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Health Law Alert

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The Medicare and Medicaid EHR Incentive Programs: What You Need To Know

I. Introduction:

CMS, pursuant to the American Recovery and Reinvestment Act of 2009 ("ARRA"), published a final rule on July 28, 2010 (the "Rule") setting forth the parameters by which certain eligible professionals and hospitals must demonstrate "meaningful use" of certified electronic health records technology ("EHR") in order to qualify for incentive payments. ARRA established 2 programs (the "EHR Programs") under which providers can receive incentive payments for meaningful use of EHR, one under Medicaid, known as the "Medicaid Incentive Program" and one under Medicare, known as the "Medicare Incentive Program."

With this Client Alert, it is our goal to decipher this complex rule and provide a concise summary so that our clients can decide whether to participate in the EHR Programs and if so, what program(s) to elect and how to best prepare themselves. We have therefore prepared this Client Alert to: (i) give you an overview of the EHR Programs; (ii) explain who's eligible to participate in the EHR Programs; (iii) summarize the financial incentives and penalties for those who do and do not meaningfully use EHR; and (iv) briefly outline how to demonstrate "meaningful use" of EHR.

Our Client Alert also provides a general action plan designed to aid you in your efforts to become a meaningful user of EHR. The action plan is a non-specific plan which may not take into account circumstances which may be specific to your personal situation and we therefore encourage you to contact one of our attorneys if you are interested in receiving guidance on circumstances specific to you. We expect there to be more clarification and guidance from the government as time goes on and we will keep you informed. Finally, we have provided a timeline of significant dates and a question and answer section which we hope will be useful to you.

II. Medicare EHR Incentive Program:[1]

A. Who's eligible?

1. ***Eligible Professionals:*** Under the Medicare EHR Incentive Program, only non-hospital-based doctors of medicine or osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, or chiropractors ("Medicare EPs") are eligible to receive the incentive payments once they have demonstrated meaningful use of EHR.[2] To qualify as non-hospital-based, the Medicare EP must not provide 90% or more of his or her services in a hospital inpatient or emergency room setting.

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1 ARRA also provides for a Medicare Advantage ("MA") Incentive Program not discussed in this Client Alert. Under this program, Medicare EHR incentive payments may be made to qualifying MA organizations for the meaningful use of EHR by their affiliated and eligible professionals and hospitals. MA organizations are those that are licensed as HMOs, or in the same manner as HMOs, by a state. To be eligible, MA-affiliated professionals must furnish, on average, at least 20 hours/week of patient-care services and be employed by the qualifying MA organization or must be employed by, or be a partner of, an entity that through contract with the qualifying MA organization furnishes at least 80% of the entity's Medicare patient care services to enrollees of the qualifying MA organization. An MA-affiliated hospital will be eligible if the hospital is under common corporate governance with the MA organization and primarily serves individuals enrolled in MA plans offered by the MA organization. For more information on the Medicare Advantage Incentive Program please contact the attorneys listed at left.

2 In contrast, midlevel practitioners may qualify under the Medicaid Incentive Program.

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2. ***Hospitals:***[3] Acute care hospitals paid under the hospital inpatient prospective payment system ("IPPS") and located in 1 of the 50 U.S. states or the District of Columbia ("Medicare Eligible Hospitals"), will qualify for the Medicare incentive payments if they demonstrate meaningful use of EHR.

B. What are the Medicare incentives?

1. ***Eligible Professionals:*** To qualify for Medicare incentive payments, Medicare EPs must be meaningful users of EHR in each year that they wish to receive these incentive payments. For those Medicare EPs who become meaningful users by 2012, they can receive up to $44,000 over a 5-year period as reflected in **Table I** below.

