Eligible Professional's Guide to the Michigan Promoting Interoperability (PI) Program

Version 6.4, 09/06/2018

MDHHS
Michigan Department of Health & Human Services

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About this document

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

- **Medicare and Medicaid Programs; Stage 3 and Modifications to Meaningful Use in 2015 Through 2017:** https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications
- **IPPS Final Rule with changes to the Medicare and Medicaid Programs**: https://www.federalregister.gov/documents/2017/08/14/2017-16434/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the
- **Centers for Medicare & Medicaid Services. 2018 Program year for Medicaid:**
- https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirementsMedicaid.html
- **Eligible Professionals 2018 Specification Sheets for Modified Stage 2:** https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_ModifiedStage2_2018.pdf
- **Eligible Professionals 2018 Specification Sheets for Stage 3:** https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_Stage3_2018.pdf
- **Michigan Medicaid PI Program website:** http://www.michiganhealthit.org/

Updates to this document

The first Eligible Professional's Guide to the Medicaid EHR Incentive Program (now known as the Promoting Interoperability (PI) Program) Version 1.0 was released on 12/21/2010. While revised regularly, significant policy changes and the continued evolution of this program rendered Version 1.0 and its subsequent revisions inadequate. **As the program continues to evolve, this EP guide along with additional 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/mailinglist.aspx

Revision history

Version	Release Date	Notes
1.0	12/21/2010	Original EP Guide
5.0	2/9/2016	2015 Modification Rules were added. Dates, links were all updated. Inclusion of the Reconsideration Form. Guide was also reformatted and reorganized.
5.1	2/17/2016	Additional information related to the Alternate Medicare Attestation was added. Trouble shooting tips were added.
5.2	5/3/2016	Updated the attestation deadline for the 2016 program year to coincide with Medicare on page 27. Addressed the 80% rule on page 20.
5.3	6/6/2016	Correction made to the MU Reporting Period for year 2016, if an EP AIU'd in 2015 and for year 2017, if an EP AIU'd in 2016. This is found in the table on page 19.
5.4	6/27/2016	Clarified that the percentage for Hospital Based providers is 89.5%.
5.5	8/18/2016	Added additional information on the Eligibility Reporting Period. Included examples.
5.6	01/18/2017	Updated table on page 19
5.7	1/26/2017	Updated links to program year 2016
5.8	03/16/2017	Updated 2018 Hardship information
5.9	03/30/2017	Additional information for Modified Stage 2 and Stage 3 in 2017. Addition of CEHRT for CQMs and CEHRT requirements for 2017 and 2018. Removal of some non-pertinent information
6.0	07/27/2017	Added clarifying information for when a provider would like to return an incentive payment.
6.1	09/25/2017	Included IPPS Final Rule changes/updates. Added SIGMA related information.
6.2	02/01/2018	Clarification to "No Cost Encounters". Removal of the Medicare Alternate Attestation option as this is no longer available starting with program year 2017.
6.3	04/09/2018	Additional clarification to "No Cost". Included additional clarification on the maximum amount of incentive money an EP may receive.
6.4	09/06/2018	Name updated from Medicaid Electronic Health Record (EHR) Incentive Program to Medicaid Promoting Interoperability (PI) Program. Dates, FAQ, links updated

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 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 Health and Human Services (MDHHS) will work closely with federal and state partners to ensure the Michigan Medicaid Promoting Interoperability 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 Promoting Interoperability 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 several 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?
- How do you determine Medicaid eligible patient volume?
- Are you non-hospital based?

- 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 is meaningful use (MU)?
- How do I register for the Michigan Medicaid Promoting Interoperability 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.

Are you one of the eligible professional (EP) 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 is determined by location only. For an individual location to be considered PA-Led, one (or more) of the following **MUST** apply:
    - When a PA is the clinical or medical director at a clinical site of practice;
    - When a PA is the owner of an RHC;
    - When a PA is the primary provider in a clinical site of practice. A "primary provider" must meet at least one of the following:
        - When there is a part-time physician and a full-time PA, the PA will be considered as the primary provider. This must be substantiated through an auditable data source.
        - When there are multiple providers, at least 1-PA needs to have more encounters during the Eligibility Reporting Period than the physician(s). This encounter data will be determined using the Eligibility Reporting Period and encounters will be assigned based on the rendering NPI.

In the first example, PA-1 sees 25% of the encounters during the reporting period. Since this is more than any other MD/DO, this FQHC/RHC would be considered PA-Led.

