MaineCare Services
An Office of the
Department of Health and Human Services

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

State of Maine Health Information Technology

MaineCare EHR Incentive Program Reference Packet

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Contents

Who qualifies for the MaineCare EHR Incentive Program?

Medicaid Patient Volume Thresholds

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

What Professionals are NOT eligible?

Final Rules Related to Hospital-based Professionals

- Hospital-based Professionals are excluded from incentive programs — defined as professionals that provide "substantially all" of Medicare or Medicaid covered professional services in a hospital setting, whether inpatient or emergency room

- CMS is proposing "substantially all" to mean 90% — so Professionals who have less than 90% would be eligible for Medicare or Medicaid incentives

- CMS will use place of service code (POS) on physician claims to determine whether an EP furnishes "substantially all" of professional services in hospital setting. There are two POS codes which would be considered a hospital setting:
  - 21 – Inpatient Hospital
  - 23 – Emergency Room, Hospital
- The Hospital-based status of a professional would get reassessed each year based on the claims data from the year immediately preceding the payment year

Eligibility Scenarios

Provider Description	Description	Eligible Y/N	
Hospital-based physician	"Substantially all" of the physician's clinical activity is conducted in an inpatient setting (e.g., Hospitalist, Radiologist)		N
Emergency Department Room physician	Emergency Department physician is a contracted clinical resource and 100% devoted to emergency room care		N
Emergency Department Room physician	Hospital-owned physician works 50% of time in the Emergency Department; remaining work is in ambulatory clinic	Y	
Hospital-owned Surgeon	Surgeon conducts 60% of clinical work in hospital (e.g., surgeries). Remaining work is in clinic	Y	
Ambulatory physician	Hospital-owned physician; works in the adjoining outpatient clinic	Y	
Ambulatory physician (not owned)	Does not utilize Hospitalist program. Spends 100% of time in a clinic setting	Y	

How are incentive payments calculated?

Eligible Provider: Medicaid – Illustrative Calculation

An individual provider is eligible to receive a maximum incentive payment of **$63,750**

For example, a provider organization of 5 providers may receive **5 payments of $63,750** (equaling **$318,750**)

	Medicaid EPs who begin adoption in					
Calendar Year	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
2011	$21,250	----------	----------	----------	----------	----------
2012	$8,500	$21,250	----------	----------	----------	----------
2013	$8,500	$8,500	$21,250	----------	----------	----------
2014	$8,500	$8,500	$8,500	$21,250	----------	----------
2015	$8,500	$8,500	$8,500	$8,500	$21,250	----------
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	----------	$8,500	$8,500	$8,500	$8,500	$8,500
2018	----------	----------	$8,500	$8,500	$8,500	$8,500
2019	----------	----------	----------	$8,500	$8,500	$8,500
2020	----------	----------	----------	----------	$8,500	$8,500
2021	----------	----------	----------	----------	----------	$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Note: The total maximum payment per Eligible Professionals is $63,750 over 6 years.

While CMS is responsible for calculating EH incentive payments, MaineCare is responsible for calculating, collecting attestation information about patient volume, and auditing payments.

Eligible Hospital: Medicaid – Illustrative Calculation

Initial amount *times* Medicaid Share *times* Transition Factor for each eligible year = Incentive Potential

Initial Amount			
Hospital	**Base Amount**	**Incremental increase**	**Sum of Base and Incremental Increase**
	$2,000,000	$200 * discharges between 1,149 and 23,000	
Hospital X	$2,000,000	17,078 discharges *200 = **$3,415,600**	**$5,415,600**

	Data Required for Calculation			Medicare Share and Incentives Calculation		
Hospital	**Total Patient Days**	**Adjusted Total Patient Days defined (ratio) as Non Charity Care / Total Charges**	**Medicaid Patient Days**	**Patient Days * Adjusted Patient Days**	**Medicaid Days Adj Patient Days**	**Initial Amount X Medicaid Share = Estimated Incentive**
Hospital X	63,073	$742,744,485 (CC) $775,439,349 (Total Charges)	19,418	63,073 * 96%	19,418 / 60,550	32% * $5,415,600
		96%		60,550 APD	32%	$1,732,992