Table I: Medicare EP Incentive Payments

PAYMENT YEAR	INCENTIVE PAYMENT LIMIT STARTING IN 2011	INCENTIVE PAYMENT LIMIT STARTING IN 2012	INCENTIVE PAYMENT LIMIT STARTING IN 2013	INCENTIVE PAYMENT LIMIT STARTING IN 2014	INCENTIVE PAYMENT LIMIT STARTING IN 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	------
2016	------	$2,000	$4,000	$4,000	------
Total*	**$44,000**	**$44,000**	**$39,000**	**$24,000**	**$0****

*Please note that for Medicare EPs who predominantly (more than 50%) furnish services in a health professional shortage area ("HPSA"), the incentive payment maximum is increased by 10%.
**While there are no incentive payments for meaningful users in 2015, participation as a meaningful user by 2015 will prevent Medicare EPs from being subject to penalties as described below.

a. How are the incentive payments calculated? The incentive amount, subject to the annual limits listed above in **Table I**, will be equal to 75% of a Medicare EP's Medicare physician fee schedule allowed charges for the calendar year ("CY") submitted no later than 2 months after the end of the CY. For 2011, this means the incentive payment would be 75% of the Medicare EP's Medicare physician fee schedule allowed charges for CY 2011 based on claims for services performed by the Medicare EP between 01/1/2011-12/31/2011 and submitted to the Medicare EP's contractor no later than 2/29/2012, subject to an $18,000 limit.

b. What are the important timeframes to consider? Medicare EPs may receive incentive payments for up to 5 years if he or she begins to participate in 2011 or 2012. For example and as reflected in **Table I**, if a Medicare EP demonstrates meaningful use by 2011 or 2012, the Medicare EP may qualify to receive incentive payments for 5 years. On the other hand, if the Medicare EP starts in 2013 or 2014, he or she will only receive incentive payments for 4 or 3 years, respectively, and the incentive maximum amounts are reduced. If a Medicare EP demonstrates meaningful use in 2015, the incentive payment will be $0 but there will be no reduction or penalty in the Medicare reimbursement rate for that provider (see Section c. below).

[3] Please note that Critical Access Hospitals ("CAHs") are also eligible to receive Medicare and Medicaid incentive payments. The applicable rules and requirements for CAHs, however, are not discussed in this Client Alert. For more information on incentives specific to CAHs, please contact the attorneys listed below.

c. Are there any penalties for not implementing and meaningfully using EHR? If a Medicare EP does not successfully demonstrate meaningful use of EHR by 2015, his or her fee schedule amount for covered professional services will be reduced by 1% in 2015, 2% in 2016, and 3% in 2017 and thereafter. Moreover, if CMS determines for 2018 and subsequent years that less than 75% of all Medicare EPs are meaningful users of EHR, then the payment adjustment will decrease a further 1% annually until it reaches 5%. The Rule provides for a hardship exception, which if applicable, will exempt a Medicare EP from the payment adjustment on an annual basis for up to 5 years.[4]

2. Hospitals:

a. How are the incentive payments calculated? In general, the Medicare incentive payment for eligible hospitals is the product of 3 factors:

The "Initial Amount" multiplied by the "Medicare Share" multiplied by the applicable "Transition Factor"

i. Initial Amount: The Initial Amount equals the base amount of $2,000,000 plus the discharge amount. The discharge amount provides an additional $200 for each acute care hospital discharge during the relevant payment year, beginning with the Medicare Eligible Hospital's 1,150th discharge and ending with the 23,000th discharge. No additional discharge payments are made for the Medicare Eligible Hospital's discharges made before the 1,150th discharge or after the 23,000th discharge. Please see **Table II** for an example of an Initial Amount Calculation.

Table II: Initial Amount Calculation for Medicare Eligible Hospitals

Type of Hospital	Hospitals with 1,149 or fewer discharges during the payment year	Hospitals with at least 1,150 but no more than 23,000 discharges during the payment year	Hospitals with 23,001 or more discharges during the payment year
Base Amount	$2,000,000	$2,000,000	$2,000,000
Discharge-Related Amount	$0	$200 x (n-1,149) (n is the number of discharges during the payment year)	$200 x (23,001-1,149)
Total Initial Amount	$2,000,000	Between $2M and $6,370,400 depending on the number of discharges	Limited by law to $6,370,400

ii. Medicare Share: The formula for the Medicare Share calculation is as follows: Number of Inpatient Medicare Part A Bed Days plus Number of Inpatient Medicare Part C Days divided by Total Inpatient Bed Days multiplied by (Total charges minus Charges Attributable to Charity Care) divided by Total charges.

$$\frac{\text{\# of IP Part A Bed Days + \# of IP Part C Days}}{\text{Total IP Bed Days}} \times \frac{\text{[Total Charges - Charges Attributable to Charity Care]}}{\text{Total Charges}}$$

[4] The criteria to qualify for the hardship exception have not yet been issued.

