



Medicaid EHR

INCENTIVE PROGRAM

Eligible Professional's Guide to the Michigan Medicaid EHR Incentive Program 2014

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Table of Contents

- About this document 4
 - Updates to this document 4
 - Revision history 4
- Introduction and background 6
- Walking the “Path to Payment” by way of this EP guide 6
- How do I determine if I am eligible? 7
 - Are you one of the eligible professional types? 7
 - Are you non-hospital based? 7
 - Eligibility Reporting Period – Defined 8
 - How do you determine Medicaid eligible patient volume? 8
 - Does your Medicaid eligible patient volume meet eligibility thresholds? 11
 - Summary of Medicaid eligible patient volume thresholds 11
 - What options exist for calculating patient volume thresholds? 12
 - Out-of-state Medicaid encounters 12
 - Calculating based on individual EP encounter data only 12
 - Calculating based on group encounter data/group proxy option 12
 - Including MCO panel-assigned patients 13
 - Special criteria for FQHCs and RHCs calculating encounter data 14
 - Needy individual encounters 14
 - Eligible patient volume using needy individual encounters 15
- What is meaningful use (MU)? 15
 - Three MU stages 15
 - Certified electronic health record technology (CEHRT) 16
 - Adoption, Implementation, Upgrading (AIU) 16
 - AIU defined 16
 - MU reporting period 17
 - Percent of encounters required in CEHRT- Meaningful Use requirement 17
- What are the meaningful use (MU) objectives/measures? 18
 - MU objectives/measures 18

Core Objectives	18
Menu Objectives	19
Clinical Quality Measures	19
What special considerations exist for reporting MU data?	20
What do the numerators and denominators mean in measures that are required to demonstrate MU for the Medicaid EHR Incentive Program?	20
How should an EP that sees patients in multiple practice locations equipped with CEHRT calculate numerators and denominators for MU objectives and measures?	20
What about MU measures requiring a yes or no answer? How should they be approached when dealing with multiple CEHRT locations?	21
How can I avoid Medicare payment adjustments?	21
Hardship Exception	22
Retention of Attestation Documentation	23
How do I register for the Michigan Medicaid EHR Incentive Program?	23
Federal level registration	23
What information will an EP need when registering with CMS?	23
Additional items prior to state level registration	24
State level registration	24
What information will you need when you register at the state level?	25
After all this work how much are the incentive payments?	25
Switching Programs or Switching States	26

About this document

This document is provided as an informational guide for eligible professionals (EP) enrolling in the Michigan Medicaid EHR Incentive Program. Additional information can be found at:

- Michigan Department of Community Health: Medical Services Administration policy bulletins: <http://www.michigan.gov/mdch/>
- Centers for Medicare & Medicaid Services 42 CFR Parts 412, 413, 422 et al.: Medicare and Medicaid Electronic Health Record Incentive Programs Final Rule: <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>
- Incentive Program website: <http://www.michiganhealthit.org/>
- CMS' Frequently Asked Questions: <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html>

Updates to this document

The first Eligible Professional's Guide to the Medicaid EHR Incentive Program Version 1.0 was released on 12/21/2010. While revised regularly, significant policy changes and the continued evolution of the Michigan Medicaid EHR Incentive Program rendered Version 1.0 and its subsequent revisions inadequate. Version 2.0 released on 8/01/2012 represented a significant update, but applied only to the 2012 program year. This current Version 3.4 contains new guidance from CMS, along with additional clarification. It represents the Michigan Department of Community Health's current policy for program year 2014. **As the incentive program continues to evolve, new documents will be revised as needed.** Providers are encouraged to periodically check the website and sign up for the e-mail lists at: <https://michiganhealthit.org/signup/maillinglist.aspx>

Revision history

Version	Release Date	Notes
1.0	12/21/2010	Original EP Guide
2.0	08/01/2012	Significant updates applying to program year 2012
3.0	02/06/2013	Significant updates applying to program year 2013
3.1	10/09/2013	Addition of HK-Dental on page 9, eligible patient volume rounding-up on page 10, new EPs and the group-proxy option on page 12, 80% rule on page 16, Medicare payment adjustment language on page 19, elimination of MU Spec Sheets and Clinical Quality Measures from back of this guide (download at: https://www.michiganhealthit.org/mu/), updated hyperlinks throughout.
3.2	1/13/2014	Clarified PA qualification on page 7. Group proxy verbiage clarification on page 12. 2014 MU Reporting Period requirements added on Page 17. Addition of Stage 2 changes on pages 17 & 18.

3.3	2/18/2014	Inclusion of Transition of Care Summary testing on page 19 for Stage 2 EPs. Addition of Hardship Exception information on page 22.
3.4	2/26/2014	Inclusion of Document Retention Clarification of 'Prior twelve month' definition for eligibility reporting period.
3.5	4/7/2014	Clarification on Hardship Exceptions as well as MU reporting in year 1.

Introduction and background

The Centers for Medicare & Medicaid Services (CMS) have offered, through provisions in the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to certain medical providers participating in Medicaid. Medicaid incentives up to \$63,750 are available to those Medicaid providers who meet eligibility requirements and meaningfully use a certified electronic health record technology (CEHRT).

CMS goals for this program include:

- 1) Enhancing care coordination and patient safety
- 2) Reducing paperwork and improving efficiencies
- 3) Facilitating electronic information sharing across providers, payers, and state lines, and
- 4) Enabling data sharing using state Health Information Exchanges (HIEs) and the National Health Information Network (NHIN)

Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce the costs of healthcare nationwide. This begins with the individual healthcare provider's use of a CEHRT.

The Michigan Department of Community Health (MDCH) will work closely with federal and state partners to ensure the Michigan Medicaid EHR Incentive Program fits into both Michigan's Health Information Technology (HIT) Plan and the national goals outlined above.

Walking the "Path to Payment" by way of this EP guide

Participation in the Michigan Medicaid EHR Incentive Program will require a healthcare provider, or as termed in this document an eligible professional (EP), to collect a significant amount of data and to meet a number of requirements. A provider is not truly an "EP" until these requirements are met.