Provider at a FQHC or RHC:		Percentage of Encounters:
Full time	PA-1	25
Full time	PA-2	22
Full time	MD-1	24
Full time	DO-2	14
Part time	MD-3	10
Part time	CNM-1	5

In the following example, this location would **NOT** be considered PA-Led. Although collectively the PAs see more encounters than the Physicians, there is no 1-single PA that sees more encounters than the MD or DO.

Provider at a FQHC or RHC:		Percentage of Encounters:
Full time	PA-1	23
Full time	PA-2	21
Part time	PA-3	11
Full time	DO-1	30
Part time	MD-2	15

Once it has been determined that an FQHC/RHC is PA-Led, additional PAs practicing at the same location in question can also apply for incentives as well. (Assuming they have met all of the other requirements for participation in the Medicaid Promoting Interoperability Program.)

Guidance from CMS says that, "A claim that a PA leads a FQHC or a RHC should be so clearly substantiated it would be hard to contest the claim, since by default the Physician is expected to be the lead."

How do you determine Medicaid eligible patient volume?

Medicaid eligible patient volume is determined by looking at encounter percentages during the *Eligibility Reporting Period*. The encounter percentage is determined by dividing the numerator (an EP's total *Medicaid Encounters)* by and the denominator (EP's *Total Encounters*).

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

Definitions of terms necessary to calculate Medicaid eligible patient volume:

Eligibility Reporting Period- A continuous 90-day reporting period during which the EP demonstrates that he or she has maintained an adequate Medicaid eligible patient volume to be eligible for the Medicaid PI Program. This continuous 90-day reporting period is within one of the two following time frames:

> ***Prior Twelve Months:*** This option is defined as the prior 365 days from the date of EP attestation/registration.
>
> ***Prior Calendar Year:*** This option is defined as January 1st through December 31st of the prior calendar year to the program year in question. *Example: When attesting to Program year 2015, the Prior Calendar Year would be January 1, 2014 through December 31, 2014.*

Points of Consideration for the Eligibility Reporting Period:

- When choosing Prior Calendar Year, the start date and end date of the Eligibility Reporting Period must be during the prior year and can't span across two calendar years.
- When choosing Prior Twelve Months, it is possible for the consecutive 90 day Eligibility Reporting Period to span between two calendar years, if attesting during a tail period. (The tail period is a period of time during the following calendar year when providers can attest before the deadline.)
    - *Example: Program year 2015 starts on 1/1/2015 and ends on 12/31/2015. Providers could attest to a 2015 registration during the tail period which is in 2016. Provider "A" attests to her first year (2015) of participation on 2/1/2016 and chooses an Eligibility Reporting Period of 11/01/2015-01/29/2016. Please note that this is different from a Meaningful Use Reporting Period which cannot span 2 calendar years.*
- Eligibility Reporting Periods can't overlap from one year to the next. No dates during an eligibility period may be "re-used" in subsequent program years.
    - *Example: Provider "A" in the example above received her incentive payment for program year 2015. For program year 2016, the eligibility period can't overlap the dates used earlier of 11/01/2015-01/29/2016.*
- If a group of providers have attested to a program year using the organization's group NPI for a given program year (i.e. used the Group Proxy Option), and hire additional providers that will register and attest in a subsequent year, the new providers added to the group can't use dates that overlap the previous year's Eligibility Reporting Period since they will be attesting as part of the same organization NPI which have already used the dates in question.
    - *Example: Providers "B", "C", and "D" attested in 2015 using organizational NPI "1111111111". For program year 2016, providers "E" and "F" have started working at the practice and will attest using the same organizational NPI of "1111111111". Even though providers "E" and "F" never attested before they will not be allowed to attest using any part of the Eligibility Reporting Period used previously by their new colleagues for program year 2015. If, however, providers "E" and "F" started working at the practice during 2015, they would be able to attach themselves to the*

Eligibility Reporting Period attested to by providers "B", "C", and "D" and also attest for 2015 by that program year's attestation deadline (typically at least 60 days into the next calendar year).

- Providers need to be aware of "unavailable dates" if they choose to attest to a program year during that program year's tail period.
    - *Example: Provider "G" is attesting to program year 2015 on 2/28/2016, during the tail period. He wants to use an Eligibility Reporting Period of 1/1/2015-3/30/2015. He will not be able to use that eligibility period because attesting on 2/28/2016 using the "Prior Twelve Months" option only goes back 365 days from the date of attestation (not all the way back to 1/1/2015). Using the "Prior Calendar Year" option would only allow him to use dates between 1/1/2014 through 12/31/2014. In this example, the dates of 1/1/2015 through 2/28/2015 would be "unavailable dates".*

***Medicaid Encounters**:* 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.

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.

