

STATEMENT OF EMERGENCY

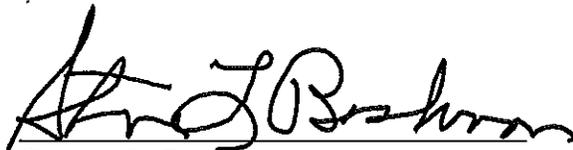
907 KAR 6:005E

(1) This emergency administrative regulation is being promulgated to establish Medicaid electronic health record (EHR) incentive payment policies in accordance with federal law and regulation. EHR incentive payments are payments, authorized by the American Recovery and Reinvestment Act (ARRA), to eligible professionals and eligible hospitals that adopt, implement, upgrade, or demonstrate "meaningful use" of certified EHR technology in the first year of participation or then demonstrate meaningful use for up to five more years of EHR incentive payment program participation.

(2) This action must be implemented on an emergency basis to protect the health, safety, and welfare of Medicaid recipients by offering incentive payments to certain Medicaid providers, including hospitals, to acquire and implement electronic health record technology. The use of electronic health record technology has been proven to enhance patient care across diverse settings including reduced deaths and complications in hospitals. Uses of electronic health records include enabling patient data to be quickly shared, electronic note taking, electronic treatment records, electronic test results, electronic drugs orders, and the use of decision-support systems which can inform clinical staff regarding treatment options and drug interactions.

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.



Steven L. Beshear
Governor



Janie Miller, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Information Systems

4 (New Emergency Administrative Regulation)

5 907 KAR 6:005E. Electronic health record incentive payments.

6 RELATES TO: KRS 205.520(3)

7 STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1),

8 205.520(3), 42 USC 1396b(a)(3)(F), and 42 USC 1396b(t)

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
10 Services, Department for Medicaid Services has responsibility to administer the
11 Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation,
12 to comply with a requirement that may be imposed, or opportunity presented by federal
13 law for the provision of medical assistance to Kentucky's indigent citizenry. This
14 administrative regulation establishes Medicaid electronic health record incentive
15 payment requirements and policies.

16 Section 1. Definitions. (1) "Department" means the Department for Medicaid Services
17 or its designee.

18 (2) "EHR" means electronic health record.

19 (3) "Eligible hospital" is defined in 42 CFR 495.100.

20 (4) "Eligible professional" is defined in 42 CFR 495.100.

21 (5) "Federal financial participation" is defined in 42 CFR 400.203.

1 2. Department's List of Excluded Providers; and

2 (e) Has not have already received an electronic health record incentive payment

3 from:

4 1. Another state within the current program year; or

5 2. Kentucky within the current program year; or

6 (2) An entity shall be an eligible hospital that:

7 (a) Is physically located in the commonwealth of Kentucky; and

8 (b) Is currently enrolled in the Kentucky Medicaid program pursuant to 907 KAR

9 1:672; and

10 (c) Is currently participating in the Kentucky Medicaid program pursuant to 907 KAR

11 1:671.

12 (d) Is not on the:

13 1. United States Department of Health and Human Services, Office of Inspector

14 General's List of Excluded Individuals and Entities; or

15 2. Department's List of Excluded Providers; and

16 (e) Has not have already received an electronic health record incentive payment

17 from:

18 1. Another state within the current program year; or

19 2. Kentucky within the current program year.

20 Section 3. EHR Incentive Payment Provider Scope and Eligibility. To qualify for an
21 EHR incentive payment:

22 (1) An eligible professional shall meet the:

1 (2) An eligible hospital shall meet the:

2 (a) Requirement established in 42 CFR 495.304(e); and

3 (b) Requirements established in Section 2(2) of this administrative regulation.

4 Section 4. Establishing Patient Volume. (1) An eligible:

5 (a) Professional shall establish his or her patient volume in accordance with 42 CFR
6 495.306(a)(1); or

7 (b) Hospital shall establish its patient volume in accordance with 42 CFR
8 495.306(a)(2).

9 (2)(a) The establishment of the patient volume of an eligible professional who
10 practices predominantly in a federally-qualified health center (FQHC) or a rural health
11 clinic (RHC) shall comply with 42 CFR 495.306(c).

12 (b) An eligible professional shall be determined to practice predominantly in an FQHC
13 or RHC if over fifty (50) percent of his or her total patient encounters over a six (6)-
14 month period in the most recent calendar year occurred in an FQHC or an RHC.

