



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Patient Volume and Incentive Payments

FQHC and RHCs

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May 16, 2012

Agenda for Today's Meeting

- Patient volume requirements
- Calculating the patient volume %
- Individual vs. proxy patient volume
- Proxy at the clinic vs. organizational level
- Payment amounts and rules
- Payment reassignment

Before We Begin - Rosters

- Every FQHC and RHC must complete a provider roster
- We need one provider roster for every clinic
- If submitted prior to application/attestation they can be submitted directly to the program
- If not, the application/attestation review for eligibility will be delayed until it is received

Patient Volume Approach Options

Patient volume can be calculated in two ways:

1. Based on the individual provider
2. Based on the group (group proxy)

Group proxy may be calculated:

- At the clinic level, or
- At the organizational level

Patient Volume Requirements

- Eligible professionals (EPs) must have 30% or more needy or Medicaid patient volume encounter rate
 - Based on a representative, consecutive 90-day period in the previous calendar year
- Pediatricians can meet patient volume encounter requirements at 20% or more Medicaid
 - Based on a representative, consecutive 90-day period in the previous calendar year
 - 20-29% Medicaid patient volume will result in 2/3rds of full payment

Definition of Needy

Needy defined as:

- Received medical assistance from Medicaid including the Children's Health Insurance Program (CHIP)
- Furnished uncompensated care by the provider due to inability to pay
- Furnished services at a reduced cost based on a sliding scale determined by the individual's ability to pay

What is a Patient Encounter?

- For the EHR Incentive Program a patient encounter is a unique patient, date of service, place of service combination, i.e., 1 patient 1 day = 1 encounter
- Encounters for out-of-state patients (border states only) may be included in the patient volume calculation
 - Only if needed to meet patient volume threshold and
 - If using out-of-state encounters they must be included in the denominator (total patient encounters)

Calculating Patient Volume

General Approach

Total Medicaid + CHIP + needy patient
encounters
in any **consecutive** 90-day period in the
preceding
calendar year
Divided by
Total patient encounters in
that same 90-day period

Supporting Patient Volume

To support the volume reported, you are asked to submit a *Patient Encounter Report* (in pdf format and generated electronically) that includes:

- Date report was generated
- 90-Day Period – start & end date
- Provider name and NPI, clinic NPI
- Total Medicaid encounters shown daily or weekly
- Out of state encounters identified
- Total patient encounters

Patient Volume Options

Eligible Professionals (EPs) can calculate patient volume in one of two ways:

1. Individual Volume: EP uses individual patient encounter %
 - Numerator = Total # Medicaid, CHIP and needy patient encounters that EP had
 - Denominator = Total # of all patient encounters that EP had

 2. Group Proxy Volume: EP uses GROUP patient volume calculation
 - Numerator = Total of Medicaid, CHIP and needy patient encounters for **ALL PRACTITIONERS** that are part of that group
 - Denominator = Total # of all patient encounters for **ALL** practitioners
- * Proxy is always based on the ENTIRE GROUP

Group Proxy Patient Volume

EPs should determine PRIOR to registering whether group or individual volume will be used by each group. Three conditions must exist:

1. Group volume must be appropriate as a patient volume methodology calculation for the EP (i.e., they must serve needy or Medicaid patients)
2. Auditable data source supporting the group's patient volume
3. All providers attesting for the group use the same patient volume calculation approach

* Please see CMS FAQ Answer ID # 10362 for details on proxy

Group Proxy Patient Volume cont'd

RULES THAT APPLY:

- **A group is defined as all individuals working under a stated NPI number they provide in the Idaho Incentive Management System (IIMS)**
- Encounter data from the entire group is used to perform the calculation (not just certain providers and **not just for all EPs**)
- All EPs within the group using the proxy calculation must have at least one needy encounter since hire date
- If EP also works outside of the group's clinic, then only those encounters associated with the group's clinic are included in the patient volume calculation, and not the EP's outside encounters.

New Information On New Employees!!!!

New providers of the group may use the group proxy patient volume (PV) calculation to meet the patient volume threshold requirement if:

- They have provided at least one needy or Medicaid service since the time of employment

Scenario # 1: A provider may join your practice June 1st and use the group proxy data for that clinic taken the previous year.

Scenario #2: EPs from the clinic have used individual patient volume (PV). A new EP must wait to meet the 90 day PV requirement.

