

LegalNotes

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LegalNotes is a regular online *Aligning Forces for Quality* (AF4Q) publication that provides readers with short, readable summaries of developments in the law that collectively shape the broader legal environment for efforts to improve quality, reduce health care disparities, and improve the transparency of price and quality information.

Meaningful Use & Medicaid— Challenges for States and Providers

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The American Recovery and Reinvestment Act of 2009 (ARRA)¹ directed the adoption and meaningful use of health information technology (HIT) as a national policy priority. Within ARRA, the Health Information Technology for Economic and Clinical Health (HITECH) Act established a legal framework for advancing HIT adoption and use.² It also amended the Social Security Act to create financial incentives in the Medicare and Medicaid programs to encourage qualifying health care professionals to become meaningful users of certified electronic health records (EHR) technology.³

On July 13, 2010, the Office of the National Coordinator for Health Information Technology (ONC) (established under HITECH) and the Centers for Medicare and Medicaid Services (CMS) jointly released two sets of complementary final rules to implement the Medicare and Medicaid EHR incentive programs. The ONC regulations specify the technical capabilities EHR technology must have to be certified and to support providers in achieving the meaningful use objectives.⁴ The CMS regulations implement the changes to the Medicare and Medicaid programs by specifying the objectives providers must achieve in 2011 and 2012 to be meaningful users.⁵

A forthcoming analysis of the entire rule will examine both Medicare and Medicaid. However, because the Medicaid reforms are central to the goal of health reform and can address disparities in health and health care, we separately analyze Medicaid here. This issue of Legal Notes briefly reviews the provisions of the final CMS rule defining meaningful user for the Medicaid EHR incentive program compared to the proposed rule.

Statutory Framework for the Medicaid EHR Incentive Program

The HITECH Act authorizes the payment of financial incentives to eligible health care professionals who participate in Medicare and Medicaid and who are meaningful users of certified EHR technology.⁶ While Medicare incentives are limited to reimbursements for providers who can demonstrate meaningful use, Medicaid incentive payments are available for costs incurred by qualified providers related to “adopting, implementing, or upgrading” (AIU) certified EHRs,⁷ in addition to the bonus payments (for up to five years) for providers who “demonstrate meaningful use of certified EHR technology.”⁸

Adoption of the incentives payment system is not a mandatory condition of participation for state programs; instead, the legislation encourages state participation through the use of enhanced federal payments to support state implementation, including 90 percent of the administrative costs associated with implementation and 100 percent of the cost of payments to participating providers.

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Eligible Medicaid Providers

The Medicaid HIT amendments specify two types of eligible Medicaid providers: professionals and hospitals. An eligible professional (EP) is defined as a physician, dentist, certified nurse-midwife or nurse practitioner.⁹ EPs also include physician assistants practicing in federally qualified health centers (FQHC) or rural health clinics (RHC) but only for those entities that are physician assistant-led.¹⁰ (That is, physician assistants in practice at FQHCs or RHCs are not eligible for the incentive payments unless they work at a clinic that is led by a physician assistant. While thousands of physician assistants work in clinical settings in medically underserved communities, very few clinics are actually led by physician assistants.)

For an EP to qualify for payments, at least 30 percent of patient volume must be attributable to Medicaid patients (20% for pediatricians), unless the EP is a pediatrician or practices predominately in a FQHC or RHC setting, in which case EPs are those whose patients are 30 percent needy, defined as Medicaid-enrolled or uninsured.¹¹ Eligible hospitals in the Medicaid incentive program include children's hospitals with any Medicaid patient volume and acute-care non-children's hospitals with at least a 10 percent Medicaid patient volume.¹² The meaningful use final rule clarifies that critical access hospitals (CAHs) with at least a 10 percent Medicaid patient volume are also eligible to participate in the Medicaid incentive program.¹³

The law excludes certain behavioral health providers, such as clinical psychologists, clinical case workers and social workers, as well as post-acute, long-term, and home health care providers.

