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

A. Funding Table

(Dollars in Millions)

Project/Activity	Program Level Estimate	FY 2009 Actual	FY 2010 Estimate	FY 2011 Estimate	FY 2012 – FY 2019 Estimate
Incentives (including Medicare penalties)/1					
Medicare Incentives (High scenario)	$16,600.0	$0.0	$0.0	$2,700.0	$13,900.0
Medicare Incentives (Low scenario)	6,800.0	0.0	0.0	1,800.0	5,000.0
Medicaid Incentives (High scenario)	10,600.0	0.0	0.0	2,300.0	8,400.0
Medicaid Incentives (Low scenario)	7,300.0	0.0	0.0	1,300.0	5,900.0
Subtotal, Medicare and Medicaid Incentives (High Scenario)	27,200.0	0.0	0.0	5,000.0	22,300.0
Subtotal, Medicare and Medicaid Incentives (Low Scenario)	14,100.0	0.0	0.0	3,100.0	10,900.0
State Medicaid Administration	2,308.0	0.2	151.7	282.6	1,874.0
CMS Administrative Costs /2					
Medicare	745.0	3.0	74.3	TBD	TBD
Medicaid	300.0	1.0	48.5	TBD	TBD
Subtotal, CMS Administrative Costs	1,045.0	4.0	122.8	TBD	TBD

/1 Estimates for Medicare and Medicaid incentives are from the proposed regulation (CMS-2009-0117-0002) impact analysis. Physician impact assumes current law physician updates from FY 2010 President's Budget.
/2 For Medicare, from FY 2009 through FY 2015, CMS is appropriated $100 million per year for administrative spending. For FY 2016, the amount is $45 million. For Medicaid, CMS is appropriated $40 million per year for FY 2009 through FY 2015 and $20 million in FY 2016. Funds for each fiscal year are available until expended.

B. Objectives

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 EPs and hospitals who fail to demonstrate meaningful use of certified EHRs beginning in 2015.

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 EPs between calendar years 2011 to 2016 and for hospitals that meaningfully use certified EHRs by fiscal years 2011 to 2016. Starting in 2015, eligible professionals and hospitals failing to demonstrate meaningful use of 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 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 corresponds to the HHS strategic objective to improve health care quality, safety, cost and value.

C. Activities

The Recovery Act appropriated to CMS $140 million for each of fiscal years (FY) 2009 through 2015 and $65 million for FY 2016 for administrative funding, and made these funds available until expended. Initially CMS used 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 is now being 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 registration, attestation, payment, reporting, and accounting/monitoring.

In coordination with the Office of the National Coordinator for Health Information Technology (ONC), CMS published the proposed rule (CMS-2009-0117-0002) on January 13, 2010, including a proposed definition of "meaningful use." The final rule for the EHR incentive program is expected to be issued in late spring 2010. 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 the EHR incentive program including provider eligibility, selection of Medicare or Medicaid incentive programs for eligible providers, incentive

payments, and the demonstration of "meaningful use." CMS' outreach efforts will complement ONC's efforts to inform providers about HIT adoption and EHR certification and standards.

State payment of Medicaid incentive payments will require each State to determine how it will implement, oversee, and monitor incentive payments, within CMS guidelines, as well as require modification to CMS Medicaid reporting and data systems. CMS and State 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

Below is a brief description of the overall activities necessary for implementation of the EHR incentive payments program. Except where indicated, we expect the activities to be performed through FY 2016:

Regulatory Work

This effort will include ongoing support for development of regulations for implementing Medicare and Medicaid incentive payments as well as technical information and guidance to the States on the implementation of HITECH. Subsequent rulemaking will be required for stage two and stage three of meaningful use.

Planning and Business Analysis

This includes overall program coordination and planning. Business process modeling support to develop audit and appeals models, help desk models, Medicaid State interaction models, etc. are planned. Systems engineering support involving planning, architecture and development of new systems as well as leveraging existing systems to implement requirements for HITECH.

Plan/Provider Registration/Attestation

CMS will develop a national level repository (NLR) to compile registration, attestation and payment activity for EPs and Hospitals. CMS will leverage the Provider Enrollment Chain and Ownership System (PECOS) and the National Plan and Provider Enumeration System (NPPES) functionality and data.

