TITLE 8 SOCIAL SERVICES
CHAPTER 300 MEDICAID GENERAL INFORMATION
PART 22 ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM

8.300.22.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.300.22.1 NMAC - N, 8/1/2011; A, 7/1/2024]

8.300.22.2 SCOPE: The rule applies to the general public.
[8.300.22.2 NMAC - N, 8/1/2011]

8.300.22.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27/1/2012 et seq. Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.300.22.3 NMAC - N, 8/1/2011; A, 7/1/2024]

8.300.22.4 DURATION: Permanent
[8.300.22.4 NMAC - N, 8/1/2011]

8.300.22.5 EFFECTIVE DATE: August 1, 2011, unless a later date is cited at the end of a section.
[8.300.22.5 NMAC - N, 8/1/2011]

8.300.22.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.300.22.6 NMAC - N, 8/1/2011]

8.300.22.7 DEFINITIONS: [**RESERVED**]

8.300.22.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.300.22.8 NMAC - N, 8/1/2011; A,]

8.300.22.9 ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM: The New Mexico medical assistance division (MAD) administers the medicaid electronic health records incentive program (medicaid EHR incentive program) as authorized by the federal American Recovery and Reinvestment Act of 2009. Under this program, New Mexico MAD providers may qualify for incentive payments if they meet the eligibility guidelines in this section and demonstrate they are engaged in efforts to adopt, implement, upgrade (AIU), or meaningfully use certified electronic health records (EHR) technology. The medicaid EHR incentive program is governed by the rule in this section, the electronic health records program final rule issued by centers for medicare and medicaid (CMS) in CMS-0033-F and 45 CFR 170, and the conditions of approval of the MAD plan approved by CMS. New Mexico MAD providers must also follow MAD instructions for enrolling in the medicaid EHR incentive program and provide documentation as required. Payments are made with federal funds and are contingent on the availability of those funds and federal requirements for reimbursement. Should the federal government discontinue funding, the incentive payments, inclusive, then incentive payments from the department will terminate.
[8.300.22.9 NMAC - N, 8/1/2011]

8.300.22.10 ELIGIBLE PROVIDERS:
A. Health care to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement or a MAD EHR incentive payment agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be approved before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care

programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When approved, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement or a MAD EHR incentive payment agreement, and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only.

B. To qualify for incentive payments, a provider must be an eligible professional or an eligible hospital. A provider who receives incentive payments must have an existing fee-for-service (FFS) MAD provider participation agreement or a MAD EHR incentive payment agreement, and at least one of their facilities must be located within the state of New Mexico.

(1) An eligible professional provider may not be hospital-based, unless they practice predominantly at a federally qualified health center (FQHC) or a rural health center (RHC) as defined by the CMS final rule. A professional provider is considered "hospital-based" if he/she furnishes 90 percent or more of his/her medicaid professional services during the relevant EHR reporting period in a hospital inpatient or emergency room, using the facilities and equipment of the hospital. An eligible professional provider may not participate in both the medicaid EHR incentive payment program and medicare EHR incentive payment program during the same payment year. Eligible professional providers include:

(a) a physician;

(b) a physician assistant practicing in a FQHC or RHC led by a physician assistant;

(c) a board certified pediatrician;

(d) a nurse practitioner;

(e) a certified nurse midwife;

(f) a dentist; or

(g) other type of provider when specifically allowed by CMS.

(2) Eligible hospitals are children's hospitals or acute care hospitals, including critical access hospitals and cancer hospitals. A hospital must meet either of the following definitions to be eligible for incentive payments:

(a) an acute care hospital is defined as a health care facility where the average length of patient stay is 25 days or fewer and that has a CMS certification number that has the last four digits in the series 0001-0879 and 1300-1399; or

(b) a children's hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

[8.300.22.10 NMAC - N, 8/1/2011]

8.300.22.11 ELIGIBLE RECIPIENT VOLUME: An eligible professional provider and an eligible hospital must meet eligible recipient volume criteria to qualify for incentive payments. Eligible recipient volume criteria compliance will be verified by MAD through claims and encounter data and audits. Eligible recipient volume requirements represent Title XIX (medicaid) eligible recipients as a percent of total eligible recipients, except for an eligible professional provider practicing predominately in a FQHC or RHC, who may use "needy individuals" as defined below in calculating eligible recipient volume.

A. The CMS final rule provides two options for determining patient volume percentages. New Mexico MAD will allow both options, as described below:

(1) eligible recipient encounter method: medicaid eligible recipient encounters in any 90-day reporting period in the preceding calendar year divided by total eligible recipient encounters in same 90-day period; or

(2) unduplicated eligible recipient method: see formula below.

(total medicaid eligible recipients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period) + (unduplicated medicaid encounters in that same 90-day period) *100 divided by (total eligible recipients assigned to the provider in the same 90 days with at least one encounter in the year preceding the start of the 90-day period) + (all unduplicated encounters in that same 90-day period).

