA EPs and MA EHs for which an incentive payment would be sought.

### Strategic Considerations for Qualifying MA Organizations

Qualifying MA Organizations seeking an MA EHR incentive payment for CY 2011 will be required to make a “preliminary identification” of potential MA EPs and MA EHs in the CY 2011 bid submission, due in June 2010. Identifying information would include the provider’s name, address and NPI. Thus, Qualifying MA Organizations intending to apply for the incentive payment should begin the process of identifying potential MA EPs and MA EHs soon. Additionally, processes and procedures will be necessary to collect (and verify) information supporting the Qualifying MA Organization’s attestations to CMS regarding the MA EPs’ and MA EHs’ status as Meaningful EHR Users as well as to calculate the estimated incentive payment for MA EPs, particularly if the Qualifying MA Organization will be required to estimate the portion of a salaried EP’s income that is attributable to Part B-coverable services.

MA Organizations that may be Qualifying MA Organizations that do not anticipate seeking MA EHR incentive payments during the initial years of the program nevertheless should consider the potential implications of the downward adjustment for future MA Plan payments. Such an analysis may indicate whether an MA Organization’s payments will be adversely affected in CY 2015 and future years, such that implementation of Certified EHR Technology is prudent, and could be implemented in a timeframe that permits the MA Organization to benefit under the MA EHR incentive program.

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<sup>103</sup> *Id.* at 1999-2000 (to be codified at § 495.204(c)). The payment year would be defined as the federal fiscal year, rather than the MA Program benefit year (*i.e.*, the calendar year).

<sup>104</sup> *Id.* at 1928.

## Part 5: Medicaid EHR Incentive Program

Under the HITECH Act,<sup>105</sup> state Medicaid programs, at their option, may receive payments from the federal government known as federal financial participation (FFP) for 100 percent of their expenditures for EHR incentive payments to Medicaid-eligible professionals and eligible hospitals. Unlike the Medicare incentives, the Medicaid incentive program allows eligible providers to receive an incentive payment even before they have begun to meaningfully use Certified EHR Technology if they are engaged in efforts to adopt, implement or upgrade to Certified EHR Technology. The Proposed Rule includes regulations to implement these provisions.

### Incentive Payments for Medicaid-Eligible Professionals

#### QUALIFIED MEDICAID-ELIGIBLE PROFESSIONALS

The following types of Medicaid-participating professionals are eligible for Medicaid incentives: physicians; dentists; certified nurse-midwives; nurse practitioners; and physician assistants practicing in federally qualified health centers (FQHCs) or rural health clinics (RHCs) that are led by physician assistants. Hospital-based professionals are not eligible for incentives unless the professional practices predominately in an FQHC or RHC.<sup>106</sup> To qualify for an EHR incentive payment, a Medicaid-eligible professional must meet one of the following patient volume thresholds: have a minimum 30 percent Patient Volume (as defined below) attributable to individuals receiving Medicaid; have a minimum 20 percent Patient Volume attributable to individuals receiving Medicaid, and be a pediatrician; or practice predominantly in an FQHC or RHC and have a minimum 30 percent Patient Volume attributable to Needy Individuals (as defined herein).<sup>107</sup> Needy Individuals are persons who received medical assistance from Medicaid or the Children's Health Insurance Program, were furnished uncompensated care by the eligible professional, or were furnished services either at no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay.<sup>108</sup>

CMS proposes to define patient volume (Patient Volume) as the fraction in which<sup>109</sup>:

- The numerator is the total number of Medicaid (including Medicaid managed care) patients or Needy Individuals treated in any representative 90-day period in the most recent calendar year preceding the reporting.
- The denominator is all patient encounters in the same 90-day period.

Medicaid-eligible professionals would be required to annually re-attest to meeting the Patient Volume thresholds to continue to qualify for Medicaid incentive payments.<sup>110</sup> A State may propose an alternative Patient Volume measure to CMS for approval.<sup>111</sup>

#### INCENTIVE PAYMENT CALCULATION FOR ELIGIBLE PROFESSIONALS

Under the Proposed Rule, Medicaid incentive payments to qualified Medicaid-eligible professionals are equal to 85 percent of Net Average Allowable Costs (as defined below) for Certified EHR Technology (and support services for the technology), subject to statutory caps of \$21,250 (*i.e.*, 85 percent of \$25,000) in the first payment year and \$8,500 (*i.e.*, 85 percent of \$10,000) in the five subsequent years.<sup>112</sup> The maximum aggregate incentive payment for the six-year period is \$63,750 provided that the first payment year is no later than 2016. The payment years are calendar years.

