



EHR Incentive Program Final Rule: Medicaid Provisions

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HITECH Legislation: Purpose

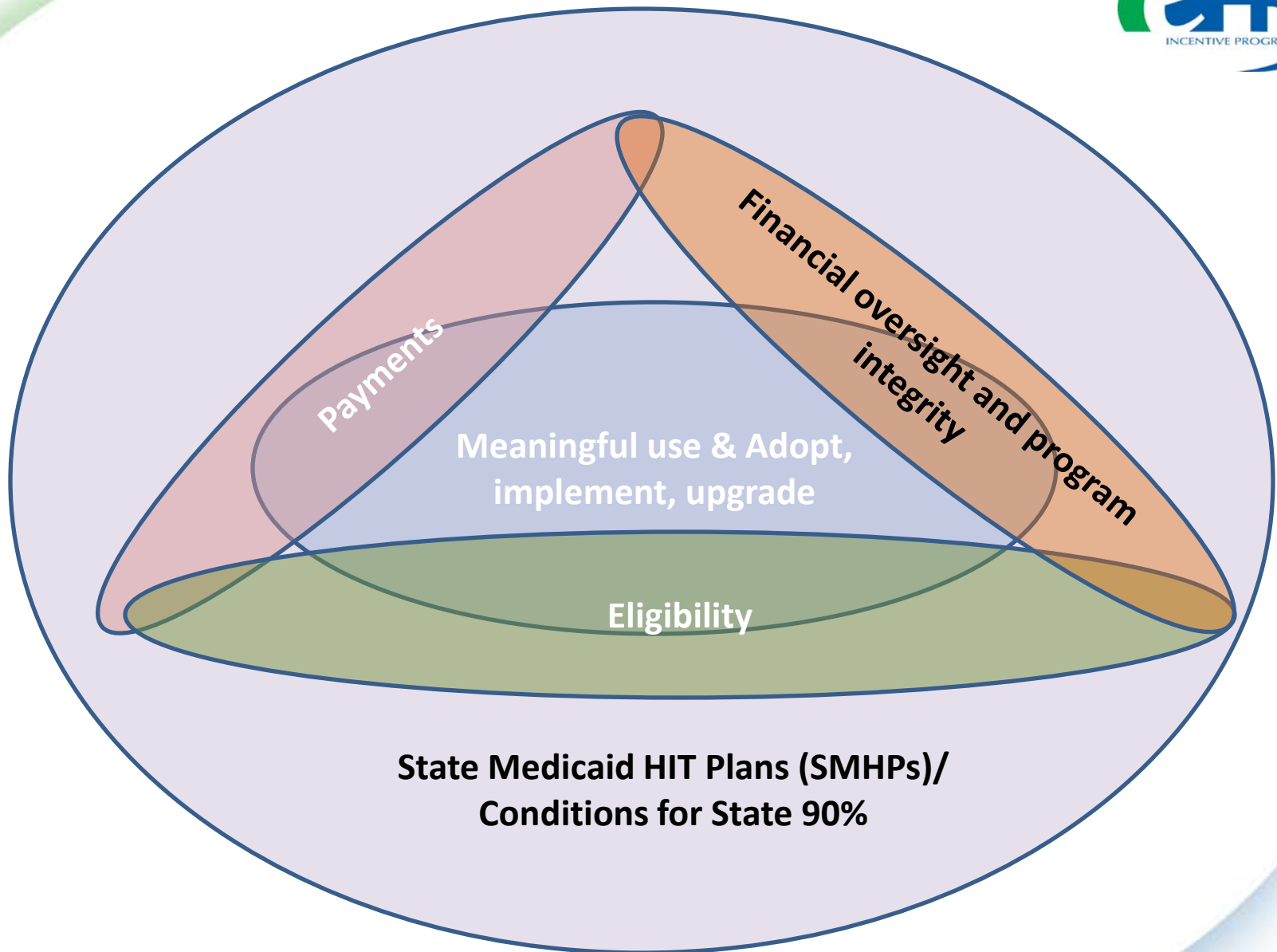
Improve outcomes, facilitate access, simplify care and reduce costs by providing:

- Major **financial support** to providers and States
- Learning opportunities created and leveraged through **TA** from CMS and others
- Will establish sustainable data-driven infrastructure that will create a **framework** for improving healthcare quality and outcomes



What is not in the CMS EHR Incentives Final Rule?

