Addendum to the Texas State Medicaid Health Information Technology Plan:

Medicaid EHR Incentive/ Promoting Interoperability Program Changes

Texas Health and Human

Services Commission

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1. Introduction

The United States Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS), through the federal rulemaking process, have made changes to the Medicare and Medicaid Promoting Interoperability (PI) Programs (formerly known as the Electronic Health Record (EHR) Incentive Programs). This addendum to the State Medicaid Health Information Technology Plan (SMHP) describes program and policy updates necessary to comply with recent federal Final Rules, including meeting CMS' mandated deadlines for funding as the program moves toward statutory sunset in 2021. This addendum also addresses additional minor program updates and clarifications, including renaming the program.

CMS published two Final Rules in 2018 that impacted the Medicaid EHR Incentive/PI Program:

- A Final Rule titled "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims," published in the Federal Register (Vol. 83, No. 160) on August 17, 2018, and hereafter referred to as the 2019 IPPS Rule.
- A Final Rule titled "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program—Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions From the Medicare Shared Savings Program—Accountable Care Organizations—Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder Under the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act," published in the Federal Register (Vol. 83, No. 226) on November 23, 2018, and hereafter referred to as the 2019 PFS QPP Rule.

Program changes related to these Final Rules and additional updates are discussed below.

2. Program Name Change

On April 24, 2018, CMS issued an announcement to change the name of the Medicare and Medicaid EHR Incentive Programs to the Promoting Interoperability (PI) Programs for eligible hospitals and eligible professionals. To minimize provider confusion and ensure program continuity, the Texas Health and Human Services Commission (HHSC) now refers to its program as the Medicaid EHR Incentive/PI Program. This name change will be reflected in future updates to the SMHP.

3. Medicaid EHR Incentive/PI Program: 2019 to 2021

This addendum adds the following new section to the SMHP titled, "Medicaid EHR Incentive/PI Program: 2019 to 2021." This section will be included in the next SMHP update submitted to CMS.

Program Years 2019 to 2020

Reporting Periods, CEHRT, Meaningful Use Measures

The 2019 IPPS Rule made several changes to the Medicaid EHR Incentive/PI Program for eligible professionals (EPs) and eligible hospitals (EHs) participating in Program Years (PY) 2019 and 2020. Since the last year for EHs to participate in the Texas program was 2018, the EH-specific program changes established in the Final Rule are not relevant to Texas EHs and are not addressed in detail in this addendum. The 2019 IPPS Rule made the following changes to the program:

- Establishes a 90-day meaningful use/PI reporting period for all eligible professionals and eligible hospitals in PYs 2019 and 2020
- Requires the use of 2015 edition certified electronic health record technology (CEHRT) for reporting meaningful use/PI measures beginning in PY 2019

- Requires all providers to attest to Stage 3 meaningful use/PI measures beginning in PY 2019

The 2019 PFS QPP Rule also made changes to the Medicaid EHR Incentive/PI Program for PY 2019. Specifically, the 2019 PFS QPP Rule:

- Aligns the list of available electronic clinical quality measures (eCQMs) for EPs in 2019 with the list of eCQMs available for Eligible Clinicians under the Merit-based Incentive Payment System (MIPS) in 2019

- Requires returning meaningful users to report on a one year eCQM reporting period and allows first-time meaningful users to report on a 90-day eCQM reporting period

- Requires EPs to report on any six eCQMs related to their scope of practice, including at least one outcome or high-priority measure (if relevant)

- Allows states to identify additional high-priority measures (from the list of available eCQMs selected by CMS) that align with specific state health goals or programs

- Allows EPs other than those in urgent care settings to attest to the Syndromic Surveillance measure to meet Objective 8 (Public Health)

- Maintains a threshold of 5% for Measure 1 (View, Download, Transmit) and Measure 2 (Secure Electronic Messaging) of Meaningful Use Stage 3 EP Objective 6 (Coordination of Care Through Patient Engagement) in 2019 and through the end of the program

The required changes will be implemented and ready for provider attestations in MI360, the state level repository, by April 2019. HHSC has not identified additional eCQM measures to categorize as high-priority for Texas and will implement eCQM measures as finalized in the Rule.