Any encounter where services were provided to a patient enrolled under one of the XIX or XXI Funded Programs should be included in the numerator of the eligible patient volume calculation.

Starting January 1, 2016, Children's Health Insurance Program (CHIP) encounters (known in Michigan as MiChild), may now be counted as Medicaid encounters for all EPs, not just those practicing at an FQHC/RHC using Needy Individual Encounters. All providers should include MiChild encounters in their Medicaid Encounters.**Please note: Providers attesting at an FQHC/RHC-should no longer include MiChild encounters in their Needy Individual encounters total and only account for them in their Medicaid Encounter totals to ensure these encounters are not duplicated.**

The following link will take you to a list of benefit plans along with their Funding Source (5th Column). Please reference this list when looking for those plans that are either Title XIX or XXI:

http://www.michigan.gov/documents/mdch/Benefit_Plan_Table_293077_7.pdf ** Please note that there may be some Benefit Plans listed within this chart that have a funding source OTHER THAN XIX and XXI.

The following types of encounters can be counted as Medicaid encounters as long as the patient was enrolled in Michigan Medicaid on the date of service. Multiple Medicaid encounters for the same patient, on the same day, count as only one encounter.

"No-Cost" Encounters: Are eligible encounters that Medicaid did not pay for, specifically:

- Claims denied because service limits are maxed out
- Claims denied because the service is not covered under Medicaid
- Claims denied because another payer's payment exceeded the Medicaid amount
- Claims denied for failure to submit in a timely manner
- Pre/post-natal care and/or surgery and surgery post-op where multiple visits are bundled into a single delivery payment (each visit is considered an encounter) please see "Global Billing"
- A Medicaid encounter that was NOT-BILLED because the claim was paid entirely by another insurance

****Please note, claims that are paid at $0.00 are NOT considered "No-Cost", and should be considered a regular Medicaid Encounter.**

"Global Billing" Encounters: This is an example where not every payer pays for the same care in the same way. This is 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". These encounters should be included in the "No-Cost" encounters described earlier.

"Needy Individual" Encounters: These encounters can only be included for those EPs attesting as part of an FQHC/RHC and would like to include them.

> ***"Charity Care" Encounters:*** A Charity Care encounter is a fee-for-service encounter provided for which no payment is received. A patient, who is billed for a service and does not pay, and the service is later written off, does not count as charity care.
>
> ***"Sliding-Fee" Encounters:*** A Sliding Fee Scale encounter is a fee-for-service encounter provided at a reduced charge based on the patient's income.
>
> ***MiChild Encounters:*** ***Since all providers can now use MiChild encounters, please do not include MiChild encounters as part of the Needy Individual Encounter totals. Please include these in the Medicaid Encounter total.***

Total Encounters*:* All encounters for all payers where a medical service is rendered to an individual on a date falling within the 90-day Eligibility Reporting Period. **Multiple encounters for the same patient, on the same day, count as only one encounter.**

Are you non-hospital based?

Non-hospital based is currently defined as a medical professional who provides less than 89.5% of their encounters in a hospital/ER setting during the Eligibility Reporting Period. *(This percentage has been updated to 89.5% beginning with program year 2016 so that the rounding of percentages is consistent across all scenarios)*

EPs must be non-hospital based. The data used to populate the numerator and denominator is captured during the *Eligibility Reporting Period*. This is determined by looking at the numerator (an EP's *total hospital and ER encounters)* divided by the denominator (an EP's *total encounters* including hospital encounters).

$$\frac{\text{Total Hospital \& ER Encounters}}{\text{Total Encounters}}$$

Definition of terms for calculating non-hospital based status:

Eligibility Reporting Period- A continuous 90-day reporting period during which the EP demonstrates that he or she has maintained an adequate Medicaid eligible patient volume to be eligible for the Medicaid PI Program. This continuous 90-day reporting period is within one of the two following time frames:

> ***Prior Twelve Months:*** This option is defined as the prior 365 days from the date of EP attestation/registration.
>
> ***Prior Calendar Year:*** This option is defined as January 1st through December 31st of the prior calendar year to the program year in question. *Example: When attesting to Program year 2015, the Prior Calendar Year would be January 1, 2014 through December 31, 2014.*

Hospital & ER Encounter*:* An encounter that 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 (POS) code 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. Hospital and ER 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.

