



Office of Media Affairs

CMS FACT SHEET

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Contact: CMS Office of Media Affairs
(202) 690-6145

CMS PROPOSES REQUIREMENTS FOR THE ELECTRONIC HEALTH RECORDS (EHR) MEDICAID INCENTIVE PAYMENT PROGRAM

The Centers for Medicare & Medicaid Services (CMS) today announced a proposed rule to implement the provisions of the American Recovery and Reinvestment Act of 2009 (Recovery Act) that provide incentive payments for the meaningful use of certified EHR technology. The Medicare EHR incentive program will provide incentive payments to eligible professionals (EP), eligible hospitals, and critical access hospitals (CAHs) that are meaningful users of certified EHRs. The Medicaid EHR incentive program will provide initial incentive payments to EPs and hospitals for efforts to adopt, implement, upgrade or meaningfully use certified EHR technology or for meaningful use, and incentive payments in subsequent years for meaningful use.

This fact sheet summarizes provisions in the proposed rule affecting state Medicaid programs and Medicaid providers.

The Office of the National Coordinator for Health Information Technology (ONC) will be issuing a closely related interim final rule that specifies the Secretary's adoption of an initial set of standards, implementation specifications, and certification criteria for EHR. ONC will also issue a separate notice of proposed rulemaking related to the certification of health information technology.

The Recovery Act amended the Medicaid statute to provide 100 percent Federal financial participation (FFP) for state expenditures for provider incentive payments to encourage Medicaid health care providers to adopt, implement, and operate certified EHR technology. It also established a 90 percent FFP match for state expenses for administration of the incentive payments and for promoting EHR adoption.

On September 1, 2009, CMS released a State Medicaid Director's Letter that provides preliminary guidance on state expenses related to activities in support of the administration of incentive payments to providers. The letter advised States they are able to immediately request 90 percent FFP for administrative planning activities. Planning activities for which the 90 percent match are available are related to administering the incentive payments to providers, auditing and monitoring of payments, and participating in statewide efforts to promote interoperability and meaningful use of EHR technology.

The proposed rule CMS released today would establish requirements for Medicaid incentive payments. CMS provides a 60-day comment period on the proposed rule. CMS intends to issue a final rule in 2010. Further, CMS anticipates that some States could begin providing incentive payments to eligible providers as early as the Fall of 2010.

The Medicaid provisions of the proposed rule address seven topics:

- Eligibility
- Payments
- Adopting, implementing, or upgrading certified HER technology
- Demonstrating meaningful use of HER technology
- Conditions for FFP for states
- Financial oversight/combating fraud and abuse.

The paragraphs below summarize the rule's treatment of these topics.

Eligibility

The proposed rule:

- Discusses Medicaid eligible professionals (EPs) and eligible hospitals that may participate. EPs are physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants practicing predominantly in a Federally Qualified Health Center or Rural Health Clinic (FQHC/RHC) that is directed by a physician assistant. Eligible hospitals that may participate are acute care hospitals and children's hospitals;
- Establishes that EPs must annually meet patient volume thresholds, measured by a ratio where the numerator is the total number of Medicaid patient encounters (or, in the case of eligible professionals practicing predominately at FQHCs and RHCs, needy individual encounters) over any representative continuous 90-day period in the most recent calendar year and the denominator is all patient encounters over that same 90-day period. For all EPs except pediatricians, the patient volume threshold is 30 percent; for pediatricians, it is 20 percent. EPs practicing predominately at FQHCs/RHCs, defined as having more than 50 percent of their encounters over a six-month period in the most recent calendar year occurring at an FQHC/RHC, must attest that a minimum of 30 percent of their patient encounters over any continuous 90-days period in the most recent calendar year was with needy individuals. Needy individuals are those receiving medical assistance from Medicaid or the Children's Health Insurance Program, individuals furnished uncompensated care by the provider, or individuals furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay. If a State has an alternative approach to the established timeframe for measuring patient volume, the State must submit the approach to CMS for review and prior approval.
- Establishes that EPs must also not be hospital-based, meaning they do not provide "substantially all of his or her professional services in a hospital setting." "Substantially all" is defined to mean that 90 percent or more of the services are performed in the hospital setting. The proposed rule aligns the definition of hospital-based with the Medicare definition,

- Defines an acute care hospital as a primary health care facility where the average length of patient stay is 25 days or fewer. Hospitals with an average length of stay of 25 days or fewer and with a CMS Certification Number (CCN) that has the last four digits in the series 0001 – 0879 are eligible. This specification includes short term general hospitals and the 11 cancer hospitals in the United States. Acute care hospitals also must meet patient volume threshold requirements (at least 10 percent of patient volume being Medicaid patients).
- Defines a children's hospital as a separately certified children's hospital, either freestanding or hospital-within-hospital, that has a certification number with the last 4 digits in the series 3300-3399 and predominately treats individuals under 21 years of age.
- Specifies that entities promoting the adoption of certified EHR technology may be designated by states for EPs to voluntarily assign their incentive payments. The statute allows EPs to assign their incentive payments to their employers or to state-designated "entities that promote the adoption of certified EHR technology." The regulation's definition of such an entity requires the entity to enable oversight of the business, operational and legal issues involved in the adoption and implementation of EHR and/or the exchange and use of electronic health information between participating providers, in a secure manner.

