

DEPARTMENT OF HEALTH CARE FINANCE

NOTICE OF FINAL RULEMAKING

The Director of the Department of Health Care Finance (DHCF), pursuant to the authority set forth in An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat.744; D.C. Official Code § 1-307.02 (2013 Supp.)), and Section 6(6) of the Department of Health Care Finance Establishment Act of 2007, effective February 27, 2008 (D.C. Law 17-109; D.C. Official Code § 7-771.05(6) (2012 Repl.)), hereby gives notice of the adoption of a new Chapter 89, of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled “Medicaid Electronic Health Record Incentive Payment Program.”

This rule sets forth the conditions of provider participation, reimbursement, and administrative appeal procedures for the Medicaid Electronic Health Record Incentive Payment Program (MEIP). MEIP is established pursuant to the Health Information Technology and Clinical Health Act (HITECH) of 2009, enacted under Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111–5) (codified as amended in Title 42 of the Code of Federal Regulations, Part 495) and the corresponding State Medicaid Health Information Technology Plan (SMHP) approved by the U.S. Department of Health and Human Services (HHS) on April 23, 2012. MEIP may grant incentive payments to eligible hospitals and eligible professionals, who adopt, implement, upgrade, and demonstrate the meaningful use of certified Electronic Health Records (EHR) technology.

A Notice of Emergency and Proposed Rulemaking was published on August 9, 2013 (60 DCR 011687). No comments were received. No substantive changes have been made. The Director adopted these rules as final on December 20, 2013 and they shall become effective on the date of publication of this notice in the *D.C. Register*.

Title 29 (Public Welfare) of the DCMR is amended as follows:

Add a new Chapter 89, MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENT PROGRAM to read as follows:

89 MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENT PROGRAM (MEIP)

8900 Provider Eligibility

8900.1 The Department of Health Care Finance (DHCF) shall administer the Medicaid Electronic Health Record Incentive Payment Program (MEIP), which provides incentive payments to certain eligible providers participating in the District of Columbia Medicaid program as they adopt, implement, upgrade, or demonstrate meaningful use of certified Electronic Health Record (EHR) technology.

8900.2 The following providers shall be eligible for participation in MEIP:

- (a) Eligible professionals as identified in Subsection 8900.3; and
- (b) Eligible hospitals as identified in Subsection 8900.5.

8900.3 An eligible professional shall be one (1) of the following:

- (a) A physician licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));
- (b) A dentist licensed to engage in the practice of dentistry as defined by § 102(5) of the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.));
- (c) A certified nurse midwife licensed as an advanced practice registered nurse pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)), and certified by the American Midwifery Certification Board (AMCB);
- (d) A nurse practitioner licensed as an advanced practice registered nurse pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)); or
- (e) A physician's assistant, licensed in accordance with the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201 *et seq.* (2007 Repl. & 2012 Supp.)), who practices in a Federally Qualified Health Center (FQHC).

8900.4 Consistent with the requirements of Subsection 8900.3, an eligible professional shall not be hospital-based, unless the professional's eligibility for incentive payments is based on practice at a FQHC.

8900.5 An eligible hospital shall be one (1) of the following:

- (a) An acute care hospital located in the District of Columbia; or
- (b) A children's hospital located in the District of Columbia.

8900.6 For each year of MEIP participation, an eligible provider shall meet all of the following requirements:

- (a) Have no current or pending sanction identified by the United States Department of Health and Human Services, Office of Inspector General or the District of Columbia list of excluded providers;
- (b) Declare the intent to participate by electronically registering with the CMS using the Medicare and Medicaid electronic health record incentive program registration and attestation website;
- (c) Use the District of Columbia State Level Registry to attest to the provider's qualifications to receive the incentive payment; and submit an electronic copy of a signed attestation form at <http://dc.araaincentive.com>;
- (d) Meet Medicaid patient volume requirements consistent with the requirements of Section 8901, "Methodology for Volume Requirements", and the District of Columbia State Medicaid Health Information Technology Plan (SMHP);
- (e) Submit a Certified Health IT Product List (CHPL) Product Number; and
- (f) Declare, if applicable, the intent to reassign incentive payments to a third party subject to the requirements of 42 C.F.R. § 495.10(f).

