MeHI
MASSACHUSETTS eHEALTH INSTITUTE

at the MassTech Collaborative

MassHealth

Frequently Asked Questions

The Massachusetts Medicaid EHR Incentive Payment Program

Patient Threshold Questions

Q: If Medicaid is the secondary insurance, can it be included when computing Medicaid Patient Volume Threshold?

A: Yes, as long Medicaid (including Medicaid 1115 Waiver Population) paid for part or all of the service or an individual's premiums, co-payments or cost sharing that is associated with that service.

Denied MassHealth fee-for-service claims may not be included when calculating Medicaid Patient Volume Threshold.

Q: If an eligible professional practices at multiple locations, can they include Medicaid patients from all sites when calculating Medicaid Patient Volume Threshold?

A: If reporting Medicaid Patient Volume using individual practitioner encounter data, eligible professionals may choose to include Medicaid encounters from one (or more) clinical practice sites; this should include encounters from at least one of the practice sites that is adopting, implementing or upgrading to federally certified EHR technology.

Q: What documentation will be needed to prove reported Medicaid Patient Volume Threshold?

A: Documentation that shows where Medicaid (including Medicaid 1115 Waiver Population) paid for part or all of the service including an individual's premiums, co-payments or cost-sharing.

For compliance purposes, when requested, we ask that the eligible professional or preparer only send data elements that will allow our staff to verify the reported Medicaid Patient Volume Threshold; such as Medicaid ID, Date of Discharge or Service, Charges paid by Medicaid, Primary or Secondary insurance source, or location/place of service, etc. The patient's name, date of birth, diagnosis, etc. are not needed for verification and should not be included with the supporting documentation.

Q: If attesting with group level encounter data, does the eligible professional or preparer need to enter both the individual provider's Medicaid Patient Volume and the group level encounter data or at the group level encounter data only?

A: When reporting group level encounter data to calculate Medicaid Patient Volume Threshold, the eligible professional or preparer will only be required to enter the group level encounter data for each eligible professional. A group is defined as two or more providers practicing at the same site.

Q: What is an unduplicated encounter?

A: Reporting Medicaid patient volume using an individual practitioner panel is for those providers that practice in a managed care/medical home setting. The equation to calculate Medicaid patient volume would be as follows:

[Total Medicaid patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [Unduplicated Medicaid encounters in that same 90-day period]

-DIVIDED BY-

[Total patients assigned to the provider in the same 90-day with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [All unduplicated encounters in that same 90-day period]

"Unduplicated" means that the provider may not include the same encounter more than once when calculating Medicaid patient volume threshold. An "unduplicated encounter" would be an encounter with non-panel patients that occurred within the same continuous 90 day period from the previous calendar year (fee-for-service patients).

Q: When reporting Medicaid Patient Volume Threshold, should eligible professionals or preparers also include prenatal visits (which are not billed per visit but rather are billed as part of a global delivery at the end of the pregnancy)?

A: Yes, providers can include prenatal visits in both the numerator and denominator when calculating their Medicaid Patient Volume Threshold. In the case where there is a MassHealth global payment for obstetric services, the preparer or the professional may use the estimate of 4 visits per patients who are being reimbursed under a MassHealth OB global payment arrangement for the continuous 90 day period. The preparer or professional must include this estimate in both the numerator and the denominator. Please contact the Medicaid EHR Incentive Operations staff at 1-855-MassEHR or via email at massehr@masstech.org with any questions.

Q: What payers are included in the Medicaid 1115 Waiver Population?

A: Encounters associated with MassHealth Standard, MassHealth Breast/Cervical Cancer Treatment, MassHealth CommonHealth, MassHealth Family Assistance, MassHealth Basic, MassHealth Essential, MassHealth Limited, MassHealth Prenatal, MassHealth Insurance Partnership, Commonwealth Care, Medical Security Plan, and Healthy Start can be included in the numerator when calculating Medicaid Patient Volume Threshold.

Please find a complete list of the 1115 Medicaid Waiver Population in the Tools and Resources section of our website.

