Practitioner Panel Eligible Professional Checklist

Defining an "Eligible Professional"

The following are considered Medicaid eligible professionals (EPs):

- Physicians (Doctors of Medicine (MD) and Doctors of Osteopathy (DO))
  - Residents (if organization's proposal was approved by the Massachusetts Medicaid EHR Incentive Payment Program)
- Dentists
  - Limited Licensed Dentists
- Certified Nurse-Midwives
- Nurse Practitioners
- Physicians Assistants practicing at an FQHC/RHC, so led by a Physician's Assistant

Please Note: If 90% or more of an EP's encounters occur in an inpatient (POS 21) or emergency room (POS 23) setting, they are not eligible. However, EPs who can demonstrate they contributed funds to the acquisition, implementation, and maintenance of Certified EHR Technology, including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an Eligible Hospital or CAH; and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT) are now eligible for EHR Incentive Payments.

Determine Patient Volume Methodology – Practitioner Panel

Medicaid Patient Volume must be reported annually for all six years of participation in the program.

A Practitioner Panel is for those providers who practice in a managed care/medical home setting.

- Patient Encounter methodology, Practitioner Panels can be used to meet individual, needy individual (FQHC only), and group practice thresholds.
- In managed care/medical home settings, employing the Practitioner Panel methodology requires the provider to have documented, auditable data sources. Providers must also be able to identify which patients are on their panels.

Below are some definitions and data elements needed to calculate Medicaid Patient Volume Threshold:

- For the purposes of participating in the Massachusetts Medicaid EHR Incentive Payment Program, you can select to use one of the two methodologies for calculating patient volume thresholds (please reference the Medicaid 1115 Waiver Document: http://www.maehi.org/sites/default/files/documents/Medicaid%201115%20Waiver%20Populations%208-13-12.pdf, which outlines the Fee-For-Service (FFS) and Managed Care Organization (MCO) encounters that may be included when calculating patient volume)

  1. A patient encounter is defined as: one service, per day, per patient, where Medicaid or a Medicaid 1115 Waiver Population ***paid*** for all or part of the service or ***paid*** for all or part of the individual's premium, co-payment or cost-sharing.

  2. A patient encounter is also defined as: one service, rendered any day, to a Medicaid or Medicaid 1115 Waiver ***enrolled*** individual, regardless of payment liability. This includes zero pay encounters that may have been paid by Medicare or by another third party, and denied claims, excluding denied claims due to the provider or individual being ineligible on that date of service.

- Start and end date for selected continuous 90-day reporting period in either the preceding CY or 12

months before the date of attestation. EPs who use the 12 months preceding the date of attestation cannot select the same 90 day period for which they received payment for in the previous payment year.

- To calculate Medicaid patient volume with a panel assignment, providers select a 90-day reporting period in the preceding calendar year (or in the 12 months before attestation) and apply it to the following formula.
    - # of Medicaid/Medicaid 1115 Waiver patients assigned to the practitioner's panel in any representative, continuous 90-day period in either the preceding CY or in the 12 months preceding attestation, when at least one Medicaid/Medicaid 1115 Waiver encounter took place with the patient in the 24 months prior to the beginning of the 90-day period **PLUS** Unduplicated encounters with Medicaid/Medicaid 1115 Waiver patient during the chosen 90-day reporting period = **(Total Numerator)**
    - Total patients assigned to the practitioners panel during the same chosen 90-day reporting period that had at least one encounter in the CY prior to the start of the 90-day reporting period (Denominator)
    - Total patients assigned to panel with at least one encounter in the last 24 months before the reporting period (Denominator)

- A Children's Health Insurance Program (CHIP) Factor of 3.09% must be applied to reduce the Medicaid encounters in order to meet a CMS requirement that CHIP encounters may not be included in Medicaid Patient Volume Threshold.
    - The CHIP factor percentage is updated annually and therefore may vary from year to year.
    - The CHIP factor is not required to be applied for EPs practicing predominantly at an FQHC/RHC and utilizing the needy individual requirement.

For more Information regarding the calculation of Practitioner Panel Methodology and other helpful resources, please visit the Massachusetts Medicaid EHR Incentive Payment Program Tools & Resources Section of the MeHI Website: (http://www.maehi.org/what-we-do/medicaid/tools-and-resources).

If you require assistance during any portion of the application process, please contact the Massachusetts Medicaid EHR Incentive Payment Program via phone at 1-855-MassEHR (1-855-627-7347) or via email at massehr@masstech.org.