Using Group Proxy Patient Volume at the Organizational Level

Idaho will NOT accept organizational level proxy that includes out of state clinics, all sites included in the organizational level proxy must be physically located in Idaho.

If using organizational level proxy, those clinics included can not be restricted in any way other than by in state vs. out of state sites.

A Few More Notes About Proxy

- Patient volume and use of proxy require good communication with staff so all EPs use the same approach when applying/attesting for the payment
- *A Proxy Calculation Worksheet* will be on the website and in the Provider Handbook. One worksheet should be completed per clinic/organization, converted to pdf. and given to all providers to submit at attestation
- **The first provider attest/apply sets the patient volume approach for all, proxy vs. individual. All EPs after that must use the same method when applying to Medicaid for an incentive that year**

Payment

Payment Year by EP Type	Incentive Amount	Maximum cumulative incentive over 6 years
Year 1 for most EPS	\$21,250	\$63,750
Years 2-6 for most EPS	\$8,500	
Year 1 for pediatricians with a minimum 20% patient volume, but less than 30% Medicaid patient volume	\$14,167	\$42,500
Years 2-6 for pediatricians with a minimum 20% patient volume, but less than 30% Medicaid patient volume	\$5,667	

Reassigning Payment

- EPs may “voluntarily reassign” their incentive payment to the clinic or practice
- You may ONLY reassign payments to a group practice or like organization with whom you have a business relationship
- For payment reassignment to be voluntary, the EP must be informed of and consent to the reassignment
- During the application/attestation process, EPs or **designees** must attest to the voluntariness of the reassignment. Recommend clinics to retain written, signed consent from their participating EPs.

Reassigning Payment (cont'd)

- Make sure you have the proper TIN and NPI for reassignment prior to registering with CMS
- Any changes to reassignment designation may ONLY be done at the CMS Registration site
- You will assign/reassign payment each year you participate in the program
- There is only one annual payment to one payee. Payment may NOT be split between a professional and organization or two organizations
- See the Informational Paper on Payment Reassignment on our website for more details

Enrolling as a Vendor

The recipient of the incentive payment must be enrolled as a vendor with the State of Idaho (process takes about two weeks)

If you are unsure if you are already a vendor, please call the Idaho EHR help desk at 208-332-7989

See the Informational Paper on '*Becoming a Vendor for Payment*' on our website

Path to Payment

1. Verification - Once attestations are completed, they are verified by Idaho Medicaid. If any problems are found, providers are notified with instructions on how to address any issue. The verification process will be slow at the start of the program.
2. Notification - Providers will be notified once the verification process has been completed and when to expect an incentive payment. Payments can be made within 45 days of eligibility determination.
3. Future Payments - EPs are eligible for 5 additional incentive payments based upon the meaningful use of their certified EHR technology (as defined by CMS).

Keep an eye towards MU, first year of MU will be based upon a 90-day reporting period

What Can You Do Now?

- Identify a subject matter expert now
- Submit the provider roster for your clinic
- Get your CMS EHR certification # now
- Decide your patient volume approach (individual vs. proxy) identify your 90-period, calculate the patient volume, EPs can complete a *Patient Encounter Report* (see informational papers)
- Get the AIU documentation gathered and ready
- Be sure the recipient of the payment is enrolled as a vendor with the State of Idaho

Helpful Resources

- Idaho Medicaid Website
www.MedicaidEHR.dhw.idaho.gov (“Ask the Program”)
- CMS EHR Incentive Program Website
www.cms.gov/EHRIncentivePrograms
 - Frequently Asked Questions (FAQs)
 - Meaningful Use Attestation Calculator
 - Attestation User Guides
 - Listserv
- HHS Office of National Coordinator Health IT -certified EHR technology list <http://healthit.hhs.gov/CHPL>

Additional Information

- Sign up for e-mail updates by visiting the Idaho EHR Website www.MedicaidEHR.dhw.idaho.gov and click on “*Monitor This Page*” and follow instructions
- Submit questions by visiting the Idaho EHR Website and click on the email link in the “*Ask the Program*” section

WIREC's Contact Information

Phone: (208) 364-9700, or

Toll free: 1 (800) 949-7536

Website: www.wirecqh.org

There you can apply for assistance,
subscribe to their mailing list, or send them
an email.

Thank you for your participation!

- Presentation and recording will be available on our website www.MedicaidEHR.dhw.idaho.gov
- We will be capturing and posting a transcript of this presentation, including questions and answers
- If you have additional questions, please email us at EHRIncentives@dhw.idaho.gov