Total Encounters*:* All encounters for all payers where a medical service is rendered to an individual on a date falling within the 90-day Eligibility Reporting Period. **Multiple encounters for the same patient, on the same day, count as only one encounter.**

Special Consideration for hospital-based EPs*:*
EPs who **are** considered hospital based, but 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.

Does your Medicaid 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 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% patient volume is required. This would include the Medicaid encounters plus the Needy Individual encounters - (charity care, sliding fee).

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 PI 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.

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

A NP, PA, CNM, or resident 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 PI Program is for an individual EP. However, one concession has been made to help those EPs working within a group, called the "Group Proxy Option". An EP registering using this option would then use the **entire clinic or group practices' eligible patient volume** as opposed to their 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.

When registering using the Group Proxy Option, multiple encounters on the same day, seen by different EPs within the group, are only counted as **one encounter**.

If an EP works both in a clinic using the Group Proxy Option as well as another outside clinic, then the clinic/practice level encounter data needs to include **only** those encounters associated with the clinic/practice using the Group Proxy Option. Any encounters seen by an EP at a location other than the one using the Group Proxy Option should **NOT** be included.

It is **not an option** to include managed care panel-assigned patients when using the Group Proxy Option.

Note: New EPs, recently joining the group, can also use the group proxy option, even if they were not with the practice during the 90-day Eligibility Reporting Period. They must meet all other eligibility requirements and be associated with the practice/group in the CHAMPS Provider Enrollment subsystem at the time of attestation.

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 eligibility 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 Reporting 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 Reporting 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

A site/location must have been granted a status of either an FQHC or RHC prior to the first day of a reporting period and maintain that status throughout the whole reporting period in order for a provider to attest at an FQHC or RHC.

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. (Details on these types of encounters can be found earlier in this guide):

- 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 PI 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.

Eligible patient volume using needy individual encounters

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

$$\frac{\text{Medicaid Encounters + Needy individual encounters}}{\text{Total patient encounters}}$$

Encounters must fall within the 90-day Eligibility Reporting Period.

What is Certified Electronic Health Record Technology (CEHRT)?

To qualify for the Medicaid PI 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.

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.

Products can be searched using the following link https://chpl.healthit.gov/#/search. Note: this link is subject to change but the CHPL will always be available from the ONC's main page at https://www.healthit.gov/.

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

Certified EHR Technology requirements:

For program year 2018, EPs have the choice of either attesting to Modified Stage 2 or to Stage 3. The CEHRT you have, will play a role in which option you can chose to attest to.

2018 Program Year:

- EPs attesting to Modified Stage 2 in 2018 will require either a 2014 CEHRT, a 2015 CEHRT, or a 2014/2015 hybrid CEHRT.
- EPs attesting to Stage 3 in 2018 will require either a 2014/2015 hybrid CEHRT or a 2015 CEHRT.

Starting with program year 2019, all providers will need to have and use a 2015 CEHRT.

Providers will have the ability to use a second certified EHR technology for their Clinical Quality Measures (CQMs). The CEHRT for the CQMs will be populated from the information entered at the federal level. If using a second (different) CEHRT for CQMs, providers will be able to edit the pre-populated CEHRT number during the registration process. The use of a second (different) certified EHR technology is optional.

What is Meaningful Use (MU)?

Meaningful Use is using certified electronic health record technology to: Improve quality, safety, efficiency, and reduce health disparities. Engage patients and family. Improve care coordination, and population and public health. Maintain privacy and security of patient health information.

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.

Originally MU had three different stages.

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

As the program has evolved CMS has modified these three stages to also include “Modified Stage 2”:

- Beginning in program year 2015 and continuing through program year 2018, the Centers for Medicare & Medicaid Services (CMS) released final rules that simplify requirements and add new flexibilities for providers to make, electronic health information available when and where it matters most and for health care providers and consumers to be able to readily, safely, and securely exchange that information.

- CMS evaluated the current programs and identified areas where modifications could be made to align with the long-term vision and goals for Stage 3. CMS restructured the objectives and measure of the PI Programs in 2015 through 2018 to align with Stage 3. These modifications will be summarized below both for 2015 through 2018 as well as for Stage 3.

MU/PH & CQM Reporting Period

MU Reporting Periods are any continuous period of time from 90 days up to a full calendar year. MU Reporting Periods must fall within the calendar year, i.e. starting at the earliest on January 1 and ending at the latest on December 31. MU & CQM Reporting Periods can’t span across 2 calendar years.