This EP guide is provided to walk an EP down the path towards his or her first incentive payment and, should he or she choose to continue in subsequent years, all six incentive payments available to those eligible. In this document, requirements will be introduced in an order that allows the EP to determine his or her potential eligibility in a logical manner. The intention is to save the time of those who may be found ineligible early on. As an EP progresses through this guide, and it becomes clear that he or she will meet initial requirements, more detailed and complete information will follow.

Questions that will be answered along the path to payment:

- Are you one of the eligible professional (EP) types?
- Are you non-hospital based?
- How do you determine Medicaid eligible patient volume?
- Does your Medicaid patient volume meet eligibility thresholds?

- What options exist for calculating patient volume thresholds?
- What is certified electronic health record technology (CEHRT)?
- What does it mean to adopt, implement, or upgrade to CEHRT in year 1?
- What are meaningful use (MU) requirements for years 2 and 3?
- How do I register for the Michigan Medicaid EHR Incentive Program?
- What incentives do I receive after all this work?

It is important to note that this program is for the individual EP. Every program year, the individual EP must meet the necessary requirements, have access to a CEHRT, attest to program adherence and if found eligible, receive payment. The individual EP may also be audited, so EPs should be active in the process and provide accurate information to avoid recoupment of incentive dollars by the state of Michigan.

How do I determine if I am eligible?

Are you one of the eligible professional types?

EPs must be Michigan Medicaid providers who physically practice in the state and belong to one of the following professional types:

- Physicians
 - Medical Doctor (M.D.)
 - Doctor of Osteopathic Medicine (D.O.)
- Dentists (D.D.S. or D.M.D.)
- Optometrists (O.D.)
- Nurse Practitioners (NP)
- Certified Nurse-Midwives (CNM)
- Physician Assistants (PA) practicing in a PA-led Federally Qualified Health Center (FQHC) or a PA-led Rural Health Clinic (RHC). PA-led includes:
 - When a PA is the primary provider in a clinic;
 - When a PA is the clinical or medical director (or in a similar role with similar responsibilities) at a clinical site of practice;
 - When a PA is the owner of an RHC; or

Additional PA's practicing at a **PA-led FQHC/RHC** site can apply for incentives as well, assuming they meet all of the other requirements including the eligible patient volume.

Are you non-hospital based?

EPs must be non-hospital based. "Non-hospital based," is determined by looking at encounter percentages, a number produced by dividing a numerator by a denominator. The numerator is an EP's *total hospital encounters* and the denominator is an EP's *total encounters* including hospital encounters.

Total hospital encounters

Total encounters

Non-hospital based is currently defined as a medical professional who provides less than 90% of their encounters in a hospital setting during the eligibility reporting period.

Definition of terms for calculating non-hospital based status:

Eligibility reporting period: A continuous 90-day reporting period within the preceding 365 days from the date of EP registration/attestation **or** within the previous calendar year (January 1st through December 31st) during which time the EP captures encounter data required for the non-hospital based calculation.

Encounter: An encounter occurs when a medical service is rendered to an individual on a date falling within the 90-day eligibility reporting period. Multiple claims for the same patient, on the same day, count as only one encounter for each rendering EP.

Hospital encounter: A hospital encounter occurs when a medical service is rendered to an individual on a date falling within the 90-day eligibility reporting period using Place of Service code (POS) 21 inpatient, and/or POS 23 emergency department. Multiple claims for the same patient, on the same day, count as only one encounter for each rendering EP.

New for 2013, a hospital based EP who can demonstrate that he or she is funding the acquisition, implementation, and maintenance of a certified EHR technology, without receiving reimbursement from an eligible hospital or Critical Access Hospital (CAH), and use such CEHRT at a hospital in lieu of using the hospital's CEHRT, can be determined non-hospital based and eligible for incentive payments. Application for this determination will be through CMS.

Encounters are not to be confused with discharges. Any EP providing hospital services (POS 21 & 23) at any time during the eligibility reporting period must provide encounter data from all practice locations so the percentage can be accurately calculated.

Eligibility Reporting Period – Defined

Prior Twelve Months option: Starting in 2013, this option is defined as the prior 365 days from the date of EP attestation/registration.

Prior Calendar Year option: This option is defined as January 1st through December 31st of the prior calendar year.

How do you determine Medicaid eligible patient volume?

Medicaid eligible patient volume is determined by looking at encounter percentages, a number produced by dividing a numerator by a denominator. The numerator is generally an EP's total *Medicaid encounters* and the denominator is generally an EP's *total encounters* including Medicaid.

$$\frac{\text{Medicaid encounters}}{\text{Total encounters}}$$

Definitions for terms necessary to calculate Medicaid eligible patient volume:

Eligibility reporting period: A continuous 90-day reporting period within the preceding 365 days from the date of EP registration/attestation **or** within the previous calendar year (January 1st through December 31st) during which the EP demonstrates that he or she has maintained adequate Medicaid eligible patient volume to be eligible for the Medicaid EHR Incentive Program. Encounters used for calculating eligibility must fall within this 90-day period. It is the same period used in the hospital-based calculation.

Total encounters: For the purposes of calculating EP eligible patient volume, an encounter occurs when a medical service is rendered to an individual on a date falling within the 90-day eligibility reporting period. Multiple claims for the same patient, on the same day, count as only one encounter.

Additionally, please consider the following provisions:

- Michigan does not include in encounter calculations charity care by non-profit health care providers/clinics. Only EPs in FQHCs or RHCs can do so.
- Not every payer pays for the same care in the same way. Global billing is one example frequently used in prenatal care and/or surgery and surgery post-op. Some payers pay for the *individual* office visits while other payers bundle the costs for all visits into a single delivery payment. In the latter case, Michigan considers each episode of care (i.e., office visit) that occurs during the eligibility reporting period to be an “encounter.”

All encounters meeting the above definition (including Medicaid encounters) are to be included in the total encounters (denominator) for calculating EP eligible patient volume.

