Frequently Asked Questions
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Frequently Asked Questions

1. How does an Eligible Professional calculate Medicaid patient volume?

A Medicaid provider must annually meet patient volume requirements of Utah's Medicaid EHR Incentive Program. Providers must demonstrate 30% Medicaid patient volume for a 90-day period. Pediatricians who do not reach the 30% threshold can qualify for a reduced payment by reaching 20-30% Medicaid patient volume. (Note that CMS allows the state to round up from 29.5 to 30%, and from 19.5 to 20%.) Providers may choose:

- Any consecutive 90-day period in the previous calendar year, OR
- Any consecutive 90-day period in the 12 months preceding the date of the provider's attestation.

Out of state Medicaid encounters may be included towards meeting the threshold; please calculate these separately.

A Medicaid encounter is defined as service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes:

- Paid claims: Encounters where Utah Medicaid or another State's Medicaid paid for part or all of the service; or part or all of their premiums, co-payments, and/or cost-sharing, (excluding Utah Premium Partnership (UPP) premium payments as the incentive program does not have a way of tracking patient utilization with this program)
- Claims denied due to service limitation audits
- Claims denied due to non-covered service
- Claims denied due to timely failing
- Services rendered on Medicaid members that were not billed due to the provider's understanding of Medicaid billing rules (medical services that are not covered under the state's Medicaid program.)
- A patient list of non-billed encounters must be provided to verify patients' Medicaid eligibility.

2. Leveraging Group Patient Volume

In specific circumstances, eligible providers in a group or clinic can leverage the entire clinic's volume to meet the Medicaid patient volume threshold. The group may receive one combined check for all providers deemed eligible. The following conditions apply:

- The clinic or organization must use the entire clinic's or organization's patient encounters and cannot limit it in any way. The patient volume calculation must include the encounters of ALL practitioners, both **eligible** and non-eligible. (Non-eligible practitioners may include physical therapists, social workers, etc.)
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

- Each eligible professional using the group proxy calculation must have an active Medicaid contract and see Medicaid patients in order for the group patient volume to be an appropriate proxy.
- All eligible professionals in the group practice or clinic must use the same methodology for the payment year.
- If the proxy is completed at the organizational level, only in-state clinics may be included.

3. Which Medicaid programs are eligible for inclusion in the Medicaid patient volume calculation?

Both Medicaid fee for service (FFS) and Medicaid managed care patients can be included in this calculation.

- Medicaid FFS
- Molina Medicaid
- Healthy U
- Select Health Community Care
- PCN
- Health Choice Utah

Note that CHIP medical or dental encounters are NOT to be included in the Medicaid encounters. The only providers who can include their CHIP encounters are those practicing in a Federally Qualified Health Center or Rural Health Center. Please see the incentive program user guide for additional documentation.

4. What are the attestation deadlines for the Utah Medicaid EHR Incentive Program?

The Utah Medicaid Attestation Deadlines are listed in the following table:

	Program Year	Last Day to Attest		Program Year	Last Day to Attest
EPs	2011	2/29/2012	**EHs**	2011	11/30/2011
	2012	2/28/2013		2012	12/31/2012
	2013	3/31//2014		2013	12/31/2013
	2014	2/28/2015		2014	11/30/2014
	2015	2/28/2016		2015	11/30/2015
	2016	2/28/2017		2016	11/30/2016

Note that in order to complete the state registration process by the deadline, you must have the **CMS registration step** completed a day in advance, so that the record can be sent to the state. This only needs to be done once, unless you need to make a change to your contact information or tax ID information.

Please refer to the **CMS Participation Timeline** for additional guidance regarding deadlines.

5. What types of providers are eligible for the incentive program?

In accordance with the final rule, Medicaid has determined that the following providers and hospitals are potentially eligible to enroll in the Utah Medicaid EHR Incentive Program:

Physicians = Any provider who has a Provider Type 20 and/or 24 and Specialty other than 45 (Pediatrics)

Physician Assistant [Provider Type 201] practicing in a FQHC [Provider Type 52] or RHC [Provider Type 57] led by a Physician Assistant. An FQHC or RHC is considered to be PA led in the following instances:

- The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
- The PA is the clinical or medical director at a clinical site of the practice
- The PA is the owner of the RHC

Pediatrician = Any provider with a Provider Type 20 and/or 24 and Specialty 45
Nurse Practitioner = Any provider with a Provider Type 47 and not Provider Type 37 Certified Nurse Midwife (CNM)
Certified Nurse Midwife = Any provider with a Provider Type 37
Dentist = Any provider with a Provider Type 40
Acute Care Hospital = Any provider with a Provider Type 01
Children's Hospital = Any provider with a Provider Type 01 and Specialty 45
Critical Access Hospital (CAH) = Any provider with a Provider Type 01
Cancer Hospital = Any provider with a Provider Type 03

EPs and EHs must be currently enrolled or affiliated with an entity in the Utah Medicaid Management Information System (MMIS) for a minimum of 90 days. Currently PAs are not enrolled in the Utah MMIS and are handled as a special case. Provider enrollment forms and instructions can be accessed at **http://health.utah.gov/medicaid/provhtml/providerenroll.htm.**

6. How soon can providers attest for their second year incentive payment?

Only one payment can be made per program year. For a provider who received the first payment in the 2012 program year, the soonest you could attest for the second payment would be April 2013 (assuming that you can use January-March 2013 as your Meaningful Use EHR reporting period.) For eligible professionals, the EHR reporting period always matches the program (calendar) year, regardless of what 90 day period is being used for the patient volume reporting period.

