MaineCare Services
An Office of the
Department of Health and Human Services

John E. Baldacci, Governor Brenda M. Harvey, Commissioner

State of Maine Health Information Technology

Update on the State Medicaid HIT Plan (SMHP) and EHR Incentive Program Patient Volume Calculation

September 1, 2010

Agenda

Meeting Objectives

Impact of Final Rule on Project Timeline

Who Qualifies?

Discussion on the Patient Volume calculation

Wrap-Up

Meeting Objectives

The objective of this meeting is to:

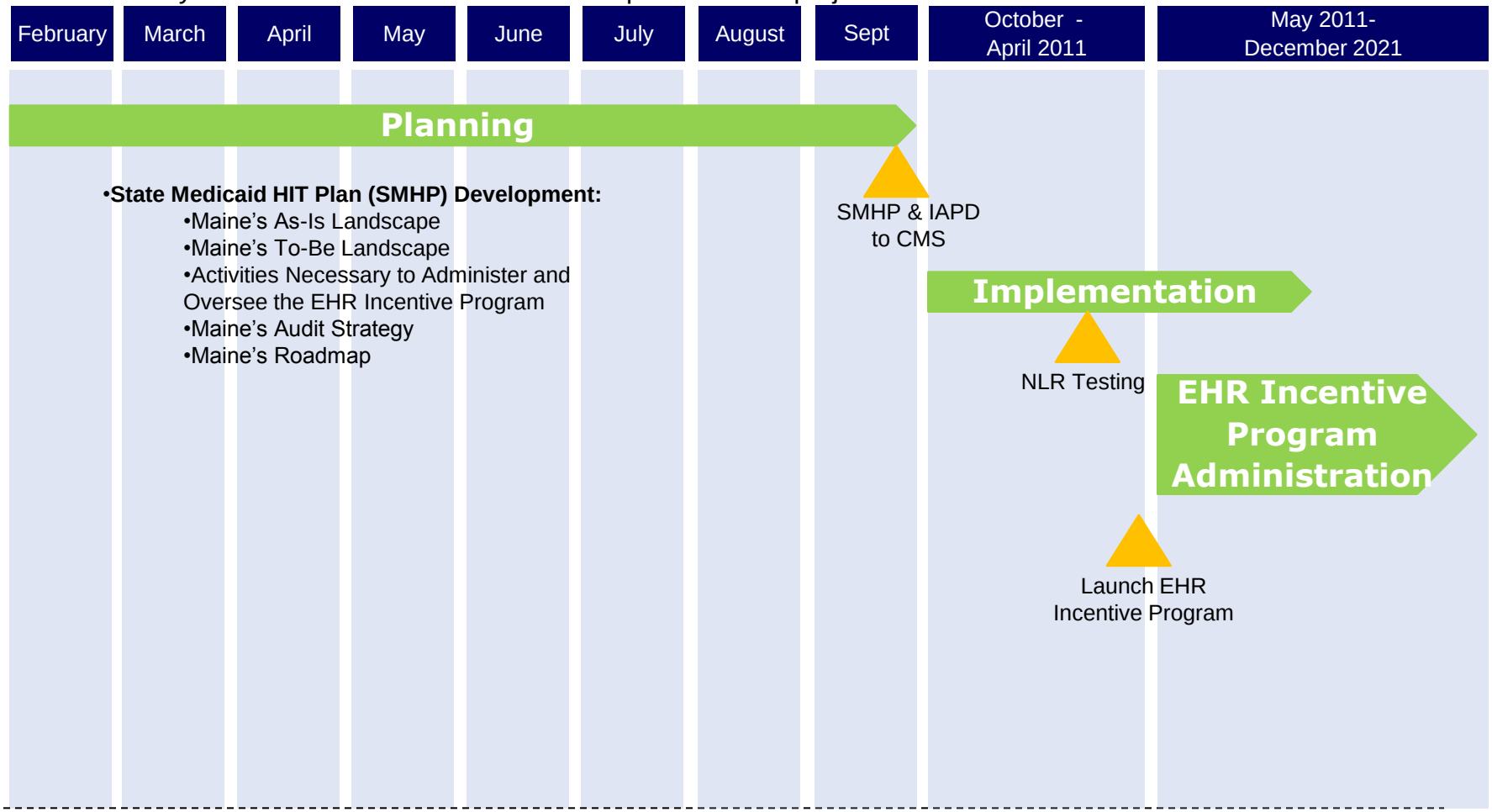
- Provide an update on the SMHP project
- Discuss and gather feedback on the State's patient volume calculation to be used for provider eligibility in the EHR Incentive Program