Medicaid encounters: For purposes of calculating EP eligible patient volume, a Medicaid encounter occurs when an EP provides a medical service to a Medicaid enrolled patient on a date falling within the 90-day eligibility reporting period. This includes “zero-pay” claims. Medicaid zero-pay claims that can be counted as Medicaid encounters include:

- Claims denied because service limits are maxed out
- Claims denied because the service is not covered under Michigan Medicaid
- Claims denied because another payer's payment exceeded the Medicaid amount
- Claims denied for failure to submit in a timely manner

All of the above can be counted as Medicaid encounters as long as the patient was enrolled in Michigan Medicaid on the date of service. Multiple Medicaid claims for the same patient, on the same day, count as only one encounter for each rendering EP.

Medicaid is defined as any program administered by the state authorized under Title XIX or a Medicaid extension program authorized under Title XXI, of the Social Security Act. This includes both fee-for-service and managed care. It does not include any other non-Medicaid extension programs authorized under Title XXI of the Social Security Act, including the Children's Health Insurance Program (CHIP).

The chart below lists the Title XIX Medicaid programs and Title XXI Medicaid extension programs in Michigan. Any encounter where services were provided to a patient enrolled under one of the programs below should be included in the numerator of the eligible patient volume calculation.

	Benefit Plan name
ABW	Adult Benefits Waiver Program
ABW-ESO	Adult Benefits Waiver (Emergency Services)
ABW-MC	Adult Benefits Waiver Program (Managed Care)
ALMB	Additional Low Income Medicare Beneficiary
BMP	Beneficiary Monitoring Program
CWP	Children’s Home and Community Based Services Waiver
SED	Children’s Serious Emotional Disturbance Waiver Program
SED-DHS	Children’s Serious Emotional Disturbance Waiver-DHS
CMH	Community Mental Health
ESRD	End Stage Renal Disease
Plan First	Family Planning Waiver
HK-Dental	Healthy Kids Dental
HK-EXP	Full Fee-for-Service Healthy Kids - Expansion
MA	Full Fee-for-Service Medicaid
HSW	Habilitation Supports Waiver Program
HK-EXP-ESO	Healthy Kids Expansion Emergency Services
MI Choice	Home and Community Based Waiver Services
Hospice	Hospice
Hospice-18	Hospice Medicare Benefit Plan
INCAR-ABW	Incarceration--ABW
INCAR-ESO	Incarceration – Emergency Services
INCAR-MA	Incarceration – MA
INCAR-MA-E	Incarceration – MA – Emergency Services
INCAR	Incarceration – Other
ICF/MR-DD	Intermediate Care Facility for Mentally Retarded – DD
MA-MC	Medicaid Managed Care
MA-ESO	Medical Assistance Emergency Services
Spenddown	Medical Spend-down
MOMS	Maternity Outpatient Medical Services
NH	Nursing Home
PIHP	Prepaid Inpatient Health Plan
PACE	Program All-Inclusive Care for Elderly
QDWI	Qualified Disabled Working Individual
QMB	Qualified Medicare Beneficiary – All Inclusive
SLMB	Special Low Income Medicare Beneficiary
SPF	State Psychiatric Hospital
SA	Substance Abuse

Does your Medicaid eligible patient volume meet eligibility thresholds?

With the encounter, Medicaid encounter, and eligibility reporting periods defined, an EP can calculate the required Medicaid eligible patient volume thresholds. These thresholds use encounter data from the 90-day eligibility report period. The eligibility threshold is a minimum of a 30% Medicaid eligible patient volume for most EPs and 20% for pediatricians.

Medicaid eligible patient volume is calculated using total Medicaid encounters in the numerator and total patient encounters in the denominator. EPs that “practice predominantly” at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC), while required to meet a 30% threshold, may include “needy individual” encounters (e.g., Medicaid in addition to MI Child, charity care, sliding fee, etc.) in their numerators and denominators.

Summary of Medicaid eligible patient volume thresholds

- a) A minimum 30% patient volume attributable to encounters having Michigan Medicaid enrolled patients
- b) For pediatricians, a minimum 20% patient volume attributable to encounters having Michigan Medicaid enrolled patients
- c) For those who practice predominantly in an FQHC or RHC, a minimum 30% needy individual patient volume is required (needy individuals include Medicaid encounters in addition to MI Child, charity care, sliding fee, etc.)

If a pediatrician has greater than 20% but less than 30% Medicaid eligible patient volume, his or her annual incentive cap is reduced to 2/3 the full incentive. Pediatricians who achieve a 30% Medicaid eligible patient volume are eligible to receive the full incentive.

Pediatrician: For the purposes of the EHR Incentive Program only, Michigan Medicaid defines a pediatrician as:

A physician who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must hold a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree and hold a current, in good-standing, board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP).

-OR-

A physician who diagnoses, treats, examines, and prevents diseases and injuries in children, and must hold a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree. Also, at least 50% of the EPs total patient population must be 18 years old and under.

Note: EPs may now round-up from 29.5% or higher to 30% to meet general patient volume calculation guidelines, and from 19.5% or higher to 20% to meet pediatrician patient volume calculation guidelines.

What options exist for calculating patient volume thresholds?

Out-of-state Medicaid encounters

An EP has the option to include encounters from other states in his or her Medicaid patient volume thresholds. The inclusion of out-of-state encounters will initiate an eligibility verification audit; Medicaid staff may contact the other state Medicaid programs to confirm encounter data. While done on a case by case basis, this may delay payment.

Calculating based on individual EP encounter data only

Individual EPs may choose one (or more) clinical sites of practice in order to calculate and meet the requirement for 30% Medicaid patient volume. If choosing more than one practice site, the EP would add Medicaid encounter data from each site to find the numerator and add total encounter data from each site to find the denominator.

This calculation does not need to be across all of an EP's sites of practice. However, at least one of the locations where the EP is adopting or meaningfully using CEHRT should be included in the patient volume. In other words, if an EP practices in multiple locations, one with CEHRT and one without, the EP should be sure to include the patient volume of the site having CEHRT.

