



**MEDICAID EHR TEAM**  
ANALYSIS, TRAINING & TECHNICAL ASSISTANCE

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# Medicaid EHR Incentive Program Eligibility: Patient Volume & Practicing Predominantly

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## EXECUTIVE SUMMARY

This document addresses the patient volume (PV) and practicing predominantly (PP) provisions of the Medicaid Electronic Health Record (EHR) Incentive program established as part of the Health Information Technology for Economic and Clinical Health Act (HITECH) and the American Recovery and Reinvestment Act (Recovery Act) of 2009.

We describe key issues in determining PV and PP, provide background on requirements for eligible professionals (EPs) and eligible hospitals (EHs), identify the primary challenges in verifying eligibility and highlight approaches and alternatives to calculate and verify PV and PP. Even with data availability limitations and resource and logistical issues to collect all data sources, States are developing CMS-approved approaches for pre-payment PV and PP verification.

## ISSUE

State Medicaid agencies (SMAs) are responsible for defining their State's method of calculating PV and PP as a part of their State Medicaid Health Information Technology Plan (SMHP). State methods, which must be submitted to the Center for Medicare and Medicaid Services (CMS) for approval, must identify "verifiable data sources" available for the SMA and providers, and may be based on either the CMS Patient Volume Method (method) or an approved State Alternative Method (alternative).

Medicaid Incentive payments are available for EPs who: Meet Medicaid PV threshold, or PP in a Federal Qualified Health Center (FQHC) or Rural Health Clinic (RHC) and a threshold for serving "needy individuals."<sup>1</sup> The primary issues faced by SMAs in determining PV and PP are:

- 1) What are the **verifiable data sources** available for providers and SMAs to determine the provider's total patient count, which is the denominator in the PV and PP calculations?
- 2) What is the SMA's **pre-payment method** to verify the number of eligible patients (the numerator) and the number of total patients?
- 3) How will the SMA **consistently apply their method statewide** across a range of different providers, including individuals and groups, fee-for-service and managed care programs, and Federally Qualified Health Center (FQHCs) and Rural Health Centers (RHCs)?

## BACKGROUND

The CMS Final Rule<sup>2</sup> specifies types of EPs and EHs, sets requirements to qualify for incentive payments, and defines methods to calculate PV and PP.

**Eligible Professionals** – EPs are "non-hospital-based"<sup>3</sup> physicians (such as doctors of medicine, doctors of osteopathy, and pediatricians), dentists, certified nurse-midwives (CNMs) and nurse

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<sup>1</sup> "Needy individuals" include Medicaid or CHIP enrollees, persons receiving uncompensated care from the provider, or persons receiving services at no cost or on a sliding fee scale, pursuant to 42.U.S.C. Sec. 1903(t)(3)(F).

<sup>2</sup> 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule. Accessed at: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

practitioners (NPs). EPs also include physician assistants (PA) practicing in an FQHC or RHC that is led by a PA.<sup>4</sup>

**Eligible Hospitals** – EHs include acute care hospitals, critical access and cancer hospitals with an average length of stay of 25 days or less, and children’s hospitals.

**Qualifying** – To qualify for the Medicaid EHR Incentive program, EPs and EHs must meet Medicaid PV thresholds or the PP standards in an FQHC or RHC, as summarized in Table 1.

**Table 1. Eligible Providers and Eligible Hospitals PV and PP Thresholds**

Entity	Minimum Medicaid PV threshold	PP Standard
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC and meets a 30% needy individual patient volume threshold
• Pediatricians	20%	
Dentists	30%	
CNMs	30%	
PAs when practicing at an FQHC/RHC that is led by a PA	30%	
NPs	30%	
Acute care hospitals	10%	Not an option for hospitals
Children’s hospitals	No requirement	

**Practicing Predominantly** – EPs who do not meet Medicaid PV thresholds can meet needy individual PV thresholds, if they practice predominantly in an FQHC or RHC. The PP standard is met if more than 50 percent of an EP’s encounters over a six-month period in the most recent calendar year occurred at an FQHC or RHC, and at least 30 percent of their patient encounters during any continuous 90-day period in the most recent calendar year were serving “needy individuals.”

