



**HHS American Recovery and Reinvestment Act (Recovery Act) Implementation Plan
Health Information Technology – Medicare and Medicaid Incentives and Administrative Funding**

Report Provisions	Analysis and Comment – Excerpts from the Law Offering further detail
<p>CMS: Implementation Plan for: ARRA</p> <p>Section 4101: Medicare Incentives for eligible professionals Section 4102: Medicare Incentives for hospitals Section 4103: Implementation Funding Section 4201: Medicaid provider HIT adoption and operation payments</p> <p>The law provides financial incentives for the adoption of certified electronic health records (EHRs). The plan is the CMS interpretation of the law and its “high level” approach to implementation for FY 2009 and FY2010 etc.</p> <p>The plan covers Medicare and Medicaid bonus payments for participating eligible professionals (EPs) and to become “meaningful users” of certified EHRs. The law establishes maximum annual incentive amounts and includes Medicare penalties for failing to meaningfully use EHRs <u>beginning in 2015</u> for professionals and hospitals that fail to adopt certified EHRs. Lastly, it addresses the administrative requirements for CMS and the States for Medicare and Medicaid implementation and funding to pay for it.</p> <p>For FY2009, CMS funding for both <u>Medicare and Medicaid</u>:</p> <ul style="list-style-type: none"> • Coordinate with ONC to develop policies required to implement statutory requirements (e.g., define “meaningful user” of EHRs, operationalize the definition of “certified EHR technology, etc.), 	<p><u>Medicaid Analysis and Comment</u> ARRA Title IV Section 4101: Medicare Incentives for eligible professionals (Page 353 of the Law)</p> <p>The ARRA (See Page 375 of the Law) amends the Social Security Act by authorizing “states” to pay providers through the Medicaid program 100% <u>federal funds</u> to encourage the adoption and use of certified EHR technology and 90 % <u>federal funds</u> for reasonable administrative expenses related to the administration of incentive payments to providers. Presumably, the state may provide 10% local match although there is no mention of it in the law.</p> <p>The term ‘Medicaid provider’ means an eligible professional which includes:</p> <ul style="list-style-type: none"> • physician; • dentist; • certified nurse mid-wife; • nurse practitioner; and • physician assistant insofar as the assistant is practicing in a rural health clinic that is led by a physician • assistant or is practicing in a Federally qualified health center that is so led; <p>who is not hospital-based (most of services provided in the hospital) and has <u>at least 30 percent</u> of the professional’s patient volume attributable to patients who are receiving Medicaid. This calculation permits counting Medicaid Managed Care patients.</p> <p>It applies to Pediatricians who are not hospital-based and have <u>at least 20 percent</u> of their patient volume attributable to individuals receiving Medicaid.</p> <p>It applies to eligible professionals who practice predominantly in a Federally qualified health center or rural health clinic and have <u>at least 30 percent</u> of the professional’s patient volume attributable to “needy individuals”. The term ‘needy individual’ means, with respect to an individual:</p>

- Establish Medicare and Medicaid payment policies, processes, and tracking methods,
- Develop and publish proposed regulations to provide the opportunity for public notice and comment.
- Conduct initial assessments of potential systems and measures required to pay incentives (including calculation of incentive payments, capturing attestations, tracking and accepting quality measures),
- Plan extensive provider outreach on Medicare and Medicaid incentives and Medicare penalties,
- Plan audit and reimbursement work,
- With contractor support, and in coordination with ONC and the regional extension programs provide States with technical assistance through guidance, outreach and education, and
- Hire additional Federal employees to help implement these provisions.

FY 2010 funds will allow for continued education and outreach, analysis, and extensive contractor support to make system modifications and/or develop new systems.

Systems will be required to process incentive process selection, to determine payments, to assess meaningful use, to make and track payments (including posting names of incentive recipients online) and to capture quality data.

- who is receiving Medicaid assistance
- who is receiving assistance under title XXI;
- who is furnished uncompensated care by the provider;
- for whom charges are reduced by the provider on a sliding scale basis based on an individual's ability to pay.

It applies to Children's hospitals or acute-care hospitals that have at least 10 percent of the hospital's patient volume attributable to individuals who are receiving Medicaid.