EPs registering with individual data having Medicaid managed care panel-assigned patients and/or work predominantly in an FQHC or RHC have additional options for calculating patient volume which are described later.

EPs seeing the same patient on the same day may apply that encounter in each provider's individual patient volume calculation.

A NP or PA rendering service and their associated supervising physician may both include an encounter for the same patient on the same day in their individual encounter calculation so long as it can be proven through an auditable data source.

Calculating based on group encounter data/group proxy option

As mentioned in the Introduction, the Michigan Medicaid EHR Incentive Program is for the individual EP. However, one concession has been made to help those EPs working within a group, called the group proxy option. An EP is allowed to use the entire clinic or group practice's eligible patient volume as a proxy to his or her own individual eligible patient volume. For the purposes of this program, a clinic or group is a collection of healthcare practitioners organized as one legal entity under one Tax Identification Number (TIN).

The organization may be made up of multiple NPIs (as is the case with many FQHCs), but if they are all one legal entity paid under one tax ID then the eligible patient volume may be calculated in aggregate for all NPIs in the organization or at each NPI location. EPs that elect this option are required to select a group NPI from a drop down list. The only group NPI(s) that will appear in the drop down list are the group(s) that the EP is currently associated with in the Provider Enrollment subsystem of CHAMPS or any group whom the EP was associated with at least one day during the patient volume reporting period. Please contact the CHAMPS Provider Support Hotline at 800-292-2550 regarding any missing group associations.

In order to use this proxy option, all of the following criteria must be met:

- 1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP. For example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation;
- 2) There is an auditable data source to support the clinic's patient volume determination; *and*
- 3) The practice and EPs must use one methodology in each year. In other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic while others use the clinic-level data. The clinic or practice must use the entire practice's patient volume and not limit it in any way. This includes encounters from non-EPs.

Whereas multiple EPs registering individually may each claim an encounter when each provides services to the same patient on the same day, this is not the case when using the group proxy option.

If the EP works both in the clinic used as proxy and an outside clinic, then the clinic/practice level encounter data includes only those encounters associated with that clinic/practice used as proxy. It is not an option to include managed care panel-assigned patients when using the proxy option.

Including MCO panel-assigned patients

An EP who is a primary care provider registering with individual data and has Medicaid managed care organization (MCO) or medical home patients assigned, has the option to include encounters by patient panel-assignment in his or her eligible patient volume threshold calculation. Encounters for patients assigned to a patient panel that occurred during the reporting period should be recorded as encounters, whereas patients who did not have an encounter during the 90-day eligibility reporting period, but were assigned within the previous 24 months as allowed below, may be counted on the panel.

The formula for determining eligible patient volume using patient panel assignments is:

[Total Medicaid patients assigned to the EP during the 90-day eligibility period with at least one encounter in the 24 months 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 EP during the 90-day eligibility period with at least one encounter in the 24 months preceding the start of the 90-day period] -PLUS- [All unduplicated encounters in that same 90-day period]

In this calculation "unduplicated" simply means that an EP may not include the same encounters more than once. There may be multiple encounters with patients (even with patients included on the panel) but these may not be counted in more than one place in the equation.

Special criteria for FQHCs and RHCs calculating encounter data

An EP registering using individual encounter data may use the special criteria detailed below to determine his or her eligible patient volume if *both* of the following criteria are met:

1. The EP wishes to register as an individual as opposed to using the group proxy option.
2. The EP "practices predominantly" at an FQHC and/or RHC. (An EP practices predominantly at an FQHC and/or RHC when over 50% of his or her total patient encounters occur at an FQHC and/or RHC during a six month period within the preceding 365 days from the date of EP registration/attestation **or** within the previous calendar year (January 1st through December 31st).

If both criteria are met, when calculating encounters at an FQHC and/or RHC, the EP may include the following "*needy individual encounters*" toward their 30 percent Medicaid encounter volume:

- MIChild
- Sliding fee scale
- Charity care

An EP registering individually may include encounter data from other sites of his or her practice if they choose; however, EPs must *exclude* individual encounters from locations that have already applied for the Medicaid EHR Incentive Program using the proxy option (to avoid counting encounters twice). If the EP is a general practitioner, unduplicated patient panel encounters may be added to the numerator.

FQHCs and RHCs providing eligibility data for all their EPs using the group proxy option may take advantage of reporting needy individual encounters, but not panel-assigned patients.

Needy individual encounters

For purposes of calculating needy individual eligible patient volume, a needy patient encounter occurs when services are rendered to an individual on any one day where:

- Medicaid and/or Children's Health Insurance Program (CHIP, known as MIChild in Michigan, or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act) paid for part or all of the service;
- Medicaid or CHIP, or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act, paid all or part of the individual's premiums, co-payments, or cost-sharing;
- The services were furnished at no cost (charity); or
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

Note: Medical services provided as charity, are provided as charity on the date of service. A patient, who is billed for services rendered and does not pay, and is later written off, does not count as charity.

Eligible patient volume using needy individual encounters

The formula for calculating eligible patient volume using needy individual encounters includes total needy individual encounters (including Medicaid) as numerator and total patient encounters as denominator.

$$\frac{\text{Needy individual encounters}}{\text{Total patient encounters}}$$

Encounters must fall within the 90-day eligibility period.

What is meaningful use (MU)?

Three MU stages

In order to receive and continue to receive incentive payments, EPs must achieve and maintain a set of meaningful use (MU) measures as defined by CMS. MU employs a three stage approach, with each stage building on the preceding stage.

- Stage 1 -2012: Data capture and sharing
- Stage 2 -2014: Expand upon the Stage 1 criteria to encourage the use of health information technology and exchange for continuous quality improvement
- Stage 3 -2017: Expand on Stage 2 with a focus on promoting improved outcomes in quality, safety, and efficiency

First Year of Participation	AIU	Stage 1		Stage 2			Stage 3				
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500					
2012		\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500				
2013			\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500			
2014				\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500		
2015					\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	
2016						\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500

Note: Maximum incentive amount is \$63,750. Payments are made over 6 years and do not have to be consecutive. 2016 is the last year that Medicaid EPs can begin participation in the program. EPs may participate in A/I/U in their first year; or they may immediately begin the program with Meaningful Use (MU) effective in 2014. An EP must complete 2 years of Stage 1 prior to advancing to Stage 2; likewise, an EP must complete 2 years of Stage 2 prior to advancing to Stage 3.

