

Medicaid Patient Volume Calculation for EHR Incentive Program Eligible Hospitals

WHICH HOSPITALS ARE ELIGIBLE?

The eligible hospital types are:

- Hospitals which have a CCN that end in 0001-0879 OR 1300-1399. Must meet a Medicaid patient volume of **10%** in any consecutive 90 day period in the 12 months preceding the date the attestation is received.
- Children's Hospitals which have a CCN which ends in 3300-3399. **No minimum Medicaid patient volume is needed for Children's Hospitals.**

DEFINITION OF ENCOUNTER

Include all of the following in counting the Medicaid patient volume:

- Count inpatient discharges where the patient was enrolled in an allowable Medicaid program at the time of the discharge
- Count emergency room visits where the revenue code is 450-459 and the patient was enrolled in an allowable Medicaid program. If the same patient was treated in the emergency room more than once on a given day, only count as one encounter.
- The patient must have been enrolled in a Medicaid program at the time the service was rendered, regardless of whether or not Medicaid paid anything on the bill. This would include claims where Medicaid paid zero. Only Medicaid encounters paid through funding under Title XIX or CHIP under Title XXI of the Social Security Act can be included. Medicaid encounters for other programs such as state-only funded programs and Federal grant-funded programs cannot be included.
- Include managed care encounters
- Include nursery bed days, psychiatric care, regular inpatient care, etc.

PATIENT VOLUME DETERMINATION

The formula for determining eligible patient volume using patient encounters is:

[Total Medicaid patient encounters in any representative, continuous 90 day period within the 12 months preceding attestation] - DIVIDED BY - [Total patient encounters in the same period]. Hospital patient volume may be rounded from 9.5% and higher to 10%.

At the time of attestation, providers will be asked to supply the following:

- 1) The date range selected for patient volume calculation (any continuous 90-day period in the 12 months preceding attestation).
- 2) The number of Medicaid encounters for the selected period.
- 3) The number of total encounters for the same period.

DHHS will work with providers to reconcile any questions concerning eligibility prior to final eligibility determination.