Q: When referencing Medicaid paying a patient's premiums or part of the premiums, is this referencing premiums from a private insurer only?

A: No, Medicaid patient volume is defined as an encounter where *Medicaid* (including Medicaid 1115 Waiver Population) paid for part or all of the service or paid for all or a portion of the individual's premiums, co-payments or cost-sharing.

Q: When reporting Medicaid Patient Volume Threshold, must the eligible professional or preparer use 90 days from the previous year? Or can the 90 day period be from the current year?

A: When reporting Medicaid Patient Volume Threshold, the eligible professional must choose a continuous 90 day reporting period from the *previous* calendar year. For example, if the eligible professional is registering for their first year incentive payment in 2012, they must choose a continuous 90 day period from calendar year 2011 to report Medicaid Patient Volume Threshold.

Q: Does an eligible professional's Medicaid Patient Volume need to be calculated from the previous calendar year for each year they participate in the program or only once?

A: Medicaid Patient Volume Threshold must be calculated each year of participation using data from the previous calendar year.

Q: When calculating Medicaid Patient Volume Threshold, can eligible professionals include on-call patients that the physicians may have seen?

A: On-call services are typically non-billable visits. Eligible professionals may include on-call patients as long as Medicaid (including Medicaid 1115 Waiver Population) paid for part or all of the service or all or part of the individual's premiums, co-payments or cost sharing.

Q: Can group level data be used for each eligible professional that is being registered?

A: If reporting group level data, all eligible professionals within the group must report the same group level data. The numerator would include all Medicaid (including Medicaid 1115 Waiver Population) encounters within the practice where Medicaid paid for all or part of the service or all or part of an individual's premiums, co-payments or cost-sharing; including those providers that are not eligible to participate in the program (nutritionists, social workers, etc.). The denominator includes all paid encounters for all payers including Medicaid; including those providers that are not eligible to participate in the program (nutritionists, social workers, etc.).

For Example, the following EPs practice at Central Medical Center:

- Physician 1: has 40% Medicaid Encounters (80/200)
- Physician 2: has 50% Medicaid Encounters (50/100)
- Nurse Practitioner: has 10% Medicaid Encounters (30/300)
- Nutritionist: has 75% Medicaid Encounters (150/200)

In total, there are 800 encounters within the 90 day selected reporting period (previous CY); 310 were Medicaid Encounters. The following formula would apply:

310/800 =.3875 x 100 = **38.75%**

Based upon this scenario **3** of the **4** would be eligible to participate in the Medicaid Incentive Program. The Nutritionist is not considered EP but their volume must be included to report at the group level.

Q: What is the Children's Health Insurance Plan (CHIP) factor and where should it be applied?

A: Eligible Professionals must apply a CHIP Reduction Factor of 3.13% to the number of MassHealth encounters used in the Medicaid Patient Threshold numerator in order to meet a Centers for Medicare and Medicaid (CMS) requirement that a state's CHIP encounters may not be included in Medicaid Patient Volume Threshold. Eligible Hospitals must apply a CHIP Factor of 2.43% to the number of MassHealth encounters used in the Medicaid Patient Threshold numerator.

For Example, an eligible professional has chosen a continuous 90-day period from the previous calendar year and extracted the following:

In State Medicaid Encounters: 150

A CHIP Factor Reduction of 3.13% must be applied to in state Medicaid encounters. Therefore, after the CHIP reduction, the instate Medicaid Encounters would be 145.665.

.0313 x 150 = 4.695

150-4.695 = 145.305

Other Medicaid Encounters: 5

Total Patient Encounters: 300

Medicaid patient volume threshold:

145.305 + 5 = 150.305
150.305/300 = .5010
.5010 x 100 = 50.10%

This example the eligible professional exceeds the Medicaid Patient Volume Threshold.

Q: When the CHIP factor is applied, does the same volume go into the denominator?

A: No, eligible professionals and hospitals are required to apply their respective CHIP factor reductions to their MassHealth Medicaid Patient Encounter Numerator only. The denominator should include total patient encounters for the chosen 90-day reporting period from the previous calendar year. This includes CHIP and Medicaid patient encounters, as well.

