MEDICAID		
FAQ Number	**Question**	**Answer**
3585	For the Medicaid Promoting Interoperability Program, can a non-hospital based eligible professional (EP) include their in-patient encounters for purposes of calculating Medicaid patient volume even if the patient is included in the eligible hospital's patient volume for the same 90-day period?	Yes, an EP who sees patients in an in-patient setting, and is not hospital based, can include the in-patient encounter in their Medicaid patient volume calculation. Both an eligible hospital and an EP can include an encounter from the same patient in their Medicaid patient volume calculations, respectively. This is because the services performed by the EP are distinct from those performed by the eligible hospital. Section 495.306 defines an encounter as a service rendered to an individual enrolled in a Medicaid program by either an EP or an eligible hospital. An EP who sees patients in an in-patient setting bills Medicaid for the services personally rendered by the EP, while at same time the hospital bills Medicaid for the services rendered by the hospital, such as the bed and medications. Given that these are two distinct sets of services for the same patient, both the eligible hospital and the EP can count them as an encounter for Medicaid patient volume if they happened to select the same 90-day period.
7537	The Promoting Interoperability Programs Stage 2 Rule describes changes to how a state considers CHIP patients in the Medicaid patient volume total when determining provider eligibility. Patients in which CHIP programs are now appropriate to be considered in the Medicaid patient volume total?	States that offer CHIP as part of a Medicaid expansion under Title 19 or Title 21 can include those patients in their provider's Medicaid patient volume calculation as there is cost liability to the Medicaid program in either case (under the Stage 1 Rule, only CHIP programs created under a Medicaid expansion via Title 19 were eligible). Patients in standalone CHIP programs established under Title 21 are not to be included in the Medicaid patient volume. This change to the patient volume calculation is applicable to all EPs, regardless of the stage of the Medicaid Promoting Interoperability Program they are participating in.
2823	For the Medicaid Promoting Interoperability Program, if the EHR Reporting Period is calendar year (CY) 2013, then the payment year also refers to 2013 even though an eligible professional (EP) may receive the actual incentive payment in early 2014, correct?	The payment year is the year for which the payment is made (see 42 CFR 495.4 and the definition of "First, second, third, fourth, fifth, or sixth payment years."). So, the questioner is correct that if the EHR reporting period is in CY 2013, the payment year also refers to 2013.
2825	Does each State have the latitude to define the 12-month period from which to derive the Medicaid share data for the purposes of the Medicaid Promoting Interoperability Program. Neither the preamble nor the regulatory text of the Stage 1 final rule explicitly stipulate that the 12-month period selected by the state for the Medicaid share data needs to be in the federal fiscal year (FY) before the hospital's FY that serves as the first payment year. In other words, a state could use two different 12-month periods to calculate the discharge-related amount and the Medicaid share?	No, this is not correct. The regulation is clear that the discharge-related amount must be calculated using a 12-month period that ends in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year. 42 CFR 495.310(g)(1)((I)(B). This statement also was made in the preamble, where we stated: "For purposes of administrative simplicity and timeliness, we require that States use data on the hospital discharges from the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year" 75 FR 44498. In addition, the regulation indicates that the period that is used for the Medicaid share is the same period as that used for the discharge-related amount. See 42 CFR 495.310(g)(2)(I) referring to "the 12-month period selected by the State." Use of "the" in 495.310(g)(2) indicates that this is the same 12-month period that is used under 495.310(g)(1). In addition, we believe that using different periods for the Medicaid share versus the discharge-related amount would lead to inaccurate estimates, as data would be drawn from inconsistent periods.
2833	Is data sharing with neighboring States permitted regarding total Medicaid days for purposes of paying full incentives to hospitals or eligible professionals (EPs) with utilization in multiple states under the Medicaid Promoting Interoperability Program?	Yes. The CMS Stage 1 final rule clarifies the policy about calculating patient volume for Medicaid providers with clinical practices in more than one State, both in terms of what is "Medicaid patient volume" and about the cross-border issue. See 75 FR 44503, stating: "[W]e recommend that States consider the circumstances of border State providers when developing their policies and attestation methodologies. To afford States maximum flexibility to develop such policies, we will not be prescriptive about whether a State may allow a Medicaid EP to aggregate his/her patients across practice sites, if the State has a way to verify the patient volume attestation when necessary. States will propose their policies and attestation methodologies to CMS for approval in their State Medicaid HIT plans." However, as stated in the Stage 1 final rule, EPs and hospitals are permitted to receive payment from only one State in a payment year (495.310(e)).

2835	Does a State have the option of solely using a state-submitted alternative methodology (pending CMS approval) for determining patient volume, or is the State additionally required to use one of the CMS specified methodologies (patient encounter or patient volume) for the Medicaid Promoting Interoperability Program?	Yes, the State can submit to us for approval only the alternative methodology that meets the requirements of 495.306(g). As we stated in the preamble to the Stage 1 final rule, we believe most States will not submit alternative methodologies until after the first year of the program, allowing for alternatives to recognize evolving State and provider experience with patient volume estimate methodologies. We recommend that States consider the methodologies that were put forward in the Stage 1 final rule, prior to proposing only an alternative in their State Medicaid Health Information Technology Plans (SMHPs). If a State alternative methodology is approved by us, we will post this methodology on our website, so that other States may adopt the methodology as well.