- The numerator of the Medicare Share is the sum of the estimated number of acute care inpatient-bed-days attributable to individuals for whom payment may be made under Part A plus the estimated number of acute care inpatient days attributable to individuals who are enrolled in a Medicare Advantage program under Part C.

- The denominator of the Medicare Share is the product of the estimated total number of acute care inpatient-bed-days for the Medicare Eligible Hospital during such period plus the estimated total amount of the Medicare Eligible Hospital's charges during such period not including any charges that are attributable to charity care[5] divided by estimated total amount of the Medicare Eligible Hospital's charges during such period.

iii. Transition Factor: The Transition Factor equals 1, .75, .50 and .25 for the first, second, third and fourth payment years, respectively. For late starters, the Transition Factor is reduced to .75 and .50 if the first payment year is in 2014 or 2015, respectively, as shown in **Table III** below.

Table III: Transition Factors for Medicare 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

b. What are the important timeframes to consider? Medicare Eligible Hospitals that are meaningful users of EHR can begin receiving incentive payments in FY 2011 through 2015. Medicare Eligible Hospitals that demonstrate meaningful use by FYs 2011, 2012 or 2013 can receive up to 4 years of incentive payments. Medicare Eligible Hospitals that demonstrate meaningful use starting in 2014 will receive incentive payments for 3 years and if starting in 2015 for 2 years. As indicated in **Table III** above, a reduced transition factor will apply if a Medicare Eligible Hospital first qualifies for Medicare incentive payments in 2014 or 2015.

c. Are there any penalties for not implementing and meaningfully using EHR? If a Medicare Eligible Hospital is not a meaningful user of EHR by 2015, its market basket update to the IPPS payment rate will be reduced by .25, .50 and .75 for FYs 2015, 2016 and 2017 (and subsequent years), respectively.

III. Medicaid EHR Incentive Program:

A. Who's eligible?

1. Eligible Professionals: Under ARRA, State Medicaid programs may elect to have a Medicaid Incentive Program to make Medicaid EHR incentive payments to non-hospital-

[5] Charity care is defined as the uncompensated and indigent care described/used for Medicare cost report purposes.

based eligible professionals ("Medicaid EPs") who demonstrate meaningful use of EHR. As with the Medicare Incentive Program, a provider will be considered to be hospital-based and thus, ineligible to receive Medicaid incentive payments, if he or she provides 90% or more of their services in an inpatient hospital or hospital emergency room setting.[6] Unlike the Medicare Incentive Program, however, Medicaid EPs can include not only physicians[7] and dentists but also certified nurse-midwives, nurse practitioners and physician assistants ("PA") who practice in a Federally Qualified Health Center ("FQHC") or Rural Health Clinic ("RHC") that is "led"[8] by the PA. While the types of providers who are eligible in the Medicaid Incentive Program is broader than in the Medicare Incentive Program, the Medicaid Incentive Program adds the additional requirement that Medicaid EPs satisfy a 30% Medicaid patient volume minimum threshold (that is 30% of all of the Medicaid EPs patient encounters over any continuous 90-day period must be Medicaid patients) to receive the incentive payments. The only 2 exceptions to this patient volume requirement are pediatricians (who have a 20% patient volume requirement) and Medicaid EPs who practice predominantly in FQHCs or RHCs who have a 30% "needy individual"[9] (instead of Medicaid patient) patient volume requirement. Thus, we believe that more providers will qualify for the Medicare Incentive Program than the Medicaid Incentive Program.

2. ***Hospitals:*** Acute care and children's hospitals ("Medicaid Eligible Hospitals"), as defined by CMS, are eligible to receive incentive payments under the Medicaid Incentive Program.[10] Acute care hospitals are defined as a health care facility where the average length of stay is 25 days or fewer and with a CMS Certification Number ("CCN") that has the last 4 digits in the series 0001-0879 (i.e. short-term general hospitals and 11 cancer hospitals in the U.S.). Children's hospitals are defined as a separately certified children's hospital, with CCNs of 3300-3399, and predominantly treats individuals under the age of 21. In addition, acute care hospitals must also meet a 10% Medicaid patient threshold to qualify for incentive payments. Children's hospitals do not need to meet this 10% patient threshold to qualify for incentive payments.

