Psychiatric Clinical Nurse Specialists: Patient Volume Threshold (PVT)

Massachusetts Medicaid EHR Incentive Program

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Today's presenter:

Al Wroblewski, PCMH CCE, Client Services Relationship Manager

MeHI MASSACHUSETTS eHEALTH INSTITUTE at the MassTech Collaborative

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Agenda

- Massachusetts Medicaid EHR Incentive Program
- Patient Volume Threshold Requirements
- Methodology: Individual vs. Group Proxy
- Calculating Patient Volume Threshold
    - Paid Claims vs. Enrollees
- Data Entry and Supporting Documentation
- Common Issues
- Questions

Massachusetts Medicaid EHR Incentive Program

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What is the MA Medicaid EHR Incentive Program?

The Health Information Technology for Economic and Clinical Health (HITECH) Act introduced financial incentives, offered through Medicare or Medicaid, for Eligible Professionals (EPs) who demonstrate Meaningful Use (MU) of Certified EHR Technology (CEHRT)

- The MA Executive Office of Health and Human Services (EOHHS) oversees the MA Medicaid EHR Incentive Program
- MassHealth contracted with MeHI to administer key components of the program
- Through the Medicaid EHR Incentive Program, EPs may receive a maximum payment of $63,750 over six years
  - $21,250 in the first payment year; $8,500 in subsequent payment years
- In their first year of participation, Medicaid EPs have the option to Adopt, Implement, or Upgrade (AIU) to CEHRT; in subsequent years, they must demonstrate Meaningful Use (MU)

New Eligible Professional: Psychiatric Clinical Nurse Specialist

The Centers for Medicare and Medicaid Services (CMS) recently approved Psychiatric Clinical Nurse Specialists (PCNS) as a new category of EPs

- Program Year 2016 is the last year for all EPs (including PCNS) to initiate program participation
- Attestations for Program Year 2016 will be accepted August 15, 2016 through March 31, 2017

Patient Volume Threshold Requirements

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Patient Volume Threshold Requirements

- To be eligible for the Medicaid EHR Incentive Program, providers must meet a minimum Medicaid Patient Volume Threshold (PVT) of **30%**
  - Providers may include Medicaid Fee-For-Service (FFS) and Medicaid Managed Care Organization (MCO)/CarePlus Program encounters
  - Please reference the Medicaid 1115 Waiver Population Grid for a complete list of programs and payers that may be included when calculating PVT
- Medicaid PVT is calculated using a 90-day reporting period from either the previous calendar year, or the 12-month period preceding attestation
- Medicaid PVT requirements must be met for each year of program participation. EPs must select a new PVT reporting period each year.

Medicaid 1115 Waiver Population Grid

Medicaid Fee For Service Plans
MassHealth Standard
MassHealth Breast and Cervical Cancer Treatment Program
MassHealth CommonHealth
MassHealth Family Assistance
MassHealth Limited
New Program - MassHealth CarePlus
New Program - MassHealth Small Business Employee Premium Assistance

Medicaid Contracted Payors
Boston Medical Center HealthNet Plan (BMCHP)
CeltiCare Health
Fallon Community Health Plan (FCHP) (Fallon Health)
Health New England (HNE)
Neighborhood Health Plan (NHP)
Tufts Health Plan
Boston Medical Center Senior Care Options
Commonwealth Care Alliance
Navicare (Fallon Community Health Plan)
Senior Whole Health
Tufts Medicaid Managed Care Product
United Health Care Medicaid Managed Care Product

Payor
Beacon Health Options – Boston Medical Center HealthNet Plan
Beacon Health Options – Fallon Health
Beacon Health Options – Neighborhood Health Plan
Cenpatico – CeltiCare Health
Massachusetts Behavioral Health Partnership – Health New England
Massachusetts Behavioral Health Partnership – PCC Plan
Tufts Health Plan
DentaQuest
Commonwealth Care Alliance
Tufts Health Plan

Methodology: Individual vs. Group Proxy

Methodology: Individual vs. Group Proxy

To determine their Medicaid PVT, EPs may use either individual data or Group Proxy Methodology.

- Individual data: each EP uses only his/her own patient encounters to determine Medicaid PVT
- Group Proxy Methodology: all providers in the practice (including those not eligible for the Medicaid EHR Incentive Program) aggregate their data to determine the group's Medicaid PVT
  - A group is defined as two or more EPs practicing at the same site

Methodology: Individual vs. Group Proxy

- In any given year, all EPs must use the same methodology; an organization cannot have some EPs using individual data and others using Group Proxy
- If using Group Proxy Methodology, the organization must use the entire practice's patient volume and not limit it in any way
- Group Proxy Methodology usually involves less administrative burden and often allows more EPs to participate

Dr. Green	25%
Dr. Brown	35%
Dr. Smith	35%
Dr. Jones	35%
Dr. Johnson	35%
Group Total	**33%**

- Example: using individual data, Dr. Green would not qualify; aggregating the group's data allows all five EPs to participate

- If your organization has unique billing practices and would like to use Group Proxy Methodology, MeHI will work with you to provide guidance and determine appropriate next steps

Calculating Patient Volume Threshold

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Paid Claims vs. Enrollees

To determine their PVT, EPs may use either Medicaid paid claims or Medicaid enrollees.

