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1 OVERVIEW

One of the primary eligibility requirements of the Medicaid Electronic Health Record (EHR) Incentive Program is to meet Medicaid patient volume thresholds over a representative, continuous 90-day period. Patient volume is an important requirement for the Wisconsin Medicaid EHR Incentive Program as it allows participants to demonstrate they provide services to a required minimum percentage of Medicaid patients. At its core, patient volume is a meaningful comparison between the number of Medicaid patient encounters and total patient encounters (regardless of payer) for an Eligible Professional or Eligible Hospital.

Due to the integrated delivery of Medicaid and BadgerCare Plus under Wisconsin’s ForwardHealth Program, Eligible Professionals and Eligible Hospitals are unable to determine Medicaid encounters that qualify for the Wisconsin Medicaid EHR Incentive Program without assistance from the Wisconsin Department of Health Services (DHS) Division of Medicaid Services (DMS). To mitigate this problem, DMS has developed the following methodologies for Eligible Professionals and Eligible Hospitals to calculate Medicaid patient volume.

2 ELIGIBLE PROFESSIONAL PATIENT VOLUME

This section explains DMS’s patient volume methodology for Eligible Professionals. Patient volume is a critical component in determining a provider’s eligibility for the Wisconsin Medicaid EHR Incentive Program. An Eligible Professional must meet their Medicaid patient volume threshold over a representative, continuous 90-day period.

Provider Type	Minimum Medicaid (Title XIX) Patient Volume Threshold	“Needy individuals” Patient Volume Threshold
Physicians	30%	The Eligible Professional practices predominantly in a FQHC or RHC with a minimum 30 percent “needy individuals” patient volume.
Physicians – Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
Nurse Practitioners	30%	
Physician Assistants (PAs) Practicing in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that is so Led by a PA	30%	

Figure A.01: Patient Volume Thresholds

Generally, Eligible Professionals must meet a minimum 30 percent Medicaid patient volume; however, there are some exceptions.

- **Pediatricians:** Pediatricians are eligible with a minimum 20 percent Medicaid patient volume. Pediatricians that meet the minimum 20 percent patient volume threshold but have less than 30



percent patient volume, receive a reduced incentive payment equal to two-thirds of the full Eligible Professional incentive payment amount.

- **Practicing Predominantly in an FQHC or RHC:** Eligible Professionals practicing predominantly in an FQHC or RHC must have a minimum 30 percent patient volume attributable to “needy individuals.” For more information on “needy individuals” patient volume requirements, please refer to Section 2.2.3 of this document.

2.1 Wisconsin’s Eligible Professional Medicaid Patient Volume Methodology

DMS has adopted the patient volume calculation as defined in the Medicare and Medicaid EHR Incentive programs’ final rule (herein referred to as final rule) as the core of Wisconsin’s methodology. To best understand how patient volume is calculated, this section first explains five key concepts in Wisconsin’s patient volume methodology.

- 1. 90-day Reporting Period:** For Eligible Professionals, the patient volume reporting period is a representative, continuous 90-day period. The Eligible Professional can choose the reporting period from either the calendar year preceding the program year or from within the 12 months directly preceding the attestation date. The attestation date is defined as the day when the Eligible Professional electronically signs and submits the application for the first time in the program year or the last day of the program year if the Eligible Professional submits the application during the grace period. Eligible Professionals applying during the grace period cannot extend their patient volume reporting period into the grace period and must attest to a 90-day period that falls within the acceptable attestation date range for the program year they are applying.
- 2. Patient Encounters:** It is important to know patient encounters in the reporting period are counted in a specific way for the Wisconsin Medicaid EHR Incentive Program. For purposes of calculating patient volume, an encounter is defined as the services rendered on any one day to an individual. Only one encounter can be counted for a patient per day per provider, regardless of the number of services provided to the patient in a single day by the provider.
- 3. Numerator:** The numerator is defined as the total Medicaid patient encounters in an acceptable 90-day reporting period. The numerator includes encounters where the patient is Medicaid eligible, regardless of the Medicaid reimbursement amount.¹ This guidance applies to the numerator calculations in subsections 2.2.1 to 2.2.3.
- 4. Denominator:** The denominator is defined as the total patient encounters, regardless of payer, during the same 90-day period used for the numerator.
- 5. Standard Deduction:** Eligible Professionals are presented with a barrier to accurately calculating patient volume since they cannot distinguish Medicaid (Title XIX) and Medicaid-funded Children’s Health Insurance Program (CHIP [Title XXI]) from non-eligible, non-Medicaid-funded CHIP encounters. To reduce this barrier, DMS annually calculates a standard percentage of CHIP beneficiaries to be subtracted from the total Medicaid and BadgerCare Plus beneficiary encounters.

