

# How to Earn EHR Incentive Payments

Illinois Association of Healthcare Attorneys  
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# Panelists

Laurel Fleming, Assistant General Counsel  
Northwestern Medical Faculty Foundation  
[lfleming@nmff.org](mailto:lfleming@nmff.org)

Daniel Gottlieb, Partner  
McDermott Will & Emery LLP  
[dgottlieb@mwe.com](mailto:dgottlieb@mwe.com)

Jackie Studer, General Counsel  
GE Healthcare IT  
[jackie.studer@ge.com](mailto:jackie.studer@ge.com)

# Agenda

- Overview of EHR Incentive Programs
- Provider and vendor perspectives on electronic health record (EHR) contracting and implementation issues
- Promises and future of EHR technology
- Question & Answer

# Overview of Incentive Programs

- Incentive programs generally
- Who is an eligible hospital (EHs), eligible critical access hospital (CAH) or an eligible professional (EP)?
- Meaningful Use (MU) and quality reporting
- Timeline
- Incentive Amounts and Calculations

# The HITECH Act and “Meaningful Use”

## •HITECH Act

- Part of American Recovery & Reinvestment Act of 2009 (ARRA)
- \$30B+ for HIT infrastructure and EHR adoption/use

## •Meaningful Use

- Eligible providers must demonstrate MU of a Certified EHR to receive Medicare or Medicaid EHR incentives

Certified EHR

+

Meaningful Use

=

Incentive \$

# EHR Certification Process

- ONC published the temporary EHR certification program final rule on 6/24/2010, which establishes :
  - selection process for testing and certification bodies (ONC-ATCBs)
  - parameters under which the ONC-ATCBs will test and certify that EHR meets the MU Stage 1 EHR certification requirements
- ONC has made a Certified EHR list available on its website



# Certified Health IT Product List

The Office of the National Coordinator for Health Information Technology

HealthIT.HHS.Gov

ONC CHPL - Microsoft Internet Explorer

Address: http://onc-chpl.force.com/ehrcert

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Drummond Group Inc	45170-D-37	Emdeon Inc.	Emdeon Clinician	Complete EHR	N/A	7.4	<a href="#">View Criteria</a>

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# Incentive Programs

- Medicare Part A and Part B will make incentive payments to EOs beginning in FY 2011 and EOs beginning in CY 2011
- Medicare will make incentive payments to certain Medicare Advantage plans under Part C beginning in CY 2011
- Medicaid programs will make incentive payments to EOs beginning CY 2011

# Eligible Hospitals

- Medicare EHs: a hospital located in one of the 50 states or D.C. that participates in the Medicare IPPS; Maryland acute care hospitals; and also CAHs
- Medicaid EH: acute care hospitals meeting Medicaid patient volume requirements, children's hospitals and CAHs
- Multi-campus hospital with a single provider number is a single EH

# Eligible Professionals

- Medicare EPs include doctors of: medicine or osteopathy; dental surgery or dental medicine; podiatric medicine; or optometry or chiropractry
- Medicaid EPs include following who meet Medicaid patient volume requirements: physicians and dentists; NPs; certified nurse-midwives; and PAs practicing in FQHCs or RHCs that are led by a PA
- Professionals who provide 90% or more of their covered services (based on claims) in a hospital inpatient or ER setting are not eligible

# Key Tenets of Meaningful Use

*Examples of clinical change facilitated by HIT and HIE*

## Care coordination

- Exchange key clinical information electronically
- Perform medication reconciliation
- Provide summary care record

## Engage patients

- Provide requesting patients electronic copy of health information
- Timely electronic access to health information
- Provide clinical summaries for each office visit
- Provide requesting hospital;/ED patients electronic discharge summary

## Quality, Efficiency

- CPOE, clinical decision support, eRx interaction checking
- Lab results as structured data in EHR
- Send reminders to patients
- Report quality measures to CMS or states

## Privacy

- Protect electronic health information through technology
- Review security risks and implement security updates

## Public health

- Submit electronic data to immunization registries
- Electronically submit reportable lab results
- Provide syndromic surveillance data to public agencies

# Meaningful Use Measures

- EH and EP must meet core set MU objectives and associated measures
- EH and EP must meet 5 of 10 menu set objectives and associated measures (including 1 public health measure)
- Certain objectives and measures may not be applicable to a particular provider
- If EP practices at multiple sites, 50% of patient encounters must be at site(s) with certified EHR
- Common Medicare and Medicaid measures with some ability for states to add to base

