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at the MassTech Collaborative

Revisiting Patient Volume: New Strategies and Options

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The Massachusetts eHealth Institute

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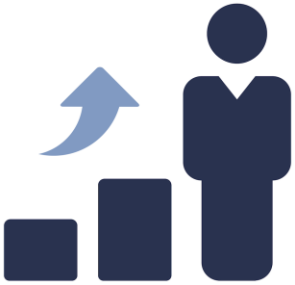
Medicaid Patient Volume Threshold – For Eligibility

Eligible Provider Type	Minimum Medicaid Patient Volume Threshold Requirement
Physicians (MDs & DOs)	30%
Pediatricians ****must be board certified****	20%
Dentists	30%
Nurse Practitioners	30%
Certified Nurse Midwives	30%

Medicaid/Medicaid 1115 Waiver Population Types



- When calculating Medicaid patient volume threshold for eligibility, EPs may include both Medicaid Fee-For-Service (FFS) and Medicaid Managed Care Organizations (MCO) encounters.
- **Some examples of populations that may be included are:**
  - BMC Healthnet Plan
  - Fallon Community Health Plan
  - Network Health
  - Neighborhood Health Plan
  - Health New England
  - Massachusetts Behavioral Health
  - Commonwealth Care Alliance
- Please reference the **Medicaid 1115 Waiver Population grid** for a complete list of which populations may be included when calculating Medicaid patient volume threshold.

Calculating Patient Volume Threshold

Two Options

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Medicaid Patient Volume Threshold Definitions

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MEDICAID PAID ENCOUNTER DEFINITION:

One service, per day, per patient, where Medicaid or a Medicaid 1115 Waiver population paid of all or part of the service or paid for all or part of the individual's premiums, copayments, or cost-sharing.

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MEDICAID ENROLLEE DEFINITION:

One service, rendered any day to a Medicaid or Medicaid 1115 Waiver enrolled individual, regardless of payment liability. This includes zero pay encounters that may have been paid by Medicare or by another third party, and denied claims, excluding denied claims due to the provider or individual being ineligible on that date of service.

Patient Volume Threshold Calculation (Option 1)

MEDICAID PATIENT VOLUME THRESHOLD =

Medicaid Paid Patient Encounters
(over any continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation)

Total Paid Patient Encounters
(over any continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation)

Where a patient encounter is defined as:
One service, per day, per patient, where Medicaid or a Medicaid 1115 Waiver Population ***paid*** for all or part of the service or ***paid*** for all or part of the individual's premiums, co-payments, or cost-sharing

- Medicaid patient volume threshold may be calculated using individual, group proxy, or practitioner panel data.
- A Children's Health Insurance Program (CHIP) reduction must be applied.

Patient Volume Threshold Calculation (Option 2)

MEDICAID PATIENT VOLUME THRESHOLD =

Medicaid Enrollees
(over any continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation)

Total Enrollees
(over any continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation)

Where a Medicaid Enrollee is defined as: One service, rendered any day to a Medicaid or Medicaid 1115 Waiver enrolled individual, regardless of payment liability. This includes zero-pay encounters that may have been paid by Medicare or by another third party, and denied claims, excluding denied claims due to the provider or individual being ineligible on that date of service.

- Medicaid Enrollee patient volume threshold may be calculated using individual, group proxy, or practitioner panel data.
- A Children's Health Insurance Program (CHIP) reduction must be applied.

CHIP factor

When calculating Medicaid patient volume threshold, Eligible Professionals and Eligible Hospitals have the option to use data from either:

- the previous calendar year (CY) or
- the 12-month period leading up to the date of attestation

CHIP factor for data from CY 2012

- Eligible Professional (EP) = 3.09%
- Eligible Hospital (EH) = 2.44%

CHIP factor for data from CY 2013 [calculated on a quarterly basis]

- For patient volume threshold reporting period end date January 1, 2013 through March 31, 2013:
  - EP = 3.05%
  - EH = 2.30%
- For patient volume threshold reporting period end date April 1, 2013 though June 30, 2013:
  - EP = 3.04%
  - EH = 2.25%

