HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

Volume Thirteen
Number Seven
July 2011
Published Monthly

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Achieving "meaningful use" in the Medicaid incentive program, Part 3: Nuts and bolts

By Janice A. Anderson, JD, BSN; and Rebecca L. Frigy, JD, MPH

Editor's note: Janice A. Anderson, Shareholder in the Chicago offices of Polsinelli Shughart PC, has over 25 years' experience focusing on health regulatory and compliance issues and over 30 years' experience working in the health care industry. She may be contacted by e-mail at janderson@polsinelli.com or by telephone at 312/873-3623.

Rebecca L. Frigy is an attorney in the St. Louis offices of Polsinelli Shughart PC and may be contacted by e-mail at rfrigy@polsinelli.com or by telephone at 314/889-7013.

The American Recovery and Reinvestment Act (ARRA) passed in February of 2009 through the Health Information Technology for Economic and Clinical Health Act (HITECH) established three incentive programs focused on promoting the adoption of electronic health record (EHR) technology: a Medicare Fee-For-Service (FFS) incentive program (addressed in our January 2011 issue), a Medicare Advantage (MA) incentive program (addressed in our June 2011 issue), and a Medicaid incentive program. This article on Medicaid is the third in this series in **Compliance Today**.

Under the HITECH Act, state Medicaid programs, at their option, may receive federal financial participation (FFP) for expenditures made as incentive payments to certain Medicaid providers for the adoption, implementation, upgrade, and meaningful use of certified EHR technology. The first round of final regulations related to the meaningful use incentive programs (the final rule) was released on July 13, 2010 by the Centers for Medicare and Medicaid Services (CMS). The final rule sets forth the exact criteria required to achieve meaningful use in the first stage of the incentive programs, the relevant time lines for each incentive program, and the amount of incentive payments that a provider may be eligible for in each program. Because the exact details of the Medicaid incentive programs will vary from state to state, the final rule only sets forth the general framework for the Medicaid incentive program. A description of this general framework is found below.

Details related to a specific state's program must be obtained from the applicable state. Registration for the state Medicaid incentive programs began on January 3, 2011 in Alaska, Iowa, Kentucky, Louisiana, Michigan, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas. Registration in the state of Alabama began on April 1, 2011; Missouri began on April 4, 2011; and registration in the states of Indiana and Ohio began on May 2, 2011. Other states that choose to participate in the Medicaid incentive program will likely launch their programs during the spring and summer of 2011. Additional information regarding specific state programs, registration, and launch times can be found at: https://www.cms.gov/apps/files/statecontacts.pdf.

Unlike in the Medicare incentive programs, a Medicaid provider is not required to meet the meaningful use criteria under the Medicaid incentive program to receive an incentive payment in the first payment year; rather,

Medicaid providers may receive an incentive payment simply for having adopted, implemented, or upgraded to certified EHR technology.

Qualifying Medicaid eligible professionals (EPs)

Medicaid participating providers who wish to receive a Medicaid incentive payment must meet the definition of "Medicaid eligible professional (EP)." This includes physicians, dentists, certified nurse midwives, nurse practitioners, optometrists (if the state's plan has specifically adopted the option of including optometrists in the Medicaid program under Section 1905(e) of the Social Security Act), and physician assistants (PA) practicing in a federally qualified health center (FQHC) or rural health clinic (RHC) that is led by a PA. A physician assistant is considered to be leading an FQHC or RHC if:

- the PA is the primary provider in the clinic,
- the PA is a clinical or medical director at the clinical site, or
- the PA is an owner of the RHC.

Medicaid EPs cannot be "hospital based," except for Medicaid EPs practicing predominantly in an FQHC or RHC, which means that more than 50% of the EP's patient encounters over a period of 6 months are provided at an FQHC or RHC. For Medicaid purposes, state Medicaid agencies will make the determination about whether or not an EP is hospital-based by analyzing an EP's Medicaid claims data; or in the case of EPs who deliver care via Medicaid managed care programs, by analyzing either patient encounter data or other equivalent data sources, at the state's option. For purposes of making this determination, states would be permitted to use data either from the prior fiscal year or calendar year.