3079	If a State utilizes the option to include patient panels when looking at patient volume for the Medicaid Promoting Interoperability Program, what does it mean to have "unduplicated encounters"?	The requirements for this option to calculate patient volume are to account for eligible professionals treating patients in a care management role (often managed care or a medical home), as well as any additional encounters outside of a care management arrangement (often fee-for-service). When a State has leveraged this option, the calculation is: Total Medicaid patients* assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [Unduplicated Medicaid encounters* in that same 90-day period] DIVIDED BY-[Total patients assigned to the provider in the same 90-day with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [All unduplicated encounters in that same 90-day period] *Note that this same equation applies to making a determination for Needy Individual patient volume, where "Medicaid" is substituted by "Needy Individuals." In this calculation, "unduplicated" simply means that an eligible professional may not include the same encounters more than once. There may be multiple encounters with patients (even with patients included on the panel), but these may not be counted in more than one place in the equation. In addition, as noted in the preamble of the July 28, 2010 Federal Register (page 44488), the "unduplicated encounters" would only be encounters with non-panel Medicaid patients that occurred during the representative 90-day period. As the question notes, not all States will use this option in determining patient volume. Please talk to your State or visit their website to get more information on how patient volume is calculated in each State. Links to state websites can be found here: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Medicaid_StatesProgramLinks.pdf.
3119	Under the Promoting Interoperability Program, will the requirement that eligible professionals and eligible hospitals choose at least one public health objectives among the meaningful use measures still apply to those States that ask CMS for approval to change the definition of meaningful use? That is the provider still required to choose another public health objective or does the new meaningful use definition in that State superseade the general definition.	If the State required any of the public health measures as core measures for the Medicaid Promoting Interoperability Program, then that would fulfill the eligible professionals (EP) requirement to select at least one public health measure. If the EP meets the exclusion criteiria for any of the public health measures that a State has moved to the core set, with CMS approval, they would stillhave to select at least one public health measure from the menu set.
3501	Per CMS #3017, my tribal clinic is considered a Federally Qualified Health Center (FQHC) for the Medicaid Promoting Interoperability Program. So our eligible professionals (EPs) need to have 30% "needy individual" patient volume in order to qualify. I understand that needy individual encounters include encounters covered by Medicaid, the Children's Health Insurance Program (CHIP), a sliding fee scale or uncompensated care. My clinic receives Indian Health Services (IHS) funding which only partially offsets the cost of these encounters that are not covered by Medicaid or CHIP, but my clinic does not impose costs on these individuals and does not have a sliding fee scale, so how do I count them?	Since your clinic receives IHS funding, the encounters are not truly "uncompensated", but the encounters would be considered services furnished at no cost (even if your clinic does not have a sliding fee scale), and therefore can be counted towards needy individual patient volume for tribal clinic-based EPs applying for the Medicaid Promoting Interoperability Program.

3101	How will eligible professionals (EPs) be required to show that they are meeting the Medicaid or needy individual patient volume thresholds of 30% for the Medicaid Promoting Interoperability Program?	To show that EPs are meeting the Medicaid or needy individual patient volume thresholds of 30% for the Medicaid Promoting Interoperability Program, States will need to propose one or more methods of calculating patient volume to CMS in their State Medicaid Health Information Technology Plans and would need to identify verifiable data sources available to the provider and/or the State. Please contact your State Medicaid Agency for more information on how your state is calculating patient volume.
3107	Are the criteria for needy patient volumes under the Medicaid Promoting Interoperability Program only applied to eligible professionals (EPs) practicing predominantly in Federally Qualified Health Centers (FQHCs) and/or Rural Health Clinics (RHCs), or can they also apply to hospital patient volumes?	Criteria for minimum patient volumes attributable to needy individuals apply only to EPs practicing predominantly in an FQHC or RHC. These criteria do not apply to hospital patient volumes.
3121	If a State proposes a new definition for meaningful use under its Medicaid Promoting Interoperability Program, will it need to include the new definition of meaningful use in its State Medicaid Health Information Technology Plan (SMHP)? When are the SMHPs due?	Yes, if a State wishes to request flexibility with the definition of meaningful use, to the extent permissible under the Medicare and Medicaid Promoting Interoperability Programs final rule, it would do so via its SMHP. SMHPs are expected to be iterative, and should be updated annually.
3123	If a state has a team of staff members who will be administering the Medicaid EHR Incentive Program from 2011-2021 (answering provider questions) Engageing in reporting and analysis, assisting providers with eligibility and verifying provider eligibility, appeals, etc) would there be 90% Federal Financial Participation for this team on an ongoing basis once.	Yes. However, If state staff members are not working full-time on the Medicaid EHR Incentive Program, their salaries need to be cost allocated appropriately. For more information about the Medicare and Medicaid EHR Incentive Program, please visit http://www.cms.gov/EHRincentivePrograms Keywords FAQ10534.
