

Frequently Asked Questions

Main Page

*Some of the FAQs found below have been adapted from the CMS FAQ Page. For more information, please see the [CMS EHR Incentive Programs website](#).

Eligibility

Am I eligible for the NC Medicaid EHR Incentive Program?

Eligibility requirements are different for eligible professionals (EPs) and eligible hospitals (EHs). Generally speaking, there are three eligibility requirements participants need to meet:

- (1) Are you an eligible provider type?
- (2) Do you have a certified EHR technology?
- (3) Do you meet the Medicaid Patient Volume threshold?
 - EPs must see 30% Medicaid patients*
 - EHs must see 10% Medicaid patients

*Pediatricians may qualify with 20% PV for a reduced incentive payment.

Detailed eligibility information is available on the [CMS EHR Incentive Program website](#).

What are the eligible provider types?

Eligible professionals include:

- Physicians (primarily doctors of medicine and doctors of osteopathy);
- Nurse practitioners;
- Certified nurse midwives;
- Dentists; and,
- PAs who furnish services in an FQHC or RHC that is led by a PA.

Eligible hospitals include:

- Acute care hospitals
- Critical access hospitals

There are some nurse practitioners (NPs) who are diploma-credentialed and educated rather than having a Master's Degree in nursing as an NP. Would these NPs have any difficulty getting enrolled with Medicaid?

NPs who meet the following education and certification requirements may begin registering for Medicaid at any time. Once they acquire a National Provider Identifier (NPI) they may register for the Medicaid EHR Incentive Program. To attest as an individual, the NP must have claims history for the selected reporting period under his/her own NPI to calculate patient volume. To attest as part of a group using group methodology, the NP may utilize existing group encounter data to calculate patient volume. North Carolina's education and certification requirements for NPs are as follows:

- Health assessment and diagnostic reasoning including: Historical data;
- Physical examination data; and,
- Organization of data base.
- Pharmacology;
- Pathophysiology;

Clinical management of common health problems and diseases such as the following shall be evident in the nurse practitioner's academic program:

- Respiratory system;
- Cardiovascular system;
- Gastrointestinal system;
- Genitourinary system;
- Integumentary system;
- Hematologic and immune systems;
- Endocrine system;
- Musculoskeletal system;
- Infectious diseases;
- Nervous system;
- Behavioral, mental health and substance abuse problems;
- Clinical preventative services including health promotion and prevention of disease;
- Client education related to Subparagraph (b) (4)–(5) of this Rule; and,
- Role development including legal, ethical, economical, health policy and interdisciplinary collaboration issues. Nurse practitioner applicants exempt from components of the core curriculum requirements listed in Paragraph (b) of this Rule are: Any NP approved to practice in North Carolina prior to January 18, 1981, is permanently exempt from the core curriculum requirement; and,
 - An NP certified by a national credentialing body prior to January 1, 1998, who also provides evidence of satisfying Subparagraph (b)(1)–(3) of this Rule shall be exempt from core curriculum requirements in Subparagraph (b)(4)–(7) of this Rule.
 - Evidence of satisfying Subparagraph (b)(1)–(3) of this Rule shall include: A narrative of course content; and,
 - Contact hours.

History Note: Authority G.S. 90-18(14); 90-171.42;

Recodified from 21 NCAC 36.0227(d) Eff. August 1, 2004;

Amended Eff. December 1, 2009; December 1, 2006; August 1, 2004.

If a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) is led by a physician assistant (PA), are all PAs at that FQHC or RHC eligible for the program?

Yes, all PAs who furnish services in an FQHC or RHC that is PA-led are eligible professionals (EPs) under the NC Medicaid EHR Incentive Program, so long as the PAs meet all other Program eligibility requirements (30% Medicaid/needily individual PV/not hospital-based, etc.).

Like other EPs at an FQHC or RHC, upon receipt of attestation, eligible PAs may be asked to provide additional documentation of any services provide either at no cost or at reduced cost based on a sliding scale determined by the individuals' ability to pay.

Are podiatrists, optometrists and chiropractors eligible for the NC Medicaid EHR Incentive Program?

No. EPs under the NC Medicaid EHR Incentive Program include:

- Physicians (primarily doctors of medicine and doctors of osteopathy);
- Nurse practitioners;
- Certified nurse midwives;
- Dentists; and,
- PAs who furnish services in an FQHC or RHC that is led by a PA.

Under the NC Medicaid EHR Incentive Program, are there a minimum number of hours per week that an EP must practice in order to qualify for an incentive payment? Could a part-time EP qualify for an incentive payment if the EP meets all other eligibility requirements?

There are no restrictions on employment type (e.g., contractual, permanent, or temporary - regardless of number of hours worked). So a part-time EP who meets all other eligibility requirements could qualify for payments under the NC Medicaid EHR Incentive Program.

Are physicians who are employed directly by a tribally-operated facility and who meet all other eligibility requirements, eligible for an NC Medicaid EHR incentive payment?

If the physician meets the other program eligibility requirements (they can demonstrate 30% Medicaid patient volume, they've demonstrated AIU or meaningfully used certified EHR technology, they are not hospital-based, etc.) then the fact that they are employed by a tribally-operated facility is irrelevant.

Will long-term care providers such as nursing homes be eligible for NC Medicaid EHR incentive payments?

The nursing home institution is not eligible for an incentive payment; however, individual EPs who work at the nursing home may qualify for an NC Medicaid EHR incentive payment and may choose to assign their payment to the nursing home facility.

If the long-term care providers meet all other program eligibility requirements, they may qualify to receive incentive payments. EPs under the NC Medicaid EHR Incentive Program include:

- Physicians (primarily doctors of medicine and doctors of osteopathy);
- Nurse practitioners;
- Certified nurse midwives;
- Dentists; and,
- PAs who furnish services in a Federally Qualified Health Center or Rural Health Center that is led by a PA.

Are ambulatory surgical centers eligible for an NC Medicaid EHR incentive payment?

The ambulatory surgical center is not eligible for an incentive payment; however, individual EPs working at the ambulatory surgical center may qualify for an NC Medicaid EHR incentive payment and may choose to assign their payment to the ambulatory surgical center.

Under Medicaid, EPs include:

- Physicians (primarily MDs and DOs)
- Nurse practitioners
- Certified nurse midwives
- Dentists; and,
- PAs who furnish services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a PA.

EHS include:

- Acute care hospitals; and,
- Critical access hospitals.

Are EPs who practice in State Mental Health and Long Term Care Facilities eligible for an NC Medicaid EHR incentive payment if they meet all other eligibility requirements?

If a provider meets eligibility requirements, the setting is irrelevant. This is true except for physician assistants (PAs), 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.

Are mental health practitioners eligible to participate in the NC Medicaid EHR Incentive Program?

Mental health providers would only be eligible for incentive payments if they meet the eligibility criteria of a Medicaid EP.

Under Medicaid EPs include:

- Physicians (primarily MDs and DOs)
- Nurse practitioners
- Certified nurse midwives
- Dentists; and,
- PAs who furnish services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a PA.

EHS include:

- Acute care hospitals; and,
- Critical access hospitals.

Will the resident physicians that are employed at university hospitals be eligible to participate in the NC Medicaid EHR Incentive Program?

Physicians who furnish substantially all (defined as 90% or more) of their covered professional services in either an inpatient or emergency department of a hospital are considered to be hospital-based.

A hospital-based EP that can demonstrate to CMS that they funded the acquisition, implementation and maintenance of certified EHR technology (CEHRT), including supporting hardware and interfaces needed for meaningful use without reimbursement from an EH or CAH, and uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT), may be determined by CMS to be a non-hospital based EP and may be eligible to participate in the Medicaid EHR Incentive Program.

What are the requirements for dentists participating in the NC Medicaid EHR Incentive Program?

Dentists must meet the same eligibility requirements as other eligible professionals (EP) in order to qualify for payments under the Medicaid EHR Incentive Program. EPs will have to evaluate whether they individually meet the Meaningful Use (MU) measures and if they qualify to meet the exclusion criteria for each applicable objective as there is no blanket exclusion for any EP.

For additional guidance on how on how dentists can reach MU, see the [HRSA website](#).

Are pediatricians eligible to receive incentive payments?

North Carolina Medicaid recognizes an Eligible Professional as being a pediatrician if they are a Doctor of Medicine (MD) or a Doctor of Osteopathic Medicine (DO) and meet one of the two requirements below:

- Enrolled in NC Medicaid with a pediatrics specialty; or,
- Board certified by a national certification board in Pediatrics, Adolescent or Child medical specialty area.

Please note, pediatricians may qualify for a reduced incentive payment with a reduced patient volume threshold of 20%.