Certified EHR Supporting Documentation Requirements (Required for 1st Payment Year)

All EPs must provide supporting documentation showing they are users of Federally Certified EHR Technology. The following criteria is needed to verify this requirement:

- CMS EHR Certification ID # (can be found by visiting the Office of the National Coordinator for Health Information Technology (ONC) Certified Health Product List (http://oncchpl.force.com/ehrcert?q=CHPL))
- Examples of EHR Supporting Documentation (you are required to submit at least one from both parties):
    - From Your EHR Vendor:
        - Executed Copy of a Data User Agreement
        - Proof of Purchase
        - Executed Licensed Vendor Contract
        - Letter from the Vendor on company letterhead stating the following:
            - Provider(s) that are currently utilizing or will be utilizing the federally certified EHR technology,
            - The Provider(s) NPI Number(s),
            - Federally Certified EHR Technology, CHPL number and version, and

        - Location(s) the Federally Certified EHR will/are being utilized.
    - From Your Office:
        - A letter, on company letterhead, from your Chief Information Officer (CIO), IS Department or Owner stating the following:
            - Provider(s) that are currently utilizing or will be utilizing the Federally Certified EHR Technology,
            - The Provider(s) NPI Number,
            - Federally Certified EHR Technology Version and CHPL number, and
            - Location(s) the Federally Certified EHR technology will/are being used.

These documents should be uploaded to the Medical Assistance Provider Incentive Repository (MAPIR). If you encounter any barriers submitting the supporting documentation, please submit the documentation via email to: massehr@masstech.org.

Meaningful Use Attestation: Core, Menu and Clinical Quality Measures

In payment years 2-6, EPs must demonstrate meaningful use of certified EHR technology.

- EPs are required to meet two general requirements:
    - At least 80% of unique patients must have their data in CEHRT during the selected EHR reporting period.
    - At least 50% of an EP's encounters must occur at a location or location(s) that utilize certified EHR technology.

- In the 2nd year of participation in the Program, EPs must select a continuous 90-day period in the current calendar year to report meaningful use measures. In years 3-6 of the program, EPs must report meaningful use measures using a continuous 365 day reporting period.

- Meaningful use measures are reported for all patients seen by an EP during the selected reporting period. This includes all Medicaid and non-Medicaid patients, as well as patients whose information is entered into a certified EHR and those that are not.

Please note, supporting documentation may be requested throughout the application process. For auditing purposes, all documentation should be kept on file for up to six years for each year of program participation.

Registration & Attestation – CMS Registration & Attestation Site

This step is required for the EP's first year of participation only.

If already registered in a previous program year and no changes must be made to your original registration, the EP or designee registering on behalf of the EP can go directly to the MassHealth Provider Online Service Center (POSC) to access the EP's Medical Assistance Provider Incentive Repository (MAPIR) application: (https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/desktop).

The EP or designee will need to register at the CMS Medicare & Medicaid EHR Incentive Program Registration & Attestation Site (CMS R&A) (https://ehrincentives.cms.gov/hitech/login.action).

The following information will be needed to complete the CMS R&A:

- National Provider Identifier (NPI) Number
- Provider Enrollment, Chain, and Ownership System (PECOS) User ID & Password (If you do not currently have PECOS ID, please click the following link to register for a PECOS ID: https://pecos.cms.hhs.gov/pecos/login.do).
- Payee Tax ID # and Payee NPI # (the payee tax ID and payee NPI must match what is in the MassHealth Medicaid Management Information System (MMIS).
- *Please note:* If you are a designee attesting on behalf of an EP, you will need to register and create an

Identity & Access (I&A) account via the PECOS System: https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do.
    - The EP must log into the PECOS system to approve your request at: https://nppes.cms.hhs.gov/NPPES/IAPecosLogin.do?forward=static.login.
- Please find the CMS R&A user guide for EPs at the following link: https://maehi.org/what-we-do/medicaid/tools-and-resources.

For assistance with the CMS R&A or CMS I&A, please contact the CMS Support Center via phone at 1-888-734-6433.

Registration & Attestation – Attesting using the Medical Assistance Provider Incentive Repository (MAPIR)

Once the EP or designee has successfully registered at the CMS R&A, the EP's information will be sent to MAPIR, which is the State's web-based EHR Incentive Program application system. The EP or designee will receive a "Welcome to MAPIR Email" with further registration and program instructions. The MAPIR application will be accessed through the Provider Online Service Center (POSC): https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/desktop.

- Please find the MAPIR user guide for EPs at the following link: https://maehi.org/what-we-do/medicaid/tools-and-resources.

If a "Welcome to MAPIR email" is not received or technical difficulties are experienced when accessing MAPIR, please contact the Massachusetts Medicaid EHR Incentive Payment Program Staff by phone at 1-855-MassEHR (1-855-627-7347) or via email at massehr@masstech.org.