3373	How does CMS define pediatrician for purposes of the Medicaid Promoting Interoperability Program?	CMS does not define pediatrician for this program. Pediatricians have special eligibility and payment flexibilities offered under the program and it is up to States to define pediatrician, consistent with other areas of their Medicaid programs. You can find your State's contact information here: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Medicaid_StatesProgramLinks.pdf
5995	For the Medicaid Promoting Interoperability Program, how do we determine Medicaid patient volume for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries? Such procedures are billed to Medicaid at a global rate where one global rate might cover several visits.	CMS leaves it up to the states how to operationalize the patient volume considerations of global payments with the following guidance: the numerator and denominator must be incorporated consistently. The total encounters can be kept global, or broken down into individual visits. If a global payment is broken down into separate visits in the numerator, then for purposes of the denominator, the state must break down any other global payments received from other payers. We recognize this could be administratively challenging and are open to reviewing strategies for doing this that may involve sampling (e.g., if the Medicaid global payment for OB averages 12 visits, we would expect to see the numerator expanded to 12 visits for Medicaid encounters, and a denominator constructed using sample data from a random file review that similarly breaks down any global payments into separate visits for Medicaid and non-Medicaid payers). Additionally, if the state's approach to global payments excludes providers from the Medicaid Promoting Interoperability Program who would otherwise be eligible, the state must create a mechanism to re-review their eligibility.

10754	The billing provider on a claim is an eligible professional (EP) but the performing provider type is not an EP. If we use claims to validate patient volume or meaningful use for the Medicaid Promoting Interoperability Program, should we count performing providers (person rendering the service) or the billing provider?	To meet the “Protect Electronic Health Information” core objective for Stage 1, eligible professionals (EP), eligible hospitals or critical access hospitals (CAH) must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process. In Stage 2, in addition to meeting the same security risk analysis requirements as Stage 1, EPs and hospitals will also need to address the encryption and security of data stored in the certified EHR technology (CEHRT). These steps may be completed outside or the EHR reporting period timeframe but must take place within the same calendar year as the EHR reporting period, and if the provider attests prior to the end of the calendar year, it must be conducted prior to the date of attestation. For example, a EP who is reporting Meaningful Use for a 90-day EHR reporting period may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed no earlier than January 1st of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period. This meaningful use objective complements but does not impose new or expanded requirements on the HIPAA Security Rule. In accordance with the requirements under (45 CFR 164.308(a)(1)(ii)), providers are required to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). Once the risk analysis is completed, providers must take any additional “reasonable and appropriate” steps to reduce identified risks to reasonable and appropriate levels. Please note that a security risk analysis or review needs to be conducted during each EHR reporting year for Stage 1 and Stage 2 of meaningful use to ensure the privacy and security of their patients’ protected health information. For more information about completing a security risk analysis, please see the following resources: Security Risk Assessment Tip Sheet: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAssessment_FactSheet_Updated20131122.pdf">https://www.cms.gov/Regulations-and-Health Information Privacy and Security: A 10 Step Plan: a http://www.healthit.gov/providers-professionals/ehr-privacy-security/Created 10/6/2014 Updated 11/5/2014 Archived 12/15/15
3015	When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid Promoting Interoperability Program?	CMS considers these two separate, but related issues. Meaningful use: Any eligible professional demonstrating meaningful use must have at least 50% of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives. Therefore, States should collect information on meaningful users' practice locations in order to validate this requirement in an audit. Patient volume: Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an eligible professional's sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an eligible professional practices in two locations, one with certified EHR technology and one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site. For more information on applying the group/clinic proxy option, see FAQ #10362 or here For more information about the Medicare and Medicaid Promoting Interoperability Program, please visit http://www.cms.gov/EHRIncentivePrograms Keywords: FAQ10416
3017	Can tribal clinics be treated as Federally Qualified Health Centers (FQHCs) for the Medicaid Promoting Interoperability Program?	CMS previously issued guidance stating that health care facilities owned and operated by American Indian and Alaska Native tribes and tribal organizations ("tribal clinics") with funding authorized by the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) must be reimbursed as FQHCs in order to be considered FQHCs in the Medicaid Promoting Interoperability Program. CMS revised this policy and will allow any such tribal clinics, as well as urban clinics that are funded by urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (Public Law 94-437, as amended) for the provision of primary health services http://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c19#3-19.2D to be considered as FQHCs for the Medicaid Promoting Interoperability Program, regardless of their reimbursement arrangements. For more information on how FQHCs are defined, please see FAQ 3017
3099	Do Federally Qualified Health Center (FQHC) sites have to meet the 30% minimum Medicaid patient volume threshold to receive payment under the Medicaid Promoting Interoperability Program?	Eligible professionals may participate in the Medicaid Promoting Interoperability Program if: 1) They meet Medicaid patient volume thresholds; or 2) They practice predominantly in an FQHC or Rural Health Clinic (RHC) and have 30% needy individual patient volume. FQHCs and RHCs are not eligible to receive payment under the program. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume. Keywords: FAQ10522

