Determining Your Patient Volume for Eligible Professionals/Groups

These instructions and the accompanying Eligibility Workbook have been developed to help providers determine their Medicaid patient volume for the Meaningful Use Incentive Payment Program (MUIPP). Please know that Alabama Medicaid Agency staff are available to help you as you complete the Eligibility Workbook and your registration. The Agency's goal is to provide accurate information quickly and as early in the process as possible to alleviate reporting discrepancies later. If you are concerned about meeting patient volume requirements, please contact the Agency and let us assist you. You may request assistance by telephone or email:

      Telephone: (334) 353-3301

      Email: info@onehealthrecord.alabama.gov

You may also contact the Alabama Regional Extension Center (REC) for help at (251) 414-8170 or www.al-rec.org.

The information contained in this "EP Tip Sheet" is used to complete the Eligibility Workbook contained on the Provider Outreach Page at http://al.arraincentive.com or that is available from the Agency's website at www.onehealthrecord.alabama.gov . *The completed workbook, along with documentation supporting your patient volume calculation, must be uploaded at Step Two in the State Level Registration System (SLR).* Please select "Eligibility Workbook" when identifying the workbook, and "Practice Management Report" for the documentation from your practice management system, or other auditable data source to support your denominator number.

THE BASICS:

- Eligible Professionals must achieve at least 30% Medicaid patient volume.
- Pediatricians, who achieve a 20% volume may qualify to receive a reduced payment amount.
- Encounter counts are based on the rendering (aka performing) provider (unless a provider is using the services of a nurse-practitioner, see next bullet)
- A supervising physician may add the encounters of a nurse-practitioner as part of the physician's volume calculation.
- If an Eligible Provider practices at multiple sites, one or all sites can be used to compute patient volume.
- An Eligible Provider must have at least 50% of all patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with the certified EHR technology.

- Group patient volume calculations may be used if all members of the group practice agree to use the group approach and all members practice in a "like fashion". This can apply to multi-specialty groups.
- All data entered in the SLR must be derived from an auditable data source and is subject to State verification and audit.
- The Medicaid patient volume is determined by first selecting a representative period, as defined below, from which patient encounter counts will be taken, and then dividing the total number of Medicaid encounters (the numerator) by the total number of patient encounters for ALL patients regardless of payer (the denominator).

REPRESENTATIVE PERIOD:

- January – March 2010 OR October – December 2010 are the two periods of time that the Medicaid Agency has already compiled Provider Medicaid-encounter data and is readily available for the 2011 payment year.
- If you do not meet the minimum Medicaid volume requirements in one of the periods above, then a different 90-day reporting period can be used. If you choose a different representative period, then the entire 90-day period must be within the 2010 calendar year.
- You must enter your chosen representative period in your Eligibility Workbook.
- Please indicate whether you used a group or individual volume calculation.
- While a "consecutive 90-day period" is the regulatory requirement, Alabama has received approval to use any "three consecutive calendar months" as a representative period (however, the reference will continue to be to the "90-day period").

COUNT METHODOLOGY:

The following is a suggested methodology for computing your Alabama Medicaid patient volume. Medicaid encounters will be verified by the State from its Medicaid Management Information System (MMIS) paid claims data. Non-Medicaid encounters must be drawn from Providers' practice management systems or other auditable data sources and will be subject to State audits. **Please note that "encounter" is defined as** *all services rendered to a single patient on a single day, i.e. an unduplicated count of patients per date of service;* **thus, Providers must be sure of how they evaluate the data from their practice management systems and are** counting encounters only**.** These steps are intended to correspond to the steps in the "Volume Determination" tab in the Eligibility Workbook.

STEP ONE: ALL PAYER ENCOUNTERS (DENOMINATOR)

Count of all encounters for Alabama patients, regardless of payer, unduplicated per date of service in a 90 day reporting period. A report from your Practice Management System (PMS) that supports your denominator must be uploaded into the SLR.

STEP TWO: MEDICAID ENCOUNTERS (NUMERATOR)

This is an unduplicated count of patients per date of service during the 90-day period where Alabama Medicaid was the payer (based on Medicaid paid-claims data).

- All Medicaid paid encounters, including inpatient (POS 21) and emergency room (POS 23) services, but only so long as services with POS 21 & 23 do not comprise 90% or more of the EP's encounters.
- In order to count a Medicaid encounter, the paid amount on the claim must be greater than zero (Medicaid must have paid for all or part of the service).
- An encounter may be counted as a Medicaid encounter even if Medicaid was not billed when Medicaid has subsidized the payment for the service (e.g. paid an insurance premium such as Medicare Part B).