Unlike hospitals, which may participate simultaneously in Medicare and Medicaid (with payments apportioned between the two programs in proportion to the patients they serve), EPs who qualify under both programs must choose to receive incentive payments from either Medicare or Medicaid, but not both.¹⁴ Thus, EPs that are high-Medicaid providers but have relatively low Medicare patient volume¹⁵ presumably will select Medicaid as the source of their incentive payments. Furthermore, the Medicare incentives program is aimed at providers paid in accordance with Medicare's resource based relative value scale (RBRVS) formula. By contrast, both FQHCs and RHCs are paid in accordance with a special, cost-related prospective payment system (PPS), and their clinical staff are either staff members or contract employees who are not paid directly. As a result, the Medicare pathway is effectively closed to these two classes of health care providers. FQHCs alone serve approximately 10 percent of all Medicaid patients, and this number is expected to rise significantly in coming years as a major health center expansion financed through health reform is implemented.

States' Power to Define Meaningful Use

The statute itself does not specifically condition states' provisions of Medicaid incentive payments on the adoption of the Medicare meaningful use system. Instead, the statute's Medicaid provisions specify that in the case of Medicaid, meaningful use is to be demonstrated through a means "approved by the State and acceptable to the Secretary,"¹⁶ which *may* be based on the methodologies applied in Medicare.

Medicaid Incentive Programs

Medicaid incentives begin in 2011 and phase down over six years. EPs may receive up to 85 percent of net average allowable costs for AIU or meaningful use of certified EHR technology, up to a maximum level of \$25,000 for the first year and \$10,000 for each subsequent year.¹⁷ Payments after the first year may continue for a maximum of five years, for up to six years total, but EPs must receive their first year payment by 2016.¹⁸ No incentive payments will be paid after 2021. Thus, an initial first-year payment for AIU or meaningful use of certified EHR technology can amount to \$21,250 (85% of \$25,000).¹⁹

EPs may then receive up to \$8,500 per year for five years for operation and maintenance, as long as they demonstrate "meaningful use of certified EHR technology."²⁰ The total amount of incentive payments over the six-year period is capped at varying amounts based on the type of provider, with a maximum of \$63,750 available over the course of the program.²¹ For Medicaid eligible hospitals, the incentive payments are limited to the amount available for eligible hospitals in the Medicare incentive program.

Unlike the Medicare incentive program, there are no penalties for Medicaid EPs or eligible hospitals who do not become meaningful users, a difference that ultimately may have implications both for the speed with which states implement the meaningful use system and the speed with which EPs and hospitals adopt and use certified technology.

Role of State Medicaid Programs

Implementation of the Medicaid EHR incentive program is optional for state Medicaid programs. However, for those states that do participate, federal support dollars are available. States are eligible for 100 percent federal financial participation (FFP) for incentive payments made to Medicaid EPs and eligible hospitals for AIU and meaningful use of certified EHR technology.²² States are also eligible for 90 percent FFP for costs related to the administration of the program (i.e., tracking and providing accurate payments to providers).²³ At the same time, federal payments are conditioned on CMS approval of several key documents detailing a state's plan

to develop basic infrastructural components to run the program. With first-year incentive payments available (at the federal level) in 2011 and required by 2016, states currently are engaged in efforts to obtain the required approvals.

In short, the extent of state participation is crucial. For high-volume Medicaid/low-volume Medicare providers, Medicaid incentives will not be an option unless states elect to participate and establish the infrastructure that must be in place to operate the program. EPs that may do so are permitted one opportunity to switch between the incentive programs.²⁴ In the case of EPs such as FQHCs and RHCs, whose providers are not paid on an RBRVS basis, the Medicare pathway is essentially non-viable.