15 Section 5. Basis for Determining an EHR Incentive Payment. (1) The department's
16 basis for determining an incentive payment shall be in accordance with 42 CFR
17 495.308.

18 Section 6. EHR Incentive Payment Amounts and Limits. (1) EHR incentive payments
19 to an eligible professional shall be limited pursuant to 42 CFR 495.310(a) through (e).

20 (2) EHR incentive payments to an eligible hospital shall be limited pursuant to 42
21 CFR 495.310(e) and (f).

22 (3)(a) An aggregate EHR hospital incentive payment amount shall be in accordance
23 with 42 CFR 495.310(g).

1 (b) If the department determines that an eligible hospital's data on charity care
2 necessary to calculate the aggregate EHR hospital incentive payment referenced in
3 paragraph (a) of this subsection is unavailable, the department shall determine an
4 approximate proxy for charity care in accordance with 42 CFR 495.310(h).

5 (c) If data, other than data referenced in paragraph (b) of this subsection, does not
6 exist, the department shall deem in accordance with 42 CFR 495.310(i).

7 (4) An eligible hospital may receive EHR incentive payments from Medicare and
8 Medicaid in accordance with 42 CFR 495.310(j).

9 (5) EHR incentive payments to state-designated entities shall be in accordance with
10 42 CFR 495.310(k).

11 Section 7. Payment Process. (1) To receive an EHR incentive payment, a provider
12 shall, in addition to satisfying the EHR incentive payment eligibility requirements
13 established in this administrative regulation, comply with 42 CFR 495.312(b).

14 (2) The department's EHR incentive payment process shall comply with 42 CFR
15 495.312(a) and (c).

16 (3) An EHR incentive payment to an eligible professional or eligible hospital shall
17 be disbursed based on the criteria established in 42 CFR 495.2 through 10.

18 (4) An EHR incentive payment to an eligible:

19 (a) Professional shall be disbursed in accordance with the timeframe established
20 in 42 CFR 495.312(e)(1); or

21 (b) Hospital shall be disbursed in accordance with the timeframe established in
22 42 CFR 495.312(e)(2).

23 Section 8. Activities Required to Receive an Incentive Payment. (1) To receive

1 an EHR incentive payment in the first payment year, an eligible professional or
2 eligible hospital shall comply with the requirements established in 42 CFR
3 495.314(a).

4 (2) To receive an EHR incentive payment in the second, third, fourth, fifth, or sixth
5 payment year, an eligible professional or eligible hospital shall:

6 (a) Meet the requirements established in 42 CFR 495.314(b).

7 Section 9. Meaningful Use Objectives and Measures. (1) An eligible professional
8 shall meet the meaningful use criteria established in 42 CFR 495.6(a), (c), and (d).

9 (2) An eligible hospital shall meet the meaningful use requirements established in 42
10 CFR 495.6(b), (c), and (e).

11 Section 10. Demonstration of Meaningful Use. (1) An eligible professional shall
12 demonstrate, in accordance with 42 CFR 495.8(a), that he or she meets the meaningful
13 use criteria established in 42 CFR 495.6(a), (c), and (d).

14 (2) An eligible hospital shall demonstrate, in accordance with 42 CFR 495.8(b),
15 that it meets the meaningful use requirements established in 42 CFR 495.6(b), (c), and
16 (e).

17 (3) An eligible professional's or eligible hospital's demonstration of meaningful use
18 shall be subject to review by:

19 (a) The department; or

20 (b) The Centers for Medicare and Medicaid Services.

21 Section 11. Meaningful Use Documentation. An eligible professional, eligible hospital
22 or critical access hospital shall maintain documentation supporting their demonstration
23 of meaningful use in accordance with 42 CFR 495.8(c)(2).

1 Section 12. Combating Fraud and Abuse. (1) On any form on which a provider
2 submits information to the department that is necessary to determine the provider's
3 eligibility to receive EHR payments, the provider must include a statement that meets
4 the requirements established in 42 CFR 495.368(b).

5 (2) If an overpayment is due from an eligible professional or eligible hospital to the
6 department, the eligible professional or eligible hospital shall repay the entire
7 overpayment within the timeframe established in 42 CFR 495.368(c).

