

## Medicaid Eligibility Reporting Period and Calculation opt

### Definition of reporting period:

Any consecutive 90 days from the previous calendar year or from the date of application for the program year you are applying for  
**Note:** The 90 day period does not have to begin on the same date to match the reporting period for an individual provider

### Individual provider encounters:

One provider's total patient encounters for a 90 day period. If a provider works in a practice setting and uses their individual encounter data, the encounters from that practice must use the individual method if it is the only practice they work for.

### Practice/Group level encounters:

To group encounter numbers together for a practice.

- (1) The clinic or group practice(s) patient volume is appropriate as a patient volume methodology calculation for the EP; and
- (2) there is an auditable data source to support the clinic's patient volume determination; and
- (3) so long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some use the individual professional or at a clinic level, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not liability for the individual professional or at a clinic level calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic, the patient volume determination includes only those encounters associated with the clinic/practice.

**Note from MaineCare HIT:** You may use your billing/claims system as well as other sources to accurately calculate your patient volume for a consecutive 90 days you chose; 3) whether you chose to determine encounters based on the individual professional or at a clinic level, if you are a professional practicing in a Federally Qualified Health Center or Rural Health Center, use the Uniform Data Set (UDS) methodology.

In order to provide examples of how to calculate, please refer to Clinics A and B, and assume that these clinics are legal.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calcul A in calculating his or her individual patient volume.

The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodo clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of cour

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**CLINIC A (with a fictional EP and provider type)**

EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)

EP# 2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)

Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)

Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)

EP #3 (physician): individually had 10% Medicaid encounters (30/300)

EP #4 (dentist): individually had 5% Medicaid encounters (5/100)

EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributak professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of th encounters at Clinic A should be included.)

**Purpose of rules:**

The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs i Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volu

**Provider working at multiple sites:**

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP #4 could choose to use the proxy-level Clinic / practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid in determining such clinic's overall Medicaid patient volume.

If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data fr

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year (2013) or a consecutive 90 day period prior to the submission of  
the first of a month. The Medicaid eligibility reporting period does not have to  
s meaningful use reporting period. They are two different reporting periods.

period divided by the # of Medicaid patients from that total. If an individual  
ncounter numbers for their Medicaid eligibility calculation then all providers  
they are also applying for the Medicaid incentive program.

practice or multiple practices the three conditions below must be met:

ind

ne of the EPs using their individual patient volume for patients seen at the  
mit it in any way. EPs may attest to patient volume under the individual  
the clinic (or with and outside a group practice), then the clinic/practice level

percentage. You will need to tell us: 1) The source of your information; 2) which  
the practice level (all of the eligible professionals in the practice). Note: If you  
) report for the previous calendar year.

lly separate entities.

EP from using the patient volume associated with Clinic B and claiming the volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy volume. In addition, the EP could not use his or her patient encounters from clinic

policy for the payment year) was to ensure against EPs within the same geographic conditions was to prevent high Medicaid volume EPs from applying using their volume to be inflated for these lower-volume EPs.

eligible to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 providers are not eligible for the program on their own, but their clinical

in this clinic (EPs #1 and #2) were to apply on their own (they have enough volume providers (e.g., EPs #4 and #5).

A patient volume data, or the patient volume associated with her individual  
d patient volume. In addition, her Clinic A patient encounters would be included

option, each such clinic would use the encounters associated with the  
om one clinic or the other.