

Medicaid HIT Webinar Questions

1. What if during the meaningful use period our Medicaid volume increases? The modeling spreadsheet is based on Medicaid allowed discharges for the last three fiscal years, is this amount of incentive refigured every year?

We will recalculate the incentive payment for subsequent years if the data changes. Note this might also cause a decrease in the overall payment amount.

2. Where do we find our CCN? Is it the last 4 digits of our Medicare Provider number?
Incentive payments for eligible hospitals will be calculated based on the provider number used for cost reporting purposes, which is the CMS Certification Number (CCN) of the main provider (also referred to as OSCAR number). For the Medicaid incentive program hospitals must have a CMS Certification Number ending in 0001-0879 or 1300-1399.

3. We know that Stage-2 reporting is 12 consecutive months, what we don't know is if they can overlap a federal fiscal year or it has to run October-September?

Don't confuse year 2 reporting with Stage 2 reporting. "Stage" refers to what qualifies as meaningful use MU. Stage 2 MU requirements are currently being developed.

Year 2 reporting refers to the requirements necessary for receiving a year two payment. For dually eligible hospitals who received both a Medicare and Medicaid payment in Year 1, the hospital must demonstrate MU (in whatever stage is currently being required during that year, currently at Stage 1) for the entire federal fiscal year. The reporting period cannot run across federal fiscal years.

4. A question needing clarification for us is what period of time (fiscal year or a 90 day period) specific to us that we have to look at to demonstrate the 10% number. One of the slides from today attempts answers this.

- 1) Example: We have a June 30 fiscal year end. We would like to file as soon as possible. The most recent completed cost report year already submitted is June 30, 2010 so is the 10% for us based on June 30, 2010 most recent submitted cost report (or a 90 day period from within the June 30, 2010 fiscal year) or is it a period subsequent to June 30, 2010 for us?

The patient threshold must be established based on a 90-day period in the previous hospital fiscal year. If you are applying now, we will be looking for a 90-day period between July 1, 2009 and June 30, 2010.

5. Hospitals need to have 90-days of data to be eligible for Medicare incentive \$. So they would need a system functioning by July 1, 2011 for 90 days ending 09/30/2011, or they are out the first year of \$, which will never be reinstated?

Those were dates for hospitals applying in FFY 2011 as their first payment year. For Medicaid, the latest a hospital can initiate program participation is FFY 2016. If a hospital applies in 2016, 2016 becomes their first participation year.

6. Looking to get confirmation on the 1/11/11 email that stated our 90-day period Medicaid amount was 14.4%. Can you confirm the 90-day period you took this from? Also, where do you get the financial numbers, as they seem skewed for year 1-3 reimbursements for a facility our size?

IHA did not use a 90-day period in the preliminary Medicaid analysis sent to hospitals in January. The data was for the entire year from the HCRIS Master File 1st Quarter 2010 release data (Cost Report Data). Financials came from the proposed rule equation and hospitals Medicare Cost Report data.

7. One part of the audio conference that confused me was eligible year-one terms. We have a fiscal year that runs from July 1-June 30. We meet the 90-day criteria, so we should be eligible to apply now, as I think you had confirmed that in our phone conference?

You can apply now. If you apply now, you will use data from your fiscal year that ended June 30, 2010.

8. If we apply "now", what would be determined as year one (current? upcoming year? do we go by our fiscal, or the state fiscal?).

Hospital payment years are based on the federal fiscal year, running from October 1 – September 30. We are currently in FFY 2011, which would be considered your first payment year. We will use data from the cost report you submitted in FFY 2010. The second payment year would be FFY 2012, beginning in October, 2011.

EHR Incentive Calculator Worksheet

9. Under Step 6 (Computation of Medicaid Share): Is this section to be completed based on 4 years aggregate data OR just one particular fiscal year (e.g. latest cost report year)? This could ultimately make quite a difference on the total Medicaid incentive payment amount.

The Step 6 calculations are based on the cost report submitted during the previous federal fiscal year.

10. Does the Medicaid Share on this worksheet have to be at least 10% to even participate in the EHR incentive?

Be careful not to confuse the calculation of patient volume with the calculation of Medicaid share necessary to determine your incentive payment. The 10% patient volume is separate from the worksheet. The worksheet numbers are not used to calculate patient volume. A separate report from your EHR system should indicate patient volume for a 90-day period in the previous hospital fiscal year.

90-day 10% Eligibility

11. FFY 2011 runs from 10-1-10 thru 9-30-11. Our cost reporting year runs from 7-1-10 thru 6-30-11. Am I correct that the first year 90-day period we select to meet the 10% eligibility requirement must come from our fiscal year 7-1-10 thru 6-30-11? Or, must the 90-day period come from the FFY of 10-1-10 thru 9-30-11?

The rule states that the 90-day period must be from the previous fiscal year. Which fiscal year to use was purposely left vague to allow states flexibility in interpreting the fiscal year. Iowa has chosen to use hospital fiscal year to align with your reporting. Therefore, you must look at a 90-day period from the hospital fiscal year that ended during the previous federal fiscal year. So, look at the cost report you submitted during FFY 2010, which ended September 30, 2010. In other words, look at the report you submitted for your fiscal year that ended 6-30-10.

12. Please define ED “encounter”. In other words, is it an ED visit (defined by CPT code)? Is it simply a patient count? Is it the number of times a patient walks into the ED (i.e. If I show up twice in one day, is it one encounter or two)? If I get admitted through the ED and bill the ED separately as outpatient, is this counted as one ED encounter in addition to a patient day?

An ED encounter is a visit on any one day. If a patient shows up twice in one day, that is one encounter. If the patient shows up twice on different days, those are two encounters. How the encounter is billed is irrelevant. Inpatient days are counted by discharges.

13. Can we include out-of-state Medicaid days (and HMO days) in the Medicaid patient threshold eligibility to attain the 10%? Assume we are NOT selecting different state incentive programs each year.

In calculating patient volume, providers can include encounters in which another state’s program paid for the encounter. During attestation you will be asked which other state’s Medicaid programs (including HMOs) paid for any encounters during the 90-day period.

14. Explain in detail how dual eligible days are included in the Medicaid patient threshold eligibility computation. (i.e. If Medicare benefits are exhausted and Medicaid pays for the rest of the stay, do we include those paid Medicaid days in our numerator of the Medicaid Share?). What if Medicaid doesn’t pay for any days, but merely covers the payment as a Secondary Payer for a Medicare deductible or coinsurance, etc.? Please address both the numerator and the denominator of this fraction in your response.

A Medicaid encounter is defined as services rendered per inpatient discharge where Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part of all or the service or Medicaid paid all or part of the individual’s premiums, co-payments and/or cost-sharing. If Medicare benefits are exhausted and Medicaid pays for any portion of the stay, those discharges count in your numerator. If Medicaid pays deductible or coinsurance, then the discharge counts. If Medicaid is secondary, but never actually makes a contribution, then you

do not count the stay in the numerator. The denominator is all ED encounters and inpatient discharges during the same 90-day period.