Objective	Measure
<b>Core set†</b>	
Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause of death in the event of mortality)	More than 50% of patients' demographic data recorded as structured data
Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data
Maintain up-to-date problem list of current and active diagnoses	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication list	More than 80% of patients have at least one entry recorded as structured data
Maintain active medication allergy list	More than 80% of patients have at least one entry recorded as structured data
Record smoking status for patients 13 years of age or older	More than 50% of patients 13 years of age or older have smoking status recorded as structured data
For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days; more than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it
On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures)	More than 50% of requesting patients receive electronic copy within 3 business days
Generate and transmit permissible prescriptions electronically (does not apply to hospitals)	More than 40% are transmitted electronically using certified EHR technology
Computer provider order entry (CPOE) for medication orders	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE
Implement drug–drug and drug–allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHR's capacity to electronically exchange information
Implement one clinical decision support rule and ability to track compliance with the rule	One clinical decision support rule implemented
Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies
Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures

The “Meaningful Use” Regulation for Electronic Health Records, David Blumenthal, M.D., M.P.P., and Marilyn Tavenner, R.N., M.H.A., NEJM, 7/13/ 2010

Menu set:	
Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period
Incorporate clinical laboratory test results into EHRs as structured data	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition
Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	More than 10% of patients are provided patient-specific education resources
Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50% of transitions of care
Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for more than 50% of patient transitions or referrals
Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)
Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Additional choices for hospitals and critical access hospitals	
Record advance directives for patients 65 years of age or older	More than 50% of patients 65 years of age or older have an indication of an advance directive status recorded
Submit of electronic data on reportable laboratory results to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
Additional choices for eligible professionals	
Send reminders to patients (per patient preference) for preventive and follow-up care	More than 20% of patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders
Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, medication allergies)	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR

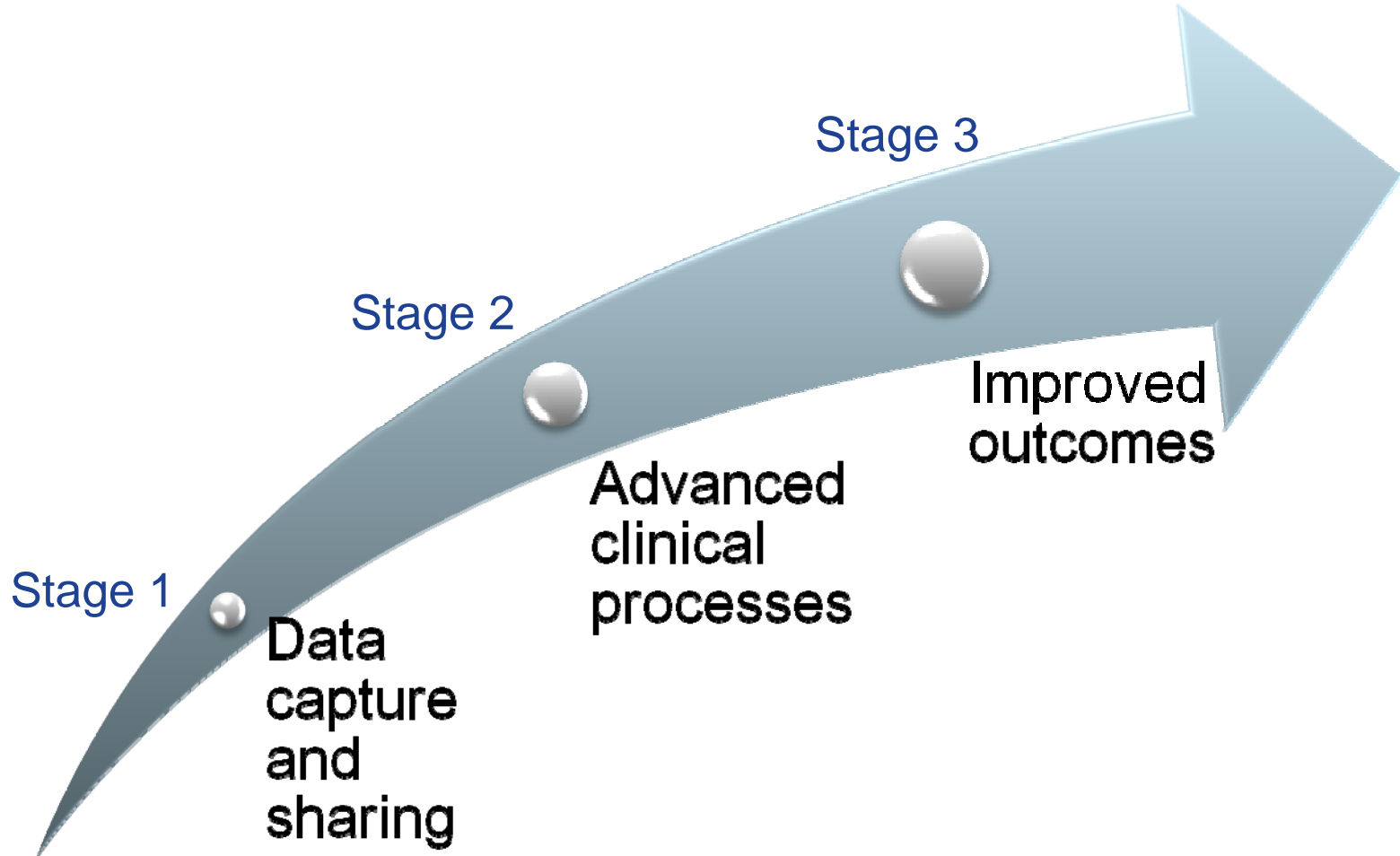
# The Path to 2015: Stages by Start Year