Whether an individual qualifies as providing dental, nurse practitioner, physician assistant, or certified nurse midwife services will be determined under state scope of practice rules. Also, states and EPs should refer to CMS regulations related to provider scope of practice. States also generally have a Medicaid State Plan (and often state statutes or regulations) that designates how each provider is eligible to participate in the state's Medicaid program by practice type. The potential EPs must meet all of these other Medicare and state eligibility requirements in order to participate in the Medicaid incentive program.

For an EP to qualify to receive an incentive payment under the Medicaid incentive program, at least 30% of the EP's patient volume must be attributable to Medicaid patients, except:

- A pediatrician must have at least a 20% Medicaid patient volume.
- EPs practicing predominantly in an FQHC or RHC must have a minimum of 30% patient volume attributable to "needy individuals." A "needy individual" is defined as meeting any of the following three criteria:
  - Receives medical assistance from Medicaid or the Children's Health Insurance Program (CHIP);
  - Receives uncompensated care by the provider; or
  - Receives services at either no cost or a reduced cost based on a sliding scale determined by the individual's ability to pay.

Medicaid eligible hospitals (EHs)

Acute care and children's hospitals are the two types of institutional providers eligible for Medicaid hospital incentive payments. For purposes of the Medicaid incentive payment program, "acute care hospital" means a health care facility where the average length of patient stay is 25 days or less and the facility has a CMS certification number (CCN) with the last four digits in the series 0001 through 0879, or 1300 through 1399 (i.e., short-term general hospitals, critical access hospitals, and cancer hospitals). This definition does not include long-term care hospitals where the average inpatient length of stay is more than 25 days. For purposes of the Medicaid incentive payment program, a facility is a

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"children's hospital" if it is a separately certified children's hospital in the 3300 through 3399 CCN series and predominately treats individuals under the age of 21.

For an acute care hospital to qualify to receive an incentive payment under the Medicaid incentive program, the acute care hospital must meet a 10% Medicaid patient volume threshold. Children's hospitals do not have patient volume requirements for Medicaid incentive program participation.

Patient volume determinations

As established above, for an EP and an acute care hospital to qualify to receive payments under the Medicaid incentive program, the EP must have at least 30% patient volume attributable to Medicaid patients (with several exceptions) and the acute care hospital must meet a 10% Medicaid patient volume threshold (See table 1).

The final rule sets forth the method for determining patient volume for purposes of Medicaid incentive payment eligibility. States may also seek approval from CMS for new methods for determining patient volume for purposes of the Medicaid incentive program. If CMS approves a method proposed by one state, the approved method may be considered an option for all states.

Providers are expected to estimate their patient volumes using verifiable data sources. In establishing the patient volume thresholds, individuals enrolled in Medicaid managed care plans should be included. This means that individuals enrolled in managed care organizations, prepaid inpatient health plans, or prepaid ambulatory health plans should be included in the calculation.

EP patient volume determinations

To determine patient volume for a Medicaid EP, the EP's applicable percentage of patient encounters must be attributable to Medicaid patients over any continuous 90-day period within the most recent calendar year prior to reporting. For purposes of determining whether the patient threshold is met, the EP may also consider Medicaid enrollees on the panel assigned to the EP within the representative 90-day period. (However, it is not intended for the EP to count a panel-assigned patient who also had an encounter more than once.) For purposes of determining patient volume for a Medicaid EP, a "patient encounter" means services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project:

- paid for part or all of the service; or
- paid all or part of the premiums, copayments, and/or cost-sharing.

For purposes of calculating needy individuals' patient volume for a Medicaid EP practicing predominantly in an FQHC or RHC, a

Table 1: Requirements for Medicaid incentive program participation

Entity	Minimum Medicaid patient volume threshold	Or the Medicaid EP practices predominantly in an FQHC or RHC with a 30% needy individual patient volume threshold
Physicians	30%	
-Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
Nurse Practitioners	30%	
Physician Assistants when practicing at an FQHC/RHC that is led by a PA	30%	
Acute Care Hospitals	10%	Not an option for hospitals
Children's Hospitals	No requirement	

"needy patient encounter" means services rendered on any one day to an individual:

- where Medicaid or CHIP or a Medicaid or CHIP demonstration project paid for part or all of the service;
- where Medicaid or CHIP or a Medicaid or CHIP demonstration project paid all or part of their premiums, co-payments, and/or cost-sharing; or
- billed on a sliding scale or that were uncompensated.

