



## Centers for Medicare & Medicaid Services: Medicare and Medicaid Incentives and Administrative Funding

### A. Funding Table

(Dollars in Millions)

Project/Activity	Program Level	FY 2009	FY 2010 – FY 2019
Incentives (including Medicare penalties)			
Medicare	\$23,100.0	\$0.0	\$23,100.0
Medicaid	21,640.0	0.0	21,640.0
Subtotal, Incentives	44,740.0	0.0	44,740.0
State Medicaid Administration	1,055.0	0.0	1,055.0
CMS Administrative Costs /1			
Medicare	745.0	35.0	710.0
Medicaid	300.0	14.0	286.0
Subtotal, CMS Administrative Costs	1,045.0	49.0	996.0
Total, Mandatory Recovery Act HIT Funds	46,840.0	49.0	46,791.0

/1 The FY 2009 and FY 2010-FY 2019 column for CMS administrative spending represent outlay estimates. The Recovery Act provided budget authority (BA) of \$100 million in 2009 for Medicare administration and \$40 million in 2009 for Medicaid administration; for the 2010-2019 period, the BA amounts are \$645 million for Medicare and \$260 million for Medicaid, respectively.

### B. Objectives

The goal of the Medicare and Medicaid Health IT provisions in the Recovery Act is to promote and provide incentives for the adoption of certified electronic health records (EHRs). To achieve this goal, the Recovery Act authorized bonus payments for eligible professionals (EPs) and hospitals participating in Medicare and Medicaid as an incentive to become meaningful users of certified EHRs. The law established maximum annual incentive amounts and includes Medicare penalties for failing to meaningfully use EHRs beginning in 2015 for professionals and hospitals that fail to adopt certified EHRs.

The statute includes three broad criteria for demonstrating one is a “meaningful EHR user” which will be defined as the implementation process moves forward: (1) Meaningful use of certified EHR technology; (2) information exchange; and (3) reporting on measures using EHR. The statute grants the Secretary discretion in defining these terms.

#### Medicare Payments

Sections 4101 and 4102 of the Recovery Act provide Medicare bonus payments to eligible professionals who meaningfully use certified EHRs by calendar years 2011 to 2014 and for hospitals that meaningfully use certified EHRs by fiscal years 2011 to



2015. Starting in 2015, eligible professionals and hospitals failing to meaningfully use certified EHRs will receive reduced Medicare payments.

### **Medicaid Payments**

Section 4201 of the Recovery Act established 100 percent Federal Financial Participation (FFP) to States for incentives to eligible Medicaid providers to purchase, implement, and operate certified electronic health records (EHR) technology and established 90 percent Federal Financial Participation (FFP) for State administrative expenses related to carrying out this provision. Many States have been moving toward interoperable health care technology and information exchange for the last several years. This provision affords States and their Medicaid providers with a unique opportunity to leverage these existing efforts to achieve the vision of interoperable information technology for health care with State Medicaid agencies playing a critically important role in fulfilling that vision.

Adoption of EHRs directly corresponds to the HHS Strategic Objective 1.3: Improve health care quality, safety, cost and value.

### **C. Activities**

The Recovery Act appropriated to CMS \$140,000,000 for each of fiscal years 2009 through 2015 and \$65,000,000 for fiscal year 2016 for administrative funding, and made these funds available until expended. CMS will use part of these funds to assess existing systems to determine whether or not modifications can be made to accommodate the requirements of the incentive program. The funding will also be used to modify and/or develop, implement, operate and maintain all systems necessary to support payment of incentives to hospitals and eligible professionals, such as systems for eligibility and enrollment, payment, quality reporting, and accounting/monitoring.

In coordination with the Office of the National Coordinator (ONC) for Health Information Technology, CMS will develop the policies, such as the definition of “meaningful use”, needed to implement the incentive program. Implementing the incentive programs will require an extensive provider education and outreach effort. This outreach will ensure providers understand all policies and requirements related to provider eligibility, selection of Medicare or Medicaid incentive programs for eligible providers, incentive payments, and the demonstration of “meaningful use.”

State payment of Medicaid incentive payments will require establishment of multi-state workgroups in order to establish core analytical criteria for State HIT planning and implementation, and modification to Medicaid reporting and data systems. Verification of payment accuracy and audits to preclude improper payment of Medicare and Medicaid incentives will be critical. Complying with Recovery Act reporting guidance will involve Federal and State staff time and require modification of accounting and payment data reporting systems.

### **CMS Administrative Funds**



Administrative funds will support the implementation of the incentives programs for the meaningful use of certified EHRs. CMS will provide EPs with information so that they can decide whether to select an incentive under Medicare or Medicaid. In coordination with ONC, we will define “meaningful use” and then determine how to identify if a provider is truly a meaningful user. We will calculate payments which will require the integration of information across multiple data sources.

