# Overview of Medicaid Incentives in the Centers for Medicare & Medicaid Services (CMS) Final Rule on Meaningful Use[1]

## *Eligibility*

**Medicaid Eligibility:** Eligible Professionals (EPs) include physicians, pediatricians (have distinct eligibility and payment rules), dentists, nurse practitioners, certified nurse midwives, and physician assistants practicing in a Federally Qualified Health Center or Rural Health Clinic (FQHC/RHC) that is led by a physician assistant.

**Hospital-Based Professionals:** EPs must also not be hospital-based, meaning they do not provide "substantially all of their professional services in a hospital setting." "Substantially all" is defined to mean that 90 percent or more of the services are performed in the hospital setting (i.e., inpatient or emergency room). The only exception to this rule is for those EPs practicing predominantly in an Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)).

## *Patient Volume*

**Patient Volume**: EPs have to annually meet patient volume thresholds, measured by a ratio where the numerator is the total number of Medicaid patient encounters (or, in the case of EPs practicing predominately at FQHCs and RHCs, "needy individual" encounters (defined below)) over any representative continuous 90-day period in the most recent calendar year and the denominator is all patient encounters over that same 90-day period.

**Patient Volume Criteria for Clinics and Group Practices:** Clinics and group practices are allowed to use the practice or clinic Medicaid patient volume (or needy individual patient volume, insofar as it applies) and apply it to all EPs in their practice under three conditions: 1) the clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation); 2) there is an auditable data source to support the clinic's patient volume determination; and 3) so long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

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[1] This document is a summary of CMS' final rule on the Medicaid Electronic Health Record Incentive Program. To view the entire rule and requirements link to: http://www.cms.gov/EHRIncentivePrograms/

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**Patient Volume Thresholds and Criteria**: Detailed below are the patient volume thresholds for Medicaid EPs.

- For all EPs, except pediatricians, the patient volume threshold is 30 percent; for pediatricians, it is 20 percent.
- EPs practicing predominately at FQHCs/RHCs are defined as having more than 50 percent of their encounters over a six-month period in the most recent calendar year occurring at an FQHC/RHC, and must attest that a minimum of 30 percent of their patient encounters over any continuous 90-days period in the most recent calendar year was with "needy individuals."
- "Needy individuals" are defined as those receiving medical assistance from Medicaid or the Children's Health Insurance Program, individuals furnished uncompensated care by the health care provider, or individuals furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.
- If a State has alternative methodologies for measuring not just the timeframe that is used in establishing patient volume, but all of the elements included in the patient volume calculation (except the thresholds established by statute), the State must submit the approach to CMS for review and prior approval.
- EPs can assign their incentive payments to their employers or to state-designated "entities that promote the adoption of certified EHR technology." The definition of such an entity requires the entity to enable oversight of the business, operational, and legal issues involved in the adoption and implementation of EHR and/or the exchange and use of electronic health information between participating providers, in a secure manner.
- EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs are able to participate in only one program, and have to designate which one they wish to participate in. After their initial designation and receipt of an incentive payment, EPs are allowed to change their program selection only once and only for a payment year before 2015.
- EPs with multi-State Medicaid practice locations must annually pick only one State from which to receive incentive payments. In other words, an EP will not be able to receive incentive payments from more than one State in the same year. Medicaid EPs could annually change the State they select when they re-attest to program requirements.

| EP | Minimum 90-day Medicaid patient volume threshold | **OR** the Medicaid EP practices predominantly in an FQHC or RHC—30% needy individual patient volume threshold |
|---|---|---|
| Physician | 30% | |
| Pediatrician | 20% | |

## *First Year Adoption*

**Adopting, Implementing, or Upgrading Certified EHR Technology:** In their first year of participation in the Medicaid incentive payment program, EPs may qualify for an incentive payment by demonstrating any of the following: that they have adopted (acquired and installed), implemented (installed and started using, trained staff, entered data, deployed tools, exchanged data), or upgraded (expanded functionality to meet certification criteria such as the addition of clinical decision support, e-prescribing functionality, CPOE, etc.) a certified EHR.

**Reporting Period:** There is no EHR reporting period for adopting, implementing, or upgrading for a Medicaid EP's first payment year. It is in their second payment year/first year of demonstrating meaningful use that they have a 90-day EHR reporting period. In addition, their 2nd year of demonstrating meaningful use has a 12 months EHR reporting period.

***Demonstrating Meaningful Use of Certified EHR Technology***

**Requirements for Medicaid EPs:** The Meaningful Use definition for Medicare is also the standard for Medicaid. States can only add additional meaningful use criteria that pertain specifically to public health objectives and data registries. States may not request approval of meaningful use measures below the Medicare standard.

## *Incentives*

**Medicaid Incentives:** EPs could receive up to $63,750 over the six year period; pediatricians with Medicaid patient volume between 20 percent to 29 percent of their total patient volume could receive two-thirds of the maximum amount ($42,500).

**Verification and Disbursement of Incentives:** States are required to verify the eligibility of and disburse payments to Medicaid EPs.

**EHR Cost Sharing for EPs:** EPs are responsible for 15 percent of the net average allowable costs of the certified EHR technology.

<table>
<tr><th>Cap on Net Average Allowable Costs under the Medicaid Incentive Program</th><th>85 Percent Allowed for Medicaid Eligible Professionals</th><th>Maximum Cumulative Medicaid Incentive over 6-year Period</th></tr>
<tr><td>$25,000 in Year 1 for most Medicaid eligible professionals</td><td>$21,250</td><td rowspan="2">$63,750</td></tr>
<tr><td>$10,000 in Years 2-6 for most Medicaid eligible professionals</td><td>$8,500</td></tr>
<tr><td>$16,667 in Year 1 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients</td><td>$14,167</td><td rowspan="2">$42,500</td></tr>
<tr><td>$6,667 in Years 2-6 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients</td><td>$5,667</td></tr>
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## *State Requirements*

**Conditions States Must Meet to Receive 90 Percent Federal Financial Participation (FFP):** Prior approval conditions must be met in order for a state to receive FFP for reasonable administrative expenses. States will be required to submit a Health Information Technology Planning Advance Planning Document (HIT PAPD), a State Medicaid Health Information Technology Plan (SMHP), and a Health

Information Technology Implementation Advance Planning Document (HIT IAPD). These documents will lay out the process States will use to implement and oversee the EHR incentive program, and will help States to construct an HIT roadmap to develop the systems necessary to support providers in their adoption and meaningful use of certified EHR technology.

### *Program Oversight*

**Financial Oversight/Combating Fraud and Abuse:** States must ensure that there is no duplication of payment between the Medicare and Medicaid programs as a requirement of the State Medicaid HIT Plan. States are required to recoup monies if overpayments or erroneous payments are found to have been paid. States are required to establish a provider appeals process for eligibility, payments, and determinations of meaningful use as part of the State Medicaid HIT Plan. States are required to have processes in place to report estimated and actual expenditures for the Medicaid EHR payment incentive program using the Medicaid Budget and Expenditure System.