

Eligibility and Patient Volume

Medicaid Eligible Professionals (EPs)

The following are Medicaid Eligible Professionals:

- Physician
- Dentist
- Advanced Practice Professional Nurses
 - Nurse practitioner
 - Certified nurse midwife
 - Clinical Nurse Specialist
 - Registered Nurse Anesthetist
- Physician assistant (PA), if practicing in a rural health clinic (RHC) or a federally qualified health center (FQHC) that is led by a PA. PA-Led criteria must meet one of the following:
 - The PA is the primary provider in the FQHC or RHC
 - The PA is the clinical or medical director at an FQHC or RHC
 - The PA is an owner of an RHC

A Medicaid EP must be a non-hospital based provider. A provider is defined as hospital based if more than 90% of their services are identified as being provided in places of service classified under two place of service codes, 21 (inpatient hospital) or 23 (emergency room hospital).

EPs must choose to participate in only one program: either Medicare or Medicaid. An EP may switch one time between the two programs once before 2015. Each EP can receive only one incentive payment per year, regardless of how many practices or locations at which they provide services. Providers serving populations in more than one state can participate only in one state.

EPs must have one of the following patient volumes during any continuous 90 day period within the previous calendar year prior to reporting:

- Minimum of 30% Medicaid patient volume.
- Minimum of 20% Medicaid patient volume and be a pediatrician to receive a 2/3 partial incentive payment.
- Practice predominantly in an FQHC or RHC and have a minimum of 30% patient volume attributable to 'needy' individuals. (Practice predominantly means 50% or more of the encounters over a 6 month period in the previous calendar year or rolling calendar year.)

A Medicaid encounter is when Medicaid has adjudicated:

- Part or all of an eligible service claim, which may include zero-dollar claims.
- Part or all of the individual's premiums, co-payments, and/or cost sharing.

'Needy' encounter is defined as an individual who receives one of the following:

- Is furnished uncompensated care by the provider.
- For whom charges are reduced by the provider based on the individual's ability to pay.

CHIP

For purposes of calculating patient volume for EPs that are non FQHC/RHC, only Medicaid encounters (services funded by Title XIX) may be counted; CHIP encounters (services funded by Title XXI) **cannot** be included. Practices 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 of the practice. For more information, please see the informational paper "CHIP and Patient Volume" under the *Educational and Training Materials* section of the Idaho Medicaid EHR web page.

Group Patient Volume Option

If you are part of a practice or clinic, the patient volume may be calculated on a group level which means the encounters for all providers (eligible and non-eligible) in a group practice are used to determine patient volume. There is a "Group Proxy Roster Worksheet" available under the *Forms for Providers* section of the Idaho Medicaid EHR web page.

Medicaid Eligible Hospitals (EHs)

Medicaid EHs must meet the following conditions:

- Be an acute care hospital, including critical access and cancer hospitals, (CCN 0001-0879 or 1300-1399) with at least 10% Medicaid patient volume for any 90-day period in the preceding fiscal year.
- Be a children's hospital (CCN 3300-3399) - No Medicaid patient volume requirement.

An EH may participate in both Medicare and Medicaid programs simultaneously (except children's hospitals, which can only qualify for Medicaid incentive payments). When an EH goes through the CMS

registration process, they should select the 'Both Medicare and Medicaid' option, even if they plan to only apply for a Medicaid incentive payment, to maintain the option to attest for a Medicare incentive payment at a later date.

Medicaid patient volume is calculated using the following formula:

$$\frac{\text{Total Medicaid inpatient discharges + emergency department encounters in any representative, continuous 90-day period in the preceding federal fiscal year}}{\text{Total inpatient discharges + emergency department encounters in the same 90-day period}}$$

Total inpatient discharges + emergency department encounters in the same 90-day period

A Medicaid encounter is when Medicaid paid for:

- Part or all of an eligible service claim, which may include zero-dollar claims.
- Part or all of the individual's premiums, co-payments, and/or cost sharing.

CHIP

For purposes of calculating patient volume for EHs, only Medicaid encounters (services funded by Title XIX) may be counted; CHIP encounters (services funded by Title XXI) **cannot** be included. Hospitals cannot always distinguish between these different funding sources. To overcome this complication, the state will calculate the Medicaid and CHIP encounters for the 90-day period the hospital identifies and send a report to the hospital. The data is used to reduce the hospital's patient volume numerator that is entered into IIMS when attesting. For more information, please see the informational paper "CHIP and Patient Volume" under the *Educational and Training Materials* section of the Idaho Medicaid EHR web page.