MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

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Subject: Electronic Health Record Incentive Program for Hospitals

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Programs Affected: Medicaid

BACKGROUND

The purpose of this bulletin is to introduce and implement a Michigan Medicaid Electronic Health Record (EHR) Incentive Program for eligible hospitals (EH). The Health Information Technology for Economic and Clinical Health Act (HITECH), enacted as part of the American Recovery and Reinvestment Act of 2009, authorized incentive payments through Medicare and Medicaid to eligible medical professionals and hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The incentive programs are designed to support providers in a period of health information technology transition and instill the use of EHRs in meaningful ways to help improve the quality, safety, and efficiency of patient health care.

The purpose of EHRs and meaningful use is to:

- Improve quality, safety, efficiency, and reduction of health disparities;
- Engage patients and families in their health care;
- Improve care coordination;
- Improve public health; and
- Ensure adequate privacy and security protections for personal health information.

The Michigan Medicaid EHR Incentive Program is consistent with the Centers for Medicare and Medicaid Services (CMS) Final Rule-0033, published in the Federal Register on July 28, 2010.

Registration and Interfaces with the National Level Repository

The first step in receiving EHR incentive payments requires registration with the National Level Repository (NLR). The NLR is the federal database which verifies basic provider information prior to notifying State Medicaid programs of a provider's intent to participate in the Medicare and Medicaid EHR Incentive Program. To register with the NLR, all EHs must have a National Provider Identifier (NPI) and be enrolled in the CMS Provider Enrollment, Chain, and Ownership System (PECOS). Registration requires an active user account in the National Plan and Provider Enumeration System (NPPES). Note that any revisions to information provided in the NLR must be modified at the NLR level.

The Michigan Department of Community Health (MDCH) will be notified upon successful registration with the NLR. EHs will be directed to the Michigan Medicaid Community Health Automated Medicaid Processing System (CHAMPS) to begin the Michigan Medicaid EHR registration process. MDCH has created an EHR Incentive Program module within the CHAMPS system to collect and record EH data. All providers have up to 30 days from MDCH receipt of the NLR file to submit completed registration information in the CHAMPS EHR module. Failure to do so in the allotted time frame could require hospitals to re-register at the NLR level. Providers must be an enrolled Michigan Medicaid provider and have an active Payee-Tax Identification on record within the

Michigan Treasury MAIN system. EHs are only required to register once for the Medicare and Medicaid EHR Incentive Programs. However, they must successfully demonstrate that they have adopted, implemented or upgraded (first participation year for Medicaid) or meaningfully used certified EHR technology each year in order to receive an incentive payment for that year. Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds.

Once all relevant information is collected through the NLR and Medicaid EHR CHAMPS module, the Medical Services Administration (MSA) of MDCH will begin eligibility verification. MSA intends to make all eligibility determinations within 30 days of the provider's completed registration in the EHR CHAMPS module.

Following a successful eligibility determination, MSA will begin calculating EH incentive payments. A final report will be filed by MSA with the NLR when an EH incentive payment has been processed.

Requirements for Participation

In order to participate in the Michigan Medicaid EHR Incentive Program, hospitals must be a Medicaid enrolled provider and have a completed Medicaid Quarterly Report, Medicaid Cost Report (MMF) and CMS 2552 Cost Report on file with MDCH that correlates with the specified timeframe from which data are pulled. Timeframes for eligibility and payment calculations are detailed in sections below. In an effort to have the most complete and accurate information for program calculations, all revisions, amendments, and modifications to data sources used in eligibility and payment calculations must be complete prior to hospital registration in the EHR Incentive Program. MDCH will not utilize incomplete data sources or data that is under revision, therefore hospital eligibility determinations and payment calculations will be delayed as a result. Attachments 1 and 2 contain a complete list of data citations.

Hospitals must review and agree to the attestation requirements outlined in the Michigan Medicaid EHR CHAMPS module. EHs will select their EHR status (e.g., Adopt, Implement, Upgrade or Meaningful User) and provide their EHR certification number. EHs must attest that the information they are providing is true, accurate, and complete.

EHs may participate in both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. Hospitals must choose only one state from which to register and receive a Medicaid EHR incentive payment.