Q: If a Nurse Practitioner (NP) bills under a supervising physician, can both the NP and Physician include the encounter when calculating Medicaid Patient Volume Threshold?

A: Yes, if the Nurse Practitioner was the servicing provider and the encounter was billed under a supervising physician, both may include the Medicaid encounter in their volume (when applying as individual eligible professionals). If reporting at the group level, the encounter may only be included once.)

Eligibility Questions

Q: Are Nurse Practitioners eligible to participate in the Medicaid EHR Incentive Payment Program?

A: Yes, Nurse Practitioners are eligible to participate in the Medicaid EHR Incentive Payment Program.

Q: Are psychiatrists eligible to participate in the Medicaid EHR Incentive Payment Program?

A: Yes, any Doctor of Medicine (MD) or Doctor of Osteopathy (DO) is eligible to participate in the Medicaid EHR Incentive Payment Program.

Q: Are we able to attest for providers that retired during 2012?

A: Yes, as long as they meet all of the eligibility requirements.

Q: If a physician has already attested under Medicare and has a Nurse Practitioner that bills under them, can the Nurse Practitioner still apply for the Medicaid EHR Incentive Payment Program?

A: Yes, the Nurse Practitioner may still apply for the Medicaid EHR Incentive Payment Program, as long as they meet the eligibility requirements (30% Medicaid threshold, adoption, implementation or upgrade to certified EHR technology, for the first year; Demonstration of meaningful use is required in all subsequent years.)

Q: If a provider started seeing Medicaid patients at a new practice in the current calendar year, would they have to wait a year to apply for their Medicaid incentive?

A: If the eligible professional recently joined a group practice in the current calendar year and is reporting Medicaid Patient Volume using group level encounter data and is currently seeing Medicaid patients and has adopted, implemented or upgraded to a federally certified electronic health record, they can file this year using the group Medicaid Patient Volume.

Likewise, if the eligible professional is reporting Medicaid Patient Volume using their individual encounter data from the previous calendar year based on their practice location they worked at last year, and has adopted, implemented or upgraded to a federally certified electronic health record, they can file this year.

Q: How do we report Medicaid Patient Volume Threshold for groups with multiple locations?

A: It is important to note that the Medicaid EHR Incentive Payment Program requires each individual eligible professional within a group or clinic to apply and attest to eligibility requirements in order to receive an incentive payment each year they participate in the program. Each eligible professional can elect to meet the Medicaid Patient Volume Threshold

requirements by using their individual provider's Medicaid encounter data from a single or multiple practice locations or the group practice's Medicaid encounter threshold data from one or more practice sites.

For example, Dr. John Smith works at both of Massachusetts Community Health Center's practice locations, Boston and Springfield. Dr. John Smith can elect to use his Medicaid patient encounters from one or both sites to meet the Medicaid Patient Volume Threshold requirements. If reporting group level encounter data, Dr. Smith must choose either Boston or Springfield to report Medicaid Patient Volume, as he can only report data from one practice site.

Q: Do eligible professionals have to be employed with a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) for 6 months to qualify for the Medicaid EHR Incentive Payment Program? Or is it only that they have to use FQHC/RHC provision to meet Medicaid Threshold?

A: The federal rule states, eligible professionals must practice predominantly at the FQHC or RHC, meaning 50% or more of their patient encounters over a six month period (of the current calendar year) occurred at the FQHC or RHC. A "new" eligible professional may qualify for the program if all eligible professionals within the FQHC/RHC choose to report Medicaid/Needy Individual Patient Volume using group level encounter data. However it is important to note that the "new" eligible professional must currently be seeing Medicaid patients.

Q: What other eligibility requirements are specific to eligible professionals practicing predominately at Federally Qualified Health Centers (FQHCs)/ Rural Health Clinics (RHCs)?

A: Eligible professionals that practice predominately at an FQHC/RHC may attest using Needy Individual Patient Volume rather than Medicaid Patient Volume. The following may be included when calculating Needy Individual Patient Volume Threshold; 1) Medicaid (including Medicaid 1115 Waiver Population), where paid for part or all of the service including an individual's premiums, co-payments or cost-sharing, CHIP and Dually Eligible for Medicare and Medicaid, 2) Uncompensated Care and 3) No cost or reduced cost services on a sliding scale based on the individual's ability to pay.