Final CMS Rule Implementing the Medicaid EHR Incentive Program

1. State flexibility to diverge from the federal definition of meaningful use

The proposed rule moved away from the broad language of the statute in an effort to more tightly align Medicare and Medicaid meaningful use criteria. It permitted states to modify the definition of meaningful use only by adding objectives or changing the way objectives are measured; at the same time, the proposed rule barred the addition of requirements that would necessitate different EHR functionality.²⁵ The final rule went even further to limit state variation by establishing the Medicare definition of meaningful EHR user as the default minimum standard for state Medicaid incentive programs, and allowing states to deviate from the minimum only to add four specific public health-related capabilities.²⁶ Since eligible hospitals are permitted to participate in both the Medicare and Medicaid incentive programs (if qualified for both programs), the Secretary exercised her authority under HITECH to deem satisfaction of the Medicare requirements as qualifying a hospital for participation in Medicaid, if so eligible.²⁸ Thus, even if a state elects to add any of the four available additional requirements to its definition of meaningful use for Medicaid hospitals, the impact of this decision would be limited, because hospitals participating in both Medicare and Medicaid incentive programs would not be subject to the additional state requirements. Instead, hospitals would be measured by the final rule's Medicare default minimum standard, which consists of a Stage 1 measure of meaningful use,²⁹ and which builds on the three-pronged test envisioned under the law: (1) the use of certified EHR technology in a demonstrably meaningful manner, such as electronic prescribing; (2) the electronic exchange of health information to improve the

quality of care; and (3) reporting on clinical quality and other measures to the Secretary of Health and Human Services.³⁰

2. Modification of the meaningful use objectives and measures

The proposed rule set forth 25 meaningful use objectives and associated measures for EPs and 23 objectives and measures for eligible hospitals.³⁰ The final rule gives providers more flexibility. It specifies both a core set of objectives, which all providers must meet to qualify for incentive payments, and a menu set, from which providers must select five additional objectives.³² Under the final rule, EPs must satisfy all of 15 core objectives and accompanying performance measures; in addition, EPs must select five additional objectives and performance criteria from a list of 10 in a new EP menu set (for a total of 20).³³ Eligible hospitals must meet 14 core objectives and accompanying performance measures, in addition to five more selected from a list of 10 in the eligible hospital menu set (for a total of 19).³⁴

3. Clinical quality measures

A core objective under HITECH is establishing incentives that assure reporting on clinical quality measures.³⁵ The proposed rule required EPs to report on 90 clinical quality measures and hospitals to report on 35 clinical quality measures.³⁶ The final rule reduces the number of measures that must be reported while at the same time bringing greater cross-payer uniformity to reporting. Under the final rule, in order to receive incentive payments, EPs must report on three required core clinical quality measures,³⁷ as well as on three additional measures from a set list of 38 (for a total of six), without regard to payer. Eligible hospitals, by contrast, are presented with a list of 15 clinical quality measures that require reporting to the extent the eligible hospital has an applicable clinical case, without regard to payer. This marks a significant reduction from the proposed rule, which required 35 clinical quality measures for eligible hospitals.

The proposed rule had proposed eight alternative Medicaid-specific clinical quality measures that reflected key demographic differences in the Medicare and Medicaid populations,³⁸ but the final rule did not include these alternative measures.

4. Requirements for participation by state Medicaid programs

The HITECH Act sets forth standards of participation for state Medicaid programs.

The final rule conditions state participation and enhanced federal payments on the submission of certain information to CMS. The purpose of these documentary submissions is to ensure that participating states have a process for determining provider eligibility and for approving, processing, and making timely incentive payments with adequate oversight.