2845	How does CMS define Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) for the purposes of the Medicaid Promoting Interoperability Program?	The Social Security Act at section 1905(l)(2) defines an FQHC as an entity which, "(I) is receiving a grant under section 330 of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant and (II) meets the requirements to receive a grant under section 330 of the Public Health Service Act, (iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, and is determined by the Secretary to meet the requirements for receiving such a grant including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity; or (iv) was treated by the Secretary, for purposes of Part B of title XVIII, as a comprehensive Federally-funded health center as of January 1, 1990, and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services. RHCs are defined as clinics that are certified under section 1861(aa)(2) of the Social Security Act to provide care in underserved areas, and therefore, to receive cost-based Medicare and Medicaid reimbursements. In considering these definitions, it should be noted that programs meeting the FQHC requirements commonly include the following (but must be certified and meet all requirements stated above): Community Health Centers, Migrant Health Centers, Healthcare for the Homeless Programs, Public Housing Primary Care Programs, Federally Qualified Health Center Look-Alikes, and Tribal Health Centers. Keywords: FAQ10127
2993	If an eligible professional (EP) in the Medicaid Promoting Interoperability Program wants to leverage a clinic or group practice's patient volume as a proxy for the individual EP, how should a clinic or group practice account for EPs practicing with them part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?	EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions: (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);(2) there is an auditable data source to support the clinic's patient volume determination; and (3) so long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice. In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities. If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from clinic A in calculating his or her individual patient volume. The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs. CLINIC A (with a fictional EP and provider type)" EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)" EP# 2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)" Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)" Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)" EP #3 (physician): individually had 10% Medicaid encounters (30/300)" EP #4 (dentist): individually had 5% Medicaid encounters (5/100)" EP #5 (dentist): individually had 10% Medicaid encounters (20/200) In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the Promoting Interoperability Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.) The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other. Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP # 4 could choose to use the proxy level Clinic A patient volume data, or the patient volume associated
3111	For the Medicaid Promoting Interoperability Program, how are the reporting periods for Medicaid patient volume and for demonstrating meaningful use affected if an eligible professional (EP) skips a year or takes longer than 12 months between attestations?	Regardless of when the previous incentive payment was made, the following reporting periods apply for the Medicaid Promoting Interoperability Program:- For patient volume, an eligible professional (EP) should use any continuous, representative 90-day period in the prior calendar year. For demonstrating they are a meaningful users of Electronic Health Records (EHRs), EPs should use the EHR reporting period associated with that payment year (for the first payment year that an EP is demonstrating meaningful use, the reporting period is a continuous 90-day period within the calendar year; for subsequent years the period is the full calendar year). Keywords: FAQ10528
3115	Can a federally-owned Indian Health Service facility qualify as an eligible hospital for the Medicaid Promoting Interoperability Program?	Acute care hospitals under the Medicaid Promoting Interoperability Program must: Have an average length of stay of 25 days or fewer; AND· have a CMS Certification Number (CCN) correctly identifying them as eligible for the Promoting Interoperability Programs. To determine whether an Indian Health Service-owned hospital meets the certification requirements to have a CCN in these ranges, reference should be made to the certification or conditions of participation (see 42 CFR Part 482). Such facilities would also need to have 10% Medicaid patient volume. For more information about the Medicare and Medicaid Promoting Interoperability Program.

3117	Under the Medicaid Promoting Interoperability Program, can a qualifying eligible professional (EP) who is an employee of a federally-owned Indian Health Services facility (other than a tribally-owned facility or Federally Qualified Health Center) assign his/her incentive payment to the federally-owned facility in the same way as other EPs?	Yes, EPs are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services, including a federally-owned Indian Health Services facility. Keywords: FAQ10531
7535	The Promoting Interoperability Programs Stage 1 Rule stated that, in order for a Medicaid encounter to count towards the patient volume of an eligible provider, Medicaid had to either pay for all or part of the service, or pay all or part of the premium, deductible or coinsurance for that encounter. The Stage 2 Rule now states that the Medicaid encounter can be counted towards patient volume if the patient is enrolled in the state's Medicaid program (either through the state's fee-for-service programs or the state's Medicaid managed care programs) at the time of service without the requirement of Medicaid payment liability. How will this change affect patient volume calculations for Medicaid eligible providers?	Importantly, this change affecting the Medicaid patient volume calculation is applicable to all eligible providers, regardless of the stage of the Medicaid Promoting Interoperability Program they are participating in. Billable services provided by an eligible provider to a patient enrolled in Medicaid would count toward meeting the minimum Medicaid patient volume thresholds. Examples of Medicaid encounters under this expanded definition that could be newly eligible might include: behavioral health services, HIV/AIDS treatment, or other services that might not be billed to Medicaid/managed care for privacy reasons, but where the provider has a mechanism to verify eligibility. Also, services to a Medicaid-enrolled patient that might not have been reimbursed by Medicaid (or a Medicaid managed care organization) may now be included in the Medicaid patient volume calculation (e.g., oral health services, immunization, vaccination and women's health services, , telemedicine/telehealth, etc.). Providers who are not currently enrolled with their state Medicaid agency who might be newly eligible for the incentive payments due to these changes should note that they are not necessarily required to fully enroll with Medicaid in order to receive the payment. In some instances, it may now be appropriate to include services denied by Medicaid in calculating patient volume. It will be appropriate to review denial reasons. If Medicaid denied the service for timely filing or because another payer's payment exceeded the potential Medicaid payment, it would be appropriate to include that encounter in the calculation. If Medicaid denied payment for the service because the beneficiary has exceeded service limits established by the Medicaid program, it would be appropriate to include that encounter in the calculation. If Medicaid denied the service because the patient was ineligible for Medicaid at the time of service, it would not be appropriate to include that encounter in the calculation. Further guidance regarding this change will be distributed to the states as appropriate.
