

§ 495.330 Termination of FFP for failure to provide access to information.

(a) HHS terminates FFP at any time if the Medicaid agency fails to provide State and Federal representatives with full access to records relating to HIT planning and implementation efforts, and the systems used to interoperate with electronic HIT, including on-site inspection.

(b) The Department may request such access at any time to determine whether the conditions in this subpart are being met.

§ 495.332 State Medicaid health information technology (HIT) plan requirements.

Each State Medicaid HIT plan must include all of the following elements:

(a) *State systems.* For State systems, interoperability, and the current and future visions:

(1) A baseline assessment of the current HIT landscape environment in the State including the inventory of existing HIT in the State. The assessment must include a comprehensive—

(i) Description of the HIT “as-is” landscape;

(ii) Description of the HIT “to-be” landscape; and

(iii) HIT roadmap and strategic plan for the next 5 years.

(2) A description of how the State Medicaid HIT plan will be planned, designed, developed and implemented, including how it will be implemented in accordance with the Medicaid Information Technology Architecture (MITA) principles as described in the Medicaid Information Technology Framework 2.0. The MITA initiative—

(i) Establishes national guidelines for technologies and processes that enable improved program administration for the Medicaid enterprise;

(ii) Includes business, information and technology architectures that provide an overall framework for interoperability, as well as processes and planning guidelines for enabling State Medicaid enterprises to meet common objectives within the framework while supporting unique local needs; and

(iii) Is important to the design and development of State EHR incentive payment systems.

(3) A description of how intrastate systems, including the Medicaid Management Information System (MMIS) and other automated mechanized claims processing and information retrieval systems—

(i) Have been considered in developing a HIT solution; and

(ii) A plan that incorporates the design, development, and implementation phases for interoperability of such State systems with a description of how any planned systems enhancements support overall State and Medicaid goals.

(4) A description of data-sharing components of HIT solutions.

(5) A description of how each State will promote secure data exchange, where permissible under the Health Insurance Portability and Accountability Act (HIPAA) and other requirements included in ARRA.

(6) A description of how each State will promote the use of data and technical standards to enhance data consistency and data sharing through common data-access mechanisms.

(7) A description of how each State will support integration of clinical and administrative data.

(8) A description of the process in place for ensuring improvements in health outcomes, clinical quality, or efficiency resulting from the adoption of certified EHR technology by beneficiaries of Medicaid incentive payments and a methodology for verifying such information.

(9) A description of the process in place for ensuring that any certified EHR technology used as the basis for a payment incentive to Medicaid providers is compatible with State or Federal administrative management systems, including the MMIS or other automated claims processing system or information retrieval system and a methodology for verifying such information.

(10) A description of how each State will adopt national data standards for health and data exchange and open standards for technical solutions as they become available.

(11) A description of how the State intends to address the needs of underserved and vulnerable populations such as children, individuals with chronic

conditions, Title IV–E foster care children, individuals in long-term care settings and the aged, blind, and disabled. This description must address the following:

- (i) Person centered goals and objectives and shared decision-making;
- (ii) Coordination of care across multiple service providers, funding sources, settings, and patient conditions—
- (iii) Universal design to ensure access by people with disabilities and older Americans; and
- (iv) Institutional discharge planning and diversion activities that are tied to community based service availability.

(b) *Eligibility.* For eligibility, a description of the process in place for all of the following:

(1) For ensuring that each EP and eligible hospital meets all provider enrollment eligibility criteria upon enrollment and re-enrollment to the Medicaid EHR payment incentive program.

(2) For ensuring patient volume consistent with the criteria in §§495.304 and 495.306 for each EP who practices predominantly in a FQHC or RHC and for each Medicaid EP who is a physician, pediatrician, nurse practitioner, certified nurse midwife or dentist and a methodology in place used to verify such information.

(3) For ensuring that the EP or eligible hospital is a provider who meets patient volume consistent with the criteria in §§495.304 and 495.306 and a methodology in place used to verify such information.

(4) For ensuring that each Medicaid EP is not hospital-based and a methodology in place used to verify such information.