¹ Unpaid encounters for services rendered to an individual enrolled in a Medicaid program may be counted as eligible Medicaid encounters. However, claims denied because the patient was not Medicaid eligible at the time of service cannot be included in an Eligible Professional’s Medicaid patient volume numerator.



The standard deduction is used to remove non-Medicaid funded CHIP encounters and isolate the patient volume numerator to Medicaid and Medicaid funded CHIP encounters. DMS communicates the standard deduction annually prior to the start of the program year via ForwardHealth Update and the Wisconsin Medicaid EHR Incentive website. Eligible Professionals must apply the standard deduction to manually remove their non-eligible CHIP volume when attesting to their Medicaid patient volume.²

Eligible Professional Patient Volume Calculation	
Patient Volume =	$\left\{ \frac{\text{Numerator} \times (1 - \text{Standard Deduction})}{\text{Denominator}} \right\} \times 100$

Figure A.02: Eligible Professional Patient Volume Calculation

2.2 Calculating Patient Volume

Eligible Professionals may choose from the following two distinct methods to aggregate Medicaid patient encounter data:

- Individual Eligible Professional
- Group Practice

Eligible Professionals are required to choose one of these patient volume methods and cannot report a mix of individual or group-level data across the numerator and denominator. All Eligible Professionals, regardless of their chosen methodology, are required to upload patient volume documentation as a part of their Wisconsin Medicaid EHR Incentive Program application in order to avoid delays in the review of the application. Eligible Professionals are required to maintain all attestation supporting documentation, including patient volume reports, for a minimum of six years. The following sections explain how to calculate Individual Eligible Professional, group practice, and “needy individual” patient volume.

2.2.1 Calculating Individual Eligible Professional Patient Volume

To calculate an individual Eligible Professional’s patient volume for the Wisconsin Medicaid EHR Incentive Program, an Eligible Professional should consider the following information:

- **Individual Eligible Professional Numerator:** Encounters included in the numerator are the individual Eligible Professional’s total Medicaid encounters (calculated using the definition under Section 2.1). Encounters with a patient may only be counted once per day per provider. Eligible Professionals

² The exception to this rule is for Eligible Professionals practicing predominately at an FQHC or RHC who include “needy individuals” in their patient volume and do not apply the standard deduction. See Section 2.2.3 for instructions on calculating a patient volume numerator that includes “needy individuals.”



attesting to individual Eligible Professional patient volume are required to submit their total Medicaid patient encounters during the reporting period.

- **Individual Eligible Professional Denominator:** Encounters included in the denominator are the individual Eligible Professional’s total encounters with individual patients, regardless of payer. Encounters with an individual patient may only be counted once per day for the rendering provider regardless of how many services were rendered for the patient. When using individual patient volume, an Eligible Professional must include all encounters, regardless of payer, during the reporting period.

To ensure an accurate count of patient encounters, DMS requires all Eligible Professionals to provide and attest to the accuracy of their submitted patient volume. Please note the definition of patient encounters under Section 2.1 must be applied to both the numerator and denominator.

For example, an Eligible Professional practicing in Wisconsin calculating patient volume at the individual-level finds he or she has 35 Medicaid and BadgerCare Plus encounters during the chosen reporting period. However, the Eligible Professional cannot distinguish Medicaid (Title XIX) and Medicaid-funded CHIP from non-Medicaid-funded CHIP (Title XXI). Since there is not a way for Eligible Professionals to differentiate between Medicaid and CHIP patients, the Eligible Professional will reduce his or her total count of Medicaid encounters by the standard deduction to eliminate the CHIP (Title XXI) encounters. In Figure A.03, there are 100 total encounters in the selected patient volume reporting period. Assuming the standard deduction is 4.65 percent,³ the 35 encounters are multiplied by 0.9535 (the simplified form of one minus the standard deduction) and then divided by the total encounters during the same period.

