

Questions Regarding the Medicaid EHR Incentive Program

1. Are payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs subject to federal income **tax**?

We note that nothing in the Act excludes such payments from taxation or as tax-free income. Therefore, it is our belief that incentive payments would be treated like any other income. Providers should consult with a **tax** advisor or the Internal Revenue Service regarding how to properly report this income on their filings.

2. When calculating Medicaid patient volume or needy patient volume for the Medicaid EHR Incentive Program, are eligible professionals (EPs) required to use visits, or unique patients?

There are multiple definitions of encounter in terms of how it applies to the various requirements for patient volume. Generally stated, a patient encounter is any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service. The requirements differ for EPs and hospitals. In general, the same concept applies to needy individuals. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume.

3. How will eligible professionals (EPs) be required to show that they are meeting the Medicaid or needy individual **patient volume** thresholds of 30% for the Medicaid EHR Incentive Program?

To show that EPs are meeting the Medicaid or needy individual **patient volume** thresholds of 30% for the Medicaid EHR Incentive Program, States will need to propose one or more methods of calculating **patient volume** to CMS in their State Medicaid Health Information Technology Plans and would need to identify verifiable data sources available to the provider and/or the State. Please contact your State Medicaid Agency for more information on how your state is calculating **patient volume**.

4. In order to meet the participation threshold of 50 percent of **patient** encounters in practice locations equipped with certified electronic health record (EHR) technology for the Medicare and Medicaid EHR Incentive Programs, how should **patient** encounters be calculated?

To be a meaningful EHR user, an EP must have 50 percent or more of their **patient** encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. For the purpose of calculating this 50 percent threshold, any encounter where a medical treatment is provided and/or evaluation and management services are provided should be considered a "**patient** encounter."

Please note that this is different from the requirements for establishing **patient volume** for the Medicaid EHR Incentive Program. You may wish to review those FAQs and other requirements related to Medicaid **patient volume**, since there is variation in what is considered to be a **patient** encounter.

5. The billing provider on a claim is an eligible professional (EP) but the performing provider type is not an EP. If we use claims to validate **patient volume** or meaningful use for the Medicaid Electronic Health Record (EHR) Incentive Program, should we count performing providers (person rendering the service) or the billing provider?

In establishing an encounter for purposes of **patient volume**, please see the regulations at 495.306(e)(2)(i)-(ii) at 75 FR 44579. Furthermore, in estimating **patient volume** for any EP or hospital, we do not specify any requirements around billing, but rather we discuss **patients**. For example, if a physician's assistant (PA) provides services, but they are billed through the supervising physician, it seems reasonable that a State has the discretion to consider the **patient** as part of the **patient volume** for both professionals. However, this policy would need to be applied consistently. In this scenario, using services provided by the PA but billed under the physician in the physician's numerator (e.g., Medicaid encounters) also would increase the physician's denominator (all encounters), because the State would need to adequately reflect the total universe of **patients** (both Medicaid and non-Medicaid) who the PA saw, but for whom the physician billed.

In terms of meaningful use, because each eligible professional must demonstrate meaningful use of certified EHR technology him or herself, if the State cannot not distinguish between the physician's claims and the PA's individual claims, then this would not be an adequate audit methodology.

Content provided at: https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage.

Below is a response from CMS regarding including QUEST, QExA, and the Developmentally Disabled/Mentally Retarded Home and Community-Based Waiver programs:

"The Medicaid program in Hawaii encompasses a couple different programs. These do include the QUEST, QExA, and the Developmentally-Disabled/Mentally Retarded Home and Community-Based Waiver programs. That being said, though, while certainly the majority of beneficiaries covered by these programs would count towards the Medicaid patient volume requirement for the purposes of the Medicaid EHR incentive program, I would hesitate in saying that all beneficiaries who are currently in these programs would automatically count towards the Medicaid patient volume. For instance, perhaps

due to the funding for certain individuals covered by these programs, they may not technically be classified as Medicaid beneficiaries.

In accordance with FAQ # 10523 (included in #3 above), to show that EPs are meeting the Medicaid or needy individual patient volume thresholds of 30% for the Medicaid EHR Incentive Program, the Hawaii Medicaid program will need to propose to CMS one or more methods of calculating Medicaid patient volume. This calculation will be included in the State's Medicaid Health Information Technology Plan, and would need to identify verifiable data sources available to the provider and/or the State."

NOTE: The "we" in the quote above refers to CMS as opposed to the HPREC.