Stage 1 is currently defined. These requirements are explained further in the CMS final rule (<http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>) and outlined in this document.

Stage 2 has also been released. Documents outlining Stage 2 can be reviewed at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Certified electronic health record technology (CEHRT)

In order to qualify for the Medicaid EHR Incentive Program, EPs must use certified EHR technology (CEHRT). CEHRT must meet or surpass minimum government requirements for security, privacy, and interoperability and allow the purchaser to meet MU measures based on the Stage they are in. A CEHRT can be a stand-alone EHR, or a series of modules put together to attain MU functionality and certification.

Starting in 2014, all Medicaid EHR Incentive Program participants will have to adopt certified EHR technology that meets the Office of the National Coordinator for Health IT (ONC) Standards & Certification Criteria 2014 Final Rule regardless of stage.

Product certification is processed through the ONC and must be listed on the Certified HIT Product List (CHPL) maintained by ONC. All certified products appear on this list. Only the product version(s) included on the CHPL are certified.

The list can be found at <http://onc-chpl.force.com/ehrcert>. Note: this link is subject to change but the CHPL will always be available from the ONC's main page at <http://healthit.hhs.gov>.

The CHPL will also assign a CMS EHR Certification ID. This is the ID required when registering for the EHR incentive programs. This number represents the product, or products that will allow for MU requirements to be met.

Adoption, Implementation, Upgrading (AIU)

A Medicaid EP does not have to meet MU criteria in his or her first year of participation. Instead, EPs may attest to adopting, implementing, or upgrading (AIU) to a CEHRT. MU criteria must be met in all subsequent participation years. The 2014 Stage 2 Final Rule clarifies that providers may not receive an AIU payment if their CEHRT does not allow them to meet MU, however this does not mean EPs attesting under AIU in 2013, have to have a Certified 2014 EHR prior to 2014. Timing the acquisition of a Certified 2014 EHR will be left to the EP.

AIU defined:

- Adoption – acquired certified EHR technology (e.g., evidence of purchasing or securing access to certified EHR technology)
- Implementation – began using EHR (e.g., staff training, data entry of patient demographic information on EHR)
- Upgrading – expanded EHR (e.g., upgraded to certified EHR technology or added new functionality to meet MU)

MU reporting period

The MU reporting period is a continuous period during which the EP successfully demonstrates meeting MU objectives. It should not be confused with the eligibility reporting period. The breakdown of each year's reporting period is as follows:

- An EP entering his or her first year in the program may attest under AIU and would not have to meet MU requirements.
- Providers registering in 2014 will have the option of selecting MU in their first payment year. Providers registering for MU for the first time in 2014 may select any 90 day MU reporting period. Providers in their second reporting period in 2014 are required to choose a quarterly reporting period in that same calendar year. Valid MU start dates are as follows: January 1st, April 1st, July 1st and October 1st.
- For all subsequent payment years, the reporting period is the full calendar year necessitating reporting and attestation in the subsequent calendar year. 2014 will be the exception as a result of Stage 2, requiring all EPs to report their MU data quarterly (not 90 days).

Note: Program years do not have to be consecutive; EPs can skip years (Medicare payment adjustments for failing to meet MU will still apply).

For example, let's say an EP registers under AIU in 2011 and receives his or her *first-year* incentive payment. To receive the *second-year* payment for 2012, the EP would have to wait at least 90 days after January 1, 2012 in order to demonstrate MU for 90 days within 2012 (a requirement for the second-year payment) before attesting. To receive the *third-year* payment (nominally, the 2013 payment), the EP would have to demonstrate MU for the entire year (all 12 months in 2013) and then attest in early 2014. To receive the *fourth-year* payment (nominally, the 2014 payment), the EP would have to demonstrate MU for a quarterly reporting period in 2014 with a 2014 compliant CEHRT. For 2015, MU reporting will again require data for the whole year if the EP is in his or her third year or more of program participation.

Percent of encounters required in CEHRT- Meaningful Use requirement

When an EP is participating in Meaningful Use, they must have 50% or more of their combined patient encounters during the MU reporting period at locations equipped with CEHRT. Hospital encounters (POS 21 & 23) are excluded, as MU requirements in these locations will be reported by the hospital. An EP who does not conduct 50% of his or her patient encounters in any one practice/location would have to meet the 50% threshold through a combination of practices/locations. Additionally, EPs must have 80% or more of their combined unique patients in locations having CEHRT, maintained in said CEHRT. For more information on supporting documentation required to validate these percentages, see FAQ question number 5, under, "FAQs Relating to Meaningful Use (MU) Reporting":

<https://www.michiganhealthit.org/faq/>

What are the meaningful use (MU) objectives/measures?

MU objectives/measures

Originally, EPs in Stage 1 MU would attest to a total of 20 MU objectives; 15 core and 5 menu objectives. At present, 18 MU objectives are required for successful attestation to Stage 1 MU as reflected in the module. EPs entering Stage 2 MU must attest to a total of 20 objectives; 17 core and 3 menu objectives. These changes are briefly described in the charts below.

