Agency
Department of Social Services

Subject
Electronic Health Records Incentive Program

Inclusive Sections
§§ 17b-34-1—17b-34-9

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Electronic Health Records Incentive Program

Sec. 17b-34-1. Scope

The department distributes Electronic Health Record Incentive Program payments to eligible providers who meet the criteria set forth in 42 CFR 495.2 to 42 CFR 495.10, inclusive, and 42 CFR 495.300 to 42 CFR 495.370, inclusive. Eligible providers include: Physicians, nurse practitioners, certified nurse-midwives, dentists, physician assistants, acute care hospitals and children's hospitals. Eligible providers shall meet applicable federal and state requirements, including licensure and scope of practice requirements.

(Effective January 13, 2013)

Sec. 17b-34-2. Definitions

Unless otherwise defined in this section, the definitions provided in 42 CFR 495.4 and 42 CFR 495.302 apply to sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies. As used in sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Adopt, implement or upgrade" or "AIU" means one or more of the following:

(A) Acquire, purchase or install a certified EHR system;

(B) install or commence use of a certified EHR system and have started one of the following: A training program for the certified EHR system; data entry of patient demographic and administrative data into the EHR; or establishment of data exchange agreements and a relationship between the provider's certified EHR system and health information exchanges or other providers including, but not limited to, laboratories and pharmacies;

(C) expand available functionality of certified EHR technology capable of meeting meaningful use requirements at a practice site, including staffing, maintenance and training; or

(D) upgrade from existing EHR technology to certified EHR technology, including, but not limited to, upgrades to the addition of clinical decision support, e-prescribing functionality and computerized physician order entry;

(2) "Certified electronic health record" or "certified EHR" means EHR technology certified in accordance with the EHR certification criteria of the Office of the National Coordinator for Health Information Technology;

(3) "CMS" means the Centers for Medicare and Medicaid Services;

(4) "Commissioner" means the Commissioner of Social Services or the commissioner's designee;

(5) "Department" means the Department of Social Services or its agent;

(6) "Electronic health record" or "EHR" means a systematic collection of electronic health information on individual patients in a digital format that includes a range of data in comprehensive or summary form, such as: Demographics; medical history; medication; medication allergies; immunization status; laboratory test results; radiology images; vital signs; and personal statistics such as age, weight and billing information;

(7) "Electronic Health Record Incentive Program" or "EHR Incentive Program" means the incentive program established pursuant to section 17b-34 of the Connecticut General Statues and authorized by 42 USC 1396b(a)(3)(F) and 42 USC 1396b(t), that enables providers to receive funding from the department to promote AIU and meaningful use;

(8) "Eligible hospital" means a children's hospital or an acute care hospital, as such terms are defined in 42 CFR 495.302;

(9) "Eligible professional" or "EP" means a professional as described in 42 CFR 495.304(b) to 42 CFR 495.304(d), inclusive;

(10) "Hospital-based EP" means an EP who furnishes ninety percent or more of the EP's covered professional services in a hospital setting as measured by data in the calendar year preceding the payment year;

(11) "Hospital setting" means a site of service that is identified by the codes used in Health Insurance Portability and Accountability Act standard transactions as an inpatient hospital or emergency room setting;

(12) "Meaningful use" means use of certified EHR in a meaningful manner, including, but not limited to: E-prescribing; the use of certified EHR technology for electronic exchange of health information to improve quality of health care; or the use of certified EHR technology to submit clinical quality and other measures;

(13) "Medicaid" means the program operated by the department pursuant to section 17b-261 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Patient volume" means the minimum participation threshold that is estimated using the methodology in 42 CFR 495.306(c);

(15) "Pediatrician" means a physician whose practice is comprised of at least ninety percent of patients age 18 and under, and who:

(A) Holds board certification by the American Board of Pediatrics in pediatrics or a pediatric subspecialty;

(B) in the opinion of the department has training or experience comparable to that required for board certification by the American Board of Pediatrics in pediatrics or a pediatric subspecialty;

(C) holds board certification by the American Board of Medical Specialties in any specialty recognized by such board and serves a pediatric patient population; or

(D) in the opinion of the department provides what is generally accepted to be specialty care to a pediatric patient population;

(16) "Physician" means a person licensed pursuant to section 20-13 of the Connecticut General Statutes; and

(17) "Provider" means a provider enrolled in Medicaid.