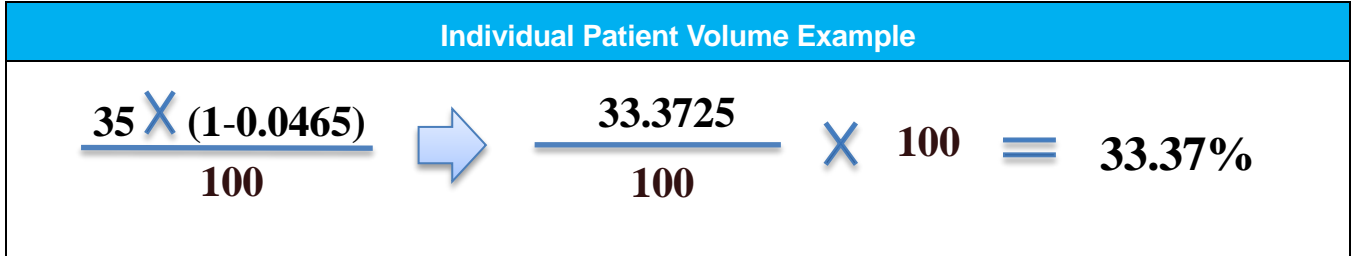


Figure A.03: Individual Patient Volume Example (with Standard Deduction Applied)

2.2.2 Calculating Group Practice Patient Volume

For the purposes of determining patient volume, a group practice is defined by the billing National Provider Identifier (NPI) of the practice. This is the billing provider NPI used on Medicaid claims submitted to DHS.

DHS deems a practice's patient volume as appropriate for an Eligible Professional only if Medicaid patients were served by the Eligible Professional during the 90-day period. Additionally, practices and clinics are permitted to calculate patient volume at the group-level in accordance with the following requirements:

³ DMS communicates the standard deduction annually prior to the start of the program year via ForwardHealth Update and the Wisconsin Medicaid EHR Incentive website.



1. All Eligible Professionals in the group practice or clinic must use the same methodology for the program year. If a group practice chooses this methodology for the patient volume calculation, all Eligible Professionals in the clinic or practice must use the group practice or clinic Medicaid patient volume when applying.
2. Group practices are required to use the entire practice's patient volume, regardless of the rendering provider's provider type or eligibility status in the Medicaid EHR Incentive Program, and must not limit patient volume in any way during the application process.
3. To use the group practice patient volume calculation, an Eligible Professional is required to have at least one encounter with a Medicaid member during the patient volume reporting period at the current group practice or another group practice or clinic where the Eligible Professional practices.
4. If an Eligible Professional works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the group practice and not the Eligible Professional's outside encounters.
5. The group practice has an auditable data source to support a group practice's patient volume determination.

Note: If the Eligible Professional is new to practicing medicine (e.g., a recent graduate of an appropriate training program), he or she does not need to provide proof of an encounter with a Medicaid member.

To calculate patient volume at the group-level, an Eligible Professional should consider the following:

- **Group Practice Numerator:** Encounters included in the numerator for the group practice represent all Medicaid claims for which the group practice is identified as the billing provider by the NPI on the claim during the reporting period (calculated using the definition under Section 2.1). Encounters with an individual patient may only be counted once per day per provider in the group practice that rendered services to the patient.
- **Group Practice Denominator:** Encounters included in the denominator are the total encounters with individual patients, regardless of payer, for the entire group practice. Encounters with an individual patient may only be counted once per day per provider in the group practice that rendered services to the patient. This includes the services rendered by all providers within the practice, regardless of provider type or eligibility status, during the reporting period.

To ensure an accurate count of patient encounters, DMS requires all Eligible Professionals to provide and attest to the accuracy of their submitted patient volume. Please note the definition of patient encounters under Section 2.1 must be applied to both the numerator and denominator.

The following example illustrates the aggregation of a group practice's patient volume. In this scenario, there are 1,200 encounters in the selected 90-day period. There are 455 encounters attributable to Medicaid and BadgerCare Plus. Assuming the standard deduction is 4.65 percent,⁴ the 455 encounters are multiplied by 0.9535 (the simplified form of one minus the standard deduction) to eliminate non-Medicaid-funded CHIP encounters, resulting in 433.8425 Medicaid encounters. The new total, which

⁴ DMS communicates the Standard Deduction annually prior to the start of the program year via ForwardHealth Update and the Wisconsin Medicaid EHR Incentive website.



accounts for the standard deduction, yields a group practice's Medicaid patient volume of 36.15 percent. This means five of the seven professionals eligible to participate in the program would meet the Medicaid patient volume criteria under the rules for the Medicaid EHR Incentive Program. Two of the professionals are not eligible for the program, but their clinical encounters at the group practice must be included.