- For EPs using paid claims, a patient encounter is defined as:

> One service, per patient, per day, where Medicaid or a Medicaid 1115 Waiver Population paid for all or part of the service rendered, or paid for all or part of the individual's premiums, co-payments, or cost-sharing

- For EPs using the enrollee approach, a patient encounter is defined as:

> One service rendered to a Medicaid or Medicaid 1115 Waiver enrolled patient, regardless of payment liability. This includes zero-pay encounters and denied claims (excluding denied claims due to the provider or patient being ineligible on the date of service)

Calculating Medicaid Patient Volume Threshold

Medicaid Patient Volume Threshold =

$$\frac{\textbf{Medicaid Patient Encounters}}{\textbf{Total Patient Encounters}}$$

Medicaid Patient Encounters
(over any continuous 90-day period from the preceding calendar year or the 12 months preceding the provider's attestation)

Total Patient Encounters
(over the same 90-day period)

Numerator: Medicaid Patient Encounters
Denominator: Total Patient Encounters

Calculating Medicaid Patient Volume Threshold

- Children's Health Insurance Program (CHIP) encounters cannot be included in Medicaid PVT
  - A percentage reduction, usually between 2.5% and 3.5%, known as the CHIP factor, must be applied to the in-state numerator
  - The CHIP factor varies depending on the PVT reporting period chosen
  - Please see the CHIP Factor Grid on our website to determine the appropriate CHIP factor to apply to your numerator

Data Entry and Supporting Documentation

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Data Entry

- When preparing PVT data to be entered into MAPIR*, ensure that you have all the data elements shown below:

90-Day PVT Data Preparation for Entering into MAPIR

Total In-State Medicaid Encounters		3,071	
CHIP Reduction	-3.20%	-98	
Reduced Total In-State Medicaid Encounters		2,973	MAPIR field #1
Out-of-State Encounters		2	
Reduced Total In-State Medicaid plus Out-of-State Encounters		2,975	MAPIR field #2
All Encounters from All Payors		9,706	MAPIR field #3
% Medicaid		30.63%	

**MAPIR - Medical Assistance Provider Incentive Repository, the system where EPs attest for the MA Medicaid EHR Incentive Program*

Supporting Documentation

- EPs are required to submit PVT supporting documentation **only upon request**
  - Supporting documentation is requested when there is a variance of +/- 25% or greater between the PVT reported in the EP's MAPIR application and the claims information extracted from the MassHealth Data Warehouse
- PVT documentation must be provided in a searchable format (i.e. Excel)
- PVT supporting documentation must contain all data elements listed in the Sample Patient Volume Templates on our website. Required data elements include:
  - Organization Name and NPI
  - Location(s)
  - 2 Unique Patient IDs (MRN and DOB)
  - Date of Service
  - Primary Payer and Total Amount Paid
  - Secondary Payer and Total Amount Paid
  - Claim Status and Denial Reason (if including Zero Pay and Denied claims)

Common Issues

Common Issues

- Excluding legitimate MassHealth payors
- Confusion over what constitutes a group
- 90-day reporting period inadvertently falls outside 12 months prior to attestation when using that method
- Data does not cover a 90-day period exactly
- Difficulty in extracting data from billing system
- Failing to remove duplicates
- Forgetting to apply the CHIP factor to the in-state numerator
- Difficulty understanding what numbers correspond to the PVT fields in MAPIR
- Patients not identified in two ways on supporting documentation

Questions

Questions?

Helpful Links

- MeHI MU Toolkit for Eligible Professionals
- Medicaid 1115 Waiver Population Grid
- Calculating Patient Volume
- CHIP Factor Grid
- Group Proxy Guide

Contact Us

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at the MassTech Collaborative

mehi.masstech.org

1.855.MassEHR

ehealth@masstech.org

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Thomas Bennett
Client Services Relationship Manager
(508) 870-0312, ext. 403
tbennett@masstech.org

Brendan Gallagher
Client Services Relationship Manager
(508) 870-0312, ext. 387
gallagher@masstech.org

Al Wroblewski, PCMH CCE
Client Services Relationship Manager
(508) 870-0312, ext. 603
wroblewski@masstech.org

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