B. Eligible recipient volume thresholds vary by type of provider and practice location.

(1) An eligible professional provider must meet a 30 percent medicaid eligible recipient volume threshold over a continuous 90-day period in the preceding calendar year. The only exception is for pediatricians, as discussed in 8.300.22.16 NMAC, below.

(2) With the exception of a children's hospital, which have no eligible recipient volume requirement, an eligible hospital must meet a 10 percent medicaid eligible recipient volume threshold over a continuous 90-day period in the preceding calendar year.

(3) An eligible professional provider practicing predominantly in an FQHC or RHC must meet 30 percent "needy individual" eligible recipient volume. To qualify as a "needy individual," patients must meet one of the following criteria:

(a) receives medicaid under an appropriate category of eligibility; or

(b) were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay, or were furnished uncompensated care by the provider.

(4) A clinic or group practice may calculate eligible recipient volume using the clinic's or group's entire eligible recipient volume under the following conditions:

(a) the clinic or group practice's eligible recipient volume is appropriate as a eligible recipient volume methodology calculation for the eligible professional provider; and

(b) there is an auditable data source to support the eligible recipient volume determination; and

(c) all eligible professional providers in the clinic or group practice use the same methodology for the payment year; and

(d) the clinic or group practice does not limit eligible recipient volume in any way; and

(e) if an eligible professional provider works inside and outside of the clinic or practice, the eligible recipient volume calculation includes only those encounters associated with the clinic or group practice, and not the eligible professional provider's outside encounters.

(5) A pediatrician may qualify for a two-thirds incentive payment if their medicaid eligible recipient volume is 20-29 percent. To qualify as a pediatrician for the purpose of receiving a two-thirds payment under the medicaid EHR incentive program, the pediatrician must be enrolled as a pediatrician provider with MAD.
[8.300.22.11 NMAC - N, 8/1/2011; A, 7/1/2012]

8.300.22.12 NATIONAL REGISTRATION AND ATTESTATION SYSTEM: An eligible professional provider or eligible hospital choosing to participate in the medicaid EHR incentive program must register with the CMS national level registry (NLR) and provide demographic information as well as participation choices. The NLR registration process is described in the medicaid EHR incentive program participation instructions.
[8.300.22.12 NMAC - N, 8/1/2011]

8.300.22.13 ATTESTATION REQUIREMENTS: An eligible professional provider or eligible hospital must attest to meeting the medicaid EHR incentive program participation requirements as a prerequisite to receiving payment. Attestation is accomplished through on-line access to the state level registry (SLR) and completion of an agreement. The agreement must be signed by the eligible professional provider or the eligible hospital and when accepted by MAD becomes part of the MAD provider participation agreement or a MAD EHR incentive payment agreement. The medicaid EHR incentive program attestation includes several elements, described in subsequent sections.

A. An eligible professional provider or eligible hospital in their first participation year under the medicaid EHR incentive program may choose to attest to adopting, implementing, or upgrading certified electronic health record (EHR) technology. Proof of A/I/U must be submitted to MAD as part of the attestation.

B. An eligible professional provider in their second through sixth participation year and an eligible hospital in their second through third, or fourth participation year must attest to meaningful use of certified EHR technology. An eligible hospital must attest to meaningful use if they are participating in both the medicare and MAD medicaid EHR incentive programs in their first participation year. The definition of "meaningful EHR user" and "meaningful use" is found in 42 CFR 495.4 and 42 CFR 495.6, respectively.
[8.300.22.13 NMAC - N, 8/1/2011]

8.300.22.14 PAYMENT REQUIREMENTS: An eligible professional provider and eligible hospital may receive yearly payments under the medicaid EHR incentive program. All medicaid EHR incentive program payments are subject to certain conditions.

A. Attestations must be accepted by MAD and the attested items verified pursuant to MAD guidelines.

B. An eligible professional provider or eligible hospital must identify a taxpayer identification number (TIN) to assign payment. Valid entities may be the individual eligible professional provider, a group with which the eligible professional provider s associated or an organization recognized by MAD as a qualified organization promoting the use of EHR technology. The "qualified organization" may not retain more than five percent of the annual medicaid EHR incentive program for those costs unrelated to the certified EHR, which will include salaries and benefits, rent, maintenance, utilities, insurance and travel.

C. The eligible professional or eligible hospital must have a current MAD provider participation agreement or a MAD EHR incentive payment agreement by MAD or its designee.

D. The eligible professional provider or eligible hospital is responsible for repayment of any identified overpayment of the medicaid EHR incentive program funds. MAD will recoup the overpaid funds by reducing any future payments, or through other arrangements as it determines.

[8.300.22.14 NMAC - N, 8/1/2011]

8.300.22.15 PAYMENT CALCULATION: MAD will calculate yearly payment amounts and the total payment amounts based on the guidelines described below.

A. An eligible professional provider may receive a maximum of $63,750 in the incentive payments over six years, unless otherwise reduced or increased by CMS.

