MeHI MASSACHUSETTS eHEALTH INSTITUTE at the MassTech Collaborative

Calculating Patient Volume Threshold

Medicaid Patient Volume Threshold is calculated by dividing Medicaid patient encounters by total patient encounters. The Centers for Medicare & Medicaid Services (CMS) have provided three possible methods for calculating Medicaid Patient Volume Threshold: 1) Individual, 2) Group Proxy, and 3) Practitioner Panel.

Using the Individual method, Eligible Professionals (EP) select a continuous, representative 90-day period from either the previous calendar year or the 12-month period preceding attestation, and report on patient encounters across one or more locations where they practiced during the 90-day reporting period. The Group Proxy method allows all EPs within a group to aggregate their patient volume data. However, encounters for all providers at the site must be included, including providers who are not eligible for the Medicaid EHR Incentive Payment Program. The Practitioner Panel method is for providers who practice in a managed care/medical home setting. All methods require the provider to have documented, auditable data sources to support their Medicaid Patient Volume Threshold calculations.

For any questions about calculating Medicaid patient volume threshold, please contact the Massachusetts Medicaid EHR Incentive Payment Program by phone at 1-855-MASSEHR (1-855-627-7347) or by e-mail at massehr@masstech.org.

Patient Encounter Method

Generally, a patient encounter is defined as one service, per patient, per day. For the purposes of calculating Medicaid Patient Volume Threshold, there are two specific ways to define a patient encounter.

Medicaid Paid Encounter

Definition: Encounters where Medicaid (including Medicaid 1115 Waiver Population) paid for all or part of the service rendered to the patient, or paid for all or part of the premiums, co-payments, or cost sharing associated with that service. Using this definition, Medicaid Patient Volume Threshold is calculated as follows:

$$\frac{\text{Medicaid Paid Patient Encounters (over any continuous 90-day period from either the preceding CY or the 12-month period preceding the provider's attestation)}}{\text{Total Paid Patient Encounters (over the same continuous 90-day period from either the preceding CY or the 12-month period preceding the provider's attestation)}}$$

Medicaid Enrollee Encounter

Definition: Encounters with all Medicaid-enrolled patients, **regardless of payment liability**. Providers may include zero-pay and denied MassHealth claims, as long as the reason for denial was not ineligibility on the date of service. Using this definition, Medicaid Patient Volume Threshold is calculated as follows:

$$\frac{\text{Total Encounters with Medicaid Enrollees (over any continuous 90-day period from either the preceding CY or the 12-month period preceding the provider's attestation)}}{\text{Total Patient Encounters (over the same continuous 90-day period from either the preceding CY or the 12-month period preceding the provider's attestation)}}$$

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Group Proxy

Group Proxy allows all Eligible Professionals within a group to aggregate their patient volume data. The reported patient volume must include patient encounter data from **all providers** whose encounters contributed to the group's patient volume during the reporting period, including providers who are not eligible to participate in the Medicaid EHR Incentive Payment Program.

A group is defined as two or more Eligible Professionals who practice at the same site. Eligible Professionals have the option to use one of the following Group Proxy Methods:

- Physician Foundations with unique NPIs or Tax IDs
- Ambulatory Clinic (typically used by hospital organizations[1]) or
- Stand-alone Outpatient Facilities; i.e., no inpatient services provided, that house multiple clinics owned and operated by the same health care organization

Provider organizations should determine which option is the most advantageous for maximizing the number of Eligible Professionals who can participate in the Medicaid EHR Incentive Payment Program.

Obtaining Approval for Selected Group Proxy Method

Prior to completing the attestation process, all health enterprise organizations (hospitals, health centers, etc.) must submit the following to the Massachusetts eHealth Institute (MeHI) for prior approval:

- Selected Group Proxy method
- Group roster listing all providers, including those not eligible for the Medicaid EHR Incentive Payment Program
- Supporting documentation for paid claims or enrollee data (e.g., numerator and denominator) for the selected 90-day patient volume threshold reporting period

Additional supporting documentation may be requested based on the selected Group Proxy method.

Practitioner Panel

Eligible Professionals who practice in a managed care/medical home setting may calculate their Medicaid Patient Volume Threshold using a practitioner panel. Using the practitioner panel method, EPs may select either definition of a patient encounter (i.e., Medicaid paid encounters or encounters with Medicaid enrollees) and may apply the practitioner panel method to either individual or group data. To calculate Medicaid patient volume using this method, an EP selects a 90-day reporting period, either in the previous calendar year or within the 12-month period preceding attestation, and uses the following formula.

Total Medicaid patients assigned to the provider in any representative continuous 90-day period [2] with *at least one encounter* in the 24-month period preceding the start of the 90-day reporting period	**+**	Unduplicated [3] Medicaid encounters in that same 90-day period
Total patients assigned to the provider in the same 90-day period with *at least one encounter* in the 24-month period preceding the start of the 90-day reporting period	**+**	All unduplicated encounters in that same 90-day period

[1] To qualify for the Medicaid EHR Incentive Payment Program, hospital- employed Eligible Professionals must practice less than 90% of their time in an Inpatient (POS 21) or Emergency Room (POS 23) setting.
[2] A continuous 90-day reporting period from either the previous calendar year or the 12-month period preceding attestation
[3] Unduplicated means that the provider may not include the same encounter more than once when calculating Medicaid Patient Volume Threshold. An "unduplicated encounter" would be an encounter with a non-panel patient (fee-for-service patient) that occurred within the same 90-day period.