**Calculating Patient Volume** – Medicaid PV is calculated by dividing the total number of Medicaid patients served in a 90-day period in the preceding calendar year by the total number of patients (from all payers) in that same period. Likewise, to calculate needy individual PV, the SMA divides the number of needy individual patients served by the total number of patients.

## CHALLENGES

The Final Rule affords SMAs flexibility in defining the method and verifiable data sources they prefer to use in calculating PV and PP for EPs. While most SMAs express interest in great flexibility to administer their Medicaid program, many have found these provider eligibility standards particularly challenging because they lack complete data to verify these requirements. They are also concerned

<sup>3</sup> A “non-hospital based” professional must have less than 90 percent of their Medicaid patient volume in a hospital inpatient or emergency department setting. A “hospital-based professional” is “an EP, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of his or her covered professional services during the relevant EHR reporting period in a hospital setting (whether inpatient or outpatient) through the use of the facilities and equipment of the hospital, including the hospital’s qualified EHRs.” [citation]

<sup>4</sup> 42 CFR Sec. 1903(t)(3)(B)

that in their highly regulated environment they may be held responsible for audit findings on requirements that could not be verified prior to payment.

A recent report from the Office of the Inspector General (OIG)<sup>5</sup> found that “data availability limits both the number of requirements that States can verify prior to payment and the completeness of those verifications.” Even though “States cannot conduct complete verifications for eligibility requirements without the necessary data,” and “most States do not plan to start collecting all of the necessary data because the effort would be resource intensive and not logistically practical,” the OIG did not issue formal recommendations. The OIG reached the following conclusions:

- Where data are available to do so, States should “plan to **compare self-reported eligibility** information to other data sources.”
- States that have not yet started their EHR incentive programs should “note the potential **inaccuracies in using MMIS claims data** to verify Medicaid patient volume...and **plan accordingly** when designing prepayment verifications.”
- States have reported that they are “in the process of **developing plans to audit eligibility requirements after payment.**”

In Sections C and D of the SMHP, SMAs are to describe their method and data sources to verify:

- the overall content of provider attestations,
- the PV calculation for EPs and acute care hospitals,
- whether EPs at FQHC/RHCs meet the PP requirement, and
- the program integrity or audit strategy, method and data elements to be used through payment controls and post-payment activities<sup>6</sup>

Clearly, pre-payment verification helps to ensure the integrity of incentive payments made by SMAs. However, many SMAs have experienced challenges defining and implementing methods to calculate and verify PV and PP prior to making incentive payments. States have struggled to determine verifiable data sources that are complete, accurate and accessible to both the SMA and providers.

**Lack of complete and accurate data to verify eligibility** – The OIG found that “over half the States did not report plans to verify three specific requirements prior to payment because necessary data are not currently collected.”<sup>7</sup> Specifically, the OIG noted that States lacked data to determine whether: 1) an EP practice in an FQHC or RHC included at least 30% needy individuals, 2) an EP who is a physician assistant practices in a PA-led FQHC or RHC, and 3) an EP or EH meets the “adopt, implement or upgrade” of a certified EHR requirement.<sup>8</sup>

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<sup>5</sup> Memorandum Report: *Early Review of States’ Planned Medicaid Electronic Health Record Incentive Oversight*, OEI-05-10-00080, HHS Office of the Inspector General, July 15, 2011. Accessed at: <http://oig.hhs.gov/oei/reports/oei-05-10-00080.pdf>.

<sup>6</sup> Post-payment program integrity and audit activities will be the subject of another Medicaid EHR Team paper.

<sup>7</sup> OIG, op. cit., p. 8.

<sup>8</sup> OIG, op. cit.

**Lack of complete and accurate data to verify PV calculation** – One of the most fundamental challenges facing SMAs is to determine PV. This calculation requires access to two types of data—number of persons served or encounters covered by Medicaid and the total number of persons served during a 90-day period in the preceding year. Many States lack complete and accurate data sources for these data.

Specifically, SMAs experience challenges with:

1. **Data for the PV denominator** – Most SMAs rely on claims data from their MMIS to calculate the PV numerator—the number of persons served covered by Medicaid. However, the denominator for the PV formulas—the total patient encounters in the specified 90-day period or total patients assigned to the provider in the specified 90-day period with at least one encounter in the year preceding the start of the 90 day period plus all unduplicated encounters in that same 90-day period—presents a greater challenge since most States lack a verifiable source of data for all payers.