8 Section 13. Overpayment Dispute Resolution Process Prior to Administrative Hearing.

9 (1)(a) An eligible professional or eligible hospital may appeal the following by first
10 requesting a dispute resolution meeting:

11 1. An incentive payment;

12 2. An incentive payment amount;

13 3. A determination regarding the demonstration of adopting, implementing, or
14 upgrading meaningful use of electronic health record technology;

15 4. An overpayment amount determined by the department to be due from the eligible
16 professional or eligible hospital.

17 (b) A provider may appeal a determination regarding the provider's eligibility for
18 electronic health record incentive payments by first requesting a dispute resolution
19 meeting.

20 (2) A request for a dispute resolution meeting shall:

21 (a) Be in writing and mailed to and received by the department within thirty (30)
22 calendar days of the date the notice was received by the provider;

23 (b) Clearly identify each specific issue and dispute;

1 (c) Clearly state the:

2 1. Basis on which the department's decision on each issue is believed to be

3 erroneous; and

4 2. Name, mailing address, and telephone number of individuals who are expected to

5 attend the dispute resolution meeting on the provider's behalf.

6 (3) The department shall not accept or honor a request for administrative appeals

7 process that is filed prior to receipt of the department's written determination that

8 creates an administrative appeal right.

9 (4)(a) The department or the party requesting a dispute resolution meeting may

10 request the presence of a court reporter at the dispute resolution meeting.

11 (b) If requested, a court reporter shall be secured in advance of a dispute resolution

12 meeting, and a dispute resolution meeting shall not be postponed solely due to the

13 failure to timely secure a court reporter.

14 (5)(a) Except if a court reporter was requested solely by a provider, the department

15 shall bear the cost of a court reporter.

16 (b) Each party shall at all times bear the costs of requested transcribed copies.

17 (6) A dispute resolution meeting involving a court reporter shall:

18 (a) Be conducted face to face; and

19 (b) Not be conducted via telephone.

20 (7) If an administrative hearing is requested at the dispute resolution meeting, the

21 dispute resolution meeting transcript shall become part of the official record of the hearing

22 pursuant to KRS 13B.130.

23 (8)(a) The department shall, within ten (10) calendar days of receipt of the request for

1 a dispute resolution meeting, send a written response to the eligible professional or
2 hospital:

3 1. Identifying the time and place in which the meeting shall be held within thirty (30)
4 days of receipt of the request; and

5 2. Identifying the department's representative who is expected to attend the meeting.

6 (b) A dispute resolution meeting shall be held within forty (40) calendar days of receipt
7 of the request, unless a postponement is requested.

8 (c) A dispute resolution meeting may be postponed for a maximum additional period of
9 sixty (60) calendar days, at the request of either party.

10 (9)(a) A dispute resolution meeting shall be conducted in an informal manner as
11 directed by the department's representative.

12 (b) An eligible professional or hospital may present evidence or testimony at a dispute
13 resolution meeting to support the case.

14 (c) Each party at a dispute resolution meeting shall be given an opportunity to ask
15 questions to clarify the disputed issue or issues.

16 (10)(a) An eligible professional, eligible hospital, or provider may, within the same
17 deadline specified in subsection (2) of this section, submit information they wish to be
18 considered in relation to the department's determination without requesting a dispute
19 resolution meeting.

20 (b) A submission of additional documentation shall not extend the thirty (30) day time
21 period for requesting a resolution meeting.

22 (11) The department, after the dispute resolution meeting or the date the information
23 to be considered was presented to the department as established in subsection (10) of

1 of this section, shall within thirty (30) calendar days:

2 (a) Uphold, rescind, or modify the original decision with regard to the disputed issue;

3 and

4 (b) Provide written notice to the eligible professional or hospital of:

5 1. The department's decision; and

6 2. The facts upon which the decision was based with reference to applicable statutes
7 or administrative regulations.

8 (12) Information submitted for the purpose of informally resolving a provider dispute
9 shall not be considered a request for an administrative hearing.

10 (13) The department may waive a dispute resolution meeting, at its sole discretion,
11 and issue a decision in lieu of the meeting, with the decision subject to administrative
12 hearing policies established in 907 KAR 1:671.