The required documents are as follows:

- HIT Planning Advanced Planning Document (HIT-PAPD), which is a preliminary plan of action by which the state can receive federal administrative payments and CMS approval to plan fully for implementation, including determining the need for and planning the acquisition of HIT equipment, services, or both.³⁹
- A fuller State Medicaid HIT Plan (SMHP), based on the HIT-PAPD, that describes the state's current and future HIT activities in support of the Medicaid EHR incentive program.⁴⁰ This includes the state's process for "tracking and verifying the activities necessary for a Medicaid EP or eligible hospital to receive an incentive payment."⁴¹
- An HIT Implementation Advanced Planning Document (HIT-IAPD), the state's final plan of action, which formally requests federal financial support and approval to acquire and implement the proposed SMHP services, equipment, or both.⁴²

Upon approval of the initial HIT-PAPD, states can begin to draw down the 90 percent FFP for expenses related to the creation of the SMHP. Upon CMS approval of the SMHP, states can submit further HIT-PAPDs for 90 percent FFP for *planning* activities described in the SMHP. Likewise, upon approval of the SMHP, states can submit an HIT-IAPD for 90 percent FFP for *implementation and administration* activities described in the SMHP.

Thus, CMS approval is required at three separate stages of planning before a state can fully implement the program and begin to make federally supported Medicaid incentive payments to providers. The final rule does not establish deadlines for the submission of these documents to CMS. At the same time, the final year in which providers first become eligible for payments is 2016, and an end date of 2021 on payments is fixed by law. Thus, a state agency whose planning has been approved and who is permitted to move into full implementation may be making payments for the first time up to five years after the year in which Medicare payments begin. As of July 18, 2010, 44 states have submitted their initial HIT-PAPDs and all have been approved.⁴³

Challenges for States and Providers

Challenges for states

Documentation: The three-stage implementation planning process under the final rule is extensive and clearly has both human and financial resource implications. Many states have received federal funds to support their preparation, but federal contributions for state administrative activities related to planning are capped at 90 percent. A number of states have identified the cost of implementation during a time of great fiscal constraint as a barrier.

State flexibility to target specific populations: The final rule takes a standardized approach to the definition of meaningful EHR user, setting the Medicare definition as the Medicaid default standard, with no state-specific subtractions allowed and only four additional requirements permitted. While this standardization may encourage adoption and create consistent quality incentives across providers that may improve care for a broad segment of the population, it may also mean that specific populations such as children and pregnant women may be underrepresented in quality measures and objectives.

Challenges for Medicaid providers

State readiness: Each provider's ability to secure Medicaid incentives depends on whether a state has been green-lighted for implementation. For reasons of patient demographics and volume, threshold qualification (in the case of FQHCs and RHCs), and availability of payments for AIU, many key types of providers (e.g., obstetricians and gynecologists, pediatricians, children's hospitals, public hospitals, and FQHCs and RHCs) will be extremely dependent on Medicaid implementation. To the extent that states experience difficulties meeting the implementation planning phases or securing the funds to even begin to plan, these providers risk either very limited payments (to the extent they treat Medicare patients), or virtually no payments because of the absence of a link to the Medicare program either as a threshold qualification matter or because they have no Medicare patient volume.

Excluded providers: The law excludes providers of long-term care services, an issue that will remain a major challenge in the coming years. When and how the initial legislation might be expanded to include the nation's system of long-term care is unclear at this point.

Conclusion

The HITECH Act and implementing regulations set ambitious goals aimed at using Medicare and Medicaid payments to leverage EHR adoption and use. Unlike Medicare but similar to other aspects of health reform, successful implementation of the Medicaid incentives program depends on a carefully choreographed phasing in of planning and implementation stages in 51 separate jurisdictions. Implementation of federal reforms is always challenging in Medicaid's case because of state variation; this type of variation is likely in the case of HIT as well. Crucial to state success in this regard will be the level of technical assistance available to states in both their initial and ongoing planning efforts. The federal government has made funds available to support states' planning efforts and holds regular all-states calls to inform states on the process of establishing their incentive programs.⁴⁴ Other HITECH programs serve as important resources, such as the HIT Regional Extension Centers. Also critical is states' willingness to make the relatively modest investment (10%) in administrative costs. Key drivers of implementation are missing in the case of Medicaid – that is, state implementation is optional, and Medicaid providers are not penalized for non-implementation. How the absence of these drivers will affect provider and state behavior is not clear at this point, although the fact that 44 states are participating in the initial planning stage is promising.