An eligible professional shall not qualify as a Medicaid provider under this subsection unless any right to payment under sections established fee schedules (SSA sec 1848(o) and 1853(1) (Medicare Choice payment) with respect to the eligible professional ***has been waived*** in a manner specified by the Secretary.

Medicaid Implementation Planning

CMS has decided to implement the Medicaid incentives program in 2011 to assure consistency with Medicare.

State payment of Medicaid incentive payments will require establishment of multi-state workgroups in order to establish core analytical criteria for State HIT planning and implementation, and modification to Medicaid reporting and data systems.

For Medicaid

Verification of payment accuracy and audits to preclude improper payment of Medicaid incentives will be critical.

Complying with Recovery Act reporting guidance will involve Federal and State staff time and require modification of accounting and payment data reporting systems.

Characteristics

CMS Administrative Activities

The administrative funding provided by the legislation will be used for both Federal in-house activities and contracting with non-Federal entities. The Federal in-house funding will be used to hire additional Federal staff, as well as pay a portion of the costs for existing staff working on HIT related activities. The non-Federal entities will be provided with funding primarily through the use of contract vehicles under the standard Federal Acquisition Regulations (FAR) requirements.

Administrative funds will support the implementation of the incentives programs for the meaningful use of certified EHRs.

For both Medicare and Medicaid and CMS and the States:

The Recovery Act provided budget authority (BA) of \$100 million in 2009 for Medicare administration and \$40 million in 2009 for Medicaid administration; for the 2010-2019 period, the BA amounts are \$645 million for Medicare and \$260 million for Medicaid, respectively.

CMS will use part of these funds to assess existing systems to determine whether or not modifications can be made to accommodate the requirements of the incentive program.

The funding will also be used to modify and/or develop, implement, operate and maintain all systems necessary to support payment of incentives to hospitals and eligible professionals, such as systems for eligibility and enrollment, payment, quality reporting, and accounting/monitoring.

CMS Medicaid Administrative funds may be used to:

- Develop an implementation strategy for issuing incentive payments to providers.
- Track, report and oversee incentive payments to assure no duplication of funding.
 - Such coordination shall include, to the extent practicable, a data matching process between State Medicaid agencies and the Centers for Medicare & Medicaid Services **using national provider identifiers.**
- Assess data from providers, practitioners and hospitals, Medicaid, CHIP, and uncompensated care patient volume/mix data.
- Conduct an environmental scan of the current State EHR/HIT environment.
- Create a vision document with an analysis of current to future State activities with a plan for transition and roadmap with milestones for achieving EHR technology goal.
- Conduct extensive outreach, training and education to providers and to State personnel
- Develop an infrastructure for health information exchange.
- Harmonize EHR/HIT technology with current State initiatives such as Medicaid Information Technology Architecture (MITA).
- Work with States to develop the infrastructures necessary to provide oversight of Recovery Act initiatives and coordinate related activities involving various stakeholders.