13 (14)(a) The department may postpone issuing its findings of a dispute resolution
14 meeting, or its review of the materials submitted in lieu of a dispute resolution meeting,
15 by mailing a written notice to the eligible professional, eligible hospital, or provider
16 stating the:

17 1. Reason for the delay; and

18 2. Anticipated completion date of the review.

19 (b) A postponement referenced in paragraph (a) of this subsection shall not extend
20 beyond 180 days.

21 Section 14. Administrative Hearing. (1) An administrative hearing shall be conducted in
22 accordance with KRS Chapter 13B by a hearing officer who is knowledgeable of Medicaid
23 policy, as established in federal and state laws.

1 (2) The secretary of the cabinet, pursuant to KRS 13B.030(1), shall delegate by
2 administrative order conferred powers to conduct administrative hearings under 907
3 KAR 1:671.

4 (3) The department shall not accept or honor a request for administrative appeals
5 process by an eligible professional or hospital that is:

6 (a) Filed at the state level for a federal-mandated exclusion subsequent to a federal
7 notice of the exclusion containing the federal appeal rights; or

8 (b) Filed at the state level for program exclusion resulting

9 (b) Filed at the state level for program exclusion resulting from a criminal conviction
10 by the court of competent jurisdiction, upon exhaustion or failure to timely pursue the
11 judicial appeal process.

12 (4) The administrative hearing process shall be used to appeal:

13 (a) An incentive payment;

14 (b) An incentive payment amount;

15 (c) A determination regarding a provider's demonstration of adopting, implementing, or
16 upgrading meaningful use of electronic health record technology;

17 (d) An overpayment amount determined by the department to be due from a

18 (d) An overpayment amount determined by the department to be due from the eligible
19 provider;

20 (e) A determination regarding a provider's eligibility for electronic health record
21 incentive payments by first requesting a dispute resolution meeting;

22 (f) A department's requirement of a provider to repay an electronic health record
23 incentive payment overpayment; or

1 (g) A department's withholding of a provider's payments in accordance with 907 KAR
2 1:671.

3 (5)(a) For a written request for an administrative hearing to be timely, the written
4 request for an administrative hearing shall be received by the department within thirty (30)
5 calendar days of the date of receipt of the department's notice of a determination or a
6 dispute resolution decision.

7 (b) A written request for an administrative hearing shall be sent to the Office of the
8 Commissioner, Department for Medicaid Services, Cabinet for Health and Family
9 Services, 275 East Main Street, 6th Floor, Frankfort, Kentucky 40621-0002.

10 (6) The department shall forward to the hearing officer an administrative record which
11 shall include:

12 (a) The notice of action taken;

13 (b) The statutory or regulatory basis for the action taken;

14 (c) The department's decision following the dispute resolution meeting process; and

15 (d) All documentary evidence provided by the:

16 1. Eligible professional, eligible hospital, or provider; or

17 2. The eligible professional's, eligible hospital's, or provider's billing agent,
18 subcontractor, fiscal agent, or another individual authorized by the eligible professional,
19 eligible hospital, or provider to provide information regarding the matter to the department.

20 (7) A notice of an administrative hearing shall comply with KRS 13B.050.

21 (a) An administrative hearing shall be held in Frankfort, Kentucky no later than sixty
22 (60) calendar days from the date the request for the administrative hearing is received by
23 the department.

1 (b) An administrative hearing date may be extended beyond the sixty (60) calendar
2 days by:

3 1. A mutual agreement between the:

4 a. Eligible profession, eligible hospital, or provider; and

5 b. The department; or

6 2. A continuance granted by the hearing officer.

7 (8) If a prehearing conference is requested, it shall be held at least seven (7) calendar
8 days in advance of the hearing date.

9 (9) Conduct of a prehearing conference shall comply with KRS 13B.070.

10 (10) If an eligible professional, eligible hospital, or provider does not appear at a
11 hearing on the scheduled date and the hearing has not been previously rescheduled, the
12 hearing officer may find the eligible professional, eligible hospital, or provider in default
13 pursuant to KRS 13B.050(3)(h).

14 (11) A hearing request shall be withdrawn only under the following circumstances:

15 (a) The hearing officer receives a written statement from an eligible professional,
16 eligible hospital, or provider stating that the request is withdrawn; or

17 (b) An eligible professional, eligible hospital, or provider makes a statement on the
18 record at the hearing that the eligible professional, eligible hospital, or provider is
19 withdrawing the request for the hearing.