The MU Reporting Period is a continuous period during which the EP successfully demonstrates meeting MU objectives. The CQM reporting period is a continuous period during which the EP is gathering data on various Clinical Quality Measures. Neither the MU or CQM reporting period

should be confused with the Medicaid Eligibility Reporting Period. The breakdown of each year's MU reporting period and CQM reporting period, for 2018 is as follows:

- For Program Year 2018, an EP attesting to either Modified Stage 2 or Stage 3 may report between **90 days and a full calendar year** of MU **and a full calendar year** of CQM data.
- For providers attesting to their first year of MU, regardless of the program year, an EP may report between **90 days and a full calendar year** of MU and between **90 days and a full calendar year** of CQM data.

Note: Program years do not have to be consecutive and EPs may skip years.

For example, let's say an EP registers under AIU in 2016 and receives his or her *first*-year incentive payment. To receive the *second*-year payment for 2017, the EP would have to wait at least 90 days after January 1, 2017 in order to demonstrate MU for 90 days within 2017 (a requirement for the second-year payment) before attesting. To receive the *third*-year payment (nominally, the 2018 payment), the EP would have to demonstrate MU for 90-365 days for MU objectives and 365 days of CQM data, and then attest in early 2019. To receive the *fourth*-year payment (nominally, the 2019 payment), the EP would then have to demonstrate MU for 90-365 days and CQM for a full year (proposed).

Skipping a year of participation for Medicaid Providers

Medicaid providers are not required to participate in consecutive years of the Medicaid PI Program. Thus, unlike Medicare providers, Medicaid providers who skip years of participation will resume their meaningful use progression where they left off. For example, if a Medicaid EP began the program in 2016 in which they attested for AIU, attested for MU in 2017 and then decided to skip 2018, they would come back in the program and attest to MU in 2019.

Program Year 2016 is the last year a provider may start the Medicaid PI Program. Continuous participation in all subsequent program years will need to be completed to capture the full 6-years of incentive payments (2016-2021) as the program is set to end with program year 2021. Providers may still skip a year of participation, but they will lose that year's incentive payment.

Patient Encounter requirements to meet Meaningful Use

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. *When entering this information into your registration, please round the percentage to the nearest whole number*.

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

EPs are required to attest to a single set of objective and measures referred to as either Modified Stage 2 or Stage 3. This now replaces the core and menu objectives structure of previous stages.

Objective & Measures for Modified Stage 2 in 2018

The following link contains the specification sheets for each of the Modified Stage 2 objectives: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_ModifiedStage2_2018.pdf

1. **Protect electronic protected Health Information (ePHI)***:* Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

2. **Clinical Decision Support (CDS):** Use clinical decision support to improve performance on high-priority health conditions.

3. **Computerized Provider Order Entry (CPOE):** Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

4. **Electronic Prescribing (eRx):** Generate and transmit permissible prescriptions electronically (eRx).

5. **Health Information Exchange:** The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

6. **Patient-Specific Education:** Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

7. **Medication Reconciliation:** The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

8. **Patient Electronic Access:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

9. **Secure Electronic Messaging**: Use secure electronic messaging to communicate with patients on relevant health information.

10. **Public Health Reporting:** The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Clinical Quality Measures

EPs will have to report on a total of six (6) Clinical Quality Measures. The National Quality Strategy (NQS) domains, which represent the US Department of Health and Human Services' NQS priorities for

health care quality improvement will remain, but there is no longer a minimum domain requirement.

The 6 NQS domains are:

1) Person and Caregiver – Centered Experience and Outcomes
2) Patient Safety
3) Communication and Care Coordination
4) Community/Population Health
5) Efficiency and Cost Reduction
6) Effective Clinical Care

Providers will have to choose and indicate what their MU-Clinical Quality Measures Reporting Period is. This reporting period is independent of the MU-Objective and MU-Public Health Measures and does not need to be the same.

Providers will have the ability to use a second certified EHR technology for their Clinical Quality Measures (CQMs). The CEHRT for the CQMs will be populated from the information entered at the federal level. If using a second (different) CEHRT for CQMs, providers will be able to edit the pre-populated CEHRT number during the registration process. The use of a second (different) certified EHR technology is optional.

The start date for the CQM reporting period can be no earlier that January 1st and the end date no later than December 31st of the calendar year in question.

Objective & Measures for Stage 3 in 2018

The following link contains the specification sheets for each of the Stage 3 objectives: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_Stage3_2018.pdf

1. **Protect electronic protected health information (ePHI)***:* Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.