Eligible Hospitals Defined

Per the CMS Final Rule (CMS-0033-F) published on July 28, 2010, eligible hospitals are described as follows:

A. Acute care hospitals (includes critical access hospitals [CAH] and cancer hospitals meeting the following requirements:

1. A health care facility where the average length of patient stay is 25 days or fewer,
2. CMS Certification Number (CCN) ending between 0001 and 0879 or 1300-1399, and
3. Meet a Medicaid patient volume threshold of at least 10%

Or

B. Children's hospitals (does not include children's wings of larger hospitals) which are:

Separately certified children's hospitals with CCN ending between 3300 and 3399.

Children's hospitals do not have to meet a minimum Medicaid patient volume threshold.

ELIGIBILITY VERIFICATION

To verify hospital eligibility, MDCH will utilize data reported to MSA on the CMS 2552, Medicaid Quarterly Report, and the MMF in the Medicaid Cost Report. Attachment I provides a complete list of data citations utilized in the calculation of hospital eligibility. Eligibility requirements will be calculated annually upon registration in the Medicaid EHR Incentive Program. Note that the Medicaid Quarterly Report and MMF have been recently modified to include out-of-state Medicaid encounters. Hospitals should confirm that all necessary data elements are complete and reported for EHR incentive calculation purposes.

Average Length of Stay (LOS)

Average LOS will be calculated by reviewing the most current CMS 2552 Cost Report and MMF report on file with MSA. The following calculation will be used:

Total Inpatient Days/Total Inpatient Discharges = Hospital Average LOS.

Medicaid Eligible Patient Volume

To calculate a hospital's Medicaid eligible patient volume, the Medicaid Quarterly Report will be used. Acute care hospitals must annually meet a 10% Medicaid eligible patient volume threshold to participate in the EHR Incentive Program. EH Medicaid eligible patient volumes will be verified each year of a hospital's participation in the EHR Incentive Program. (Children's hospitals are exempt from the volume threshold requirement.) MSA will select the hospital quarter (90-day continuous period) from the prior calendar year from their EHR registration date to derive the Medicaid eligible patient volume data. For purposes of measuring Medicaid eligible patient volume, MSA will consider an inpatient hospital day or discharge as an encounter. One of two calculation methods will be utilized to determine Medicaid eligible patient volume. MSA will evaluate which quarter of the prior calendar year and calculation method will yield greater Medicaid eligible patient volume for hospital eligibility. Patient encounters include both Fee-for-Service (FFS) and Managed Care Organization (MCO) data.

One of the following calculations will be utilized to determine Medicaid Patient Volume:

$$\frac{\text{Total Medicaid Hospital Days}}{\text{Total Hospital Days}} \times 100 = \text{Medicaid Patient Volume}$$

OR

$$\frac{\text{Total Medicaid Hospital Discharges}}{\text{Total Hospital Discharges}} \times 100 = \text{Medicaid Patient Volume}$$

INCENTIVE PAYMENT CALCULATION

EHR Incentive Program payments will be calculated in accordance with the formula outlined in HITECH under Section 495.310. Payments will be made over a total of three years and be paid 50% of the aggregate calculation in the first year, 40% in the second, and 10% in the third.

Timing

EHs that adopt, implement, and/or upgrade a certified EHR system or are meaningful users can begin receiving incentive payments in any year from fiscal year (FY) 2011 to FY 2016. The Medicaid EHR Incentive Program operates on the Federal Fiscal Year (FFY) (October 1st through September 30th) calendar. While the statute defines a payment year in terms of a FFY, a hospital does not have to begin receiving incentive payments in FY 2011. However, the last year a hospital can first receive an initial Medicaid incentive program payment is FY 2016.

EHs will be paid up to 100% of the calculated aggregate EHR hospital incentive payment amount over a three year period. Data utilized to calculate the aggregate EHR hospital incentive amount will be derived from filed hospital cost reports (CMS 2552 and MMF) from the hospital fiscal year that ends during the FFY prior to the hospital fiscal year that serves as the first payment year. For example, a hospital's fiscal year end date is December 31st. A hospital begins the EHR Incentive Program registration process in April of 2011, in effect making FFY 2011 the first payment year of the program. The EH's 2009 fiscal year cost report data will be utilized to calculate the aggregate EHR incentive amount. Table 1 describes the FFY 2011 payment year and corresponding time periods for payment calculations by hospital fiscal year ends:

Table 1

EHR Payment Year	Eligibility Timeframe for First Payment Year	FYE of Hospital Cost Report Data Used in Payment Calculation
2011 (3/11 – 9/30/11)	1/1/10 – 12/31/10	12/31/09
2011 (3/11 – 9/30/11)	1/1/10 – 12/31/10	3/31/10
2011 (3/11 – 9/30/11)	1/1/10 – 12/31/10	6/30/10
2011 (3/11 – 9/30/11)	1/1/10 – 12/31/10	9/30/10

All revisions, amendments, and modifications to data sources must be completed prior to a hospital's registration for the EHR Incentive Program. This includes revisions to the filed cost report (CMS 2552 and MMF) used to calculate the aggregate EHR incentive amount. Incomplete hospital data sources will result in delays in eligibility determinations and payment calculations. Please refer to Attachment II for a complete citation of data elements used in the calculation of EHR incentive payments.

Payment Formula

The aggregate EHR incentive amount is a one-time calculation based upon the sum of a theoretical four-year calculation period, where the amount of each year is the product of the following factors:

1. The overall EHR amount, and

2. The Medicaid Share.

The overall EHR amount is also based upon the sum over a theoretical four year calculation period where the amount of each year is the product of two factors:

1. An Initial Amount, and

2. The Transition Factor applicable to each of the four years.

(All data used in the payment calculation is derived from the same 12 month cost report period, other than discharge data used to calculate the annual growth rate).

Initial Amount and Theoretical Four Year Calculation Period

The Initial Amount is the sum of a base amount and a discharge-related amount. The base amount is $2,000,000, and the discharge-related amount provides an additional $200 for estimated discharges between 1,150 and 23,000. No discharge-related amount is made for discharges prior to the 1,150th discharge or for discharges after the 23,000th discharge.

For the first calculation year, data on hospital discharges from the hospital fiscal year that ends during the FFY prior to the hospital fiscal year that serves as the first payment year will be used as the basis for determining the discharge-related amount. To determine the discharge-related amount for the three subsequent theoretical calculation years, the number of discharges will be based on the average annual growth rate for the hospital over the most recent three years of available data. The growth rate will be based on a three year average of total discharges, beginning with the initial calculation year and including data from the three prior years. The annual

growth rate will be applied to the base year's discharges to arrive at the three subsequent year discharge amounts. If an EH's average annual rate of growth is negative over the three-year period, the rate will be applied as such.

Transition Factor

For each of the four years of the calculation, a different transition factor applies, as demonstrated in Table 2. The aggregate Medicaid EHR Incentive Payment is calculated once and is then distributed over three actual payment years. The transition factors listed in Table 2 are used to calculate the aggregate EHR amount but do not indicate that hospital payments will be recalculated on a yearly basis.

Table 2

Theoretical Calculation Period	Transition Factor
Year 1	1.00
Year 2	0.75
Year 3	0.50
Year 4	0.25

Medicaid Share

The Medicaid Share is the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients.

The numerator of the Medicaid share is the sum of:

- The estimated number of Medicaid inpatient-bed-days, and
- The estimated number of Medicaid managed care inpatient-bed-days.

The denominator of the Medicaid Share is the product of:

- The estimated total number of inpatient-bed-days for the eligible hospital during that period, and
- The estimated total number of the eligible hospital's charges during that period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during that period.
    - For the purposes of the EHR incentive payment calculation, charity care is calculated using data from the MMF Indigent Volume Form as follows:

      (Total Uncompensated Charges – Third Party Bad Debts – Uninsured Payments from Charges – Recoveries for Uninsured Bad Debt) = Charity Care

The removal of charges attributable to charity care in the formula, in effect, increases the Medicaid Share resulting in higher incentive payments for hospitals that provide a greater proportion of charity care.

Payment Calculation Summary

1. Calculate initial amount	$2 million base amount + ((discharge bonus)*200) = initial amount $200 per total discharge between 1,150 and 23,000
2. Calculate four theoretical years	Year 1: 100% of initial amount Year 2: 75% of initial amount (+ or – any change in discharge level based on annual growth rate) Year 3: 50% of initial amount (+ or – any change in discharge level based on annual growth rate) Year 4: 25% of initial amount (+ or – any change in discharge level based on annual growth rate)
3. Sum four theoretical year calculations	Year 1 + Year 2 + Year 3 +Year 4 = Aggregate Hospital EHR Incentive Amount
4. Calculate Medicaid Share	Medicaid inpatient days / (total inpatient days*((gross revenue – charity) / gross revenue))
5. Multiply Aggregate Hospital EHR Incentive Amount by Medicaid Share	Aggregate Hospital EHR Amount * Medicaid Share = Total Hospital EHR Incentive Amount
6. Pay over three payment years	Payment Year 1 = 50% of Total Hospital EHR Incentive Amount Payment Year 2 = 40% of Total Hospital EHR Incentive Amount Payment Year 3 = 10% of Total Hospital EHR Incentive Amount