Per the given definition, NPs are not eligible to qualify with a Medicaid PV threshold of 20%. All NPs need to meet the 30% Medicaid PV threshold to be eligible to receive an EHR incentive payment.

How does NC define 'hospital-based' for eligible professionals?

A hospital-based eligible professional (EP) is defined as an EP who furnishes 90 percent or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. Covered professional services are physician fee schedule (PFS) services paid under Section 1848 of the Social Security Act. To determine whether an EP is hospital-based, EPs may use encounter data from either the fiscal year prior to program year or calendar year prior to program year.

Am I able to attest to adopt, implement, upgrade (AIU) even if I purchased by EHR several years ago?

Yes. So long as the provider is in their first year of participation and has not yet received an AIU payment, they are permitted to attest to AIU any time after purchasing/implementing/upgrading their EHR. Program Year 2016 is the last year to attest to AIU.

I am an NP who has a pediatric taxonomy on NCTracks. May I qualify at the reduced Medicaid PV threshold of 20%?

No. Medicaid recognizes an Eligible Professional as being a pediatrician only if they are a Doctor of Medicine (MD) or a Doctor of Osteopathic Medicine (DO) and meet one of the following requirements below:

- Enrolled with NC Medicaid as a pediatrics specialty; or,
- Board certified by a national certification board in a Pediatrics, Adolescent or Child medical specialty area.

I am an FQHC/RHC. Do I have to attest to practicing predominantly?

It is not required for an FQHC/RHC provider to attest to practicing predominantly, unless they wish to use non-Medicaid needy individual encounters to count toward their 30% Medicaid patient volume threshold. If the EP is not using non-Medicaid needy individual encounters, they do not have to attest to practicing predominantly.

NOTE: For more complete information about eligibility requirements, please refer to the [CMS EHR Incentive Program website](#).

Registration

Do I need to have an EHR system in order to register for the NC Medicaid EHR Incentive Program?

CMS and NC require that EPs and EHs have adopted, implemented, or upgraded (AIU) certified EHR technology before they can attest with the state to receive an EHR incentive payment. So while you do not need to have a certified EHR in order to register for the NC Medicaid EHR Incentive Program, you will not be able to successfully attest or receive an incentive payment until you have a certified EHR technology. ONC maintains the most up-to-date list of certified products on [their website](#).

Do providers register only once for the NC Medicaid EHR Incentive Program or do they register every year?

Providers are only required to register once for the NC Medicaid EHR Incentive Program. However, they must successfully demonstrate that they have adopted, implemented or upgraded (AIU) (first participation year for Medicaid) or meaningfully used (MU) certified EHR technology each year in order to receive an incentive payment for that year.

Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds.

For large practices, will there be a method to registering all EPs at one time for the NC Medicaid EHR Incentive Program? Can EPs allow another person to register/attest for them?

Please note, the individual provider is liable for the information provided on the attestation.

In April 2011, CMS implemented functionality that allows an EP to designate a third party to register on his or her behalf. To do so, users working on behalf of an EP must have an Identity and Access Management System (I&A) web user account (User ID/Password) and be associated to the EP's NPI.

The North Carolina Medicaid EHR Incentive Payment System (NC-MIPS) system will not allow one person to use one NCID to attest for multiple EPs.

I need an NCID (North Carolina Identity Management Identifier) in order to register for the program. What kind of account do I need?

NCID is the standard identity management and access service provided to state, local, business, and individual users, and is required when registering for the NC Medicaid EHR Incentive Program. NCID accommodates many types of user communities, including:

- Business users request access to the State of North Carolina on the behalf of a business.
- Individuals request access to conduct online transactions with the state of North Carolina. These users may or may not be citizens of the state.
- State government employees are employed or contracted to work for an agency within the state of North Carolina government.
- Local government employees are employed or contracted to work for a North Carolina county or municipality.
- Administrators are state and local government employees who can administer user accounts within the same organization, division(s) and/or section(s) for which he or she has administrative rights (i.e. Delegated Administrators, Application Administrators, Service Desk).
- Providers who are not state or local government should register as Business users. However, in coordinating efforts with Medicaid eligibility and enrollment, including the re-credentialing process, those who are employed or contracted to work for a state agency or locality must register as state or local government employees, respectively. Any fees associated with obtaining an NCID for the purposes of attesting for an incentive payment cannot be waived by NC Medicaid.

I just recently moved to North Carolina but received a Medicaid incentive payment from the state where I practiced last year. How do I attest this year with the NC Medicaid EHR Incentive Program?

Providers need to navigate to the [CMS Registration & Attestation \(R&A\) System](#), update their state to "NC" and ensure their contact information is updated. After doing this, the provider should receive an email from NC Medicaid with further instructions about attesting with the state.

I have a new provider in our practice this year and they don't know if they've received an incentive payment. Where can I go to see if they have participated in, and received money for, the Medicare or Medicaid EHR Incentive Program?

This information can be found on [CMS' Registration & Attestation System](#) under the attesting provider's registration information.

General Program Information

What is the path to payment most EPs take?

Please visit the [NC Medicaid EHR Incentive Program website](#) for detailed information on an EP's path to payment, including links and additional resources to assist you. To see visual guidance of the path to payment if an EP attested to AIU in their first year of participation, [click here](#). To see a path to payment for an EP who attested to MU in their first year of participation, [click here](#).

For more information on the EH attestation schedule and path to payment, please visit the [NC Medicaid EHR Incentive Program website](#) and click on the "Path to Payment" tab.

Who do I contact for more information?

Email our help desk anytime! NCMedicaid.HIT@dhhs.nc.gov

Where can I find help with the attestation process?

Detailed, step by step attestation assistance can be found in the EP and EH attestation guides. These are posted on the [NC-MIPS website](#) to help providers with the attestation process.

If after reviewing the resources available, you have questions, please email the NC-MIPS Help Desk at NCMedicaid.HIT@dhhs.nc.gov.

What are the next steps after a provider emails the signed attestation?

Attestations are validated in the order they were received and go through a series of validation checks. Once the validation process is completed and if there are no attestation discrepancies, the EP will be made eligible for payment and all payments will be posted on the [program website](#) under the "Path to Payment" tab once the electronic file transfer (EFT) is processed. If there are attestation discrepancies, we will conduct outreach giving the provider 15 calendar days to address the error.

We will not begin validating until the signed attestation is received.

Providers may see the status of their attestation on the [NC-MIPS](#) Status page.

How does CMS define an FQHC and an RHC for the purposes of the NC 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 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, FQHC Look-Alike's, and Tribal Health Centers.

What do "program years," "participation years," and "payment years" mean?

Broadly speaking, program years are based on the program on a whole, while participation and payment years are based on the individual provider.

The NC Medicaid EHR Incentive Program extends 10 years, from 2011-2021. The program began in 2011 (program year one) and will count its program years consecutively. For example, as of August 18th, 2016 we are in Program Year 2016.

EPs may participate in any six of the 10 program years. These years are called participation or payment years, and they do not have to be consecutive.

In participation or payment year-one, a provider will typically attest to AIU of a certified EHR technology. In participation or payment years two and beyond, they will demonstrate MU of that technology.

Does NC verify the "installation" or "a signed contract" for AIU for participation in the NC Medicaid EHR Incentive Program?

As part of the requirements, providers need to prove they have adopted, implemented or upgraded to a certified EHR technology. One such way to prove this is through supporting documentation (e.g.: contract, software license agreement, etc.) It is optional for providers to submit documentation at the time of attestation. Per CMS' guidance, North Carolina suggests

keeping documentation related to incentive payments for six years post-attestation in case of an audit.

Are Medicaid providers subject to penalties if they do not adopt EHR technology or fail to demonstrate Meaningful Use?

No, Medicaid does not have any penalty for not being a meaningful user, and no penalties will be made to Medicaid reimbursements.

However, Medicare eligible professionals (EPs) who do not demonstrate meaningful use for the Medicare EHR Incentive Program may be subject to payment adjustments beginning on January 1, 2015. EOs will be subject to penalties beginning October 1, 2014.

For information on Medicare penalties, please visit [CMS' Payment Adjustment & Hardship Exemptions page](#).

If I am taking a Medicare hardship exemption, but participating in the NC Medicaid EHR Incentive Program, do I have to file any paperwork with NC Medicaid?

No. EPs who are applying for hardship exemptions will do so with CMS. Providers do not need to file any paperwork or documentation with NC Medicaid.

For information on Medicare penalties, please visit [CMS' payment adjustment & hardship exemptions page](#).

Please note, Medicaid does not have any provider penalties for not being deemed a meaningful user.