20 (12) Documentary evidence to be used at a hearing shall be made available in
21 accordance with KRS 13B.090.

22 (13) Information relating to the selection of an eligible professional, eligible hospital, or
23 provider for audit, investigation notes or other materials which may disclose auditor

1 investigative techniques, methodologies, material prepared for submission to a law
2 enforcement or prosecutorial agency, information concerning law enforcement
3 investigations, judicial proceedings, confidential sources or confidential information shall
4 not be revealed, unless exculpatory in nature as required pursuant to KRS 13B.090(3).

5 (14) A hearing officer shall preside over a hearing and shall conduct the hearing in
6 accordance with KRS 13B.080 and 13B.090.

7 (15) The issues considered at a hearing shall be limited to:

8 (a) Issues directly raised in the initial request for a dispute resolution meeting;

9 (b) Issues directly raised during the disputed resolution meeting; or

10 (c) Materials submitted in lieu of a dispute resolution meeting.

11 (16) KRS 13B.090(7) shall govern the burdens of proof.

12 (a) The department shall have the initial burden of showing the existence of the
13 administrative regulations or statutes upon which a determination was based.

14 (b) If a determination is based upon an alleged failure of a provider to comply with
15 applicable generally accepted business, accounting, professional, medical practices or
16 standards of health care, the department shall establish the existence of the practice or
17 standard.

18 (c) The department shall be responsible for notifying the hearing officer of previous
19 relevant violations by the eligible professional, eligible hospital, or provider under
20 Medicare, Medicaid, or other program administered by the Cabinet for Health and Family
21 Services, or relevant prior actions under 907 KAR 1:671, which the department wishes
22 the hearing officer to consider in his or her deliberations.

23 (17) A hearing officer shall issue a recommended order in accordance with KRS

1 13B.110.

2 (18)(a) Except for the requirement that a request for an administrative appeal process
3 be filed in a timely manner, a hearing officer may grant an extension of time specified in
4 this section, if:

- 5 1. Determined necessary for the efficient administration of the hearing process; or
- 6 2. To prevent an obvious miscarriage of justice with regard to the provider.

7 (b) An extension of time for completion of a recommended order shall comply with the
8 requirements of KRS 13B.110(2) and (3).

9 (19) A final order shall be entered in accordance with KRS 13B.120.

10 (20) The Cabinet for Health and Family Services shall maintain an official record of the
11 hearing in compliance with KRS 13B.130.

12 (21) In a correspondence transmitting a final order, clear reference shall be made to
13 the availability of judicial review pursuant to KRS 13B.140 and 13B.150.

14 (22) The department's appeal process for an eligible professional, eligible hospital, or
15 provider regarding electronic health record incentive payments.

16 (22) The department's appeal process for an eligible professional, eligible hospital, or
17 provider regarding electronic health record incentive payments shall be in accordance
18 with 42 CFR 495.370.

19 Section 15. Actions Taken at the Conclusion of the Administrative Appeal Process. (1)

20 A stay on recoupment granted under 907 KAR 1:671 shall not extend to judicial review,
21 unless a stay is granted pursuant to KRS 13B.140(4).

22 (2) If during an administrative appeal process, circumstances require a new or
23 modified determination letter, new appeal rights shall be provided in accordance with

1 this administrative regulation.

2 (3) Thirty (30) calendar days after the issuance of the final order pursuant to KRS

3 13B.120, the department:

4 (a) Shall initiate collection activities and take all lawful actions to collect the debt; and

5 (b) May enact:

6 1. An exclusion or fiscal penalty pursuant to 42 USC 1320a-7; or

7 2. Other action that was held in abeyance pending the decision of the administrative

8 appeal process.

9 (4) A department's decision to subject an eligible professional's, eligible hospital's or
10 provider's claims to prepayment review shall not be subject to appeal.

11 Section 17. Federal Financial Participation. A policy established in this administrative
12 regulation shall be null and void if the Centers for Medicare and Medicaid Services:

13 (1) Denies federal financial participation for the policy; or

14 (2) Disapproves the policy.

