Medicaid EHR
INCENTIVE PROGRAM

Eligible Professional's Guide to the Michigan Medicaid EHR Incentive Program 2015

Version 4.3, Released 06/11/2015

MDHHS
Michigan Department of Health & Human Services

Table of Contents

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 Health and Human Services: 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. **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/mailinglist.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.
3.6	5/22/2014	Clarification to the Meaningful use stages and reporting periods.
3.7	7/10/2014	Updates to the Title XIX and XXI Programs.
3.8	9/25/2014	Clarification on the Meaningful Use Tables and Medicare payment adjustments. Addition of CMS 2014 CEHRT Flexibility Rule information.
3.9	10/30/2014	Clarification on skipping years and switching programs. Updated information and links for the Hardship Exception.
4.0	12/30/2014	Updated information on Medicare Payment Penalties. Replacement of Title XIX & XXI programs with a link.
4.1	03/09/2015	New Medicare Payment Adjustment and Hardship timeline table added.
4.2	04/02/2015	Clarification on "no-cost" encounters. Upload document file types.
4.3	06/11/2015	Rounding of percentages when calculating the 50/80 rule. Updating of the Medicare Hardship Exception links.

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 Health and Human Services (MDHHS) 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.

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

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.

"No-Cost" Encounters are those eligible encounters that Medicaid did not pay for, or for which there was a "zero-payment". The following are some examples:

- 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)
- A Medicaid encounter that was NOT-BILLED because the claim was paid entirely by another insurance

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 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.

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.

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, 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 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.

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 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 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

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:

- 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.

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

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 - 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

** Stage 2, as part of the Certified Electronic Health Record Technology (CEHRT) Flexibility Rule that was released August 29, 2014, has been extended through 2016. The earliest a provider can begin Stage 3 is now 2017.

Start in 2011 with AIU without skipping years.		
Participation Year	**Amount**	**Stage**
1 (2011)	$21,250	AIU
2 (2012)	$8,500	Stage 1 Year 1
3 (2013)	$8,500	Stage 1 Year 2
4 (2014)	$8,500	Stage 2 Year 1
5 (2015)	$8,500	Stage 2 Year 2
6 (2016)	$8,500	Stage 2 Year 3 (Stage 3 does not begin now until 2017)

Start in 2014 with MU without skipping years.		
Participation Year	**Amount**	**Stage**
1 (2014)	$21,250	Stage 1 Year 1
2 (2015)	$8,500	Stage 1 Year 2
3 (2016)	$8,500	Stage 2 Year 1
4 (2017)	$8,500	Stage 2 Year 2
5 (2018)	$8,500	Stage 3 Year 1
6 (2019)	$8,500	Stage 3 Year 2

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. (However, if CMS post-pones the start of a new stage then it may be possible to have an additional year within a stage.)

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. * Please see "NPRM – 2014 CEHRT Flexibility Rule" for additional information regarding 2014 CERHT for Calendar Year 2014

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.

NPRM – 2014 CEHRT Flexibility Rule

CMS published this final rule on August 29 with an effective date of October 1, 2014. This rule addresses the following:

- It allows provider to meet meaningful use (MU) with electronic health records (EHRs) certified to the 2011 or the 2014 edition criteria, or a combination of both editions for an EHR reporting period in 2014.
    - The flexibility rule is only available to providers who are UNABLE TO FULLY IMPLEMENT a 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability.
    - First year Medicaid providers attesting to Adopt, Implement, or Upgrade (AIU) for 2014 MUST USE a 2014 Edition CEHRT.
    - First year Medicaid providers attesting to Meaningful Use (MU) for 2014 may take advantage of this flexibility ruling.
    - This flexibility rule DOES NOT ALLOW:
        - Providers to avoid Medicare payment penalties.
        - Objectives and measures to be mixed and matched.
- It requires provider to report using a 2014 Edition CEHRT for reporting periods in 2015.
- It also extends Stage 2 through 2016.
    - As an example, a Medicaid provider who started the program in 2011 and attested for AIU would essentially have three years at Stage 2; 2011- AIU, 2012- Stage 1 Year 1, 2013-Stage 1 Year 2, 2014 – Stage 2 Year 1, 2015 – Stage 2 Year 2, 2016 – Stage 2 Year 3 (Before this extension the provider in this example would have started Stage 3 in 2016).