2625	What is the maximum incentive an eligible professional (EP) can receive under the Medicaid Promoting Interoperability Program?	EPs who adopt, implement, upgrade, and meaningfully use EHRs can receive a maximum of $63,750 in incentive payments from Medicaid over a six year period (Note: There are special eligibility and payment rules for pediatricians). EPs must begin receiving incentive payments by calendar year 2016. Keywords: FAQ9810
3103	When calculating Medicaid patient volume or needy patient volume for the Medicaid Promoting Interoperability Program, are eligible professionals (EPs) required to use visits, or unique patients?	There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume. Generally stated, a patient encounter is any one day where an individual enrolled in a Medicaid program receives service. The requirements differ for EPs and hospitals. In general, the same concept applies to needy individuals. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume. Keywords: FAQ10524
3315	When calculating inpatient bed days for the Medicaid Promoting Interoperability Program, can Critical Access Hospitals (CAHs) exclude swing bed days from the average length of stay if this is consistent with how they complete the Medicare and Medicaid cost reports?	Swing beds days that are used to furnish skilled nursing facility (SNF) or nursing facility-level care would not normally be considered part of the inpatient acute-care part of the hospital, whereas swing bed days that are used to furnish inpatient-level care are part of the acute-care part of the hospital. However, for CAHs participating in the Medicaid Promoting Interoperability program, when there is no way to distinguish between days used to furnish SNF-level care versus inpatient acute-level care, we will allow States to exclude these days, if it is consistent with how the CAH completes the Medicare and Medicaid cost report. As the Medicaid Promoting Interoperability Program requires eligible acute care hospitals to have an average length of stay of 25 days or fewer, exclusion of swing bed days may facilitate CAH participation in the Medicaid Promoting Interoperability Program. Keywords: FAQ10668

5993	In order to qualify for payment under the Medicaid Promoting Interoperability Program for having adopted, implemented, or upgraded to (AIU) certified EHR technology, an eligible professional (EP) working at an Indian Health Services (IHS) clinic may be asked to submit to their State Medicaid Agency an official letter containing information about the clinic's electronic health record from IHS (which is an Operating Division of the United States Department of Health and Human Services). The information in this letter identifies the EHR vendor, the ONC Certified Heath IT Product List (CHPL) number of the EHR, as well as other information regarding the EHR product version and licensure. Does this letter meet states' documentation requirements for AIU?	Yes. This is an official letter from the United States Department of Health and Human Services and the IHS clinic generating this letter uses a certified EHR system created for the IHS. The state does not need to collect additional documentation for AIU (pre-payment or post-payment, or in the event of an audit) in instances where one of these letters is provided. Keywords: FAQ10956
7649	May a hospital include zero pay Medicaid eligible days in the Medicaid hospital Promoting Interoperability Program payment calculation?	No, zero pay Medicaid eligible days must be excluded from the Medicaid hospital incentive calculation. Section 1903(t)(5)(C) of the Act requires the Medicaid share to be calculated "in the same manner as the Medicare share. " In all ways possible, the Medicaid hospital incentive calculation is similar to Medicare, based on this language. Medicare retrieves data for the calculation exclusively from the Medicare cost report. Although Medicaid offers additional flexibility in data sources, the data parameters for Medicaid are the same as Medicare. This is cited in the Stage 1 final rule where CMS said: "The statute requires us to calculate the Medicaid share 'in the same manner' as the Medicare share under section 1886(n)(2)(D) of the Act and such substitute service days would not be considered 'in the same manner.' Thus, we proposed that for purposes of the Medicaid formula, we would count only those days that would count as inpatient-bed-days for Medicare purposes under section 1886(n)(2)(D) of the Act." In the CMS Stage 1 final rule, CMS also made clear: "[T]he EHR hospital incentive payment calculation requires the inclusion of only paid inpatient-bed-days." 75 Fed. Reg. at 44500. Given this, a joint FAQ was published (FAQ # 3471) that mirrored cost report data sources for the calculation. Per the cost report instructions, all acute inpatient days must be paid. While CMS uses line 2 of worksheet S-3 part 1, which contains HMO data as well as other data used to calculate the Disproportionate Share Hospital (DSH) calculation (including zero pay days), Medicare is removing all of the DSH data from line 2 and using only the paid managed care days. Medicare does not include unpaid days as acute inpatient days, so following the same manner for Medicaid means using only paid days as well. Additionally, 1903(t)(5)(C) states that the Secretary establishes how the "inpatient bed-days" used in the Medicaid numerator are counted. The statute specifically says that the Medicaid share has as its numerator "the amount that is equal to the number of inpatient-bed-days (as established by the Secretary) which are attributable to individuals who are receiving medical assistance under this title." By using only paid inpatient Medicaid days, the Secretary has "established" how she counts the number of inpatient bed days per statutory authority.