2. **Electronic Prescribing (eRX):** Generate and transmit permissible prescriptions electronically (eRx).

3. **Clinical Decision Support (CDS):** Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

4. **Computerized Provider Order Entry (CPOE):** Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who

can enter orders into the medical record per state, local, and professional guidelines.

5. **Patient Electronic Access:** The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

6. **Coordination of Care:** Use CEHRT to engage with patients or their authorized representatives about the patient's care.

7. **Health Information Exchange:** The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

8. **Public Health Reporting:** The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Clinical Quality Measures

EPs will have to report on a total of six (6) Clinical Quality Measures. The National Quality Strategy (NQS) domains, which represent the US Department of Health and Human Services' NQS priorities for health care quality improvement will remain, but there is no longer a minimum domain requirement.

The 6 NQS domains are:

1) Person and Caregiver – Centered Experience and Outcomes
2) Patient Safety
3) Communication and Care Coordination
4) Community/Population Health
5) Efficiency and Cost Reduction
6) Effective Clinical Care

Providers will have to choose and indicate what their MU-Clinical Quality Measures Reporting Period is. This reporting period is independent of the MU-Objective and MU-Public Health Measures and does not need to be the same.

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 PI incentive.

What do the numerators and denominators mean in objectives that are required to demonstrate MU for the Medicaid PI Program?

Certain objectives require the collection of data to calculate a percentage, which is the basis for determining if a 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 MU 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 or because the action related to the objective is not relevant. For these objectives, the denominator is based on actions related to patients whose records are maintained using CEHRT.

How should an EP that sees patients in multiple practice locations determine their MU objectives and measures?

EPs practicing in multiple locations should reference the following information sheet from CMS which outlines the requirements in more detail. A summary of these requirements is noted below the link:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016_EPMultipleLocations.pdf

EPs should look at the measure of each MU objective to determine the appropriate calculation method for individual numerators and denominators.

For objectives that require a simple count of numerators and denominators, 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", 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.

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 objectives 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 "Protect Patient Health Information" an EP must be able to answer yes for all CEHRT locations. Meaning, all CEHRT locations should have completed and documented a security risk analysis.

How do I register for the Michigan Medicaid PI Program?

An EP must register with the CMS registration and attestation system (CMS RAS) at the federal level to start his or her registration process. This would have been completed during the first year of participation with the Medicaid PI program. If any of the information entered at the RAS site changes, the EP **must** re-visit the RAS site to update this information.

Federal level registration

CMS RAS is available at https://ehrincentives.cms.gov/hitech/login.action.

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: https://michiganhealthit.org/wp-content/uploads/CMS-RAS-EP-Guide.pdf

Additional items prior to state level registration

An invitation letter for state level registration will be emailed 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.

State level registration

After verification that all of the information entered at the CMS RAS is current, an EP must complete his or her registration at the state level. 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 their registration is made available 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 a PI 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 PI 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 PI 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. 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 PI 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 PI 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:

- SIGMA Vendor ID
- EP 90-day Eligibility Reporting Period – along with details of how this was calculated. Starting January, 2018 providers will be asked to enter this information in the survey.
- 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 and POS code.
  - 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 and the individual NPIs 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, 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
- 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
- MU, Public Health, and CQM Data
- Contact e-mail (if not provided at federal level)

A detailed guide for state level registration is available at: https://michiganhealthit.org/wp-content/uploads/EP-State-Level-Registration-Guide.pdf

What incentives do I receive after all this work?

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 total incentive amount. No incentive payments will be made for program years after 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 PI payment of $42,500 over a six-year period.

Maximum Incentive Payment

It is possible for an EP to exceed the maximum incentive payment amount of $63,750.00 under the Medicaid program by switching programs at the right time and successfully attesting to 6 program years.

If an EP attested to the Medicare program for years 1 & 2, which resulted in the maximum payment amount for each year of $18,000.00 and $12,000.00 respectfully; then attested to the Medicaid program with an incentive payment of $8,500.00 for each year 3-6, this would result in a total incentive amount that exceeds the $63,750.00 maximum. Health Care Physician Shortage Area (HPSA) bonus payments that were issued under the Medicare program are also factored in to the maximum incentive payment allowed. Per CMS and the final rule, no EP can receive a total

cumulative incentive payment amount greater than $63,750.00. Should this apply to an EP, the program year 6 payment amount would be adjusted so that the total incentive payments (including any HPSA bonus payments) would not exceed the maximum.