“Average Allowable Costs” is defined as \$54,000 for the first Medicaid incentive payment year and \$20,610 for the five subsequent years based on data from various studies.<sup>113</sup> To determine Net Average Allowable Costs, Average Allowable Costs

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<sup>105</sup> HITECH § 4201(a)(1) (to be codified at 42 C.F.R. § 1396b(a)(3)).

<sup>106</sup> 75 Fed. Reg. at 2001 (to be codified at 42 C.F.R. § 495.304(d)).

<sup>107</sup> *Id.* at 2001 (to be codified at 42 C.F.R. § 495.304(c)).

<sup>108</sup> *Id.* at 2001 (to be codified at 42 C.F.R. § 495.302).

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* at 2002 (to be codified at 42 C.F.R. § 495.306(a)).

<sup>111</sup> *Id.* at 2002 (to be codified at 42 C.F.R. § 495.306(b)).

<sup>112</sup> *Id.* at 2002 (to be codified at 42 C.F.R. § 495.310(a)).

<sup>113</sup> *Id.* at 1933-1934.

must be reduced by any payment to the Medicaid-eligible professional that is from a source (other than a state or local government) and directly attributable to payment for Certified EHR Technology or support services. Since CMS proposes that the Average Allowable Cost for the first year is \$54,000, an eligible professional could receive as much as \$29,000 in funding from sources (other than state or local government) in that year and still receive the maximum \$21,250 Medicaid incentive payment.<sup>114</sup>

In addition, pediatricians who have a minimum of 20 percent of their patient encounters paid by Medicaid, but fall short of the 30-percent Patient Volume threshold, may receive two thirds of the incentives otherwise available, which equals a maximum first-year incentive of \$14,167 and up to \$5,667 in the five subsequent years for a total maximum six-year payment of \$42,500.<sup>115</sup>

Eligible professionals assigning Medicaid reimbursement to multiple employers or other assignees must select one assignee's tax identification number to receive Medicaid incentive disbursements.<sup>116</sup> Employers and facilities engaging such professionals should consider revising their contracts with the professionals to specify which assignee is entitled to the incentive payments.

#### PROGRAM ELECTION AND COORDINATION

Eligible professionals who meet the eligibility requirements for both the Medicare and Medicaid incentive programs must elect to receive payments from one program or the other, but may change their program election once from 2012 to 2014.<sup>117</sup> In addition, a Medicaid-eligible professional may receive an incentive payment from only one state Medicaid program in a payment year.<sup>118</sup>

### Incentive Payments for Medicaid-Eligible Hospitals

#### QUALIFYING MEDICAID-ELIGIBLE HOSPITALS

The HITECH Act also provides for 100 percent FFP for Medicaid incentives to "acute care hospitals" and "children's hospitals."<sup>119</sup>

The Proposed Rule defines an "acute care hospital" for purposes of the incentives as a health care facility where the average length of stay is 25 days or fewer and a CMS certification number (previously known as a Medicare provider number) that has the last four digits in the series 0001-0879.<sup>120</sup> That range of certification numbers includes short-term general hospitals and the 11 cancer hospitals in the United States, but excludes long-term acute care hospitals. In addition, to qualify for an EHR incentive payment, an acute care hospital must have a minimum 30 percent Patient Volume attributable to individuals receiving Medicaid.<sup>121</sup>

"Children's hospital" is defined as a separately certified children's hospital, either free-standing or hospital-within-hospital, that has a CMS certification number that has the last four digits in the series 3300-3399 and predominately treats individuals under 21 years of age.<sup>122</sup> CMS assigns that range of certification numbers to the country's 78 certified children's hospitals.

#### INCENTIVE PAYMENT CALCULATION FOR QUALIFYING ELIGIBLE HOSPITALS

The Proposed Rule includes new regulations implementing Medicaid incentive payments to Qualifying Medicaid-eligible hospitals that are equal to the product of the Overall EHR Amount and the Medicaid Share, payable over three to six years beginning before 2017. Each term is defined below:

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<sup>114</sup> *Id.* at 1934.