MaineCare HIT Planning Project Timeline Update

Impact of the Final Rule on the SMHP Project

- The final rule for the Medicare and Medicaid EHR Incentive Programs was anticipated to be released in late spring; it was released by CMS on July, 13, 2010. The delay of the release of the final rule impacted the timing of the SMHP project, including key deliverables.

- The SMHP team has reviewed the final rule in detail and participated in several trainings and webinars conducted by CMS about the final rule and developed a revised project timeline



Who qualifies and how are the incentive payments calculated?

Medicaid Patient Volume Thresholds

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

Eligible Hospital: Medicaid – Illustrative Calculation

Initial amount *times* Medicaid Share *times* Transition Factor for each eligible year = Incentive Potential

Initial Amount			
Hospital	**Base Amount**	**Incremental increase**	**Sum of Base and Incremental Increase**
	$2,000,000	$200 * discharges between 1,149 and 23,000	
Hospital X	$2,000,000	17,078 discharges *200 = **$3,415,600**	**$5,415,600**

	Data Required for Calculation			Medicare Share and Incentives Calculation		
Hospital	**Total Patient Days**	**Adjusted Total Patient Days defined (ratio) as Non Charity Care / Total Charges**	**Medicaid Patient Days**	**Patient Days * Adjusted Patient Days**	**Medicaid Days Adj Patient Days**	**Initial Amount X Medicaid Share = Estimated Incentive**
Hospital X	63,073	$742,744,485 (CC) $775,439,349 (Total Charges)	19,418	63,073 * 96%	19,418 / 60,550	32% * $5,415,600
		96%		60,550 APD	32%	$1,732,992

Transition Factor X Estimated Incentives				
Hospital/ Transition Factor	**100% (yr 1)**	**75% (yr 2)**	**50% (yr 3)**	**25% (yr 4)**
Hospital X	$1,732,992 (2)	$1,299,744	$866,496	$433,248

(1) Assumes 'meaningful use' is achieved and adoption is either in years 2011, 2012, or 2013
(2) Medicare calculation is the same with one exception. Medicate Patient Days represents the sum of Medicare Part A and C

- Incentives are calculated at the Federal level by CMS for both Medicaid and Medicare
- To participate in the Medicaid incentives, a hospital must have at least 10% Medicaid IP hospital visits
- The Eligible Hospital (EH) also must participate in the IPPS
- EH participates can "skip" a year up for compliance up to and including year 2016 (Medicaid only). Remaining compliance years must be consecutive
- Medicare compliance (e.g., Meaningful Use Core and Quality Measures) will be the same as for Medicaid
- Excluded entities are Behavioral Health
- There are no penalties for Medicaid. Medicare penalties commence FFY 2015

Transition Factors

	Adoption Year					
Fund Year	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
2011	1	0	0	0	0	0
2012	0.75	1	0	0	0	0
2013	0.5	0.75	1	0	0	0
2014	0.25	0.5	0.75	0.75	0	0
2015	0	0.25	0.5	0.5	0.5	0
2016	0	0	0.25	0.25	0.25	0

Eligible Provider: Medicaid – Illustrative Calculation

An individual provider is eligible to receive a maximum incentive payment of **$63,750**

For example, a provider organization of 5 providers may receive **5 payments of $63,750** (equaling **$318,750**)