If I attested in Program Year 2013 and skipped Program Year 2014, do I lose that payment year?

Participation years do not need to be consecutive. An EP may choose to skip a Program Year(s) and will have the opportunity to pick up where they left off. In other words, if an EP was going to attest to Stage 1 90-day MU in Program Year 2014, but skips Program Year 2014 and returns to attest in Program Year 2015, they'll attest to a 90-day MU reporting period in Program Year 2015.

There are no penalties for skipping years of participation. So long as the EP participates for six years before 2021, they have the opportunity to earn the full incentive payment of \$63,750.

How long do I have to submit my signed attestation and other attestation documents?

The signed attestation and any other required attestation documentation (signed MU Summary Pages, CQM report, etc.) must be submitted 15 days after submitting an attestation on NC-MIPS.

We will not begin validating an attestation until the required documentation is received.

I am a proxy attesting on behalf of a provider. May I sign the attestation?

No. Only the attesting EP may sign the attestation as they are the ones who will be held liable for the information submitted.

What is the last year an EP may attest to AIU?

The last year an EP may attest to AIU is Program Year 2016.

Eligible Professionals

What documentation is needed to demonstrate eligibility for being a PA-led facility?

The Final Rule states, a PA would be leading an FQHC or RHC under any of the following circumstances:

- (1) The PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);
- (2) The PA is a clinical or medical director at a clinical site of practice; or,
- (3) The PA is an owner of an RHC.

For eligibility, PA-led facilities should submit documentation on group letterhead speaking to one of the three requirements mentioned above.

In order to qualify as an encounter, an EP must "see a patient." How does an EP determine whether a patient has been "seen by the EP" in cases where the service rendered does not result in an actual interaction between the patient and the EP? Do patients seen via telemedicine qualify as an encounter?

A Medicaid encounter is defined as services rendered to an individual on a unique day where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under Section 1115 of the Social Security Act) at the time the billable service was provided. In other words, **an encounter is a unique patient on a unique day with a unique provider.**

All cases where the EP has an actual physical encounter with a patient and renders a service to the patient should be included in the denominator as "seen by the EP."

All cases where patients are seen via telemedicine qualify as encounters. All telemedicine encounters must be included in the denominator, and those encounters where Medicaid paid part, or all of the services, should be included in the numerator.

In cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by an EP" provided the choice is consistent for the entire EHR reporting period and for all the relevant meaningful use (MU) measures.

EPs who never have a physical or telemedicine interaction with patients must adopt a policy that classifies at least some of the services they render for patients as "seen by the EP." This

methodology must be consistent across the entire EHR reporting period and across MU measures that involve patients “seen by the EP.” Otherwise, these EPs would not be able to satisfy MU, as they would have denominators of zero for some measures.

NC Medicaid defines telemedicine as:

The use of two-way real-time interactive audio and video between places of lesser and greater medical capability and/or expertise to provide and support health care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telemedicine.

How will NC Medicaid determine whether an EP is hospital-based?

NC Medicaid will use data from the prior calendar year or the 12 months immediately preceding the date of attestation to determine whether an EP is hospital-based.

What is the latest date an EP can submit a Program Year 2015 attestation?

North Carolina has adopted an attestation tail period of 120 days to allow for attestation beyond the end of the payment year. This means that EPs will have until April 30, 2017 to submit a Program Year 2016 attestation. We suggest submitting your attestation well in advance of the deadline to have time to address any attestation discrepancies.

I am an office manager attesting on behalf of an EP. May I sign the attestation or does it need to be signed by the attesting EP?

All signed attestations must be signed by the attesting EP. Please note, we do not accept electronic signatures or stamps.

I attested with Medicare's EHR Incentive Program before but switched to the NC Medicaid EHR Incentive Program (before Program Year 2014). Do I attest for another first year incentive payment since this is my first year attesting with Medicaid?

No. If an EP attests with ANY EHR Incentive Program (Medicare or another state Medicaid EHR Incentive Program), that counts as a year participation in the EHR Incentive Program. So if the EP attested with Medicare during their first participation year, when attesting with Medicaid, the EP would be attesting for a year 2 payment (Stage 1 90-day MU) and will follow [Medicaid's AIU path to payment](#) as if they attested with Medicaid the entire time.

For more information, please see the [CMS EHR Incentive Programs website](#).

Do any North Carolina counties qualify for the broadband access exclusions?

No. There are two objectives in the final rule for EHR Incentive Programs in 2015 through 2017 that require providers to have broadband access; Objective 8 – Patient Electronic Access and Objective 9 (EPs only) – Secure Messaging. CMS offers exclusions and hardship exceptions for providers who face barriers in meeting meaningful use objectives that require broadband access and Internet connectivity for their locations and patients. However, there are no counties in North Carolina that do not have 4 Mbps of Broadband download speed, therefore, there are none that would qualify for the broadband access exclusions. For more information,

see https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016_BroadbandAccessExclusionsTipSheet.pdf.

Payment

In order to receive payments under the NC Medicaid Incentive Program, does a provider have to be enrolled in the Provider Enrollment, Chain and Ownership System (PECOS)?

No, Medicaid EPs do not have to be enrolled in PECOS to receive incentive payments. Medicaid EHR incentive payments are sent via EFT.

The Medicare EHR Incentive Program requires providers to be enrolled in PECOS, so EHs who choose to participate in both EHR Incentive Programs will be required to be enrolled in PECOS.

What safeguards are in place to ensure that NC Medicaid EHR incentive payments are used for their intended purpose?

Like the Medicare EHR Incentive Program, neither the statute nor the CMS final rule dictates how a Medicaid provider must use their EHR incentive payment.

After successfully demonstrating MU for the NC Medicaid EHR Incentive Program, will incentive payments be paid as a lump sum or in multiple installments?

They will be paid in installments. An EP has the opportunity to receive up to \$21,250 for their first year payment and \$8,500 each subsequent year they participate in the program. If an EP is eligible for the program as a pediatrician, they have the opportunity to earn \$14,167 in their first participation year and \$5,667 in participation years 2-6.

EH payments are calculated prior to their attestation. They will receive 50% of the total incentive payment amount in year 1, they will receive 40% of the total incentive payment in year 2, and will receive the final 10% of the total incentive payment in year 3.

Where can I find my incentive payment on my RA (remittance advice)?

An incentive payment can be found as a separate item on the RA after paid and denied claims in the "Payouts" section, before the Financial Summary page.

All payments will be posted under the 'Path to Payment' tab on the [program website](#) with the provider and payee NPI, the amount paid, the EFT date and a CCN to reconcile the payment on their RA.

What if my EHR costs more than the incentive payment? May I request additional funds?

No. The NC Medicaid Incentive Program is not a reimbursement program. Maximum payments have been set by CMS for EPs and the EH payment is calculated prior to their attesting with the NC Medicaid EHR Incentive Program. For additional information, please visit [CMS' EHR Incentive Program website](#).

May I switch between the Medicare and Medicaid's EHR Incentive Programs?

No. EPs are no longer able to switch between the Medicare and Medicaid EHR Incentive Programs.

Do recipients of NC Medicaid EHR incentive payments need to file reports under Section 1512 of the American Recovery and Reinvestment Act (ARRA) of 2009?

No. The Medicaid EHR incentive payments made to providers are not subject to ARRA 1512 reporting because they are not made available from appropriations made under the Act.

Are payments issued by the NC Medicaid EHR Incentive Program subject to federal income tax?

CMS notes that nothing in the HITECH Act excludes such payments from taxation or as tax-free income, so it is likely that payments would be treated like any other income. That being said, providers should consult with a tax advisor or the IRS regarding how to properly report this income on their filings.

In general, there are three things providers need to know regarding taxes and the NC Medicaid EHR Incentive Program:

1. If you assign your payment to a third party (such as your group practice), CMS is still obligated to report a payment to the eligible professional him or herself. The eligible professional will then bear a reporting obligation with respect to the assignment to a third party. CMS would not have a reporting obligation with respect to the third-party assignee unless CMS exercised managerial oversight with respect to, or had a significant economic interest in, the assignment.
2. Recipients must include incentive payments as part of their gross income unless they receive payments as a conduit or an agent of another and are thus unable to keep the payments. For example, Dr. Smith works at ABC Healthcare and they use a 3rd party billing agency. Dr. Smith's Electronic Funds Transfer (EFT) may get sent to the 3rd party billing agency and redirected directly to Dr. Smith. Be that the case, the 3rd party billing agency would not need to include the EHR incentive payment as gross income, but Dr. Smith would need to include the EHR incentive payment as gross income.
3. To see the CMS reporting requirements with regard to eligible providers, see section 6041 of the Internal Revenue Code.