Q: Are Residents eligible to participate in the Medicaid EHR Incentive Payment Program?

A: Residents are eligible to participate in the Massachusetts Medicaid EHR Incentive Payment Program. More information regarding the participation requirements and the validation process will be disseminated in the near future.

Adopt, Implement, Upgrade (A/I/U)

Q: Are eligible professionals and hospitals able to meet the measures for Medicare for year 1 but still Adopt, Implement, or Upgrade (A/I/U) for Medicaid in the same year?

A: Eligible professionals may not participate in both the Medicare and Medicaid programs within the same year. If they choose to participate in the Medicaid program, they must waive their right to receive a Medicare Incentive. Eligible Professionals may switch program participation once prior to 2015.

If an eligible hospital is considered "dually eligible" by Medicare, they can participate in both the Medicare and Medicaid EHR Incentive Payment Program. If deemed a meaningful user by Medicare in the first year of participation, the eligible hospital is automatically deemed a meaningful user by Medicaid and therefore cannot attest to adopt, implement or upgrade to federally certified EHR technology.

Q: We just went live with our EHR in August. Can we show Adopt, Implement, Upgrade (A/I/U) for 2011 payment and then apply for our 2012 incentive using September through December 2011 for our 90 day Meaningful Use reporting period?

A: Year one requirements for the Medicaid EHR Incentive Payment Program state that eligible professionals may Adopt, Implement, or Upgrade to federally certified EHR technology. There is no reporting period as long as they have adopted, implemented or upgraded to a federally certified EHR during or previous to the calendar year for their first Medicaid Incentive. However, when reporting Meaningful Use during the second year of participation, the eligible professional must select a continuous 90-day reporting period in the current calendar year. For example, if the Eligible Professional adopted,

implemented, or upgraded in 2011 and received their incentive payment, the earliest the eligible professional can attest for meaningful use is April 2012, using January – March as their 90 day period in the current calendar year.

Q: How quickly is Massachusetts issuing payments following Adopt, Implement or Upgrade (A/I/U)?

A: Eligible hospitals and professionals should expect to receive payment within 4-6 weeks from when the eligible hospital's or professional's Medical Assistance Provider Incentive Repository (MAPIR) application was approved.

Q: What is considered acceptable documentation to show that we have adopted, implemented or upgraded (A/I/U) to federally certified EHR technology?

A: The following are examples of what would be considered acceptable documentation for eligible hospitals and professionals; a signed copy of a Data User Agreement, Proof of Purchase, signed Licensed Vendor Contract, as well as a letter from your Chief Information Officer (CIO) or IS Department Head stating the following providers are using or will be using the federally certified EHR Technology, the certified product name and number, and the provider's NPI number. If the certified EHR will be used at multiple practice sites, please specify each practice site.

Registration and Attestation

Q: Which system(s) do National Provider Identification (NPI) Number and Tax Identification Number (TIN) match against once registered with Centers for Medicare and Medicaid Registration & Attestation System (CMS R&A)?

A: Once the eligible professional or preparer has submitted a CMS R&A application, it will interface with the Medicaid Management Information System (MMIS) by way of the Medical Assistance Provider Incentive Repository (MAPIR). If the eligible professional's NPI and TIN entered in CMS R&A successfully match what is currently listed in MMIS, the eligible professional or preparer will receive an email asking them to log into MAPIR and complete their attestation.

If the eligible professional or preparer does not receive a "Welcome to MAPIR" email, there may be a registration discrepancy. If this is the case, the MeHI Medicaid EHR Program Operations staff will contact the eligible professional or preparer within 72 hours of CMS R&A application submission.

Q: What email address will the MeHI Medicaid EHR Incentive Operations staff use to contact the eligible professional or preparer? The email address listed in the NPI Registry or in Medical Assistance Provider Incentive Repository (MAPIR)?