	Medicaid EPs who begin adoption in					
Calendar Year	2011	2012	2013	2014	2015	2016
2011	$21,250	----------	----------	----------	----------	----------
2012	$8,500	$21,250	----------	----------	----------	----------
2013	$8,500	$8,500	$21,250	----------	----------	----------
2014	$8,500	$8,500	$8,500	$21,250	----------	----------
2015	$8,500	$8,500	$8,500	$8,500	$21,250	----------
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	----------	$8,500	$8,500	$8,500	$8,500	$8,500
2018	----------	----------	$8,500	$8,500	$8,500	$8,500
2019	----------	----------	----------	$8,500	$8,500	$8,500
2020	----------	----------	----------	----------	$8,500	$8,500
2021	----------	----------	----------	----------	----------	$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Note: The total maximum payment per Eligible Professionals is $63,750 over 6 years.

While CMS is responsible for calculating EH incentive payments, MaineCare is responsible for calculating, collecting attestation information about patient volume, and auditing payments.

Registration, Attestation and Payment Process for EPs and EHs

Eligible Professional Participating in Medicaid Incentive Program

1. Registration

2. Eligibility Determination

3. Payment Request and Attestations

4. Medicaid Payment

Eligible Hospitals that are Dually Eligible for both Medicare and Medicaid Incentive Programs

1. Registration and Eligibility Determination

2. Payment Request and Attestations

3. Medicare Payment

4. Medicaid Payment

Incentive Scenarios

Provider Description	Description	Eligible Y/N	
Hospital-based physician	All of the physician's clinical activity or "substantionally all" is conducted in an IP setting (e.g., Hospitalist, Radiologist)		N
Emergency Department Room physician	ED physician is a contracted clinical resource and 100% devoted to emergency room care		N
Emergency Department Room physician	Hospital-owned physician works 50% of time in the ED; remaining work is in ambulatory clinic	Y	
Hospital-owned Surgeon	Surgeon conducts 60% of clinical work in hospital (e.g., surgeries). Remaining work is in clinic	Y	
Ambulatory physician	Hospital-owned physician. Works in the adjoining outpatient clinic	Y	
Ambulatory physician (not owned)	Does not utilize Hospitalist program. Spends 100% of time in a clinic setting	Y	

What Professionals are NOT eligible?

Final Rules Related to Hospital-based Professionals

- Hospital-based Professionals are excluded from incentive programs — defined as professionals that provide "substantially all" of Medicare or Medicaid covered professional services in a hospital setting, whether inpatient or emergency room

- CMS is proposing "substantially all" to mean 90% — so Professionals who have less than 90% would be eligible for Medicare or Medicaid incentives

- CMS will use place of service code (POS) on physician claims to determine whether an EP furnishes "substantially all" of professional services in hospital setting. There are two POS codes which would be considered a hospital setting:
  - 21 – Inpatient Hospital
  - 23 – Emergency Room, Hospital
- The Hospital-based status of a professional would get reassessed each year based on the claims data from the year immediately preceding the payment year

EP Patient Volume Calculation Options & Discussion

Discussion of the Patient Volume Calculation

- States must document in their SMHP the patient volume calculation they will be using to determine eligible providers for the EHR Incentive Program

- The final rule proposed two calculation options, which include:

  – a ratio where the numerator is the total number of Medicaid patient encounters (or needy individuals) treated in any 90-day period in the previous calendar year where the denominator is all patient encounters over the same period;

  –a similar ratio where the state may take into account Medicaid patients on a primary care patient panel.

- The final rule also permits State's to choose a third option which is to develop their own methodology

- An important note about patient volume calculation:

  –Group Practices/Clinics – Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level. However, each individual provider in that group practice or clinic must register, attest, meet meaningful use (adopt, implement, and upgrade in payment year 1), and request payment individually. The group practice/clinic patient volume calculation simply serves as a proxy for the individual provider. It does not automatically mean that all providers are compliant and eligible.