Plan/Provider Payment

CMS intends to use a Payment File Development Contractor to assist in preparing and processing Medicare incentive payments and to ensure proper funds control and accounting related to these payments.

Control/Oversight

CMS has been working on developing audit and appeals functions as well as integration with other HITECH systems to ensure incentive payments are not made to ineligible providers and that payments are made appropriately and accurately.

Education and Outreach
CMS has developed an extensive outreach and education plan and timeline. Outreach will focus on educating providers about the Medicare and Medicaid EHR programs and on educating States about how to avoid the risk of making improper incentive payments under Medicaid. Outreach and education efforts will inform providers of the requirements of the EHR incentive program. CMS has forged a strong relationship with ONC to coordinate and strengthen education efforts. ONC is responsible for recognizing the standards, implementation specifications, and certification criteria for EHR technology as well as establishing certification programs for HIT. CMS manages the Medicare and Medicaid EHR incentive program which provides incentives for the meaningful use of certified EHR technology.

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. To qualify to receive 90 percent FFP for administering the incentive program, States must develop a State Medicaid Health Information Technology Plan (SMHP), a Health Information Technology Planning Advance Planning Document (HIT PAPD), and a Health Information Technology Implementation Advance Planning Document (HIT IAPD).

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 meaningful use of certified EHR technology. The incentive payment will be calculated as 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 if an EP continues to demonstrate meaningful use of certified EHRs. Incentive payment maximums are increased by 10 percent for those EPs providing services in a health professional shortage area. EPs must choose whether to receive an incentive under 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 and hospitals. For EPs, EHR incentives will only be paid under the fee-for-service (FFS) program if the EP qualifies for the maximum incentive payment under that provision. For hospitals, incentives will be paid only 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 FFS Part A, otherwise MA organizations can be reimbursed directly for hospitals that are under common ownership and control and that serve MA plan enrollees of such organizations.

Medicaid

- The Medicaid statute provides for a 100 percent FFP for State expenditures for provider incentive payments to encourage Medicaid providers to implement, operate, and meaningfully use certified EHR technology.
  Medicaid incentive payments can cover up to 85 percent of the federally-determined "net average allowable costs" of EHR technology, including support and training for staff, up to a statutory maximum level. Eligible professionals can receive up to $21,250 for the first year of payment for the initial purchase and adoption of certified EHR technology, and up to $8,500 annually over 5-years for costs relating to the operation, maintenance and demonstration of meaningful use of such technology. Incentive payments are available for no more than a 6-year period, and initial incentive payments are not available after 2016.
- Hospital incentive payments are statutorily defined by formula. Full reimbursement of incentive payments must occur over a minimum 3-year and

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.
- 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

September 1, 2009	Released State Medicaid Directors (SMD) letter providing guidance to States on development of plans for administrative funding (HIT PAPD and SMHPs)
November 30, 2009	Published Paperwork Reduction Act Notice State Medicaid HIT Plan and Template for Implementation of Section 4201 of ARRA (CMS-10292).
January 13, 2010	Publication of Medicare and Medicaid Programs: Electronic Health Record Incentive (CMS-2009-0117-0002) proposed regulation defining “meaningful use” and other incentive payments policies.
February 2010	2nd Annual Multi-State Collaborative for HIT Conference
February 2010	External and Internal training calls and webinars to provide outreach on the proposed regulation
April 1, 2010	Registration and Attestation design and development Award-PECOS and National Plan and Provider Enumeration System (NPPES) modifications contract
May 2010	Development and validation environments available
May 1, 2010	Contract award for design and development of NLR
June 2010	Final Rule on Medicare and Medicaid Programs: Electronic Health Record Incentive on display
July 2010	Expected date of Paperwork Reduction Act approval of State Medicaid HIT Plan template and template for the abbreviated HIT Planning Advance Planning document to implement Section 4201 of ARRA (CMS-10292)
July 2010	Outreach on EHR incentive program registration and participation requirements
Aug - Dec 2010	Testing of HITECH systems
Q4 FY 2010	Complete Paperwork Reduction Act process for the Registration and Attestation modules
Q4 FY 2010	Obtain approval for the system of Records for the EHR incentive program
Q4 FY 2010	Publish and distribute to State Medicaid agencies Implementation Guidance on Implementing the Incentive Program end of 3rd quarter or early 4th quarter. Based upon approval timelines for SMHPs, it is expected that the