907 KAR 6:005E

REVIEWED:

20 DEC 10
Date

Neville J. Wise
Neville Wise, Acting Commissioner
Department for Medicaid Services

APPROVED:

12/20/10
Date

Janie Miller
Janie Miller, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 6:005E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This is a new administrative regulation which establishes Medicaid electronic health record (EHR) incentive payment policies in accordance with federal law and regulation. EHR incentive payments are payments, authorized by the American Recovery and Reinvestment Act (ARRA), to eligible professionals and eligible hospitals that adopt, implement, upgrade, or demonstrate "meaningful use" of certified EHR technology in the first year of participation or then demonstrate meaningful use for up to five more years of EHR incentive payment program participation. The program is not mandated upon states, but Kentucky's Medicaid program has elected to implement the program and in the first possible year of implementation – 2011 (specifically January 3, 2011 is the first day Medicaid programs are allowed to launch the initiative.) Eligible professionals may receive up to \$63,750 in aggregate in incentive payments if they participate in the program for six years. Eligible professionals include physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants (if the physician assistant practices in a rural health clinic or federally-qualified health center under the supervision of a physician assistant.) There is no limit to how much eligible hospitals may receive. Eligible hospitals include acute care hospitals, children's hospitals (but Kentucky currently has none), and critical access hospitals.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to enable the Department for Medicaid Services (DMS) to make EHR incentive payments to eligible hospitals and professionals as authorized by the American Recovery and Reinvestment Act (ARRA.)
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing EHR incentive payment policies in accordance with federal law and regulation.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing EHR incentive payment policies in accordance with federal law and regulation.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

- (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
 - (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
 - (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: The Department for Medicaid Services (DMS) examined past claims data and estimates that of 22,741 Medicaid (non-hospital) providers (for example, physicians, nurse practitioners, etc.) who are in the umbrella of provider types eligible for electronic health record (EHR) incentive payments (or “eligible professionals”), that 2,450 could feasibly meet the Medicaid patient volume threshold to qualify for EHR incentive payments. DMS estimates that only 85% (2,162) of those will actually acquire the certified EHR technology necessary to qualify for the incentive payments. The eligible professional provider types include physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants (if the physician assistant practices in a rural health clinic or federally-qualified health center under the supervision of a physician assistant. Medicaid recipients will also benefit from this administrative regulation.

DMS anticipates that of the sixty-five (65) acute care hospitals participating in the Kentucky Medicaid program, that sixty-one (61) will meet the Medicaid patient volume threshold (10%) necessary to qualify for EHR incentive payments.

DMS anticipates that of the twenty-nine (29) critical access hospitals participating in the Kentucky Medicaid program, that seventeen (17) will meet the Medicaid patient volume threshold necessary (10%) to qualify for EHR incentive payments.

- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: In order to qualify for electronic health record incentive payments, eligible professionals and eligible hospitals will have to adopt, implement, upgrade, or demonstrate “meaningful use” of certified EHR technology in the first year of participation or then demonstrate meaningful use for up to five more years of EHR incentive payment program participation. An eligible professional cannot begin receiving an EHR incentive payment any later than calendar year 2016 and an eligible hospital cannot begin receiving incentive payments any time after federal fiscal year 2016 (October 1, 2016 through September 30, 2017); thus, individuals and entities must act prior to those respective deadlines in order to qualify for incentive payments.

and certified by an "Authorized Testing and Certification Body (ATCB) endorsed by the national federal entity – Office of National Coordinator – in order to qualify for incentive payments. The technologies which have been approved by the ONC ATCB are listed on the ONC website.