8900.7 For the first year of MEIP participation, an eligible provider shall meet the requirements of Subsection 8900.6 and meet one (1) of the following conditions:

- (a) Demonstrate and attest to adopting, implementing or upgrading EHR technology as defined in 42 C.F.R. § 495.302 that has been certified by the Office of the National Coordinator for Health Information Technology; or
- (b) Demonstrate that it is a meaningful EHR user as defined in 42 C.F.R. § 495.4.

8900.8 An eligible provider that demonstrates and attests to adopting, implementing or upgrading EHR technology in accordance with Subsection 8900.7 shall report which certified EHR technology they have adopted, implemented or upgraded to and provide supporting documentation (*e.g.*, purchase receipts or other proof of good faith payment between purchaser and seller, or proof of binding contract) in a manner specified by DHCF.

8900.9 In the second, third, fourth, fifth, and sixth year of MEIP participation, an eligible provider shall satisfy all of the following criteria:

- (a) Meet the requirements of Subsection 8900.6;

- (b) Demonstrate that it is a meaningful EHR user as defined in 42 C.F.R. § 495.4; and
- (c) Use certified EHR technology interoperable with the system designated by the District to report clinical quality measures.

8901 Methodology for Volume Requirements

8901.1 An eligible professional shall establish and demonstrate, based on individual and group practice methodology, compliance with the following volume requirements:

- (a) An eligible professional shall have at least thirty percent (30%) of the professional's patient volume covered by Medicaid, except that:
 - (1) A board-certified pediatrician who does not practice at a FQHC shall have a minimum of twenty percent (20%) of patient encounters; and
 - (2) Any eligible professional predominately practicing at a FQHC shall have at least thirty percent (30%) of patient volume attributable to needy individuals.
- (b) An eligible professional shall calculate individual Medicaid patient volume by dividing the total Medicaid patient encounters (in and out of the District) in any continuous ninety (90) day period in the calendar year (CY) preceding the eligible professional's payment year, or in the twelve (12) months before the eligible professional's attestation; by the total patient encounters in the same ninety (90) day period;
- (c) Subject to 42 C.F.R. § 495.306(h), an eligible professional shall calculate group Medicaid patient volume by dividing the total Medicaid patient encounters (in and out of the District across the entire group or clinic) in any continuous ninety (90) day period in the CY preceding the eligible professional's payment year, or in the twelve (12) months before the eligible professional's attestation; by the total patient encounters (in and out of the District across the entire group or clinic); and
- (d) An eligible professional practicing in a FQHC shall calculate needy individual patient volume by dividing the total needy individual patient encounters in any continuous ninety day period in the CY preceding the eligible professional's attestation; by the total patient encounters in the same ninety (90) day period.

8901.2 An eligible acute care hospital shall have at least ten percent (10%) Medicaid patient volume based on individual methodology as calculated below:

- (a) An eligible hospital shall divide the total Medicaid patient encounters (in and out of the District) in any continuous ninety (90) day period in the preceding fiscal year (FY), or in the twelve (12) months before the eligible hospital's attestation; by
 - (b) The total patient encounters in the same ninety (90) day period to calculate individual Medicaid patient volume.
- 8901.3 An eligible children's hospital shall be exempt from volume requirements of Subsections 8901.1 through 8901.2.
- 8902 Provider Incentive Payments**
- 8902.1 For all payment years, MEIP incentive payments for each eligible provider shall be subject to all of the following conditions:
 - (a) Incentive payments shall be calculated pursuant to 42 C.F.R. § 495.310;
 - (b) An eligible provider may receive a MEIP incentive payment so long as the eligible provider meets all MEIP requirements as set forth in this chapter; and
 - (c) No eligible provider shall receive an incentive payment after payment year 2021.
- 8902.2 In the first payment year, to receive an incentive payment, an eligible professional shall meet all eligibility and volume requirements in accordance with Sections 8900, "Provider Eligibility" and 8901, "Methodology for Volume Requirements;" and satisfy one (1) of the following conditions:
 - (a) Demonstrate and attest to adopting, implementing or upgrading EHR technology as defined in 42 C.F.R. § 495.302 that has been certified by the Office of the National Coordinator for Health Information Technology; or
 - (b) Demonstrate that it is a meaningful EHR user as defined in 42 C.F.R. § 495.4.
- 8902.3 Incentive payments to an eligible professional in the first payment year shall meet the following requirements:
 - (a) An initial incentive payment shall not be dispersed after CY 2016;
 - (b) An incentive payment shall not exceed twenty-one thousand two hundred fifty dollars (\$21,250);