For specific provider questions, please call the Internal Revenue Service (IRS) toll-free at 800-829-3903.

Do EP payments go to the professional or the professional's practice?

NC Medicaid EHR Incentive Payments for EPs are tied to individual professionals, but may be voluntarily assigned to an employer or entity of their choosing. It is against federal and program rules for an organization to require that affiliated providers assign incentive payments to an organization or practice.

How do I track an NC Medicaid EHR incentive payment?

Once a provider has been approved for an NC Medicaid EHR incentive payment, the NC-MIPS Help Desk will post to the program website a spreadsheet with the provider NPI, the payee NPI, the payee name, the amount paid, the EFT date and a CCN which should make the payment easily identifiable on the remittance advice (RA).

The incentive payment can also be found as a separate item on the RA after paid and denied claims in the "Payouts" section, before the Financial Summary page.

The "EFT effective date" given on the spreadsheet can be used to reconcile the payment against the 835 or RA.

An EP may check the status of their attestation at any time by logging onto [NC-MIPS](#).

I attested for an incentive payment, but I entered the wrong payee NPI and the wrong person and/or organization was paid. What can I do to re-assign the payment or deal with tax liability?

Once a provider has assigned a payee in [CMS' Registration and Attestation System](#), completed attestation, and been paid, NC Medicaid will not reassign the same payment to a different payee. If a provider has assigned the payment to an unintended payee, the provider will need to facilitate a transfer of the payment between the actual and intended payee.

The provider may request a corrected 1099 from NC Medicaid by sending a copy of their 1099 along with a W-9 for the group to NC Medicaid to request the incentive payment earnings be moved to the new (intended) payee's tax ID. This will remove the incentive payment earnings from the actual (initial) payee and add the incentive payment to the new (intended) payee. Please note that corrected 1099s are mailed by NC Medicaid on April 1.

I attested for an incentive payment, but a payee other than the payee specified in CMS' Registration and Attestation System was paid. What can I do to re-assign the misdirected payment?

If a payee other than the payee specified in the CMS' Registration and Attestation System was paid, please contact [NCTracks](#). They will work with providers on a case by case basis to resolve the issue.

Will the sequestration impact NC Medicaid EHR Incentive Payments?

Per the federal sequestration, a 2% reduction will be applied to any Medicare EHR incentive payment for a reporting period that ends on or after April 1, 2013. This sequestration will not impact Medicaid payments for the EHR Incentive Program.

Please see CMS' EHR Incentive Program website for payment adjustment & hardship exemption information by [clicking here](#).

Will my incentive payment be a direct deposit or issued via check?

The payment is made via electronic funds transfer (EFT) to the account associated with the payee NPI/payee EIN given during attestation. All payments will be posted on a spreadsheet under the "Path to Payment" tab on the [program website](#). The spreadsheet will give the amount paid with the EFT date and CCN number, which should make the payment easily identifiable on the RA. An incentive payment can be found as a separate item on the RA after paid and denied claims in the "Payouts" section, before the Financial Summary page.

Can a provider who has retired or opted out of Medicaid still receive a Medicaid EHR incentive payment?

In the Medicaid EHR Incentive Program, a provider must be a Medicaid provider either 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 EP must assign payment to an NPI that is active in NCTracks. For more information, see CMS FAQ 8406 - <https://questions.cms.gov/faq.php?faqId=8406>.

I did not receive the payment listed on the Paid To Date spreadsheet. Who can help me?

If you are listed on the Paid To Date spreadsheet on the Path To Payment tab, you were approved for an NC Medicaid EHR Incentive Program payment and the Program team authorized issuance of payment to the payee NPI listed on your attestation. If you are unable to locate that payment, please contact CSRA (formerly CSC), the fiscal agent for NCDHHS, which operates the NCTracks system. You can reach them at 800-688-6696 or NCTracksprovider@nctracks.com. Request that the representative open a PEGA ticket to forward your concern to their Finance department. The Finance team can track electronic payments and provide information on when electronic funds transfer occurred and to what bank account the funds were sent. They can also provide the relevant page of the RA with details on payment.

Patient Volume (PV) for Eligible Professionals (EP)**How is PV calculated?**

EPs need 30% Medicaid PV (20% for Pediatricians - for a reduced payment) to be eligible for the incentive program.

To calculate the Medicaid PV percentage, use the following formula:

Numerator:

Medicaid PV = All billable services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (this includes zero-pay claims) in a consecutive 90-day period. To reiterate, the numerator should include all encounters where Medicaid paid at least part, even if Medicaid was not the primary payer.

Denominator:

Total PV = All encounters, regardless of the payment method in the same 90-day period.

EPs may choose as their reporting period any consecutive 90-day period within the prior calendar year for which they're attesting or the 12 months prior to the date of the attestation.

How do I calculate my PV numerator?

In general, providers should follow the general guidelines below:

Determine the total number of encounters during the PV reporting period.

From the total number of encounters, determine which patients are Medicaid-enrolled (The EP/EH must have a mechanism for determining who is Medicaid-enrolled...this will be VERY important if they are selected for audit). Include all encounters where Medicaid paid at least part, even if Medicaid was not the primary payer.

From the list of Medicaid-enrolled encounters, determine which encounters are considered 'billable services.'

What is a billable service?

Examples of billable services include:

- Encounters denied for payment by Medicaid or that would be denied if billed due to exceeding the allowable limitation for the service/procedure;
- Encounters denied for payment by Medicaid or that would be denied if billed because of lack of following correct procedures as set forth in the state's Medicaid clinical coverage policy such as not obtaining prior approval prior to performing the procedure;
- Encounters denied for payment due to not billing in a timely manner;
- Encounters paid by another payer which exceed the potential Medicaid payment; and,
- Encounters that are not covered by Medicaid such as some behavioral health services, HIV/AIDS treatment, or other services not billed to Medicaid for privacy reasons, oral health services, immunizations, but where the provider has a mechanism to verify Medicaid eligibility.

Further, the Final Rule defines billable as follows:

- Concurrent care or transfer of care visits;
- Consultant visits; or,
- Prolonged physician service without direct, face-to-face patient contact (for example, tele-health).
- A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider. The visit does not have to be individually billable in instances where multiple visits occur under one global fee.

Billable services do not include:

- Encounters denied for payment by Medicaid or that would be denied if billed because of absence of medical necessity under the state's Medicaid clinical coverage policy; and,

- Encounters denied for payment by Medicaid because the patient was not enrolled in Medicaid at the time the service was rendered.

When EPs work at more than one clinical site of practice, are they required to use data from all sites of practice to support their PV thresholds for the NC Medicaid EHR Incentive Program?

EPs may choose one (or more) clinical sites of practice in order to calculate their PV. This calculation does not need to be across all of an EP's sites of practice. However, at least one of the locations where the EP is adopting or meaningfully using certified EHR technology should be included in the PV.

What NC Medicaid PV threshold must pediatricians meet to be eligible for an EHR incentive payment?

North Carolina Medicaid recognizes an Eligible Professional as being a pediatrician if they are a Doctor of Medicine (MD) or a Doctor of Osteopathic Medicine (DO) and meet one of the following requirements below:

- Enrolled with NC Medicaid as a pediatrics specialty; or,
- Board certified by a national certification board in a Pediatrics, Adolescent or Child medical specialty area.
- A pediatrician that demonstrates at least 30% Medicaid PV, along with all other program requirements, is eligible to receive the full incentive payment amount.
- A pediatrician that demonstrates at least 20% Medicaid PV, along with all other program requirements, may also participate for a reduced payment valued at two-thirds the full incentive amount.

Are pediatric Nurse Practitioners eligible for the reduced 20% Medicaid PV threshold?

No. Pediatricians are the only group of EPs that qualify for the reduced 20% PV threshold. Other EPs, including nurse practitioners, must meet the regular requirement of 30% Medicaid PV.

North Carolina defines a pediatrician as a Doctor of Medicine (MD) or a Doctor of Osteopathic Medicine (DO) that is enrolled with NC Medicaid as a pediatrics specialty or is board certified by a national certification board in a Pediatrics, Adolescent or Child medical specialty area.

Do FQHCs or RHCs have to meet the 30% minimum Medicaid PV threshold to receive an NC Medicaid EHR Incentive Payment?

*Note: All incentive payments are tied to individual professionals or hospitals. Therefore, as entities, FQHCs and RHCs are not eligible to attest for and receive payment under the program. However, EPs who work at an FQHC or RHC may be eligible to participate and can use needy individuals to meet the PV threshold.