B. What are the Medicaid incentives?

1. ***Eligible Professionals:*** To qualify for Medicaid incentive payments, Medicaid EPs must adopt, implement, upgrade or demonstrate meaningful use of EHR in the first year of participation. Medicaid EPs must then demonstrate meaningful use in years 2-6 of participation. Medicaid EPs can receive up to $63,750 over 6 years as shown in **Table IV** below. Incentive payments for pediatricians who meet the 20% Medicaid patient volume but fall short of the 30% Medicaid patient volume are reduced to 2/3 of the incentive payment.[11]

    a. How are the incentive payments calculated? In general, payment for Medicaid EPs equals 85% of the "Net Average Allowable Costs" (the "NAAC") for the EHR. The maximum for this amount is $25,000 in the first year and up to $10,000 for each of

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6 Please note that Medicaid EPs who "practice predominantly" in a Rural Health Clinic or Federally Qualified Health Center are not subject to the hospital-based rules. Practice predominantly means that over 50% of the provider's total patient encounters over a period of 6 months occurs at the FQHC or RHC.

7 For the Medicaid Incentive Program, "physician" is defined by state law.

8 In general, "led" means either the PA (i) is the primary provider in the FQHC or RHC; (ii) is the FQHC's or RHC's clinical or medical director; or (iii) owns the RHC.

9 In general, "needy individuals" means patients who are either (i) Medicaid or CHIP beneficiaries; (ii) furnished uncompensated care; or (iii) provided services at either no cost or reduced cost based on ability to pay.

10 Critical Access Hospitals are also eligible to receive incentive payments under the Medicaid Incentive Program.

11 Pediatricians who meet the 30% patient volume requirement may qualify to receive the maximum incentive payments.

the 5 subsequent years. Thus, the maximum incentive payment over a 6-year period equals 85% of $75,000 or $63,750. A Medicaid EP's NAAC is determined by taking the costs associated with the Medicaid EP's purchase of the EHR and/or the costs of related support services, implementation, training, upgrade, operating, use and maintenance. The Medicaid EP, however, must exclude from their cost calculation any discounts or technology donations that they received. Thus, if the Medicaid EP is receiving software from the hospital he or she is affiliated with, he or she cannot include the software costs in the NAAC calculation. The only exception to this requirement is that payments from State or local governments do not reduce the average allowable costs. The resulting figure is the "net" average allowable cost, that is, average allowable cost minus payments from other sources (other than State or local governments).

b. What are the important timeframes to consider? State Medicaid agencies may begin offering EHR incentive payments as early as January 2011. The last year to begin participating in the Medicaid EHR Incentive Program is 2016. EPs may receive Medicaid EHR incentive payments for up to 6 years; 2021 is the final year for Medicaid EHR incentive payments. Unlike the Medicare Incentive Program, the Medicaid Incentive Program provides incentive payments for up to 6 years and Medicaid EPs can start as late as 2016 to receive the full 6-year amount as demonstrated in **Table IV** below.

Table IV: Medicaid EP Incentive Payments

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

2. Hospitals:

a. How are the incentive payments calculated? The Medicaid EHR incentive amount equals:

The product of the "Overall EHR Amount" multiplied by the "Medicaid Share"

i. Overall EHR Amount: The Overall EHR Amount is the sum over a theoretical 4 years of payment where the amount for each year is the product of the Initial Amount (same as Medicare) multiplied by the Medicare Share (same as Medicare) multiplied by the Transition Factor (same as Medicare).

ii. Medicaid Share:

$$\frac{\text{Estimated \# of Medicaid IP Bed Days plus Estimated \# of Medicaid Managed Care IP Bed Days}}{\text{Estimated Total \# of IP Bed Days multiplied by Estimated Total Amount of Charges (not including charity care) divided by estimated total amount of charges}}$$

- The numerator of the Medicaid Share is the sum of the estimated number of Medicaid inpatient-bed-days and the estimated number of Medicaid managed care inpatient-bed-days.

