NPAIHB POLICY BRIEF

ARRA Medicare & Medicaid Incentive Payments

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ARRA Medicare and Medicaid Incentive Payments:
How will Tribal Health Programs fit in?

It been a year since President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) on February 17th, 2009. The stimulus bill is unprecedented in its level of funding and an extraordinary response to the economic crisis unlike any since the Great Depression. It included measures to modernize our nation's infrastructure, enhance energy independence, expand educational opportunities, preserve and improve affordable health care—including $19 billion for health information technology (HIT) initiatives. Of the amount provided, $2 billion will be used for grants to states and other entities for HIT infrastructure, training, telemedicine, inclusion of HIT in clinical education, and dissemination of best practices. The remaining $17 billion will be used to establish ***temporary*** Medicare and Medicaid HIT incentive payments for hospitals and physicians over several years.

These incentive payments represent potential funding for Tribal health programs and it's important that Tribes begin to prepare to access this funding. As CMS and states begin to roll-out the incentive payments there are many unanswered questions for Tribes. A key issue is will the IHS Resource Patient Management Meaningful System's electronic health record be certified to be eligible for incentive payments? Definitions for meaningful use are developed and may not be applicable to Tribal programs. There will also be upfront investments that Tribal programs will have to make in order to be eligible. Critical issues such as how Medicaid incentives and Medicare payment penalties will apply to the *OMB encounter rate* that Tribes use. The states will be responsible for administering the Medicaid incentive payments and Tribes will need to be involved to ensure that they are included in any important decisions that set up the administrative requirements for the incentive program. Otherwise, IHS and Tribal programs could lose out on millions of dollars in incentive payments.

EHR Incentive Payments

The largest allocation of ARRA-HIT funding provides $17 billion in Medicare and Medicaid incentive payments and grants to encourage providers and hospitals to implement EHR systems. The incentive payments are triggered when a provider or hospital demonstrates it has become a "meaningful EHR user." The incentive payments will be phased in over time, with larger payments in the early years and lower payments later in the implementation process. These payments could total as much as $48,400 for eligible professionals and up to $11 million for hospitals. In addition to the incentives, the legislation establishes penalties through reduced Medicare reimbursement payments if they do not become meaningful users of EHR by 2015. Meaningful use of EHRs will be defined by CMS during a rulemaking process (currently underway) and may include reporting requirements on quality measures. ARRA also authorizes HHS to provide competitive grants to states to make loans available to health care providers to assist them with HIT acquisition and implementation costs.

Medicare Incentives

Beginning January 2011, physicians (non-hospital based) are eligible for Medicare incentive payments based on an amount equal to 75% of the allowed Medicare Part B charges, up to a maximum of $18,000 for early adopters whose first payment year is 2011 or 2012. The HHS Secretary will define the reporting period(s) with respect to a payment year. Incentive payments would be reduced in subsequent payment years, eventually phasing out in 2016. The maximum EMR reimbursement available to an individual provider under Medicare is $44,000, unless in a Health Professional Shortage Area (HPSA), in which case payments are increased 10 percent (most I/T/U sites are in a HPSA). Physicians who do not implement an EHR system before 2015 will face a reduction in their Medicare fee schedule of -1% in 2015, -2% in 2016, and -3% in 2017 and beyond. The HHS Secretary has the authority to make exceptions to this reduction on a case-by-case basis for physicians who demonstrate significant hardship (e.g., a physician who practices in rural areas without sufficient Internet access). It is likely that there will be hardships to implementing EHR in the IHS and Tribal health system and it's important the Tribes start to document these circumstances.

Medicare EMR Incentives

The following table shows how the incentives and potential reductions are expected to work from 2010-2017:

Payment Year	If the First Qualifying Year is: 2011	2012	2013	2014	2015	2016	Maximum Potential
2011	$18,000	$12,000	$8,000	$4,000	$2,000	-	$44,000
2012		$18,000	$12,000	$8,000	$4,000	$2,000	$44,000
2013			$15,000	$12,000	$8,000	$4,000	$39,000
2014				$12,000	$8,000	$4,000	$24,000
2015	Reduction in Fee Schedule for Non-Adoption/Use: -1% of Medicare Fee Schedule						
2016	Reduction in Fee Schedule for Non-Adoption/Use: -2% of Medicare Fee Scheudule						
2017 and thereafter	Reduction in Fee Schedule for Non-Adoption/Use: -3% to a maximum of -5% of Medicare Fee Schedule						

Note: Physicians in rural health professional shortage areas who adopt/use EHRs are eligible to receive a 10% increase on the incentive payment amounts described above Eligibility = Medicare billable/year = 75% of the $44,000 max = $33,000. "Meaningful Use" is yet to be defined.