- (c) Incentive payments cannot be received from more than one State or Medicaid incentive payment program in a payment year;
- (d) Incentive payments to pediatricians shall be subject to the limitations of 42 C.F.R. § 495.310(a)(4); and
- (e) Incentive payments to professionals that are Medicaid and Medicare eligible shall be subject to the limitations set forth in 42 C.F.R. § 495.10(e).

8902.4 In the second, third, fourth, fifth, and sixth payment year, to receive an incentive payment, an eligible professional shall meet all eligibility requirements in accordance with Sections 8900, "Provider Eligibility" and 8901, "Methodology for Volume Requirements;" and demonstrate that it is a meaningful EHR user as defined in 42 C.F.R. § 495.4.

8902.5 Incentive payments to an eligible professional in subsequent payment years shall meet the following requirements:

- (a) Incentive payments shall be disbursed consistent with the CY on a non-consecutive, annual basis, following verification of eligibility for the payment year;
- (b) A single incentive payment may not exceed eight thousand five hundred dollars (\$8,500);
- (c) An eligible professional shall not participate in MEIP for more than a total of six (6) years. Incentive payments shall not exceed sixty-three thousand seven hundred and fifty dollars (\$63,750) over a six (6) year period;
- (d) Incentive payments to pediatricians shall be subject to the limitations of 42 C.F.R § 495.310(a)(4); and
- (e) Incentive payments to professionals that are Medicaid and Medicare eligible shall be subject to the limitations set forth in 42 C.F.R. § 495.10(e).

8902.6 In the first payment year, to receive an incentive payment, an eligible hospital shall meet all eligibility requirements in accordance with Sections 8900, "Provider Eligibility" and 8901, "Methodology for Volume Requirements;" and satisfy one (1) of the following conditions:

- (a) Demonstrate and attest to adopting, implementing or upgrading EHR technology as defined in 42 C.F.R. § 495.302 that has been certified by the Office of the National Coordinator for Health Information Technology; or
- (b) Demonstrate that it is a meaningful EHR user as defined in 42 C.F.R. § 495.4.

8902.7 Incentive payments to an eligible hospital in the first payment year shall meet the following requirements:

- (a) Incentive payments shall be disbursed consistent with the Federal FY on a rolling basis following verification of eligibility for the payment year;
- (b) An initial incentive payment shall not be dispersed after FY 2016; and
- (c) An eligible hospital shall receive an incentive payment from only one State or Medicaid incentive payment program in a payment year.

8902.8 In the second, third, fourth, fifth, and sixth payment year, to receive an incentive payment, an eligible hospital shall meet all eligibility requirements in accordance with Sections 8900, "Provider Eligibility" and 8901, "Methodology for Volume Requirements;" and demonstrate that it is a meaningful EHR user as defined in 42 C.F.R. § 495.4.