Payment Notification and Gross Adjustments

EH Medicaid Incentive payments will be made annually via gross adjustment. EHs will not receive more than one incentive payment in each State fiscal year.

After verifying hospital eligibility, MSA will calculate incentive payments and notify the hospital of the final amount. EHs have up to 30 days from receiving their payment notice to dispute payment calculations. If no communication is received or the EH agrees with the payment notice, MSA will process the incentive payment via gross adjustment in the CHAMPS system.

ADOPT, IMPLEMENT, AND UPGRADE AND MEANINGFUL USE

To receive a first year's incentive payment, EHs must attest to adopting, implementing, or upgrading (AIU) a certified EHR system. EHs will be required to provide the certification number of their EHR system within the EHR CHAMPS module during registration as part of AIU attestation. Eligible Medicaid hospitals can receive their first year's payment for AIU attestation and not meaningful use, but must meet the meaningful use requirement in all subsequent participation years.

If an EH is eligible for both Medicare and Medicaid EHR Incentive Programs and has achieved Meaningful Use standards under Medicare, MDCH will recognize them as a Meaningful User for Medicaid purposes. For the first year of program implementation (FFY 2011) MDCH is unable to verify meaningful use unless the EH meets the standards outlined in the Medicare EHR Incentive Program and is eligible for the Medicare **and** Medicaid EHR Incentive Program. For FFY 2012, MDCH anticipates being able to verify EH Meaningful Use.

In order to continue to receive incentive payments after the first payment year, providers must achieve and maintain a set of meaningful use measures as defined by CMS. Meaningful use employs a three-stage approach, with each stage building on the preceding stage:

Stage 1 – Data capture and sharing

Stage 2 – Expand on Stage 1 criteria to encourage the use of health information technology for continuous quality improvement

Stage 3 –Expand on Stage 2 with a focus on promoting outcomes in quality, safety, and efficiency

To demonstrate Stage 1 of meaningful use, an EH must comply with a set of "core" requirements and a selection of "menu" requirements. MDCH has adopted the same requirements outlined by CMS without modification.

ADDITIONAL INFORMATION

Additional information on the Michigan Medicaid Incentive Program is available at http://michiganhealthit.org.

For a complete list of meaningful use criteria, visit http://michiganhealthit.org >> Resources >> Meaningful Use and review the final Department of Health and Human Services rule.

For a list of Office of the National Coordinator (ONC) approved Authorized Testing and Certification Bodies, visit http://healthit.hhs.gov >> Regulations and Guidance >> Standards and Certifications >> Authorized Testing and Certification Bodies.

In addition to creating Medicaid and Medicare financial incentives, to speed the adoption of EHRs, Congress has also authorized Regional Extension Centers (REC) to provide on-site technical support to help providers adopt and achieve meaningful use with an EHR. Contact Michigan's REC, M-CEITA, at 1-888-MICH-EHR or www.mceita.org.