NOTE: The remaining steps (Steps THREE through SEVEN) are not required for EPs who have substantially surpassed the minimum Medicaid patient volume requirement; however, for those EPs who after completing Step Two have not met, or have just barely met the 30% requirement (or 20% for pediatricians), it is recommended that they proceed with completing each of Steps Three through Seven that are applicable to their practice. *You may contact the Agency or the REC for assistance with the following steps.*

STEP THREE: MEDICAID MANAGED CARE PANEL

Medicaid Managed Care Panel Assignments (Patient 1st Members)

- This step takes your Patient 1st panel members assigned to you during the representative period that were not accounted for in Step Two and creates a list of members NOT SEEN.
- This list will be run against claims in the preceding 12 month period. This is known as the *"look-behind"* period.
- Any person seen at least once in the look-behind period **counts as one encounter to be added in the numerator and in the denominator.**

STEP FOUR: MEDICAID DUAL ELIGIBLES IN MEDICARE ADVANTAGE PANELS

- Your practice management system will need to run the EP's assignment report to obtain the list of Medicare Advantage health plan panel members that also had Medicaid eligibility during the representative period (Dual Eligible List).
- **A. REPRESENTATIVE PERIOD**
  1. Your practice management system will need to compare the Dual Eligible List patients to those already counted in STEP ONE, but NOT in STEP TWO.
  2. These are Medicaid patients that may be counted as Medicaid encounters during the representative period and **should be added to the numerator only**.
- **B. LOOK-BEHIND PERIOD**
  1. From your Dual Eligible List of patients, identify those Medicaid patients who were NOT SEEN during the representative period.
  2. You will then run this list of "not seen" Medicaid health plan members against claims or encounters attributable to the Medicare Advantage Plan during the preceding 12 month period (the look-behind period).

3. Any person seen at least once in the look-behind period, ***counts as one encounter to be added in both the numerator and in the denominator.***
4. If there are Medicaid encounters during the look-behind period, then non-Medicaid encounters must also be identified to be added to the denominator. See Step Six for details.

STEP FIVE: MEDICAID MATERNITY CARE OB PATIENTS

Alabama operates a Maternity Care Program in which Providers are paid a global fee that covers all prenatal, delivery and post-partum services; thus, these encounters are eligible to be counted as Medicaid encounters even though no Medicaid claims were submitted for each patient visit. In order to capture these visits, you will have to determine the total number of Maternity Care Program patient encounters during the representative period from your practice management system.

A. REPRESENTATIVE PERIOD
1. You will need to run a report from your practice management system to create a Medicaid Maternity Care Patient List to identify any maternity care patients assigned to you during the representative period.
2. From this list you will identify those patients seen during the representative period that were counted in Step One but were NOT counted in Step Two.
3. Each patient not already counted in Step Two ***is counted as one Medicaid encounter and added in the numerator only***.

B. LOOK-BEHIND PERIOD
It may be possible that there were maternity care patients assigned that were not seen during the representative period. If so, you may be able to count those patients as additional encounters.
1. From the list you ran in "A" above, identify any patient that was NOT seen during the representative period. This means they were NOT already counted in Steps One or Two.
2. Compare those patients against encounters in your practice management system for the 12 month period preceding the representative period to identify any encounters for these patients under their **current** maternity care program coverage (the look-behind period).
3. If any of these patients were seen at least once during the look-behind period, it can be ***counted as one encounter and added in both the numerator and the denominator***.

STEP SIX: NON-MEDICAID MANAGED CARE PANEL

If you are counting panel members in any of Steps Three, Four(B), or Five(B), then you MUST count Non-Medicaid Panel members assigned through other managed care arrangements, e.g. Commercial Managed Care Plans, Non- Dual Eligibles in a Medicare Advantage Plan, etc. in a look-behind period.

- ➢ Your practice management system will need to run an assignment report to obtain the list of panel members for whom the provider was responsible during the representative period and were NOT SEEN during the representative period.
- ➢ You will then run this list against claims or encounters for the related commercial payer or Medicare Advantage Plan in the preceding 12 month period (the look-behind period).
- ➢ Any person seen at least once in the look-behind period, *counts as one encounter and is added in the denominator only.*

STEP SEVEN: PATIENTS FOR WHOM MEDICAID PAID MEDICARE PART B PREMIUM

In certain circumstances, Medicaid will pay a Medicaid recipient's Medicare Part B Premium payment and when seen by a Provider, many times a Medicaid claim may not be submitted to the State's MMIS claims system. From your practice management system, run a list of Medicare patients who were also Medicaid recipients during the representative period.

- ➢ From your practice management system, obtain a list of Medicaid eligible patients for whom Medicare paid for the service and there was no crossover to Medicaid. The list must contain the patient's Medicare number and dates of service.
- ➢ Submit this list to the Agency, and it will be run against Medicaid's buy-in file to determine if Medicaid paid the Part-B premium for that patient for that month.
- ➢ If the Part-B premium was paid and the encounter was NOT counted as a Medicaid encounter in a previous step (and who would have already been counted in Step One), then each unduplicated date of service will *count as one encounter and added in the numerator only*.
- ➢ If no premium was paid, the patient cannot be counted.

GROUPS

Individual Eligible Providers who find that they do not meet the patient volume requirement on their own and are members of a group practice may be able to use the encounters of the entire group to meet the requirement.

- ➢ The encounters for each member of the group must be counted and added together for a group total.
- ➢ Encounters billed under the group's NPI may be added to the total (and must be counted in the same manner as for EPs described above).
- ➢ Each EP will use the same group numerator and denominator.

You are advised to contact the Agency for assistance if you have any questions.