<p>State Medicaid Agencies will receive Federal matching rates of 90 percent for their administrative costs of the HIT activities through the existing FMAP <u>grant payment process</u>, estimated to be \$1,055 million. This is also non-Federal entity funding.</p> <p>The HIT legislation provided CMS with \$1,045 million in administrative funding - \$745 million for Medicare and \$300 million for Medicaid - for the FY 2009-2019 period. It is anticipated that approximately 10 percent of that funding will be used for Federal in-house activities with the remaining balance going to non-Federal entities.</p>	<p>State Administrative Costs for Medicaid HIT Implementation</p> <p>Federal matching funds are provided to States for administering payments for certified EHR technology. To be eligible for funding, States must demonstrate:</p> <ul style="list-style-type: none"> • That they are using the funds provided for the purposes of <i>administering</i> payments including <i>tracking of meaningful use</i> by Medicaid providers; • Providing adequate oversight of the program including routine tracking of meaningful use attestations and reporting mechanisms, • Pursuing other initiatives to encourage the adoption of certified EHR technology for the promotion of health care quality and the exchange of health care information.
<p>Medicaid Incentives • The Medicaid statute provides for a 100 percent Federal Financial Participation (FFP) match for State expenditures for provider incentive payments to encourage Medicaid health care providers to purchase, implement, and operate certified electronic health record (EHR) technology.</p> <ul style="list-style-type: none"> • These payments can cover up to 85 percent of the federally-determined “net average allowable costs” of EHR technology, including support and training for staff. The “allowable costs” are determined on the basis of studies that the Secretary will undertake or accept from states. • A Medicaid provider described in paragraph (2)(A) is responsible for payment of the <u>remaining 15 percent</u> of the “net average allowable cost”. [Page 379 of the Law] 	<p><u>Medicare and Medicaid</u> incentive payments to eligible professionals will be made using existing or newly developed <u>Federal and State payment systems</u>. Medicare hospital incentive payments will be made using the existing cost report based process.</p> <p>Medicaid EPs must waive the right to receive incentive payments under Medicare for certified EHR technology. An EP that participates in both Medicare and Medicaid and meets the respective eligibility requirements <u>cannot</u> receive incentive payments from both Medicare and Medicaid.</p> <p>The term ‘net average allowable costs’ means for a Medicaid provider the “average allowable costs” reduced by any payment that is made to the provider from any other source other than under this program or by a State or local government that is directly attributable to payment for certified EHR technology or related support services.</p> <p>The Secretary shall study the ‘average costs’ to Medicaid providers for the purchase of certified HER Technology and its initial implementation and upgrade. The study would include the average costs to such providers for operations, maintenance, and use. In determining “average allowable costs” the Secretary HHS may utilize studies of such amounts submitted by States.</p>

- Incentive payments are available for no more than a 6-year period.
- Eligible professionals can receive up to \$21,250 for the first year of payment for the initial purchase and adoption of certified EHR technology, ending after 2016; and up to \$8,500 annually over 5-years for costs relating to the operation, maintenance and demonstration of “meaningful use” of such technology, ending after 2021.
- Hospital incentive payments are statutorily defined by formula. Full reimbursement of incentive payments cannot occur over a minimum 3-year or maximum 6-year period. The last year that a hospital can begin receiving incentive payments is 2016.
- States must assure that payments are being made directly to Medicaid providers without *any deduction or rebate*.
- Medicaid providers must demonstrate “meaningful use” as defined by the State and approved by the Secretary and may be based upon the methodologies applied for professionals and hospitals receiving EHR incentive payments under Medicare.
- Such “meaningful use” may include the reporting of clinical quality measures to the States and in such case, address populations with unique needs, like children.
- Certified EHR technology must be, to the extent possible as specified by the Secretary, compatible with State or Federal administrative management systems.

[Page 375 of the Law]

Pediatricians with 20% Medicaid patients receive only 2/3 of the “net average allowable costs” determined for other EPs. [Page 378 of the Law].

States must provide the following assurances: **[Page 379 of the Law]**

That incentive payments for the purchase of HER technology are paid directly to the provider without any deduction or rebate, or

- to an employer or facility to which the provider has assigned payments; or
- to an **entity as designated by the State** promoting the adoption of certified EHR technology as long as participation in such a payment arrangement is voluntary for the eligible professional involved and if such entity does not retain more than 5 percent of such payments for costs not related to certified EHR technology and support services including maintenance and training that is for, or is necessary for the operation of the technology.

The provider must demonstrate:

- for the first year of payment that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology; and
- for a year of payment, other than the first year of payment, the “meaningful use” of certified EHR technology.
- If the provider has completed adopting, implementing, or upgrading such technology prior to the first year of payment, then its obligation is to demonstrate that it is a “meaningful user” of the HER technology.