States do not have access to information across all payers and have encountered challenges in combining data from multiple systems. Even in states that have implemented all payer claims databases (APCDs), data limitations occur that prevent easy application of PV rules. Other systems may not include data from Medicare or on persons who are uninsured, and issues of data completeness, quality, timeliness and standardization create problems. Further APCDs often collect and contain limited site-of-service information or limited population sets.<sup>9</sup> Massachusetts found that claims data from a commercial APCD did not include: “self-insured (approximately 34% of [the expenditures]), Medicare (15%), and Medicaid (15%) claims; other payments to providers that would be required to estimate the full cost of care; and member benefit/coverage information.”<sup>10</sup>

2. **Quality and completeness of managed care data** – Encounter data are the primary records of Medicaid services provided to persons enrolled in capitated Medicaid managed care plans. Multiple studies have noted limitations in the quality and completeness of encounter data, which can be an important data element in calculating PV. The OIG found in May 2009 that 40 SMAs reported collecting encounter data, but only 25 States electronically transmitted encounter data to the CMS Medicaid Statistical Information System, as required by law.<sup>11</sup> More recently, Thompson Reuters reported on variety of roadblocks in the encounter data process.<sup>12</sup> States reported that encounter data lacked structure and has not been a priority for state MMIS fiscal

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<sup>9</sup> All-Payer Claims Databases, An Overview for Policymakers, By Patrick B. Miller, Denise Love, Emily Sullivan, Jo Porter, and Amy Costello, Prepared for State Coverage Initiatives by the National Association of Health Data Organizations and the Regional All-Payer Healthcare Information Council, Academy of Health, May 2010

<sup>10</sup> All-Payer Claims Database: Overview of Efforts in Massachusetts, Division of Health Care Finance and Policy. Accessed at: [http://www.mass.gov/Eeohhs2/docs/dhcfp/p/apcd/apcd\\_overview.pdf](http://www.mass.gov/Eeohhs2/docs/dhcfp/p/apcd/apcd_overview.pdf).

<sup>11</sup> Medicaid Managed Care Encounter Data Collection and Use, OEI-07-06-00540, OIG, May 2009. Accessed at: <http://oig.hhs.gov/oei/reports/oei-07-06-00540.pdf>.

<sup>12</sup> Improving Encounter Data Quality and Completeness, Beth Schneider, Thompson Reuters, 2010 MMIS Conference presentation. Accessed at: [http://mmisconference.org/MMIS2010\\_Agenda/Presentations/100818\\_1600\\_02/Wednesday\\_Encounter\\_Data\\_Schneider.pdf](http://mmisconference.org/MMIS2010_Agenda/Presentations/100818_1600_02/Wednesday_Encounter_Data_Schneider.pdf).

agents or States. As a result, Medicaid managed care data in some States is incomplete, which limits its use as a verifiable data source.

3. **Rules for Group practice** – Clinics or group practices will be permitted to calculate PV at the group practice/clinic level, but only in accordance with CMS requirements.<sup>13</sup> The practice must have an available auditable data source to support the PV determination, which not all clinics or group practices currently have. Additionally, the practice must use one uniform method patient for the entire practice within a given year. The practice group cannot allow some EPs to use individual PV calculation and others to use clinic-level data. This may present a challenge for some groups where some EPs would be eligible through one method but another method may be more advantageous for the overall group practice.
4. **Rules for Proxy** – CMS recognizes that that many clinics and group practices do not necessarily track data by EP and it would be disruptive to go back and compile data for the year or begin collecting data at the EP-level. Accordingly, CMS has determined that EPs may use a PV for a clinic or group practice as a proxy for their own PV under three conditions:
  - The PV for the clinic or group practice is appropriate as a PV method 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 clinic's PV determination; and
  - The practice and EPs decide to use only one method in each year (that is, clinics could not have some of the EPs using their individual PV for patients seen at the clinic, while others use the clinic-level data).<sup>14</sup>

The clinic or practice must use the entire practice's PV and not limit it in any way. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice. Where EPs adopt the group rules as a proxy for PV, many of the same challenges associated with rules for group practices will apply to EPs.