- (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). Individuals or entities will have to purchase the requisite certified EHR technology in order to qualify for EHR incentive payments.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Eligible professionals (individuals) and eligible hospitals who choose to pursue (and meet all requirements) electronic health record (EHR) incentive payments will receive incentive payments. The maximum amount of incentive payments an eligible professional may receive is \$63,500 and there is no maximum amount for eligible hospitals. The Kentucky Hospital Association (KHA) provided DMS with estimates which indicate that the lowest amount of incentive payments in aggregate that a participating acute care hospital will receive will be over \$596,000 and the highest amount a participating acute care hospital will receive will be over \$5.7 million. Medicaid recipients will benefit from the adoption and meaningful use of electronic health record technology by receiving enhanced care and across diverse settings including reduced deaths and complications in hospitals. Uses of electronic health records include enabling patient data to be quickly shared, electronic note taking, electronic treatment records, electronic test results, electronic drugs orders, and the use of decision-support systems which can inform clinical staff regarding treatment options and drug interactions. The use of EHR can also improve preventive medicine by enhancing screening – as reminders (for screenings) can be generated by electronic medical date and sent to patients. A Harvard Medical School study showed that such reminders sent to patients resulted in the patients being more likely to get screened in contrast to when reminders were only sent to physicians.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: DMS estimates that 127 eligible professionals (i.e. non-hospital) will qualify for EHR incentive payments in calendar year (CY) 2011 and that DMS will make \$2,638,987 (100% federal) in incentive payments to those eligible professionals in CY 2011. DMS estimates that sixty-one (61) of sixty-five (65) acute care hospitals will qualify for EHR incentive payments in CY 2011 and that it will make \$52,979,461 (100% federal) in incentive payments to those hospitals in CY 2011. DMS estimates that seventeen (17) of twenty-nine (29) critical access hospitals will qualify for EHR incentive payments in CY 2011 and that it will make \$6,872,308 (100% federal) in incentive payments to those hospitals in CY 2011.
 - (b) On a continuing basis: DMS estimates that in CY 2012 it will make: \$6,317,991 (100% federal) in incentive payments to eligible professionals;

\$42,383,569 (100% federal) in incentive payments to sixty-one (61) acute care hospitals; and
\$3,436,154 (100% federal) in incentive payments to seventeen (17) critical access hospitals.

DMS estimates that in CY 2013 it will make:

\$11,045,507 (100% federal) in incentive payments to eligible professionals;
\$10,595,892 (100% federal) in incentive payments to sixty-one (61) acute care hospitals; and
\$2,061,692 (100% federal) in incentive payments to seventeen (17) critical access hospitals.

DMS estimates that in CY 2014 it will make:

\$16,828,621 (100% federal) in incentive payments to eligible professionals;
\$0 in incentive payments to acute care hospitals as DMS anticipates the hospitals will have met the maximum incentive payment amount by the end of CY 2013; and
\$1,374,462 (100% federal) in incentive payments to seventeen (17) critical access hospitals

DMS estimates that in CY 2015 it will make:

\$21,053,841 (100% federal) in incentive payments to eligible professionals;
\$0 in incentive payments to acute care hospitals as DMS anticipates the hospitals will have met the maximum incentive payment amount by the end of CY 2013; and
\$0 in incentive payments to critical access hospitals as DMS anticipates the hospitals will have met the maximum incentive payment amount by the end of CY 2014; and

DMS estimates that in CY 2016 it will make:

\$22,665,571 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2017 it will make:

\$17,025,532 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2018 it will make:

\$14,863,345 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2019 it will make:

\$11,719,218 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2020 it will make:

\$7,493,999 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2021 it will make:

\$3,243,281 (100% federal) in incentive payments to eligible professionals.

As DMS anticipates that new eligible professionals will gradually participate in the EHR incentive payment program and that participating eligible professionals will hit the maximum payment threshold along the way, DMS is not indicating the projected number of eligible professionals beyond the first year (calendar year 2011) in this estimate.

DMS estimates that it will make a total amount of incentive payments by category as follows:

\$134,895,894 to eligible professionals;
\$105,958,922 to acute care hospitals; and
\$13,744,615 to critical access hospitals.

- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are 100% federal funds authorized under the American Recovery and Reinvestment Act (ARRA.)
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is applied as incentive payment requirements and amounts vary according to provider category. For example, the requirements and amounts for "eligible professionals" differs from those of acute care hospitals and critical access hospitals.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 6:005E

Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. Electronic health record (HER) incentive payments are not mandated; however, they are authorized by federal laws 42 USC 1396b(a)(3)(F) and 42 USC 1396b(t) and federal regulations 42 CFR 495.2 through 10 and 42 CFR 495.300 through 370.
2. State compliance standards. KRS 205.520(3) states, "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."
3. Minimum or uniform standards contained in the federal mandate. EHR incentive payments are not mandated.
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 6:005E

Agency Contact Person: Stuart Owen (502) 564-4321

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes X No

If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation and eligible hospitals which are owned by local government will be affected. The following eligible hospitals which are expected to participate in the electronic health record incentive (EHR) payments are owned by local government: Crittenden Health System, Fleming County Hospital, Hardin Memorial Hospital, Murray-Calloway County Hospital, Taylor Regional Hospital and Westlake Regional Hospital.