Attestation Tail Period

HHSC currently has a 75-day tail period (grace period) for attestations following the end of the program/calendar year. After the tail period deadline in March of the subsequent calendar year, it has historically taken HHSC until mid-August to complete all pre-payment reviews, issue payments, and close out the program year. HHSC begins the audit process when all attestations are processed and paid for that program year.

HHSC currently has an approximately three year lag between the end of a program year and the completion of audits for that year. In order to meet CMS deadlines for program payments and audits, HHSC is shortening the attestation tail period in PYs 2019 and 2020 from 75 calendar days to 60 calendar days. HHSC will explore other options to fast-track completion of audits and appeals, such as conducting concurrent procurements for audit services, implementing an "audit as you go" process, or both, to ensure federal program closure deadlines are met. These strategies, once finalized, will be outlined in more detail in HHSC's separate program Audit Plan.

Program Year 2021 and Program Closure

The 2019 PFS QPP Rule made changes to the Medicaid EHR Incentive/PI Program for PY 2021. Specifically the Rule:

- Establishes a 90-day meaningful use and eCQM reporting period for all EPs
- Sets a default attestation deadline of October 31, 2021, but allows states to set an earlier deadline to ensure payments can be issued by December 31, 2021

Based on historical experience with end-of-year attestation processing backlogs and audit lag times, HHSC is establishing an attestation deadline of August 1, 2021, for PY 2021. The last allowable end date for a 90-day meaningful use or eCQM reporting period would therefore be July 30, 2021.

End of Program Funding Deadlines

The 2019 IPPS Rule established deadlines for states to receive federal HITECH funding for incentives and the administration of the Medicaid EHR Incentive/PI Program. Accordingly, HHSC acknowledges the following deadlines:

December 31, 2021: Last date for states to make EHR/PI incentive payments to EPs and EHs (other than pursuant to an audit or appeal)

September 30, 2021: Last date for states to receive 90:10 HITECH funding for administrative expenditures related to health information exchange (HIE)

September 30, 2022: Last date for states to receive 90:10 HITECH funding for administrative expenditures (except related to audits and appeals) for the Medicaid EHR Incentive/PI Program

September30, 2023: Last date for states to receive 90:10 HITECH funding for administrative expenditures related to audits and appeals for the Medicaid EHR Incentive/PI Program

4. Additional Updates to the EHR Incentive/PI Program Policies

This addendum updates Section 4.2.3 of the SMHP, "Hospital EHR Payment Calculation," clarifying the policy for calculating the growth rate for hospitals who attest with less than four years of cost report data in their first payment year. The first paragraph of Section 4.2.3 (p. 38) is replaced with the following two paragraphs:

Attesting hospitals are guided through the EHR payment calculation in the MI360 portal. Hospitals are instructed to enter data directly from the appropriate Medicare cost report or other data sources if appropriate to calculate the growth rate, overall EHR amount, and Medicaid share. An onscreen example is also provided to assist hospitals with their calculations. Hospitals enter up to four years of discharge data from their Medicare cost reports to calculate the growth rate for the incentive payment calculation. If a hospital does not have four years of discharge data at the time of their first year attestation (e.g. a new hospital), the growth rate is calculated based on the available data. However, a hospital must have at least one full, continuous 12-month period of discharges to report for the initial attestation and incentive calculation. The cost report is used to determine other payment calculation factors as well, per CMS instructions. The total hospital incentive amount is then disbursed over three annual payments in a ratio of 50% (Year 1), 40% (Year 2), and 10% (Year 3).

HHSC requires hospitals with less than four years of discharge data to upload additional data each year that they attest, and the hospital payment calculation is revised accordingly, until the hospital has received all available incentive payments. Once a hospital has received all available payments, no additional data or cost reports can be submitted and no further adjustment is made to the payment calculation factors~~/~~ or payment amount. If it is determined appropriate by HHSC, an adjustment can be made as a result of an audit, HHSC review, or discovery of an incorrect payment. In certain circumstances, a hospital that has completed the program may request a review of the payment calculation factors if a Medicare cost

report used in the original calculation has been formally amended and approved by CMS. HHSC has sole authority and discretion in determining whether any request for a post-program review and payment adjustment is appropriate. Additionally, HHSC will not consider a request for review of the hospital payment calculation if it is more than twelve months after the hospital's final payment.