EPs who work at an FQHC or RHC and meet the eligibility requirements may participate in the NC Medicaid EHR Incentive Program if: 1) They meet Medicaid PV thresholds individually, or if the FQHC/RHC meets PV requirements as a group; or 2) They practice predominantly in an FQHC or RHC and have 30% needy individual PV. In addition to Medicaid-enrolled encounters,

needy individuals include NC Health Choice patients as well as patient encounters where services were provided either at no cost or at reduced cost based on a sliding scale determined by the individuals' ability to pay.

EPs may be eligible as individuals or as a group. For more information regarding group and individual methodology when calculating PV, please visit the PV tab of [our website](#).

When calculating PV, can EPs that practice primarily in a clinic, but also see patients in hospitals, count their inpatient and outpatient hospital visits as encounters?

Yes. EPs may (but are not required to) count their hospital-based encounters (inpatient and outpatient) when calculating their PV. This rule must be applied consistently to both the numerator and the denominator.

Beginning in payment year 2013, a hospital-based EP that can demonstrate to CMS that they funded the acquisition, implementation and maintenance of certified EHR technology (CEHRT), including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH, and uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT, may be determined by CMS to be a non-hospital based EP and may be eligible to participate in the Medicaid EHR Incentive Program.

For the NC Medicaid EHR Incentive Program, how should I determine Medicaid PV for procedures that are billed globally, such as obstetrician (OB) visits or some surgeries?

Global billing situations such as OB/GYN visits should be counted on the date of service, not the date of billing. Each individual date of service is considered to be one encounter. In these situations, Medicaid will account for multiple visits per global billing during the validation process.

When counting encounters in a clinic or medical group (or medical home model) for purposes of the NC Medicaid EHR Incentive Program, am I able to include the encounters of ancillary providers such as pharmacists, educators, etc. when determining if I meet the Medicaid PV threshold?

CMS regulations did not address whether these non-EP encounters could be considered in the estimate of PV for the clinic. However, they believe a state would have the discretion to include such non-EP encounters in its estimates. NC allows these encounters to be included in the PV calculation.

Again, if these non-EP encounters are included in the numerator, they must be included in the denominator as well. States also must ensure that their methodology adheres to the conditions in 42 CFR 495.306(h), and specifically to 495.306(h)(4), which says: "(4) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way."

For more information, see the [final rule](#).

If an EP wants to leverage a clinic or group practice's PV as a proxy for the individual EP, how should a clinic or group practice account for EPs practicing part-time and/or applying for the NC Medicaid EHR Incentive Program 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 PV as a proxy for their own under four conditions:

- The clinic or group practice's PV is appropriate as a PV methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- There is an auditable data source to support the clinic's PV determination;
- The EP has a current affiliation with the groups' PV they are using to attest; and,
- So long as the practice and EPs decide to use one methodology for a 90-day reporting period (in other words, clinics could not have some of the EPs using their individual PV for patients seen at the clinic, while others use the clinic-level data during the same 90-day reporting period). The clinic or practice must use the entire practice's PV and not limit it in any way. EPs may attest to PV 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.

Are FQHC look-alike's eligible for the "practicing predominantly in an FQHC" requirement of the NC Medicaid EHR Incentive Program, allowing them to use non-Medicaid needy individual encounters toward the Medicaid PV threshold?

EPs practicing at an FQHC look-alike are eligible for the "practicing predominantly" requirement of the NC Medicaid EHR Incentive Program so long as they meet all the requirements EPs of an FQHC are subject to as defined by CMS. Eligibility for "practicing predominantly in an FQHC" allows the EP to use needy individual encounters toward the patient volume requirement.

For more information, please visit [CMS' FAQ website](#).

Is it permissible to count services provided to "presumptive eligible" recipients in the PV calculation?

Yes. EPs and EAs may include patient encounters with presumptive eligible recipients in the patient volume calculation. Since presumptive eligibility is generally short-term, make sure the patient still had presumptive eligibility status when the service was provided in order to count it toward your Medicaid patient volume.

Do I need to use the same reporting period for Patient Volume and Meaningful Use?

No, these are two distinctly different reporting periods, so it is not required to use the same reporting period, but providers may choose to do so.

Patient volume reporting period: Providers can select a consecutive 90-day PV reporting period from the previous calendar year for which you're attesting or the 12 months immediately preceding the date of attestation.

MU reporting period: Providers must select a consecutive 90- or 365-day reporting period from the current calendar year for which you're attesting.

What is considered to be an auditable data source?

You must be able to support all of your attested PV numbers, including your Medicaid-enrolled zero-pay encounters, with an auditable data source, defined as an electronic or manual system that an external entity can use to replicate the data from the original data source to support their attested information.

If the providers in my practice attested using individual methodology to calculate patient volume last year but would like to attest using group methodology to calculate patient volume this year, is it ok for them to switch?

Yes. Providers are allowed to select their patient volume methodology each year of participation in the NC Medicaid EHR Incentive Program and it can alter year to year. That being said, if you can - go group!

How is 'encounter' defined for the NC Medicaid EHR Incentive Program?

For EPs, a Medicaid-paid encounter is defined as services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under Section 1115 of the Social Security Act paid for part or all of the service as stated in the Final Rule.

CMS further defines a patient encounter as any encounter where a medical treatment is provided and/or evaluation and management services are provided.

It is important to note that EPs must count actual encounters, defined as a unique patient on a unique day, from their own auditable data source, defined as an electronic or manual system that an external entity can use to replicate the data from the original data source to support their attested information.

Exclude anything from your numerator and denominator that's not an encounter, such as management fees like system-generated management fees for Carolina Access -CCNC (ICN region code 80 on Medicaid claims). These are paid Medicaid claims but there is no encounter.

Health Choice encounters may not be included in the numerator of the Medicaid patient volume calculation, except in the case of EPs who practice predominantly at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). FQHCs and RHCs can include these as non-Medicaid needy in their numerator.

Zero-pay Medicaid encounters are encounters with Medicaid patients that were billable services but Medicaid did not pay.

Examples of billable services include:

- Encounters denied for payment by Medicaid or that would be denied if billed due to exceeding the allowable limitation for the service/procedure;
- Encounters denied for payment by Medicaid or that would be denied if billed because of lack of following correct procedures as set forth in the state's Medicaid clinical coverage policy such as not obtaining prior approval prior to performing the procedure;
- Encounters denied for payment due to not billing in a timely manner;
- Encounters paid by another payer which exceed the potential Medicaid payment; and,
- Encounters that are not covered by Medicaid such as some behavioral health services, HIV/AIDS treatment, or other services not billed to Medicaid for privacy reasons, oral health services, immunizations, but where the provider has a mechanism to verify Medicaid eligibility.

Further, the Final Rule defines billable as follows:

- Concurrent care or transfer of care visits;
- Consultant visits; or,
- Prolonged physician service without direct, face-to-face patient contact (for example, tele-health).

A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider. The visit does not have to be individually billable in instances where multiple visits occur under one global fee.

Billable services do not include:

- Encounters denied for payment by Medicaid or that would be denied if billed because of absence of medical necessity under the state's Medicaid clinical coverage policy; and,
- Encounters denied for payment by Medicaid because the patient was not enrolled in Medicaid at the time the service was rendered.

How do I report incident to billing as part of my Medicaid PV calculation?

If your Medicaid-paid encounters were billed under any other provider's NPI, you will need to answer the following question on the patient volume screen in MIPS:

If another provider's NPI was listed as rendering on any of the encounters you included in your patient volume, enter that other provider's NPI and number of encounters attributable to that other provider. If none, enter NA.

In other words, if any other provider was listed as rendering on any or all of the Medicaid-paid encounters included in your numerator, enter that other provider's NPI and number of Medicaid-paid encounters attributable to that other provider. Enter only Medicaid-paid

encounters at the location you are reporting patient volume on. If your Medicaid-paid encounters were billed under more than one provider's NPI, list all.

If you do not provide this information in NC-MIPS, we will not be able to validate your patient volume and your attestation will be denied.

For additional guidance, [click here](#).

If any other provider used your NPI on Medicaid claims, you will need to answer the following question on the patient volume screen in MIPS:

If any other provider(s) used your NPI as rendering on Medicaid claims during the 90-day period, list the names and number of encounters attributable to that other provider. If none, enter NA.

In other words, if ANY other provider, for example, a nurse practitioner or resident that you supervised or a physician that was new to your practice, used your personal NPI as rendering on Medicaid claims, then you must enter the name of the other provider(s) and the number of Medicaid-paid encounters that belong to that other provider. Enter only Medicaid-paid encounters. If more than one provider used your NPI, list all.

If you do not provide this information in NC-MIPS, we will not be able to validate your patient volume and your attestation will be denied.