Medicare Payment Adjustments, Reconsideration Form, & Hardship Information

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible professionals who were not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare PI Programs. These payment adjustments will be applied beginning on January 1, 2015, for Medicare eligible professionals.

Medicaid eligible professionals who could only participate in the Medicaid Program and did not bill Medicare are not subject to these payment adjustments.

Payment Adjustments for Medicare Eligible Professionals

Medicare eligible professionals who were not meaningful users will be subject to a payment adjustment beginning on January 1, 2015.

Payment adjustments related to the Meaningful use program (program years 2013-2016 related to payment year 2015-2018) will be applied to the Medicare Physician Fee Schedule (PFS) amount for covered professional services furnished by the eligible professional during the year (including the fee schedule amount for purposes of determining a payment based on the fee schedule amount).

Eligible professionals receive the payment adjustment amount that is tied to the year that they did not demonstrate meaningful use ***(e.g., A health care professional who is eligible for a payment adjustment in 2018 will receive a 4% PFS reduction regardless if this is their first of fourth year not demonstrating meaningful use)***. 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 calendar year in question (please see "Payment Adjustment & Attestation Deadline" table below for examples).

Payment adjustments once associated to the Meaningful Use program are now part of the Quality Payment Program (QPP).

Timeline for Eligible Professionals (other than Hospital-Based) to avoid Payment Adjustment

Payment Adjustments & Attestation Deadline			
Program Year 2015			
	Meaningful Use (MU) Reporting Period	**Avoid a Medicare Payment Adjustment in CY 2016?**	**Avoid a Medicare Payment Adjustment in CY 2017?**
NEW MU Participants (NO prior successful MU attestation)	**90-day** MU Reporting Period in CY 2015	Yes, if EP successfully attests by **April 30, 2016**	Yes, if EP successfully attests by **April 30, 2016**
RETURNING MU Participants (Prior successful MU attestation)	**90-day** MU Reporting Period in CY 2015	NO	Yes, if EP successfully attests by **April 30, 2016**
Program Year 2016			
	Meaningful Use (MU) Reporting Period	**Avoid a Medicare Payment Adjustment in CY 2017**	**Avoid a Medicare Payment Adjustment in CY 2018**
NEW MU Participants (NO prior successful MU attestation)	**90-day** MU Reporting Period in CY 2016	Yes, if EP successfully attests by **October 1, 2016**	Yes, if EP successfully attests by **February 28, 2017**
RETURNING MU Participants (Prior successful MU attestation)	**Full calendar year** of MU reporting in CY 2016	NO	Yes, if EP successfully attests by **February 28, 2017**
Program Year 2017			
	Meaningful Use (MU) Reporting Period	**Avoid a Medicare Payment Adjustment in CY 2018**	**Avoid a Medicare Payment Adjustment in CY 2019**
NEW MU Participants (NO prior successful MU attestation)	**90-day** MU Reporting Period in CY 2017	Yes, if EP successfully attests by **October 1, 2017**	Refer to MACRA/MIPS for details

If a provider is the type of provider that is subject to the payment adjustment, there are only four ways to become exempt from a payment adjustment:

- Attest to MU with Medicare
- Attest to MU with Medicaid
- Submit an Alternate Medicare Attestation (see below)
- Apply for, and be granted a hardship exception.

For Medicaid PI participants, if you are receiving a Medicare payment adjustment and you believe this is being done in error, you may contact the State of Michigan by sending a detailed email to MDHHS-EHR@michigan.gov and a State employee will investigate your questions.

Frequently Asked Questions (FAQs)

To help health care providers understand the program, CMS has compiled a comprehensive list of

frequently asked questions (FAQs) and answers. To access list, please follow this link:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html

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 an incentive payment. Any provider's failure to retain the requisite documentation for review by the MDHHS 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.

Uploading supporting documentation into EHR MIPP

Providers can upload supporting documents directly into EHR MIPP. There is a file limit size of 5MB per file upload. The acceptable file types that can be uploaded include:

.txt	.html	.bmp	.htm	.ps	.zip
.doc	.xml	.dat	.jpe	.rtf	
.pdf	.docx	.eps	.jpeg	.tif	
.xls	.xlsx	.gif	.jpg	.tiff	
.ppt	.bm	.gzip	.prd	.tst	

Switching States

EPs may 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 PI Program will be notified of the change. When the switch is made, the EP enters the Michigan Medicaid PI 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.

Recovering/Returning an Incentive Payment

The following outlines the procedure an EP should follow if the EP has determined that they should not have received an Incentive payment, after a payment has already been made.