It is acceptable to include the same patient encounter for multiple providers when it is within the scope of each provider's practice, and clinics and group practices may use the practice or clinic Medicaid patient volume (or needy individual patient volume, as applicable) and apply it to all EPs in their practice, under three conditions:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (i.e., if an EP sees only Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- There is auditable data to support the clinic's patient volume determination; and
- All providers at the clinic or group practice use the same methodology in each year (i.e., clinics could not have some EPs at the clinic use their individual patient volume for patients, while others use the clinic-level data).

If an EP works both in a clinic and outside the clinic, then the clinic/practice level determination may include only those encounters associated with the clinic/practice.

Medicaid EH patient volume determinations

To determine Medicaid patient volume thresholds for EH acute care hospitals, a minimum of 10% of patient encounters must be attributable to Medicaid patients over any continuous 90-day period within the most recent calendar year prior to reporting. For purposes of calculating EH patient volume, a "patient encounter" means services rendered to an individual:

- per inpatient discharge where Medicaid or a Medicaid demonstration project paid for all or part of the service;
- per inpatient discharge where Medicaid or a Medicaid demonstration project paid all or part of the premium, co-payment, and/or cost-sharing;
- in an Emergency Department, which is part of the EH under a qualifying CCN, on any one day where Medicaid or a Medicaid demonstration project either paid for all or part of the service; or
- in an Emergency Department, which is part of the EH under a qualifying CCN, on any one day where Medicaid or a Medicaid demonstration project paid all or part of their premiums, co-payments, and/or cost-sharing.

Criteria and time line for incentive payments

Unlike the Medicare incentive programs, the Medicaid incentive program allows EPs and EHs to receive an incentive payment in the first year simply for adopting, implementing, or upgrading certified EHR technology without fulfilling the meaningful use criteria. To prove this, Medicaid EPs and EHs will have to attest to having adopted or commenced utilization of certified EHR technology; or expanded the available functionality of certified EHR technology and commenced utilization at their practice site.

To establish "adoption," a provider must be able to demonstrate the actual installation of EHR prior to the incentive, rather than "efforts" to install EHR technology. Adoption does not include activities that may not necessarily result in actual installation, such as researching EHRs. To establish the "implementation" of EHR technology, a provider must have installed certified EHR technology and started using the EHR technology in clinical practice. Implementation

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includes staff training, data entry of patient demographics and administrative data, and establishing data exchange agreements and relationships between the provider's certified EHR technology and other providers, such as laboratories, pharmacies, or health information exchanges. Efforts to redesign provider workflow would also be considered implementation of EHR technology. To establish the "upgrade" of EHR technology, a provider must show the expansion of the functionality of certified EHR technology, such as the addition of clinical support, e-prescribing functionality, computerized physician order entry (CPOE) systems, or other enhancements that facilitate the meaningful use of certified EHR technology.

For years beyond a year in which a provider receives Medicaid incentive payments for adopting, implementing, or upgrading certified EHR technology, states must implement the same meaningful use requirements and criteria (including clinical quality reporting measures and the use of certified EHR technology) used in the Medicare EHR incentive programs. States, however, are able to seek a modification to such criteria or to propose alternative criteria; the state must submit the proposed methods to CMS for prior approval.

Because there is concern that many states do not currently have the electronic infrastructure to receive and store clinical quality measures and because Medicaid providers may receive Medicaid incentive payments for adopting, implementing, or upgrading certified EHR technology in their first payment year (prior to demonstrating meaningful use of EHR technology), the final rule gives states the ability to identify in their state Medicaid Health Information Technology (HIT) Plans how the state intends to accept clinical quality data from Medicaid providers who seek to demonstrate meaningful use, either via attestations or via electronic reporting. States must include in their state Medicaid HIT Plans an environmental scan of existing HIT and quality measure reporting activities related to Medicaid. States are expected to include details about how these other on-going efforts can be leveraged and supported under HITECH, and how HITECH will not result in duplicative and/or burdensome reporting requirements on the same providers or organizations. Therefore, unless otherwise approved by CMS, Medicaid EPs and EHs must meet the same meaningful use requirements and submit the same required information for clinical quality measures as for the Medicare incentive program for years after the year in which they have received an incentive for adopting, implementing, or upgrading EHR technology.

Computation of incentive payments

Medicaid EPs

EPs may participate in the Medicaid incentive program for up to 6 years (an incentive for adopting, implementing, and upgrading EHR technology plus additional incentive payments for up to 5 years for demonstrating meaningful use). A Medicaid EP who has already adopted, implemented, or upgraded certified EHR technology and can meaningfully use EHR technology in the first incentive payment year will be permitted to receive the same maximum payments as a Medicaid EP who merely adopted, implemented, or upgraded certified EHR technology in the first year. Therefore, the maximum incentive payments for Medicaid EPs who demonstrate that they are meaningful users in the first payment year will be identical to the maximum payments available to those who demonstrate adoption, implementation, or upgrading certified EHR technology in the first year. Medicaid providers in their second participation year (or their first payment year, if they are qualifying based on meaningful use) will need to demonstrate meaningful use over a 90-day reporting period and

over 12-months for their third and subsequent years.

Medicaid EPs are not required to participate in the incentive program on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP may receive incentive payments is 2021. Medicare EPs do not have this same flexibility. This means that an EP may receive a Medicaid incentive payment in 2012 for adopting, implementing and upgrading EHR technology, not meet the meaningful use criteria in 2013, and then begin receiving Medicaid incentive program payments again in 2014 when it is able to meet the meaningful use criteria. This also means that if an EP does not receive an incentive payment for a given year, then that year would not constitute a payment year. For example, if a Medicaid EP receives incentive payments in 2011 and 2012, but fails to qualify for an incentive payment in 2013, the EP would still be potentially eligible to receive incentives for an additional four payment years.

Payment for EPs under the Medicaid incentive program equals 85% of the "net average allowable costs" of EHR technology (See table 2). "Net average allowable costs" are the average allowable costs of EHR technology minus payments from other sources (other than states or local governments). The net average allowable costs are capped at $25,000 in the first year, and $10,000 for each of the five subsequent years (pediatricians who have a minimum 20% patient volume may qualify for up to a maximum of $14,167 in the first incentive payment year and up to a maximum of $5,667 in the five subsequent incentive payment years). Therefore, the maximum incentive payment an EP could receive under the Medicaid incentive program equals 85% of $75,000, or $63,750, over a period of 6 years (or for pediatricians, no more than $42,500 over the maximum 6 year period). EPs must begin receiving incentive payments no later than calendar year 2016 (which means the final incentive payment, assuming meaningful use is maintained, will be made in 2021).

States must have a process and a methodology for verifying that payment incentives are not paid at amounts higher than 85% of the net average allowable cost and that Medicaid EPs pay 15% of the net average allowable cost of the certified EHR technology. As such, states may choose to establish a process whereby individuals attest to having completed their forms correctly. In states that choose this attestation method, Medicaid EPs run the risk of audit in the event that the state has reason to believe a form was not appropriately completed. States may also allow EPs to count their initial costs

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Table 2: Net average allowable costs

Cap on net average allowable costs	85% allowed for EPs	Maximum cumulative incentive over a 6-year period
$25,000 in Year 1 for most EPs	$21,250	$63,750
$10,000 in Years 2-6 for most EPs	$8,500	
$16,667 in Year 1 for pediatricians with a minimum 20% patient volume, but less than 30% patient volume, Medicaid patients	$14,167	$42,500
$6,667 in Years 2-6 for pediatricians with a minimum 20% patient volume, but less than 30% patient volume, Medicaid patients.	$5,667	

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in purchasing EHR technology for purposes of meeting the 15% threshold, because there is no prescribed time frame for when the EP's initial expenditure must have occurred.

Under the Medicaid incentive program, states will disburse Medicaid incentive payments to EPs in alignment with the calendar year. The reason for this is to align Medicaid incentive payment disbursements with that of the Medicare incentive programs, in order to support consistency between the programs, as well as among the states.

Medicaid EHs

The payments to an EH under the Medicaid incentive program are similar to those under the Medicare incentive programs. A Medicaid EH may receive an incentive payment equal to its overall EHR expense amount times its Medicaid Share. The EH's Medicaid Share is based on its Medicaid inpatient bed days, total inpatient bed days, and charges for charity care. The Medicaid share includes both Medicaid inpatient-bed-days and Medicaid managed care inpatient-bed-days.

States may pay an EH up to 100% of an aggregate EHR hospital incentive amount provided over a minimum of a 3-year period and a maximum of a 6-year period. No payments can be made to an EH after 2016 unless the EH received a payment in the previous year, and payment years after 2016 must be consecutive. As under the Medicare incentive programs, an EH will receive Medicaid incentive payments in alignment with the federal fiscal year (beginning October 1 and ending September 30 of the subsequent calendar year). An EH may receive incentive payments from both the Medicare and Medicaid incentive programs, contingent on successful demonstration of meaningful use and other requirements under both programs. Additionally, in any given payment year, no annual Medicaid incentive payment to an EH may exceed 50% of the EH's aggregate EHR incentive payments.

States are responsible for using auditable data sources to calculate Medicaid EH incentive amounts. Auditable data sources include providers' Medicare cost reports, state-specific Medicaid cost reports, payment and utilization information from the state's Medicaid Management Information Systems, and EH financial statements and accounting records.

Process for making and receiving Medicaid incentive payments

EPs must make a selection between receiving incentive payments through either the Medicare or Medicaid incentive programs. EPs are prohibited from receiving incentive payments under the Medicaid incentive program unless the EP has waived any rights to incentive payments under the Medicare FFS or MA incentive programs.

Furthermore, the HHS Secretary is required to assure no duplication of funding with respect to a physician and the Medicaid and Medicare programs. To aid in such efforts, the HITECH Act requires the Secretary to post online the names of Medicare EPs, EHs, and CAHs that are meaningful EHR users for the relevant payment year. EPs receiving a Medicaid incentive payment would remain eligible for incentives under the Medicare Improvements for Patients and Providers Act (MIPPA) E-Prescribing Incentive Program. EPs can change their election once during the life of the incentive programs after making the initial election for payment years 2014 and before.

If an EP switches programs, the EP will be placed in the payment year the EP would have been in had the EP begun in and remained in the program to which he or she has switched. An EP may make one incentive program election change prior to the 2015 payment year, and no switching is permitted after the 2014 payment year. In any event, no incentive payments will be made to any EP

that would allow the EP to exceed the Medicaid threshold.

Medicaid EPs and EHs must select one state from which to receive incentive payments. Medicaid EPs and EHs can annually change the state they select when they re-attest to program requirements. EPs in multiple group practices must select one tax identification number (TIN) for Medicaid incentive payments. EPs are not permitted to require a state to divide payments among different practices based upon group TINs; however, once a payment is disbursed from the state, nothing precludes the EP from further disbursing the incentive payment, subject to applicable fraud, waste, and abuse laws, regulations, and rules.

Generally, incentive payments must be made directly to the EP; however, there is an exception which allows incentive payments to be made to "entities promoting the adoption of certified EHR technology" if participation in the payment arrangement is voluntary for the EP involved. Additionally, the entity must not retain more than 5% of the incentive payment for costs unrelated to certified EHR technology and support services, including maintenance and training.

An entity is "promoting" the adoption of certified EHR technology if it enables and provides 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. Using this definition as a guideline, states will have the discretion to identify entities that promote the adoption of certified EHR technology and must assure that such entities receive no more than 5% for costs not related to certified EHR technology.

The waiver and non-duplication requirement applies only to EPs who meet both the Medicare FFS/MA and Medicaid EHR incentive program eligibility criteria, and does not apply to EHs (which, if eligible could receive incentive payments from both Medicare and Medicaid simultaneously).

Provider compliance and audit

Under the Medicaid incentive program, CMS explicitly contemplates that states will fight fraud and abuse related to the Medicaid incentive program, including ensuring that no duplication of payments occurs between the Medicare and Medicaid programs. States are required to set forth compliance mechanisms related to the Medicaid incentive payments in their state Medicaid HIT Plans. Because providers are required to attest to their ability to meet the patient volume eligibility requirements, in most state Medicaid HIT Plans there will no doubt be an audit and verification procedure to ensure the accuracy of all information attested to by a provider. Additionally, CMS has required that states also include in the state Medicaid HIT Plans, a process for recoupment of monies, if overpayments or erroneous payments are found to have been paid. ■