(1) An eligible professional provider must initiate registration to receive payment in 2016 in order to participate in the program.

(2) An eligible professional provider may receive payment on an annual or non-consecutive basis for up to six years between 2011 through 2021.

(3) Payment will be made one time per year per eligible professional provider.

(4) To receive an incentive payment in the second, third, fourth, fifth and sixth payment year, the eligible professional provider must demonstrate that it is a meaningful user of EHR technology, as described in 42 CFR 495.4.

	PY 2011	**PY 2012**	**PY 2013**	**PY 2014**	**PY 2015**	**PY 2016**
CY 2011	**$21,250**					
CY 2012	**$8,500**	**$21,250**				
CY 2013	**$8,500**	**$8,500**	**$21,250**			
CY 2014	**$8,500**	**$8,500**	**$8,500**	**$21,250**		
CY 2015	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$21,250**	
CY 2016	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$21,250**
CY 2017		**$8,500**	**$8,500**	**$8,500**	**$8,500**	**$8,500**
CY 2018			**$8,500**	**$8,500**	**$8,500**	**$8,500**
CY 2019				**$8,500**	**$8,500**	**$8,500**
CY 2020					**$8,500**	**$8,500**
CY 2021						**$8,500**
Potential:	***$63,750***	***$63,750***	***$63,750***	***$63,750***	***$63,750***	***$63,750***

B. An eligible hospital aggregated incentive amount calculation will be a one-time, up front calculation for each hospital, based on the methodology described in Paragraph (2) of Subsection B below.

(1) An eligible hospital has a base amount of $2,000,000 for each of four years, plus a discharge-related amount, times the MAD share of the total. The detailed formula is below.

{Sum over four years of [(base amount + discharge related amount applicable for each year) * transition factor applicable for each year]} * [(MAD inpatient-bed-days + MAD managed care inpatient-bed-days) / {(total inpatient-bed-days) * (estimated total charges – charity care charges) / (estimated total charges)}].

(2) MAD will make payment to a hospital as follows:

(a) A hospital will be eligible for funding over three years with payments distributed at 50 percent of the total payment in the first participation year of program enrollment, 40 percent of the total payment in the second participation year of program enrollment, and 10 percent in the third participation year of program enrollment.

(b) MAD will accept the most recent submitted cost reports as the basis for calculation of EHR incentive program payments.

(c) MAD will use the MAD management information system (MMIS) data as the basis for validating hospital MAD eligible recipient volume.

(d) MAD will use the federal fiscal year as the basis for calculation of all measures related to a hospital.

(e) MAD will use the hospital audit agent to support the MAD calculation of each eligible hospital incentive payment, and reach agreement with the eligible hospital and their representative, the New Mexico hospital association on the accuracy of each eligible hospital calculation before submitting the results for payment.

(f) A hospital may not request a re-calculation of the medicaid EHR incentive program payment once the parties have agreed to the base year for the medicare cost report.

[8.300.22.15 NMAC - N, 8/1/2011]

8.300.22.16 AUDIT AND RECORD RETETION: Medicaid EHR incentive program participation and payments are subject to audit and recoupment if determined to be paid improperly. MAD will provide both prepayment verification and post payment audit of the payments made through the medicaid EHR incentive program.

A. MAD expects to verify most aspects of medicaid EHR incentive program eligibility as part of its pre-payment screening, including:

(1) active MAD provider participation agreement for an eligible professional provider and an eligible hospital or a MAD EHR incentive payment agreement;

(2) MAD eligible recipient volume for an eligible professional provider in an independent practice (broken out by FFS and for each contracted MCO);

(3) participation in the group practice identified by the eligible professional provider as meeting the threshold for MAD eligible recipient volume;

(4) total MAD eligible recipient for group practice;

(5) all members of a group use the same methodology for assigning eligible recipients to participating eligible professional providers;

(6) A/I/U certified EHR software for eligible professionals;

(7) not a hospital based provider for eligible professional providers;

(8) hospital eligible recipient volume from audit reports; and

(9) hospital incentive payment calculation (one-time process).

B. MAD may conduct post payment audits of any medicaid EHR incentive program participant. Post payment audits may include any aspect of medicaid EHR incentive program eligibility. An eligible professional provider, group or eligible hospital must maintain and make available documentation to support their participation in the medicaid EHR incentive program. Post payment audits will focus on verification of eligibility components not readily available to MAD as part of normal MAD program administration, including:

(1) validation of total eligible recipient volume, including “needy individuals” for all eligible professional providers;

(2) out-of-state medicaid eligible recipients;

(3) practices predominantly in a FQHC or RHC for eligible professional providers claiming that status; and

(4) meaningful use through meeting objectives for collecting and submitting clinical quality measures.

C. MAD eligible professional providers and eligible hospitals participating in the medicaid EHR incentive program must maintain all documentation supporting their participation in the program for six years from the date of receipt of any payment.

[8.300.22.16 NMAC - N, 8/1/2011]

HISTORY OF 8.300.22 NMAC: [RESERVED]