Transition Factor X Estimated Incentives				
Hospital/ Transition Factor	**100% (yr 1)**	**75% (yr 2)**	**50% (yr 3)**	**25% (yr 4)**
Hospital X	$1,732,992 (2)	$1,299,744	$866,496	$433,248

(1) Assumes 'meaningful use' is achieved and adoption is either in years 2011, 2012, or 2013
(2) Medicare calculation is the same with one exception. Medicate Patient Days represents the sum of Medicare Part A and C

- Incentives are calculated at the Federal level by CMS for both Medicaid and Medicare
- To participate in the Medicaid incentives, a hospital must have at least 10% Medicaid IP hospital visits
- The Eligible Hospital (EH) also must participate in the IPPS
- EH participates can "skip" a year up for compliance up to and including year 2016 (Medicaid only). Remaining compliance years must be consecutive
- Medicare compliance (e.g., Meaningful Use Core and Quality Measures) will be the same as for Medicaid
- Excluded entities are Behavioral Health
- There are no penalties for Medicaid. Medicare penalties commence FFY 2015

Transition Factors

	Adoption Year					
Fund Year	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
2011	1	0	0	0	0	0
2012	0.75	1	0	0	0	0
2013	0.5	0.75	1	0	0	0
2014	0.25	0.5	0.75	0.75	0	0
2015	0	0.25	0.5	0.5	0.5	0
2016	0	0	0.25	0.25	0.25	0

How is patient volume calculated?

What is the Patient Volume Calculation?

- States must document in their SMHP the patient volume calculation they will be using to determine eligible providers for the EHR Incentive Program

- The final rule proposed two calculation options, which include:

  – a ratio where the numerator is the total number of Medicaid patient encounters (or needy individuals) treated in any 90-day period in the previous calendar year where the denominator is all patient encounters over the same period;

  –a similar ratio where the state may take into account Medicaid patients on a primary care patient panel.

- The final rule also permits State's to choose a third option which is to develop their own methodology

- An important note about patient volume calculation:

  –Group Practices/Clinics – Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level. However, each individual provider in that group practice or clinic must register, attest, meet meaningful use (adopt, implement, and upgrade in payment year 1), and request payment individually. The group practice/clinic patient volume calculation simply serves as a proxy for the individual provider. It does not automatically mean that all providers are compliant and eligible.

MaineCare's Proposed Patient Volume Calculations

Method	Patient Volume Calculation[1]
1) Encounters[2]	$= \frac{\text{Total number of Medicaid (or needy individual) patient encounters}}{\text{All patient encounters}}$
2) State Methodology	$= \frac{\text{Total number of Medicaid patient (or needy individual) charges}}{\text{All patient charges}}$

[1] Both calculations are based on encounters or charges over a 90 day period. Calculations are subject to CMS approval.
[2] Encounter is defined as the set of services provided by a single EP on a single date.

Definitions

Term	Definition
Patient Volume	The minimum participation threshold that is estimated through a numerator and denominator, consistent with the SMHP.
Encounter	Defined as the set of services provided by a single EP on a single date in any representative continuous 90-day period in the preceding calendar year (see Final Rule section 495.306 (e) for a complete description).
Needy Individuals	Individuals that meet one of the following: 1. Received medical assistance from Medicaid or CHIP 2. Were furnished uncompensated care by the provider 3. Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay
Practices Predominantly	An EP for whom the clinical location for over 50 percent of his/her total patient encounters over a period of 6 months in the most recent calendar year occurs at a FQHC or RHC.

What is the process for participating in the MaineCare EHR Incentive Program?

Provider Registration, Attestation and Payment Process

Eligible Professional (EP) Participating in Medicaid Incentive Program

1. Registration

2. Eligibility Determination

3. Payment Request and Attestations

4. Medicaid Payment

Eligible Hospitals (EH) that are Dually Eligible for both Medicare and Medicaid Incentive Programs

