HITECH Act Health IT Incentives – State Medicaid Implementation

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New Proposed Regulations under HITECH*

• ONC released an interim final rule (RIN 0991-AB58) on December 30, 2009, establishing an initial set of standards, implementation specifications, and certification criteria for EHRs qualified for federal funding
  – ONC will soon release a notice of proposed rulemaking on the process for certification of EHR technology

• Proposed rule from CMS (CMS-0033-P) that same day for implementing the Medicare and Medicaid incentives for health IT
  – Includes the “meaningful use” criteria


• Comments are encouraged; comments due March 13, 2010
  – CMS proposed rule, modified to incorporate comments, becomes final in late spring
  – ONC interim final rule becomes effective 30 days after publication; final rule issued in 2010

Proposals Common to Both Programs

• Standards, implementation specifications, and certification criteria in the ONC rule will apply to Medicare and Medicaid programs, and to other federal health IT initiatives
  – Standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, laboratory tests, medications and allergies; and standards for the secure transportation of this information
  – Rule seeks to coordinate with other major standards adoption, e.g., HIPAA codes sets and e-prescribing
• Common definitions and methodologies across both programs are proposed in CMS rule
  – Both programs require “meaningful use” of “certified EHR technology”
  – Identification of eligible recipients, reporting years, payment years, EHR functionality requirements, clinical quality reporting, validation/attestation, and timing of payments
• Meaningful use criteria are proposed to be implemented in increasingly rigorous stages; later stages remain open for input
Standards, Implementation, Certification Criteria

• From the statute: “(13) QUALIFIED ELECTRONIC HEALTH RECORD.-- … means an electronic record of health-related information on an individual that-- “(A) includes patient demographic and clinical health information, such as medical history and problem lists; and “(B) has the capacity-- “(i) to provide clinical decision support; “(ii) to support physician order entry; “(iii) to capture and query information relevant to health care quality; and “(iv) to exchange electronic health information with, and integrate such information from other sources.”

• ONC adopts the concepts “complete EHR” and “EHR module”; in combination, a set of modules, separately certified, could meet meaningful use requirements; provider responsibility

• An EHR qualified for incentives is one certified to (1) have the functions necessary to meet stage 1 of the meaningful use criteria using (2) standards adopted by HHS
  – Burden is on the vendor, not the provider, to meet these requirements
ARRA: Medicaid Health IT Incentives

• 100% FMAP for payments to providers to encourage health IT adoption or to entities promoting health IT adoption
• 90% FMAP for reasonable administrative expenses for the incentives program, if state demonstrates:
  – Expenses are related to administering payments and tracking meaningful use
  – Oversight, including routine tracking of use attestations and reporting; and
  – Pursuit of initiatives to promote adoption and exchange of data for quality improvement
• Standard state FMAP for other activities related to program administration, if not directly related to the ARRA incentives
Overview – Providers

• Eligible providers
  – Non-hospital professionals (doctors, dentists, certified nurse midwives, NPs, and certain PAs)
  – Acute care hospitals
  – Children’s hospitals
• Year 1: provider must demonstrate efforts to adopt, implement or upgrade qualified technology
  – “the process by which providers have installed and commenced utilization of certified EHR technology capable of meeting meaningful use requirements; or expanded the available functionality and commenced utilization of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training.”
  – Reporting period: representative continuous 90-day period in previous year
• Years 2-6 (or year 1 for those that have already adopted): provider must demonstrate “meaningful use” of “certified EHR technology”
  – Reporting period: full calendar year
• Provider must elect only one state Medicaid program
Eligible Professionals

- Non-hospital professionals
  - With some exceptions, individual provider must have 30% Medicaid volume (includes managed care patients), by encounter; pediatricians – 20%
  - Those practicing 50% or more in FQHC or RHC – can include “needy” in count
  - “Hospital-based” – 90% of services in hospital setting; includes outpatient if patients are registered hospital outpatients
  - No provision for aggregating at group practice level
- Payment is for 85% of provider’s “net average allowable costs”
  - Up to $63,750 (pediatricians with 20-30%: $42,500) in federal contributions toward adoption, implementation, upgrade, maintenance, and operation of certified EHR technology
    - Up to $21,250 (85% of 25K) for adopting, implementing or upgrading for first year
    - Up to $8500 (85% of 10K) for “meaningful use” each year up to 5 years, or 6 years if there was no “adoption” year
- Provider must pay remaining 15%
Eligible Professionals

- “Average allowable costs”
  - First year: average costs of purchase and initial implementation or upgrade (including support services) as determined by HHS ($54,000 proposed)
  - Following years: average costs relating to maintenance and use as determined by HHS ($20,610/year proposed)
- “net” – reduced by any amounts provider receives from other sources
- Can assign payments to an entity that promotes EHRs
- Reporting and payments are by calendar year
- When eligible for both Medicare and Medicaid, must choose one
- Coordination of states with CMS to assure no duplicate payments under Medicare incentive program; data matching between states and CMS
Hospitals