The EP should contact MDHHS by sending an email to the MDHHS-EHR@michigan.gov inbox notifying us that you would like to return an Incentive payment. Please make sure that the email contains the following information: name(s) and NPI(s) of the individual(s) involved, the payment year and program year for which the money is being returned, the tax ID and SIGMA vendor ID in which the payment was made to, and the method in which you would like to return the funds (See OPTION 1 and OPTION 2 immediately below). This will allow MDHHS-EHR staff to enter the appropriate

information in the system, and follow up with you with additional steps that may need to be completed.

There are two options in which the funds can be recovered.

OPTION 1: Recovery of an Incentive Payment from future Medicaid Payments
If this option is chosen, a recovery will be entered into the eMIPP system and the amount of money to be recovered will be withheld from any future Medicaid payments issued until the full amount of the incentive payment is recovered. No further action is required from the provider.

OPTION 2: Sending in a check to MDHHS

If this option is chosen, an EP would send to MDHHS-Accounting Division a letter and a separate check for each incentive payment made. Please note that if an incentive payment is being returned for multiple program years or for multiple providers, a separate check would need to be issued for each transaction.

Example 1: "Provider Smith" determined that he didn't meet the Meaningful Use requirements for program years 2012 and 2013 for which he received an incentive payment of $8,500.00 for each year and would like to voluntarily return these payments. "Provider Smith" would need to send back two separate checks. One check would be for year 2012 and the other would be for year 2013, each in the amount of $8,500.00.

Example 2: "Health Clinic A" determined that all five of the EPs that attested for program year 2012 didn't meet the Meaningful Use requirements and want to voluntarily return the $8,500.00 incentive payments for each of the five providers. "Health Clinic A" would need to send back five separate checks, each in the amount of $8,500.00.

When sending in a check, **DO NOT send back a check until someone from the Medicaid PI program has followed up with you.** Failure to do so, may result in the accounting department returning the check back to you. You will be given specific information from the MDHHS-EHR team that will need to be included in the letter being sent.

The letter(s) and check(s) would then be sent back to:

DHHS
Accounting Division
PO Box 30437
Lansing, MI 48909

Trouble shooting tips while using eMIPP

If you are experiencing any issues while in eMIPP the easiest tip to try first would be to

clear/reset your browser by holding Ctrl + F5. If that didn't work, try Ctrl + R, then press F5.

If you receive a "Stack Trace" error: first try the steps outlined immediately above. If this doesn't correct the problem and you receive a "Stack Trace" error again, click "click to view stack trace", then copy and paste the entire text into a word document. Contact the State by sending an email to the MDHHS-EHR@michigan.gov. Include some background information, your NPI and attach the word document with the Stack Trace error to the email. By capturing this information it will help the developers determine what the issue is and find a solution.
The table below lists some of the more common errors providers experience during registration. If you come across any of these errors, please follow the steps outlined in the table below to remedy the issue.

Type of Error / Error Message	Reason for the error	Steps you should take to correct the problem(s)
Confirmation ID not found	You have entered the wrong confirmation ID.	Re-enter the confirmation ID. If this issue persists, contact CMS to verify your ID.
Inactive enrollment status	Your current CHAMPS provider enrollment status is inactive.	Contact Provider Enrollment at 1-800-292-2550 to verify your enrollment status.
Inactive License	Your license is inactive in CHAMPS.	Contact Provider Enrollment at 1-800-292-2550 to update your license.
No Associated payee tax ID	You have no payee Tax ID (or SSN) in CHAMPS.	Contact Provider Enrollment at 1-800-292-2550 and provide a payee tax ID.
Payee Tax ID address missing	You have not established a pay to address for this tax ID (or SSN).	Contact Provider Enrollment at 1-800-292-2550 and provide an address for this tax ID (or SSN).
No W-9 on file	You have not provided an updated W-9.	Contact Provider Enrollment at 1-800-292-2550 and provide an updated W-9.
Registration is currently in progress	You have updated information at CMS, but have not submitted the updated information.	Go to the CMS website and verify the accuracy of the information. Be sure to submit the changes and agree/disagree to the disclaimer on the following page. Upon submission, wait 24 hours and then try to login to the EHR module again.
Your Registration has already been submitted for State review	You have already completed and submitted a registration for the current program year.	Your registration is under review by the State. No further action is required. If more information is needed, you will be contacted.
No group associations found	The EP is not associated within CHAMPS to the group NPI.	Contact Provider Enrollment at 1-800-292-2550 and request to have the association created prior to attestation.