Eligible Based on Provider Type?	Description	Numerator	Denominator
Yes	Physician: individually had 40 percent Medicaid and BadgerCare Plus encounters	80	200
Yes	Nurse practitioner: individually had 50 percent Medicaid and BadgerCare Plus encounters	50	100
No	Registered nurse, but not an Eligible Professional: individually had 75 percent Medicaid and BadgerCare Plus encounters	150	200
No	Practitioner at the clinic, but not an Eligible Professional (pharmacist): individually had 80 percent Medicaid and BadgerCare Plus encounters	80	100
Yes	Physician: individually had 10 percent Medicaid and BadgerCare Plus encounters	30	300
Yes	Dentist: individually had 5 percent Medicaid and BadgerCare Plus encounters	5	100
Yes	Dentist: individually had 30 percent Medicaid and BadgerCare Plus encounters	60	200
Total		455	1,200

Figure A.04: Group Patient Volume Example


Group Practice Patient Volume Calculation Example			
$\frac{455 \times (1 - 0.0465)}{1,200}$		$\frac{433.8425}{1,200} \times 100 = 36.15\%$	

Figure A.05: Group Practice Patient Volume Calculation Example (with Standard Deduction Applied)

2.2.3 FQHC and RHC Eligible Professionals

Eligible Professionals practicing predominantly in an FQHC or RHC are eligible to apply for the Medicaid EHR Incentive Program using the “needy individual” patient volume calculation (defined below in 2.2.3.1). Eligible Professionals are considered to be practicing predominantly at a FQHC or RHC when at least 50 percent of total patient encounters over a six-month period occurs in the most recent calendar year or



12-month period at the FQHC or RHC clinical location. Medicaid Eligible Professionals practicing predominantly in an FQHC or RHC will calculate the numerator in a unique way because there is no standard deduction applied. For calculating the denominator, Eligible Professionals should refer back to the sections on calculating individual Eligible Professional and group practice patient volume (2.2.1 and 2.2.2, respectively).

As previously stated, Eligible Professionals practicing predominantly in an FQHC or RHC must have a minimum of 30 percent patient volume attributable to “needy individuals” encounters over any representative, continuous 90-day period in the calendar year preceding the payment year or in the 12 months preceding the attestation date. For purposes of calculating Eligible Professional’s patient volume, an encounter is defined as services rendered on any one day to an individual (see patient encounter definition under Section 2.1). Multiple visits or services rendered to the same patient by the same provider on the same day may only be counted as one encounter.

2.2.3.1 Understanding the Needy Individual Patient Volume Numerator

When calculating the “needy individual” patient volume numerator, the following types of encounters may be included:

1. Services rendered on any one day to an individual where the patient was a Medicaid-enrolled individual (calculated using the definition under Section 2.1)
2. Services rendered on any one day to an individual where CHIP under Title XXI paid for part or all of the service
3. Services rendered on any one day to an individual furnished by the provider as uncompensated care
4. Services rendered on any one day to an individual furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay

To calculate a “needy individual” patient volume at the individual-level, only those encounters where the Eligible Professional personally rendered services should be included in the numerator.

To calculate a “needy individual” patient volume at the group-level, the numerator may include all “needy individual” encounters attributable to the practice for each provider billing under the practice’s billing NPI.

2.3 Best Practices for Eligible Professionals

It is recommended that Eligible Professionals follow these best practices:

- Include claim number data on the report used for patient volume calculations.
- Patient volume periods should include the start date and end date of the 90-day reporting period.
- Consistently aggregate individual or group-level data across the numerator and denominator.
- Eligible Professionals practicing at multiple locations may choose from one or more practice sites (that use certified EHR technology) in order to meet their patient volume threshold but are not required to use patient volume data from all practice sites.
- Multiple visits or services rendered on the same day to the same patient (by the same provider) may only be counted as one encounter, but if multiple providers provide services to the patient, each provider may count the encounter.