Three Ways to Achieve Patient Volume Threshold

Individual, Group Proxy, or Practitioner Panel

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Individual Approach

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Paid Encounters vs. Medicaid Enrollee Approach

Example using an individual provider's encounters:

- Dr. Blue, Internal Medicine Provider
- Practices at one location where certified EHR technology is utilized

Paid Medicaid Encounters	All Medicaid Enrollee Encounters
Continuous 90-day reporting period: October 1, 2012 – December 30, 2012	Continuous 90-day reporting period: October 1, 2012 – December 30, 2012
Total encounters: 1280	Total encounters: 1280
Encounters where services were rendered and paid by an eligible Medicaid or an 1115 Waiver program: 309	All encounters where billable services were rendered to a Medicaid or an 1115 Waiver program enrollee: 421
309/1280 = .24 x 100 = 24%	421/1280 = .33 x 100 = 33%
Does not achieve the Medicaid patient volume threshold at this location	**Achieves the Medicaid patient volume threshold at this location**

Multiple Practice Locations

Example using PAID encounters*:

- Dr. Green, Internal Medicine Provider
- 2 practice locations. Both locations utilize certified EHR technology

*Same concept can be used for Medicaid Enrollee approach

East Medical Center
Continuous 90-day reporting period: October 1, 2012 – December 30, 2012
Total paid encounters: 500
Encounters where Medicaid or an 1115 Waiver population paid for all or part of the service, premium, copayment or cost-sharing: 95
95/500 = .19 x 100 = 19%
Does not achieve the Medicaid patient volume threshold at this location

North Medical Center
Continuous 90-day reporting period: October 1, 2012 – December 30, 2012
Total paid encounters: 85
Encounters where Medicaid or an 1115 Waiver population paid for all or part of the service, premium, copayment or cost-sharing: 35
35/85 = .41 x 100 = 41%
Achieves the Medicaid patient volume threshold at this location

Calculating Needy Individual Patient Volume Threshold For Federally Qualified Community Health Centers

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Needy Individual – Patient Volume Threshold: Two Options

- "Practice Predominately" at a Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) means 50% or more of an EP's patient encounters over a six-month period (in the current CY) occurred at an FQHC/RHC.

- EPs that practice predominately at an FQHC/RHC must meet a minimum needy individual patient volume:

  - 30% needy individual patient volume over a over any continuous 90-day period either from the preceding CY or in the 12 months preceding the Provider's attestation

"Needy Individual" is defined as a person receiving care from any of the following:

- Medicaid or Medicaid 1115 Waiver Population, CHIP, and those dually eligible for Medicare and Medicaid (includes MCO and FFS)
- Uncompensated care
- No cost or reduced cost services on a sliding scale based on individuals' ability to pay

Option 1

NEEDY INDIVIDUAL PATIENT VOLUME =

Needy Individual Paid Encounters
(over any continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation)

Total Paid Patient Encounters
(over any continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation)

Where a patient encounter is defined as:
One service, per day, per patient, where Medicaid (including Medicaid 1115 Waiver Population, CHIP, those dually eligible for both Medicare and Medicaid) ***paid*** for all or part of the service including an individual's premium, copayment, or cost sharing;

- Uncompensated care; or
- Services furnished at either no cost or reduced cost, based on a sliding scale

Needy individual patient volume threshold may be calculated using individual, group proxy, or practitioner panel data.

Option 2

NEEDY INDIVIDUAL PATIENT VOLUME =

Enrolled Needy Individual Encounters
(over any continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation)

Total Patient Encounters
(over any continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation)

- Threshold may be calculated using services rendered on any one day to a Medicaid-enrolled individual, ***regardless of payment liability***:
  - Based on MassHealth enrollment on date-of-service
  - Includes zero-pay claims and denied claims
    Does not include claims denied because either the provider or the member is ineligible on the date of service
- One service, per day, per patient, where the patient is ***eligible*** for all or part of the service (including an individual's premium, copayment, or cost sharing) under
  - Medicaid (including Medicaid 1115 Waiver Population, CHIP, or is dually eligible for both Medicare & Medicaid);
  - Uncompensated care; or
  - Services furnished at either no cost or reduced cost, based on a sliding scale
- Needy individual patient volume can be calculated using individual, group proxy, or practitioner panel data.