Core Objectives

	Stage 1	Stage 2	Notes
Use CPOE for drug orders	Y	Y	2013-optional alternative measure available
Check drug-drug/drug-allergy interaction	Y		Integrated in to Clinical Decision Support rule in Stage 2
Maintain current and active diagnoses	Y		Integrated in to Summary of Care in Stage 2
E-prescribe (eRx)	Y	Y	
Maintain active medication list	Y		Integrated in to Summary of Care in Stage 2
Maintain active allergy list	Y		Integrated in to Summary of Care in Stage 2
Record patient demographics	Y	Y	Stage 2 records data for 80% of unique patients
Record vital signs	Y	Y	2013-optional addition of alternative age limitations available, and a new exclusion Stage 2 records data for 80% of unique patients
Record smoking status	Y	Y	Stage 2 records data for 80% of unique patients
Report clinical quality measures	Y		2013-onward, removed as a core objective, and is instead considered a stand-alone MU requirement
Clinical Decision Support rule	Y	Y	Stage 2 - changed to include 5 clinical decision support interventions as well as integrating drug-drug & drug-allergy interaction checks in to core objective
Provide electronic health information to patients	Y	Y	
Provide clinical summaries	Y	Y	
Exchange electronic clinical info	Y		2013-no longer required
Protect patient data privacy and security	Y	Y	
Incorporate clinical lab test results		Y	Menu objective in Stage 1
Send care reminders to patients		Y	Menu objective in Stage 1
Generate patient lists by condition		Y	Menu objective in Stage 1
Identify patient-specific education resources		Y	Menu objective in Stage 1
Perform medication reconciliation between care settings		Y	Menu objective in Stage 1
Generate summary of care for transferred patients		Y	Menu objective in Stage 1
Submit immunization data to registries		Y	Menu objective in Stage 1
Secure electronic messaging through CEHRT		Y	

Menu Objectives

	Stage 1	Stage 2	Notes
Implement drug formulary checks	Y		
Incorporate clinical lab test results	Y		Becomes core objective in Stage 2
Generate patient lists by condition	Y		Becomes core objective in Stage 2
Send care reminders to patients	Y		Becomes core objective in Stage 2
Provide patient with timely access to electronic health information	Y		2014-onward, removed as a menu objective in Stage 1
Identify patient-specific education resources	Y		Becomes core objective in Stage 2
Perform medication reconciliation between care settings	Y		Becomes core objective in Stage 2
Generate summary of care for transferred patients	Y		Becomes core objective in Stage 2
Submit immunization data to registries*	Y		2013-language “except where prohibited” added; becomes core objective in Stage 2
Submit epidemiology data to public health*	Y	Y	2013-language “except where prohibited” added
Maintain electronic notes in patient records		Y	
Imaging Results accessible through CEHRT		Y	
Maintain patient family health history records		Y	
Submit cancer data to public health		Y	
Submit specific cases to specialized registry		Y	

Note:

- In Stage 1 EPs must select one of the public health menu measures, as indicated by the asterisk, to complete attestation. Detailed MU specification sheets can be downloaded at: <https://www.michiganhealthit.org/mu/>. For information on how to connect to the public health systems for meeting MU, visit: <http://www.michiganhealthit.org/public-health/>.
- In Stage 2 EPs must demonstrate cross vendor exchange capability for transition of care patients. EPs will find an overview of the testing process on NIST-ONC’s site, along with the registration at: <https://ehr-randomizer.nist.gov/ehr-randomizer-app/#/home>.

Clinical Quality Measures

Starting in 2014, irrespective of the Stage of MU the EP is participating in, EPs must also report on a total of 9 clinical quality measures (CQMs) across 3 domains. In addition to reporting CQMs through attestation, EPs will have the option to report a limited sub-set of CQMs through the Physician Quality Reporting System (PQRS). Similarly, EPs will have the option of uploading a QRDA category III file generated by their CEHRT. A detailed list of CQMs can be downloaded at:

<https://www.michiganhealthit.org/mu/>. Additional information can be found at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html.

What special considerations exist for reporting MU data?

When reporting MU data, EPs must collect and combine data from all practice locations utilizing CEHRT. MU reporting is concerned with CEHRT equipped sites only. This excludes hospital data (POS 21 & 23) as hospitals will report this information for their own EHR incentive. So when MU core requirement 6 says, “More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no medication allergies) recorded as structured data,” it means all unique patients in locations having CEHRT (excluding POS 21 & 23).

CMS has a parallel Medicare EHR Incentive program requiring reporting of MU data in the first year of participation (not having AIU). While Medicare and Medicaid EHR incentive programs have differing eligibility requirements, each program’s MU requirements are identical. Clarifications that CMS has made for Medicare EPs can similarly be applied to the Medicaid EHR Incentive Program. These CMS clarifications are considered below.

What do the numerators and denominators mean in measures that are required to demonstrate MU for the Medicaid EHR Incentive Program?

There are 15 measures for EPs that require the collection of data to calculate a percentage, which is the basis for determining if an MU objective was met according to a minimum threshold for that objective.

Objectives requiring a numerator and denominator to generate this calculation are divided into two groups: one where the denominator is based on patients seen or admitted during the EHR reporting period, regardless of whether their records are maintained using certified EHR technology (within a given CEHRT location); and a second group where the objective is not relevant to all patients either due to limitations (e.g., recording tobacco use for all patients 13 and older) or because the action related to the objective is not relevant (e.g., transmitting prescriptions electronically). For these objectives, the denominator is based on actions related to patients whose records are maintained using CEHRT.

This grouping is designed to reduce the burden on providers. Table 3 in the Medicare and Medicaid EHR Incentive program’s final rule (FR 75 44376 - 44380) lists measures sorted by the method of measure calculation, and is included at the very back of this document.

How should an EP that sees patients in multiple practice locations equipped with CEHRT calculate numerators and denominators for MU objectives and measures?

EPs should look at the measure of each MU objective to determine the appropriate calculation method for individual numerators and denominators. The calculation of the numerator and denominator for each measure is explained in the detailed MU measure outlines included in the last half of this document.

For objectives that require a simple count of actions (e.g., the number of permissible prescriptions written for the objective of "Generate and transmit permissible prescriptions electronically (eRx)"), EPs must add the numerators and denominators calculated by each CEHRT in order to arrive at an accurate total for the numerator and denominator of the measure.