8902.9 Incentive payments to an eligible hospital in subsequent payment years shall meet the following requirements:

- (a) Incentive payments shall be disbursed consistent with the Federal FY on a rolling basis following verification of eligibility for the payment year;
- (b) Prior to FY 2016, incentive payments may be disbursed on a non-consecutive, annual basis for the fiscal year;
- (c) After 2016, incentive payments shall be dispersed only to an eligible hospital that received an incentive payment in the prior FY;
- (d) Incentive payments shall be dispersed over a minimum of a three (3) year period and a maximum of a six (6) year period;
- (e) An eligible hospital shall receive an incentive payment from only one State or Medicaid incentive payment program in a payment year;

- (f) No single incentive payment may exceed fifty percent (50%) of the aggregate EHR incentive amount as calculated under 42 C.F.R. § 495.310(g);
- (g) The total incentive payment received over all payment years of the program shall be no greater than the aggregate EHR incentive amount as calculated under 42 C.F.R. § 495.310(g); and
- (h) No incentive payments over a two (2) year period may exceed ninety percent (90%) of the aggregate EHR hospital incentive amount as calculated in 42 C.F.R. § 495.310(g).

8902.10 Incentive payments, identified in Subsections 8902.1 through 8902.9, may be assigned to a third party employer or to an entity under the following conditions:

- (a) The third party must have a contractual arrangement with the eligible hospital that allows the third party to bill and receive payment for the eligible hospital's covered professional services;
- (b) Assignments in Medicare must be consistent with § 1842(b)(6)(A) of the Social Security Act and 42 C.F.R. §§ 424.70 – 424.90;
- (c) Medicaid eligible providers may also assign their incentive payments to a Taxpayer Identification Number (TIN) for an entity promoting the adoption of EHR technology, consistent with 42 C.F.R. §§ 495.300 – 495.370; and
- (d) Each eligible provider may reassign the entire amount of the incentive payment to only one employer or entity.

8902.11 Incentive payments, identified in Subsections 8902.1 through 8902.9, that are disbursed through Medicaid managed care plans shall not exceed one hundred and five percent (105%) of the capitation rate pursuant to 42 C.F.R. § 438.6(c)(5)(iii).

8902.12 Incentive payments assigned to third party employers and other entities as described in Subsection 8902.10 shall not be implemented until on or after November 1, 2013.

8903 Program Integrity

8903.1 An eligible provider shall retain documentation that verifies its eligibility for MEIP for a minimum of ten (10) years and cooperate with DHCF and any other duly authorized agent of a governmental agency seeking to audit compliance with MEIP requirements.

- 8903.2 An eligible provider's cooperation shall include, but is not limited to, the following:
- (a) Making available to DHCF, or its designee, upon request, all necessary and complete records and other documentation for audit purposes as specified in the request;
 - (b) Permitting DHCF, or its designee, to audit, inspect, examine, excerpt, copy and/or transcribe the records related to this incentive program; and
 - (c) Permitting DHCF, or its designee, to access its premises to inspect and monitor its compliance with program requirements.
- 8903.3 DHCF shall prevent fraud, waste, and abuse by employing the following actions:
- (a) Conduct a full investigation or refer the case to the State Medicaid fraud control unit upon suspicion or detection of fraud or abuse by an eligible provider;
 - (b) Refer the case to the appropriate law enforcement agency upon suspicion or detection of fraud by a beneficiary; and
 - (c) Comply with all other laws and regulations designed to prevent fraud, waste, and abuse, including, but not limited to applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. § 3729 *et seq.*), the Anti-Kickback Statute (42 U.S.C. § 1320a-7b), § 1128B(b) of the Social Security Act, and 42 C.F.R. § 495.368.
- 8903.4 DHCF may take the following actions with respect to an eligible provider found deficient or in violation of this rule:
- (a) Suspend an incentive payment until the eligible provider has removed the deficiency to the satisfaction of DHCF;
 - (b) Require full repayment of all or a portion of an incentive payment; or
 - (c) Terminate the eligible provider's MEIP participation.
- 8903.5 DHCF shall issue a written notice when any action is taken pursuant to Subsection 8903.3 in accordance with the requirements set forth in Chapter 13 of Title 29 DCMR.
- 8904 Appeals**
- 8904.1 A provider may appeal any of the following issues:

- (a) Incentive payment amounts;
- (b) Provider eligibility determinations; and
- (c) Demonstration of adopting, implementing, upgrading, and meaningful use of technology.

