



**STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY**

Eligible Professional Volume Attestation for Nevada EHR Incentive Payments System

Group, Clinic, and Individual Volume Attestation

- 1. Attesting as part of a Group or as part of a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Indian Health Program (IHP) that includes Indian Health Service/Tribal Organization/Urban Indian Organization (I/T/U) (Clinic)**

Note: Attesting as part of a clinic may only be done by those Eligible Professionals (EP) choosing to attest as part of an FQHC/RHC/IHP-I/T/U. Clinics are not considered groups in the Nevada Incentive Payment Program for Electronic Records.

If you are attesting as part of a group or clinic, the following should be considered:

- a. All Medicaid encounters performed as part of the group are included for every practitioner in the group/clinic (numerator and denominator), regardless of whether the practitioner is eligible for the incentive program. Do not include encounters from outside the attestation group or the clinic.
- b. If an EP chooses not to participate in the group/clinic, the encounters generated by that EP may still be used in the calculation (numerator and denominator) for that particular group/clinic. The EP cannot use those encounters for calculating volumes for another practice or individually if the group/clinic has already included them in their volume calculation.
- c. For Group Attestations:
 - i. The first person attesting will enter the reporting period, the number of members in the group, the group name, and the group volume (numerator and denominator). Each subsequent person in the group to attest will select the group they are attesting with, attest to information provided by the first person in the group, and provide other required information pertaining to their attestation. See **Determining your Group's Patient Volume** below for information on how to calculate your group's volume.
 - ii. Group Volume Option Encounters vs. Panel.

For Clinic Attestations

- iii. Each EP attesting as part of an FQHC/RHC/IHP-I/T/U will be required to indicate the clinic or individual volume at the time of attestation.

2. Determining your Group's or Clinic's Patient Volume

- a. Determine your reporting period. The reporting period is any three full consecutive month period in the previous calendar year.

Note: Providers attesting as part of an FQHC/RHC/IHP-I/T/U do not have the panel option available.

- i. Encounter option: Use the following calculation:

- 1. ***Medicaid encounters divided by Total patient encounters times 100:

$$\frac{\text{Your Medicaid Patient Encounters}}{\text{Your Total Patient Encounters}} * X 100$$

* Use all Medicaid encounters from all practitioners in the group, even those who are not eligible for incentives and those who chose not to participate.

** Use all patient encounters from all practitioners in the group, even those who are not eligible for incentives and those who chose not to participate.

*** Providers attesting as part of a clinic (FQHC/RHC/IHP-I/T/U) will include the Needy Patient Volume in the numerator and denominator.

- ii. Patient Panel option: Use the following calculation:

- 1. All Medicaid encounters (using the methodology above) plus any patients in the group's managed care panel who:

- Are not already included in the Medicaid encounter number.
- Had a visit/encounter in the 12 months prior to the 90-day reporting period.

Divided by total group patient encounters plus total group patient panel not already included in the encounters but with an encounter in the 12 months prior to the 90-day reporting period.

$$\frac{\text{All Medicaid + Medicaid MCO Clients Encounters Assigned to Group}^*}{\text{All Patient + All MCO Clients Encounters Assigned to Group}^*} X 100$$

* Who had at least 1 encounter in the 12 months immediately preceding the 90-day reporting period and are not already included in the Medicaid encounters

3. Determining your Individual Patient Volume

a. Determine your reporting period. The reporting period is any three full consecutive month period in the previous calendar year.

i. Encounter option: Use the following calculation:

$$\frac{\text{Your Medicaid Patient Encounters}}{\text{Your Total Patient Encounters}} \times 100$$

* Use all Medicaid encounters from all places where you practice.

** Use all patient encounters from all places where you practice

ii. Patient Panel option: Use the following calculation:

1. All Medicaid encounters (using the methodology above) plus any patients in your managed care panel who:

- Are not already included in the Medicaid encounter number.
- Had a visit/encounter in the 12 months prior to the 90-day reporting period.

Divided by total patient encounters plus total patient panel not already included in the encounters but with an encounter in the 12 months prior to the 90-day reporting period.

$$\frac{\text{All Medicaid + Medicaid MCO Clients Encounters} + \text{Assigned to EP}^*}{\text{All Patient + All MCO Clients Encounters} + \text{Assigned to EP}^*} \times 100$$

* Who had at least 1 encounter in the 12 months immediately preceding the 90-day reporting period and are not already included in the Medicaid encounters