- For globally billed events, multiple providers may submit an encounter for the same individual if the encounter takes place within the providers’ scope of practice.
- Globally billed events may be included as long as treatment and/or evaluation and management services are provided and all globally billed events are included consistently.
- Midwives should remember to count both mother and baby as separate encounters when determining patient volume.

3 HOSPITAL PATIENT VOLUME

Patient volume is a critical component in determining if Wisconsin hospitals are eligible for the Wisconsin Medicaid EHR Incentive Program. As one of the primary eligibility requirements of the Medicaid EHR Incentive Program, Medicaid patient volume thresholds must be met by a hospital over a representative, continuous 90-day period. This section explains Wisconsin’s patient volume methodology for hospitals and the process through which DMS prequalifies hospitals for the patient volume eligibility requirement.

To participate in the Wisconsin Medicaid EHR Incentive Program, a hospital must be classified as an acute care hospital, defined as a hospital within the Centers for Medicare & Medicaid certification number (CCN) range of 0001–0879 or 1300–1399, or a children’s hospital, defined as a hospital within the CCN range of 3300–3399.⁵ Hospitals must also meet their respective Medicaid patient volume threshold.

Acute care and critical access hospitals (CAHs) must meet a 10 percent Medicaid patient volume to be eligible for the Wisconsin Medicaid EHR Incentive Program. Children’s hospitals are not required to record Medicaid patient volume as part of the application process for the Wisconsin Medicaid EHR Incentive Program; therefore, the following section is only applicable to acute care and CAHs.

Provider Type	Medicaid (Title XIX) Patient Volume Threshold
Acute Care or CAHs	10%
Children's Hospitals	No Requirement

Figure A.06: Hospital Patient Volume Threshold

3.1 Wisconsin’s Hospital Medicaid Patient Volume Methodology

DMS has adopted the patient volume calculation as stated in the final rule as the basis for its methodology. To assist hospitals in understanding how patient volume is calculated, this section explains the components of Wisconsin’s patient volume methodology.

- 1. 90-Day Reporting Period:** For acute care and CAHs, the patient volume reporting period is one of the federal fiscal year (FFY) quarters, a 90-day period, in the FFY preceding the program year. If a hospital fails to meet the patient volume requirement using the data from one of the quarters,

⁵ Hospitals that predominately treat individuals under the age of 21 as a freestanding hospital or hospital within a hospital but do not have CCNs are also eligible for the Medicaid EHR Incentive Program as long as they meet existing criteria.



DMS reassesses patient volume during an alternate 90-day period in the FFY preceding the program year.

2. **Patient Encounters:** For purposes of calculating the patient volume for Eligible Hospitals, an encounter is defined as:

- a. Services rendered to an individual per inpatient discharge on any one day.
- b. Services rendered to an individual in an emergency department on any one day.

3. **Numerator and Denominator:** Medicaid patient volume is calculated by dividing the individual hospital's total Medicaid (Title XIX) and Medicaid-funded CHIP patient encounters in any representative, continuous 90-day period in the preceding FFY (the numerator) by all patient encounters, regardless of payer, during the same 90-day period (the denominator).

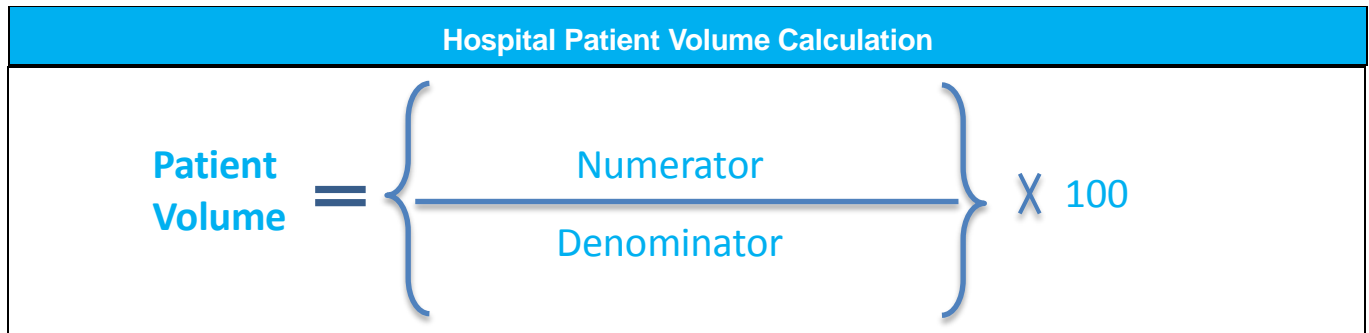


Figure A.07: Hospital Patient Volume Calculation

3.1.1 Understanding the Hospital Medicaid Patient Volume Numerator

For the patient volume numerator, a Medicaid encounter is defined as:

- 1. Services rendered to an individual per inpatient discharge where the individual is enrolled in a Medicaid- or Medicaid-funded CHIP program, or a Medicaid demonstration project.
- 2. Services rendered to an individual in an emergency department on any one day where the individual is enrolled in a Medicaid- or a Medicaid-funded CHIP program or a Medicaid demonstration project.

Encounters denied because the patient is not Medicaid eligible at the time of service are not to be included in a hospital Medicaid patient volume numerator.

DMS uses the following conditions when aggregating institutional claims into a hospital encounter.

Condition	Description
Hospital	Only encounters attributed to the hospital through the billing provider NPI on the submitted encounter are included in the Medicaid patient volume numerator. In order to limit to those attributed to the hospital, provider type codes and internal system assigned keys are used.
Claim Types	The Medicaid patient volume numerator only includes inpatient, inpatient crossover, outpatient, and outpatient crossover encounters attributed to the hospital.



Condition	Description
Claim Status	The Medicaid patient volume numerator only includes Medicaid-enrolled patient encounters.
Payer	To clearly differentiate Medicaid encounters from non-Medicaid-funded CHIP encounters, DMS uses internal fund codes assigned to all managed care and fee-for-service encounters. A fund code is a predetermined combination of attributes that identifies any financial transaction in Wisconsin's Medicaid Management Information System, ForwardHealth interChange. Only Medicaid assigned fund codes are included in the Medicaid patient volume numerator.
Active Indicator	To prevent duplicate counting of resubmitted encounters, only encounters with the active indicator set to "Yes" will be included in the Medicaid patient volume numerator.
Patient Status	The Medicaid patient volume numerator includes only Medicaid inpatient and inpatient crossover encounters with a patient status indicating a discharge, left against medical advice, or deceased. Patient transfers are not considered discharges.
Inpatient Discharges	Inpatient discharges include only one encounter for each inpatient discharge regardless of the number of services rendered during the inpatient stay.
Emergency Department	The Medicaid patient volume numerator includes only encounters taking place in an emergency department, identified through revenue codes "0450," "0451," "0452," and "0459." Using these identified encounters, the encounters are then consolidated by grouping all encounters from each day so that only one encounter per Medicaid member per day is counted, regardless of the number of services rendered during the emergency department visit. Note: Urgent care encounters, identified through revenue code 0456, are not included in the Medicaid patient volume numerator.

Figure A.08: Hospital Encounter Conditions for Patient Volume Calculation

3.1.2 Calculating Patient Volume Denominator

In order to provide health care providers, insurers, consumers, governmental agencies, and others information concerning health care providers, all Wisconsin hospitals are required, pursuant to Wis. Stat. ch. 153, to provide quarterly discharge data to an entity contracted by DHS. That entity is the Wisconsin Hospital Association (WHA) Information Center.

The inpatient, emergency department visit, outpatient surgery, and observation care data collected by the WHA Information Center is subject to certain data verification, review, and comment procedures specified by Wis. Stat. ch. 153, by Wis. Admin. Code ch. DHS 120, and by contract with the State of Wisconsin. Pursuant to § DHS 120.11(3)c., the hospital's chief executive officer or designee must sign an affirmation that the data submitted by the hospital to the WHA Information Center is accurate to the best of his or her knowledge. Facilities that fail to comply with data submission requirements may be subject to forfeitures. Finally, pursuant to Wis. Stat. ch. 153, the WHA Information Center is required to provide the collected data to DHS.



To calculate Eligible Hospital patient volume for the Wisconsin Medicaid EHR Incentive Program, the WHA Information Center provides DMS denominator data broken out into six categories, each of which is defined and explained below.