	Implementation APD's will be approved after guidance has been issued
September 2010	Award Payment File Development Contractor (PFDC)
November 2010	Production environment available
January 2011	Hospitals and eligible professionals may begin registration for incentive payments
January 2011	State Medicaid agencies may begin making incentive payments to hospitals and eligible professionals
April 2011	Medicare hospitals may begin attestation for incentive payments
April 2011	Medicare EPs may begin attestation for incentive payments
May 2011	CMS begins making Medicare Hospital incentive payments
May 2011	CMS begins making Medicare EP incentive payments
2011-2016	CMS makes EP and hospital incentive payments for Medicare and monitor payments (monitoring will be ongoing beyond 2016)
2011-2021	State Medicaid Agencies make Medicaid incentive payments to EPs and Hospitals and monitor payments
2015	Initiate payment reductions to Medicare hospitals and eligible professionals that fail to demonstrate "meaningful use"

F. Environmental Review Compliance

The CMS and Department of Health and Human Services are committed to sustainable operations of its activities and facilities through sound environmental stewardship including preferential procurement of environmentally preferred products and electronic stewardship of IT and data center operations.

As programs are developed, CMS will incorporate contract and/or grant language to mitigate the environmental impacts of acquisition of IT and other products and equipment and services and provide guidance to encourage the following:

- Green procurement' based on the HHS Affirmative Procurement Plan and similar guidance from the Environmental Protection Agency (EPA) and the President's Council on Environmental Quality (CEQ)

- Electronic Stewardship including the use of electronic products that are Energy Star® compliant and Electronic Product Environmental Assessment Tool (EPEAT) Silver registered or higher when available; the activation of Energy Star® features on all equipment, when available; environmentally sound 'end-of-life' management practices (including reuse, donate, sell, or recycle 100% of electronic products;) and best operation and management practices for energy efficient data centers.

G. Measures

The Department is working to develop a suite of measures on meaningful use to gauge participation of eligible providers and hospitals participating in the Medicare and Medicaid Incentive Programs when the regulation is finalized and CMS begins making these incentive payments. It is intended for data to be collected and reported quarterly at earliest May 2011. CMS and ONC will work together to ensure that measures are coordinated and reflect common goals. Such measures may include the ones identified below:

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 after the regulation has been finalized.	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 after the regulation has been finalized.	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 after the regulation has been finalized.	Quarterly
Meaningful Use of certified EHRs by Hospitals (Medicaid)	# of Hospitals qualifying as meaningful users under the Medicaid incentive program	Outcome	2011 target will be set after the regulation has been finalized.	Quarterly

In the interim, the following performance measures will help track the achievement of critical implementation milestones:

Goal	Measure	Type	Target	Reporting Frequency
Approval of State Medicaid Planning documents	Submittal and approval of State Medicaid planning documents including SMHP, HIT PAPD, and HIT IAPD.	Process	Review and approval of SMHPs and IAPDs within 60 business days post-States' submission	Ongoing
Successfully establish registration processes	Hospitals and EPs can begin registering for the incentive program	Process	Accomplish 6 months after the regulation has been finalized	NA
Successfully establish attestation processes	Medicare hospitals and EPs can begin submitting attestations	Process	Accomplish 9 months after the regulation has been finalized	NA
Successfully establish payment processes	CMS begins making payments to Medicare hospitals and EPs	Process	Accomplish 11 months after the regulation has been finalized	NA
Successfully establish payment processes	CMS begins making incentive funding available to participating State Medicaid agencies for provider incentive payments	Process	Accomplish 11 months after the regulation has been published	NA

H. Monitoring and Evaluation

The CMS programs are assessed for risk to ensure that appropriate internal controls are in place. These assessments are 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" (including Appendices A, B and C).

