CHCANYS
Community Health Care Association of New York State
*Defining New Directions*

HEALTH CENTER NETWORK NEW YORK
CARING FOR OUR COMMUNITIES TOGETHER

**Eligibility Calculations for Meaningful Use Incentives**

Volume Criteria:

- General Rule: **30% patient encounters attributable to those receiving Medicaid**. To be measured over any continuous 90-day period in the previous calendar year.

  ⇨ *Regular Medicaid + Managed Medicaid + Family Health Plus*

- Two Exceptions:
  1. If EP practices *predominantly* in an **FQHC or RHC, must have 30% of patient encounters attributable to "needy individuals"**

     Definition of *predominantly* = over 50% of patient encounters over a period of 6 months occurs at an FQHC or RHC

     Definition of *needy individuals* = receiving medical assistance from Medicaid or CHIP; receiving uncompensated care; or receiving care at no-cost or reduced cost based on a sliding-scale

  ⇨ *Regular Medicaid + Managed Medicaid + Family Health Plus + Child Health Plus + Sliding Fee + Uncompensated Care*

  2. Pediatricians may have at least 20% patient encounters attributable to those receiving Medicaid

Definitions

- "Uncompensated care" may not include bad debt
- A "Medicaid encounter" is defined as:

  1) 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;

  2) 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, copayments, and/or cost-sharing.

  - Only paid claims should be counted
  - Secondary claims (Medicaid and needy) should be counted

***New Information:***
***For Payment Year 2011, an encounter may be used in the patient volume calculation provided it was rendered in the 90-day period in Calendar Year 2010 and was paid before the Payment Year 2011 deadline, which is April 29, 2012.***

**Practice-wide vs. Individual EP Volume Calculations**

Clinics or group practices may use a practice-wide volume calculation for all EP's, or calculate individual volume for each EP.

Excerpt from the Final Rule regarding practice-wide volume calculation

We will allow clinics and group practices to use the practice or clinic Medicaid patient volume (or needy individual patient volume, insofar as it applies) **and apply it to all EPs** in their practice under three conditions:

> (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
>
> (2) there is an auditable data source to support the clinic's patient volume determination;
>
> (3) so long as the practice and EPs decide to use one methodology in each year (in other words, **clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data)**.

**The clinic or practice must use the entire practice's patient volume and not limit it in any way**. EPs may attest to patient volume under the individual calculation or the group/ clinic proxy in any participation year. 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.

***New Information:***
***A Provider who joins a practice before the Payment Year 2011 deadline (April 29, 2012) may attest for the NY Medicaid EHR Incentive Program Payment Year 2011 using the practice's aggregate patient volume data from Calendar Year 2010.***

**Alternative Calculation**

An alternative calculation exists for those with high managed care penetration.

- Numerator:
  - EP's total number of Medicaid patients assigned through a Medicaid managed care panel, medical or health home program panel, or similar provider structure with capitation and/or case assignment, plus all other Medicaid encounters for that EP

- Denominator:
  - all patients assigned to the EP or hospital for the same 90-day period, also with whom the provider had at least one encounter in the prior calendar year as a proxy, as well as any other unduplicated Medicaid encounters during the representative 90-day period