MeHI
MASSACHUSETTS eHEALTH INSTITUTE

at the MassTech Collaborative

MassHealth

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The Massachusetts eHealth Institute Patient Volume Thresholds

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MeHI Overview

MeHI is a division of the Massachusetts Technology Collaborative, a public economic development agency

MeHI is designated state agency for:

- Coordinating health care innovation, technology and competitiveness
- Accelerating the adoption of health information technologies
- Promoting health IT to improve the safety, quality and efficiency of health care in Massachusetts
- Advancing the dissemination of electronic health records systems in all health care provider settings
- Connecting providers through the statewide HIE
- Managing HIE and REC grants from Office of National Coordinator

MeHI | How We Help

Regional Extension Center

Support priority primary care providers implement and meaningfully use EHRs and engage in HIE

Medicaid

Partnership with EOHHS to support key operational components of the Medicaid Incentive Payment Program

Health Information Exchange

Connects participants to, enables integration with, and maximizes adoption of the Mass HIway

MeHI - How We Help

Education

- MeHI Website
- MeHI Community

EHRs

- REC IOO Program
- Medicaid Incentive Payment Program
- Health IT Adoption Program (2014)

HIway

- HIway Last Mile Adoption Program
- Vendors
- Technical Support
- Provider Communities
- Implementation Stories and Support

Innovation

- eHealth Roundtable
- Identify and Promote Technology

Outreach - Communication

Calculating Patient Volume Threshold

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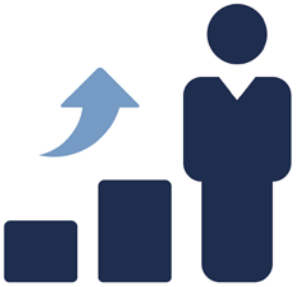
Medicaid/Medicaid 1115 Waiver Population Types



- 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.

Medicaid Patient Volume Threshold Definitions

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.

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 of **3.09** must be applied. The CHIP reduction for CY2013 is TBD.

Patient Volume Threshold Calculation (Option 2)

MEDICAID PATIENT VOLUME THRESHOLD =

Medicaid Enrollee 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 Medicaid Enrollee Encounter 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 of **3.09** must be applied. The CHIP reduction for CY2013 is TBD.

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%

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	North Medical Center
Continuous 90-day reporting period: October 1, 2012 – December 30, 2012	Continuous 90-day reporting period: October 1, 2012 – December 30, 2012
Total paid encounters: 500	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: 95	Encounters where Medicaid or an 1115 Waiver population paid for all or part of the service, premium, copayment or cost-sharing: 35
95/500 = .19 x 100 = 19%	35/85 = .41 x 100 = 41%
Does not achieve the Medicaid patient volume threshold at this location	**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 and 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 of **3.09** must be applied to the in-state number of paid Medicaid encounters.

Group Proxy Approach

Definition of Group Proxy

WHAT IS GROUP PROXY?

- A group is defined as two or more Eligible Professional's, who are practicing at the same site.
- 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 an EP 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 Method (cont.)

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.

Note:

- 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.
- Hospitals that use the same NPI and Tax ID for all of their Ambulatory clinics will need to further breakdown their patient encounter data by Ambulatory Clinic and practice site location. For more information, please contact MeHI for guidance.

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.

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 **(*continuous 90-day period from the preceding CY* or in the12 months preceding attestation)**	**1/1/12 – 3/31/12**
# of **Medicaid/Medicaid 1115 Waiver patients** assigned to the practitioner's panel during the chosen 90-day reporting period that had at least one encounter in the 24-month period prior to the start of the 90-day reporting period	250
Unduplicated encounters with **Medicaid/Medicaid 1115 Waiver patients** 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 24-month period prior to the start of the 90-day reporting period	550
Total unduplicated encounters during 90-day reporting period in the preceding 24 months	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)

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)

300/650 = .46 x 100

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

IMPORTANT

PLEASE NOTE:

- Patient Threshold is **required** for A/I/U and each stage of Meaningful Use.
- Patient Threshold and EHR Reporting Period are two separate requirements.
- 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.

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 supporting documentation for a minimum of six years from attestation for auditing purposes

Contact Us

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