5. **Children's Health Insurance Program (CHIP) exclusion** – States report significant frustration and administrative burden with the requirement to exclude children covered by the CHIP program from the PV calculation. States that combine Medicaid and CHIP services have found that providers do not have an easily accessible method to determine whether the child is covered by Medicaid or CHIP. States contest that this creates an unnecessary burden that is contrary to the State's role in supporting integrated, seamless healthcare.

**Lack of complete and accurate data to verify needy individual volume** – EPs who attest to practicing predominantly in an FQHC or RHC must meet a different threshold and so encounter different challenges. EPs qualifying under the PP standard must have a minimum of 30% of their patient volume attributable to needy individuals. While it may be possible to verify needy individuals covered

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<sup>13</sup> 75 Federal Register 144 (July 28, 2010), pp 44579.

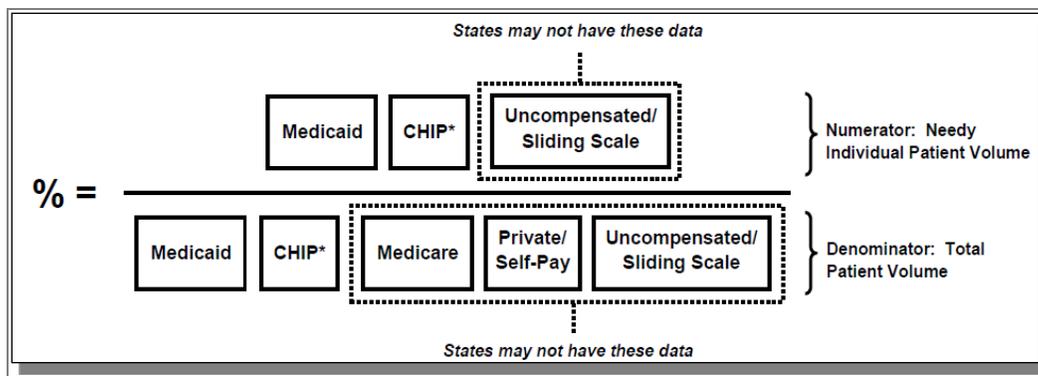
<sup>14</sup> 75 Federal Register (July 28, 2010), pp 44489.

by Medicaid or CHIP, most States will face challenges in verifying the number individuals who received services at either no cost or reduced cost because states lack any data on these encounters.

In a recent survey some States reported that practitioners' needy patient volume and total patient volume are not reflected in States' MMIS and States do not otherwise regularly collect this information.<sup>15</sup>

Figure 1 represents some these challenges.

**Figure 1. Needy Individual Patient Volume Percentage Calculation for EPs PP in FQHC or RHC**



**SOURCE:** Memorandum Report: *Early Review of States' Planned Medicaid Electronic Health Record Incentive Oversight*, OEI-05-10-00080, HHS Office of the Inspector General, July 15, 2011.

### STATE APPROACHES FOR VERIFYING PV & PP

The Final Rule outlines two methods for estimating Medicaid PV based on encounters for individual EPs, and/or a patient panel for EP groups such as managed care or health homes. States have the option to select and detail either or both methods for calculating PV, as defined in the Final Rule, in their SMHP. The formulas for these methods are as follows:

- 1) **Encounter method:** The PV threshold is determined by the percentage of:

$$\frac{\text{TOTAL MEDICAID PATIENT ENCOUNTERS IN A 90-DAY PERIOD IN THE PRECEDING CALENDAR YEAR}}{\text{TOTAL PATIENT ENCOUNTERS IN THAT SAME 90-DAY PERIOD}}$$

- 2) **Patient panel method:** The PV threshold is determined by the percentage of:

$$\frac{\begin{aligned} &(\text{TOTAL MEDICAID PATIENTS ASSIGNED TO THE PROVIDER IN ANY REPRESENTATIVE CONTINUOUS 90-DAY PERIOD IN THE PRECEDING CALENDAR YEAR WITH AT LEAST ONE ENCOUNTER IN THE YEAR PRECEDING THE START OF THE 90-DAY PERIOD}) \\ &+ (\text{UNDUPLICATED MEDICAID ENCOUNTERS IN THE SAME 90-DAY PERIOD.}) \end{aligned}}{\begin{aligned} &(\text{TOTAL PATIENTS ASSIGNED TO THE PROVIDER IN THE SAME 90-DAY PERIOD WITH AT LEAST ONE ENCOUNTER IN THE YEAR PRECEDING THE START OF THE 90-DAY PERIOD}) \\ &+ (\text{ALL UNDUPLICATED ENCOUNTERS IN THAT SAME 90-DAY PERIOD}) \end{aligned}}$$

<sup>15</sup> OIG, op. cit.