## CMS Eased Stage Compression for Later Starts

First Payment Year	2011	2012	2013	2014	2015 and later**
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD
2015 and later*					TBD

NPRM had compressed path to Stage 3 for starts after 2011 so all aligned by 2015 – In Final Ruled, CMS defers on establishing policy after 2014

# Evolution of Meaningful Use



# Clinical Quality Reporting

- To earn incentives, eligible providers must also report information on clinical quality measures (CQMs) to CMS
- EPs must report on 3 core (or alternative core) CQMs and 3 additional CQMs
- EHs and CAHs must report on 15 CQMs

# Registration

- To participate in incentive programs, eligible provider must register on incentive program website at <http://www.cms.gov/EHrIncentivePrograms/>
- Medicaid programs will interface with program registration website
- Registration begins in January 2011

# CMS EHR Incentives Website


U.S. Department of Health & Human Services [www.hhs.gov](http://www.hhs.gov)

**CMS** Centers for Medicare & Medicaid Services

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EHR Incentive Programs	Overview
<ul style="list-style-type: none"><li>▶ <b>Overview</b></li><li>» <a href="#">Spotlight and Upcoming Events</a></li><li>» <a href="#">Getting Started</a></li><li>» <a href="#">Eligibility</a></li><li>» <a href="#">Certification</a></li><li>» <a href="#">Meaningful Use</a></li><li>» <a href="#">Registration</a></li><li>» <a href="#">Medicare Eligible Professional</a></li><li>» <a href="#">Medicaid Eligible Professional</a></li><li>» <a href="#">Hospitals</a></li><li>» <a href="#">Medicare Advantage</a></li><li>» <a href="#">Information for States</a></li></ul>	<p style="text-align: center;"><i>Connecting America for Better Health</i></p>  <p><b>The Official Web Site for the Medicare and Medicaid EHR Incentive Programs</b></p> <p>This official web site provides up-to-date, detailed information about the Electronic Health Record (EHR) incentive programs. Use the tabs to the left to find additional information regarding various aspects of the program.</p> <p><b>Background</b></p> <p>The nation's healthcare system is undergoing a transformation in an effort to improve quality, safety and efficiency of care, from the upgrade to ICD-10 to information exchanges of EHR technology. To help facilitate this vision, the Health Information Technology for Economic and Clinical Health Act, or the "HITECH Act" established programs under Medicare and Medicaid to provide incentive payments for the "meaningful use" of certified EHR technology. The Medicare and Medicaid EHR incentive programs will provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The programs begin in 2011. These incentive programs are designed to support providers in this period of Health IT</p>