<sup>115</sup> *Id.* at 2002 (to be codified at 42 C.F.R. § 495.310(b)).

<sup>116</sup> *Id.* at 2006 (to be codified at 42 C.F.R. § 495.332(c)(9)(i)).

<sup>117</sup> *Id.* at 2002 (to be codified at 42 C.F.R. § 495.310(c)).

<sup>118</sup> *Id.* at 2002 (to be codified at 42 C.F.R. § 495.310(e)).

<sup>119</sup> HITECH Act § 4201 (to be codified at 42 U.S.C. §1396b).

<sup>120</sup> 75 Fed. Reg. at 2000 (to be codified at 42 CFR 495.302).

<sup>121</sup> *Id.* at 2001 (to be codified at 42 CFR 495.304(e)(1)).

<sup>122</sup> *Id.* at 2001 (to be codified at 42 CFR 495.302).

- The “Overall EHR Amount” is equal to the sum over four years of (I)(a) \$2,000,000 plus (b) the discharge-related amount defined as \$200 for the 1,150th through the 23,000th discharge for the first payment year (for subsequent payments years, state Medicaid programs must assume discharges increase by the hospital’s average annual rate of growth for the most recent three years for which data are available per year); multiplied by (II) the transition factor applicable for each year, which is one in Year 1, ¾ in Year 2, ½ in Year 3 and ¼ in Year 4.<sup>123</sup>
- The “Medicaid Share” means the fraction where:
  - The *numerator* is the *sum* (for the 12-month period selected by the State Medicaid program and with respect to the eligible hospital) of (a) the estimated number of inpatient-bed-days which are attributable to Medicaid individuals; plus (b) the estimated number of inpatient-bed-days which are attributable to individuals who are enrolled in certain Medicaid managed care plans
  - The *denominator* is the *product* of (a) the estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and (b) the estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during such period.<sup>124</sup>

#### DUAL ELIGIBILITY FOR INCENTIVES

A hospital may receive incentive payments from both Medicare and a state Medicaid program if it meets all eligibility requirements of both incentive programs.<sup>125</sup> A hospital may only receive an incentive payment from one state Medicaid program in a payment year.<sup>126</sup>

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<sup>123</sup> *Id.* at 2002-2003 (to be codified at 42 CFR 495.310(g)(1)).

<sup>124</sup> *Id.* at 2003 (to be codified at 42 CFR 495.310(g)(2)).

<sup>125</sup> *Id.* at 2003 (to be codified at 42 CFR 495.310(j)).

<sup>126</sup> *Id.* at 2003 (to be codified at 42 C.F.R. § 495.310(e)).

Table 1—Certification Criteria		
Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals <sup>127</sup>	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospital
<b>A Complete EHR or EHR Module must include the capability to:</b>		
<b>Use Computerized Provider Order Entry (CPOE)<sup>128</sup></b>	<p>Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types:</p> <ol style="list-style-type: none"> <li>1. Medications;</li> <li>2. Laboratory;</li> <li>3. Radiology/imaging; and</li> <li>4. Provider referrals.</li> </ol>	<p>Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types:</p> <ol style="list-style-type: none"> <li>1. Medications;</li> <li>2. Laboratory;</li> <li>3. Radiology/imaging;</li> <li>4. Blood bank;</li> <li>5. Physical therapy;</li> <li>6. Occupational therapy;</li> <li>7. Respiratory therapy;</li> <li>8. Rehabilitation therapy;</li> <li>9. Dialysis;</li> <li>10. Provider consults; and</li> <li>11. Discharge and transfer.</li> </ol>
<b>Implement drug-drug, drug-allergy, drug-formulary checks</b>	<ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>3. Provide certain users with administrator rights to deactivate, modify, and add rules for drug-drug and drug-allergy checking.</li> <li>4. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.</li> </ol>	
<b>Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®</b>	<p>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<sup>%</sup> specified in Table 2A row 1.</p>	

<sup>127</sup> The table in Appendix A includes a percent symbol “%” superscript to indicate instances where the version of an adopted standard (specified in the regulation text) will be “at a minimum” the version to which a Complete EHR or EHR Module must be tested and certified in order to be considered compliant with the adopted standard.

<sup>128</sup> 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).”

