

Iowa Medicaid Health Information Technology (HIT) and Electronic Health Record (EHR) Incentive Payment Program for Eligible Hospitals

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HOW TO DETERMINE IF HOSPITAL IS ELIGIBLE FOR EHR INCENTIVE PAYMENTS?

Hospitals eligible for Medicaid incentive payments are acute care hospitals, critical access hospitals, and children's hospitals. Incentive payments to eligible hospitals are based on a formula in which a base incentive amount for all hospitals is modified by the number of Medicaid patient discharges, as well as other factors.

ACUTE CARE AND CRITICAL ACCESS HOSPITALS

- Must have a Medicaid patient volume of at least 10% to be eligible to receive payments. (see below).
- Must have a CMS Certification Number (CCN) with the last 4 digits of 0001 - 0879 or 1300 - 1399. These CCNs cover short-term general hospitals, cancer hospitals and critical access hospitals. Under the definition of the final rule, acute care hospitals and critical access hospitals must have an average length of patient stay of 25 days or fewer.

CHILDREN'S HOSPITALS

- Do not have to meet a Medicaid patient volume threshold in order to be eligible.
- Must have a CCN with the last 4 digits of 3300 - 3399.

Note: Some hospitals may receive incentive payments from both Medicare and Medicaid if they meet all eligibility criteria.

PATIENT VOLUME

Hospitals must meet patient volume requirements every year of program participation. Patient volume requirements are calculated based on a 90-day period during the previous hospital fiscal year that ended during the previous federal fiscal year (October – September). Many hospitals' fiscal year is (July – June). Here is a scenario that should help you define which 90-day period to select for determining if you meet the patient volume requirements.

Hospital fiscal year ends June 30. The hospital wants to apply for a 2012 incentive payment. The previous hospital fiscal year ended June 30, 2011. The previous federal fiscal year ended September 30, 2011. Therefore, the 90-day period selected by the hospital should be from hospital fiscal year 2011.

Once the 90-day period is selected, the hospital must calculate whether 10% of their patient encounters were attributable to Medicaid. This determination is based on counting inpatient

discharges and adding them to emergency room (department) encounters and is calculated as follows:

Inpatient discharges plus emergency room (department) visits covered by Medicaid

_____divided by_____

ALL inpatient discharges plus ALL emergency room (department) visits

The emergency room visits are based on encounters for any one day. Therefore, if a single patient is seen in the ER four times on four different days during the 90-day period, that counts as four encounters. If a patient is seen in the ER and admitted as an inpatient, then discharged on a different day, that is two encounters: one for the ER visit and one for the discharge.

A visit is “covered by Medicaid” for purposes of the numerator if Medicaid paid for a portion of the encounter. This means at least one penny was paid toward the encounter, and includes payments where Medicaid was the secondary insurer.

