
Presented by Jessica Kahn and Michelle Mills
Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP, and Survey & Certification

July 16, 2010
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
Meaningful use & Adopt, implement, upgrade

Payments

Financial oversight and program integrity

Eligibility

State Medicaid HIT Plans (SMHPs)/Conditions for State 90%
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?

<table>
<thead>
<tr>
<th>Eligible providers in Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ELIGIBLE PROFESSIONALS (EPs)</strong></td>
</tr>
<tr>
<td>Physicians</td>
</tr>
<tr>
<td>- Pediatricians have special eligibility &amp; payment rules</td>
</tr>
<tr>
<td>- Clarified physician for Medicaid = MDs, DOs, and optometrists in some states</td>
</tr>
<tr>
<td>Nurse practitioners (NPs)</td>
</tr>
<tr>
<td>Certified Nurse Midwives (CNMs)</td>
</tr>
<tr>
<td>Dentists</td>
</tr>
<tr>
<td>Physician Assistants (PAs) when practicing at an FQHC/RHC that is <em>so led</em> by a PA</td>
</tr>
<tr>
<td>- Clarified “so led”</td>
</tr>
<tr>
<td><strong>ELIGIBLE HOSPITALS</strong></td>
</tr>
<tr>
<td>Acute care hospitals (including CAHs and cancer hospitals)</td>
</tr>
<tr>
<td>Children’s hospitals</td>
</tr>
</tbody>
</table>
Eligibility: Hospitals

• One CMS Certification Number (CCN) = one hospital
• Acute care hospital
  – Average length of stay of $\leq 25$ 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

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

\[
\text{Total (Medicaid) patient encounters in any 90-day period in the preceding calendar year} \times 100
\]

\[
\text{Total patient encounters in that same 90-day period}
\]

*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:

\[
\frac{[\text{Total Medicaid patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period}] + [\text{Unduplicated Medicaid encounters in that same 90-day period}]}{[\text{Total patients assigned to the provider in the same 90-day with at least one encounter in the year preceding the start of the 90-day period}] + [\text{All unduplicated encounters in that same 90-day period}]} \times 100
\]

*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)

\[
\begin{align*}
$54,000 & \quad \rightarrow \quad $29,000 \\
$29,000 & \quad \rightarrow \quad $25,000 \\
$25,000 & \quad \rightarrow \quad $21,250
\end{align*}
\]

AAC
Max allowed from other sources
Maximum incentive (and also the maximum NAAC)
Reduced to 85% = actual $ in pocket
## Payments: EP Incentives

<table>
<thead>
<tr>
<th>Cap on Net Average Allowable Costs, per Recovery Act</th>
<th>85% allowed for EPs</th>
<th>Maximum cumulative incentive over 6-year period</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000 in Year 1 for most EPs</td>
<td>$21,250</td>
<td>$63,750</td>
</tr>
<tr>
<td>$10,000 in Years 2-6 for most EPs</td>
<td>$8,500</td>
<td></td>
</tr>
<tr>
<td>$16,667 in Year 1 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients</td>
<td>$14,167</td>
<td>$42,500</td>
</tr>
<tr>
<td>$6,667 in Years 2-6 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients</td>
<td>$5,667</td>
<td></td>
</tr>
</tbody>
</table>
## Payments: EP Adoption Timeline

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$8,500</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
</tr>
</tbody>
</table>
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
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

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

<table>
<thead>
<tr>
<th>NPRM</th>
<th>Final Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>States could propose requirements above/beyond MU floor, but not with additional EHR functionality</td>
<td>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</td>
</tr>
<tr>
<td>Core clinical quality measures (CQM) and specialty measure groups for EPs</td>
<td>Modified Core CQM and removed specialty measure groups for EPs</td>
</tr>
<tr>
<td>90 CQM total for EPs</td>
<td>44 CQM total for EPs – must report total of 6</td>
</tr>
<tr>
<td>CQM not all electronically-specified at time of NPRM</td>
<td>All final CQM have electronic specifications at time of final rule publication</td>
</tr>
<tr>
<td>35 CQM total for eligible hospitals and 8 alternate Medicaid CQM</td>
<td>15 CQM total for eligible hospitals</td>
</tr>
<tr>
<td>5 CQM overlap with CHIPRA initial core set</td>
<td>4 CQM overlap with CHIPRA initial core set</td>
</tr>
</tbody>
</table>
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

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

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

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

General questions: Jessica Kahn & Michelle Mills