CMS' risk management process fits within the overall governance structure established at HHS to address Recovery Act program risks. The HHS Risk Management and Financial Oversight Board provides executive leadership and establishes accountability for the risk assessment process related to internal controls over financial reporting, and the HHS Senior Assessment Team (SAT) ensures that risk assessment objectives are clearly communicated throughout the Department. The CMS has a risk management and Financial Oversight committee, comprised of cross-functional senior leadership, to oversee and manage program implementation, and to address risk across the agency, including risk that impacts financial management. It meets monthly to monitor and assess the effectiveness of mitigation strategies, identify emerging risks and ensure the correction of program weaknesses. The CMS SAT performs an annual assessment in accordance with HHS' guidance regarding OMB circular A-123, Appendix A, Internal Control Over Financial Reporting.

In addition, CMS will present its high level risks to the Recovery Act Implementation Team. Chaired by the Deputy Secretary and comprised of senior policy officials from throughout the Department, the Implementation Team convenes monthly to monitor progress in carrying out Recovery Act programs and address the obstacles and risks that could impact their success.

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. 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. CMS expects to conduct periodic reviews to assess the State's progress described in its approved HIT PAPD and HIT IAPD. Regularly scheduled meetings are conducted between CMS and ONC, and both CMS and ONC will evaluate SMHPs on an on-going basis. A portal is being established so State APDs, SMHPs and correspondence will be accessible to CMS and ONC.

I. Transparency

CMS is open and transparent in all of its contracting and grant activities involving Recovery Act funding; the Agency is in compliance with statute and OMB guidance on transparency. All Recovery Act activities are either posted in Federal Business Opportunities (www.fbo.com) (contracts) or Grants.gov (grants) to highlight to the public the actions being undertaken by the Agency in support of the Recovery Act. In addition, CMS ensures that recipient reports required by Section 1512 of the Recovery Act are submitted and reviewed for material omissions and significant errors that would mislead or confuse the public. CMS informs recipients of their reporting requirements and defines these requirements in both its contracts and grants terms and conditions. CMS will continue its transparency activities including

implementation of new requirements effective October 2010 regarding subcontract reporting.

CMS 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 has built upon and strengthened existing processes. CMS has forged a strong relationship with ONC to coordinate and strengthen overall efforts. The CMS Program Management Office (PMO) for HITECH is located in the Office of E-Health Standards and Systems and is in consultation and close collaboration with ONC and other senior Department officials on a regular basis. Senior CMS Center for Medicaid, CHIP and Survey and Certification officials 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. The personnel performance appraisal system also incorporates Recovery Act program stewardship responsibilities for program and business function managers.

State Responsibilities:
States are responsible for tracking and verifying the activities necessary for a Medicaid EP or eligible hospital to receive an incentive payment for each payment year. Under the proposed rule, the State would submit a State Medicaid HIT Plan to CMS that includes: (1) A detailed plan for monitoring, verifying and periodic auditing of the requirements for receiving incentive payments; and (2) A description of the how the State will collect and report on provider meaningful use of certified EHR technology.

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 has been proposed but needs to be finalized so that EHRs can be certified for the incentive program.
2. Meaningful EHR user criteria. Working with ONC, CMS proposed, and is in the process of finalizing, the definition of meaningful use. Providers must successfully demonstrate meaningful use to receive an incentive payment.

Extensive outreach will be conducted to educate providers about the meaningful use requirements.

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.
5. Federal systems to support incentive payments. Compressed timeline for the systems development and testing for registration, attestation, payment and other systems

L. Federal Infrastructure

Not applicable.

Summary of Significant Changes:

- Revised estimates in Section A so they are consistent with the NPRM published on January 13, 2010. All other estimates reflect the FY2011 President's Budget.
- Added language about providers (Hospital and EP's) registration and attestation requirements to Section C.
- Updated the Administrative funds section under Section C to be consistent with planning approach as outlined in both Operating Plan and Spend Plan.
- Added a chart to Section G to identify the actual Number of States drawing temporary increase in Medicaid DSH funds per quarter.
- Added language to Section D about how providers (Hospitals and EP's) will be paid an incentive payment.
- Updated Section E to be consistent with planning approach as outlined in Spend Plan.
- Updated Sections F, H and I to reflect updated HHS policies on Environmental Review Compliance, Monitoring and Evaluation, and Transparency.
- Updated Section J to reflect CMS re-alignment structure and added a paragraph about State responsibility.
- Updated Section K to reflect progress made to date.