In addition, the Final Rule affords SMAs the flexibility to propose an alternate method for determining PV and PP in their SMHP that complies with provisions of the Final Rule and is approved by CMS.

**State Approaches** – More than half of States have received CMS approval of their SMHP, which includes the State’s method for determining PV and PP. Most States have defined a method based on a comparison of provider-reported PV or PP data with data available from the State’s MMIS. All thirteen States in the OIG report indicated that they “plan to verify self-reported eligibility information for at least half eligibility requirements prior to payment,” and all “plan to audit eligibility requirements after payment.”<sup>16</sup> This strategy, in which States seek to verify as much as they can using existing or accessible data pre-payment and develop risk profiles and a tiered approach for post-payment review and audit, provides a more comprehensive approach to program integrity.

Most States are relying upon existing data sources from MMIS and State databases to approximate PV and PP. A few States are accessing additional data sources from other State agencies or the Health Resources and Service Administration (HRSA) reports on FQHCs. Some of data sources and processes for verification of attestations for PV and PP include:

1. **Provider self-reported PV and PP data** – States are requiring EPs and EHs to report PV and PP data through the attestation process. Some States, like Alabama, have developed an online “workbook” for EPs and EHs to enter data and determine which method would be most advantageous for them. Texas has implemented an online “worksheet” for EPs and for EHs that also includes line items to verify discharges, charity charges and inpatient stays for traditional and managed care days.
2. **Medicaid claims and encounter data** – States are using Medicaid claims and encounters as a primary data source for comparison of self-reported PV and PP data. These States recognize that they are able to verify only part of the calculation (the Medicaid portion) and do not have access to the data needed for the PV denominator. Some States report difficulties in obtaining accurate calculations of PV for children due to the CHIP exclusion.
3. **Medicare and Medicaid cost reports** – Several States reference both Medicaid and Medicare cost reports as data sources to verify hospital self-reported Medicaid PV. These reports contain discharge volume and hospital days. Texas indicates that the Medicaid cost reports distinguish Medicaid managed care from other managed care, so the Medicaid managed care claims reported through attestation are compared to two other data sources—Disproportionate Share Hospital (DSH) reports and the Medicaid managed care encounter database.
4. **Attestation system checks** – States are developing and implementing systems to receive attestations and check PV prior to processing the attestation. The Medical Assistance Provider Incentive Repository (MAPIR) system that is being implemented by Pennsylvania and a number of other States includes a Patient Volume Calculator for EPs and EHs as well as pre-payment PV system checks. When an attestation is submitted through the web portal, MAPIR uses the

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<sup>16</sup> OIG, op. cit., p. 7.

provider's National Provider Identification number to verify patient volumes across differing provider locations, including from FQHCs or RHCs, and suspends an attestation if the provider does not meet the PV threshold.

5. **All Payer Claims Database** – An APCD provides critical data to assist States in verifying the total number of patients served (PV denominator) during the reporting period. Even though States with operational APCDs are still dealing with incomplete databases, these States have a higher degree of certainty in their verification process than States that are relying on provider-reported data. There is growing interest in the development of such systems or capabilities for interoperable data systems that could allow greater verification accuracy prior to payment.

States use these data sources to independently verify provider-reported data. In developing policies and procedures to ensure consistent statewide implementation of their PV and PP methods, States must also determine what level of risk they are willing to assume in their pre-payment verification process, as well as what additional program integrity procedures they will implement through payment controls, and post-payment reviews and audits.