A: The MeHI Medicaid EHR Incentive Operations staff will use the email address and telephone number provided in CMS R&A and MAPIR to contact the eligible professional or preparer.

Q: If a third party registers in Centers for Medicare and Medicaid Registration & Attestation System (CMS R&A) on behalf of an eligible professional, who will receive the "Welcome to MAPIR" email notification?

A: When an eligible professional or preparer registers with CMS R&A, the eligible professional or preparer will be asked for a contact email and telephone number. The email address entered in CMS R&A will receive the "Welcome to MAPIR" email.

Q: From what email address would the special enrollment package come from?

A: If an eligible professional requires a special enrollment, the PDF packet will be sent using the following email address: massehr@masstech.org.

Q: Please clarify the number of individual eligible professionals a preparer can register in Centers for Medicare and Medicaid Registration & Attestation System (CMS R&A)?

A: Preparers may register up to 300 individual eligible professionals in CMS R&A.

Please note: The number of eligible professionals that a preparer may register via CMS has varied. If you have any questions or concerns, please contact the Medicaid EHR Incentive Payment Program Operations staff at 1-855-MassEHR or via email at massehr@masstech.org.

Q: Are you able to stop half way through the registration process, save and then return to complete an application?

A: Yes. All applications may be started and complete at another time. Please make sure to click "save" after completing each page.

Q: How do I register on behalf of an eligible professional?

A: If an eligible professional has authorized someone other than themselves to attest on the eligible professional's behalf, there are multiple steps that must be completed.

Step 1: If the preparer does not already have an Identity and Access Management System Login, then they must register for one. Once completed, the eligible professional that the preparer is submitting the application on behalf of will receive an email. They must click the link within this email in order to confirm that the preparer is authorized to register and attest on their behalf.

Step 2: The preparer has successfully registered with CMS R&A. The contact listed in CMS R&A receives an email stating "Welcome to MAPIR." Click the link provided in the email and the preparer will be directed to the Provider Online Service Center. On the left side of the page, there is a link that reads "EHR Incentive Program." Click on this link. It will then ask the preparer to login using their username and password. If the preparer does not have a POSC username or password, they must complete a data collection form.

Step 3: Once the preparer receives their username and login, they should be able to access MAPIR and continue with the attestation process on behalf of the eligible professional.

If a preparer is experiencing technical difficulty at any point during the registration process, please contact the MeHI Medicaid EHR Incentive Program Operations staff by telephone at 1-855-MassEHR or via email at massehr@masstech.org.

Q: After Registering and Attesting at Centers for Medicare and Medicaid Registration & Attestation (CMS R&A), how soon should the eligible professional or preparer receive their "Welcome to MAPIR" email?

A: Within 72 hours of submitting their CMS R&A application, eligible professionals or a preparer registering on behalf of the eligible professional should expect to receive an email from CMS R&A, stating that they have successfully completed registration and now must attest at the state level in MAPIR, assuming the provider does not require a special enrollment.

If the eligible professional or preparer does not receive an email within 72 hours and you have not been contacted by anyone from MeHI Medicaid EHR Incentive Payment Operations team regarding your application, please call 1-855-MassEHR.

Q: When does registration/attestation begin? What is the deadline to have all enrolled?

A: Registration and Attestation for the Medicaid EHR Incentive Payment Program opened on October 3, 2011. An attestation reporting tail or "grace period" for both Eligible Professionals and Eligible Hospitals has been identified. In Massachusetts, eligible professionals that adopted, implemented or upgraded to federally certified EHR technology in CY2012 will have until March 30, 2013 to submit applications for their first year incentive payments and eligible hospitals will have until December 29, 2012 to submit applications for the Federal Fiscal Year FFY2012 payments.

The earliest an eligible professional can apply for their second year payments and attest to meaningful use is April 2012. The reporting period for their first year of meaningful use is a continuous 90 day period within the same calendar year during the calendar year for which they are applying. (Example: An eligible professional received their first Medicaid incentive payment for A/I/U in calendar year 2011, and is applying for their second payment in calendar year 2012. Their

first meaningful use reporting period would be a continuous 90 day period between January 1, 2012 and December 31, 2012.)