¹ The American Recovery and Reinvestment Act (ARRA), P.L. 111-5, 123 Stat. 115 (2009).

² Public Health Service Act § 3000 et seq. [42 U.S.C. § 201 et seq.] (as added by ARRA § 13101). The term "HITECH Act" refers collectively to ARRA's Title XIII ("Health Information Technology") of Division A and Title IV ("Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions") of Division B.

³ Social Security Act § 1903 (a)(3)(F) [42 U.S.C. § 1396b et seq.] (as added by ARRA § 4201(a)(1)).

⁴ Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Final Rule, 75 Fed. Reg. 44590 (July 28, 2010) (to be codified at 45 C.F.R. pt. 170). ONC also issued a final rule for a temporary EHR certification program on June 24, 2010 that establishes the process that organizations will need to follow in order to be authorized by ONC to test and certify EHR technology. Establishment of the Temporary Certification Program for Health Information Technology, 75 Fed. Reg. 36158 (June 24, 2010) (to be codified at 45 C.F.R. pt. 170). A final rule on the permanent EHR certification program is expected by the end of 2010.

⁵ Medicare and Medicaid Programs: Electronic Health Record Incentive Program; Final Rule, 75 Fed. Reg. 44314 (July 28, 2010) (to be codified at 42 C.F.R. pts. 412, 413, 422 and 495).

⁶ Social Security Act § 1848(o)(1)(A)(i) [42 U.S.C. § 1395w-4 et seq.] (as added by ARRA § 4101(a)) (Medicare incentive program); Social Security Act § 1903 (a)(3)(F) [42 U.S.C. § 1396b et seq.] (as added by ARRA § 4201(a)(1)) (Medicaid incentive program).

⁷ Social Security Act § 1903(t)(6)(C)(i)(I) [42 U.S.C. § 1396b et seq.] (as added by ARRA § 4201(a)(2)).

⁸ Social Security Act § 1903(t)(6)(C)(i)(II) [42 U.S.C. § 1396b et seq.] (as added by ARRA § 4201(a)(2)).

⁹ Social Security Act § 1903(t)(3)(B) [42 U.S.C. § 1396b et seq.] (as added by ARRA § 4201(a)(2)).

¹⁰ *Id.*

¹¹ Social Security Act § 1903(t)(2)(A) [42 U.S.C. § 1396b et seq.] (as added by ARRA § 4201(a)(2)). Pediatricians may be eligible for incentive payments if at least 20 percent of their patient volume is attributable to Medicaid patients. EPs practicing predominately in a FQHC or RHC are eligible if at least 30 percent of their patient volume is attributable to needy individuals, defined as patients who are either covered by Medicaid or who receive uncompensated care, or for whom charges are prospectively adjusted according to ability to pay.

¹² Social Security Act § 1903(t)(2)(B) [42 U.S.C. § 1396b et seq.] (as added by ARRA § 4201(a)(2)).

¹³ 75 Fed. Reg. 44314, 44577 (to be codified at 42 C.F.R. pt. 495.302).

¹⁴ 75 Fed. Reg. 44314, 44579 (to be codified at 42 C.F.R. pt. 495.310(c)). Qualified eligible hospitals, by contrast, may participate in both the Medicare and Medicaid incentive programs simultaneously.

¹⁵ The Medicare EHR incentive program makes bonus payments to EPs calculated at 75 percent of the overall Medicare reimbursements for a given EP during a given billing period; thus Medicare patient volume is key to maximizing incentive payments in the Medicare incentive program.

¹⁶ Social Security Act § 1903(t)(6)(C) [42 U.S.C §1396b et seq.] (as added by ARRA §4201(a)(2)).