Did you know?

- EPs that have practiced less than six months in the current CY at an FQHC/RHC are still eligible to receive an incentive payment as long as the following criteria are met:
  - The FQHC/RHC must use the **group proxy method** to calculate patient volume threshold.
  - The FQHC/RHC must calculate *Medicaid Patient Volume Threshold* rather than *Needy Individual Patient Volume Threshold*. Therefore, the following may not be included:
    - CHIP and those dually eligible for Medicare and Medicaid (includes MCO and FFS)
    - Uncompensated care
    - No cost or reduced cost services on a sliding scale based on individuals' ability to pay
  - A CHIP factor must be applied to the in-state number of paid Medicaid encounters.

Group Proxy Approach

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Definition of Group Proxy

WHAT IS GROUP PROXY

- A group is defined as two or more EPs who are practicing at the same site or within a physician foundation with a unique NPI or Tax ID.
- The group proxy calculation is used by all of the group members to apply for the Medicaid EHR Incentive Payment Program. By doing this, an organization has the possibility of qualifying more EPs than if EPs applied individually.

WHY USE GROUP PROXY?

- Less administrative burden
- Most inclusive option for all EPs practicing at the same site
- Provides for quick validation and easy auditable data

Group Proxy Reporting Example: Option 1

Example using PAID Medicaid encounters

- 5 Providers
- Same practice location
- Utilizing certified EHR technology

Continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation

Provider	Paid Medicaid Encounters (where Medicaid or Medicaid 1115 Waiver Population paid for all or part of the service, premium, copayment, or cost-sharing)	Total Paid Encounters
Physician 1	80	200
Physician 2	50	100
Nurse Practitioner	30	300
Nutritionist	150	200
Resident	0	0
Total	**310**	**800**

310/800 = .3875 x 100 = 38.75%

4 out of 5 professionals meet the Medicaid patient volume threshold requirement and would be eligible to participate.

Group Proxy Reporting Example: Option 2

Example using ALL encounters for Medicaid enrollees

- 5 Providers
- Same practice location
- Utilizing certified EHR technology

Continuous 90-day period either from the preceding CY or in the 12 months preceding the Provider's attestation

Provider	Medicaid-Enrolled Encounters (where eligible for Medicaid or Medicaid 1115 Waiver for all or part of the service, premium, copayment, or cost-sharing)	Total Encounters
Physician 1	120	200
Physician 2	100	100
Nurse Practitioner	45	300
Nutritionist	175	200
Resident	0	0
Total	**440**	**800**

440/800 = .5500 x 100 = 55.00%

4 out of 5 professionals meet the Medicaid patient volume threshold requirement and would be eligible to participate.

Group Proxy Method

GROUP PROXY OPTIONS

Eligible Professionals have the option to use one of the following Group Proxy Methods:

- Physician Foundations that have separate NPIs or Tax IDs
- Ambulatory Clinic (typically used by hospital organizations) or
- Stand-Alone Outpatient Facilities (no inpatient services provided) that house multiple clinics that are owned and operated by the same health care organization **(new)**

Provider organizations should determine which option is the most advantageous for maximizing the number of Eligible Professionals who can participate in the Medicaid EHR Incentive Program.

Group Proxy Method (cont.)

Process to obtain approval for selected Group Proxy Method:

Prior to completing the attestation process, all health enterprise organizations must submit to the Massachusetts eHealth Institute (MeHI) for prior approval:

1. Group Proxy Method chosen

2. A group roster, listing all providers, including those not eligible for the Medicaid EHR Incentive Payment Program

3. Supporting documentation for paid claims or enrollee data (e.g. numerator and denominator) for the selected 90-day patient volume threshold reporting period

   Please note that additional supporting documentation may be requested

Group Proxy Method

WHO MAY USE A GROUP PROXY?

- EPs may use a clinic or group practice's patient volume as a proxy under these circumstances:
  - There is an auditable data source to support the patient volume determination.
  - EPs use one methodology in each year - the group cannot have some using individual patient volume and others using clinic-level data.
  - The clinic or practice must use the entire practice's patient volume and not limit it in any way.
  - The reported patient volume must include **all providers** whose encounters contributed to the group's patient volume during the reporting period. This includes providers that are not eligible to participate in the Medicaid EHR Incentive Program.