(Effective January 13, 2013)

Sec. 17b-34-3. General Requirements for Participation

To be eligible for participation in the EHR Incentive Program, a provider shall:

(1) Be an EP or an eligible hospital but not a hospital-based EP;

(2) comply with sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies;

(3) meet all applicable requirements of 42 CFR 495.304;

(4) be enrolled in Medicaid with a valid provider enrollment agreement on file with the department and comply with all of the department's Medicaid requirements, including, but not limited to, sections 17b-262-522 to 17b-262-532, inclusive, of the Regulations of Connecticut State Agencies;

(5) not have any current sanctions that temporarily or permanently bar the provider from participation in the Medicare program or any state's Medicaid program;

(6) demonstrate, in a manner specified by the department, that the provider:

(A) For the first payment year, is adopting, implementing or upgrading an EHR system; and

(B) for the second and subsequent payment years, satisfies the meaningful use criteria applicable to the provider under 42 CFR 495.6;

(7) comply with all requirements in 42 CFR 495.310 regarding limitations on provider participation in more than one EHR incentive program; and

(8) comply with all other applicable requirements in 42 CFR 495, Subparts A and D, including 42 CFR 495.304.

(Effective January 13, 2013)

Sec. 17b-34-4. Incentive Payment Requirements for Eligible Professionals

In addition to meeting the requirements of section 17b-34-3 of the Regulations of Connecticut State Agencies, an EP shall meet the following requirements in order to be eligible to participate in the EHR Incentive Program:

(1) Comply with all applicable requirements of 42 CFR 440, be licensed pursuant to Title 20 of the Connecticut General Statutes and act within the EP's scope of practice under state law.

(2) Except for the first payment year as provided in subdivision (3) of this section, satisfy the requirements for meaningful use, as follows:

(A) Unless otherwise provided in 42 CFR 495.6(a), an EP shall meet: (i) All of the objectives and associated measures in 42 CFR 495.6(d), (ii) five objectives of the EP's choice from the objectives in 42 CFR 495.6(e) and (iii) if applicable, the criteria in 42 CFR 495.6(h); and

(B) as provided in 42 CFR 495.8(a), an EP shall attest, in a manner specified by the department, that the EP satisfies each of the applicable objectives and associated measures required pursuant to 42 CFR 495.6(a).

(3) In the first payment year only, an EP may either satisfy the requirements for meaningful use provided in subdivision (2) of this section or the EP may demonstrate that the EP has adopted, implemented or upgraded an EHR system during the payment year by attesting that:

(A) The EP has adopted, implemented or upgraded certified EHR technology; and

(B) the EP meets the applicable patient volume requirements in 42 CFR 495.304.

(4) Except as otherwise provided in subdivision (3) of this section, for program years one through six, an EP shall attest not more than ninety days after the close of each program calendar year that the EP has met the requirements for meaningful use of certified EHR technology, as follows:

(A) In program calendar years one and two, the EP shall attest to meeting the objectives and associated measures of meaningful use criteria in subdivision (2) of this section for any continuous ninety-day period within such program calendar year; and

(B) in program calendar years three through six, the EP shall attest to meeting the objectives and associated measures of meaningful use criteria in subdivision (2) of this section for the entirety of each program calendar year.

(5) An EP shall submit the information described in 42 CFR 495.10 to the department in the manner specified by CMS.

(Effective January 13, 2013)

Sec. 17b-34-5. Incentive Payment Requirements for Eligible Hospitals

In addition to meeting the requirements of section 17b-34-3 of the Regulations of Connecticut State Agencies, an eligible hospital shall meet the following requirements in order to be eligible to participate in the EHR Incentive Program:

(1) Hold a valid license issued by the Department of Public Health and comply with all applicable state statutes and regulations.

(2) Except for the first payment year as provided in subdivision (3) of this section, satisfy the requirements for meaningful use, as follows:

(A) Unless otherwise provided in 42 CFR 495.6(b), an eligible hospital shall meet: (i) All of the objectives and associated measures of the criteria in 42 CFR 495.6(f); (ii) five objectives of the eligible hospital's choice, from the objectives in 42 CFR 495.6(g); and (iii) if applicable, the criteria in 42 CFR 495.6(i); and

(B) as provided in 42 CFR 495.8(b), an eligible hospital shall attest, in a manner specified by the department, that the eligible hospital satisfies each of the objectives and associated measures required pursuant to 42 CFR 495.6(b).

(3) In the first payment year only, an eligible hospital may either satisfy the requirements for meaningful use provided in subdivision (2) of this section or demonstrate that it has adopted, implemented or upgraded an EHR system during the payment year by attesting to the criteria in section 17b-34-4(c) of the Regulations of Connecticut State Agencies.