# Attestation

- Eligible providers demonstrate MU to CMS through one-time, secure web-based attestation in 2011 and attestation and electronic reporting of clinical quality information in 2012
- Providers may submit attestations to CMS as early as April 2011 and payment begins as early as May 2011 following attestation
- State Medicaid programs must determine attestation and/or reporting mechanisms

# Medicare Incentives Timeline

- *Fall 2010*: Certified EHR technology on EHR incentive program website
- *January 2011*: Registration begins on incentive program website
- *April 2011*: Attestation of MU begins through web tool
- *May 2011*: Medicare incentive payments begin

# Medicare FFS Incentives to EPs

- Medicare EPs may receive incentives equal to an additional 75% of the Medicare allowable charge under the Medicare Physician Fee Schedule for covered professional services, for up to five years beginning as early as CY 2011
- Incentive payments are subject to annual caps which allow total incentives of \$44,000 per physician over the five-year period

# Medicare Incentive Payments

Calendar year	First calendar year in which the Eligible Professional receives an incentive payment				
	2011	2012	2013	2014	2015 +
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>

**Medicare Penalties: % of allowed charges: 2015 (1%), 2016 (2%), 2017+**

# Medicaid Incentives to EPs

- Medicaid incentive payments to qualified Medicaid EPs are equal to 85 percent of “Net Average Allowable Costs” for certified EHR technology (and support services for the technology), subject to caps of \$21,250 in the first payment year and \$8,500 in the five subsequent years
- The maximum aggregate incentive payment for the six-year period is \$63,750, provided that the first payment year is no later than 2016

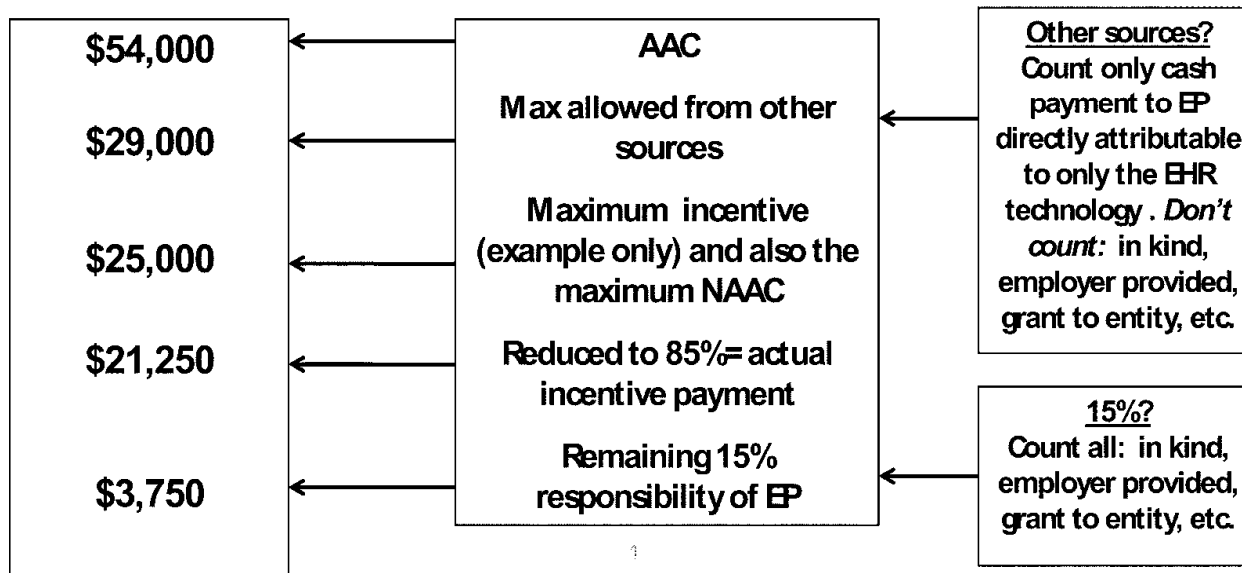
# Medicaid Incentives to EPs

## Payments: NAAC calculation

Average allowable costs (AAC) minus payments from other sources:

– State and local sources not considered

= Net average allowable costs (NAAC)



# Medicaid Incentive Payments

Adoption year	First calendar year in which the qualifying Eligible Professional receives an incentive payment					
	2011	2012	2013	2014	2015	2016
2011	\$21,250					
2012	\$8,500	\$21,250				
2013	\$8,500	\$8,500	\$21,250			
2014	\$8,500	\$8,500	\$8,500	\$21,250		
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018			\$8,500	\$8,500	\$8,500	\$8,500
2019				\$8,500	\$8,500	\$8,500
2020					\$8,500	\$8,500
2021						\$8,500
<b>TOTAL</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>

