Medicaid EHR Incentive Program
Patient Volume Requirements Rule References

The following excerpts from the official Final Rules establishing the EHR Incentive Program provide definitive guidance for calculating Medicaid patient volume. Yellow highlight generally refers to Eligible Professional criteria, and blue highlight generally refers to Eligible Hospital criteria.

Source: Code of Federal Regulations
Title 42: Public Health
PART 495—STANDARDS FOR THE ELECTRONIC HEALTH RECORD TECHNOLOGY INCENTIVE PROGRAM
Subpart D—Requirements Specific to the Medicaid Program
Sections 495.304 and 495.306

Links to the complete Rule language are follows:
75 Federal Register 44565; July 28, 2010
77 Federal Register 54160, Sept. 4, 2012
Electronic Code of Federal Regulations (e-CFR), for an updated, unofficial compilation of CFR material and Federal Register amendments.

Sec. 495.304 Medicaid provider scope and eligibility.
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(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 Sec. 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
Sec. 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.

Sec. 495.306 Establishing patient volume.

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(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 calendar 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, or in the 12 months before the EP's attestation; by

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

"**Needy individuals**" are defined as individuals meeting any of the following three criteria: (1) They are receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP); (2) they are furnished uncompensated care by the provider; or (3) they are furnished services at either no cost or reduced cost based on a sliding scale.

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Definition of Medicaid encounter

(e) For purposes of this section, the following rules apply:

(1) A Medicaid encounter means services rendered to an individual on any one day where:

(i) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.

(ii) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and cost-sharing.

(iii) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(2) For purposes of calculating hospital patient volume, both of the following definitions in paragraphs (e)(2)(i) and (e)(2)(ii) of this section may apply:

(i) A Medicaid encounter means services rendered to an individual per inpatient discharge when any of the following occur:

(A) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.

(B) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and/or cost-sharing.

(C) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(ii) A Medicaid encounter means services rendered in an emergency department on any 1 day if any of the following occur:

(A) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.

(B) Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and cost-sharing.

(C) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(3) For purposes of calculating needy individual patient volume, a needy patient encounter means services rendered to an individual on any 1 day if any of the following occur:

(i) Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act) paid for part or all of the service.

(ii) Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, or cost-sharing.

(iii) The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

(iv) The services were furnished at no cost; and calculated consistent with Sec. 495.310(h).

(v) The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

(f) Exception. A children's hospital is not required to meet Medicaid patient volume requirements.

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(h) Group practices. Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

(1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP.

(2) There is an auditable data source to support the clinic's or group practice's patient volume determination.

(3) All EPs in the group practice or clinic must use the same methodology for the payment year.

(4) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.

(5) If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.