- The denominator of the Medicaid Share is the product of the estimated total number of inpatient-bed-days for the Medicaid Eligible Hospital during that period and the estimated total amount of the Medicaid Eligible Hospital's charges during that period, not including any charges that are attributable to charity care divided by the estimated total amount of the Medicaid Eligible Hospital's charges during that period.

b. What are the important timeframes to consider? Assuming the state where the Medicaid Eligible Hospital is located is participating in the Medicaid Incentive Program, Medicaid Eligible Hospitals can begin receiving incentive payments in any FY from 2011-2016. States may pay Medicaid Eligible Hospitals up to 100% of a total EHR incentive amount over a minimum of a 3-year period and maximum 6-year period.

IV. What constitutes meaningful use for both the Medicare and Medicaid Incentive Programs?

To receive either the Medicare or Medicaid incentive payments, a provider must be a meaningful user of EHR. "Meaningful use" requires: (1) use of EHR in a **meaningful manner**; (2) connection of this EHR in a manner that provides for the **electronic exchange** of health information to improve the quality of care; and (3) in using this technology, the provider submits to CMS information on **clinical quality measures** and such other measures selected by CMS.

Currently, the Rule only establishes parameters for meaningful use during fiscal years or calendar years 2011 and 2012 ("Stage 1 of the EHR Programs"). Additional objectives and measures will be added in the future and providers will need to meet such additional objectives. For Stage 1 of the EHR Programs, meaningful use is demonstrated if the provider meets the threshold objectives and associated measures set forth in the Rule. For eligible professionals, he or she must meet 15 of the core objectives identified by the Rule plus an additional 5 objectives from a menu set of objectives. Eligible hospitals are required to meet 14 core objectives plus an additional 5 objectives from a set of 10 menu objectives.

The following have been identified as "core objectives":

- Use Computerized Physician Order Entry
- Implement drug to drug and drug allergy interaction checks
- E-prescribing
- Record demographics (preferred language, gender, race, ethnicity, date of birth and date and cause of death in event of mortality)
- Maintain an up-to-date problem list
- Maintain active medication list
- Maintain active medication allergy list
- Record and chart changes in vital signs
- Record smoking status (for patients 13 years and above)
- Implement one clinical decision support rule
- Report clinical quality measures as specified by the Department of Health and Human Services
- Electronically exchange key clinical information
- Provide patients with an electronic copy of their health information
- Provide patients with electronic copy of their discharge instructions (eligible hospital/CAH only)

- Provide clinical summaries for patients for each office visit (eligible professionals only)
- Protect electronic health information created or maintained by EHR

The following have been identified as "menu objectives":

- Implement drug-formulary checks
- Record advance directives for patients 65 years old or older (applies to eligible hospitals only)
- Incorporate clinical lab-test results into EHR technology as structured data
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach
- Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the eligible professional (applies to eligible professionals only)
- Use EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
- Eligible provider who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation
- The eligible provider who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care for each transition of care or referral
- Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice
- Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice (applies to eligible hospitals only)
- Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice

In addition to meeting the core objectives and their associated measures above and the menu objectives and their associated measures, providers must meet certain clinical quality core measures. An eligible professional must meet 6 clinical quality measures, 3 of which must be from the core clinical quality measures and 3 from the alternative clinical quality measures for eligible professionals. Eligible hospitals are required to meet 15 clinical quality measures.[12] Finally it is important to note that for Stage 1, the requirement is solely to report on all these measures, not satisfy them.

V. Relationship of Stark and Anti-Kickback Statute Safe Harbors to the Medicare and Medicaid Incentive Programs:

Eligible professionals and hospitals may consider working cooperatively to adopt and implement EHR through a donation of EHR software by a hospital to an eligible professional. When contemplating such an arrangement, the parties must ensure compliance with both the Stark and Anti-kickback laws. If certain requirements are satisfied, both laws permit hospitals to donate EHR software and related training services to physicians. Key requirements common to both laws include a written agreement, the software being deemed "interoperable" by an appropriate certifying organization and the physician paying 15% of the donor hospital's cost.