9822	For Eligible Professionals (EP) in the Medicaid Electronic Health Records (EHR) Incentive Program using the group proxy method of calculating patient volume, how should the EPs calculate patient volume using the "12 months preceding the EP's attestation" approach, as not all of the EPs in the group practice may use the same 90-day period.	In the Stage 2 final rule, CMS adopted a final policy that allows states the option for their providers to calculate patient volume in any representative, continuous 90-day period in the 12 months preceding the eligible professional's (EP) attestation (see 77 FR 54121, 42 CFR 495.306(b)). This option is in addition to the method of calculating patient volume in any representative, continuous 90-day period in the calendar year preceding the payment year for which the EP is attesting. For EPs who calculate patient volume at the group practice or clinic level under 42 CFR 495.306(h), although we expect the same 90-day period to be used for all EPs in the group practice or clinic, we understand this may not be feasible in scenarios where EPs attest on different dates. For example, for the 2013 payment year, if one EP in the group attested on April 1, 2013 and another EP in the group attested on February 1, 2014, there would not be a continuous 90-day period that occurred within the 12 months preceding the first EP's attestation and also within the 12 months preceding the second EP's attestation. In such scenarios where it would be impossible to use the same representative, continuous 90-day period for EPs in the group practice or clinic, we would allow different representative, continuous 90-day periods to be used, as long as all of the provisions of 42 CFR 495.306(h) are satisfied. For more information, please visit the Stage 2 Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.

2819	Do States need to verify the "installation" or "a signed contract" for adopt, implement, or upgrade (AIU) in the Medicaid Promoting Interoperability Program?	States should make clear to providers when they attest for AIU what documentation they must maintain, and for how long, in case of audit. If States determine that certain provider types are a high risk for potential fraud/abuse for AIU, then they can ask for some verification of adopting, implementation or upgrading but CMS encourages that this be done in a targeted manner, with the most electronic and simple means possible and not in such a way that would be burdensome to providers. For AIU, a provider does not have to have installed certified EHR technology. The definition of AIU in 42 CFR 495.302 allows the provider to demonstrate AIU through any of the following: (a) acquiring, purchasing or securing access to certified EHR technology capable of meeting meaningful use; (b) installing or commencing utilization of certified EHR technology capable of meeting meaningful use requirements; or (c) expanding the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the EHR certification criteria published by the Office of the National Coordinator of Health Information Technology (ONC). Thus, a signed contract indicating that the provider has adopted or upgraded would generally be sufficient. However, if a provider has been identified as high risk, states could further investigate the provider's intention (or lack thereof) to AIU. While a signed contract indicating that the provider has adopted or upgraded might generally be sufficient to establish an intent to AIU, the state could still determine that other, contradictory evidence demonstrated that the provider in fact had no intent to AIU. In such cases, that contradictory evidence might outweigh the presence of a signed contract. For more information about the Medicare and Medicaid Promoting Interoperability Program, please visit "http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10100 Updated on 4/2/2014
2831	For calculation of a Medicaid hospital's Promoting Interoperability payment, is the estimated growth rate for hospitals most recent three years based on growth in total days or growth in discharges?	The average annual growth rate should be for discharges (see 1903(t)(5)(B), referring to the annual rate of growth of the most recent 3 years for "discharge data.") We agree that the sources are different. Hospitals would probably have to use MMIS or auditable hospital records to get accurate discharge data rate of growth. To view the Stage 1 ;final rule, please visit: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf" Keywords: FAQ10108
2839	Under the Medicaid Promoting Interoperability Program, how long is the EHR reporting period for each participation year demonstrating meaningful use?	Under the Medicaid Promoting Interoperability Program, if a provider adopts, implements or upgrades (AIU) certified EHR technology in their first year, the provider will not have to demonstrate meaningful use (MU) in order to receive payment. In the second year they will have to demonstrate MU for a 90 day period only. A provider that is already a meaningful user would have to demonstrate for a 90 day period the first year and subsequent years they would have to demonstrate it for the full year. The exception to this rule is for the year 2014. 24 CFR 495.4 establishes a one-time exception for providers attesting to meaningful use in 2014 during which the reporting period for Medicaid providers is any continuous 90-day period within the reporting year. Keywords: FAQ10112
3113	Can a State access enhanced matching funds for the Medicaid Promoting Interoperability Program to participate in the creation of a Health Information Exchange (HIE) that is not directly administered by the State Medicaid Agency?	The enhanced match rate depends upon whether the Health Information Exchange solution is using Medicaid Management Information System (MMIS) funding or Health Information Technology for Economic and Clinical Health (HITECH) funding. Governance only is relevant under the MMIS regulations, as it pertains to the matching rate determination. States should talk to CMS about their ideas in draft, informally, so that CMS can give a more State-specific response around appropriate funding, matching rates, etc. For more information about the Medicare and Medicaid Promoting Interoperability Program.