Please note: Massachusetts is currently implementing and testing a new version of its EHR incentive program attestation, reporting and payment system called the Medical Assistance Provider Incentive Repository or MAPIR. This new version of MAPIR will allow hospitals to apply for their second Medicaid incentive payment and attest to meaningful use criteria. This new version of MAPIR will be deployed in April of 2012. Massachusetts will begin accepting and processing FFY2012 Medicaid incentive applications from hospitals beginning in April. In the meantime, dually eligible hospitals that received their first Medicaid incentive in FFY2011 can begin applying for their Medicare incentive at the CMS Registration and Attestation System at https://ehrincentives.cms.gov/hitech/login.action.

Eligible Hospitals applying for their second year payment as a Medicaid eligible only hospital may submit their Massachusetts Medicaid EHR Incentive Program applications for the first year of Meaningful Use (90 days reporting period) between April 2012 and December 29, 2012. The 90 day meaningful use reporting period must fall between October 1, 2011 and September 30, 2012.

Eligible hospitals applying for their second year Medicaid incentive payment must attest to Stage 1 of Meaningful Use; which requires a continuous 90 day reporting period in the current federal fiscal year. Hospitals that are considered "dually eligible" for both Medicare and Medicaid may begin applying through the Centers for Medicare and Medicaid (CMS) Medicare EHR Incentive Program on January 1, 2012 as a dually eligible hospital. If deemed a meaningful user of federally certified EHR technology by Medicare, the hospital may begin applying for the second year Medicaid EHR Incentive payment in April 2012.

Eligible hospitals applying for their second payment year after being deemed eligible by Medicare for Meaningful Use in FFY2011 may begin applying through CMS Medicare Program on October 1, 2012 due to the 365 day reporting period for year 2 of Meaningful Use. Once deemed eligible by Medicare, the eligible hospital may submit their applications for Massachusetts Medicaid Incentives between October 1, 2012 and December 29, 2012.

Q: How are group registrations going to work? Can an administrator do the full registration or does the provider have to do the initial piece?

A: At this time, there is no group registration feature offered. This issue is currently under review by CMS. An administrator may complete the full registration on behalf of the eligible professional, as long as the eligible professional has authorized them to do so.

Q: How long will it take to register and attest on behalf of each eligible professional?

A: Assuming appropriate accounts are established for each system involved, attestations should take 30 minutes per eligible professional. However, setting up the accounts can be a lengthy process.

Q: Can an administrator log on using the Provider's National Provider Identifier (NPI) username and Password to complete registration and attestation?

A: Administrators are not able to login using the eligible professional's NPI username and Password. This is in direct violation of Centers for Medicare and Medicaid (CMS) regulations.

Miscellaneous Questions

Q: Do I have the ability to schedule a site visit for my practice?

A: Yes. The Medicaid EHR Incentive Payment Program operations staff is more than willing to do site visits. You may request a site visit by sending an email to massehr@masstech.org, or by telephone at 1-855-MassEHR.

Q: How will a provider be able to identify the payment if we already have an EFT with MassHealth?

A: It will state, "EHR Incentive Payment" and the eligible professional's National Provider Identifier (NPI) Number.

Q: What is the payment method, process, and timing?

A: Payment can be electronic as long as the Payee has an approved electronic funds transfer form on file with MassHealth. If multiple eligible professionals have assigned payment to someone other than themselves, the electronic explanation of payment will have the NPI of each Eligible Professional included in the disbursement. The line item will be designated as an EHR Incentive Program Payment. Payments should arrive within 4-6 weeks of the eligible professional's Medical Assistance Provider Incentive Repository (MAPIR) application being approved.

Q: What is the definition of a "group" for purposes of the Medicaid EHR Incentive Payment Program?

A: A group is defined as two or more providers practicing at the same site. As stated previously, each eligible professional must be registered individually, as there is no capability to register multiple eligible professionals at one time.

Contact Information:

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http://www.maehi.org/content/medicaid-ehr-incentive-payment-program

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