

**Meaningful Use Workgroup Hearing:  
 Medicaid Electronic Health Record (EHR) Incentive Program  
 October 6, 2011  
 Written Testimony  
 Julie Boughn, Deputy Director  
 Center for Medicaid and CHIP Services  
 Centers for Medicare & Medicaid Services**

**Program Description**

The Medicaid Electronic Health Record (EHR) Incentive Program provides incentive payments to eligible professionals<sup>1</sup>, eligible hospitals<sup>2</sup>, and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. The Medicaid EHR Incentive Program is voluntarily offered by individual States and territories and began on January 3<sup>rd</sup> in 11 States. Under Medicaid, providers have until 2016 to begin participation in the program and can receive incentive payments through the 2021 payment year.

**Program Status**

As of October 6, 2011, 33 States have launched their Medicaid EHR Incentive Programs. However, the Centers for Medicare & Medicaid Services (CMS) estimates that 46 States will launch by the end of 2011. The remaining four States and 3 US territories will launch in early 2012.

**Medicaid EHR Incentive Program Launch Dates**

Actual				Projected	
Jan-Mar 2011	April-Aug 2011	Sept 2011	October 2011	Nov-Dec 2011	2012
AK, IA, KY, LA, MI, MS, NC, OK, SC, TN, TX (11)	AL, AZ, CT, IN, MO, NM, OH, PA, RI, WA, WI, WV (12)	FL, GA, IL, OR (4)	CA, MD, MA, UT, VT, ME (6)	AR, CO, DC, DE, ID, KS, MN, MT, ND, NE, NV, NY, PR, SD, WY (15)	VA, ID, NH, HI, AS, GU, MP (7)

<sup>1</sup> Eligible professionals under Medicaid include physicians (primarily doctors of medicine and doctors of osteopathy), nurse practitioners, certified nurse-midwives, dentists, physician assistants who furnish services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.

<sup>2</sup> Eligible hospitals under Medicaid include acute care hospitals (including CAHs and cancer hospitals) with at least 10% Medicaid patient volume; and Children's hospitals (no Medicaid patient volume requirements).

## State Administrative Costs and Medicaid EHR Incentive Payments

To assist States with the development, implementation, and administration of their Medicaid EHR Incentive Programs, CMS provides States with a 90 percent federal match for their costs related to program administration, including auditing and oversight expenses. CMS also pays 90 percent matching funds for the creation of State-level provider portals that support data collection and provider attestation for the incentive payments. Additionally, States can request a 90% federal match from CMS for contribution to the development of a State Health Information Exchange and other tools that would facilitate meaningful use of EHRs by Medicaid eligible providers. Through September 26, 2011, CMS has provided \$417.9 million to 54 States and Territories for HIT planning and implementation activities in support of their Medicaid EHR Incentive Programs.

The actual provider EHR incentive payments for the incentive programs are 100 percent federally funded. As of October 2011, 21 States have disbursed federally-funded Medicaid incentive payments totaling over \$500 million. The table below reflects estimates and actual for the Federal Fiscal Year 2011.

FY 2011 Medicaid Incentive Payments <i>outlays in billions</i>		
Final Rule Estimates		Actual as of 9/30/11
<u>High</u>	<u>Low</u>	
\$1.7	\$0.6	\$0.53

### Medicaid Provider Participation

While CMS does not have State level estimates, program registration in States that have launched has been positive. Among States such as Louisiana, Iowa, and Kentucky, provider registration and attestation exceeded expectations. However, hospital registration numbers are lower than expected (see Challenges section below).

To further encourage registration, several States, such as Kentucky, Virginia, Texas, California, and Alabama, are contracting or are planning to contract with Regional Extension Centers to provide technical assistance to Medicaid specialty (non-primary care) providers on EHR adoption and implementation.

Total payments have been greater than many States have initially anticipated, including Louisiana, Kentucky and Texas.

**Medicaid Incentive Program Registration and Adopt, Implement, Upgrade and Meaningful Use Payments. Cumulative Data as of September 30, 2011**

	Registration	Payment	
	Number	Number	\$ in millions
Eligible Professional.....	23,993	6,236	\$128.7
Eligible Hospital (Medicaid-only).....	37	19	\$42
Medicare and Medicaid Hospital (Medicaid) <sup>1</sup> .....	2,215	384	\$331.9
<i>Medicare and Medicaid Hospital (Meaningful Use)</i>	-	25	\$21.5
<b>Total.....</b>		<b>6,639</b>	<b>\$502.7</b>

<sup>1</sup>Represents Medicaid payments to hospitals which may register for both the Medicare and Medicaid Incentive Programs.

The above table indicates that of the \$502.7 million paid in Medicaid EHR incentive payments, \$21.5 million was for meaningful use (for acute care hospitals and CAHs eligible for both incentives) and the remainder was for adopt, implement or upgrade.

