MeHI
MASSACHUSETTS eHEALTH INSTITUTE
at the MassTech Collaborative

MassHealth

Massachusetts Medicaid EHR Incentive Program

Resident Participation Requirements

Massachusetts received approval from CMS to allow residents to participate in the Medicaid EHR Incentive Program. However, not all residents are eligible to participate. To determine eligibility, organizations must first assess whether their residents are hospital-based, as CMS guidelines prohibit hospital-based providers from participating in the Medicaid EHR Incentive Payment Program. The guidelines define *hospital-based* as a provider who renders 90% or more of services in POS 21 (Inpatient) or POS 23 (ED). This definition is often referred to as "the 90% inpatient test."

Because residents bill under an attending physician, billing data cannot be used to determine their hospital-based status. Organizations that wish to attest on behalf of their residents must first submit a proposal that offers an alternate methodology for determining the hospital-based status of their residents. Organizations must also demonstrate a commitment to supporting their residents in the Meaningful Use of Certified EHR Technology (CEHRT).

Note: Participation in the Medicaid EHR Incentive Program is voluntary, and residents can elect not to participate in the program. Organizations must seek approval directly from each resident to enroll them into the program and complete the CMS registration and MAPIR attestation on the resident's behalf.

General Considerations to Determine Hospital-Based Status of Residents		
1	Timeframe	Previous Calendar Year: January 1 – December 31
2	Department	Each department defined by separate NPI / TIN / Clinic Number
3	Department Patient Volume	≥ 30% Medicaid Patient Volume Threshold, calculated using group proxy method

Defining and Classifying Resident Schedules and Rotations		
1	Define Rotation Titles	List titles used to document resident schedules (Resident Database) and provide definitions of any abbreviations/acronyms in the proposal
2	Map Rotation Titles to Location of Service	Residency Program Coordinators should manually map titles to inpatient or outpatient locations of care
• Inpatient is defined as: POS 21 (Inpatient) or POS 23 (Emergency Department) • Outpatient is defined as: all other POS codes • If location is both Inpatient and Outpatient, such as the Cardiac Catheterization Lab, evaluate using auditable hospital data from previous calendar year to properly weight the rotation. Denominator is all encounters; numerator is all inpatient or outpatient encounters.		
3	Define Exclusions	Vacation; Computer; Absence; Teaching; Anatomy Course; Research; Elective; Break; etc.

Standardizing Data to Calculate Hospital-Based Test	
For each resident, every rotation is evaluated to determine either days worked OR sessions (AM/PM) worked in each setting (inpatient and outpatient).	You must consider the total days/sessions **worked** by each resident, using data from Jan 1 through Dec 31 of the previous calendar year.
Account for overlapping rotations in the analysis. For example, subtract Family Medicine night float rotations that overlap with outpatient blocks from the outpatient days/sessions, and treat these as inpatient days/sessions.	
The calculation for determining hospital-based status of a resident is: inpatient days worked divided by the total days worked	

An organization's Resident Proposal must include the following:

1. List of residents for whom the organization plans to apply, with current information for each resident, including full name, NPI, program information, and licensure information: license type, number and expiration date.
2. Narrative explaining the organization's proposed alternate methodology to determine hospital-based status
3. Ambulatory/inpatient information for each resident, and documentation of the calculations used to determine inpatient percentage (90% test), including detailed supporting documentation regarding the calculations. **Note**: This must include rotations actually worked, not rotations assigned.
4. Sample payment reassignment letter signed by all residents for which you propose to attest, documenting the following:
    - Residents are aware of the Medicaid EHR Incentive Payment Program and that the organization plans to apply for incentive payments on their behalf
    - Residents have agreed to reassign payment to the organization
5. Authorization letter from Residency Director/Chair granting permission for the organization to attest on behalf of the residents
6. Statement regarding resident access to and use of the organization's Certified EHR Technology (CEHRT)
7. Meaningful Use (MU) commitment statement, documenting that a) the organization is committed to supporting MU for residents, and b) implementation of MU prioritizes the following:
    - Education and training regarding Meaningful Use measures
    - Data tracking at the provider level (including residents) employing EHR data dashboards
    - Performance monitoring and remediation to assist providers in meeting MU measures

Note the following:

- To be eligible for the Medicaid EHR Incentive payments, residents must be working at one of the group's locations and be currently seeing Medicaid (reference Medicaid 1115 Waiver Population Grid) patients at the time of attestation. In addition, all residents must have an active, valid Massachusetts medical license (full or limited) at the time of attestation.
- Because hospital-based calculations require a full year of data from the previous calendar year, PGY1 residents are not eligible.
- The organizations must calculate their patient volume threshold using group proxy methodology for all providers who will be attesting for the program year in question. The organization must include all encounters for providers practicing in the group, regardless of whether or not the provider is eligible to participate in the Medicaid EHR Incentive Program.
- A group proxy is defined as two or more eligible professionals who are practicing at the same site.
- Hospitals that use the same NPI and Tax ID for all of their ambulatory clinics will need to further breakdown their patient encounter data by Ambulatory Clinic and practice site location.

Review and Approval Process

Resident proposals undergo three levels of review: preliminary, advanced, and final. After preliminary review, the organization is notified of any issues and/or additional supporting documentation that may be required. Similarly, following the advanced review, the organization may be contacted for further clarification and/or if additional documentation is required. Final review is conducted by the Medicaid Operations Director. Once a proposal has been reviewed and approved by the Medicaid Operations Director, the organization may begin applying on behalf of their residents.

Note that the review and approval process for resident proposals can be lengthy and requires significant documentation. In general, proposals are approved 2–3 weeks after all requested documentation has been received.

Residents do not have a MassHealth ID number, and therefore require special enrollment. Upon approval of your resident proposal, our Provider Enrollment and Verification Team will be happy to assist you with the special enrollment process. *Please do not submit any special enrollment documentation for residents until your resident proposal has received final approval.*

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Contact Information

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