

# Hospital Patient Volume

## Idaho Medicaid Electronic Health Record (EHR) Incentive Program

Created March 2012

*Note to Providers: There is a good possibility that business processes will change after the program is launched. Potential efficiencies as well as potential problems are likely to become evident. This paper describes the business as of spring 2012. Please be sure to return to the information on the website and in the provider handbook often for updates. Creation dates will be noted on each paper.*

### Introduction

Patient volume thresholds must be established every year a provider applies for an incentive payment. Each year of participation, a Medicaid eligible provider must meet the following patient volume requirements:

Provider Type	Minimum 90-day Medicaid Patient Volume Threshold	Or Medicaid eligible professionals (EP) practicing predominantly in an FQHC or RHC, with 30% “needy individual” patient volume threshold
Physicians	30%	
Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
Physician Assistants (PAs) practicing at an FQHC/RHC led by a PA	30%	
Nurse Practitioners	30%	
Acute Care Hospital	10%	N/A
Children’s Hospital	N/A	N/A

### Calculating the Patient Volume Percentage

Patient volume is calculated by dividing the number of unduplicated Medicaid encounters during any representative and continuous 90-day period in the preceding fiscal year by the total number of unduplicated encounters in that same period. In other words, patient volume is a percentage derived from a fraction: the numerator is Medicaid encounters and the denominator is total encounters.

The Centers for Medicare and Medicaid Services (CMS) does not believe the tracking of encounters to establish patient volume should be impossible or onerous for hospitals, seeing as “[they] are businesses and there is an expectation that they are tracking their receivables from all entities (including Medicaid) associated with specific patients.”

That said, CMS also indicates that determining patient volume is not an exact science:

*“We expect providers and States to make estimation in accordance with the methodologies we established here. The estimation would need to be made with reasonable effort, using verifiable data sources by the provider and the State.”*

With benchmark data and averages, the state will know only what is reasonable for the denominator value (total encounters) of any given hospital. The state will assume that the total encounter numbers submitted during application are supported by reasonably accurate business data, which can be requested, submitted, and reviewed in the event of an audit. From the Idaho Medicaid Management Information System (MMIS), the state has much more information regarding numerator values, which will be used to validate the numbers submitted by hospitals when they complete their online state application.

For purposes of calculating patient volume, only Medicaid (title XIX) encounters may be counted; CHIP (Title XXI) encounters or encounters funded through other state programs cannot be included. We realize hospitals cannot always distinguish between these different funding sources. To overcome this complication, the state is providing a multiplier — calculated from statewide data — that deducts an estimation of non-Medicaid encounters from the general “medical assistance” totals maintained by the hospital. That information will be provided to the hospital. Here is how it will work:

- A Medicaid staff person will contact the hospital soon after Idaho Medicaid receives notice from CMS that the hospital has registered for a Medicaid incentive payment.
- The hospital will be asked to provide:
  - The date in the previous completed federal fiscal year (FFY) the hospital wishes to begin the 90-day period for calculating patient volume (if you apply/attest in July 2012, you would use FFY 2011).
  - The total number of discharges plus emergency room visits during that same 90-day period.
  - The hospital’s charity care amount for the federal fiscal year prior to the hospital fiscal year that serves as the first payment year. Charity care is equal to uncompensated care minus bad debt.
  - Documentation to support the charity care information you provide.
  - Documentation to support AIU, if the hospital has not yet received a Medicare incentive payment for meaningful use.
- When Medicaid receives this information, a report will be run to determine the total number of Medicaid discharges that occurred during the identified 90-day reporting period along with the total number of emergency room visits. The report will also identify which of those discharges and emergency room visits were with Medicaid recipients whose services were funded with CHIP funds.

*Note:* As described above, these services are not eligible to be included in the number of Medicaid patient encounters that will be used to determine your 10% eligible patient volume or your payment amount. For more information about this, please see the information paper called *CHIP and Patient Volume* or that section of the Provider Handbook found on the Medicaid EHR Incentive Program website at [www.MedicaidEHR.dhw.idaho.gov](http://www.MedicaidEHR.dhw.idaho.gov).

- The Medicaid EHR Incentive payment amount will also be calculated.
- A payment calculation worksheet, approved by CMS, will be completed.
- Staff will email the hospital the encounter information as well as the completed payment worksheet. The hospital should carefully review the information provided. The hospital is expected to use the information provided to complete the application/attestation to Idaho.

## Encounters

Patient volume calculations depend on the definition of “encounter.” How CMS intends the word and concept to be understood is discussed in the Final Rule, Section II.D.3.d, pages 44486 through 44491, where a Medicaid encounter is defined as:

- Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service.
- Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing.

In other words, a hospital encounter occurs only in a hospital’s inpatient department where one encounter is tallied for each inpatient discharge, or in the emergency room (ER): one patient one day equals one encounter. If Medicaid paid for any part of the patient’s stay and for the ER visit (no more than one per patient per day), that counts as a single encounter.

The patient volume calculation for a hospital is calculated by identifying a representative, continuous 90-day period in the preceding fiscal year and, for that period, dividing as follows:

<p style="text-align: center;">The number of inpatient discharges for which Medicaid paid for any part of the patient's stay</p> <p style="text-align: center;">+</p> <p style="text-align: center;"><u>The number of ER visits on any one day for which Medicaid paid any part of the visit</u></p> <p style="text-align: center;">(divided by)</p> <p style="text-align: center;">The total number of inpatient discharges, plus the total number of ER visits on any one day</p>
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For an acute care or critical access hospital to be eligible for an incentive payment under the Medicaid EHR Incentive Program, the result of this calculation must reach at least the federally required 10%.

## Additional Information

For questions about this or other issues concerning the Idaho EHR Incentive Program, please go to [www.MedicaidEHR.dhw.idaho.gov](http://www.MedicaidEHR.dhw.idaho.gov). There you will find an “Ask the Program” feature that will allow you to send questions to program staff. You can also call the Idaho Medicaid EHR Program Helpdesk at (208) 332-7989.