Medicare incentives will be paid on a phased-out schedule over a set number of years, for a maximum of five years. The first year in which physicians can qualify for incentive payments is 2011. Physicians that can demonstrate that they qualify in 2011 or 2012 will qualify to receive phased-out incentive payments over a five-year period. Physicians that qualify in 2013 or 2014 will receive phased-out incentive payments for four or three years respectively. No incentive payments will be paid for physicians first qualifying after 2014. Physicians that are not "meaningful users" by the beginning of 2015 are subject to financial penalties through reductions in the Physician Fee Schedule amount. These reductions will be phased-in over a three-year period beginning in 2015.

Medicaid Incentives

ARRA also establishes 100 percent Federal Financial Participation (FFP) for States to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate (including support services and training for staff) certified EHR technology. It also establishes 90 percent FFP for State administrative expenses related to carrying out this provision. Eligible professionals include physicians, dentists, certified nurse midwives, nurse practitioner, and physician assistants practicing in rural health clinics or Federally-Qualified Health Centers (FQHC) led by a physician assistant. Providers will have to elect to be reimbursed by Medicare or Medicaid, but not both. Medicaid providers will be required to sign an affidavit certifying they are not also collecting Medicare incentive payments.

Since most IHS and Tribal health facilities are designated as FQHCs they will be eligible for Medicaid incentive payments. Many IHS and Tribal health programs have also begun to implement EHR systems and can now qualify for funding to off-set costs associated with implementing EHR systems. In order to be eligible, non-hospital based health professionals must have at least a 30% patient volume enrolled in the Medicaid program and/or physicians who practice in federally qualified health center or rural health clinic programs must have a Medicaid patient volume of at least 30 percent. The legislation does not indicate how CMS or the State must determine or calculate an eligible professional's patient volume percentage. The Medicaid incentive payment program begins January 1, 2011 and spreads payments over a 6-year period with a first-year payment of up to $21,250 and five subsequent annual payments of up to $8,500. The eligible professional must demonstrate meaningful use of a certified EHR by the second payment year. A Medicaid payment schedule is displayed below.

Medicaid EMR Incentives *

Payment Year	Adoption Year								Maximum Potential
	2011	2012	2013	2014	2015	2016	2017	2018	
2011	$25,000	$10,000	$10,000	$10,000	$10,000				$65,000
2012		$25,000	$10,000	$10,000	$10,000	$10,000			$65,000
2013			$25,000	$10,000	$10,000	$10,000	$10,000		$65,000
2014				$25,000	$10,000	$10,000	$10,000	$10,000	$65,000
2015					$25,000	$10,000	$10,000	$10,000	$55,000
2016						$25,000	$10,000	$10,000	$45,000

* **MEDICAID**: Avaialable to Physicians whose caseloads include at least 30% Medicaid patients are eligible to receive up to $65K over the course of 5 years.

* Available only to non-hospital based physicians, clinicians, including dentists, certified nurse midwives, and physician assistants practicing in rural health clinics or FQHCs.

* Minimum for Medicaid participation: 30% of a physician's/clinician's patients must use Medicaid, with the exception of pediatricians, who only need 20% of their patients using Medicaid.

* Startup incentive: State will pay up to 85% of the average allowable cost ("average allowable cost" has not been defined yet) of a EHR not to exceed $25,000 for implementation.

* After receiving startup funds, providers who can prove "meaningful use" can receive up to $10,000 annually for an additional four years.

* No penalties have been defined by Medicaid for lack of adoption.

In addition to the Medicaid provider incentives, certain professionals can receive a one-time incentive payment for up to 85% of net average allowable costs (not to exceed $25,000 or less based on HHS studies of average

costs) for the purchase, and initial implementation and upgrade of a certified EHR technology, including support services and training. After acquiring an EHR and receiving the first incentive payment, eligible professionals can then subsequently receive incentive payments for up to five years for the net average allowable costs to operate, maintain, and use their EHR (allowable cap per year is $10K or less based on HHS studies of average costs) if they meet the definition of a meaningful EHR user in accordance with regulations to be established. A Medicaid provider who has completed adopting and implementing, or upgrading to a certified EHR technology prior to 2011 must be a meaningful EHR user to receive the first payment as well as subsequent payments.