Practitioner Panel Method

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Definition of Practitioner Panel

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PRACTITIONER PANEL – A practitioner panel is for Eligible Professionals that practice in a ***managed care/medical home*** setting.

Practitioner Panel Example

90-day reporting period	1/1/12 – 3/31/12
# of Medicaid/Medicaid 1115 Waiver patients assigned to the practitioner's panel in any representative, continuous 90-day period in either the preceding CY or in the 12 months preceding attestation, when at least one Medicaid/Medicaid 1115 Waiver encounter took place with the patient in the 24 months prior to the beginning of the 90-day period.	400
# of Medicaid/Medicaid 1115 Waiver patients assigned to the practitioner's panel during the same chosen 90-day reporting period that had at least one encounter in the CY prior to the start of the 90-day reporting period	250
Unduplicated encounters with Medicaid/Medicaid 1115 Waiver patient during the chosen 90-day reporting period	50
Total patients assigned to the practitioners panel during the same chosen 90-day reporting period that had at least one encounter in the CY prior to the start of the 90-day reporting period	550
Total unduplicated encounters during 90-day reporting period in the preceding CY	100

Practitioner Panel Example (cont.)

250

(Patients assigned to Practitioner Panel with at least one Medicaid encounter in the 24 months prior to the beginning of the 90-day period)

+

50

(Medicaid unduplicated encounters)

(chosen continuous 90-day period from the preceding CY or in the 12 months preceding attestation*)*

550

(Total patients assigned to the Practitioner Panel with at least 1 encounter in the 24 months prior to the beginning of the 90-day period)

+

100

(all unduplicated encounters)

(during the same chosen continuous 90-day period from the preceding CY or in the 12 months preceding attestation*)*

300/650 = .46 x 100

✓ **46% - Provider meets the Medicaid patient volume threshold requirements**

Important Notes

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IMPORTANT

PLEASE NOTE:

- Patient Volume Threshold is required for Adopt, Implement, Upgrade (AIU) and each stage of Meaningful Use (MU).
- If a provider selects to use a 12-month period that overlaps with a previous selected patient volume threshold 90-day reporting period, they will be required to select a different patient threshold reporting period.
- If your clinic or institution has unique billing practices and would like to use the group proxy method to calculate the Medicaid patient volume threshold, the Medicaid Operations Team will work with you and your organization to determine appropriate next steps.

IMPORTANT

- Patient Volume Threshold Reporting Period and EHR Reporting Period are two separate requirements.

Level	Medicaid Patient Volume Threshold Reporting Period	EHR Reporting Period
	Preceding Calendar Year (CY) or 12-month period preceding attestation	**Current Calendar Year (CY)**
AIU: Adopt, Implement, Upgrade	90 days	N/A
Stage 1 MU	90 days	90 days
Stage 1 MU	90 days	365 days ***Exception:*** *In 2014 all participants will have a 90-day reporting period due to the new ONC certification requirements*
Stage 2 MU	90 days	365 days ***Exception:*** *In 2014 all participants will have a 90-day reporting period due to the new ONC certification requirements*
Stage 2 MU	90 days	365 days
Stage 3 MU	90 days	365 days

Patient Volume Threshold Supporting Documentation

- The MeHI Medicaid EHR Operations Staff are required to request supporting documentation when the following discrepancies are identified:
  - A variance of +/- 25% between what is reported as the Medicaid patient volume numerator in the Medical Assistance Provider Incentive Repository (MAPIR) and the MCO and FFS claim information extracted from the MassHealth Data Warehouse claim files

- Types of documentation we may request:
  - Claim remittance
  - Patient accounts management reports
  - Patient registration reports
  - Patient eligibility reports

Note: According to state guidelines, all EPs must keep their MU supporting documentation for a minimum of six years from attestation for auditing purposes

Contact Us

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Contact Us

For specific questions regarding Medicaid EHR Incentive Payment applications, please contact:

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Questions?