7. How does CMS define Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) for the purposes of the Medicaid EHR Incentive 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.

Program eligibility requirements for providers and hospitals include meeting 30% Medicaid patient volume (20% for pediatricians); however, the threshold for providers practicing in an FQHC or RHC is different where they can

use their CHIP, uncompensated care and sliding fee patient volume to reach 30%. For information regarding Utah regulatory requirements for RHCs contact Kelly Criddle, at KCRIDDLE@utah.gov or (801) 538-6545.

8. What are the reporting periods for hospitals eligible for both the Medicare and Medicaid EHR Incentive Programs?

Hospital Participating In:			
Payment Year	Medicaid 1st, then Medicare in same FY	Medicaid 1st, then Medicare in later FY	Medicare and Medicaid Simultaneously / Medicare 1st, then Medicaid in a later FY
1st payment year	AIU (Medicaid); MU, 90 day reporting period (Medicare)	AIU	MU, 90 day reporting period
2nd payment year	MU, 12 month reporting period	MU, 90 day reporting period	MU, 12 month reporting period
3rd payment year	MU, 12 month reporting period	MU, 12 month reporting period	MU, 12 month reporting period

9. Special notes for the 2014 program year

When the Stage 2 Meaningful Use regulations are put in place (10/1/2013 for eligible hospitals, 1/1/2014 for eligible providers) some other changes will accompany this:

- **Changes to stage 1 meaningful use.**
- Changes to certification requirements for EHR systems. **YOUR SYSTEM MUST BE CERTIFIED TO THE 2014 STANDARD TO RECEIVE A 2014 PROGRAM YEAR INCENTIVE, even for Stage 1 payments.** (This does not affect providers or hospitals whose program year 2013 incentives are paid in calendar year 2014.) Please consult your vendor or use the **ONC's website** to determine if your system is ready for the 2014 changes.
- EHR reporting period change **for program year 2014 only**: regardless of what stage of meaningful use, in 2014 all providers and hospitals will report on 90 days of meaningful use. The state of Utah has decided to allow reporting on any 90 days, and will not restrict participants to reporting on the calendar quarters.

10. Acronyms

Acronyms in the Utah Medicaid EHR Incentive Program:

ACA	Patient Protection and Affordable Care Act
AIU	Adopt, Implement, or Upgrade
ARRA	American Reinvestment & Recovery Act of 2009
CAH	Critical Access Hospital

CCN	CMS Certification Number
CHIP	Children's Health Insurance Program (US Government Health Care Finance Administration)
cHIE	Clinical Health Information Exchange (Utah's HIE)
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare and Medicaid
CNM	Certified Nurse Midwife
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality Measure
CY	Calendar Year
DMHF	Division of Medicaid & Health Financing (Utah Dept of Health)
EH	Eligible Hospital
EHR	Electronic Health Record
EIN	Employer Identification Number
EP	Eligible Professional
eRx	E-Prescribing
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
HHS	U.S. Dept of Health & Human Services
HIE	Health Information Exchange
HIT	Health Information Technology
HITPC	Health Information Technology Policy Committee
HIPAA	Health Insurance Portability & Accountability Act of 1996
HPSA	Health Professional Shortage Area
MA	Medicare Advantage
MAR	Management & Administrative Reporting
MCMP	Medicare Care Management Performance Demonstration
MMIS	Medicaid Management Information System
MSIS	Medicaid Statistical Information System
MU	Meaningful Use
NCVHS	National Committee on Vital & Health Statistics
NLR	National Level Registry
NP	Nurse Practitioner
NPI	National Provider Identifier
NPRM	Notice of Proposed Rulemaking
OMB	Office of National Coordinator of Health Information Technology

ONC	Office of the National Coordinator for Health Information Technology (United States Government Health and Human Services)
PA	Physician Assistant
PCN	Primary Care Network (Utah 1115 Waiver)
PECOS	Provider Enrollment, Chain and Ownership System (Medicare provider online enrollment system)
PPS	Prospective Payment System (Part A)
PQRI	Medicare Physician Quality Reporting Initiative
REC	Regional Extension Center (HealthInsight, in Utah)
RHC	Rural Health Center
RHQDAPU	Reporting Hospital Quality Data for Annual Payment Update
SLR	State Level Repository
TIN	Taxpayer Identification Number