- EHR standards and certification requirements
- Procedures to become a certifying body
- Information about grants (e.g., RECs, State HIE Cooperative Agreements, and broadband access)
- Changes to HIPAA





Eligibility: Overview

- Eligible providers
- Terminology defined under Final Rule
 - Practices predominantly, needy individuals, hospital-based eligible professionals, entities promoting the adoption of certified EHR technology, etc.
- Changes from NPRM → Final Rule

Eligibility: What is a Medicaid Eligible Provider?



Eligible providers in Medicaid

ELIGIBLE PROFESSIONALS (EPs)

Physicians

- Pediatricians have special eligibility & payment rules
- Clarified physician for Medicaid = MDs, DOs, and optometrists in some states

Nurse practitioners (NPs)

Certified Nurse Midwives (CNMs)

Dentists

Physician Assistants (PAs) when practicing at an FQHC/RHC that is *so led* by a PA

- Clarified “so led”

ELIGIBLE HOSPITALS

Acute care hospitals (including CAHs and cancer hospitals)

Children’s hospitals

Eligibility: Hospitals

- One CMS Certification Number (CCN) = one hospital
- Acute care hospital
 - Average length of stay of ≤ 25 days + CCN [0001-0879; 1300-1399]
 - Includes: Cancer hospitals; CAHs; and general, short-term stay
- Children's hospital
 - 77 children's hospitals, CCN [3300-3399]
 - Not children's wings of larger hospitals



Eligibility: Patient Volume

Entity	Minimum Medicaid patient volume threshold	Or the Medicaid EP <i>practices predominantly in an FQHC or RHC—30% need individual patient volume threshold</i>
Physicians	30%	
- Pediatricians	20%	
Dentists	30%	
CNMs	30%	
PAs when practicing at an FQHC/RHC that is so led by a PA	30%	
NPs	30%	
Acute care hospitals	10%	Not an option for hospitals
Children's hospitals	No requirement	



Eligibility: Patient Volume

- Several changes from NPRM
- Defined “encounter”
- 2 main options for calculating patient volume
 - Encounters
 - Patient panel
- State picks from these or proposes new method for review and approval
- If CMS approves a method for one state, it may be considered an option for all states



Eligibility: Patient Volume

Defines encounter differently in 3 scenarios:

1. Fee-for-service
2. Managed care and medical homes
3. Hospitals



Eligibility: Patient Volume

General approach:

$$\frac{\text{Total (Medicaid) patient encounters in any 90-day period in the preceding calendar year}}{\text{Total patient encounters in that same 90-day period}} * 100$$

*May also be used to calculate needy individuals patient volume
May be used for hospitals and EPs*



Eligibility: Patient Volume

Managed care/medical home approach:

[Total Medicaid patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period] + [Unduplicated Medicaid encounters in that same 90-day period]

***100**

[Total patients assigned to the provider in the same 90-day with at least one encounter in the year preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day period]

May be used for EPs (not hospitals) and to calculate needy individuals

Eligibility: Practices Predominantly & Needy Individuals



- No changes from the NPRM
- EP is also eligible when *practicing predominantly* in FQHC/RHC providing care to *needy individuals*
- *Practicing predominantly* is when FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year
- *Needy individuals* (specified in statute) include:
 - Medicaid or CHIP enrollees;
 - Patients furnished uncompensated care by the provider; or
 - furnished services at either no cost or on a sliding scale.



Eligibility: Physician Assistants

- Physician assistants are eligible when working at an FQHC or RHC that is so led by a physician assistant
- In response to comments, we clarified “so led” to mean:
 - 1) When a PA is the primary provider in a clinic;
 - 2) When a PA is a clinical or medical director at a clinical site of practice; or
 - 3) When a PA is an owner of an RHC.

Eligibility: Hospital-based EPs



- Statute specifies most EPs must not be *hospital-based* for participation
 - Does not apply to EPs practicing predominantly in FQHC/RHC
- *Hospital-based* is an EP who “furnishes *substantially all* of the individual’s professional services in a hospital setting...”
- Determination must be made based on site of service, as defined by Secretary



Eligibility: Hospital-based EPs

- If more than 90% of the EP's services are conducted in an inpatient hospital or ER:
= *hospital-based* (i.e., ineligible)
- Must use place of service codes from claim forms
- States may make the determination
 - this methodology will be included in the SMHP



Eligibility: Entities Promoting the Adoption of EHR Technology

- States may designate *entities*; “promoting the adoption” defined in NPRM
- EPs may voluntarily assign their incentive payments to these entities
- Promotion would include:
 - enabling and oversight of the business operational and legal issues involved in the adoption and implementation of EHR and/or the secure exchange and use of electronic health information
 - maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by EPs
- Required transparency guidelines for selection