**Table 1—Certification Criteria**

Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals <sup>127</sup>	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospital
<b>A Complete EHR or EHR Module must include the capability to:</b>		
<b>Generate and transmit permissible prescriptions electronically (eRx)</b>	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
<b>Maintain active medication list</b>	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.	
<b>Maintain active medication allergy list</b>	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).	
<b>Record demographics<sup>129,130</sup></b>	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.
<b>Record and chart changes in vital signs:</b> <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>	
<b>Record smoking status for patients 13 years old or older</b>	Enable a user to electronically record, modify, and retrieve the smoking status of a patient to: current smoker, former smoker, or never smoked.	

<sup>129</sup> For eligible professionals the full proposed meaningful use Stage 1 objective is: “record demographics: preferred language, insurance type, gender, race, ethnicity, date of birth.”

<sup>130</sup> 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.”

**Table 1—Certification Criteria**

Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals <sup>127</sup>	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospital
<b>A Complete EHR or EHR Module must include the capability to:</b>		
<b>Incorporate clinical lab-test results into EHR as structured data</b>	<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>131</sup></li> <li>4. Enable a user to electronically update a patient’s record based upon received laboratory test results.</li> </ol>	
<b>Generate lists of patients by specific conditions to use for quality improvement reduction of disparities, and outreach</b>	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.	
<b>Report quality measures to CMS or the States<sup>132,133</sup></b>	<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>	
<b>Send reminders to patients per patient preference for preventive/ follow up care</b>	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

<sup>131</sup> 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.

<sup>132</sup> For eligible professionals the full proposed meaningful use Stage 1 objective is “Report ambulatory quality measures to CMS or the States.”

<sup>133</sup> For eligible hospitals the full proposed meaningful use Stage 1 objective is “Report hospital quality measures to CMS or the States.”

**Table 1—Certification Criteria**

Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals <sup>127</sup>	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospital
<b>A Complete EHR or EHR Module must include the capability to:</b>		
<b>Implement 5 clinical decision support rules</b> <sup>134,135</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 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.</li> <li>3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.</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, alerts and care suggestions based upon clinical decision support rules and evidence grade.</li> <li>3. Automatically and electronically track, record, and generate reports on the number of alerts responded to by a user.</li> </ol>
<b>Check insurance eligibility electronically from public and private payers</b>	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.	
<b>Submit claims electronically to public and private payers</b>	Enable a user to electronically submit claims to public or private payers in accordance with the applicable standards specified in Table 2A row 4.	
<b>Provide patients with an electronic copy of their health information upon request</b> <sup>136,137</sup>	Enable a user to create an electronic copy of a patient's clinical information, including, at a minimum, diagnostic test results,	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,

<sup>134</sup> 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”

<sup>135</sup> 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”

<sup>136</sup> 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”

<sup>137</sup> 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”

**Table 1—Certification Criteria**

Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals <sup>127</sup>	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospital
<b>A Complete EHR or EHR Module must include the capability to:</b>		
	problem list, medication list, medication allergy list, immunizations, and procedures in: 1) human readable format; and 2) accordance with the standards <sup>%</sup> specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.	immunizations, discharge summary, and procedures in: 1) human readable format; and 2) accordance with the standards <sup>%</sup> specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.
<b>Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request</b>	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.
<b>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</b>	Enable a user to provide patients with online access to 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
<b>Provide clinical summaries for patients for each office visit</b>	<ol style="list-style-type: none"> <li>1. Enable a user to provide clinical summaries to patients (in paper or electronic form) for each office visit that include, at a minimum, diagnostic test results, medication list, medication allergy list, procedures, problem list, and immunizations.</li> <li>2. If the clinical summary is provided electronically (i.e., not printed), it must be provided in: 1) human readable format; and 2) accordance with the standards<sup>%</sup> specified in Table 2A row 1 to provide to a patient on electronic media, or through some other electronic means.</li> </ol>	No Associated Proposed Meaningful Use Stage 1 Objective

