



# Medicaid Provisions in the CMS HITECH NPRM

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# Session Purpose

- **HITECH purpose**

- Improve outcomes
- Reduce costs
- Simplify care
- Facilitate access

- **Medicaid role**

- Policy development/enforcement (e.g., regulations)
- Strategic vision for Medicaid
- Operations
- Facilitate multi-disciplinary perspectives across States/Federal government
- Efficiently leverage resources



# Session Purpose & Notices

- Highlights of the Medicaid-relevant sections of the NPRM
- Caveat: This is all just proposed policy
- All comments should be made through [www.regulations.gov](http://www.regulations.gov)
  - Comments not considered officially submitted for consideration because you shared them with a Federal staff person



# What is not in the CMS HITECH NPRM?

- EHR certification requirements or standards
- Procedures to become a certifying body
- Information about applying for HIT/E grants
- Changes to HIPAA

# Eligibility: What is a Medicaid Eligible Provider?

## Eligible providers in Medicaid

### ELIGIBLE PROFESSIONALS (EPs)

Physicians

-Pediatricians have special eligibility & payment rules

Nurse practitioners (NPs)

Certified Nurse Midwives (CNMs)

Dentists

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

### ELIGIBLE HOSPITALS

Acute care hospitals

Children's hospitals



# Eligibility: Hospitals

- One CMS Certification Number (CCN) = one hospital
- Acute care hospital
  - Average length of stay of  $\leq 25$  days + CCN [0001-0879]
  - Includes cancer hospitals
- Children's hospital
  - 78 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</i> in an FQHC or RHC—30% <i>needy individual</i> patient volume threshold |
|---|---|--|
| 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: “Practices Predominantly” & “Needy Individuals”

- EP is also eligible when *practicing predominantly* in FQHC/RHC providing care to *needy individuals*
- Proposes *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: Hospital-based EPs, statute

- 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, NPRM

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



# Payments: Overview

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



# Payments: Timing

- Payments largely begin in 2011
  - Align with Medicare
  - Calendar year for EPs, FFY for hospitals
- Proposes States may request approval to implement as early as 2010
  - Early payments only for adoption, implementation, upgrading of certified EHR technology; not meaningful use



# Payments: Early Adopters

- **NPRM proposes to allow States to make incentive payments for adopt, implement and upgrade prior to the initiation of the Medicare payments, which are predicated on meaningful use of certified EHRs**
- **Accepting comments**



# 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
- States must use auditable data sources in calculating the hospital incentive (e.g., cost report)
- NPRM has narrative and sample calculation



# Activities Required for Incentives: Overview

- **Adopt, implement, upgrade (AIU)**
  - First participation year only
- **Meaningful use (MU)**
  - Successive participation years; and
  - Proposed option for early adopters in year 1
- States may propose to CMS for approval limited additional criteria for MU, beyond the NPRM
  - NPRM is the MU base-level requirement
- Prioritizing coordination between:
  - CHIPRA and HITECH



# Activities Required for Incentives: Adopt, Implement, or Upgrade

**Adopt:** Acquired and installed

- e.g., evidence of acquisition, installation etc.

**Implement:** Commenced utilization

- e.g., staff training, data entry of patient demographic information into EHR, data use agreements

**Upgrade:** Version 2.0; expanded functionality

- e.g., ONC EHR certification (short-term) or additional functionality such as clinical support or HIE capacity (longer-term)



# Activities Required for Incentives: Meaningful Use

**A provider must demonstrate meaningful use by:**

1. Use of certified EHR technology in a meaningful manner such as through 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 clinical quality measures in a form and manner approved by the Secretary



# Activities Required for Incentives: Meaningful Use, Stage 1

- **For Eligible Professionals:**
  - Three (3) core measures for all EPs
    - Tobacco screening
    - Blood pressure management
    - Medication management in the elderly
  - And selection of a set of specialty measures (e.g. primary care, pediatrics, etc) and report on all of them, as applicable.
- **For Hospitals:**
  - Must attest to (and later report on) all proposed QMs for each patient to whom the QM applies, regardless of payer, discharged from the hospital during the 90-day reporting period
  - Medicaid's alternative list: includes newborn measures, pediatric measures and "never event" measures



# Activities Required for Incentives: Hospitals

- Eligible hospitals, unlike EPs, may receive incentives from Medicare and Medicaid
  - Subsection(d) hospitals, also acute care
- Hospitals meeting Medicare MU requirements may be deemed for Medicaid , even if the State has an expanded (approved) definition of meaningful use



# Activities Required for Incentives: Other Priorities

- There is a deliberate overlap between the CHIPRA core measures and the Stage 1 measures for MU.
  - BMI 2-18 yrs old
  - Annual hemoglobin A1C testing (all children and adolescents diagnosed with diabetes)
  - Pharyngitis - appropriate testing 2-18 yrs old
  - Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication



# Activities Required for Incentives: Timing Overview

- The Medicaid EHR Incentive Program starts in 2011 and ends in 2021
- The latest that a Medicaid provider can initiate the program is 2016
- A Medicaid provider can initiate the program under the Adopt, Implement and Upgrade bar but in their 2<sup>nd</sup> and subsequent years, they must meet MU at the stage that is in place, per rule-making.



# 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 and 100% FFP for the payments themselves
- NPRM defines numerous previously undefined terms in CFR
  - Medicaid Management Information Systems (MMIS)
  - Medicaid IT Architecture (MITA)



# 90/10 Administrative Funding to States

## Statutory Conditions of Use of the HITECH Admin Funds:

1. Administration of incentives, including tracking of meaningful use by Medicaid EPs and eligible hospitals;
2. Oversight, including routine tracking of meaningful use attestations and reporting mechanisms; and
3. Pursuing initiatives to encourage the adoption of certified EHR technology for the promotion of health care quality and the exchange of health care information.



# State Medicaid HIT Plans

- 3 Key Elements: What is the current HIT landscape? What is the State's Vision for the next 5 years? **How will they implement and oversee a successful EHR Incentive Program?**
- NPRM proposes States uses MITA principles in developing SMHP
- SMHP will include State's methodologies for verifying eligibility; disbursing payments; coordinating with stakeholders; contracting; privacy & security; curtailing fraud & abuse; and other activities



# 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 Incentive Programs

| 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 EP incentive is \$63,750   | Max EP incentive is \$44,000  |
| States can make adjustments to MU (common base definition)                 | MU will be common for Medicare  |
| Medicaid managed care providers must meet regular eligibility requirements | Medicare Advantage physicians have special eligibility accommodations                   |
| Program sunsets in 2021; last year a provider may initiate program is 2016 | Program sunsets in 2016; fee schedule and market basket update reductions begin in 2015 |
| Five EPs, two types of hospitals   | Only physicians, subsection(d) and critical access hospitals                            |



# What's Next?

- Public comment period ends on this NPRM on March 15
- Continuing to review States' P-APDs
- Will issue additional guidance on CMS expectations for Implementation APDs and State Medicaid HIT Plans
- On-going Technical Assistance to States
- On-going Federal Coordination (ONC, AHRQ, HRSA, IHS, FCC, etc.) on State HIT/E activities, technical assistance, HIE infrastructure, barriers to MU, etc.

# Questions?

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