1. Registration and Eligibility Determination

2. Payment Request and Attestations

3. Medicare Payment

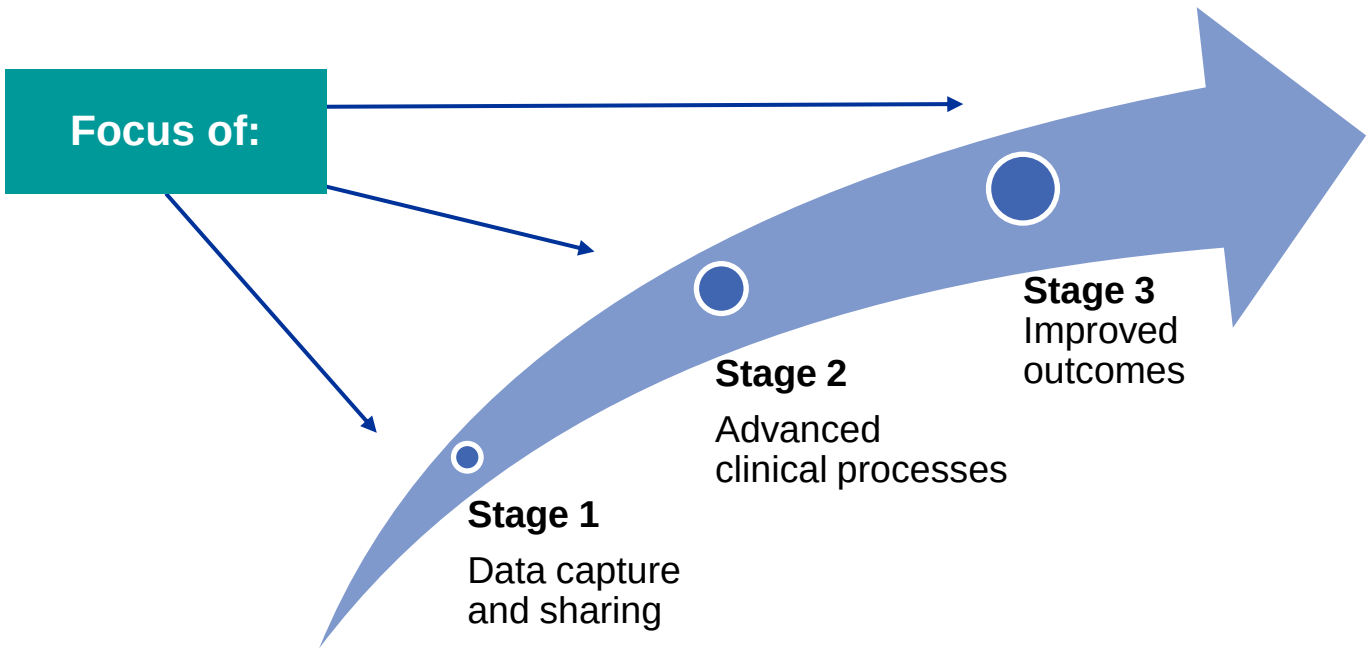
4. Medicaid Payment

What is Meaningful Use?

Staging of Meaningful Use

- The stages of Meaningful Use represent a graduated approach to arriving at the ultimate goal
- Meaningful Use regulations will be further defined in three, bi-yearly stages: 2011, 2013, 2015

