NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Medicaid Patient Volume Calculation for EHR Incentive Program

Eligible Professionals

Who are Eligible Professionals?

Participation in the Medicaid EHR Incentive Payment Program requires an Eligible Professional (EP) to meet specific patient volume requirements. Medicaid patient volume is determined from any consecutive 90 day period within the 12-months preceding the date of attestation. The list of eligible professionals and percentage of Medicaid patient volume necessary to qualify is outlined below:

Each year of participation a Medicaid provider must meet patient volume requirements as follows:	**Minimum 90-day Medicaid Patient Volume Threshold**
Physicians (M.D. and D.O.)	30%
Pediatricians (if Medicaid patient volume is not at 30%, but is 20% or more, can receive 2/3 of the payment)	20%
Dentists	30%
Certified Nurse Midwives	30%
*Physician Assistants (PAs) practicing at an FQHC/RHC led by a PA	30%
Nurse Practitioner	30%

Note: EPs who practice 50% or more in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) can use needy patient volume in addition to Medicaid patient volume. See the section under FQHC for further information.

*PAs are only eligible if they are practicing in an FQHC or RHC that is "so led" by a PA. This is defined by CMS as:

- When a PA is the primary provider in an FQHC/RHC.
- When a PA is a clinical or medical director at a clinical site of practice in an FQHC/RHC.
- When a PA is an owner of an FQHC/RHC.

DHHS will confirm this by using the Health Resources and Services Administration (HRSA) report to determine if the PA is the primary provider. If the PA is the owner or medical director, this will be confirmed with the CMS-29. If the documentation in the HRSA or the CMS-29 is not current, providers will need to furnish documentation to support the PA eligibility.

For more information click on the EP EHR decision tool at this CMS website and answer a few questions to determine whether or not you are eligible for the Medicaid EHR program.

The setting in which the provider practices is generally irrelevant to determining eligibility for the Medicaid EHR Incentive Program as long as the provider is not hospital-based (having 90% or more of their services performed in an inpatient or emergency room setting). EPs in Mental Health facilities, Long Term Care facilities, etc. can also qualify if all eligibility requirements are met.

What is "an Encounter"?

Patient volume calculations depend upon the definition of "encounter." The Medicaid encounter definition was expanded on January 1, 2013 as follows:

- The patient must have been enrolled in an allowable Medicaid program at the time the service was rendered, regardless of whether or not Medicaid paid anything on the bill. This would include Medicaid patients where:
  - claims were denied due to service limitation
  - claims were denied due to non-covered services
  - claims were denied due to timely filing
  - services were rendered on Medicaid patients that were not billed due to the provider's understanding of Medicaid billing rules

  This can be for any type of service (lab work, immunization, office visit, nursing home visit, ER visit, etc.).
- Only one service rendered per day per patient per provider can be counted. For example if a patient came in for an office visit and was also given an allergy shot on that same day by the same physician, this is considered one encounter. If the patient came in on Monday for an office visit and then back on Tuesday for an allergy shot, this is two encounters.

- Only Medicaid encounters for patients eligible through funding under Title XIX or the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act can be included in the encounters. Medicaid encounters for patients eligible for other programs such as state-only funded programs and Federal grant-funded programs cannot be included. Nebraska pays all of these under the Medicaid program and there is no distinction of the funding source on the Medicaid card or claim. We will validate the Medicaid encounter data and if there is an issue with the Medicaid patient volume showing more than a 10% difference from the provider's report, we will work with the provider directly to determine the allowable Medicaid encounters.
- Both Medicaid as primary and secondary insurer can be counted toward the encounters. If Medicaid is secondary and the primary insurance paid more than the Medicaid allowable share (so Medicaid paid zero), then it would still be counted as an encounter.

Patient Volume Determination

There are different methods that can be used in determining a patient volume. Most eligible professionals will follow the formula listed below or the group practice volume calculation which follows.

***Formula for determining Medicaid patient volumes**:*

The formula for determining eligible patient volume using patient encounters is:

[Total Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year up to the date of attestation] – DIVIDED BY – [Total patient encounters in the same 90-day period]. Eligible Professional patient volume may be rounded from 29.5% and higher to 30%.

The method for determining the Medicaid volume must follow the method for determining your total patient volume.

Example:

> An OB-GYN bills Medicaid once when a baby is born which includes all prenatal visits and delivery charges. This will be counted as one encounter. When the total patient volume is counted, one per patient must also be used. A different OB-GYN bills Medicaid for separate prenatal visits and a separate charge for the delivery/birth expenses. The actual encounters would be used for both the Medicaid encounters and the other non-Medicaid patient

encounters. Either method can be used, but must be used for both the Medicaid patients and the other patients.

Group Practice/Clinic Volume Calculation

Incentive payments are for individual providers; however, individual providers practicing in clinics or group practices (including FQHCs and RHCs) may use the group practice/clinic patient volume (or needy population patient volume, as applicable for FQHCs and RHCs as described below). Please note that in these instances a National Provider Identifier (NPI) must identify the group. All locations can be included if they all have the same NPI or Tax ID number (TIN). The following conditions apply to group practice calculations:

- The group practice/clinic patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial or self-pay patients, this is not an appropriate calculation).
- There is an auditable data source to support the group practice/clinic patient volume determination.
- All EPs in the group practice/clinic must use the same methodology for the payment year.
- **The group practice/clinic uses the entire practice or clinic's patient volume and does not limit patient volume in any way.**
- 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.

Although the patient volume for the entire clinic or practice can be used (including patient encounters with non-EPs such as physician assistants, dieticians, nurses, etc.), only those EPs who qualify would be eligible for an incentive payment.

Example:

> Clinic has 5 family practice physicians and 2 pediatricians in the same clinic. Add all encounters for everyone in the clinic. Include the non-eligible providers such as registered nurses, dieticians, etc. also include any visits for lab work, immunizations, office visits, etc. Divide the total patient volume by the Medicaid volume. If the total is 30% or more, then all 7 eligible providers would qualify. If the total is 20-29%, then only the 2 pediatricians would qualify.

Alternative Methods in Determining Patient Volume

Managed Care or Medical Home with capitation or case assignment

Patient panel assignment is an **alternative** volume calculation available only to EPs that are primary care providers (PCP) that have Medicaid managed care or medical home patients assigned to them. These providers have the option to include encounters by patient panel assignment in their eligible patient volume calculation. **Please contact DHHS before using this method.**

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)

EPs that perform over 50% of patient encounters in a FQHC or RHC over a six-month period in the 12 months preceding the date of attestation are deemed to 'practice predominantly' in such a location. EPs that 'practice predominately' may utilize Needy Individuals to calculate patient volume. Needy Individuals include all Medicaid encounters (regardless of the funding source), patients whose services were furnished at no cost, and services paid for at reduced cost based on a sliding scale determined by the individual's ability to pay. EPs using needy individual volumes to qualify for the Electronic Health Record (EHR) Incentive program must meet a 30% volume threshold. EPs qualifying for inclusion of Needy Individuals would simply substitute Needy Individual volume in either formula where "Medicaid patient(s)" is indicated. This would include managed care providers who practice predominantly in an FQHC or RHC.

Medicaid Received from States Other than Nebraska

If you meet the necessary patient volume thresholds using Nebraska Medicaid, then it is not necessary to obtain out of state Medicaid encounters for your attestation. However, if you do not meet the threshold using Nebraska Medicaid, but may meet it using another state's Medicaid encounters include this on your attestation. We will contact the other state(s) to determine the Medicaid volume. The combination of Nebraska Medicaid and other state's Medicaid will be used to determine if the necessary patient volume has been met.