For FY2009, these funds will allow CMS to begin to:

- Coordinate with ONC to develop policies required to implement statutory requirements (e.g., define “meaningful user” of EHRs, operationalize the definition of “certified EHR technology, etc.),
- Establish Medicare and Medicaid payment policies, processes, and tracking methods,
- Develop and publish proposed regulations to provide the opportunity for public notice and comment.
- Conduct initial assessments of potential systems and measures required to pay incentives (including calculation of incentive payments, capturing attestations, tracking and accepting quality measures),
- Plan extensive provider outreach on Medicare and Medicaid incentives and Medicare penalties,
- Plan audit and reimbursement work,
- With contractor support, and in coordination with ONC and the regional extension programs provide States with technical assistance through guidance, outreach and education, and
- Hire additional Federal employees to help implement these provisions.

The FY 2010 funds will allow for continued education and outreach, analysis, and extensive contractor support to make system modifications and/or develop new systems. Based on our initial assessment, systems will be required to process incentive process selection, to determine payments, to assess meaningful use, to make and track payments (including posting names of incentive recipients online) and to capture quality data. Additional systems requirements may be necessary but have not yet been identified. Through continuing analysis we will determine if existing systems can be modified or if new systems will need to be developed. We will develop and/or modify systems necessary to post the recipients of the EHR incentives online after we start to make incentive payments.

In the Medicaid program, the proper staging of these activities is critical to ensuring a smooth implementation. CMS has decided to implement the Medicaid incentives program in 2011 to assure consistency with Medicare. CMS strategies must be coordinated with ONC, AHRQ, and others to minimize confusion and provide clear guidance and direction to States, vendors, and potential participants in the incentives programs.

In addition Medicaid Administrative funds may be used to:

- Develop an implementation strategy for issuing incentive payments to providers.
- Track, report and oversee incentive payments to assure no duplication of funding.



- Assess data from providers, practitioners and hospitals, Medicaid, CHIP, and uncompensated care patient volume/mix data.
- Conduct an environmental scan of the current State EHR/HIT environment.
- Create a vision document with an analysis of current to future State activities with a plan for transition and roadmap with milestones for achieving EHR technology goal.
- Conduct extensive outreach, training and education to providers and to State personnel
- Develop an infrastructure for health information exchange.
- Harmonize EHR/HIT technology with current State initiatives such as Medicaid Information Technology Architecture (MITA).
- Work with States to develop the infrastructures necessary to provide oversight of Recovery Act initiatives and coordinate related activities involving various stakeholders.

Several of these activities will need to be closely coordinated with ONC initiatives authorized by Recovery Act such as the grants to states for information exchanges (section 3013).

#### **D. Characteristics**

The administrative funding provided by the legislation will be used for both Federal in-house activities and contracting with non-Federal entities. The Federal in-house funding will be used to hire additional Federal staff, as well as pay a portion of the costs for existing staff working on HIT related activities. The non-Federal entities will be provided with funding primarily through the use of contract vehicles under the standard Federal Acquisition Regulations (FAR) requirements.

State Medicaid Agencies will receive Federal matching rates of 90 percent for their administrative costs of the HIT activities through the existing FMAP grant payment process, estimated to be \$1,055 million. This is also non-Federal entity funding. Medicare and Medicaid incentive payments to eligible professionals will be made using existing or newly developed Federal and State payment systems. Medicare hospital incentive payments will be made using the existing cost report based process.

The HIT legislation provided CMS with \$1,045 million in administrative funding - \$745 million for Medicare and \$300 million for Medicaid - for the FY 2009-2019 period. It is anticipated that approximately 10 percent of that funding will be used for Federal in-house activities with the remaining balance going to non-Federal entities.

#### **State Administrative Costs for Medicaid HIT Implementation**

Federal matching funds are provided to States for administering payments for certified EHR technology. To be eligible for funding, States must demonstrate:

- Appropriate use of funds including tracking of meaningful use by Medicaid providers
- Adequate oversight of the program is being conducted, including routine tracking of meaningful use attestations and reporting mechanisms,



- Other initiatives are being pursued to encourage the adoption of certified EHR technology for the promotion of health care quality and the exchange of health care information.