**Table 1—Certification Criteria**

Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals <sup>127</sup>	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospital
<b>A Complete EHR or EHR Module must include the capability to:</b>		
<p><b>Capability to exchange key clinical information among providers of care and patient authorized entities electronically</b><sup>138,139</sup></p> <p><b>Provide summary care record for each transition of care and referral</b></p>	<ol style="list-style-type: none"> <li>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 specified in Table 2A row 1, displaying it in human readable format.</li> <li>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<sup>o</sup> specified in Table 2A row 1.</li> </ol>	<ol style="list-style-type: none"> <li>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.</li> <li>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<sup>o</sup> specified in Table 2A row 1.</li> </ol>
<p><b>Perform medication reconciliation at relevant encounters and each transition of care</b></p>	<p>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.</p>	
<p><b>Capability to submit electronic data to immunization registries and actual submission where required and accepted</b></p>	<p>Electronically record, retrieve, and transmit immunization information to immunization registries in accordance with the standards<sup>o</sup> specified in Table 2A row 8 or in accordance with the applicable state-designated standard format.</p>	

<sup>138</sup> For eligible professionals the full proposed meaningful use Stage 1 objective is “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.”

<sup>139</sup> For eligible hospitals the full proposed meaningful use Stage 1 objective is “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.”

**Table 1—Certification Criteria**

Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals <sup>127</sup>	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospital
<b>A Complete EHR or EHR Module must include the capability to:</b>		
<p><b>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</b></p>	<p>No Associated Proposed Meaningful Use Stage 1 Objective</p>	<p>Electronically record, retrieve, and transmit reportable clinical lab results to public health agencies in accordance with the standards<sup>%</sup> specified in Table 2A row 6.</p>
<p><b>Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice</b></p>	<p>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.</p>	
<p><b>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</b></p>	<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 set period of time.</li> <li>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.</li> <li>8. Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.</li> </ol>	

**Table 1—Certification Criteria**

Proposed meaningful use Stage 1 objectives	Certification criteria to support the achievement of meaningful use Stage 1 by eligible professionals <sup>127</sup>	Certification criteria to support the achievement of meaningful use Stage 1 by eligible hospital
<b>A Complete EHR or EHR Module must include the capability to:</b>		
	<p>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.</p> <p>10. Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in Table 2B row 6.</p>	

For certain certification criteria in Appendix A, a percent symbol “%” superscript is included to indicate instances where the version of an adopted standard (specified in the regulation text) will be “at a minimum” the version to which a Complete EHR or EHR Module must be tested and certified in order to be considered compliant with the adopted standard.

APPENDIX B

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

Row No.	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 <sup>+</sup>	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 Orders and Results	V	LOINC® when LOINC® codes have been received from a laboratory	LOINC®
2	<b>Drug Formula 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

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

Row No.	Purpose	Category	Adopted standard(s) to support meaningful use stage 1	Candidate standard(s) to support meaningful use stage 2
		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 <sup>+</sup>	RxNorm
4	<b>Administrative Transactions</b>	Cx	Applicable HIPAA transaction standards required by law	Applicable HIPAA transaction standards required by law
5	<b>Quality Reporting</b>	Cx	CMS PQRI 2008 Registry XML Specification <sup>#,+</sup>	Potentially newer version(s) or standards based on HIT Standards Committee Input
6	<b>Submission of Lab Results to Public Health Agencies</b>	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	<b>Submission to Public Health Agencies for Surveillance or Reporting (excluding adverse event reporting)</b>	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	<b>Submission to Immunization Registries</b>	Cx	HL7 2.3.1 or HL7 2.5.1	Potentially newer version(s) or standards based on HIT Standards Committee Recommendations
		V	CVX <sup>*,+</sup>	CVX

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.

APPENDIX C

Table 2B—Adopted Privacy and Security Standards		
Row #	Purpose	Adopted Standard
1	<b>General Encryption and Decryption of Electronic Health Information</b>	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). <sup>+</sup>
2	<b>Encryption and Decryption of Electronic Health Information for Exchange</b>	An encrypted and integrity protected link must be implemented (e.g., TLS, IPv6, IPv4 with IPsec). <sup>+</sup>
3	<b>Record Actions Related to Electronic Health Information (i.e., audit log)</b>	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). <sup>+</sup>
4	<b>Verification that Electronic Health Information has not been Altered in Transit</b>	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). <sup>+</sup>
5	<b>Cross -Enterprise Authentication</b>	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). <sup>+</sup>
6	<b>Record Treatment, Payment, and Health Care Operations Disclosures</b>	The date, time, patient identification (name or number), user identification (name or number), and a description of the disclosure must be recorded. <sup>+</sup>

A plus sign “+” indicates a standard that is not a voluntary consensus standard.