- Acute care hospitals – avg patient LOS 25 days or fewer, by CCN number; 10% Medicaid volume, by encounter; payments capped similarly to Medicare
- Children’s hospitals separately certified – any Medicaid volume
- May qualify for both Medicare and Medicaid incentives
- Amount: “Overall hospital EHR amount” x “Medicaid share” x “transition factor”
  - “Overall hospital EHR amount”: sum of a base amount ($2M) added to its discharge-related payment
    - Discharge-related amount: $200 for each discharge, for 1,150th through its 23,000th discharges
    - For years 2-6, add growth factor – average annual growth rate in discharges from previous 3 years
  - Medicaid share: Medicaid portion of inpatient bed days, including Medicaid managed care patients, adjusted upward for charity care (may not include Medicare bad debt)
  - Transition factor as in Medicare
Hospitals

- Discharge data based on cost reports from hospital’s fiscal year that ends during the FFY prior to the FY that is the payment year
- First year payments must start by 2016; phased out over 4 years
- Reporting and payment years are based on federal FY to align with Medicare
- Multi-site hospitals with one CCN are considered one hospital for calculation purposes
- States may not pay more than 50% of an aggregate amount to a hospital in any year,
- Payments must be made over at least 3 years (showing meaningful use), but no longer than 6 years
- No single payment may exceed 50% of the aggregate hospital amount
- No payments over a 2-year period may exceed 90%
State Administration of EHR Incentives

• Optional early state start
  – For “adoption” only, states may elect to begin paying providers in 2010
  – Must have electronic registration system for these providers
  – Allows head start on capital investment in IT before Medicare program starts; two 90-day reporting years in a row
  – Must be capable of using CMS’s single provider election repository

• Coordination of payments with CMS using data matching process
• Verification and monitoring of election by EPs (program and state) and coordination of payments (both programs) to hospitals
• Establish processes for attestation or other documentation of eligibility, Medicaid volume, and meaningful use
  – Issues with border states
State Administration

• Establish meaningful use requirements and method for demonstrating
  – Attestation and process to verify and validate to CMS provider eligibility, EHR certification, meaningful use, program integrity and other program requirements met
  – Quality reporting program
• Payments may be made to “entities promoting the adoption of certified EHR technology,” as designated by the State, if participation in the payment arrangement is voluntary for the EP involved
  – Entity may retain up to 5% of payments for costs unrelated to certified technology
  – “Promoting adoption” defined: the enabling and oversight of the business, operational and legal issues involved in the adoption and implementation of EHR and/or exchange and use of electronic health information between participating providers, in a secure manner, including maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by EPs
Requirements for Federal Match

• State Medicaid Health IT Plan (SMHP) – to define current status and target state of Medicaid IT program
  – Plan EHR program to be compatible with MMIS
  – Use MITA state self-assessment
    • Map different IT solutions to existing enterprise business requirements using MITA business areas and processes list
  – Include planning and coordination with other state health IT activities
    • Use MITA model to expand Medicaid business processes, ultimately to support the EHR incentive program and align with industry
  – Document analysis of alternative solutions considered
    • Includes landscape of existing state health IT status
    • Vision for future and plan to achieve
Requirements for Federal Match

• EHR program planning
  – Phase 1, governed by Health IT Planning Advance Planning Document (HIT PAPD):
    • initial planning and development, deliverable: SMHP
  – Phase 2, governed by Health IT Implementation Advance Planning Document (HIT IAPD):
    • Implementation of the SMHP, with changes as development and acquisition progresses
    • Compliance with all federal procurement requirements

• States must work closely with CMS prior to developing the documents and implementing either phase; approval required for all, including RFPs and contracts
Other Federal Health IT Programs for States
Technical Assistance

• Existing technical assistance for states through AHRQ’s Resource Center: http://healthit.ahrq.gov/portal/server.pt?open=512&objID=654&PageID=14760&mode=2

• “Health information technology regional extension centers” – to provide technical assistance and disseminate best practices and knowledge from the research center
  – Applicants can be non-profits
  – Priority assistance to
    • Public or non-profit hospitals or CAHs
    • FQHCs, rural or underserved area providers
    • Small practices
State Planning and Implementation Grants

- ONC to make grants to states or their designees for planning or implementation grants “to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards”
- **Planning** – to be specified by the Secretary
- **Implementation** activities – broad and varied participation in exchange; identify state and local resources available toward the nationwide effort; complement other federal efforts; technical assistance; promote strategies for adoption; assisting patient use of records; encouraging providers to work with regional centers; support public health participation; and promoting quality improvement with health IT
- Must be consistent with ONC strategic plan
Planning and Implementation Grants

• State-Designated Entity
  – Designated by the state
  – Non-profit with broad stakeholder representation
  – Demonstrate one of principal goals to use health IT to promote quality
  – Adopt conflict of interest and non-discrimination policies
  – Must consult with specified list of stakeholders

• State match (non-federal contribution)
  – Pre-FY2011 – as Secretary determines
  – 2011: 1:10
  – 2012: 1:7
  – 2013: 1:3
State Grants for Loan Programs

- Competitive grants to states, through ONC, to establish loan programs for providers
- Purposes: purchase certified EHR technology, train personnel in use, and improve the secure electronic exchange of health information
- States/tribes must:
  - Establish qualified HIT loan fund
  - Submit a strategic plan
  - Provide matching funds: 1:5
  - Assure providers will submit reports on quality measures and use qualified technology
- 10-year loan terms
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