7809	What funding sources may States use to fund the 10% non-federal share of HITECH administrative expenditures?	States must fund the 10 percent non-federal share of the Health Information Technology (HITECH) Act administrative expenditures consistent with the law and regulations applicable to the non-federal share for all Medicaid expenditures. Consistent with that authority, which includes Social Security Act sections 1902(a)(2), 1903(a), 1903(w), and 42 CFR Part 433, subpart B, states may fund the non-federal share of Medicaid expenditures through legislative appropriations to the Medicaid agency, intergovernmental transfers (IGTs), certified public expenditures (CPEs), permissible health-care related taxes, and bona-fide donations. States must submit their proposed strategies for funding the non-federal share of HITECH administrative payments to CMS for review as part of the HIT plan approval process. CMS will review each individual State's proposal to ensure that each proposed non-federal share funding source meets federal requirements. During this process, CMS can address specific questions about funding the non-federal share of Medicaid expenditures. CMS strongly urges States to work on their funding proposals with their CMS HIT Coordinators as early as possible before claiming for HITECH administrative expenditures, to ensure funding structures are appropriate. HITECH administrative expenditures, like other title XIX expenditures, are subject to audit, and federal funds may be at risk if funding sources are found not to be in compliance with federal requirements. Below are some statutory and regulatory citations pertaining to non-federal share financing requirements. Please note this is not an all-inclusive list of funding requirements. Use of Federal Funds Social Security Act §1903 42 CFR 433.51(c)•State Appropriations Social Security Act §1902(a)(2) 42 CFR 433.51•Intergovernmental Transfers Social Security Act §1903(w)(6)(A) 42 CFR 433.51•Certified Public Expenditures Social Security Act §1903(w)(6)(A)42 CFR 433.51 Healthcare-Related Taxes and Provider-Related Donations 42 CFR part 433, subpart B Created 2/7/2013
8902	Can a state capture electronic Clinical Quality Measures, or eCQMs, for the Medicaid Promoting Interoperability Program through a Health Information Exchange (HIE)	Yes, a state can capture clinical quality data for eCQMs using an HIE, and states should consider the health data landscape of their state when designing a system to collect eCQMs for the Medicaid Promoting Interoperability Program. Utilizing an HIE can allow the state to collect more sophisticated patient-level data, to encourage provider adoption, and to facilitate alignment between various programs, such as those authorized under the HITECH Act, Accountable Care Organizations, and Medical Homes. In order to use an HIE for quality data collection, a state would need to develop infrastructure to capture electronic clinical quality measures through the Quality Reporting Data Architecture (QRDA) format. In addition, eligible professionals and hospitals would either have to generate the QRDA files using the provider's Certified EHR Technology and/or the HIE itself would have to be certified as an EHR module for eCQMs. The Office of the National Coordinator for Health Information Technology and CMS published a state-focused electronic clinical quality reporting toolkit to provide support for states developing the policy and IT infrastructure for electronic clinical quality measurement. Further, states can request Federal Financial Participation at the 90/10 HITECH rate to assist in building the infrastructure to submit eCQMs electronically for the Medicaid Promoting Interoperability program. For more information, please see the State Medicaid Directors Letter #11-004: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/ Created on 7/24/2013
8037	Can eligible professionals (EPs) or eligible hospitals round their patient volume percentage when calculating patient volume in the Medicaid Electronic Health Records (EHR) incentive program?	To participate in the Medicaid Promoting Interoperability program, EPs are required to demonstrate a patient volume of at least 30% Medicaid patients over a 90-day period in the prior calendar year or in the 12 months before attestation. The Centers for Medicare and Medicaid Services allow rounding 29.5% and higher to 30% for purposes of determining patient volume. Similarly, pediatric patient volume may be rounded from 19.5% and higher to 20%. Finally, acute care hospitals are required to demonstrate a patient volume of at least 10% Medicaid patients over a 90-day period in the prior fiscal year preceding the hospital's payment year or in the 12 months before attestation. Hospitals' patient volume may be rounded from 9.5% and higher to 10%. Created on 3/13/2013
2767	Are eligible professionals (EPs) who practice in State Mental Health and Long Term Care Facilities eligible for Medicaid Promoting Interoperability payments if they meet the eligibility criteria (e.g., patient volume, non-hospital based, certified EHR)?	The setting in which a physician, nurse practitioner, certified nurse-midwife, or dentist practices is not relevant in determining eligibility for the Medicaid Promoting Interoperability Program (except for purposes of determining whether an EP can qualify through "needy individual" patient volume). Setting is relevant for physician assistants (PA), as they are eligible only when they are practicing at a Federally Qualified Health Center (FQHC) that is led by a PA or a Rural Health Center (RHC) that is so led. All providers must meet all program requirements prior to receiving an incentive payment (e.g. adopt, implement or meaningfully use certified EHR technology, patient volume, etc.). For more information about the Medicare and Medicaid Promoting Interoperability Program, please visit "http://www.cms.gov/EHRIncentivePrograms" Keywords: FAQ10069 Updated 5/12/2016