SMAAs are using pre-payment verification to identify outliers. But, rather than immediately rejecting the attestation and forcing the individual or entity to appeal, states try to work with provider to address the identified issues. For example, for EPs and EHs with only small variance between their reported data and the State verification data, States have established a consultative and technical assistance role. Texas has established risk thresholds for the level of variance they are willing to tolerate before requiring a meeting with the hospital to resolve the variance prior to payment. They define a “significant variance” is when a hospital has a variance between what was calculated using cost report data and what the hospital calculated using attested data, or if they find a variance between data received and hospital data. In either of these cases, the State directly contacts the hospital to review additional billing or other financial documentation and compare their documentation with Medicaid claims data to resolve the discrepancy. Similarly, in Kentucky if the state finds significant discrepancies between attestations and verifiable data, staff will contact the EP or EH. Pennsylvania has also developed a process for review if calculations are close to the allowable thresholds.

**Alternative State Methods** – CMS allows States to propose alternate methods to determine PV and PP. The following three States have received CMS approval to implement alternative methods:

- Texas uses a three month reporting period, rather than “any 90 days in the previous CY,”
- California is pre-qualifying providers based on a full calendar year of data, and
- Alabama is using a tiered approach.

States are also exploring new data sources to verify all or part of needy individual PV thresholds prior to payment. Two States are directly contacting EPs to obtain documentation, and one State is using FQHC reports submitted to HRSA to verify needy individual PV. As in all verification approaches, none of the sources identified by the OIG provides complete assurance. Verification should be viewed as

one part of a larger program integrity approach that “helps States proactively ensure the integrity of their EHR incentive payments.”<sup>17</sup>

Appendix A summarizes these approved methods as options for other States to consider and/or adopt as appropriate.

**Methods to verify PP** – The OIG report found most States in their early implementer sample did not plan to verify two key requirements related to PP, but their identified data sources for partial or complete verification are listed in Table 2.

**Table 2. Eligibility Requirements and Pre-Payment Verification Data Sources**

Eligibility Requirements	Pre-Payment Verification Data Sources
EPs must have at least 30% needy individual patient volume if they are practicing predominantly in an FQHC or RHC	<ul style="list-style-type: none"> <li>• Direct contact with FQHC or RHC</li> <li>• FQHC reports</li> <li>• Documentation submitted by the EP</li> </ul>
If an EP is a PA, he or she must practice in a PA-led FQHC or RHC	<ul style="list-style-type: none"> <li>• FQHC reports</li> <li>• Direct contact with PA, FQHC or RHC</li> </ul>

## CONCLUSION

States have the flexibility to define their PV and PP calculation methods, consistent with the Final Rule, or to submit an alternative approach in their SMHP for CMS to approve. CMS has approved SMHPs for more than half of all States, of which three State proposals include alternate methods. This document provides information on approved State methods and alternate approaches for pre-payment verification of PV and PP to minimize eligibility verification risks. While States may not currently possess all data needed to complete eligibility verification, States are making great strides implementing a new and complex program to incentivize meaningful use of EHRs with the goal of improving health outcomes, care delivery and cost effectiveness while also safeguarding the integrity of the Medicaid EHR Incentive payment process.

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<sup>17</sup> OIG, op cit., p. 7.

SMAs may submit alternative methods to calculate PV and PP in their SMHP to be approved by CMS. This Appendix summarizes these CMS-approved State Methods as options for other States to consider.<sup>18</sup>

**TEXAS** – Texas has identified auditable data sources for most types of EPs and EHs. However, they have developed an alternative method that allows EPs and EHs to identify the three-month period for their self-report, and the SMA will develop monthly rather than 90-day MMIS profiles, to allow for more consistency in the dates. Provider profiles will be refreshed with a data file of encounter volumes by month and by provider. Using the rolling, full-month approach allows the state to quickly and efficiently verify volume reports. Medicaid will encourage providers to use full three-month attestations for a smoother PV verification approach. However, providers who feel it would be beneficial to use partial month volumes will be accommodated. If a provider opts to use partial months, volume attestations will need to be validated with provider-specific, date-specific queries, which may delay the payment.

**CALIFORNIA** – The California alternative approach focuses on *pre-qualifying provider, panel and clinics* for the Medi-Cal EHR Incentive Program. This method is supported by California's Primary Care Association and allows the SMA to decrease the time and workload of prepayment verification and refocus attention on provider outreach and education.