# Medicare Incentives to Hospitals

- Medicare incentives to EHs are based on a formula that takes into account the number of discharges and the proportion of discharges that are Medicare FFS and Advantage patients
- Medicare incentives to CAHs are based on the same factors and also the CAH's reasonable costs for the purchase of Certified EHR Technology

# Medicare Incentive Policies: Hospitals

## Incentive Payment Calculation for Hospitals

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

- **Initial Amount** = \$2,000,000 + [\$200 per discharge for the 1,150<sup>th</sup> – 23,000<sup>th</sup> discharge]
- **Medicare Share** =  $Medicare / (Total * Charges)$ 
  - **Medicare** = [number of Inpatient Bed Days for Part A Beneficiaries] plus [number of Inpatient Bed Days for MA Beneficiaries]
  - **Total** = [number of Total Inpatient Bed Days]
  - **Charges** = [Total Charges minus Charges for Charity Care\*] divided by [Total Charges]
- **Transition Factor**: Year 1 -1, Year 2 - .75, Year 3 - .5, Year 4 - .25

\*If data on charity care unavailable, HHS will use data on uncompensated care as proxy. If proxy data unavailable, “Charges” equal 1.

# Medicare Incentive Policies: Hospitals

## 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

**Hospital penalties start 2015: .25., .5, .75 of annual “market basket” update: CMS expects to be major driver of hospital adoption**

# Medicaid Incentives to Hospitals

- Medicaid incentives to EHs are based on a formula that takes into account the number of hospital discharges of Medicaid patients and the share of bed days attributable to Medicaid patients
- Unlike EPs, EHs and CAHs may receive both Medicare and Medicaid incentives

# Contracting and Implementation

- IT/IP risk allocation in EHR agreements
  - Analytical framework
  - Types of risk and variables
  - Tools to mitigate and manage risk
- Specific risk considerations
- Representations and warranties
- Avoiding false claim liability

# Allocation of IT/IP Risk

- Analytical framework for allocating risk in an EHR license agreement:
  - Can the risk be eliminated for both parties?
  - If not, which party is best situated to manage the risk? It is helpful to distinguish between what is in the provider's control or the vendor's control.
  - For a risk that remains with a party, how can that party manage, mitigate or transfer the risk?

# Allocation of IT/IP Risk (cont'd)

- The available mechanisms for managing, mitigating or transferring risk depend on the type of risk and other variables
- Types of risk include:
  - PHI
  - Infringement of intellectual property rights
  - Testing and acceptance
  - Implementation

# Allocation of IT/IP Risk (cont'd)

- Variables affecting License Agreements:
  - Whether hardware, software, consulting, maintenance and/or support is included
  - Off-the-shelf or customized products (including customized interfaces for HIE)
  - Relative sophistication of the parties
  - Each party's available resources
  - Compatibility of product with existing HIT
  - Applicable laws (e.g., MU, HIPAA & HITECH)

# Tools to Mitigate IT/IP Risk

- What tools are available to mitigate, manage or transfer risk?
  - Clear delineation of each party's responsibilities
  - Clear definition of services being purchased
  - Clear expectations regarding resources & timing
  - Policies and procedural safeguards
  - Training
  - User documentation
  - Contractual duty to mitigate
  - Insurance
  - Milestone payments tied to implementation schedule

# Tools to Mitigate IT/IP Risk (cont'd)

- Aligning liability with risk management:
  - Indemnification
  - Limitation of liability
  - Remedies
    - Termination
    - Refunds and liquidated damages
    - Specific performance
    - Repairs

# MU Risk Considerations

- Vendor responsibility for obtaining EHR certification
  - Has vendor obtained or applied for certification of EHR from ONC-ATCB?
  - Has provider obtained certification of custom EHR?

# MU Risk Considerations (cont'd)

- Clarify steps and timetable required for provider to achieve MU in 2011 or future
  - What MU implementation steps is vendor responsible for?
  - Does contract include a detailed work plan with MU implementation schedule, including testing and acceptance and training?
  - What support is vendor providing to provider's MU implementation efforts?

