

Medicaid Informational Guide on Skipping Years

Eligible Professionals:

- Professionals are permitted to skip any number of years under the Medicaid Incentive Program as Medicaid does not have payment penalties based on Meaningful Use (at this time).

However:

- If a professional receives Medicare Fee-for-Service payments but fails to meet Meaningful Use by year 2015 then the professional will receive an adjustment to their fee schedule in Medicare payments by 2015. See the statement below for a more in-depth explanation.
- Exceptions have been made to this payment adjustment which you can see below in the Stage 2 Final Rule highlighted in yellow.

Eligible Hospitals:

- Eligible Hospitals may skip a program year without penalty under the Medicaid EHR Incentive Program

However:

- An EH that receives any Medicare payments must meet Meaningful use in 2013, 2014 (by July 1, 2014)

Stage 1 Final Rule (Allowing Medicaid EP's to skip multiple years):

“That is, Medicare EPs do not have the same flexibility afforded to Medicaid EPs, who are permitted to participate in a non-consecutive annual basis, or to skip years, in other words, without the omitted years necessarily reducing the total number of years for which they may receive payment.”

Stage 1 Final Rule:

“Statutory Basis for the Medicare & Medicaid EHR Incentive Programs

Section 4101(a) of the HITECH Act adds a new subsection (o) to section 1848 of the Act. Section 1848(o) of the Act establishes incentive payments for demonstration of meaningful use of certified EHR technology by EPs participating in the original Medicare program (hereinafter referred to as the Medicare Fee-for-Service (FFS) program) beginning in calendar year (CY) 2011. Section 4101(b) of the HITECH Act also adds a new paragraph (7) to section 1848(a) of the Act. Section 1848(a)(7) of the Act provides that beginning in **CY 2015, EPs who do not demonstrate that they are meaningful users of certified EHR technology will receive an adjustment to their fee schedule for their professional services of 99 percent for 2015 (a reduction of 1%),** (or, in the case of an eligible professional who was subject to the application of the payment adjustment under section 1848(a)(5) of the Act, 98 percent for 2014) **(2% reduction),** 98 percent for 2016, and 97 percent for 2017 and each subsequent year. Section 4101(c) of the HITECH Act adds a new subsection (l) to section 1853 of the Act to provide incentive payments to certain Medicare Advantage (MA) organizations for their affiliated EPs who meaningfully use certified EHR technology and meet certain other requirements, and requires a downward adjustment to Medicare payments to certain MA organizations for professional services provided by any of their affiliated EPs who are not meaningful users of certified EHR technology, beginning in 2015.”

Stage 2 Final Rule:

“Medicare payment **adjustments are required by statute to take effect in 2015.** We are finalizing a process by which payment adjustments will be determined by a prior reporting period. Therefore, we specify that **EPs and eligible hospitals that are meaningful EHR users in 2013 will avoid payment adjustment in 2015.** Also, if such providers **first meet meaningful use in 2014, they will avoid the 2015 payment adjustment,** if they are able to demonstrate meaningful use at least 3 months prior to the end of the **calendar (for EPs) or fiscal year (for eligible hospitals)** and meet the registration and attestation requirement by **July 1, 2014 (for eligible hospitals) or October 1, 2014 (for EPs).** We also are finalizing exceptions to these payment adjustments. This final rule outlines four categories of exceptions based on **(1) the lack of availability of internet access or barriers to obtaining IT infrastructure; (2) a time-limited exception for newly practicing EPs or new hospitals that will not otherwise be able to avoid payment**

adjustments; (3) unforeseen circumstances such as natural disasters that will be handled on a case-by-case basis; and (4) (EP only) exceptions due to a combination of clinical features limiting a provider's interaction with patients or, if the EP practices at multiple locations, lack of control over the availability of CEHRT at practice locations constituting 50 percent or more of their encounters. Modifications to Medicaid EHR Incentive Program¹⁷We are expanding the definition of what constitutes a Medicaid patient encounter, which is a required eligibility threshold for the Medicaid EHR Incentive Programs. We include encounters for individuals enrolled in a Medicaid program, including Title XXI-funded Medicaid expansion encounters (but not separate Children's Health Insurance Programs (CHIPs)). We also specify flexibility in the look back period for patient volume to be over the 12 months preceding attestation, not tied to the prior calendar year. We are also making eligible approximately 12 additional children's hospitals that have not been able to participate to date, despite meeting all other eligibility criteria, because they do not have a CMS Certification Number since they do not bill Medicare. These changes would take effect beginning with payment year 2013."