RPMS Certification

The IHS Resource Patient Management System (RPMS) has received provisional certification for meeting the 2007 testing criteria by the Certification Commission for Health Information Technology (CCHIT), which prior to the HITECH Act was the sole certification body for EHR systems. The continued certification of RPMS as a certified EHR technology will be driven largely by the "Meaningful Use" criteria that is currently being developed. The criteria will establish the Secretary's adoption of an initial set of standards, implementation specifications, and certification criteria for EHRs. Certifying RPMS will mean that it has met the minimum government requirements for security, privacy, and interoperability, and that it can produce the meaningful use results that the CMS expects.

The IHS website (www.ihs.gov/recovery/index) states that, "in order to ensure that its customers - IHS Federal/Tribal/Urban hospitals and clinics - are positioned to be eligible in 2011 for financial incentives based on meaningful use of certified EHR, the IHS intends to seek recertification of RPMS as an ambulatory EHR, as well as initial certification of RPMS under the inpatient EHR criteria, both in 2010. Certification of RPMS as a behavioral health add-on to ambulatory EHR is planned in 2011. In addition, IHS will seek certification for health information exchanges (HIE) when it is available." Many anticipate that the RPMS system will meet the certification requirements and can produce meaningful use results required.

Incentive Payments: State Administration

CMS has issued guidance to State Medicaid programs (SMD Letter #09-006) on funding and initial planning for State administration of Medicaid provider incentive payments. The CMS guidance includes a description of the process by which States can receive the 90 percent match for initial planning activities related to the administration of incentive payments. CMS advises that States can immediately request the 90 percent match for initial planning regarding the design and development of a State Medicaid HIT Plan (SMHP), and should submit and receive approval of a HIT Planning - Advance Planning Document prior to initiating planning activities and expending funds. The guidance in the Letter is described as "preliminary" and focuses on the planning aspect rather than the actual implementation of the SMHP.

States have applied and received 90% FFP funds to begin administrative planning for the Medicaid incentive payments. It is important for the Tribes to engage with State Medicaid programs on how IHS and Tribal EHR systems and providers will meet the meaningful use requirements and to ensure that they are able to track such use, consistent with federal rules. For example, Oregon's Health Information Technology Oversight Council (HITOC) has been charged with developing a statewide strategic plan for electronic health information exchange, coordinating public and private efforts to increase adoption of electronic health records, setting

technology standards, ensuring privacy and security controls, and creating a sustainable business plan to support meaningful use of health information technology. It is anticipated that this work will in part be financed by the 90% FFP funds under the Medicaid incentive payments. Similar activities are underway in Washington and Idaho.

It is important that Tribes work with their States at the front-end of implementing the Medicaid payment incentives. The states have already begun working to gather information on such issues as barriers to the use of EHRs, provider eligibility for EHR incentive payments and the creation of State Medicaid HIT Plans, which will be used to define the state's vision for its long-term HIT use. It will be important for Tribes to request that States address this issue over the next year in our State/Tribes meetings as implementation gets underway.

Key Issues for Tribes

In addition to the items discussed, the following is a short list of issues of things that IHS and Tribes will have to be aware of as they begin to engage with States and CMS around Medicare and Medicaid incentive payments:

- Will RPMS meet certification and security requirements for being designated a EMR?;
- Implementation begins January 1, 2011, which means hospitals, clinics, and providers must be ready by October 1, 2010;
- State Administration Issues for Medicaid Incentive payments: How will States and Tribes develop consensus around "meaningful use" criteria: Can the outcome measures be tracked?;
- Medicare payments concerns related to the same "meaningful use" criteria applied in IHS and Tribal settings: Can the outcome measures be tracked? ;
- Will the upfront investments be cost prohibitive for the I/T/U to participate in Medicare and Medicaid incentive program, Medicare payment penalties and their application to the OMB encounter rate;
- If a Tribe is reimbursed as FQHC for Medicare, and the OMB Rate for Medicaid: (1) are there eligibility issues, or; (2) will they be required to pick Medicare or can they choose the Medicaid program which has more incentive money?; and
- IHS hospital providers may not be eligible if they bill under a Hospital sponsored CMS Code?

HIT - Upcoming Meetings

"Second Annual Multi-State Health IT Collaborative for E-Health Conference": February 8, 2010, Washington, D.C., Grand Hyatt Hotel. State-Tribal Affairs Panel focusing on how States can effectively include IHS and Tribal health partners in HIT planning and implementation of the Medicaid Incentive Program. www.blsmeetings.net/CMSHealthIT2010/

"Indian Health Information Management Conference": May 11-14, 2010, Scottsdale, AZ, Scottsdale Plaza Resort. Meaningful Use Track will provide information on the new standards, implementation specifications, and certification criteria for EHR set forth by the Office of the National Coordinator for HIT and requirements to achieve meaningful use of certified EHR technology.

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