EPs can qualify using either of the two formulas in the Final Rule or through pre-qualification. The SMA utilizes Medicaid encounter data for 2010 and from the American Academy of Family Physicians Practice Study to project the expected number of outpatient encounters for a full-time physician and to define the pre-qualifying PV threshold (30% PV = 1116 encounters). The SMA utilizes a similar projection method to establish an average number of encounters per year to determine the panel size threshold for pre-qualification "to achieve a 30% Medi-Cal threshold the provider would be expected to treat 318 Medi-Cal patients per year."

For the clinic method, the SMA utilizes data from the Office of Statewide Health Planning (OSHPD) to determine which clinics have 30% or more encounters attributable to Medi-Cal patients and needy individuals. The OSHPD data includes clinic-wide patient volumes for all payers, so the State can more accurately determine the all-payer denominator.

**ALABAMA** – Alabama has set two reporting periods (January – March 2010 or October – December 2010) for which Medicaid has data available. If an EP does not meet the PV threshold in one of these periods, then the EP can use a different 90-day reporting period. The EP is to specify their chosen reporting period and whether they are going to use individual or group calculation.

1. **All Payer Encounter Denominator** – The EP is to provide an unduplicated count of all encounters for patients, regardless of payer, within a 90-day reporting period. If the provider has a Practice Management System (PMS), then the EP can upload a report from that system as a part of their registration and attestation process in the State Level Repository to document the denominator.

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<sup>18</sup> 42 CFR Parts 412, 413, 422 et.al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule, p 44488-44489.

2. **Medicaid Encounter Numerator** – The EP is to provide an unduplicated patient count by date of all encounters, including inpatient (POS 21) and emergency room (POS 23) services, within a 90-day period with a paid amount greater than zero.

NOTE: If the EP has not met PV threshold at Step 2, the EP should proceed with the following steps and is encouraged to call the SMA or Regional Extension Center for assistance.

3. **Medicaid Managed Care Panel** – The EP is to develop and submit a list of Patient 1<sup>st</sup>-assigned panel members who did not have an encounter during the reporting period (based on the last month of the reporting period to the SMA. The list is compared with a claims run for the “look-behind period” in the previous calendar year.
4. **Medicaid Dual Eligibles in Medicare Advantage Panels** – The EP is to produce a PMS assignment report for the last month of the reporting period to document assigned panel members, and compare that report to those members identified in Step 2. Then the EP is to compare that list with the claims and encounters covered by the Medicare Advantage Plan in the previous calendar year to identify members assigned but not served during the reporting period.
5. **Non-Medicaid Managed Care Panel** – To identify panel members who are covered by commercial managed care plans, non-dual eligibles in Medicare Advantage plans and assigned to a managed care plan, the EP is to create a PMS assignment report based on the last month of the reporting period. The EP is to compare this list of panel members for whom the provider is responsible to the claims or encounters for the commercial payers and/or Medicare Advantage Plans in the previous calendar year.
6. **Medicaid Maternity Care OB Patients** – Alabama operates a Maternity Care Program covering primary care through a global fee used to contract with individual practitioners who do not submit claims through the MMIS. Primary care contractors report into the state’s RMEDE data system, which is used to determine the utilization data, including the rendering provider and number of prenatal and postpartum visits. The SMA uses the NPI to determine count of prenatal and postpartum visits for patients within the reporting and look-behind period for each provider. To determine the total visits for Medicaid Maternity Care Program OB patients within the reporting period, the SMA counts the visits in the numerator only or, if they are in the look-behind period, counts them in both the numerator and the denominator.
7. **Patients for Whom Medicaid Paid Medicare Part B Premium** – For qualified individuals, Medicaid pays the Medicare Part B Premium payment, but this does not result in an encounter in the MMIS. The EP is to create and submit to the SMA a PMS report listing the Medicare number and date of service for individuals for whom Medicaid paid the Medicare premium and there was no crossover encounter in Medicaid. The SMA is to compare that list to the Medicaid Buy-In file to verify that Medicaid paid the premium for that month. If a premium was paid and the encounter was not counted in a previous step, then the individual counts in the numerator only. If no premium was paid, the individual cannot be counted.