- 1. Total inpatient discharges (INP):** This data represents all inpatient discharges of Wisconsin residents from an inpatient hospital unit in the specified time period. The total was calculated by summing for each hospital the number of reported inpatient DISCHARGE DATES in which the patient had a PATIENT ZIP CODE in Wisconsin and did not have an MS-DRG (Medicare severity diagnosis-related group) that corresponded to a “normal newborn” (MS-DRG 795).
- 2. Emergency department (ER):** This data represents all discharges of Wisconsin residents from a hospital emergency department in the specified time period, except when an individual is discharged from the emergency room to an inpatient unit, an observation unit, or outpatient surgery. The total was calculated by summing for each hospital the number of reported emergency DISCHARGE DATES in which the patient had a PATIENT ZIP CODE in Wisconsin, except that only a single DISCHARGE DATE was counted if a patient had multiple discharges from the same hospital’s emergency department on the same day. It is important to note that discharges from a hospital emergency department to an inpatient unit, an observation unit, or outpatient surgery are not reported to the WHA Information Center as an emergency room discharge. Rather, such discharges are reported as an ER-INP, ER-OBS, or ER-OPS patient; these totals are explained below.
- 3. Inpatient that came from the emergency department (ER-INP):** This data represents all discharges of Wisconsin residents from an inpatient hospital unit in the specified time period in which the discharged patient came to the inpatient unit from the hospital’s emergency department. The total was calculated by summing for each hospital the number of reported INPATIENT DISCHARGE DATES in which the patient had a PATIENT ZIP CODE in Wisconsin and had a TYPE OF BILL CODE of 11x or 12x that also corresponds to a revenue code of 0450, 0451, 0452, or 0459.
- 4. Observation unit patient that came from the emergency department (ER-OBS):** This data represents all discharges of Wisconsin residents from a hospital observation unit in the specified period in which the discharged patient came to the observation unit from the hospital’s emergency department. The total was calculated by summing for each hospital the number of reported OBSERVATION UNIT STATEMENT PERIOD END DATES in which the patient had a PATIENT ZIP CODE in Wisconsin and had REVENUE CODES of 0760 or 0762 (observation) AND 0450, 0451, 0452, or 0459 (emergency department).
- 5. Outpatient surgery patient that came from the emergency department (ER-OPS):** This data represents all discharges of Wisconsin residents from a hospital outpatient surgery department in which the discharged patient came to the outpatient surgery department from the hospital’s emergency department. The total was calculated by summing for each hospital the number of reported OUTPATIENT SURGERY PROCEDURE DATES in which the patient had a PATIENT ZIP CODE in Wisconsin and had REVENUE CODES of 036x, 0481, 049x, or 0750 (outpatient surgery) AND 0450, 0451, 0452, or 0459 (emergency department).
- 6. Total:** This is the sum of items 1 through 5 above.

To streamline the application process, DMS uses data from the WHA Information Center to determine total inpatient and emergency department denominator data for all Wisconsin hospitals.



3.2 Hospital Patient Volume Process

Due to the integrated delivery of benefit programs under Wisconsin ForwardHealth, DMS anticipates difficulty for hospitals to determine their Medicaid encounters without intervention and assistance from DMS. To simplify the identification of Medicaid encounters and ease the application process, DMS prequalifies Eligible Hospitals that meet the patient volume eligibility requirement.

3.2.1 Hospital Prequalification Process

DMS prequalifies Eligible Hospitals to participate in the Medicaid EHR Incentive Program by aggregating the total Medicaid encounter data (numerator) through managed care and fee-for-service claims stored in the Data Warehouse/Decision Support System. To clearly delineate eligible encounters from ineligible ones, DMS uses internal fund codes assigned to all managed care and fee-for-service encounters, which is the same method used to report quarterly Medicaid expenditures through CMS-64.⁶ The WHA Information Center also provides the total encounter data (denominator) to DMS so a complete patient volume calculation can be made for prequalification purposes.

Medicaid patient volume is calculated for all acute care and CAHs for the first quarter of the FFY. DMS communicates qualification under patient volume requirements and the FFY quarter under which the hospital qualified through email. Only those hospitals that do not meet the patient volume threshold in the first quarter will continue to have their patient volume analyzed for additional quarters of the year. DMS maintains a list of the prequalified hospitals that meet the patient volume requirement for each program year and uses this list to verify each hospital's prequalification during the application process. If a hospital fails to meet the patient volume requirement using the data from one of the quarters, DMS reassesses patient volume during an alternate 90-day period in the FFY preceding the program year.

⁶ A fund code is a predetermined combination of attributes, including its program component, which identifies any financial transaction in Wisconsin's Medicaid Management Information System, ForwardHealth interChange.