Centers for Medicare & Medicaid Services, HHS

§ 495.304

Medicaid information technology architecture (MITA) is both an initiative and a framework. It is a national framework to support improved systems development and health care management for the Medicaid enterprise. It is an initiative to establish national guidelines for technologies and processes that enable improved program administration for the Medicaid enterprise. The MITA initiative includes an architecture framework, models, processes, and planning guidelines for enabling State Medicaid enterprises to meet common objectives with the framework while supporting unique local needs.

Medicaid management information system (MMIS) means a mechanized claims processing and information retrieval system—referred to as Medicaid Management Information Systems (MMIS)—that meets specified requirements and that the Department has found (among other things) is compatible with the claims processing and information retrieval systems used in the administration of the Medicare program. The objectives of the MMIS are to include claims processing and retrieval of utilization and management information necessary for program administration and audit and must coordinate with other mechanized systems and subsystems that perform other functions, such as eligibility determination.

Needy individuals mean individuals that meet one of following:

(1) Received medical assistance from Medicaid or the Children’s Health Insurance Program. (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act).

(2) Were furnished uncompensated care by the provider.

(3) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals’ ability to pay.

Patient volume means the minimum participation threshold (as described at §495.304(c) through (e)) that is estimated through a numerator and denominator, consistent with the SMHP, and that meets the requirements of §495.306.

Practices predominantly means an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months (within the most recent calendar year or, as an optional State alternative beginning for payment year 2013, within the 12-month period preceding attestation) occurs at a federally qualified health center or rural health clinic.

Service oriented architecture or service component based architecture means organizing and developing information technology capabilities as collaborating services that interact with each other based on open standards.

State Medicaid health information technology plan (SMHP) means a document that describes the State’s current and future HIT activities.

State self-assessment means a process that a State uses to review its strategic goals and objectives, measure its current business processes and capabilities against the (MITA) business capabilities and ultimately develops target capabilities to transform its Medicaid enterprise to be consistent with the MITA principles.

(a) General rule. The following Medicaid providers are eligible to participate in the HIT incentives program:

(1) Medicaid EPs.

(2) Acute care hospitals.

(3) Children’s hospitals.

(b) Medicaid EP. The Medicaid professional eligible for an EHR incentive payment is limited to the following when consistent with the scope of practice regulations, as applicable for each professional (§§ 440.50, 440.60, 440.100; §§ 440.165, and 440.166):

(1) A physician.

(2) A dentist.

(3) A certified nurse-midwife.

(4) A nurse practitioner.

(5) A physician assistant practicing in a Federally qualified health center (FQHC) led by a physician assistant or a rural health clinic (RHC), that is so led by a physician assistant.
(c) Additional requirements for the Medicaid EP. To qualify for an EHR incentive payment, a Medicaid EP must, for each year for which the EP seeks an EHR incentive payment, not be hospital-based as defined at §495.4 of this subpart, and meet one of the following criteria:

(1) Have a minimum 30 percent patient volume attributable to individuals enrolled in a Medicaid program.

(2) Have a minimum 20 percent patient volume attributable to individuals enrolled in a Medicaid program, and be a pediatrician.

(3) Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals, as defined at §495.302.

(d) Exception. The hospital-based exclusion in paragraph (c) of this section does not apply to the Medicaid-EP qualifying based on practicing predominantly at a FQHC or RHC.

(e) Additional requirement for the eligible hospital. To be eligible for an EHR incentive payment for each year for which the eligible hospital seeks an EHR incentive payment, the eligible hospital must meet the following criteria:

(1) An acute care hospital must have at least a 10 percent Medicaid patient volume for each year for which the hospital seeks an EHR incentive payment.

(2) A children’s hospital is exempt from meeting a patient volume threshold.

(f) Further patient volume requirements for the Medicaid EP. For payment year 2013 and all subsequent payment years, at least one clinical location used in the calculation of patient volume must have Certified EHR Technology—

(1) During the payment year for which the EP attests to having adopted, implemented or upgraded Certified EHR Technology (for the first payment year); or

(2) During the payment year for which the EP attests it is a meaningful EHR user.


§ 495.306 Establishing patient volume.

(a) General rule. A Medicaid provider must annually meet patient volume requirements of §495.304, as these requirements are established through the State’s SMHP in accordance with the remainder of this section.

(b) State option(s) through SMHP. (1) A State must submit through the SMHP the option or options it has selected for measuring patient volume.

(2) (i) A State must select the method described in either paragraph (c) or paragraph (d) of this section (or both methods).

(ii) Under paragraphs (c)(1), (c)(2), (d)(1), (d)(2), (e)(1), (e)(2), (f)(1), and (f)(2) of this section, States may choose whether to allow eligible providers to calculate total Medicaid or total needy individual patient encounters in any representative continuous 90-day period in the 12 months preceding the EP or eligible hospital’s attestation or based upon a representative, continuous 90-day period in the calendar year preceding the payment year for which the EP or eligible hospital is attesting.

(3) In addition, or as an alternative to the method selected in paragraph (b)(2) of this section, a State may select the method described in paragraph (g) of this section.

(c) Methodology, patient encounter—(1) EPs. To calculate Medicaid patient volume, an EP must divide:

(i) The total Medicaid patient encounters in any representative, continuous 90-day period in the fiscal year preceding the EP’s payment year or in the 12 months before the EP’s attestation; by

(ii) The total patient encounters in the same 90-day period.

(2) Eligible hospitals. To calculate Medicaid patient volume, an eligible hospital must divide—

(i) The total Medicaid encounters in any representative, continuous 90-day period in the fiscal year preceding the hospitals’ payment year or in the 12 months before the hospital’s attestation; by

(ii) The total encounters in the same 90-day period.

(3) Needy individual patient volume. To calculate needy individual patient volume, an EP must divide—

(i) The total needy individual patient encounters in any representative, continuous 90-day period in the calendar year preceding the EP’s payment year,