Payments

The proposed rule:

- Specifies payment amounts, the basis for payments, and the process for making payments including that there must be no duplication with Medicare for EPs; EPs can receive up to \$63,750 over the six year period; pediatricians with Medicaid patient volume between 20 percent to 29 percent of their total patient volume can receive two-thirds of the maximum amount, and hospital payments are based on a formula outlined in the statute;
- Aligns Medicaid payment incentives with the Medicare incentive program, where possible. This includes initiating payments for most Medicaid programs for adopting, implementing, upgrading or meaningfully using certified EHR technology in Calendar Year 2011.
- Proposes the maximum incentive payments allowed in the statute, verified through analysis of studies on the average cost of EHR technology undertaken by the Secretary;
- Requires states to verify the eligibility of and disburse payments to Medicaid eligible providers;
- Specifies that, while eligible hospitals may receive incentives from Medicare and Medicaid, EPs must select one program. Furthermore, Medicaid EPs and hospitals must select one state from which to receive their incentive payment each year.
- Specifies that states must have a system capable of coordinating with a national database to verify provider eligibility and identity, and collect data necessary to incentive program administration and coordination.

For hospital payments, the calculation is:

$$\begin{aligned} & \text{(Overall EHR Amount) times (Medicaid Share)} \\ & \text{where} \\ & \text{Overall EHR Amount} \\ & \text{Equals} \\ & \{ \text{Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year)} \\ & \quad \text{times Transition Factor Applicable for Each Year]} \} \text{ times} \\ & \text{Medicaid Share} \\ & \text{Equals} \\ & \{ (\text{Medicaid inpatient-bed-days plus Medicaid managed care inpatient-bed-days}) \text{ divided by} \\ & \quad [(\text{total inpatient-bed days}) \text{ times } (\text{estimated total charges minus charity care charges}) \text{ divided by} \\ & \quad \quad (\text{estimated total charges})] \} \end{aligned}$$

Adopting, Implementing, or Upgrading Certified EHR Technology

The proposed rule:

- Discusses that providers in their first year of participation in the Medicaid incentive payment program may qualify for an incentive payment by demonstrating any of the following: that they have adopted (that is, acquired and installed), implemented (that is, trained staff, deployed tools, exchanged data) or upgraded (that is, expanded functionality or interoperability) a certified EHR;
- Describes the methodology for demonstrating adoption, implementation and upgrading, and the requirements for monitoring these activities;

Demonstrating Meaningful Use of Certified EHR Technology

The proposed rule:

- Proposes a shared minimum definition of meaningful use with Medicare. However, states may request CMS approval to implement meaningful use measures above the minimum, as appropriate, but may not request approval of meaningful use measures below the minimum;
- Discusses how clinical quality measures reporting are to be submitted to the states by Medicaid providers, such as via attestation or electronically via EHRs.

Conditions States Must Meet to Receive 90 Percent FFP

The proposed rule:

- Specifies the prior approval conditions that must be met in order to receive FFP for reasonable administrative expenses;

- Requires a Health Information Technology Advance Planning Document (HIT-APD) as well as a requirement for a State Medicaid Health Information Technology Plan (HIT Plan), and explains the activities that must be conducted by the state using MITA (Medicaid Information Technology Architecture) principles.

Financial Oversight/Combating Fraud and Abuse

The proposed rule:

- Provides that states must fight fraud and abuse, including ensuring that there is no duplication of payment between the Medicare and Medicaid programs as a requirement of the State Medicaid HIT Plan;
- Requires recoupment of monies if overpayments or erroneous payments are found to have been paid;
- Requires a provider appeals process for eligibility, payments, and determinations of meaningful use as a requirement of the State Medicaid HIT Plan;

Establishes that States must have processes in place to report estimated and actual expenditures for the Medicaid EHR payment incentive program using the Medicaid Budget and Expenditure System.

The proposed rule may be viewed at http://www.cms.hhs.gov/Recovery/11_HealthIT.asp.

Other Departmental Health Insurance Technology (HIT) Activities

ONC serves as the principal federal entity charged with coordinating the overall effort to implement a nationwide health information technology infrastructure that allows for the electronic use and exchange of health information.

Specifically, ONC is authorized by Title XXX of the Public Health Service Act (PHS) to provide grant funding to support states' efforts in achieving meaningful use of certified EHRs. To that end, on August 20, 2009, the Vice President announced the availability of two grant programs to help hospitals and health care providers implement and use EHRs.

The grants made available under Section 3012 of the PHS Act provide funding for Health Information Technology Regional Extension Centers that will provide primary care, small and solo practice clinicians with technical assistance in the selection, acquisition, implementation and meaningful use of certified EHR technology.

The grants made available under Section 3013 of the PHS Act provide funding for the State Health Information Exchange Cooperative Agreement Program. This grant funding opportunity establishes funding through cooperative agreements to support efforts to achieve widespread and sustainable health information exchange (HIE) within and among states, and to facilitate and expand the secure, electronic movement and use of health information among organizations according to nationally recognized standards.

State programs to promote HIE will maximize the impact of EHRs in improving the coordination, efficiency and quality of care. These grants will support statewide planning and implementation and funding for the states' overall HIT strategy.

State Medicaid programs are a critical, decisional partner in these comprehensive statewide plans for the electronic exchange of health information and state Medicaid program should coordinate with other state efforts in the development of their health IT plans and implementation of the state incentive programs. Additionally, CMS recognizes that Medicaid EHR incentives are one important part of overall planning efforts for statewide HIT adoption and HIE that will be supported by these grant programs.

Ultimately, the Recovery Act provisions are not focused solely on information systems or information technology. The Recovery Act also focuses on leveraging a wide range of stakeholders and resources to achieve improved health care quality through the secure exchange and use of health information.

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