Meaningful User [Page 355 and 356 of the Law]

The eligible professional demonstrates to the satisfaction of the Secretary (by attestation, submission of claims data or other requested reporting) that during payment periods the professional is using certified EHR technology in a meaningful manner, which shall include

- the use of electronic prescribing

	<ul style="list-style-type: none"> • that during such period the EHR technology is connected in a manner that provides, in accordance with law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination. • the eligible professional submits information for such period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures that may be designated.
<p>Medicare Provisions</p> <p>The goal of the Medicare and Medicaid Health IT provisions in the Recovery Act is to promote and provide incentives for the adoption of certified electronic health records (EHRs). The Recovery Act authorized bonus payments hospitals participating in Medicare and Medicaid as an incentive to become meaningful users of certified EHRs. The law established maximum annual incentive amounts and includes Medicare penalties for failing to meaningfully use EHRs beginning in 2015 for professionals and hospitals that fail to adopt certified EHRs.</p> <p>Hospital incentive payments <i>are statutorily defined by formula</i>. Full reimbursement of incentive payments cannot occur over a minimum 3-year or maximum 6-year period. The last year that a hospital can begin receiving incentive payments is 2016.</p>	<p>HOSPITAL PAYMENT AMOUNT [Page 363 of the Law]</p> <p>Section 4102 of the Law - The applicable amount specified for an eligible hospital for a payment year is equal to the product of the following:</p> <p><u>INITIAL AMOUNT</u>.—The sum of—</p> <p>The base amount (\$2M) plus the discharge related amount for a 12-month period with respect to the payment year. The Discharge Related Amount for a 12-month period is \$ 200 for each discharge regardless of source between 1149 discharges (minimum) and 23,000 discharges (maximum).</p> <p><u>MEDICARE SHARE</u>.—The Medicare share specified under this subparagraph for an eligible hospital for a period selected by the Secretary for a payment year is equal to the fraction—</p> <p>(i) the <u>numerator</u> of which is the sum (for such period and with respect to the eligible hospital) of—</p> <p>(I) the estimated number of inpatient-bed days (as established by the Secretary) which are attributable to individuals with respect to whom payment may be made under part A; and</p> <p>(II) the estimated number of inpatient-bed days (as so established) which are attributable to individuals who are enrolled with a Medicare Advantage organization under part C; and</p> <p>(ii) the <u>denominator</u> of which is the product of—</p> <p>(I) the estimated total number of inpatient bed-days with respect to the eligible hospital during such period; and</p>

Medicare Payments

Sections 4101 and 4102 of the Recovery Act provide Medicare bonus payments to eligible professionals who meaningfully use certified EHRs by calendar years 2011 to 2014 and for hospitals that meaningfully use certified EHRs by fiscal years 2011 to 2015. Starting in 2015, eligible professionals and hospitals failing to meaningfully use certified EHRs will receive reduced Medicare payments. Payment may be made in a single total payment.

Incentive Payments Medicare • Medicare EPs may receive incentives for the adoption and meaningful use of certified EHR technology. The incentive payment will be calculated on 75 percent of the allowable charges for services furnished by the EP during the payment year, not to exceed payment maximums set by law. Payments will be made from 2011 through 2016. For example, the maximum payment for 2011 is \$18,000 with a maximum of \$44,000 paid over 5 years.

Incentive payments are increased by 10 percent for those EP providing services in a health professional shortage area. EPs must choose whether to receive an incentive under the Medicare or Medicaid.

Medicare will also pay incentives to subsection 1886(d) hospitals and critical access hospitals. Eligible hospitals that are meaningful EHR users by 2015 for a reporting period specified by the Secretary could receive up to four years of incentive payments beginning in FY 2011.

(II) the estimated total amount of the eligible hospital’s charges during such period, not including any charges that are attributable to charity care (as such term is used for purposes of hospital cost reporting under this title), divided by the estimated total amount of the hospital’s charges during such period.

TRANSITION FACTOR.—The transition factor specified in subparagraph (E) for the eligible hospital for the payment year. [Page 364]

The transition factor specified for an eligible hospital for a payment year is as follows:

- (I) For the first payment year for such hospital, 1.
- (II) For the second payment year for such hospital, 3/4.
- (III) For the third payment year for such hospital, 1/2.
- (IV) For the fourth payment year for such hospital, 1/4.
- (V) For any succeeding payment year for such hospital, 0.

PHASE DOWN FOR ELIGIBLE HOSPITALS FIRST

ADOPTING EHR AFTER 2013.—If the first payment year for an eligible hospital is after 2013, then the transition factor specified in this subparagraph for a payment year for such hospital is the same as the amount specified in clause (i) for such payment year for an eligible hospital for which the first payment year is 2013.