Manual Maintenance

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration

Data Elements for EH Eligibility Calculations

Data Element	Source	Column Name	Worksheet	Column	Line	Line Description	Provider
Total Inpt Days	CMS-2552	Total All Patients	S-3 Pt 1	6	12 plus (26.00 through 26.99)	Total Hospital	Med Surg and main hospital provider for Free Standing Rehabs and Free Standing Psychs
	CMS-2552	Total All Patients	S-3 Pt 1	6	14 or 14.01	Subprovider I, Subprovider II	Rehab Per Diem and Distinct Part Psych
	MMF		Hospital Days		2	Domestic Bed Days	Med Surg/MCO Psych/Rehab Per Diem
Total Hospital Charges	MMF		Indigent Volume		13.3	Net Hospital Charges	IP Med Surg/OP Med Surg/IP Psych/IP Rehab
FFS Discharges	Qtr Report		Discharges		2	Title XIX	IP Med Surg/IP Rehab
Medicaid/CSHCS Discharges	Qtr Report		Discharges		3	Title XIX/V	IP Med Surg/IP Rehab
MCO Discharges	Qtr Report		Discharges		5	QHP-MHO Title XIX	IP Med Surg/IP Rehab
Total Discharges	Qtr Report		Discharges		1	All Patients	IP Med Surg/IP Rehab
FFS Days	Qtr Report		Days		2	Title XIX	IP Med Surg/IP Rehab
Medicaid/CSHCS Days	Qtr Report		Days		3	Title XIX/V	IP Med Surg/IP Rehab
MCO Days	Qtr Report		Days		5	QHP-MHO Title XIX	IP Med Surg/IP Rehab
Total Days	Qtr Report		Days		1	All Patients	IP Med Surg/IP Rehab
Out of State Medicaid Days (FFS and MCO)	Qtr Report		Days				IP Med Surg/IP Rehab
Out of State Medicaid Discharges (FFS and MCO)	Qtr Report		Days				IP Med Surg/IP Rehab

Data Elements for EH Payment Calculation

Calculation	Data Element	Source	Column Name	Worksheet	Column	Line	Line Description	Provider
Payment	Total Discharges	CMS-2552	Total All Patients	S-3 Pt 1	15	12	Total Hospital	IP Med Surg
Payment	Total Discharges	CMS-2552	Total All Patients	S-3 Pt 1	15	14	Subprovider I	Rehab
Payment	Total Discharges	CMS-2552	Total All Patients	S-3 Pt 1	15	14.01	Subprovider II	Rehab
Payment (Medicaid Share)	Total Hospital Charges	MMF		Indigent Volume		13.3	Net Hospital Charges	IP Med Surg, OP Med Surg, IP Psych, IP Rehab
Payment (Medicaid Share)	MCO Inpt Days	MMF		MCO Summary		4	Adults and Peds Days	IP Med Surg
						5	Intensive Care Days	IP Med Surg
						6	Coronary Care Days	IP Med Surg
						7	Burn Intensive Care Days	IP Med Surg
						8	Surgical Intensive Care Days	IP Med Surg
						9	Other Special Care Days	IP Med Surg
						10	Nursery Days	IP Med Surg
				MCO Summary		4	Adults and Peds Days	IP Psych
						5	Intensive Care Days	IP Psych
						6	Coronary Care Days	IP Psych
						7	Burn Intensive Care Days	IP Psych
						8	Surgical Intensive Care Days	IP Psych
						9	Other Special Care Days	IP Psych
						10	Nursery Days	IP Psych
				MCO Summary		4	Adults and Peds Days	IP Rehab per diem

Data Elements for EH Payment Calculation

Calculation	Data Element	Source	Column Name	Worksheet	Column	Line	Line Description	Provider
						5	Intensive Care Days	IP Rehab per diem
						6	Coronary Care Days	IP Rehab per diem
						7	Burn Intensive Care Days	IP Rehab per diem
						8	Surgical Intensive Care Days	IP Rehab per diem
						9	Other Special Care Days	IP Rehab per diem
						10	Nursery Days	IP Rehab per diem
Payment (Medicaid Share)	FFS Inpt Days	CMS-2552	Title XIX	S-3 Pt 1	5	12 plus (26.00 through 26.99)	Total Hospital	Med Surg, Rehab, IP Psych
						14 or 14.01	Subprovider I, Subprovider II	Rehab per diem, Distinct Part Psych
Payment (Medicaid Share)	Total Inpt Days	CMS-2552	Total All Patients	S-3 Pt 1	6	12 plus (26.00 through 26.99)	Total Hospital	Med Surg, Rehab, IP Psych
		CMS-2552	Total All Patients	S-3 Pt 1	6	14 or 14.01	Subprovider I, Subprovider II	Rehab per diem, Distinct Part Psych
		MMF		Hospital Days		2	Domestic Bed Days	Med Surg, MCO Psych, Rehab per diem
Payment (Medicaid Share)	Charity Care Charges	MMF		Indigent Volume		(6.5-6.38-6.6-10.96)= Charity Care	6.5=Total Uncomp Charges, 6.38=Third Party Bad Debts, 6.6=Uninsured Payments from Charges, 10.96= Recoveries from uninsured Bad Debt	
Payment (Medicaid Share)	Total Out of State Medicaid Inpt Days	MMF	Total All Patients					