An eligible professional who decides to participate in a donation arrangement with a hospital should consider how such a donation might affect his or her incentives under the Medicare and Medicaid Incentive Programs. Under the Medicare Incentive Program, receiving donated

[12] The clinical quality measures can be found at Table 6 on pages 44398-44408 of the Rule found at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

software from a hospital will not affect the amount of incentives an eligible professional may receive. However, under the Medicaid Incentive Program, because the incentives are tied to actual costs, an eligible professional cannot claim donated items as a cost when determining incentive payments. Thus, eligible professionals should consider the impact of hospital donations when deciding which EHR Program to enroll in.

VI. Getting Started/Action Plan:

A. Determine if you are an eligible professional or eligible hospital under the Medicaid or Medicare Incentive Programs.

B. For eligible professionals who qualify for both the Medicare and Medicaid Incentive Programs, decide which one to apply for because you cannot participate in both. Clearly, if you do not meet the Medicaid patient volume thresholds, Medicare will be your only choice.

   NOTE: CMS is developing a section on its website to assist individuals to determine if they are eligible for the EHR Programs and which program is best for them.

C. Assuming you qualify as an eligible professional or hospital, you must begin the process of obtaining certified software. CMS is creating a list of vendors who can provide you with such technology and software and will be posting such list on its website. At this time, CMS has only listed its certifying agents.

D. Register / Enroll in the incentive program through CMS's online portal or through your state's Medicaid Incentive Program. Note that eligible hospitals and professionals enrolling in the EHR Programs must have a National Provider Identifier (NPI) and be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS). Most providers will also need an active user account in the National Plan and Provider Enumeration System (NPPES). Medicaid eligible professionals who are only participating in the Medicaid Incentive Program are not required to enroll in PECOS.[13]

VII. CMS Timeline of Important Dates for the EHR Incentive Programs:

A. Fall 2010: Certified EHR available and listed on the Office of the National Coordinator's ("ONC") website located at www.hhs.gov/healthit/

B. Winter 2011:
   1. Registration for the Medicare Incentive Program begins (January 2011)
   2. States may choose to launch their Medicaid Incentive Programs

C. Spring 2011:
   1. Meaningful use attestation for the Medicare Incentive Program begins (April 2011)
   2. Medicare EHR incentive payments begin (May 2011)

D. Fall 2011: Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for FY 2011 (November 30, 2011)

E. Winter 2012: Last day for eligible professionals to register and attest to receive an incentive payment for CY 2011 (February 29, 2010)

F. 2014: Last year to begin participation in the Medicare Incentive Program

G. 2015: Medicare payment adjustments begin for eligible professionals and hospitals that are not meaningful users of EHR

[13] https://www.cms.gov/EHRIncentivePrograms/50_Registration.asp#TopOfPage

H. 2016: Last year to receive Medicare incentive payments

I. 2021: Last year to receive Medicaid incentive payments

VIII. Frequently Asked Questions:

A. Have CMS or other agencies provided any guidance or published any resources regarding the EHR Programs?
Answer: Yes. Please see the following links for additional information and guidance.

Helpful Websites:
- CMS EHR Incentive Programs: https://www.cms.gov/EHRIncentivePrograms/
- ONC Health Information Technology: http://healthit.hhs.gov

CMS Hospital Tip Sheets:
- EHR Incentive Program Tip Sheet for Medicare Hospitals: [http://www.shipmangoodwin.com/files/upload/EHRIncPr.pdf]
- EHR Incentive Program Tip Sheet for Critical Access Hospitals: [http://www.shipmangoodwin.com/files/upload/EHRIncPrCritAcc.pdf]
- Medicaid Hospital Incentive Payments Calculations: [http://www.shipmangoodwin.com/files/upload/MedicaidHospPmt.pdf]

CMS Eligible Professional Tip Sheets:
- Medicare EHR Incentive Payments for Eligible Professionals: [http://www.shipmangoodwin.com/files/upload/MedicareEHRPmt.pdf]
- Medicaid EHR Incentive Payments for Eligible Professionals: [http://www.shipmangoodwin.com/files/upload/MedicaidEHRPmt.pdf]

B. Will the meaningful use standards change over time?
Answer: Yes. CMS will issue rules for Stage 2 and 3 meaningful use criteria.