For additional guidance, please [click here](#).

To see a webinar explaining an example of incident to with multiple providers, please [click here](#). (WMV, 118,425KB) For the complete slide deck (with notes), please [click here](#). (Powerpoint, 5,120KB)

To see a webinar explaining a simpler example of incident to, please [click here](#). (WMV, 126,976KB) For the complete slide deck (with notes), please [click here](#). (Powerpoint 4,701KB)

To see a comprehensive overview of incident to webinar, please [click here](#). (WMV 32,739 KB) For the complete slide deck (with notes), please [click here](#). (Powerpoint 5,568 KB)

I am a nurse practitioner whose encounters were billed to Medicaid using a supervising physician's NPI on claims. How do I report my Medicaid-paid encounters?

If your Medicaid-paid encounters were billed under another provider's NPI, you will need to answer the following question on the patient volume screen in NC-MIPS:

11) If another EP was listed as attending on any of the encounters included in patient volume, enter that EP's NPI and number of encounters attributable to that EP.

In other words, if another provider was listed as attending on any or all of the Medicaid-paid encounters included in your numerator, enter that other provider's NPI and the number of Medicaid-paid encounters attributable to that other provider. Enter only Medicaid-paid encounters. If your Medicaid-paid encounters were billed under more than one provider's NPI, list them all.

If you do not provide this information in NC-MIPS, we will not be able to validate your patient volume and your attestation will be denied.

For additional guidance, please [click here](#).

I am a physician who supervises a nurse practitioner. The NP uses my NPI on Medicaid claims. Do I need to report this when I attest?

Yes. If any other provider used your NPI on Medicaid claims, you will need to answer the following question on the patient volume screen in NC-MIPS:

- 10) If any other provider(s) used your NPI during the 90-day period, show the name(s) and number of encounters attributable to that provider.

In other words, if any other provider, such as a nurse practitioner that you supervised or a physician that was new to your practice, used your personal NPI as attending/rendering on Medicaid claims, then you must enter the name of that other provider and the number of Medicaid-paid encounters that belong to that other provider. Enter only Medicaid-paid encounters. If more than one provider used your NPI, list them all.

If you do not provide this information in NC-MIPS, we will not be able to validate your patient volume and your attestation will be denied.

For additional guidance, please [click here](#).

Should I include encounters paid by Health Choice in my PV numerator?

Health Choice encounters may not be included in the numerator of the Medicaid patient volume calculation, except in the case of EPs who practice predominantly at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). FQHCs and RHCs can include these as non-Medicaid needy in their numerator.

We have a new billing NPI. For PV, do we report our new NPI or old NPI?

On the patient volume page in NC-MIPS, for practice billing NPI or group billing NPI, enter the NPI that you used as billing NPI on your Medicaid claims during your reported 90-day patient volume reporting period.

I attested to Program Year 2014 using a PV reporting period from calendar year 2014. When attesting to Program Year 2015, may I use the same 2014 PV reporting period?

Yes. So long as the PV reporting period is a consecutive 90-day reporting period in either: 1. the previous calendar year for which you're attesting (so if attesting to PY 2016 - that'd be calendar

year 2015) or 2. the 12 months immediately preceding the date of attestation (so if attesting on August 1, 2016, that's any 90 days between July 31, 2015 and July 31, 2016), it is a valid PV reporting period & you may use it!

Can I include my numerator encounters that were paid for by another state's Medicaid program?

Yes. Please submit a billing memo on your practice's letterhead regarding this with your attestation. Include a break-out of Medicaid encounters by state. If you had both Medicaid-paid and zero-pay, you'll need break out each category of encounter by state. You must include any identifiers (similar to North Carolina's NPI) that you used on claims for the other state(s). We will reach out to the other state(s) to verify the encounters you report.

How do I report Medicaid encounters that were billed through an LME?

If you billed any of your Medicaid claims through an LME for your encounters reported in your attestation, you will need to complete the behavioral health template and then submit the completed template with your signed attestation.

[Click here](#) for the BH template.

Can I include Carolina ACCESS encounters in my numerator?

You can include in your numerator actual encounters, defined as a unique patient on a unique day, with Medicaid patients for billable services. If you include in your numerator Medicaid encounters for billable services where no claim was submitted to Medicaid (because the visit was covered by the management fee), please submit with your signed attestation a memo on your practice letterhead reporting the number of Medicaid encounters that fall into this category. Be sure to keep this memo and the documentation from your auditable data source that was used to come up with your patient volume numbers in case of post-payment audit.

You cannot include system-generated management fees for Carolina Access -CCNC (ICN region code 80 on Medicaid claims). These are paid Medicaid claims but there is no encounter.

Can I include Children's Health Insurance Program (CHIP) encounters in my numerator?

In NC, we refer to Title XIX expansion CHIP as MCHIP (Medicaid CHIP). Per the Stage 2 Final Rule, as of October 2012, NC permits these encounters to be counted in the numerator of their patient volume calculation. CHIP encounters may be included in the numerator only if they are part of Title XIX expansion or part of Title XXI expansion. EPs are still not permitted to include CHIP stand-alone Title XXI encounters as part of their numerator.

Is my practice allowed to use group methodology to calculate patient volume if some EPs are attesting to MU while others are attesting to AIU?

Yes. Group methodology may be used by any EP who has a current group affiliation regardless if they, or any other EP in the group, is attesting to AIU or MU. AIU/MU is based solely on the individual attesting EP and has no impact on the way patient volume is calculated. For more

information on calculating patient volume using group methodology, please refer to the Patient Volume tab of the [program website](#).

Can patients participating in the special program where Medicaid pays their Medicare Part B premium be counted in the Medicaid-enrolled numerator?

No. Service has to be provided to a Medicaid-eligible patient to be included in the numerator – participating in a special program (like a limited Medicare Savings Program (MQB-B)) does not count.

Meaningful Use (MU)

What is Meaningful Use (MU)?

MU refers to the use of certified EHR technologies by health care providers in ways that measurably improve health care quality and efficiency.

The ARRA defines MU as:

- Use of certified EHR in a meaningful manner (i.e., e-prescribing);
- Use of certified EHR for electronic exchange of health information to improve quality of health care; and,
- Use of certified EHRs to submit Clinical Quality Measures (CQM).

The ultimate goal is to bring about health care that is:

- Patient-centered;
- Evidence-based;
- Prevention-oriented;
- Efficient; and,
- Equitable.

When EPs work at more than one clinical site of practice, are they required to use data from all sites of practice of support their demonstration of MU for the NC Medicaid EHR Incentive Program?

Any EP demonstrating MU must have at least 50% of their 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 MU objectives.

Once I receive my first payment, do I need to attest every consecutive year?

Medicaid EPs may receive payments on a non-consecutive, annual basis.

Can an EP meet MU without having seen any patients during their MU reporting period?

No. An EP must have had performed at least one professional service during their meaningful use reporting period and would need to have met all meaningful use requirements to qualify for a meaningful use payment.

Do I need to use the same reporting period for PV and MU?

No, these are two distinctly different reporting periods, so it is not required to use the same reporting period. MU reporting periods must be a consecutive 90- or 365-day reporting period from the current calendar year for which they're attesting (if attesting for Program Year 2016, MU data should be collected during calendar year 2016).

The computerized provider order entry (CPOE) core MU measure indicates that the medication order needs to be directly entered by any licensed healthcare professional. How does the NC Medicaid EHR Incentive Program define a licensed healthcare professional?

For the purposes of the NC Medicaid EHR Incentive Program, a licensed healthcare professional is one who has been recognized by an accredited authorizing entity as being capable to practice healthcare in North Carolina. It is the responsibility of the practice to regulate that only those employees who are authorized to enter orders into the medical record per state, local, and professional guidelines are doing so to meet the CPOE measure.

Please note, the order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order.

May I report zeros in my CQMs denominator?

Yes, zeros are an acceptable entry for CQM denominators, provided it was produced by a certified EHR technology.

Do I need to meet Stage 1 MU before I can attest to Stage 2 MU?

Yes. Per CMS, all providers must demonstrate Stage 1 MU before they are able to attest to Stage 2 MU.

Where can I find more information about CMS' Stage 3 and Modification to MU in 2015 Through 2017 Final Rule?

Please [click here](#) for the Stage 3 and Modifications to Meaningful Use in 2015 through 2017 (Modified Stage 2) Final Rule.

Please [click here](#) for CMS' Program Year 2016 Tip Sheet.

Please [click here](#) for a copy of the Modified Stage 2 Specification Sheets.

More information about CMS' new Final Rule can also be found on [CMS' EHR Incentive Program website](#).