Payments: Overview

- Timing, options
- Development of incentives for EPs
- Payments to EPs, hospitals
- Registration
- State/federal systems for disbursement

Payments: Timing

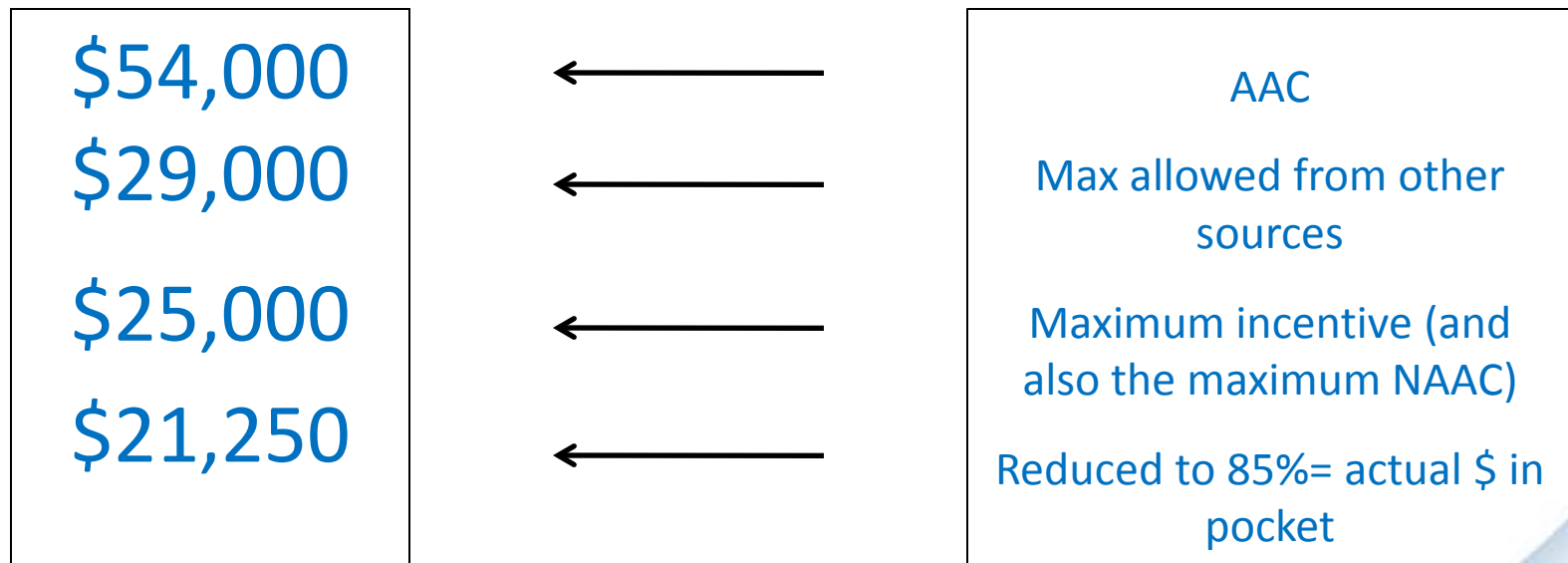
- Payments may begin in 2011
 - Align with Medicare
 - CY for EPs, FFY for hospitals
- Finalized rule without the option that States may request approval to implement as early as 2010

Payments: NAAC calculation

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

– State and local sources not considered

= Net average allowable costs (NAAC)





Payments: EP Incentives

Cap on Net Average Allowable Costs, per Recovery Act	85% allowed for EPs	Maximum cumulative incentive over 6-year period
\$25,000 in Year 1 for most EPs	\$21,250	\$63,750
\$10,000 in Years 2-6 for most EPs	\$8,500	
\$16,667 in Year 1 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$14,167	\$42,500
\$6,667 in Years 2-6 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients	\$5,667	



Payments: EP Adoption Timeline

	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

Payments: Hospitals

- Similar to Medicare hospital methodology
- Payment is calculated, then disbursed over 3-6 years
- No annual payment may exceed 50% of the total calculation; no 2-year payment may exceed 90%
- Hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016
- States must use auditable data sources in calculating the hospital incentive (e.g., cost report)



Payments: Hospital Calculation

(Overall EHR Amount) * (Medicaid Share)

or

{Sum over 4 years of [(Base Amount + Discharge Related Amount Applicable for Each Year) * Transition Factor Applicable for Each Year]} *