For objectives that require an action to be taken on behalf of a percentage of "unique patients" (e.g., the objectives of "Record demographics," "Record vital signs," etc.), EPs may also add the numerators and denominators calculated by each CEHRT in order to arrive at an accurate total for the numerator and denominator of the measure. Previously, CMS had advised providers to reconcile information so that they only reported unique patients. However, because it is not possible for providers to increase their overall percentage of actions taken by adding numerators and denominators from multiple systems, CMS now permits simple addition for all meaningful use objectives.

Patients seen at CEHRT locations who, for whatever reason, have records maintained outside of the CEHRT will need to be added to denominators whenever applicable in order to provide accurate numbers.

What about MU measures requiring a yes or no answer? How should they be approached when dealing with multiple CEHRT locations?

MU measures requiring yes or no answers should be answered with all CEHRT locations (excluding POS 21 & 23) taken into account. For example, in order to answer "yes" to "Enable drug formulary checks?" an EP must be able to answer yes for all CEHRT locations. All CEHRT locations should have drug formulary checks enabled.

How can I avoid Medicare payment adjustments?

Medicare eligible professionals (EPs) who do not demonstrate meaningful use for either the Medicare Electronic Health Record (EHR) Incentive Program or Medicaid EHR Incentive Program may be subject to payment adjustments beginning on January 1, 2015. Because payment adjustments are mandated to begin on the first day of the 2015 calendar year, CMS will determine the payment adjustments based on meaningful use data submitted prior to the 2015 calendar year.

These payment adjustments will be applied to the Medicare physician fee schedule amount for covered professional services furnished by the EP in 2015. EPs who do not demonstrate meaningful use in subsequent years will be subject to increased payment adjustments in 2016 and beyond.

EPs that began participation in 2011 or 2012

EPs who first demonstrated meaningful use in 2011 or 2012 must demonstrate meaningful use for a full year in 2013 to avoid payment adjustments in 2015.

EPs that begin participation in 2013

EPs who first demonstrate meaningful use in 2013 must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid payment adjustments in 2015.

EPs that plan to begin participation this year in 2014

EPs who first demonstrate meaningful use in 2014 must attest prior to October 1, 2014 to avoid payment adjustments in 2015. This reporting period must occur in the first 9 months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, in order to avoid the payment adjustments.

Note: EPs must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

Eligibility

Only EPs that are eligible for the Medicare EHR Incentive Program are subject to payment adjustments. Medicaid EPs who can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

Resources

For more information on EP payment adjustments, view the “Payment Adjustments and Hardship Exceptions Tipsheet for EPs,” and the “How Payment Adjustments Affect Providers Tipsheet,” found at the link below: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Hardship Exception

An EP may qualify for a hardship exception if they are unable to meet Meaningful Use prior to the Medicare payment adjustment deadline. Further information related to the hardship exception can be found at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html. The application and supporting documentation must be e-mailed to ehrhardsip@provider-resources.com or by fax (814) 464-0147. **Please retain a copy of the application after submission.**

Important dates for hardship exception:

- Returning providers who met MU in 2013 are excluded from the payment adjustment and do not need to submit an application for 2015,
- Returning providers who did not meet MU in 2013 must submit their application no later than midnight EST on July 1, 2014,
- EPs who have not participated in the EHR Incentive program must successfully attest by October 1, 2014, OR
- EPs who have not participated in the EHR Incentive program must submit their application no later than midnight EST on July 1, 2014.

Note: The following applications indicate Medicare; CMS has instructed Medicaid EPs to use the same application. The EP application can be found at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipException_EP_Application.pdf. An addendum for submitting multiple NPIs, to be submitted with the EP Application, can be found at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipException_EP_Application_MultipleNPIs.pdf.

Also note that 2014 EHR Vendor Issues were recently added as a valid hardship reason on the exception form.

Retention of Attestation Documentation.

Providers are required to retain documentation uploaded in their eMIPP application for a minimum period of six (6) years from the date of an approved application that resulted in a Michigan Medicaid EHR incentive payment. Any provider's failure to retain the requisite documentation for review by the MDCH or by independent auditors for the six (6) year period may result in adverse action against that provider, including, but not limited to, recoupment of incentive payments and sanctions.

How do I register for the Michigan Medicaid EHR Incentive Program?

An EP must register with the CMS registration and attestation system (RAS) at the federal level to start his or her registration process. Once registered at the federal level, an EP will be invited to complete his or her registration at the state level.

Federal level registration

To register with the CMS RAS, all EPs must have a National Provider Identifier (NPI). The CMS RAS is available at <https://ehrincentives.cms.gov/hitech/login.action>.

To access the CMS RAS, an EP will need a username and password. An EP may use the same user ID and password used for the National Plan and Provider Enumeration System (NPPES). If an EP does not have an active user ID and password for NPPES, he or she can request them via CMS Identity & Access Management, available at <http://www.cms.gov/>. When requesting, an EP will need a type 1 NPI, Taxpayer Identification Number (TIN), and address from IRS Form CP-575. A copy of IRS Form CP-575 will need to be mailed as directed.

What information will an EP need when registering with CMS?

EPs must provide basic information at the CMS RAS.

- Individual (type 1) National Provider Identifier (NPI)
- Payee Tax Identification Number (if you are reassigning your benefits)
- Payee National Provider Identifier (NPI) (if you are reassigning your benefits)
- Demographic information including state and the program (Medicare or Medicaid), in which you are participating

A guide to registering in the CMS RAS is available at: <https://www.michiganhealthit.org/register/>

Additional items prior to state level registration

An EP is not required to provide his or her CMS EHR certification number when registering with the CMS RAS. However, it is strongly recommended that EPs do so since it will speed up the registration process at the state level.

An invitation letter for state level registration will go to the address provided in the CMS RAS. The invitation letter will contain the CMS registration number which will be required for access to state level registration.

Any changes to the information in the CMS RAS must be made by the EP in the CMS RAS. Once changes have been made at the CMS RAS, it is important that the EP submit these changes so the state level registration can be properly updated. Failure to submit changes will cause a delay in receiving an incentive payment.

