

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

RELATES TO: KRS 205.520(3), 42 C.F.R. 170.102, 495.4, 495.6, 495.8, 495.100, 400.203, 495.304, 405.306, 405.308, 495.312, 495.314, 495.368, 495.370, 42 U.S.C. 1396(a)(3)(F), (t), STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396b(a)(3)(F), 1396b(t)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed, or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry. 42 U.S.C. 1396(a)(3)(F) authorizes states to establish a Medicaid electronic health record (EHR) incentive payment program to provide payments to Medicaid providers who acquire and implement electronic health records. This administrative regulation establishes Medicaid electronic health record incentive payment requirements and policies.

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

- (2) "EHR" means electronic health record.
- (3) "Eligible hospital" is defined in 42 C.F.R. 495.100.
- (4) "Eligible professional" is defined in 42 C.F.R. 495.100.
- (5) "Federal financial participation" is defined in 42 C.F.R. 400.203.
- (6) "Meaningful EHR user" is defined in 42 C.F.R. 495.4.
- (7) "Program year" means:
 - (a) A calendar year for eligible professionals; or
 - (b) A federal fiscal year for eligible hospitals.
- (8) "Provider" is defined by KRS 205.8451(7).
- (9) "Qualified electronic health record" or "qualified EHR" is defined in 45 C.F.R. 170.102.
- (10) "Qualifying critical access hospital" or "qualifying CAH" is defined in 42 C.F.R. 495.100.
- (11) "Qualifying eligible professional" is defined by 42 C.F.R. 495.100.
- (12) "Qualifying hospital" is defined by 42 C.F.R. 495.100.

Section 2. General Requirements of EHR Incentive Payment Eligibility. To be eligible for an EHR incentive payment:

- (1) An individual shall be an eligible professional who:
 - (a) Has an office of practice that is physically located in the Commonwealth of Kentucky;
 - (b) Is currently enrolled in the Kentucky Medicaid Program pursuant to 907 KAR 1:672;
 - (c) Is currently participating in the Kentucky Medicaid Program pursuant to 907 KAR 1:671;
 - (d) Is not on the:
 1. United States Department of Health and Human Services, Office of Inspector General's List of Excluded Individuals and Entities, which is available at <http://oig.hhs.gov/fraud/exclusions/exclusions-list.asp>; or
 2. Department's DMS List of Excluded Providers, which is available at <http://chfs.ky.gov/dms/provEnr>; and
 - (e) Has not already received an electronic health record incentive payment from:
 1. Another state within the current program year; or
 2. Kentucky within the current program year; or
- (2) An entity shall be an eligible hospital that:
 - (a) Is physically located in the Commonwealth of Kentucky;

- (b) Is currently enrolled in the Kentucky Medicaid Program pursuant to 907 KAR 1:672;
- (c) Is currently participating in the Kentucky Medicaid Program pursuant to 907 KAR 1:671;
- (d) Is not on the:

1. United States Department of Health and Human Services, Office of Inspector General's List of Excluded Individuals and Entities, which is available at <http://oig.hhs.gov/fraud/exclusions/exclusions-list.asp>; or

2. Department's DMS List of Excluded Providers, which is available at <http://chfs.ky.gov/dms/provEnr>; and

(e) Has not already received an electronic health record incentive payment from:

- 1. Another state within the current program year; or
- 2. Kentucky within the current program year.

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

(1) An eligible professional shall meet the:

(a) Requirements established in 42 C.F.R. 495.304(c) unless exempt pursuant to 42 C.F.R. 495.304(d); and

(b) Requirements established in Section 2(1) of this administrative regulation; or

(2) An eligible hospital shall meet the:

(a) Requirement established in 42 C.F.R. 495.304(e); and

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

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

(a) Professional shall establish his or her patient volume in accordance with 42 C.F.R. 495.304 and 495.306(c)(1); or

(b) Hospital shall establish its patient volume in accordance with 42 C.F.R. 495.304 and 405.306(c)(2).

(2)(a) The establishment of the patient volume of an eligible professional who practices predominantly in a federally-qualified health center (FQHC) or a rural health clinic (RHC) shall comply with 42 C.F.R. 495.304(c)(3) and 495.306(c)(3).

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

Section 5. Basis for Determining an EHR Incentive Payment. The department's basis for determining an incentive payment shall be in accordance with 42 C.F.R. 495.308.

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

(2) EHR incentive payments to an eligible hospital shall be limited pursuant to 42 C.F.R. 495.310(e) and (f).

(3)(a) An aggregate EHR hospital incentive payment amount shall be in accordance with 42 C.F.R. 495.310(g).

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

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

(4) An eligible hospital may receive EHR incentive payments from Medicare and Medicaid in accordance with 42 C.F.R. 495.310(j).

(5) EHR incentive payments to state-designated entities shall be in accordance with 42 C.F.R. 495.310(k).

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

(2) The department's EHR incentive payment process shall comply with 42 C.F.R. 495.312(a) and (c).

(3) An EHR incentive payment to an eligible professional or eligible hospital shall be disbursed based on the criteria established in 42 C.F.R. 495.2 through 495.10.

(4) An EHR incentive payment to an eligible:

(a) Professional shall be disbursed in accordance with the timeframe established in 42 C.F.R. 495.312(e)(1); or

(b) Hospital shall be disbursed in accordance with the timeframe established in 42 C.F.R. 495.312(e)(2).

Section 8. Activities Required to Receive an Incentive Payment. (1) To receive an EHR incentive payment in the first payment year, an eligible professional or eligible hospital shall comply with the requirements established in 42 C.F.R. 495.314(a).