3471	If the State chooses to use the cost report in the Medicaid Promoting Interoperability hospital payment calculation, what data elements should be used in the Medicare cost report, Form CMS 2552-96 and the Form CMS 2552-10?	Based on the Medicare cost report guidance, Form CMS 2552-96 will be used until the implementation of the new Medicare cost report, Form CMS 2552-10. Although the State may choose to use the following data elements, it is the States' and hospitals' responsibility to ensure the integrity and regulatory compliance of the data. The CMS 2552-96 data elements are as follows: Total Discharges - Worksheet S-3 Part 1, Column 15, Line 12-Medicaid Days - Worksheet S-3, Part I, Column 5, Line 1 + Lines 6-10-Medicaid HMO Days - Worksheet S-3, Part I, Column 5, Line 2-Total Inpatient Days - Worksheet S-3 Part 1, Column 6, Line 1, 2 + Lines 6 -10-Total Hospital Charges - Worksheet C Part 1, Column 8, Line 101-Charity Care Charges - Worksheet S-10, Column 1, Line 30 The CMS 2552-10 data elements are as follows:-Total Discharges - Worksheet S-3 Part 1, Column 15, Line 14-Medicaid Days - Worksheet S-3, Part I, Column 7, Line 1 + Lines 8-12-Medicaid HMO Days - Worksheet S-3, Part I, Column 7, Line 2-Total Inpatient Days - Worksheet S-3 Part 1, Column 8, Line 1, 2 + Lines 8 - 12-Total Hospital Charges - Worksheet C Part 1, Column 8, Line 200-Charity Care Charges - Worksheet S-10, Column 3, Line 20 For information about the cost report data elements that are used in the Medicare hospital incentive calculation, please see http://questions.cms.hhs.gov/app/answers/detail/a_id/10717/" FAQ #10717Keywords: FAQ10771
10754	How can a provider meet the “Protect Electronic Health Information” core objective in the Promoting Interoperability Program?	To meet the “Protect Electronic Health Information” core objective for Stage 1, eligible professionals (EP), eligible hospitals or critical access hospitals (CAH) must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process. In Stage 2, in addition to meeting the same security risk analysis requirements as Stage 1, EPs and hospitals will also need to address the encryption and security of data stored in the certified EHR technology (CEHRT). These steps may be completed outside or the EHR reporting period timeframe but must take place within the same calendar year as the EHR reporting period, and if the provider attests prior to the end of the calendar year, it must be conducted prior to the date of attestation. For example, a EP who is reporting Meaningful Use for a 90-day EHR reporting period may complete the appropriate security risk analysis requirements outside of this 90-day period as long as it is completed no earlier than January 1st of the EHR reporting year and no later than the date the provider submits their attestation for that EHR reporting period. This meaningful use objective complements but does not impose new or expanded requirements on the HIPAA Security Rule. In accordance with the requirements under (45 CFR 164.308(a)(1)(ii)), providers are required to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI). Once the risk analysis is completed, providers must take any additional “reasonable and appropriate” steps to reduce identified risks to reasonable and appropriate levels. Please note that a security risk analysis or review needs to be conducted during each EHR reporting year to ensure the privacy and security of their patients’ protected health information. For more information about completing a security risk analysis, please see ONC's website at https://www.healthit.gov/topic/privacy-security-and-hipaa.
10755	If an EP or EH fails a post payment audit of a program year 2016 attestation, and 2016 was the providers’ first year of participation in the Medicaid Promoting Interoperability Program; how should states proceed if the EP or EH already attested and received payment in a subsequent year? Would the EP or EH need to return all payments due to not meeting program requirements in 2016?	A provider’s first participation year may be any year between 2011 through 2016. The last year a Medicaid EP or EH may begin receiving payments under the Medicaid Promoting Interoperability Program is 2016. Therefore, if 2016 was the providers’ first year of participation in the Medicaid Promoting Interoperability Program and they fail a post payment audit of the 2016 attestation, the provider would lose eligibility to attest for 2017 and any subsequent years. If the provider already attested and received payment for any program year after 2016, all future payments must be recouped.
8406	If an EP either retires or opts out of Medicaid, can he/she still receive an incentive payment?	In the Medicaid Promoting Interoperability Program, a provider must be a Medicaid provider at the time they adopt, Implement or upgrade (AIU) Certified EHR Technology or during the EHR reporting period for MU. A provider who subsequently retires or opts out of a state's Medicaid program is still entitled to the incentive payment. Note that the rules for how a provider gets paid may vary by state. A state may be unable to process a payment to a provider who is not enrolled in its Medicaid Management Information Systems (MMIS) and therefore may require that a provider be enrolled in order to receive an incentive payment. For more information, Medicaid providers should contact their state directly.