[(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) / {(total inpatient-bed days) * (estimated total charges – charity care charges)/(estimated total charges)}]



Payments: Registration

- No duplicate payments
- EPs and hospitals be required to register with CMS
 - Name, NPI, business address, phone
 - Tax payer ID Number (TIN)
 - Hospitals must provide the CCN
- EPs must select Medicare or Medicaid
 - May switch once between programs before 2015
- If Medicaid, must select one state
 - May switch states annually

Payments: Registration

States will:

- Connect to federal repository to continue provider registration at State
- Continue verification of eligibility
- Disburse payment after cross-checking for potential duplicative or inappropriate payments
- Disbursed payment to *one* eligible TIN
- Notify the national repository a payment was disbursed



AIU & MU: Overview

- Adopt, implement, upgrade (AIU)
 - First participation year only
 - No EHR reporting period
- Meaningful use (MU)
 - Successive participation years; and
 - Early adopters and some dually-eligible hospitals in year 1
- Medicaid Providers' AIU/MU does not have to be over six consecutive years
- States may propose to CMS for approval limited revisions to MU as it pertains to 4 public health related objectives

AIU & MU: AIU

- **Adopted:** Acquired and installed
 - e.g., evidence of installation prior to incentive
- **Implemented:** Commenced utilization of
 - e.g., staff training, data entry of patient demographic information into EHR
- **Upgraded:** Expanded
 - e.g., upgraded to certified EHR technology or added new functionality to meet the definition of certified EHR technology



AIU & MU: MU

Per statute, a provider must demonstrate meaningful use by:

1. Use of certified EHR technology in a **meaningful manner** such as e-prescribing;
2. That the certified EHR technology is connected 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 the Secretary information on **clinical quality measures** and such other measures selected by the Secretary

MU: Changes from the NPRM to the Final Rule



NPRM	Final Rule
Meet all MU reporting objectives	Must meet “core set”/can defer 5 from optional “menu set”
25 measures for EPs/23 measures for eligible hospitals	25 measures for EPs/24 for eligible hospitals
Measure thresholds range from 10% to 80% of patients or orders (most at higher range)	Measure thresholds range from 10% to 80% of patients or orders (most at lower to middle range)
Denominators – To calculate the threshold, some measures required manual chart review	Denominators – No measures require manual chart review to calculate threshold
Administrative transactions (claims and eligibility) included	Administrative transactions removed
Measures for Patient-Specific Education Resources and Advanced Directives discussed but not proposed	Measures for Patient-Specific Education Resources and Advanced Directives (for hospitals) included

MU: Changes from the NPRM to the Final Rule



NPRM	Final Rule
States could propose requirements above/beyond MU floor, but not with additional EHR functionality	States' flexibility with Stage 1 MU is limited to seeking CMS approval to require 4 public health-related objectives to be core instead of menu
Core clinical quality measures (CQM) and specialty measure groups for EPs	Modified Core CQM and removed specialty measure groups for EPs
90 CQM total for EPs	44 CQM total for EPs – must report total of 6
CQM not all electronically-specified at time of NPRM	All final CQM have electronic specifications at time of final rule publication
35 CQM total for eligible hospitals and 8 alternate Medicaid CQM	15 CQM total for eligible hospitals
5 CQM overlap with CHIPRA initial core set	4 CQM overlap with CHIPRA initial core set



MU: Basic Overview of Final Rule

Stage 1 (2011 and 2012)

- To meet certain objectives/measures, 80% of all patients must have records in the certified EHR technology
- EPs have to report on 20 of 25 MU objectives
- Eligible hospitals have to report on 19 of 24 MU objectives
- Reporting Period – 90 days for first year; one year subsequently

MU: Applicability of Objectives and Measures

- Some MU objectives are not applicable to every provider's clinical practice, thus they would not have any eligible patients or actions for the measure denominator.
 - Exclusions do not count against the 5 deferred measures
- In these cases, the EP, eligible hospital or CAH would be excluded from having to meet that measure

E.g.: Dentists who do not perform immunizations;
Certified Nurse-Midwives do not e-prescribe

States' Flexibility to Revise MU

States can seek CMS prior approval to require 4 MU objectives be core for their Medicaid providers:

- Generate lists of patients by specific conditions for quality improvement, reduction of disparities, research or outreach (can specify particular conditions)
- Reporting to immunization registries, reportable lab results and syndromic surveillance (can specify for their providers how to test the data submission and to which specific destination)

AIU & MU: Hospitals

- Eligible hospitals, unlike EPs, may receive incentives from Medicare and Medicaid
 - Subsection(d) hospitals, acute care (including CAHs)
- Hospitals meeting Medicare MU requirements may be deemed for Medicaid , even if the State has additional requirements



AIU & MU: Other Issues/Priorities

- There is an overlap between the CHIPRA core measures and the Stage 1 measures for MU.
 - BMI 2-18 yrs old
 - Pharyngitis - appropriate testing 2-18 yrs old
 - Childhood Immunization status
 - Chlamydia screening in women

Alignment of these programs is a CMS priority.