(5) To ensure that a hospital eligible for incentive payments has demonstrated an average length of stay of 25 days or less and a methodology for verifying such information.

(6) For ensuring that at least one clinical location used for the calculation of the EP's patient volume has Certified EHR Technology during the payment year for which the EP is attesting.

(c) *Monitoring and validation.* Subject to paragraph (g) of this section, for monitoring and validation of information States must include the following:

(1) A description of the process in place for ensuring that, because of CMS' and the States' oversight responsibilities, all provider information for attestations including meaningful use, efforts to adopt, implement, or upgrade and any information added to the CMS Single Provider Repository including all information related to patient volume, NPI, Tax identification number (TIN), are all true and accurate and that any concealment or falsification of a material fact related to the attestation may result in prosecution under Federal and State laws and a methodology in place used to verify such information.

(2) A description of the process in place for ensuring that the EP or eligible hospital is eligible to receive an incentive payment consistent with the criteria outlined in §495.314 and a methodology in place used to verify such information.

(3) A description of the process in place for capturing attestations from each EP or eligible hospital that they have meaningfully used certified EHR technology during the EHR reporting period, and that they have adopted, implemented, or upgraded certified EHR technology and a description of the methodology in place used to verify such information.

(4) A description of the process in place for capturing clinical quality data from each EP or eligible hospital and a description of the methodology in place used to verify such information.

(5) A description of the process in place for monitoring the compliance of providers coming onto the program with different requirements depending upon their participation year and a methodology for verifying such information.

(6) A list of the specific actions planned to implement the EHR incentive program, including a description and organizational charts for workgroups within State government including external partners.

(7) A description of the process in place to ensure that no amounts higher than 100 percent of FFP will be claimed by the State for reimbursement of expenditures for State payments to Medicaid eligible providers for the certified

EHR technology incentive payment program and a methodology for verifying such information.

(8) A description of the process in place to ensure that no amounts higher than 90 percent of FFP will be claimed by the State for administrative expenses in administering the certified EHR technology incentive payment program and a methodology for verifying such information.

(9) A description of the process and methodology for ensuring and verifying the following:

(i) Amounts received under section 1903(a)(3)(F) of the Act with respect to payments to a Medicaid EP or eligible hospital are paid directly to such provider (or to an employer or facility to which such provider has assigned payments) without any deduction or rebate.

(ii) All incentive payment reassignments to an entity promoting the adoption of certified EHR technology, as designated by the State, are voluntary for the Medicaid EP involved.

(iii) Entities promoting the adoption of certified EHR technology do not retain more than 5 percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training) that is for, or is necessary for the operation of, such technology.

(10) A description of the process in place for ensuring that each Medicaid EP or eligible hospital that collects an EHR payment incentive has collected a payment incentive from only one State even if the provider is licensed to practice in multiple States and a methodology for verifying such information.

(11)(i) A description of the process in place for ensuring that each EP or eligible hospital that wishes to participate in the EHR incentive payment program will receive a NPI; and

(ii) A description of how the NPI will be used to coordinate with the CMS so that the EP will choose only one program from which to receive the incentive payment and the hospital payments are tracked accordingly.

(12) A description of the process in place for ensuring that each EP or eligible hospital who wishes to participate in the EHR incentive payment program will provide a TIN to the

State for purposes of the incentive payment.

(d) *Payments.* For payments, States must provide descriptions of the following processes that are in place:

(1) The process in place for ensuring that there is no duplication of Medicare and Medicaid incentive payments to EPs and a methodology for verifying such information.

(2) The process in place to ensure that any existing fiscal relationships with providers to disburse the incentive payments through Medicaid managed care plans does not result in payments that exceed 105 percent of the capitation rate, in order to comply with the Medicaid managed care incentive payment rules at § 438.6(b)(2) of this chapter and a methodology for verifying such information.

(3) The process in place to ensure that only appropriate funding sources are used to make Medicaid EHR incentive payments and the methodology for verifying such information.