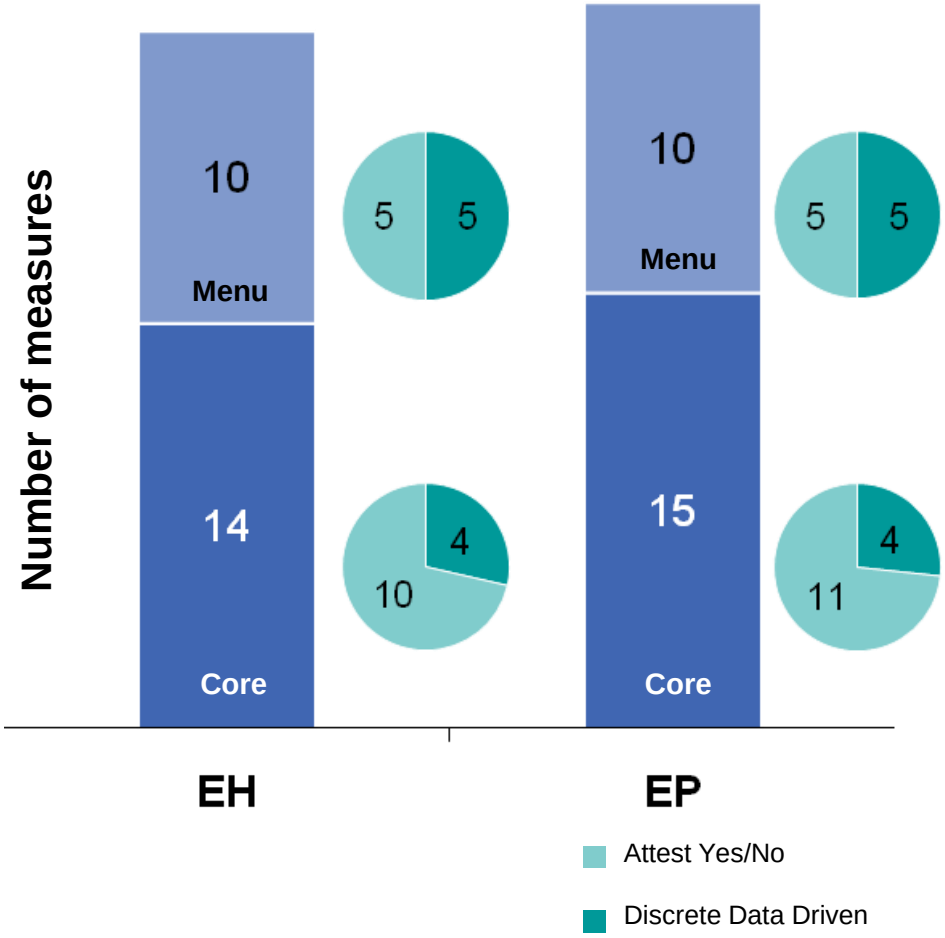
Moral of the story is: it pays to adopt early!



Connecting for Health, Markle Foundation "Achieving the Health IT Objectives of the American Recovery and Reinvestment Act" April 2009

Meaningful Use Stage 1 Measures Overview

The Final Rules on Meaningful Use distinguish between a “core set” of required criteria and a flexible “menu set” of additional criteria that presents choice in implementation.



- The EH and EP can rule out 5 of the 10 menu set measures
- EHs and EPs must choose at least one of the population and public health measures to demonstrate as part of the menu set
- Measures must be attested to with either a yes or no response or a discrete data reporting requirement

What is the difference between the Medicaid and Medicare EHR Incentive Programs?

Notable Differences Between EHR Incentive Programs

Medicaid	Medicare
Voluntary for States to implement	CMS will implement
No fee schedule reductions	Fee schedule reductions begin in 2015 for physicians who are not Meaningful Users
Providers may begin with Adopting Implementing, or Upgrading in Payment Year 1	Providers must begin with achieving Meaningful Use in Payment Year 1
▪ Max incentive for EPs is $63,750 ▪ Hospital incentives based on discharges and Medicaid share	▪ Max incentive for EPs is $44,000[1] ▪ Hospital incentives based on discharges and Medicare share
States may make adjustments to Meaningful Use requirements[2]	Meaningful Use requirements will be common for Medicare
May appeal decisions	Appeals process yet to be developed
Program ends in 2021; last year a provider may initiate program is 2016	Program ends in 2016; fee schedule reductions begin in 2015
Eligibility: ▪Medicaid eligible professionals ▪ Acute care hospitals ▪ Children's hospitals	Eligibility: ▪Medicare eligible professionals ▪ Subsection (d) hospitals ▪ Critical Access Hospitals

[1]10% increase if the EP practices in an FQHC ($48,400).

[2] Only applicable to menu set measures for EPs.

Resources for Providers

MaineCare Services
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MaineCare HIT Webpage

- Information specific to Maine's EHR Incentive Program
- http://www.maine.gov/dhhs/oms/HIT/index.html

State HIT Webpage

- Information about Statewide HIT Initiatives
- http://www.maine.gov/hit/

CMS EHR Incentive Program Website

- Information about the Incentive Programs, including Path to Payment, Eligibility, Registration, Attestation, Certified EHR technology, and Meaningful Use
- http://www.cms.gov/EHRIncentivePrograms/

Contact Information

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Frequently Used Acronyms

ARRA – American Recovery and Reinvestment Act

CMS – Centers for Medicare and Medicaid Services

EH – Eligible Hospital

EP – Eligible Professional

HIE – Health Information Exchange

HIT – Health Information Technology

HITECH – Health Information Technology for Economic and Clinical Health

NLR – National Level Repository

ONC – Office of the National Coordinator

OSC – Office of the State Coordinator