(2) To receive an EHR incentive payment in the second, third, fourth, fifth, or sixth payment year, an eligible professional or eligible hospital shall meet the requirements established in 42 C.F.R. 495.314(b).

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

(2) An eligible hospital shall meet the meaningful use requirements established in 42 C.F.R. 495.6(b), (c), and (e).

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

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

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

(a) The department; or

(b) The Centers for Medicare and Medicaid Services.

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

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

(2) If an overpayment is due from an eligible professional or eligible hospital to the depart-

ment, the eligible professional or eligible hospital shall repay the entire overpayment within the timeframe established in 42 C.F.R. 495.368(c).

Section 13. Overpayment Dispute Resolution Process Prior to Administrative Hearing. (1)(a) An eligible professional or eligible hospital may appeal the following by first requesting a dispute resolution meeting:

1. An incentive payment;
2. An incentive payment amount;
3. A determination regarding the demonstration of adopting, implementing, or upgrading meaningful use of electronic health record technology; or
4. An overpayment amount determined by the department to be due from the eligible professional or eligible hospital.

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

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

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

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

(c) Clearly state the:

1. Basis on which the department's decision on each issue is believed to be erroneous; and
2. Name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf.

(3) The department shall not accept or honor a request for an administrative appeals process that is filed prior to receipt of the department's written determination that creates an administrative appeal right.

(4)(a) The department or the party requesting a dispute resolution meeting may request the presence of a court reporter at the dispute resolution meeting.

(b) If requested, a court reporter shall be secured in advance of a dispute resolution meeting, and a dispute resolution meeting shall not be postponed solely due to the failure to timely secure a court reporter.

(5)(a) Except if a court reporter was requested solely by a provider, the department shall bear the cost of a court reporter.

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

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

(a) Be conducted face to face; and

(b) Not be conducted via telephone.

(7) If an administrative hearing is requested at the dispute resolution meeting, the dispute resolution meeting transcript shall become part of the official record of the hearing pursuant to KRS 13B.130.

(8)(a) The department shall, within ten (10) calendar days of receipt of the request for a dispute resolution meeting, send a written response to the eligible professional or hospital:

1. Identifying the time and place in which the meeting shall be held; and

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

(b) A dispute resolution meeting shall be held:

1. No sooner than ten (10) calendar days and no later than twenty (20) calendar days of receipt of the request for a dispute resolution meeting;

2. Sooner than ten (10) calendar days of receipt of the request for a dispute resolution meeting if both parties agree to the sooner date; or

3. At a date later than the date established in subparagraph 1. of this paragraph if a post-

ponement is requested.

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

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

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

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

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

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

(11) Within thirty (30) calendar days after the dispute resolution meeting or the date the information to be considered was presented to the department as established in subsection (10) of this section, the department shall:

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

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

1. The department's decision; and

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

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

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

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

1. Reason for the delay; and

2. Anticipated completion date of the review.

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

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

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

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

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

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

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

(a) An incentive payment;

- (b) An incentive payment amount;
- (c) A determination regarding a provider's demonstration of adopting, implementing, or upgrading meaningful use of electronic health record technology;
- (d) An overpayment amount determined by the department to be due from the eligible provider;
- (e) A determination regarding a provider's eligibility for electronic health record incentive payments by first requesting a dispute resolution meeting;
- (f) A department's requirement of a provider to repay an electronic health record incentive payment overpayment; or
- (g) A department's withholding of a provider's payments in accordance with 907 KAR 1:671.

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

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

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

- (a) The notice of action taken;
- (b) The statutory or regulatory basis for the action taken;
- (c) The department's decision following the dispute resolution meeting process; and
- (d) All documentary evidence provided by the:
 - 1. Eligible professional, eligible hospital, or provider; or
 - 2. The eligible professional's, eligible hospital's, or provider's billing agent, subcontractor, fiscal agent, or another individual authorized by the eligible professional, eligible hospital, or provider to provide information regarding the matter to the department.

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

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

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

- 1. A mutual agreement between the:
 - a. Eligible profession, eligible hospital, or provider; and
 - b. The department; or
- 2. A continuance granted by the hearing officer.

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

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

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

(11) A hearing request shall be withdrawn only if:

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

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

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

(13) Information relating to the selection of an eligible professional, eligible hospital, or provider for audit, investigation notes or other materials which may disclose auditor investigative techniques, methodologies, material prepared for submission to a law enforcement or prosecutorial agency, information concerning law enforcement investigations, judicial proceedings, confidential sources or confidential information shall not be revealed, unless the material is exculpatory in nature as required pursuant to KRS 13B.090(3).

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

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

- (a) Issues directly raised in the initial request for a dispute resolution meeting;
- (b) Issues directly raised during the dispute resolution meeting; or
- (c) Materials submitted in lieu of a dispute resolution meeting.

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

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

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

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

(17) A hearing officer shall issue a recommended order in accordance with KRS 13B.110.

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

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

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

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

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

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

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

Section 15. Actions Taken at the Conclusion of the Administrative Appeal Process. (1) A stay on recoupment granted under 907 KAR 1:671 shall not extend to judicial review, unless a stay is granted pursuant to KRS 13B.140(4).

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

(3) Thirty (30) calendar days after the issuance of the final order pursuant to KRS 13B.120,

the department:

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

(b) May enact:

1. An exclusion or fiscal penalty pursuant to 42 U.S.C. 1320a-7; or

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

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

Section 16. Federal Financial Participation. A policy established in this administrative regulation shall be null and void if the Centers for Medicare and Medicaid Services:

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

(2) Disapproves the policy. (37 Ky.R. 2111; 2424; eff. 5-6-2011; Crt eff. 7-23-2018; TAm eff. 3-20-2020.)