If the first payment year for an eligible hospital is after 2015 then the transition factor for a hospital and for such year and any subsequent year shall be 0.



The payments will be based on *the statutory formula* which includes a **\$2 million base payment** that is adjusted based on the number of discharges, the Medicare share of inpatient bed days, and charity care.

Hospitals that become meaningful users after 2015 would not receive these incentives.

Medicare may also pay EHR incentives to certain Medicare Advantage (MA) organizations that employ or contract with certain EPs. EHR incentives will only be paid under the fee-for-service program if the EP qualifies for the maximum incentive payment under that provision.

Hospital incentives will be paid under the fee-for-service program if at least one-third of a hospital's Medicare discharges (or bed days) of Medicare patients for the year are covered under Medicare Part A, otherwise MA organizations can be reimbursed directly for hospitals that are under common ownership and control and that primarily treat MA plan enrollees.



Starting in 2015, eligible professionals and hospitals failing to meaningfully use certified EHRs will receive reduced Medicare payments.

Incentive Payment may be made in a single total payment.

Hospital Payments Sanctions [Page 368 of the Law]

Hospital **Non-EHR users** are penalized after 2015 according to the following reductions to their Medicare payments by adjusting their Cost Reports to reflect these reductions.

INCENTIVE MARKET BASKET ADJUSTMENT.— [Page 368-369 of the Law]

Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended— (A) in clause (viii)(I), by inserting “(or, beginning with fiscal year 2015, by one-quarter)” after “2.0 percentage points”; and (B) by adding at the end the following new clause:

For purposes of clause (i) for fiscal year 2015 and each subsequent fiscal year, in the case of an eligible hospital that is **not a meaningful EHR user** for an EHR reporting period for such fiscal year, three-quarters of the applicable percentage increase otherwise applicable under clause (i) for such fiscal year shall be reduced by 33¹/₃ percent for fiscal year 2015, 66²/₃ percent for fiscal year 2016, and 100 percent for fiscal year 2017 and each subsequent fiscal year. Such reduction shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i) for a subsequent fiscal year.

Exemption from Sanction

(II) The Secretary may, on a case-by-case basis, exempt a subsection (d) hospital from the application of subclause (I) with respect to a fiscal year if the Secretary determines, subject to annual renewal, that requiring such hospital to be a meaningful EHR user during such fiscal year would result in a significant hardship, such as in the case of a hospital in a rural area without sufficient Internet access. In no case may a hospital be granted an exemption under this subclause for more than 5 years.

(III) For fiscal year 2015 and each subsequent fiscal year, **a State** in which hospitals are paid for services under section 1814(b)(3) shall adjust the payments to each subsection (d) hospital in the State that is not a meaningful EHR user in a manner that is designed to result in an aggregate reduction in payments to hospitals in the State that is equivalent to the aggregate reduction that would have occurred if payments had been reduced to each subsection (d) hospital in the State in a manner comparable to the reduction under the previous provisions of this clause. **The State** shall report to the Secretary the methodology it will use to make the payment adjustment under the previous sentence.

	<p>Critical Access Hospitals</p> <p>For cost reporting periods beginning in fiscal year 2015 or a subsequent fiscal year, in the case of a critical access hospital that is not a meaningful HER user but is an eligible hospital for an EHR reporting period with respect to such fiscal year, its Medicare payments are reduced by:</p> <p>The percent described in this subparagraph is—</p> <ul style="list-style-type: none"> (i) for fiscal year 2015, 100.66 percent; (ii) for fiscal year 2016, 100.33 percent; and (iii) for fiscal year 2017 and each subsequent fiscal year, 100 percent.
<p><u>Hospital Meaningful User & Testing</u></p>	<p>MEANINGFUL EHR USER.— [Page 366 of the Law]</p> <p>An eligible hospital is a meaningful EHR user for an EHR reporting period for a payment year if <u>each</u> of the following requirements are met:</p> <p>The eligible hospital demonstrates to the satisfaction of the Secretary that during the period the hospital is using <i>certified EHR technology in a meaningful manner</i>.</p> <p>INFORMATION EXCHANGE.—The eligible hospital demonstrates to the satisfaction of the Secretary that during the period its certified EHR technology is connected in accordance with the law and standards applicable to the exchange of information, for the electronic exchange of health information to improve the quality of health care, such as promoting care coordination.</p> <p>REPORTING ON MEASURES USING EHR.— The eligible hospital submits information through its certified HER technology for the period, in a form and manner specified by the Secretary, on such clinical quality measures and such other measures as selected by the Secretary.</p> <p>The Secretary shall seek to improve the use of electronic health records and health care quality over time by requiring more stringent measures of meaningful use selected under this paragraph.</p>

REPORTING ON MEASURES.— [Page 366 of the Law]

SELECTION.—The Secretary shall select quality measures for reporting purposes but only consistent with the following:

(I) The Secretary shall provide preference to clinical quality measures that have been selected for purposes of applying payment incentives or that have been endorsed by the entity with a contract with the Secretary under section 1890(a) of the SSA – [Performance Measurement].

(II) Prior to any measure (other than a clinical quality measure that has been selected for purposes of applying payment incentives) being selected under this subparagraph, the Secretary shall **publish** in the Federal Register such measure and provide for a period of **public comment** on such measure.

LIMITATIONS.—The Secretary may *not* require the electronic reporting of information on clinical quality measures unless the Secretary has the capacity to accept the information electronically, which may be on a pilot basis.

COORDINATION OF REPORTING OF INFORMATION.— In selecting measures, and in establishing the form and manner for reporting measures, the Secretary shall seek to avoid redundant or duplicative reporting with reporting otherwise required, including payment incentives reporting.

DEMONSTRATION OF MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY AND INFORMATION EXCHANGE.—

An eligible hospital may satisfy the demonstration requirement of clauses (i) and (ii) of subparagraph (A) through means specified by the **Secretary, which may include:**

- (I) an attestation;
- (II) the submission of claims with appropriate coding (such as a code indicating that inpatient care was documented using certified EHR technology);
- (III) a survey response;
- (IV) reporting under subparagraph (A)(iii);and
- (V) other means specified by the Secretary.

(ii) USE OF PART D DATA.—Notwithstanding sections 1860D–15(d)(2)(B) and 1860D–15(f)(2), the Secretary may use data regarding drug claims submitted for purposes of section 1860D–15 that are necessary for purposes of subparagraph (A).

Testing and Reporting

Section 4104 [Page 374-375 of the Law]

SEC. 4104. STUDIES AND REPORTS ON HEALTH INFORMATION TECHNOLOGY.

(a) STUDY AND REPORT ON APPLICATION OF EHR PAYMENT INCENTIVES FOR PROVIDERS NOT RECEIVING OTHER INCENTIVE PAYMENTS.—

The Secretary of Health and Human Services shall conduct a study to determine the extent to which and manner in which payment incentives (such as under title XVIII or XIX of the Social Security Act) and other funding for purposes of implementing and using certified EHR technology (as defined in section 1848(o)(4) of the Social Security Act, as added by section 4101(a)) should be made available to health care providers who are receiving minimal or no payment incentives or other funding under this Act, under title XIII of division A, under title XVIII or XIX of such Act, or otherwise, for such purposes.

DETAILS OF STUDY.— The study shall include an examination of—

- (i) the adoption rates of certified EHR technology by such health care providers;
- (ii) the clinical utility of such technology by such health care providers;
- (iii) whether the services furnished by such health care providers are appropriate for or would benefit from the use of such technology;
- (iv) the extent to which such health care providers work in settings that might otherwise receive an incentive payment or other funding under this Act, under title XIII of division A, under title XVIII or XIX of the Social Security Act, or otherwise;

(v) the potential costs and the potential benefits of making payment incentives and other funding available to such health care providers; and

(vi) any other issues the Secretary deems to be appropriate.

CONGRESSIONAL REPORT.—Not later than **June 30, 2010**, the Secretary shall submit to Congress a report on the findings and conclusions of the study conducted under paragraph (1).