Analysis of Patient Volume Calculation – Option 1

Encounters Final Rule Section: 495.306 (c)	**Numerator:** a ratio where the numerator is the total number of Medicaid patient encounters (or needy individuals) treated in any 90-day period in the previous calendar year **Denominator:** all patient encounters over the same period.	This appears to be the most straight forward calculation. From an EP perspective, this may be less straightforward. The EP must have a system in which a staff person would need to write & run fairly sophisticated queries. A small practice that has a few physicians may have the system and staff to do this, but will most likely not have staff solely dedicated to reporting. Furthermore, the data would be coming from a Practice Management System not an Electronic Medical Record.	The encounter is defined as the set of services provided by a single EP on a single date. This information may not be obtainable from claims with present provider claims practices. Provider Information: Reports & Physician Schedules from Provider as well as some manual count. MaineCare Audit – Review (desk or on site) documentation from providers as well as re-run the calculation to perform audit.

Calculation:

$$\frac{\text{Total (Medicaid) patient encounters in any 90-day period in the preceding calendar year}^{1}}{\text{Total patient encounters in that same 90-day period}} * 100$$

May also be used to calculate needy individuals patient volume
May be used for hospitals and EPs

1 – For FQHC numerator is total needy individual patient encounters/total patient encounters

Analysis of Patient Volume Calculation – Option 2

Patient Panel Final Rule Section: 495.306 (d)	This calculation presents a similar ratio as above where the State may take into account Medicaid patients on a primary care patient panel The numerators will be generally easy to identify through claims and PCCM system and enrollment. The denominator is the same with the addition of patient panel from commercial and Medicare Advantage programs.	This appears to be more complicated than the Encounters option since you would have to identify all the panel patients and who has been seen in previous year. There will be a tendency to shy away from this scenario as it could be a more complicated calculation. However, this calculation might favor EPs in terms of the number of eligible providers.	This method may advantage certain MaineCare primary care providers, as few other payers assign panels of patients to providers. Provider Information: Panels are sent to providers and practices on a regular basis (usually) monthly. MaineCare Audit: Review (desk or on site) Audit would be you practice have to provide the panel reports.

Calculation:

$$\frac{\text{[Total Medicaid patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period] + [Unduplicated Medicaid encounters in that same 90-day period]}^{1}}{\text{[Total patients assigned to the provider in the same 90-day with at least one encounter in the year preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day period]}} * 100$$

May be used for EPs (not hospitals) and to calculate needy individuals

1 – For FQHC numerator is total needy individual patient encounters/total patient encounters

Analysis of Patient Volume Calculation – Option 3

State Proposed Methodology Final Rule Section: 495.306 (g)	States may propose a new calculation that is reviewed by CMS. If approved, all states could consider it as an option. Proposed MaineCare Option: Total Medicaid charges (NOT payment) divided by total all-payer charges	This option appears more straightforward than any other solution. This option involves data which will likely be readily accessible from any automated or organized practice management system.	MaineCare suspects that the results from this method would track closely with results from Method #1. Audit procedures would be similar to the first option. MaineCare EP charges are straightforward and easy to obtain from the MMIS. Although, the time frame of charges as shown from the MMIS may vary by up to 10% from charges as shown on provider systems. This is because of issues with MaineCare payment date versus provider posting dates. All-payer charges can be checked historically from the Maine All-Payer Claims Database. A formal audit will require EP submission of detailed all-payer charge information and possibly on-site auditing.

Definitions

Term	Definition
Patient Volume	The minimum participation threshold that is estimated through a numerator and denominator, consistent with the SMHP.
Encounter	Defined as the set of services provided by a single EP on a single date in any representative continuous 90-day period in the preceding calendar year (see Final Rule section 495.306 (e) for a complete description).
Needy Individuals	Individuals that meet one of the following: 1. Received medical assistance from Medicaid or CHIP 2. Were furnished uncompensated care by the provider 3. Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay
Practices Predominantly	An EP for whom the clinical location for over 50 percent of his/her total patient encounters over a period of 6 months in the most recent calendar year occurs at a FQHC or RHC.

Wrap-up & Questions

- **Questions?**