¹⁷ Social Security Act § 1903(t)(4)(A) [42 U.S.C §1396b et seq.] (as added by ARRA §4201(a)(2)).

¹⁸ *Id.*

¹⁹ Social Security Act § 1903(t)(1) [42 U.S.C §1396b et seq.] (as added by ARRA §4201(a)(2)).

²⁰ Social Security Act § 1903(t)(6)(C)(i)(II) [42 U.S.C §1396b et seq.] (as added by ARRA §4201(a)(2)).

²¹ Social Security Act § 1903(t)(4)(B) [42 U.S.C §1396b et seq.] (as added by ARRA §4201(a)(2)).

²² Social Security Act § 1903(a)(3)(F)(i) [42 U.S.C §1396b et seq.] (as added by ARRA §4201(a)(1)).

²³ Social Security Act § 1903(a)(3)(F)(ii) [42 U.S.C §1396b et seq.] (as added by ARRA §4201(a)(1)).

²⁴ 75 Fed. Reg. 44314, 44579 (to be codified at 42 C.F.R pt. 495.310(d)).

²⁵ 75 Fed. Reg. 1844, 2004 (to be codified at 42 C.F.R pt. 495.316(d)(2)(i)-(iv)).

²⁶ 75 Fed. Reg. 44314, 44581 (to be codified at 42 C.F.R pt. 495.316(d)(2)(i)-(iv)).

²⁷ Social Security Act § 1903(t)(8) [42 U.S.C §1396b et seq.] (as added by ARRA §4201(a)(2)).

²⁸ 75 Fed. Reg. 44314, 44566 (to be codified at 42 C.F.R pt. 495.4).

²⁹ 75 Fed. Reg. 44314, 44566-67 (to be codified at 42 C.F.R pt. 495.6(b)).

³⁰ Social Security Act §1848(o)(2)(A) [42 U.S.C. §1395w-4 et seq.] (as added by ARRA §4101(a)).

³¹ 75 Fed. Reg. 1844, 1993-95 (to be codified at 42 C.F.R pt. 495.6).

³² 75 Fed. Reg. 44314, 44566-70 (to be codified at 42 C.F.R pt. 495.6).

³³ *Id.*

³⁴ *Id.*

³⁵ 75 Fed. Reg. 44314, 44567 (to be codified at 42 C.F.R pt. 495.6(d)(10)).

³⁶ 75 Fed. Reg. 1844, 1874-1900 (Tables 3-21).

³⁷ The core group of clinical quality measures are: blood pressure management, tobacco use assessment/cessation intervention, and adult weight screening and follow-up. The final rule also provides for an alternate set of core clinical quality measures that EPs must use if one of the regular core measures is not applicable to the physician's scope of practice.

³⁸ 75 Fed. Reg. 1844, 1993-1995 (Table 21).

³⁹ 75 Fed. Reg. 44314, 44581-84 (to be codified at 42 C.F.R pts. 495.316, 495.324, 495.332).

⁴⁰ 75 Fed. Reg. 44314, 44581 (to be codified at 42 C.F.R pt. 495.316).

⁴² 75 Fed. Reg. 44314, 44581-82 (to be codified at 42 C.F.R pt. 495.324).

⁴³ Centers for Medicare and Medicaid Services Office of Public Affairs, "Maryland to Receive Federal Matching Funds for Electronic Health Record Incentives Program." U.S. Department of Health and Human Services, <http://www.cms.gov/apps/media/press/release.asp?Counter=3741&intNumPerPage=10&checkDate=&checkKey=2&srchType=2&numDays=0&srchOpt=0&srchData=electronic+health+record&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=1&pYear=&year=0&desc=&cboOrder=date> (accessed August 23, 2010).

⁴⁴ Centers for Medicare and Medicaid Services Office of Public Affairs, "Information for States." U.S. Department of Health and Human Services, http://www.cms.gov/EHRIncentivePrograms/91_Information_for_States.asp#TopOfPage (accessed September 15, 2010).