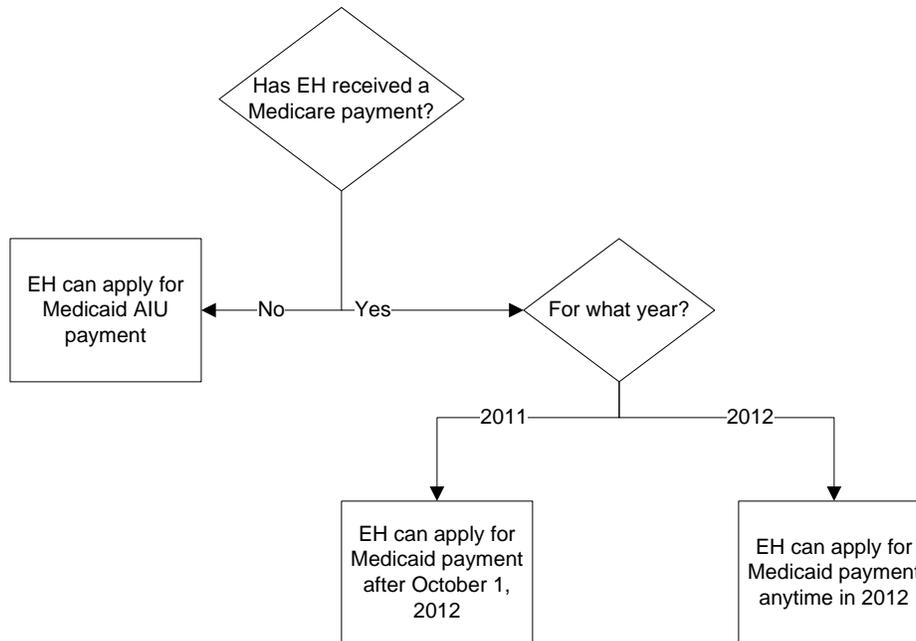
TIMING OF INCENTIVE PAYMENT APPLICATION

The timing of applying for a Medicaid payment in relation to applying for a Medicare payment is important. Generally, a hospital that meets the patient volume requirements for Medicaid should apply for a payment as soon as the hospital becomes eligible. Because Medicaid allows year one payments to hospitals for adopting, implementing or upgrading (AIU) to certified EHR technology without showing meaningful use, this is an easier threshold to meet.

If, however, a hospital received a Medicare payment first, then the hospital is no longer eligible for an AIU payment and the year in which the hospital received the Medicare payment becomes relevant. A hospital must show 90-days of meaningful use in order to receive a Medicare payment and can use that same 90-day period to show meaningful use for Medicaid, but only if the attestation for BOTH programs is done in the same year.

For example, if the EH received a 2011 payment from Medicare, but isn't attesting to Medicaid in the same year (2011) but is waiting until the following year (2012), then the hospital must show a full year of meaningful use for both programs. The following chart illustrates when a hospital can apply for a Medicaid payment:

When to Apply for a Medicaid Payment Eligible Hospitals



HOSPITAL PAYMENT CALCULATIONS

Hospital payments are based on data contained in the Medicare Cost Reports from the previous four hospital fiscal years. The formula is:

(Overall EHR Amount) times (Medicaid Share) where Overall EHR Amount Equals {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]} and Medicaid Share Equals {(Medicaid inpatient-bed-days plus Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

HOSPITAL CALCULATOR

Please click [here](#) to access the approved hospital incentive payment calculator. Please note the calculations on the spreadsheet are based on calculations as provided in the final meaningful use rule published in the Federal Register on July 28, 2010 and found at 42 CFR 495.2, et seq. This sheet is intended to be a tool for providers to estimate the amount of incentive payment based on their facility data as submitted in previous year's Medicare cost reports. Hospital providers will be required to attest to the accuracy of the data provided at the time of payment and will agree to cooperate with IME verification and audit requirements. This spreadsheet should not be considered a promise of payment. Updates to this spreadsheet are expected.

To use this spreadsheet, you may use data from your Medicare cost reports for the past three fiscal years. However, data from any auditable data source is acceptable. Enter your facility's data in the fields highlighted in yellow. The Medicaid aggregate EHR incentive amount indicates the incentive payment amount to be paid out over a three-year period. The hospital must meet patient volume requirements for each of the three-participation year.

ELIGIBLE HOSPITALS PAYMENT REGISTRATION

In order to receive payments, eligible hospitals must first register for the incentives at the CMS registration and attestation site that can be found here -

<https://ehrincentives.cms.gov/hitech/login.action>

All of Iowa's eligible hospitals should indicate that they are dually eligible for both the Medicaid and Medicare incentive payment programs.

Hospitals must choose one state from which to receive Medicaid payments. Additionally, hospitals meeting Medicare meaningful use requirements are deemed to meet meaningful use requirements for Medicaid incentive payments and can receive payments for both Medicare and Medicaid.

HOSPITAL GRACE PERIOD

The incentive payment year for hospitals is on the federal fiscal year. The period of meaningful use (whether 90 days or a full year) must occur during the payment year. Iowa allows an eligible hospital to attest for the current payment year for up to 60 days after the end of the federal fiscal year (October 1 - September 30). Therefore, hospitals have until November 30 to attest for a payment from the previous federal fiscal year.

REGISTRATION AND ATTESTATION PROCESS

STEP ONE:

Register on the [CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System](#). For the most up-to-date information about registration into the [CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System](#).