AIU & MU: Reporting Period

- The *reporting period* is a continuous period where the provider successfully demonstrates meaningful use of certified EHR technology
- 90-day period in the provider's first year demonstrating MU
- Full annual period in the provider's successive payment years
- There is no reporting period for AIU



Conditions for State Participation

- Prior approval for reasonable administrative expenses (P-APD, I-APD)
- Establish a State Medicaid HIT Plan (SMHP)
- State may receive 90% FFP to implement the program and 100% FFP for the incentives



State Medicaid HIT Plans

- Key elements:
 - As-Is landscape (results of the environmental scan)
 - Plans for implementing the program
 - Incremental approach allowed
 - Timeline and key benchmarks
 - To-Be Vision and HIT Roadmap
 - Incremental approach allowed with future updates
- Meant to be an iterative document
- Accompanied by IAPDs to request CMS funding

Financial Oversight & Program Integrity



- States and CMS must assure there is no duplication of payments to providers (between States and between States and Medicare)
- States are required to seek recoupment of erroneous payments and have an appeals process
- CMS/Medicaid has oversight/auditing role including how States implement the EHR Incentive Program (90% FFP) and how they make correct payments to the right providers for the right criteria (100% FFP).

Notable Differences Between Medicare & Medicaid



Medicaid	Medicare
Voluntary for States to implement	Feds will implement
No Medicaid fee schedule reductions	Medicare fee schedule reductions begin in 2015 for physicians who are not MUers
AIU option is for Medicaid only	Medicare must begin with MU in Y1
Max incentive for EPs is \$63,750	Max incentive for EPs is \$44,000
States can make adjustments to MU (common base definition)	MU will be common for Medicare
May appeal decisions	Appeals process yet to be developed
Program sunsets in 2021; last year a provider may initiate program is 2016	Program sunsets in 2016; fee schedule reductions and market basket update begin in 2015
Five EPs, two general types of hospitals (includes CAHs)	Only physicians, subsection(d) hospitals, and CAHs

What's Next?

- Issuing a State Medicaid Director Letter
- CMS outreach campaign beginning this summer through the fall
- MMIS health IT track
 - Portland, OR: August 14-19
- I-APDs and SMHPs
- Working with States on NLR interfaces

Other Federal Efforts in HIT



Department	Initiative
HHS, ONC	Grants under Recovery Act, HITECH section 3012 establishing Regional Extension Centers (RECs)
HHS, ONC	Grants under Recovery Act, HITECH section 3013 for State Health Information Exchange Cooperative Agreement Program
HHS, CMS & AHRQ	Pediatric and adult core measure sets through CHIPRA and ACA
HHS, CMS & AHRQ	Announcement of grant solicitation for pediatric EHR format, as specified from CHIPRA section 403
HHS, AHRQ	National Resource Center for HIT
HHS, IHS	Resource & Patient Management System (RPMS) EHR platform
FCC, USDA, Commerce	Rural Broadband Access Grants and coordination (National Rural Broadband Plan/ FCC) under Recovery Act, Title VI
VA	Veterans Health Information Systems and Technology Architecture (VistA) open-source EHR



Contacts

Policy area	Contact
Directing Medicaid HIT/EHR Activities	Rick Friedman
Meaningful use; Adopt, implement, upgrade; Efforts to promote EHR adoption and HIE	Jessica Kahn, Michelle Mills
Incentive Payments to EPs & Hospitals	Michelle Mills, Venesa Day
States Administrative Claiming	Jess Kahn, Venesa Day , Judi Wallace
Medicaid Provider Eligibility	Michelle Mills, Jessica Kahn
State Medicaid HIT Plans and IAPDs (administrative funding)	Rick Friedman, Jessica Kahn, David Meacham
Program integrity, auditing, oversight	Jessica Kahn, Alison Loughran
External affairs, communications	John Allison

General questions: Jessica Kahn & Michelle Mills