**Table 2—Stage 1 Criteria for Meaningful Use**

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 lists of patients who need care and use them to reach out to patients.	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.
	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 .. o preferred language o insurance type o gender o race o ethnicity o date of birth	Record demographics .. o preferred language o insurance type o gender o race o ethnicity o date of birth o date and cause of death in the event of mortality	Record demographics .. o preferred language o insurance type o gender o race o ethnicity o date of birth o date and cause of death in the event of mortality	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: o height o weight o blood pressure o Calculate and display: BMI.	Record and chart changes in vital signs: o height o weight o blood pressure o Calculate and display: BMI.	Record and chart changes in vital signs: o height o weight o blood pressure o Calculate and display: BMI.	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.

**Table 2—Stage 1 Criteria for Meaningful Use**

Health outcomes policy priority	Care goals	Stage 1 objectives		Stage 1 measures
		Eligible professionals	Hospitals	
		<p>oPlot and display growth charts for children 2–20 years, including BMI.</p> <p>Record smoking status for patients 13 years old or older.</p> <p>Incorporate clinical lab-test results into EHR as structured data.</p> <p>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach.</p>	<p>oPlot and display growth charts for children 2–20 years, including BMI.</p> <p>Record smoking status for patients 13 years old or older.</p> <p>Incorporate clinical lab-test results into EHR as structured data.</p> <p>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach.</p>	<p>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.</p> <p>At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.</p> <p>Generate at least one report listing patients of the EP or eligible hospital with a specific condition.</p>

**Table 2—Stage 1 Criteria for Meaningful Use**

Health outcomes policy priority	Care goals	Stage 1 objectives		Stage 1 measures
		Eligible professionals	Hospitals	
Engage patients and families in their health care.	Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health.	<p>Report ambulatory quality measures to CMS or the States.</p> <p>Send reminders to patients per patient preference for preventive/follow up care.</p> <p>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.</p> <p>Check insurance eligibility electronically from public and private payers.</p> <p>Submit claims electronically to public and private payers.</p> <p>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request.</p> <p>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.</p> <p>Provide clinical summaries for patients for each office visit.</p>	<p>Report hospital quality measures to CMS or the States.</p> <p>.....</p> <p>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.</p> <p>Check insurance eligibility electronically from public and private payers.</p> <p>Submit claims electronically to public and private payers.</p> <p>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, procedures), upon request.</p> <p>Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.</p> <p>.....</p> <p>.....</p>	<p>For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule.</p> <p>For 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule.</p> <p>Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over.</p> <p>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).</p> <p>Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP or admitted to the eligible hospital.</p> <p>At least 80% of all claims filed electronically by the EP or the eligible hospital.</p> <p>At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours.</p> <p>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.</p> <p>At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information.</p>

**Table 2—Stage 1 Criteria for Meaningful Use**

Health outcomes policy priority	Care goals	Stage 1 objectives		Stage 1 measures
		Eligible professionals	Hospitals	
Improve care coordination.	Exchange meaningful clinical information among professional health care team.	<p>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.</p> <p>Perform medication reconciliation at relevant encounters and each transition of care.</p> <p>Provide summary care record for each transition of care and referral.</p>	<p>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.</p> <p>Perform medication reconciliation at relevant encounters and each transition of care.</p> <p>Provide summary care record for each transition of care and referral.</p>	<p>Clinical summaries are provided for at least 80% of all office visits.</p> <p>Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.</p> <p>Perform medication reconciliation for at least 80% of relevant encounters and transitions of care.</p>
Improve population and public health.	Communicate with public health agencies.	<p>Capability to submit electronic data to immunization registries and actual submission where required and accepted.</p> <p>Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.</p>	<p>Capability to submit electronic data to immunization registries and actual submission where required and accepted.</p> <p>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.</p> <p>Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.</p>	<p>Provide summary of care record for at least 80% of transitions of care and referrals.</p> <p>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.</p> <p>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).</p> <p>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).</p>
Ensure adequate privacy and security protections for personal health information.	<p>Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law.</p> <p>Provide transparency of data sharing to patient.</p>	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.	<p>Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary.</p>

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