(4) Except as otherwise provided in subdivision (3) of this section, for program years one through six, an eligible hospital shall attest not more than 90 days after the close of each program federal fiscal year that it has met meaningful use of certified EHR technology, as follows:

(A) To be considered a meaningful EHR user in program federal fiscal years one and two, an eligible hospital shall attest to meeting the objectives and associated measures of

meaningful use criteria in subdivision (2) of this section for any continuous ninety-day period within the program federal fiscal year; and

(B) to be considered a meaningful EHR user in program federal fiscal years three through six, an eligible hospital shall attest to meeting the objectives and associated measures of meaningful use criteria in subdivision (2) of this section for each program federal fiscal year in its entirety.

(5) An eligible hospital shall submit the information described in 42 CFR 495.10 to the department in the manner specified by CMS.

(Effective January 13, 2013)

Sec. 17b-34-6. Methodology for Determining Patient Volume

(a) Each EP and eligible hospital shall, on an annual basis, meet the applicable patient volume requirements of 42 CFR 495.304 using the methodology in 42 CFR 495.306(c).

(b) Only an EP who is a pediatrician as defined in section 17b-34-2 of the Regulations of Connecticut State Agencies may use the reduced minimum Medicaid patient volume requirement for participation in the EHR Incentive Program pursuant to 42 CFR 495.304(c). Such pediatrician shall comply with applicable requirements of 42 CFR 495.310.

(Effective January 13, 2013)

Sec. 17b-34-7. Incentive Payments

To receive incentive payments, an EP or eligible hospital shall meet the applicable requirements under 42 CFR 495.314. The department shall make incentive payments to each eligible Medicaid provider in accordance with 42 CFR 495.308, 42 CFR 495.310 and sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies.

(Effective January 13, 2013)

Sec. 17b-34-8. Initial Review and Right to Request an Administrative Hearing

(a) A provider aggrieved by a decision concerning only the issues set forth in 42 CFR 495.370(a) or section 17b-34(c) of the Connecticut General Statutes may request an initial review of the department's determination, and such review shall occur only if the department receives the provider's written request for an initial review, together with any supporting documents or data, not more than thirty days after the provider received the department's determination.

(b) An individual other than the person who made the department's determination shall conduct the initial review. The individual who conducts the initial review shall issue a written decision to the provider not more than thirty days after the department receives the request for initial review.

(c) If the provider is aggrieved by the outcome of the initial review, the provider may request an administrative hearing in writing to the commissioner, together with a detailed written description of all items of aggrievement, not more than fourteen days after the date the written initial review decision was issued.

(d) The department shall conduct an administrative hearing requested pursuant to subsection (c) of this section in accordance with chapter 54 of the Connecticut General Statutes.

(Effective January 13, 2013)

Sec. 17b-34-9. Audits and Documentation

(a) The department may access all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to verify provider attestations or conduct pre-payment or post-payment audits to assure compliance with the provisions of sections 17b-34-1 to 17b-34-9, inclusive, of the Regulations of Connecticut State Agencies and other regulatory and statutory requirements. The department may disallow or recover any amounts paid or pending to the provider for which required documentation is not maintained or not provided to the department upon request.

(b) For purposes of documenting AIU, the provider shall make available to the department all relevant documents, including, but not limited to, one or more of the following documents, as directed by the department:

(1) Contract;

(2) software license;

(3) receipt or evidence of cost;

(4) purchase order;

(5) evidence of cost or contract for training; or

(6) payroll record demonstrating hiring of staff to assist with the implementation.

(c) After conducting an audit, if the department finds that the provider was not eligible for payments made to the provider, the department may disallow and recover those funds. The provider shall promptly repay all disallowed funds to the department not more than forty-five days after receiving notice of the disallowance. In addition to taking any other lawful actions, the department may also offset such funds against current or future payments that the department otherwise would have made to the provider.

(d) A provider aggrieved by a decision in a final written audit conducted under this section may request a written review from the department. The provider shall request such review in writing and not later than thirty days after the department's final audit report was issued, together with a detailed written description of each specific item of aggrievement. The scope of the review shall not include or consider facts or circumstances outside of the audit and the final written audit report. An individual other than a person who conducted the audit or made the department's final audit determination shall conduct the review. At the discretion of the person presiding over the review, the person may make informal inquiries to the provider or the department; accept written statements from the provider and the department; and hold an informal conference with the department and the provider for the purpose of fact finding, accepting oral statements, or hearing witness testimony, after giving appropriate notice thereof to the provider and the department. After completing the final review, the person presiding over the review shall issue a final written decision

regarding what, if any action will be taken, including, but not limited to, revising the final written audit or any other action within the scope of the department's authority.

(Effective January 13, 2013)