Challenges

One of the factors determining how many providers have registered and/or received EHR incentive payments is States' timeline for launching their EHR Incentive Programs. States determine their own schedule for implementation of their Medicaid EHR Incentive Program. A number of factors affect their timelines, including leadership changes, financial deficits, and competing priorities. Examples of these issues include:

- New Leadership: States that have had a change in their legislature, Governor, Medicaid director, or HIT Coordinator have faced delays while new leadership becomes familiar with the Incentive Payment Program and has a chance to approve on-going activities.
- State Budget Concerns: Montana, Minnesota and Michigan reconsidered implementation of the program due to State budget concerns, but resolved in the end to proceed.
- Competing Priorities: All States are juggling HITECH with ICD-10 and 5010 implementation, which is the transition in electronic data interchange code sets for health care transactions. States are also challenged with major budget shortfalls. Additionally, many States are also managing MMIS (the Medicaid Management Information System is the mechanized claims processing and information retrieval system which states are required to have) and eligibility/enrollment updates and system changes.

Medicaid Program Outreach

CMS has supported States with guidance and direct technical assistance, as well as peer-to-peer assistance. States are also complementing CMS' efforts by developing outreach materials, websites, user guides, and brochures. They are partnering locally to maximize their outreach through the State primary care associations, State hospital associations and State chapters of the

American Academy of Pediatrics and the Healthcare Information and Management Systems Society (HIMSS).

Since enactment of HITECH, CMS issued four State Medicaid Directors letters and held two national conferences. CMS also supports intensive technical assistance through Communities of Practice, an online document repository for templates and examples, a State Medicaid HIT Plan template and checklist, a program launch checklist, and bi-weekly All-State conference calls. CMS maintains two large technical assistance contracts to support States successfully linking with the CMS registration and attestation system and successful implementation of the State programs.

CMS is using peer-to-peer technical assistance to provide “short-cuts” to understaffed States and to save time and resources. This peer-to-peer technical assistance includes:

- Establishing three Communities of Practice—State Planning<sup>3</sup>, Auditing, and Meaningful Use—to facilitate the development of solutions to common implementation issues.
- Providing the source code from the Medicare attestation module for States to analyze the basics behind such a system. States have indicated that these source documents have saved many man-hours of coding.
- Providing the detailed EP Meaningful Use Audit Strategy developed for Medicare, to save States time and resources and encourage a consistent approach to auditing MU.
- Creating a series of training modules designed to be used by State staff to teach new staff about the HITECH Act and the EHR Incentive Programs. These modules are online and designed to be self-paced, so that States can be assured that new staff are receiving accurate information about the EHR Incentive Programs.

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<sup>3</sup> *There are 3 planning documents required for States:*

**HIT Planning Advance Planning Document (PAPD):** Must be approved before States start drawing down administrative funds for planning. The PAPD is a document States submit to CMS to request CMS matching funds for reasonable administrative expenses for the planning for their EHR Incentive Programs.

**State Medicaid HIT Plans (SMHPs):** Provides details about how State will implement and oversee the program; must be approved before implementation begins. The SMHP will include the results of an environmental scan of each State’s “as-is” HIT landscape; their roadmap for how they will implement the EHR Incentive program, including registration, attestation, payments, communications/outreach and other efforts to promote EHR adoption and meaningful use; their HIT vision for their “to-be” HIT landscape, including how the EHR Incentive program fits in with other State and Federal HIT activities and goals and; how they will oversee and audit the program to avoid improper payments, including a process for provider appeals and recoupment. These plans are iterative and will be updated by the States at least annually.

**Implementation Advanced Planning Document (IAPD):** Must be approved before States start drawing down administrative funds for program implementation and eligible professionals and hospitals incentive payments. The IAPD is a document States submit to CMS to request CMS matching funds for reasonable administrative expenses for the administration and oversight of the EHR Incentive Programs.

## Lessons Learned

States that launched earlier this year have indicated the importance of provider outreach, and the development of user-guides for attestation.

## **Audits**

CMS has identified improper incentive payments as the primary risk to the EHR Incentive Programs. Improper incentive payments can occur when: 1) a provider attests to being meaningful user of electronic health records without actually being one, 2) a provider receives payments via both Medicare and Medicaid, 3) a provider is paid by more than one State, or 4) an incentive payment is made to a provider who is statutorily ineligible (Medicare and Medicaid each allow the participation of different provider types). To prevent improper payments, CMS has incorporated extensive prepayment edits into the functionality of the program systems and encouraged States to do the same with their systems. However, CMS and States will conduct post-payment reviews as well to ensure that the EHR Incentive Payments are proper and accurate.

### CMS Audit Activity

CMS will perform audits of components of the Medicaid EHR Incentive Program on dual-eligible hospitals and Medicaid-only hospitals. These audits will focus on whether providers and hospitals have accurately reported all required core, menu and clinical quality measures.

CMS will also audit a random sample of program participants based on identified risk factors. These audits will be conducted through desk reviews and onsite audits.

### State Audit Activity

CMS works collaboratively with States as part of the planning and approval process to develop and establish State auditing strategies. As part of the State EHR Incentive Program approval process, States have agreed to perform the following audits within four months of making the first incentive payments:

- Meaningful Use audits on Medicaid Eligible Professionals;
- Financial audits on Medicaid payments for both EPs and EHs;
- Eligibility audits for both EPs and EHs, and
- Adopt/Implement/Upgrade audits on Medicaid providers.

States described their methods to avoid making improper payments and their auditing strategies in the State Medicaid HIT Plans (SMHPs). CMS monitors States' compliance with their SMHPs through a variety of means, including site visits, reviews of State website materials, monitoring provider feedback and questions and analysis of reported data. With one exception, all States have been notifying CMS (via the program systems) within five business days of making an incentive payment or determining a provider was ineligible for payment. The program system

file exchanges are working effectively and represent daily snapshots of State and provider activity.

This year the States' auditing strategies are focused on eligibility requirements and the adoption/implementation/upgrade to certified EHR technology (not meaningful use). The OIG report "Early review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight" (OEI-05-10-00080) found that "data availability limits both the number of eligibility requirements that States plan to verify prior to payment and the completeness of those verifications."

The OIG report derived its data from States that had been in full implementation for less than 90 days. States clearly understand that their responsibility is to audit all eligibility criteria, including patient volume. All approved SMHPs included plans to audit patient volume, although CMS did not require that verification of all eligibility occur prior to payment. Certain elements, such as verification against the OIG sanctions list and the Master death file, do occur pre-payment. States will verify patient volume, and other criteria, such as adoption/implementation/upgrade and meaningful use post-payment, in most instances, due to a lack of ready access to all-payer data on eligible providers.

Budgetary issues have not hindered States' ability to effectively audit Medicaid EHR incentive payments. They are undertaking these activities both in-house and via external contracts and leveraging existing data sources and technology where possible to lower costs and provider burden. States plan on utilizing HIEs to audit Medicaid providers' demonstration of meaningful use, starting in 2012. CMS awarded a contract for a performance evaluation of States' 2011 implementation of the EHR Incentive Program.

CMS and States are in the process of defining meaningful use protocols for 2012 audits and initiating the procurement necessary to conduct them. CMS will share the final expectations regarding State oversight and audit strategies when completed. Starting in 2012, CMS will be conducting on-site performance reviews of States that have been implementing their EHR Incentive Programs for at least 12 months.

### Medicaid Quality

Medicaid EPs and Medicaid-only EHs will attest to meaningful use to the States. This includes submission of clinical quality measure data electronically from EHRs, with a target date of 2013. CMS expects that the infrastructure established using our 90% FFP to accept this data from Medicaid providers' EHRs will be leveraged for the submission of other clinical quality data, such as under the CHIPRA program, or the new ACA Section 2701 Adult measures. Medicaid quality measurement extends beyond the reach of meaningful use and providers eligible for incentives, encompassing long-term care, behavioral health and into other healthcare settings, such as home and community-based care for persons with disabilities. State Medicaid Agencies are being asked to look across their programs, as we at CMS are doing, to harmonize quality measurement and quality reporting efforts. CMS' efforts to harmonize the clinical quality measures included in Stage 2 of meaningful use, as proposed, would go a long way to assisting States in their quality measurement efforts through the linkage to certified EHR technology.

Medicaid is a strong advocate for the inclusion in Stage 2 of clinical quality measures beyond what is applicable to Medicare populations or used in Medicare quality reporting but to include NCQA medical home accreditation, Medicaid health home measures, CHIPRA, HEDIS, etc. The measure concepts produced by the Quality Measure workgroup resonated with Medicaid's quality measurement goals, however additional work is needed to ensure the existence of demonstrative, e-specified clinical quality measures for Medicaid providers (e.g. pediatricians, obstetricians, children's hospitals, dentists, etc.).

### Medicaid and HIE

State Medicaid Agencies are partners with the HIE Cooperative Agreement Grantees and their State Public Health colleagues to foster access to the electronic exchange of health information. CMS has issued guidance on the conditions under which States may request administrative matching funds to support HIE infrastructure as part of encouraging adoption and meaningful use of EHRs. Medicaid is taking the long-view, again in light of concurrent priorities for expanded Medicaid eligibility and enrollment, State insurance exchanges, etc, on what HIE services or IT components can be reused across a shared enterprise. Given all that is on States' plates (including ICD-10, 5010), one of the challenges has been how to juggle priorities and maximize staff and financial resources. Providers' meeting meaningful use as it is enabled through HIE is only one aspect of a larger investment and discussion among payers and the provider community of which CMS and State Medicaid Agencies are involved.