8904.2 DHCF shall issue a written determination to a provider if it finds the following:

- (a) The initial MEIP amount will not be issued because the calculation is incorrect;
- (b) The initial MEIP amount will not be issued because the provider has an outstanding balance due which was offset against the MEIP payment;
- (c) Failure to meet MEIP eligibility requirements;
- (d) Failure to meet the meaningful use requirements; or
- (e) Failure to provide sufficient documentation to support adopting, implementing, or upgrading a certified electronic health record.

8904.3 The written determination described in Subsection 8904.2 shall include the following:

- (a) A finding as described in Subsection 8904.2 that includes a description of why the criteria were not met;
- (b) The policy, rule, or statute upon which the determination was made; and
- (c) An explanation of the right to request an administrative review as well as the timeframes for a request.

8904.4 Within thirty (30) calendar days of receipt of the written determination set forth in Subsections 8904.2 and 8904.3, a provider that disagrees with the determination shall have the right to request an administrative review with DHCF. The written request for administrative review shall include the reason for the request, the relief requested and documentation in support of the relief requested.

8904.5 DHCF shall issue a formal written determination relative to the administrative review no later than sixty (60) calendar days after receipt of the provider's written request for administrative review.

8904.6 Within thirty (30) calendar days after receipt of DHCF's written response to the administrative review, the provider may appeal the decision by filing a written notice of appeal with the D.C. Office of Administrative Hearings.

8999

DEFINITIONS

Acute care hospital: A health care facility: (1) where the average length of patient stay is twenty-five (25) days or fewer; and (2) with a Centers for Medicare and Medicaid Services (CMS) certification number (previously known as the Medicare provider number) that has the last four (4) digits in the series 0001–0879 or 1300–1399 pursuant to 42 C.F.R. § 495.302.

Children’s hospital: A separately certified children’s hospital, either freestanding or hospital-within-hospital that (1) has a CMS certification number (CCN), (previously known as the Medicare provider number), that has the last four (4) digits in the series 3300–3399; or (2) does not have a CCN but has been provided an alternative number by CMS for purposes of enrollment in MEIP as a children’s hospital; and; (3) predominantly treats individuals under twenty-one (21) years of age, pursuant to 42 C.F.R. § 495.302.

Hospital based professional: As defined in 42 C.F.R. § 495.4, a professional who furnishes ninety (90) percent or more of covered professional services in sites of service identified by the codes used in the Health Insurance Portability and Accountability Act of 1996, enacted August 21, 1996 (Pub.L. 104–191, 110 Stat. 1936) (HIPAA) standard transaction as an inpatient hospital or emergency room setting in the year preceding the payment year, or in the case of a payment adjustment year, in either of the two (2) years before such payment adjustment year.

Federally Qualified Health Center (FQHC): An entity that meets the definition set forth in § 1905(l)(2)(B) of the Social Security Act (42 U.S.C. § 1396d(l)(2)(B)).

Medicaid encounter: Services rendered in accordance with 42 C.F.R. § 495.306(e).

Needy individuals: As defined at 42 C.F.R. § 495.302, individuals who: received medical assistance from Medicaid or the Children’s Health Insurance Program (or a Medicaid or CHIP demonstration project approved under § 1115 of the Social Security Act); were furnished uncompensated care by the provider; or were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals’ ability to pay.

Patient Encounter: Services rendered to an individual pursuant to 42 C.F.R. § 495.306(e).

Patient Volume: The minimum participation threshold pursuant to 42 C.F.R. § 495.304(c)-(e), § 495.306, and the District of Columbia State Medicaid Health Information Technology Plan.

Payment year: For an eligible professional, a calendar year (CY) beginning with CY 2011 and for an eligible hospital, a federal fiscal year (FFY) beginning with FFY 2011.

Provider: For the purposes of this section, the term “provider” shall include both health care professionals and hospitals.