

Eligible Professional Patient Volume Calculation

Idaho Medicaid Electronic Health Record (EHR) Incentive Program

Created June 2012

Note to Providers: There is a good possibility that business processes will change after the program is launched. Potential efficiencies as well as potential problems are likely to become evident. This paper describes the business as of spring 2012. Please be sure to return to the information on the website and in the provider handbook often for updates. Creation dates will be noted on each paper.

Introduction

Patient volume thresholds must be established every year a provider applies for an incentive payment. Patient volume is based on encounters with Medicaid participants, excluding CHIP. This is referred to as ‘Medicaid Based Encounters’. There is one exception to this rule. Providers who practice predominantly at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) may choose to base their patient volume on encounters with ‘needy’ patients. This is referred to as “Needy Based Encounters”.

- **Medicaid Based Encounters:** Eligible professionals who work outside of a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) **MUST** base their patient volume on encounters with **Medicaid** participants (excluding CHIP).
- **Needy Based Encounters:** Eligible professionals (EP) who practice predominantly at an FQHC or RHC may choose to base their patient volume on ‘needy’ patients. Needy patients include Medicaid participants, CHIP participants, and those persons who received services free or on a sliding scale based on ability to pay.

The following chart summarizes the patient volume requirements that must be met each year of participation:

Provider Type	Minimum 90-day Medicaid Patient Volume Threshold	Or the Medicaid eligible professional (EP) practices predominantly in an FQHC or RHC, must meet the 30% “needy individual” patient volume threshold
Physicians	30%	
Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
Physician Assistants (PAs) practicing at an FQHC/RHC led by a PA	30%	
Nurse Practitioners	30%	
Acute Care Hospital	10%	N/A
Children’s Hospital	N/A	N/A

Calculating Patient Volume Percentage Based on Medicaid Only

Patient volume based on Medicaid encounters is calculated by dividing the number of Medicaid encounters during any representative and continuous 90 calendar day period in the preceding

calendar year by the total number of all encounters in that same period. In other words, patient volume is a percentage derived from a fraction with a numerator of Medicaid encounters and a denominator of total encounters.

The Centers for Medicare and Medicaid Services (CMS) does not believe the tracking of encounters to establish patient volume should be impossible or onerous for providers, seeing as “[they] are businesses and there is an expectation that they are tracking their receivables from all entities (including Medicaid) associated with specific patients.”

For purposes of calculating patient volume using the Medicaid Based Encounters approach, only Medicaid encounters funded by Title XIX may be counted. CHIP encounters, which are funded by Title XXI, cannot be included. We realize practices cannot always distinguish between these different funding sources. To overcome this complication, the state is providing a multiplier of 7% — calculated from the statewide data — so EPs may deduct that average estimation of CHIP encounters from the general Medicaid encounters they have on record. For more information about this, please see the informational paper called *CHIP and Patient Volume* or that section of the Provider Handbook found on the Medicaid EHR Incentive Program website at www.MedicaidEHR.dhw.idaho.gov.

Calculating Patient Volume Percentage Based on Needy

Eligible professionals who provide more than 50% of their services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) during a six month period in the previous calendar year are the only eligible professionals who can meet their patient volume threshold using “needy individual” encounters. Needy individuals are those that meet one of the following requirements:

- Received medical assistance from Medicaid or the Children’s Health Insurance Program (CHIP), or a Medicaid or CHIIP demonstration project approved under section 1115 of the Social Security Act
- Were furnished uncompensated care by the provider
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay

NOTE: The no cost, reduced cost, and sliding scale should be the result of a policy to provide no cost or reduced cost services for needy individuals. These classifications do not include, for example, write-offs of bad debt or fee discounts when patients pay at the time of service.

To determine the patient volume based on needy, divide the number of needy encounters during any representative and continuous 90 calendar day period in the preceding calendar year by the number of total encounters in that same period. In other words, patient volume is a percentage derived from a fraction with a numerator of needy encounters and a denominator of total encounters.

Encounters

Patient volume calculations depend on the definition of “encounter.” How CMS intends the word and concept to be understood is discussed in the Final Rule, Section II.D.3.d, pages 44486 through 44491, where a Medicaid 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 Act paid for part or all of the service.
- Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing.

Group Proxy Calculations

CMS is allowing practice or clinic-level patient volume data as a proxy to establish patient volume, which applies to both Medicaid and needy individual patient volume calculations (where applicable), but only under the following conditions:

- The clinic or group practice’s patient volume is appropriate as a patient volume methodology calculation for the eligible professional.
- There is an auditable data source supporting the clinic’s or group practice’s patient volume.
- All eligible professionals in the group practice or clinic must use the same methodology for the payment year.

The clinic or group practice must use the entire practice or clinic’s patient volume and cannot limit patient volume in any way. If an eligible professional 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 eligible professional’s outside encounters.

In Idaho the group proxy calculation can be set at the organization level or at the clinic level. If using an organization level group proxy calculation, all clinics within that organization must be included. The clinics that are included cannot be an arbitrary group of clinics selected to maximize patient volumes. There is one exception to this rule. An organization level proxy must include all of the organization’s clinics that are physically located within the state of Idaho. No out-of-state clinics will be allowed to be included in the proxy. So for example, if an organization has three clinics in Idaho and two clinics in Washington, only the Idaho clinics can be a part of the organization level group proxy calculation. Also, all three Idaho clinics **MUST** be included; there can be no random grouping of the clinics in the group proxy.

For more details please see the informational paper called *Use of a Group Proxy Calculation* or that section of the Provider Handbook found on the Medicaid EHR Incentive Program website at www.MedicaidEHR.dhw.idaho.gov.

Medicaid or Needy Patients from Other States

It is Idaho’s decision that out of state encounters will be allowed in the patient volume calculation **ONLY** when in-state encounters alone are not sufficient to meet the patient volume

threshold needed, AND those out of state encounters are likely to support eligibility. In such a case providers will be asked to identify all out of state encounters and the state where those encounters occurred in an encounter report. For more information on this please see the informational paper called *Developing Your Patient Encounter Report* or that section of the Provider Handbook found on the Medicaid EHR Incentive Program website at www.MedicaidEHR.dhw.idaho.gov. The Idaho, Washington, Utah, Montana, and Oregon EHR programs are collaborating to establish appropriate data-sharing relationships for purposes of validating Medicaid volume tallies across state borders.

Retaining an Audit Trail

All patient volume data and calculations should be supported and documented for two reasons: to be fully prepared for an audit and to identify the specific data sources and record the processes by which patient volume was determined. Providers are expected to retain all appropriate records for seven years.

Additional Information

For questions about this or other issues concerning the Idaho EHR Incentive Program, please go to www.MedicaidEHR.dhw.idaho.gov. There you will find an “Ask the Program” feature that will allow you to send questions to program staff. You can also call the Idaho Medicaid EHR Program Helpdesk at (208) 332-7989.