Eligible Hospitals will need the following information to complete registration:

- CMS Identity and Access Management (I&A) User ID and Password
- CMS Certification Number (CCN)
- National Provider Identifier (NPI)
- Hospital Tax Identification Number

Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid", or "dually eligible" during the registration process.

NOTE: You do not have to provide information on the certified EHR technology you are using when you register. However, this information is required when you attest.

STEP TWO:

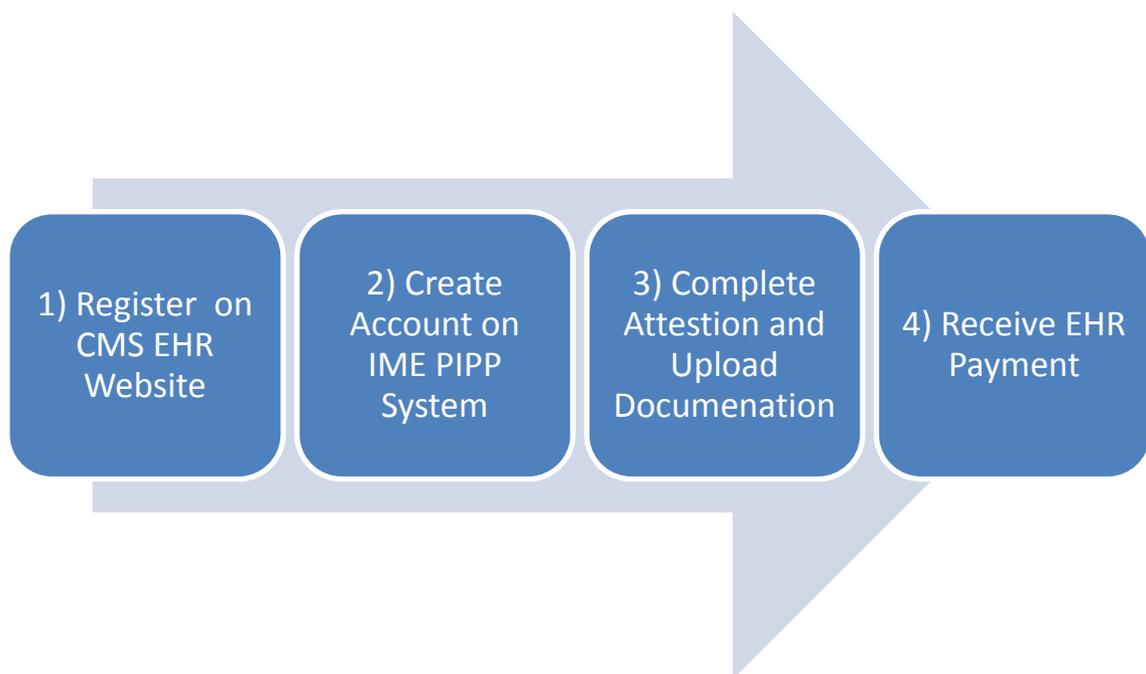
Create an account on the [Iowa Medicaid Enterprise \(IME\) Provider Incentive Payment Program \(PIPP\) web portal](#) if an account is not set up already. The user manual found on the website walks the provider through each step of registration and attestation.

NOTE: if you are applying for a meaningful use payment from Medicaid you must first be approved by Medicare within the same payment year. Iowa hospitals complete meaningful use attestation on the CMS website. CMS transmit the meaningful use data to Iowa so the provider does not have to re-enter the data. However, CMS does not transmit the data until the provider is approved and Iowa Medicaid cannot approve a meaningful use payment without it.

STEP THREE:

Start attestation process after a 24 hour period review from IME staff. Answer all EHR attestation questionnaires and upload any documentation such as:

- Proof of Patient Volume
- Proof of Certified EHR



Medicaid provider interested in learning more about the incentive payments, please send an email to imeincentives@dhs.state.ia.us or call Kelly Peiper, Medicaid HIT Provider Incentive Coordinator, at [515-974-3071](tel:515-974-3071) or Melissa Brown, EHR Incentive Program Specialist, at [515-974-3123](tel:515-974-3123).