(4) The process in place and the methodology for verifying that information is available in order to ensure that Medicaid EHR incentive payments are made for no more than a total of 6 years; that no EP or eligible hospital begins receiving payments after 2016; that incentive payments cease after 2021; and that an eligible hospital does not receive incentive payments after FY 2016 unless the hospital received an incentive payment in the prior fiscal year.

(5) The process in place to ensure that Medicaid EHR incentive payments are not paid at amounts higher than 85 percent of the net average allowable cost of certified EHR technology and the yearly maximum allowable payment thresholds and a methodology for verifying such information.

(6) The process in place to ensure that all hospital calculations and hospital payment incentives are made consistent with the requirements of this part and a methodology for verifying such information.

(7) The process in place to provide for the timely and accurate payment of incentive payments to EPs and eligible hospitals, including the timeframe specified by the State to meet the timely payment requirement.

(8) The process in place and a methodology for verifying such information to provide that any monies that have been paid inappropriately as an improper payment or otherwise not in compliance with this subpart will be recouped and FFP will be repaid.

(e) *For combating fraud and abuse and for provider appeals.* (1) A description of the process in place for a provider to appeal consistent with the criteria described in § 495.370 and a methodology for verifying the following related to the EHR incentives payment program:

- (i) Incentive payments.
- (ii) Provider eligibility determinations.
- (iii) Demonstration of efforts to adopt, implement or upgrade and meaningful use eligibility for incentive payments under this part.

(2) A description of the process in place, and a methodology for verifying such information, to address Federal 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 (32 U.S.C. 3729 *et seq.*), and the anti-kickback statute (section 1128B(b) of the Act).

(f) *Optional—proposed alternatives.* A State may choose to propose any of the following, but they must be included as an element in the State Medicaid HIT Plan for review and approval:

(1) An alternative methodology for measuring patient volume, consistent with § 495.306(g).

(2)(i) A revised definition of meaningful use of certified EHR technology consistent with §§ 495.4 and 495.316(d)(2) of this part.

(ii) Any revised definition of meaningful use may not require additional functionality beyond that of certified EHR technology and conform with CMS guidance on Stage 1. See also § 495.316(d)(2).

(3) An alternative date within CY 2021 by which all “EHR reporting periods” (as defined under § 495.4) for the CY 2021 payment year for Medicaid EPs demonstrating they are meaningful EHR users must end. The alternative date selected by the state must be earlier than October 31, 2021, and must not be any earlier than the day prior to the

attestation deadline for Medicaid EPs attesting to that state.

(4) An alternative date within CY 2021 by which all clinical quality measure reporting periods for the CY 2021 payment year for Medicaid EPs demonstrating they are meaningful EHR users must end. The alternative date selected by the state must be earlier than October 31, 2021, and must not be any earlier than the day prior to the attestation deadline for Medicaid EPs attesting to that state.

(5) For the CY 2019 payment year and beyond, a state-specific listing of which clinical quality measures selected by CMS are considered to be high priority measures for purposes of Medicaid EP clinical quality measure reporting.

(g) *Optional—signed agreement.* At the State’s option, the State may include a signed agreement indicating that the State does all of the following:

(1) Designates CMS to conduct all audits and appeals of eligible hospitals’ meaningful use attestations.

(2) Is bound by the audit and appeal findings described in paragraph (g)(1) of this section.

(3) Performs any necessary recoupments if audits (and any subsequent appeals) described in paragraph (g)(1) of this section determine that an eligible hospital was not a meaningful EHR user.

(4) Is liable for any FFP granted to the State to pay eligible hospitals that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users.

[75 FR 44565, July 28, 2010, as amended at 77 FR 54162, Sept. 4, 2012; 81 FR 27901, May 6, 2016; 83 FR 60096, Nov. 23, 2018]

§ 495.334 [Reserved]

§ 495.336 Health information technology planning advance planning document requirements (HIT PAPD).

Each State’s HIT PAPD must contain the following:

(a) A statement of need and objective which clearly state the purpose and objectives of the project to be accomplished and the necessity for the project.

(b) A project management plan which addresses the following: