Tips for Eligible Hospitals Applying for an Iowa Medicaid Enterprise Electronic Health Record (EHR) Incentive Program Payment

Note: This guidance is intended to assist hospitals and others in understanding Medicaid hospital incentive payment calculations. However, all hospitals should refer to CMS's final rule for the final policies on hospital incentive payments; in the event of a conflict, CMS final rules take precedence. Nothing in this guidance is intended to alter or supersede such rules.

*When applying for an incentive payment, all documentation must be retained for **6 years** for audit purposes.*

CMS Stage 1 Final Rule
https://www.federalregister.gov/documents/2010/07/28/2010-17207/medicare-and-medicaid-programs-electronic-health-record-incentive-program

What should I be able to document?

All information under attestation is subject to audit. This includes documentation for both the eligibility determination AND the payment calculation. This documentation should be readily available because it was needed for attestation.

Eligibility

At a minimum, the detailed information to validate eligibility should include patient name, Medicaid member ID, if applicable, date of service, and payer source. Eligibility information that you attested to includes:

- Numerator: A detailed list of Medicaid inpatient and emergency room encounters during your selected 90-day eligibility period, excluding dually-eligible (Medicare/Medicaid) encounters, nursery days, and sub-provider days. The numerator should exclude CHIP/HAWK-I encounters.
- Denominator: A detailed list of all inpatient and emergency room encounters (the numerator should be an identifiable sub-set of the denominator) that occurred during the 90-day eligibility period.

Aggregate Incentive Payment Calculation

The detailed information to validate the aggregate payment calculation could include census, financial, or other internal reports to support ***(the supporting documentation should not be limited to solely cost report data)***:

- Discharges
- Total Acute Days
- Acute Medicaid Days (fee-for-service and managed care)
- Charity Care Charges
- Hospital Charges

The detailed criteria for each report is outlined below.

Discharges

Documentation to support 4 years of reported acute inpatient discharges utilized to calculate the growth rate and discharge-related amount. The documentation could include detailed admit/discharge reports or census reports for the base year and three consecutive prior years. This documentation should include the following fields: patient name or unique identifier, discharge date, and visit type (this could be in the form of DRG codes, revenue codes, CPT codes, hospital service codes, etc.) Please include a data legend for the visit type information.

*Note: The facility's previous fiscal year is the **base year** for calculating the hospital incentive payment.*

For example, for Program Year 2016, if the hospital's fiscal year end is 6/30 then the hospital's base year would be 7/1/2014 – 6/30/2015.

Total Acute Days
Documentation to support the Total Acute Days for the base year utilized to calculate the Medicaid Share. At a minimum, this documentation should include the following fields: patient name or unique identifier, admission date, discharge date, and visit type (this could be in the form of DRG codes, revenue codes, CPT codes, hospital service codes, etc.) Please include a data legend for the visit type information.

Acute Medicaid Days
Documentation to support the Acute Medicaid Days for the base year utilized to calculate the Medicaid Share. At a minimum, this documentation should include the following fields: patient name or unique identifier, admission date, discharge date, payer, amount paid, and visit type (this could be in the form of DRG codes, revenue codes, CPT codes, hospital service codes, etc.) Please include a data legend for the visit type information. ***NOTE: This report can be a subsection of the Total Acute Days report if the Total Acute Days report includes the payer and amount paid.***

*Note: The Acute Medicaid Days calculation should include only **paid** Medicaid days (including secondary, tertiary, quaternary, etc. Medicaid payers). However, dual eligible Medicare days must be excluded from the calculation if the patient days were considered Medicare days in the hospital's Medicare EHR incentive payment calculation.*

Charity Care Charges
Documentation to support Charity Care Charges for the base year. Examples include, but are not limited to: trial balance, general ledger, etc.

Hospital Charges
Documentation to support Hospital Charges for the base year. Examples include, but are not limited to: trial balance, general ledger, etc.

What is Included in Acute Care?

Page 44450 and page 44453 of the final rule state that statutory language clearly restricts discharges and inpatient bed-days for the hospital calculation to **discharges and inpatient bed-days related to the acute care portion of a hospital**, because of the definition of "eligible hospital" in section 1886(n)(6)(B) of the Social Security Act (the Act).

Page 44497 of the final rule explains that statutory parameters placed on Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. Therefore, as Medicaid is held to the same parameters as Medicare, the same statutory definition of total discharges applies to Medicaid EHR incentive program hospital calculations.

The acute care portion of the hospital is defined as the portion of the hospital that receives Medicare payment under the inpatient PPS.

Examples of Non-Acute Care/Excluded services

- Low-level Nursery
- Hospice
- Observation
- Swing Bed
- Skilled Nursing Facility (SNF)
- Psychiatric Unit (separate unit of hospital)
- Rehabilitation Unit (separate unit of hospital)