Do I have to submit my attestation via email?

Yes. To meet MU, the signed attestation, signed MU Summary pages & CQM report directly from the EPs EHR demonstrating they met the CQMs for which they attested, must be submitted electronically (via email) to NCMedicaid.HIT@dhhs.nc.gov.

Technology

Do providers have to contribute a minimum dollar amount toward their certified EHR technology to receive an EHR incentive payment?

No. Payments are not a reimbursement of costs so providers are not required to contribute a minimum amount toward the purchase or maintenance of their certified EHR technology in order to participate.

Where can I get answers to my privacy and security questions about EHRs?

The Office for Civil Rights (OCR) is responsible for enforcing the Privacy and Security rules related to the HITECH program. More information is available at [OCR's website](#).

What is the purpose of certified EHR technology?

Certification of EHR technology will provide assurance to purchasers and other users that an EHR system or product offers the necessary technological capability, functionality, and security to help them satisfy the MU objectives for the Medicaid EHR Incentive Program. Providers and patients must also be confident that the electronic health information technology (IT) products and systems they use are secure, can maintain data confidentially, and can work with other systems to share information. Confidence in health IT systems is an important part of advancing health IT system adoption and realizing the benefits of improved patient care.

For more information, please visit the [Office of the National Coordinator's website](#).

Must provider have their EHR technology certified prior to beginning the EHR reporting period in order to demonstrate MU under the NC Medicaid EHR Incentive Program?

No. A provider may begin the EHR reporting period for demonstrating MU before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, MU must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for certified EHR technology.

How do I know if my EHR system is certified? How can I get my EHR certified?

The Medicaid EHR Incentive Program requires the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments. The [Certified Health IT Product List](#) (CHPL) is available online and as new products become certified and available, they will be updated on the site.

For Program Year 2016, providers must have 2014 certified EHR technology.

My EHR system is certified by the Certification Commission of Health IT (CCHIT). Does that mean it is certified for the NC Medicaid EHR Incentive Program?

No. The Medicaid EHR Incentive Program requires the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs

to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments.

Do I have to upgrade to 2014 certified EHR technology?

Yes, all program participants attesting in Program Year 2016 must attest using a 2014 certified EHR technology.

NC-MIPS

On NC-MIPS, what is the difference between the cancel and the withdraw buttons?

In short, the cancel button is used while an attestation is still in progress and the withdraw button is used after an attestation has been submitted through the NC-MIPS Portal.

The cancel button will be used when an EP or EH realizes they are unable to meet AIU or meaningful use for that year and do not want to proceed with their attestation. Selecting the cancel button will stop any correspondence from the NC Medicaid EHR Incentive Program for that year. After canceling an attestation, providers are still allowed to come back at any point and continue their attestation.

The withdraw button will be used when an EP or EH has submitted their attestation, but wishes to withdraw it from the validation process. This action may also be taken if an error is found on a submitted attestation. The user may withdraw the attestation, correct any information and re-submit for validation at any time. The information entered in the original attestation will be saved within the system, making resubmission easy for the provider.

How do I withdraw and re-attest?

Please visit the NC-MIPS Portal at <https://ncmips.nctracks.nc.gov/>, click 'withdraw' on the status page. After withdrawing, click 'proceed' on the status page and address the discrepancy and re-submit (previous data is saved) online. Please be sure to have the provider sign the attestation and submit the printed copy to one of the following:

Withdrawing and Re-attesting

Please visit the NC-MIPS Portal at <https://ncmips.nctracks.nc.gov/>, withdraw the attestation for this provider and re-submit (previous data is saved) online. Please be sure to have the provider sign the attestation and send it via email to NCMedicaid.HIT@dhhs.nc.gov.

NC-MIPS is not displaying an address in the NC column on the Demographics page. What do I need to do?

If the North Carolina demographic information is not automatically populating within NC-MIPS, please reference NCTracks to verify your information. If there are any discrepancies between the information on file with CMS or NCTracks, please contact them to update your information.

NCTracks (CSC) Call Center: 800-688-6696

CMS EHR Information Center: 1-888-734-6433 or 1-888-734-6563

If the information matches between those two entities, you may continue with your attestation even if the information is not populating in the NC column.

My NCID username and password work on all other Medicaid sites, but I am getting an error when I try to login to NC-MIPS. What should I do?

Please ask yourself the following questions:

1. Has the eligible professional (EP) or eligible hospital (EH) already registered on CMS' Registration & Attestation (R&A) system?

If yes, 2. Has the EP or EH already completed the First Time Account Setup in NC-MIPS?

If yes, 3. Has the EP or EH changed their NCID username since completing the First Time Account Setup?

If so, please update the provider's NCID username using the NC-MIPS NCID Username Update Tool.

For more NC-MIPS troubleshooting assistance, please refer to the [NC-MIPS Quick Reference Guide](#).

Please refer to the EP AIU or MU Attestation Guides (right side of [NC-MIPS](#)) for more information on successfully registering and attesting for the NC Medicaid EHR Incentive Program.

I am receiving a warning message that I need to complete my registration with CMS. What do I need to do?

That message will populate if the CMS registration has not been fully submitted or if an EHR certification number was not entered during CMS registration.

To enter an EHR certification number on CMS' R&A system:

1. Go to <https://ehrincentives.cms.gov>
2. Click Continue
3. Check the box, click continue
4. Log in using the NPPES username & password
5. Click on the Registration tab to continue
6. Click on Modify in the Action column to continue
7. Click on Topic 1 - "EHR Incentive Program"
8. Click Yes at "Do you have a certified EHR?"
9. Enter the EHR number
10. Click Save & Continue
11. Click Save & Continue
12. Click Save & Continue
13. Click on Proceed with Submission

14. Review the information then click Submit Registration
15. Click Agree

Please allow 24 hours for system updates. If you have any questions or need assistance, please contact the CMS EHR Information Center, Monday through Friday at 1-888-734-6433 or 1-888-734-6563 (TTY number) (Hours of Operation 7:30 a.m. – 6:30 p.m – CST – excluding Federal Holidays).

To ensure all CMS registration information is fully submitted:

1. Go to <https://ehrincentives.cms.gov>
2. Click Continue
3. Check the box, click continue
4. Log in using the NPPES username & password
5. Click on the Registration tab to continue
6. Click on Modify in the Action column to continue
7. Click on Proceed with Submission
8. Review the information then click Submit Registration
9. Click Agree

I am trying to register with NC-MIPS but it is asking me for a Medicaid Provider Number (MPN). I enrolled with Medicaid after July 1, 2013 and was not issued an MPN. What should I put in that field?

If the EP enrolled with NC Medicaid after July 1, 2013, they may enter XXXXXXXX in that field. Please refer to the EP AIU or MU Attestation Guides (right side of [NC-MIPS](#)) for more information.

If I make updates to my attestation, do I have to re-print & re-send the signed attestation?

Yes. If the EP's attestation is in any way altered or updated, you will need to re-print and re-send the signed attestation. The EP's signature is authorizing that the information submitted was true and accurate. If any of the information changes, the EP's signature is no longer valid and will not be accepted.

If attesting to MU, and you had to re-submit your attestation, please either cross out the dates on the MU summary pages so it matches the date of the most recently submitted attestation or write a note on the new attestation/your letterhead stating the MU measures have not been altered.

I am a proxy attesting on behalf of a large practice. May I use one login for all my providers?

No. All attesting EPs must have a unique login (their individual NCID username & password).

Eligible Hospitals

If the state chooses to use the cost report in the NC Medicaid incentive 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

** As permitted by Medicare cost reporting regulations, some hospitals have included both inpatient days paid by a North Carolina LME / PIHP (Prepaid Inpatient Health Plan) and Medicaid eligible days in the Medicaid (Title XIX) HMO Inpatient Days cost report field. Hospitals are reminded that 42 CFR §495.310 permits only inpatient bed days in the calculation of the Medicaid share of the EHR payment. EHs who submit attestations for EHR payments should identify only those inpatient days from their Medicaid cost report which were paid by a North Carolina LME / PIHP in the HMO data field. Providers including HMO days on their EH attestations are required to provide patient level detailed documentation in support of the number of inpatient bed days listed in the HMO days' data field of the attestation.

A number of measures for MU objectives for EHs include patients admitted to the Emergency Department (ED). Which ED patients should be included in the denominators of these measures for the NC Medicaid EHR Incentive Program?

On September 17, 2010, CMS issued an FAQ that explained that their intent to include in the denominator visits to the emergency department (ED) of sufficient duration and complexity that all of the MU objectives for which the ED is included would be relevant. Therefore they explained that EHs and CAHs should count in the denominator patients admitted to the inpatient part of the hospital through the ED, as well as patients who initially present to the ED and who are treated in the ED's observation unit or who otherwise receive observation services.