C. Are standards for being a meaningful user the same under Medicare and Medicaid?
Answer: Yes, however, each state which chooses to initiate a Medicaid Incentive Program may propose to CMS that some of the public health related menu objectives identified by CMS be moved to the core measures. The state, however, would need to demonstrate to CMS that no undue burden is imposed by the additional objectives being added as a core objective.

D. Can a hospital qualify and receive incentive payments under both the Medicare and Medicaid Incentive Programs?
Answer: Yes.

E. Can an eligible professional participate in multiple incentive programs at the same time?
Answer: No. In the event an eligible professional qualifies for both the Medicare and Medicaid Incentive Programs in the same year, the eligible professional must select to receive incentive payments from 1 or the other and cannot receive both. In addition, if a Medicare EP elects to receive Medicare EHR incentive payments, the Medicare EP is not eligible to receive payment through the Medicare Electronic Prescribing Incentive Program (the "eRx Program") and vice-versa. In contrast to the Medicare Incentive Program, however, eligible professionals who receive an EHR incentive payment through the Medicaid Incentive Program may also be eligible to receive an incentive payment through eRx Program.

F. If a hospital qualifies as a meaningful user under Medicare does it need to comply under Medicaid?
Answer: No. A hospital who meets the requirements for Medicare need not meet additional requirements imposed by the state Medicaid Incentive Program.

G. What if I already have EHR?
Answer: Your EHR will still need to be certified by accredited credentialing bodies which will be identified on the ONC website available at www.hhs.gov/healthit/ to qualify for Medicare or Medicaid incentives.

H. Where can I purchase certified EHR?
Answer: CMS is in the process of credentialing entities to certify EHR software as meeting the requirements necessary to calculate meaningful use measures. Certified EHR software will be listed on the Certified HIT Products List ("CHPL") and a link to this list will be available at www.hhs.gov/healthit/.

I. Must I buy EHR first or can I receive incentive payments and then get reimbursed?
Answer: Only the Medicaid Incentive Program reimburses for actual adoption/installation of EHR. You must first spend the money to be provided the incentive payment. Donations from hospitals, however, will not be included in the Medicaid EP's costs.

J. How long must I demonstrate meaningful use to receive payment?
Answer: During the first incentive payment year for the Medicare Incentive Program, a provider must demonstrate meaningful use for a period of only 90 days. After year 1, the provider must demonstrate meaningful use for the full year.

K. If I am eligible for a payment, when and how will I be paid?
Answer: CMS will make single, consolidated, annual incentive payments to Medicare EPs on a rolling basis as soon as CMS determines that the Medicare EP has meaningfully used EHR for the applicable reporting period (i.e. 90 days for the first year or a calendar year within 12 months for subsequent years) and reached the threshold for maximum payment. For Medicaid EPs, the rules will be issued by the individual State Medicaid programs, but at a minimum will have to be consistent with the Medicare rules (i.e. on a rolling basis following verification of eligibility for the applicable year).

L. I am an eligible professional. Can I assign EHR incentive payments to my employer?
Answer: Yes. An eligible professional may assign EHR incentive payments to an employer.

M. Will there be penalties under the EHR Programs if I choose not to become a meaningful user of EHR?
Answer: There are no penalties under the Medicaid Incentive Program. CMS will begin decreasing Medicare reimbursement rates for providers who are not meaningful users of EHR.

N. If I am a participant in the Medicare and/or Medicaid Incentive Programs can I skip a year of demonstrating meaningful use?
Answer: Yes. You may skip a year of demonstrating meaningful use under both the Medicare and Medicaid Incentive Programs, but in the Medicare Incentive Program the total amounts you can receive will be reduced.
- For the Medicare Incentive Program, the provider has a total 5 year maximum for incentive payments and incentive payments must be consecutive. Once a provider first demonstrates meaningful use, the 5-year time period starts tolling and failure to be eligible in a subsequent year affects the total payments you can receive since you essentially skip a year of payment.
- For the Medicaid Incentive Program, payments are not required to be consecutive so you can skip a year of being a meaningful user and then start again the next year if

you demonstrate meaningful use. Although you should note that after 2017 hospitals will have a consecutive requirement imposed in the Medicaid Incentive Program and Medicaid Eligible Hospitals must receive an incentive in FY 2016 to receive payment in FY 2017 and later.

