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| ***Defining an “Eligible Hospital”*** |
| Children’s Hospitals, Acute Care Hospitals, Cancer Care Hospitals and Critical Access Hospital are all defined as eligible hospitals (EHs) and must meet the following criteria:  Acute Care Hospitals, Cancer Hospitals and Critical Access Hospitals   * An Average Length of Stay (ALOS) of less than 25 days. * Must have a CMS Certification Number (CCN) with the last 4 digits that fall in the range of (0001-0879) or (1300-1399). * Must meet or exceed 10% minimum Medicaid Patient Volume Threshold over a continuous 90-day period in the previous Federal Fiscal Year.   Children’s Hospitals   * An Average Length of Stay (ALOS) of less than 25 days. * Children’s Hospitals are not required to meet a minimum Medicaid Patient Volume Threshold. * Must have a CMS Certification Number (CCN) with the last 4 digits that fall in the range of (3300-3399). * Definition of Children's Hospital also includes any separately certified hospital, either freestanding or hospital within hospital that predominately treats individuals under 21 years of age; and does not have a CMS certification number (CCN) because they do not serve any Medicare beneficiaries but has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program. |

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Checklist for Eligible Hospitals

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| ***Certified EHR Supporting Documentation Requirements (Required for 1st Payment Year)*** |
| All EHs must provide supporting documentation showing they are users of 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: * From both Your EHR Vendor and Hospital: * Executed Copy of a Data User Agreement * Proof of Purchase * Executed Licensed Vendor Contract * Letter from the vendor on company letterhead stating the following: * Hospital is currently utilizing or will be utilizing the Federally Certified EHR Technology, * Hospital NPI Number(s), * Federally Certified EHR Technology CHPL number and version, and * Location(s) the Federally Certified EHR will/are being utilized.   These documents should be uploaded to the Medical Assistance Provider Incentive Repository (MAPIR). If the designee encounters any barriers submitting the supporting documentation, please submit the documentation via email to [massehr@masstech.org](mailto:massehr@masstech.org). |

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| ***Determine Medicaid Patient Volume Threshold Methodology (Not Required for Children’s Hospitals)*** |
| Medicaid Patient Volume must be reported annually for all three years of participation in the program. The following data elements will be needed each year:  Below are some definitions and data elements that will be needed each year in order 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.  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. * In-State Medicaid Encounter Volume (POS21 +POS23) (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), Managed Care Organization (MCO) and Health Safety Net (HSN) encounters that may be included when calculating patient volume) **PLUS** Out-of-State Medicaid Encounter Volume (POS21 + POS23) = **Total Medicaid Encounters (POS21 +POS23) (Total Numerator).** * Total 90-day encounter volume (POS21 + POS23) (across all payers) (Denominator). * A Children’s Health Insurance Program (CHIP) Factor of 2.44% 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 may vary from year to year. |

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| ***Hospital Cost Reporting*** |
| EHs can use the CMS 2552-96 (2011 program year only) or 2552-10 cost report as well as the DHCFP 403 Schedule III cost reports or alternative 12 month data source to calculate the EH’s total incentive payment, which will be paid over a three year period: Hospitals that begin their first year of participation in 2013 and later can now use the most recent continuous 12 month period for which data are available prior to the payment year.   * Year 1: 50% of total incentive amount * Year 2: 30% of total incentive amount * Year 3: 20% of total incentive amount   The required CMS 2552-10 data elements are as follows:   * Total Discharges - Worksheet S-3, Part 1, Column 15, Line 14 * Medicaid Days - Worksheet S-3, Part I, Column 7, Line 1 + Lines 8 through 12 * Medicaid HMO Days - Worksheet S-3, Part I, Column 7, Line 2 * Total Inpatient Days - Worksheet S-3, Part 1, Column 8, Line 1, 2 + Lines 8 through 12 * Total Hospital Discharges - Worksheet C, Part 1, Column 8, Line 200   Cost Report Exclusions (the following may not be included when calculating an EH’s incentive amount):   * Medicare and Medicaid dually eligible bed days must be omitted from the Medicaid Inpatient Days. * Nursery, Psych and Rehab Bed Days may not be included in the acute inpatient (hospital) bed days. * Dually eligible hospitals may not include acute inpatient bed days in the numerator for patients where Medicare Part A or Medicare Advantage under Part C was the primary payer. * EHs will need to exclude the following from their Charity Care Charges: bad debt, Health Safety Net reimbursement, courtesy charges and employee charges. |

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| ***Meaningful Use Attestation: Core, Menu and Clinical Quality Measures*** |
| Through the various years of participation, EHs are required to demonstrate meaningful use of certified EHR technology and may be required to submit aggregated de-identified patient level data and additional supporting documentation to demonstrated compliance with EHR regulations.   * When first attesting to meaningful use, EHs must select a continuous 90-day period in the current federal fiscal year. In subsequent years of participation, EHs must report meaningful use measures using a continuous 365 day reporting period. * EHs are required to meet the following general requirement: * At least 80% of unique patients must have their data in certified EHR technology during the selected 90-day EHR reporting period. * If a hospital is dually eligible, they may be qualified to receive payments from both the Medicare and Medicaid EHR Incentive Payment Program in the same year. * EHs that choose to apply to participate in the Medicaid program first will need to demonstrate the hospital adopted, implemented or upgraded to certified EHR technology. In their second year of participation, EHs will need to be deemed as a meaningful user of certified EHR technology by Medicare prior to applying for their Medicaid EHR Incentive Payment. * EHs that choose to participate in the Medicare EHR Incentive Program, first, will attest to being a meaningful user of certified EHR technology. As a result EHs deemed as a meaningful user by Medicare, are then required to attest to meaningful use in their first year of participation in the Medicaid program (cannot attest to A.I.U). * The Massachusetts Medicaid EHR Incentive Payment Program receives confirmation from Medicare of all eligible hospitals deemed meaningful users. * Non-dually EHs (e.g. Children’s Hospitals) are required to report on meaningful use measures through the State of Massachusetts.   Meaningful use measures are reported for all patients seen by an EH during the selected reporting period. This includes all Medicaid and non-Medicaid patients, as well 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 a minimum of six years for each year of program participation. Hospitals are responsible for the accuracy of their cost report data or alternate data source documentation. |

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| ***Registration & Attestation – CMS Registration & Attestation Site*** |
| This step is required for the EH’s first year of participation only.   * If already registered in a previous program year and the designee attesting on behalf of the hospital does not need to make changes to the original registration, they can go directly to the Provider Online Service Center (POSC) to access the EH's Medical Assistance Provider Incentive Repository (MAPIR) application:   (<https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/desktop>).   * If not, EHs will need to register at the CMS Medicare & Medicaid EHR Incentive Program Registration & Attestation (CMS R&A) Site (<https://ehrincentives.cms.gov/hitech/login.action>).   The following information will be needed to complete your CMS R&A:   * CMS Certification Number (CCN) * 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 EH, 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 authorized hospital official must log into the PECOS system to approve your request at: <https://nppes.cms.hhs.gov/NPPES/IAPecosLogin.do?forward=static.login>   For assistance with the CMS R&A or CMS I&A, please contact the CMS Support Center via phone at 1-888-734-6433. |

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| ***Registration & Attestation – Attesting using the Medical Assistance Provider Incentive Repository (MAPIR)*** |
| Once the designee has successfully registered at the CMS R&A, your information will be sent to MAPIR, which is the State’s web-based EHR Incentive Program application system. You 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>.  If a “Welcome to MAPIR email” is not received or the designee is having trouble 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](mailto:massehr@masstech.org). |

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