Medicaid Patient Volume Calculation

Medicaid Eligibility Requirements:	To be eligible for the Medicaid EHR Incentive Program, providers must meet a minimum percentage threshold of Medicaid patient encounters. • 30% minimum Medicaid encounters • 20% minimum for Pediatricians (at a reduced payment). • All providers that meet or exceed 30% receive the full payment.
Reporting Period for Medicaid Patient Volume Calculation:	Any consecutive 90-days from the previous calendar year or a consecutive 90-day period prior to the submission of application for the program year. We do restrict that the time not go into the next calendar year beyond the application year. • The 90-day patient volume reporting period does **not** need to begin on the first day of a month. • The 90-day patient volume reporting period does **not** need to match the reporting period for a provider's meaningful use reporting period.

Methods for developing the Medicaid Patient Volume Calculation

1. Individual provider method:

- **Numerator**: One provider's Medicaid patient volume for a 90-day period from the previous CY or the last 12 months before application submission.
- **Denominator**: Total number of all patient volume in the same 90-day period.

Example: Dr. A saw 200 patients from 1/1/xx to 3/30xx. Of those 200 patients, 89 had Medicaid as a primary, secondary or tertiary insurance. The calculation is 89 divided by 200 = 0.45; 0.45 equals 45%. Dr. A has a 45% Medicaid patient volume rate for the selected 90-day period.

Please note: If an individual works in a practice setting and uses their individual patient volume for their Medicaid patient volume calculation, then all providers at that practice site must use the individual method if they are applying for the Medicaid incentive program.

2. **Practice/Group level encounters: (FQHC/RHC/IHS may add reduced fee and no fee claims for a "Needy" calculation, all others must use the Medicaid numbers)**

- **Numerator**: All Medicaid or Needy (as applicable for FQHCs) patient volume for a 90-day period
- **Denominator**: Total number of all patient volume in the same 90-day period.

Note: To group patient volume numbers together for a practice or multiple practices the three conditions below must be met:

1. The clinic or group practice(s) patient volume is appropriate as a patient volume methodology calculation for the EP; and
2. There is an auditable data source to support the clinic or group practice patient volume determination; and
3. So long as the practice and eligible providers decide to use one methodology in each year (in other words, clinics could not have some of the providers using their individual patient volume, while others use the clinic-level data).
    - If you choose to report at the practice/group level you must use the **entire** practice/group patient volume and not limit it in any way.
    - If an EP works in both the practice/group and outside the practice/group then the practice/group level determination includes only those encounters associated with the practice/group; the resulting Medicaid patient volume calculation will be used by all providers in the practice/group applying for the Medicaid Incentive Program for the program year.

Please Note: FQHC/RHCs may no longer use only the UDS table 4 for documentation of patient volume as it has been determined to not be accurate for a post payment audit.

Documentation you must maintain:

- You may use your billing/claims system as well as other sources to accurately calculate your percentage.
- You must retain the following documentation for a minimum of six (6) years:
    - 1) The source of your information
    - 2) The 90 day period chosen
    - 3) How the Medicaid eligibility calculation was developed - Individual professional or Practice/Group level
    - 4) If utilizing the Practice/Group proxy methodology, the submitting entity should be able to document that all encounters associated with all group members have been included in the calculation; not only the providers participating in the Medicaid Incentive program.
    - 5) Detailed information to validate patient eligibility must include:
        - Patient name, Medicaid member ID number, if applicable, date of service, payer source, payment amount, and servicing physician

- You will need detailed patient level data to document how a patient encounter was identified as a Medicaid patient, or a different insurance type. We are required to validate your documentation.
- It is optional to submit the detailed documentation with the Medicaid Eligibility Worksheet, but it will be mandatory for an audit.