O. If I practice in more than 1 state can I collect Medicaid incentive payments in more than 1 state?
Answer: No. You must choose 1 state under which to receive Medicaid incentive payments.

P. How do I report core and clinical quality measures?
Answer:
- For the Medicare Incentive Program, it is unlikely that by 2011 there will be adequate testing and demonstration of the ability to receive required transmitted information on a widespread basis. Thus, for 2011 providers can use an attestation methodology to submit information on clinical quality measures rather than electronic submission. They must attest to the clinical measures calculated results (numerator, denominator, and exclusion) as automatically calculated by the EHR). After 2012 providers will need to submit information on clinical quality measures electronically (beginning in CY 2012 for eligible professionals and FY 2012 for eligible hospitals).
- For the Medicaid Incentive Program, the Rule indicates that states must identify to CMS in their State Medicaid HIT Plans how they plan to accept data from Medicaid providers who seek to demonstrate meaningful use by reporting on clinical quality measures, either by attestation or by electronic reporting, subject to CMS prior approval, and must describe how the state will inform providers of a timeframe to begin providing information electronically.

Q. Can I switch between the Medicare and Medicaid Incentive Programs?
Answer: Yes. There is a limit of 1 opportunity to switch between EHR Programs.

R. What happens if I leave my practice and go to another?
Answer: Incentive payments are tied to individual eligible professionals and not a place of practice; so an eligible professional can leave one practice and go to a new practice and continue receiving incentive payments if the eligible professional continues to be a meaningful user in the new practice.

S. What happens if I practice in more than 1 location?
Answer: For eligible professionals practicing in more than 1 location, they are meaningful users if 50% or more of patient encounters are at a location with EHR. EHR is available at a location if it is available at the start of the EHR reporting period regardless of its actual availability for any given day during the EHR reporting period.

T. If I qualify for payments under other Medicare programs, do I automatically qualify for payments under the Medicare Incentive Program?
Answer: No. Just because a provider participates in qualified health information exchange networks or Medicare electronic health records demonstration programs, it does not mean the provider is meeting the meaningful use criteria.

U. What happens if I cannot meet one of the core objectives?
Answer: Each objective and measure indicates whether there is an option for an eligible professional or hospital to report that the objective/measure does not apply to them because the provider has no patients or insufficient number of actions to allow calculation of the meaningful use measure. Providers would need to attest to meeting criteria of the exception under the Rule for it not to apply.

V. Will the EHR calculate associated measures?
Answer: For EHR to be certified, it must have the ability to calculate the measures specified by CMS.

W. Will CMS publicize the names of eligible professionals and hospitals who successfully demonstrate meaningful use of EHR?
Answer: Yes. CMS is required to post on-line the names of all individuals and entities who are meaningful users of EHR for the relevant payment year.

X. Can CMS audit eligible professionals and hospitals to confirm meaningful use of EHR?
Answer: Yes. CMS will conduct selected compliance reviews of eligible professionals and hospitals who receive EHR incentive payments. Medicare Incentive Program recipients will need to maintain evidence of qualification for incentive payments for 10 years after they register for the Medicare Incentive Program.

Y. I currently use EHR software that was deemed "interoperable" for Stark and Anti-kickback purposes. Does this mean that I can use the software to obtain meaningful use incentive payments?
Answer: No. Even if the EHR technology you are currently using is "interoperable," the software must still be certified under the Rule for purposes of qualifying for meaningful use incentive payments.

IX. Closing Comments:

The Medicare and Medicaid incentive payments for meaningful users of EHR are intended to create incentives for providers to transition to and implement EHR. While the incentive payments may not completely cover the costs associated with becoming a meaningful user, they do offset what will likely become costs when EHR becomes a mandate or a necessity, rather than a preference. Presumably, with more emphasis on pay for performance and the demonstration of quality, providers will need to be positioned to produce the type of data required to be a meaningful user. It is also worth noting that large national managed care payors have announced their plans to create financial incentives for physicians who integrate EHR in their practices. Therefore, we urge all providers to get started and maximize their ability to receive Medicare and/or Medicaid incentives.

Questions or Assistance? If you have any further questions regarding the EHR Incentive Programs, please feel free to contact one of the following attorneys:

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