# MU Risk Considerations (cont'd)

- Use of third-party software in certified product
  - Complete EHR : A provider may license a complete EHR product meeting all certification requirements from a single vendor that incorporates third-party software
  - Modular Approach: Provider may license a coordinated bundle of certified modules which create a complete EHR from one vendor or separately license the modules from applicable vendors

# MU Risk Considerations (cont'd)

- A license agreement covering third-party software should address responsibility for
  - Certification of modules if applicable
  - IP risk related to third-party software
  - Flow down of third-party license requirements and representations and warranties
  - Other typical third-party software issues

# Risk Considerations (cont'd)

- Use of existing products to attain MU
  - Providers should confirm which versions of a vendor's EHR software are certified
  - What assurances can vendor provide regarding updates for MU stage 2 and 3?

# Risk Considerations (cont'd)

- Customization of EHR technology
  - Customization of an otherwise certified EHR may require provider to seek certification of the customized version of the EHR
  - Vendors should notify provider if provider's customization will cause product to lose certification

# Risk Considerations (cont'd)

- Relationships among providers
  - If a professional or professional group will rely on a facility's EHR to demonstrate MU, it should take reasonable steps to confirm certification of facility's EHR
  - Providers should consider amending employment agreements and other contracts with eligible professionals to address reassignment of right to receive incentive payments if contracts are unclear

# HIT Certification

## HIT certification assurances:

- Check CMS Website for certified products
- Determine requirements: modular or complete
- Reputation and size of vendor
- Skin in the game
- Representations, warranties and remedies
  - Unknown future certification & MU requirements
  - Rev Rec
  - FDA
  - False Claims



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CCHIT	45170-C-83	Greenway Medical Technologies, Inc.	PrimeSuite	Complete EHR	N/A	2011	<a href="#">View Criteria</a>
CCHIT	45170-C-83	SuiteMed	Intelligent Medical Software (IMS)	Complete EHR	N/A	V14	<a href="#">View Criteria</a>
CCHIT	45170-C-83	nextEMR, LLC	nextEMR, LLC	Complete EHR	N/A	1.5	<a href="#">View Criteria</a>
CCHIT	45170-C-83	DocPatientNetwork	Docutations	Complete EHR	N/A	2	<a href="#">View Criteria</a>
Drummond Group Inc	45170-D-37	Kabot Systems	VistA++ EHR Office Edition	Complete EHR	N/A	2.0.0.1	<a href="#">View Criteria</a>
Drummond Group Inc	45170-D-37	Emdeon Inc.	Emdeon Clinician	Complete EHR	N/A	7.4	<a href="#">View Criteria</a>

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# Representations and Warranties (cont'd)

- Receipt of Incentive Payments:
  - Warranties from vendor that provider will receive incentive payment should be viewed with suspicion
  - How can a vendor warrant that a provider has attested accurately?

# False Claims Liability

- An eligible provider must attest that it is a meaningful user of a certified EHR to receive incentive payments and report quality measures
- False attestation may be the basis for an action under False Claims Act (or similar state law)
- How can an eligible provider avoid or limit its liability for civil and criminal penalties for false claims for MU incentives?

# False Claims Liability (cont'd)

- What can the provider control?
  - Exceed minimum number of MU menu set measures and CQMs
  - Implement compliance program procedures:
    - Training of EPs and hospital personnel on MU requirements and documentation
    - Auditing and monitoring of compliance
    - Document compliance with requirements for receiving the incentive payments

# False Claims Liability (cont'd)

- A vendor's false statements could be the basis of an allegation that the vendor caused a provider to submit a false claim
- How can a vendor limit its potential liability under false claims laws as a result of how it markets its EHR technology?

# False Claims Liability (cont'd)

- What can the vendor control?
  - Avoid overstatements in marketing and advertising materials
  - Avoid promises outside the vendor's control
  - Do not assume responsibility for provider implementation efforts outside the vendor's control

# Future Promise

- Enhanced role of IT in practice of medicine: A tool or a medical device?
- Use of EHR data for development and delivery of personalized medicine and evidence-based care
- Development of a new approach to patient safety and liability/accountability for adverse events

# Questions



# How to Earn EHR Incentive Payments

Illinois Association of Healthcare Attorneys  
28<sup>th</sup> Health Law Symposium  
October 26, 2010