## **Incentive Payments**

### Medicare

- Medicare EPs may receive incentives for the adoption and meaningful use of certified EHR technology. The incentive payment will be calculated on 75 percent of the allowable charges for services furnished by the EP during the payment year, not to exceed payment maximums set by law. Payments will be made from 2011 through 2016. For example, the maximum payment for 2011 is \$18,000 with a maximum of \$44,000 paid over 5 years. Incentive payments are increased by 10 percent for those EP providing services in a health professional shortage area. EPs must choose whether to receive an incentive under the Medicare or Medicaid.
- Medicare will also pay incentives to subsection 1886(d) hospitals and critical access hospitals. Eligible hospitals that are meaningful EHR users by 2015 for a reporting period specified by the Secretary could receive up to four years of incentive payments beginning in FY 2011. The payments will be based on the statutory formula which includes a \$2 million base payment that is adjusted based on the number of discharges, the Medicare share of inpatient bed days, and charity care. Hospitals that become meaningful users after 2015 would not receive these incentives.
- Medicare may also pay EHR incentives to certain Medicare Advantage (MA) organizations that employ or contract with certain EPs. EHR incentives will only be paid under the fee-for-service program if the EP qualifies for the maximum incentive payment under that provision. Hospital incentives will be paid under the fee-for-service program if at least one-third of a hospital's Medicare discharges (or bed days) of Medicare patients for the year are covered under Medicare Part A, otherwise MA organizations can be reimbursed directly for hospitals that are under common ownership and control and that primarily treat MA plan enrollees.

### Medicaid

- The Medicaid statute provides for a 100 percent Federal Financial Participation (FFP) match for State expenditures for provider incentive payments to encourage Medicaid health care providers to purchase, implement, and operate certified electronic health record (EHR) technology. These payments can cover up to 85 percent of the federally-determined "net average allowable costs" of EHR technology, including support and training for staff.
- Eligible professionals may receive up to 85 percent of the net average allowable costs for certified EHR technology, including support and training (determined on the basis of studies that the Secretary will undertake), up to a maximum level, and incentive payments are available for no more than a 6-year period. Certain eligible professionals can receive up to \$21,250 for the first year of payment for the initial purchase and adoption of certified EHR technology, ending after 2016; and up to \$8,500 annually over 5-years for



costs relating to the operation, maintenance and demonstration of meaningful use of such technology, ending after 2021.

- Hospital incentive payments are statutorily defined by formula. Full reimbursement of incentive payments cannot occur over a minimum 3-year or maximum 6-year period. The last year that a hospital can begin receiving incentive payments is 2016.
- States must assure that payments are being made directly to Medicaid providers without any deduction or rebate.
- Medicaid providers must demonstrate “meaningful use” as defined by the State and approved by the Secretary and may be based upon the methodologies applied for professionals and hospitals receiving EHR incentive payments under Medicare. Such meaningful use may include the reporting of clinical quality measures to the States and in such case, address populations with unique needs, like children.
- Certified EHR technology must be, to the extent possible as specified by the Secretary, compatible with State or Federal administrative management systems.
- Medicaid EPs must waive the right to receive incentive payments under Medicare for certified EHR technology. An EP that participates in both Medicare and Medicaid and meets the respective eligibility requirements cannot receive incentive payments from both Medicare and Medicaid.

## E. Delivery Schedule

Description	Date (s)
1. Coordinate with ONC to develop policies such as the definition of meaningful use 2. Develop proposed rules to allow public input to the incentive program policies 3. Plan systems and other requirements needed to support the incentives programs 4. Plan national outreach program	2009
1. Conduct outreach to eligible professionals and providers and to State Medicaid Agencies 2. Develop systems to support the payment of incentives 3. Develop final rules to establish policies needed to pay incentives 4. Develop systems to monitor and evaluate incentive payments	2010
1. Start to pay hospital incentives for Medicare and monitor payments	No sooner than October 2010
1. Start to pay eligible professionals for Medicare and monitor payments 2. Begin and monitor Medicaid incentives payments to eligible professionals and hospitals	No sooner than January 2011
Continue paying hospital incentives for Medicare and monitor payments	2011-2016



Description	Date (s)
Continue paying eligible professionals incentives for Medicare and monitor payments	2011-2016
Continue paying Medicaid incentives to eligible professionals and hospitals and monitor payments	2011-2021
Initiate payment reductions to Medicare hospitals and eligible professionals that fail to adopt EHRs	2015 and thereafter

## F. Environmental Review Compliance

Funds under Division B of the Recovery Act do not require 1609(c) certification under National Environmental Policy Act (NEPA). Therefore, CMS has nothing to report for the following Division B Funding Projects:

Section 4101: Medicare Incentives for Eligible Professionals

Section 4102: Medicare Incentives for Hospitals

Section 4103: Implementation Funding

Section 4201: Medicaid Provider HIT Adoption and Operations Payments

## G. Measures

HHS is working to develop cross-cutting outcome measures for health information activities across the Department. Initial outcome measures will be developed by December 1, 2009. In addition, the measures below will be reported quarterly and will help HHS track progress toward the program's goals and objectives.