Two state-owned hospitals, UK Healthcare and University of Louisville Hospital, plan to participate in the EHR incentive payment program.

3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 CFR 495.2 through 10 and 42 CFR 495.300 through 370.
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

- (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? Projected revenues by hospital by calendar year (CY) are as follows:

Hospital	CY 2011	CY 2012	CY 2013
University of Louisville Hospital	\$2,272,151	\$1,817,720	\$454,430
UK Healthcare	\$2,851,921	\$2,281,537	\$570,384
Crittenden Health System	\$332,429	\$265,943	\$66,486
Fleming County Hospital	\$321,688	\$257,350	\$64,338
Hardin Memorial Hospital	\$957,429	\$765,943	\$191,486
Murray-Calloway Co. Hospital	\$522,320	\$417,856	\$104,464

Hospital	CY 2011	CY 2012	CY 2013
Taylor Regional Hospital	\$522,320	\$417,856	\$104,464
Westlake Regional Hospital	\$561,077	\$448,862	\$112,215

- (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? Projected revenues by hospital by calendar year (CY) are as follows:

Hospital	CY 2011	CY 2012	CY 2013
University of Louisville Hospital	\$2,272,151	\$1,817,720	\$454,430
UK Healthcare	\$2,851,921	\$2,281,537	\$570,384
Crittenden Health System	\$332,429	\$265,943	\$66,486
Fleming County Hospital	\$321,688	\$257,350	\$64,338
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Taylor Regional Hospital	\$522,320	\$417,856	\$104,464
Westlake Regional Hospital	\$561,077	\$448,862	\$112,215

- (c) How much will it cost to administer this program for the first year? DMS estimates that 127 eligible professionals (i.e. non-hospital) will qualify for EHR incentive payments in calendar year (CY) 2011 and that DMS will make \$2,638,987 (100% federal) in incentive payments to those eligible professionals in CY 2011. DMS estimates that sixty-one (61) of sixty-five (65) acute care hospitals will qualify for EHR incentive payments in CY 2011 and that it will make \$52,979,461 (100% federal) in incentive payments to those hospitals in CY 2011. DMS estimates that seventeen (17) of twenty-nine (29) critical access hospitals will qualify for EHR incentive payments in CY 2011 and that it will make \$6,872,308 (100% federal) in incentive payments to those hospitals in CY 2011.

- (d) How much will it cost to administer this program for subsequent years? DMS estimates that in CY 2012 it will make:

\$6,317,991 (100% federal) in incentive payments to eligible professionals;
\$42,383,569 (100% federal) in incentive payments to sixty-one (61) acute care hospitals; and
\$3,436,154 (100% federal) in incentive payments to seventeen (17) critical access hospitals.

DMS estimates that in CY 2013 it will make:

\$11,045,507 (100% federal) in incentive payments to eligible professionals;
\$10,595,892 (100% federal) in incentive payments to sixty-one (61) acute care hospitals; and
\$2,061,692 (100% federal) in incentive payments to seventeen (17) critical access hospitals.

DMS estimates that in CY 2014 it will make:

\$16,828,621 (100% federal) in incentive payments to eligible professionals;
\$0 in incentive payments to acute care hospitals as DMS anticipates the hospitals will have met the maximum incentive payment amount by the end of CY 2013; and
\$1,374,462 (100% federal) in incentive payments to seventeen (17) critical access hospitals

DMS estimates that in CY 2015 it will make:

\$21,053,841 (100% federal) in incentive payments to eligible professionals;
\$0 in incentive payments to acute care hospitals as DMS anticipates the hospitals will have met the maximum incentive payment amount by the end of CY 2013; and
\$0 in incentive payments to critical access hospitals as DMS anticipates the hospitals will have met the maximum incentive payment amount by the end of CY 2014; and

DMS estimates that in CY 2016 it will make:

\$22,665,571 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2017 it will make:

\$17,025,532 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2018 it will make:

\$14,863,345 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2019 it will make:

\$11,719,218 (100% federal) in incentive payments to eligible professionals.

DMS estimates that in CY 2020 it will make:

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will hit the maximum payment threshold along the way, DMS is not indicating the projected number of eligible professionals beyond the first year (calendar year 2011) in this estimate.

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