State level registration

An EP must complete his or her registration at the state level after registration in the CMS RAS. EPs will receive a letter inviting them to complete the registration process in the Community Health Automated Medical Processing System (CHAMPS). However, the EP does not need to wait for this letter, and can begin the state-level registration process 24 hours after successful registration in the CMS RAS. EPs have a 90-day window from the time of federal registration to complete state level registration. EPs not registered in CHAMPS, or who are providing services through managed care entities, must be individually registered as a Medicaid provider in good standing in CHAMPS to be eligible to receive an EHR incentive. Information entered at the CMS RAS must match the information provided in CHAMPS.

- *Currently a Medicaid-Enrolled Provider* - Once Medicaid receives a valid EP request from the CMS RAS, Medicaid will send a welcome letter to the EP with instructions for logging into the CHAMPS EHR module to register for the EHR incentive payment. Once the EP submits registration information, Medicaid staff will start the review/validation process.
- *Not Currently a Medicaid-Enrolled Provider* - Once Medicaid receives a valid EP request from the CMS RAS, Medicaid will send a welcome letter to the EP with instructions for enrolling in CHAMPS. Note that this enrollment is for EHR incentive purposes only. To access the CHAMPS system for enrollment, the EP must follow the directions on the website at [http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-145006--_00.html#Accessing the CHAMPS System](http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-145006--_00.html#Accessing_the_CHAMPS_System). The toll free number for help enrolling in CHAMPS is (800) 292-2550. Once approved, the EP will receive a letter with instructions on completing the EHR portion of the enrollment.

An EP will have to register and attest in the CHAMPS EHR module every year he or she wishes to participate. This will ensure EPs meet eligibility requirements and report on MU. EPs will also be required to complete an annual survey that will address general EHR issues.

Note: EPs are not required to return to the CMS RAS unless there is an update to any demographic or payment information (i.e. address, e-mail address, payee tax ID).

What information will you need when you register at the state level?

In addition to the items submitted to the CMS RAS, EPs must provide several items at the state level. These items include:

- EP 90-day eligibility reporting period
- Type of provider, with additional items for Physician Assistants
- The following encounter types:
 - Any encounters in the hospital inpatient or emergency room setting broken down by Medicaid and total encounters in each setting
 - If using the Eligible Patient Volume by Practice/Organization Proxy option, encounters broken down by Medicaid and total encounters and the NPI of the organization whose encounters are being used as a proxy
 - Any encounters in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) broken down by Medicaid, MICHild, charity care, sliding fee scale and total patient encounters in the FQHC and/or RHC setting
 - Any Medicaid managed care primary care patient panel encounters that are included, broken down by Medicaid patients assigned to PCP panel, unduplicated Medicaid patient encounters (i.e., fee for service encounters), total patients assigned to PCP panel (including any other payers) and total unduplicated patient encounters (OPTIONAL)
 - All other encounters in any other setting broken down by Medicaid and total encounters
 - All states, other than Michigan, in which encounters are being reported
- EHR stage information; adopt, implement, upgrade or meaningful use
- CMS EHR Certification ID, available from EHR vendor (if not provided at federal level). Note: the CMS EHR Certification ID is case sensitive and should be entered in all upper case
- Contact e-mail (if not provided at federal level)

A detailed guide for state level registration is available at:

<https://www.michiganhealthit.org/register/>

After all this work how much are the incentive payments?

The goal of all this effort, in addition to improving safety, quality and efficiency is to receive a payment incentive! Each EP can receive a maximum total incentive of \$63,750 over a six year period. The first year's maximum amount is \$21,250 and years two through six are capped at \$8,500 per year.

Calendar Year	2011	2012	2013	2014	2015	2016
2011	\$21,250	-----	-----	-----	-----	-----
2012	\$8,500	\$21,250	-----	-----	-----	-----
2013	\$8,500	\$8,500	\$21,250	-----	-----	-----
2014	\$8,500	\$8,500	\$8,500	\$21,250	-----	-----
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	-----
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	-----	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	-----	-----	\$8,500	\$8,500	\$8,500	\$8,500
2019	-----	-----	-----	\$8,500	\$8,500	\$8,500
2020	-----	-----	-----	-----	\$8,500	\$8,500
2021	-----	-----	-----	-----	-----	\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

EPs may start the program as early as calendar year 2011. EPs may not start the program any later than calendar year 2016. Consecutive years are not required for participation. However, EPs starting in 2016 must participate in consecutive years in order to receive the full incentive amount. No incentive payments will be made after calendar year 2021.

The total for pediatricians who meet the 20 % patient volume but fall short of the 30 % patient volume is \$14,167 in the first year and \$5,667 in subsequent years. This adds up to a maximum Medicaid EHR incentive payment of \$42,500 over a six-year period.

Switching Programs or Switching States

An EP is allowed to switch participation from the Medicare EHR Incentive Program to the Michigan Medicaid EHR Incentive Program one time. When an EP switches from Medicare to the Medicaid incentive in the CMS RAS, the Michigan Medicaid EHR Incentive Program will be notified of the change. An EP making a switch to Medicaid will be subject to the same EHR reporting period that he or she would have been under had he or she remained in the Medicare incentive program. So for example, a Physician participating in the Medicare incentive for program year 2012, using a 2012 90 day MU reporting period, would need to report MU data for a full year in 2013 if he or she switched to the Medicaid incentive in program year 2013.

Additionally, only one payment can be received each year regardless of which program an EP is enrolled in. So, an EP that was paid by Medicare for participation in program year 2012 would need to wait until program year 2013 to participate with Medicaid.

EPs may also switch states and still be eligible for the program. When an EP switches his or her state to Michigan in the CMS RAS, the Michigan Medicaid EHR Incentive Program will be notified of the

change. When the switch is made, the EP enters the Michigan Medicaid EHR Incentive Program with the same MU status that he or she reached in their previous state. EPs may only claim one incentive payment per program year, regardless of which state the payment came from.

In previous versions of this guide, detailed Stage 1 Meaningful Use Specification Sheets, and a Clinical Quality Measure Outline were provided. These are now available to be downloaded separately at: <https://www.michiganhealthit.org/mu/>, and are also available at: <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html>.