CMS is revising their revised FAQ to allow EHs, as an alternative, for Stage 1 of MU, to use a method that is consistent with the plain language of the regulation. There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of MU objectives. EHs and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, EHs and CAHs must choose either the "Observation Services method" or the "All ED Visits method" to be used with all measures. Providers cannot calculate the denominator of some measures using the "Observation Services method," while using the "All ED Visits method" for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators.

Observation Services method. The denominator should include the following visits to the ED:

The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) MU measure. Similarly, other actions taken within the ED would count for purposes of determining MU.

The patient initially presented to the ED and is treated in the ED's observation unit or otherwise receives observation services. Details on observation services can be found in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator.

All ED Visits method. An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use.

Prior to hospitals converting over to cost report 2552-10, both Charity Care and Bad Debt were combined and reported as Uncompensated Care on worksheet S-10 of the former hospital cost report 2552-96. As Charity Care is a required field in NC-MIPS, how should EHs calculate and report Charity Care in NC-MIPS for years that utilized old cost reports?

When entering information on older cost reports that do not contain separate fields for Charity Care, EHs should use cost report 2552-10 instructions to calculate their Charity Care for reporting in NC-MIPS.

EHs may not enter their total Uncompensated Care, inclusive of Bad Debt, in the Charity Care field in NC-MIPS. Below are the definition and instructions for reporting Charity Care from form CMS-2552-10, Section 4012, Worksheet S-10.

Charity Care: Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt.

Line 20: Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient's total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

What information is required for EHs to attest in NC-MIPS and where do they find it?

EHs will need to enter information about their previous year PV (both Medicaid and total inpatient acute care and ED visits) and information from the prior years' 12-month cost reports. For more information, see the NC-MIPS website and refer to the EH AIU/MU Attestation Guide.

What should I be attesting to with Medicaid?

Medicaid attestation schedules vary for EHs based on when they attest with Medicare. EHs may choose to attest to AIU with Medicaid during their first year of participation, but once an EH attests with Medicare, they must follow Medicare's attestation schedule.

The attestation schedule for EHs can be found [here](#).

Are nursery days and nursery discharges (for newborns) included as acute-inpatient services in the calculation of hospital incentives for the NC Medicaid EHR Incentive Program?

No, nursery days and discharges are not included in inpatient bed-day or discharge counts in calculating hospital incentives. We exclude nursery days and discharges because they are not considered acute inpatient services based on the level of care provided during a normal nursery stay.

Will nursery days (for newborns) be included as inpatient-bed-days in the calculation of hospital incentives for the NC Medicaid EHR Incentive Program?

No, nursery days will not be included as inpatient-bed-days in the calculation of hospital incentives for the Medicaid EHR Incentive Program. Nursery days are excluded because they are not considered inpatient-bed-days based on the level of care provided during a normal nursery stay.

If an EH is dually-eligible and initially registers only for the NC Medicaid EHR Incentive Program, but later decides that it wants to also register for the Medicare EHR Incentive Program, can the EH go back and change its registration from Medicaid-only to both Medicare and Medicaid?

Hospitals that register only for the Medicaid program will not be able to manually change their registration (i.e., change to “Both Medicare and Medicaid” or from one program to the other) after a payment is initiated and this may cause significant delays in receiving a Medicare EHR incentive payment.

When calculating an EH's Medicaid incentive payment, is the estimated growth rate for a hospital's 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 three 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.

North Carolina Medicaid requires EHs to use full 12-month cost reports as the auditable data source to get accurate discharge data to determine the average annual rate of growth.

How can an EH or CAH avoid a Medicare payment adjustment?

EHs and CAHs that are eligible to participate in the Medicare EHR Incentive Program may be subject to Medicare payment adjustments. For further information about the Medicare payment adjustment schedule and hardship exceptions, please [click here](#) for CMS’ payment adjustment and hardship exception website.

All questions about the Medicare EHR Incentive Program or Medicare payment adjustments should be directed to CMS.

What is the last day an EH may submit a Program Year 2016 attestation?

North Carolina has adopted an attestation tail period of 120 days to allow for attestation beyond the end of the calendar year. This means that EHs will have until April 30, 2017 to submit a 2016 attestation.

Can a state use two different 12-month periods to calculate the discharge-related amount and the Medicaid share?

No, 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. For more information see the Final Rule: 42 CFR 495.310(g)(1)((i)(B).

If I didn't provide four consecutive periods of full 12-month Medicaid cost report data when I submitted my first year attestation, do I need to submit additional cost report data when I submit attestations for my second and third year payments?

Yes. The NC Medicaid EHR Incentive Program requires four consecutive periods of full 12-month Medicaid cost report data to accurately complete the final calculation of your incentive payment. Eligible hospitals who included less than four consecutive periods of full 12-month Medicaid cost report data with their first attestation, are required to submit additional cost report data with future attestations until they have met the cost report data requirement. The NC Medicaid Incentive Payment System (NC-MIPS) will prompt EHRs for additional cost report data as needed. Please note that DMA will recalculate the total incentive payment amount each time additional cost report data is submitted, which could result in payment adjustments.

If I did provide four consecutive periods of full 12-month Medicaid cost report data when I submitted my first year attestations, do I need to submit additional cost report data when I submit attestations for my second and third year payments?

No. Those hospitals who are attesting for a year 2 or 3 payment, and provided all cost report data in their first year, do not need to provide cost-report data or patient-level documentation with their attestation.

Audits

Who will be conducting audits for the NC Medicaid EHR Incentive Program?

The NC Medicaid EHR Incentive Program will be conducting audits for EPs and CMS will be conducting audits for EHRs.

What can I do to prepare my organization in case of audit?

An audit may include a review of any of the documentation needed to support the information that was provided in the attestation.

The primary documentation that will be requested for all North Carolina audits are supporting documentation that the provider used when completing the attestation. This documentation should come from an auditable data source and provide a summary of the data that supports the information entered during attestation. Ideally, this would be a report from the certified EHR system, but other documentation may be used if a report is not available or the information entered differs from the report.

This summary document will be the starting point of most reviews and should include, at minimum:

- Proof of patient volume numerator and denominator for the PV reporting period
- The numerators and denominators for the MU measures
- The time period the report covers
- Evidence to support that it was generated for that eligible professional, eligible hospital, or critical access hospital.

EPs and EHs are encouraged to maintain all documentation for at least six years post-payment in case of an audit. The EP/EH will be held accountable for all information provided in their attestation, so they will need to prove everything to which they attest.

If an EP fails an audit and the money is recouped (i.e. adverse audit for first year payment of \$21,250), can the EP attest again for that same payment later in the program (i.e. can they re-attest for the \$21,250)?

No. If the state has made a payment to an EP, and the EP later fails an audit, they must give the payment back to the state, and will be unable to re-attest to receive the first year payment of \$21,250.

In other words, if the first year payment is recouped, an EP will be unable to get another first year payment. Similarly, if an EP has their second year payment recouped, they are ineligible to receive another second year payment.

Therefore, an EP that participates successfully for all six program years may receive up to \$63,670; however, if the EP fails an audit and their first payment of \$21,250 is recouped by the state, the most the EP would qualify for during the life of the program is \$42,420 ($\$63,670 - \$21,250 = \$42,420$).

What is considered to be an auditable data source?

In the event of an audit, at a minimum, providers should have available electronic or paper documentation that supports providers' completion of the Attestation Module responses, including the specific information that supports each measure.

In addition, providers should have documentation to support the submission of CQMs, including the specific information that supports each measure. Providers should also maintain documentation to support their incentive payment calculations, for example data to support amounts included on their cost report, which are used in the calculation. As indicated in the Stage 1 final rule, providers should keep documentation for at least six years following the date of attestation.

If a provider has assigned payment to someone else, and then the provider fails post-payment audit, who is responsible for repayment of the incentive?

The individual EP is responsible for the attestation, regardless of who the payment was made to. So if the EP fails the audit and the payment is being recouped, the individual EP is responsible for returning the incentive payment.

To CMS, it is irrelevant whether the EP or the EP's group got the incentive payment; the EP has to return the payment amount. It is up to the EP to seek reimbursement from the group after the EP has returned the incentive payment, if they so choose.

Please be sure to keep a copy of all documentation supporting your attestation for at least six years, in case of post-payment audit.

Contact Us

Providers should use the email listed below for all correspondence with the N.C. Medicaid EHR Incentive Program.

Email: NCMedicaid.HIT@dhhs.nc.gov.