Goal	Measure	Type	Target	Reporting Frequency
Meaningful Use of certified EHRs by EPs (Medicare)	# of EPs qualifying as meaningful users under the Medicare incentive program	Outcome	2011 - target will be set using OACT projections	Quarterly
Meaningful Use of certified EHRs by EPs (Medicaid)	# of EPs qualifying as meaningful users under the Medicaid incentive programs	Outcome	2011 - target will be set using OACT projections	Quarterly
Meaningful Use of certified EHRs by Hospitals (Medicare)	# of Hospitals qualifying as meaningful users under the Medicare incentive program	Outcome	2011 - target will be set using OACT projections	Quarterly
Meaningful Use of certified EHRs by Hospitals	# of Hospitals qualifying as	Outcome	2011 - target will be set	Quarterly



Goal	Measure	Type	Target	Reporting Frequency
(Medicaid)	meaningful users under the Medicaid incentive program		using OACT projections	

The present performance indicator for HHS Strategic Plan objective 1.3 lists the most recent result for the adoption of EHRs by physicians as 10% for FY 2005 as measured by the National Ambulatory Medical Care Survey. The current target for 2012 in the HHS Strategic Plan is 40%. This target may need to be updated. Additional measures may be added as policies are developed to meaningfully reflect HHS objectives. CMS will work with ONC to ensure that measures are not duplicative.

Measures for eligible professionals need to be coordinated across the Medicare and Medicaid programs because eligible professionals may only participate in one of the incentive programs.

## H. Monitoring and Evaluation

All Recovery Act programs will be assessed for risk and to ensure that appropriate internal controls are in place throughout the entire funding cycle. These assessments will be done consistent with the statutory requirements of the Federal Manager’s Financial Integrity Act and the Improper Payments Information Act, as well as OMB’s circular A-123 “Management’s Responsibility for Internal Control.”

CMS will develop policies and procedures to ensure proper and accurate identification of providers to determine program eligibility and to prevent duplicate payments. CMS will track payments to ensure that maximum payment limits are not exceeded. CMS has consulted with the Office of the Inspector General and will use CMS’ internal control infrastructure to monitor incentive payments. We will develop mechanisms to help ensure correct payments and account for and recover any overpayments.

In the Medicaid program, to ensure the proper use of funds, States must demonstrate to the satisfaction of the Secretary that the State is using the funds provided for the purposes of administering payments, conducting adequate oversight, and pursuing initiatives to encourage the adoption of certified EHR technology.

## I. Transparency

CMS will be open and transparent in all of its contracting that involves spending of Recovery Act funding consistent with statutory, OMB, and HHS guidance. We will provide information for posting on Recovery.gov. In addition, CMS will post the names of those receiving Medicare incentives online. States will be encouraged to share similar information. The Secretary of HHS will submit reports to the Congress on the status, progress, and oversight of payments paid under the Medicaid incentive program. These reports will also describe the extent of adoption of certified EHR



technology among Medicaid providers resulting from the incentives and any improvement in health outcomes, clinical quality, or efficiency resulting from adoption. Note that Medicare incentives will not be paid prior to October 2010.

## **J. Accountability**

To ensure that managers are held to high standards of accountability in achieving program goals under the Recovery Act, CMS will build on and strengthen existing processes. Senior CMS officials will meet regularly with senior Department Officials to ensure that projects are meeting their program goals, assessing and mitigating risks, ensuring transparency, and incorporating corrective actions. In order to ensure successful overall implementation of the Recovery Act provisions, elements will be added to Senior Executive Service (SES) employees' performance plans. CMS will also use existing processes for ensuring accountability including contracting oversight, performance appraisals, and program audits.

## **K. Barriers to Effective Implementation**

Effective implementation is heavily dependent on getting the basic framework and criteria for the programs established as soon as possible. There are a number of critical factors that will create barriers to effective implementation if not implemented early enough including:

1. EHR certification criteria – payment is based on meaningful use of a certified EHR. The Recovery Act instructs the ONC to revisit the current criteria for certification, a process that is still under development.
2. Meaningful EHR user criteria – working with ONC, CMS must propose and finalize the definition of meaningful use which will include the demonstration of information exchange.
3. State systems to support the incentive programs – Sufficient lead time is necessary to conduct a gap analysis of current systems and to develop a Health Information Exchange (HIE) infrastructure in the near-term to enable the States to make incentive payments.
4. Accurate State and provider reporting – An analysis of existing reporting systems will be necessary to properly execute, accurately record and issue in a timely manner, transactions made by States to their providers.

## **L. Federal Infrastructure**

Not applicable.