** In the event of a post-payment audit, providers taking advantage of the flexibility rule will need to provide proof from their vendor that they were not fully able to implement a 2014 edition CEHRT.

Tool available for clarification:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CEHRT_Rule_DecisionTool.pdf

Adoption, Implementation, Upgrading (AIU)

A Medicaid EP does not have to meet MU criteria in his or her first year of participation. Starting in 2014, a Medicaid EP will have the option of attesting to MU or AIU their first year. 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.
- Currently, subsequent payment years will require a full year of MU reporting. This is of course subject to change depending on future CMS guidance. 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.

Skipping a year of participation for Medicaid Providers

Medicaid providers are not required to participate in consecutive years of the Medicaid EHR Incentive 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 2012 in which they attested for AIU, attested for MU in 2013 (Stage 1 Year 1) and then decided to skip 2014 and 2015, they would come back in the program and attest to MU in 2016 which would be their Stage 1 Year 2. Please keep in mind that by not attesting to MU will subject you to the Medicare payment adjustments if you are a qualifying provider.

CMS's FAQ7737 https://questions.cms.gov/faq.php?id=5005&faqId=7737

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*.

Additionally, EPs must have 80% or more of their combined unique patients in locations having CEHRT, maintained in said CEHRT. *When entering this information into your registration, please round the percentage to the nearest whole number*. 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 interation 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 regsitry		Y	

Note:

- In Stage 1, EPs must select one of the public health menu measures, as indicated by the asterisk, to complete attestation. If you can claim exclusion to either one of the public health measures; you must follow the required steps for the alternate public health measure and attest to it. Only the following providers may claim exclusion to both MCIR and MSSS: dentist & dental surgeons, optometrists & ophthalmologists, podiatrists, and certified nurse midwives. 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/.

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.

Medicare payment adjustments

Overview

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible professionals who are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs. These payment adjustments will be applied beginning on January 1, 2015, for Medicare eligible professionals. Medicaid eligible professionals who can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

Payment Adjustments for Medicare Eligible Professionals

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

This payment adjustment 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)***. Depending on the total number of Medicare eligible professionals who are meaningful users under the EHR Incentive Programs after 2018, the maximum payment

adjustment can reach as high as 5%. 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 below for examples).

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

EP payment adjustment year (calendar year)	Demonstrate MU during EHR reporting period 2 years prior to year of payment adjustment	or	For an EP demonstrating meaningful use for the first time in the year prior to the payment adjustment year, EHR reporting period is a continuous 90-day reporting period beginning no later than	or	Apply or otherwise qualify for an exception no later than
2015	CY 2013 (with submission no later than February 28, 2014).		July 3, 2014 (with submission no later than October 1, 2014).		July 1, 2014.
2016	CY 2014 (with submission no later than February 28, 2015).		July 3, 2015 (with submission no later than October 1, 2015).		July 1, 2015.
2017	CY 2015 (with submission no later than February 29, 2016).		July 3, 2016 (with submission no later than October 1, 2016).		July 1, 2016.
2018	CY 2016 (with submission no later than February 28, 2017).		July 3, 2017 (with submission no later than October 1, 2017).		July 1, 2017.
2019	CY 2017 with submission no later than February 28, 2018).		July 3, 2018 (with submission no later than October 1, 2018).		July 1, 2018.

Notes: (CY refers to the calendar year, January 1 through December 31 each year.)
The timelines for CY 2020 and subsequent calendar years will follow the same pattern.

Information taken directly from the Stage 2 Final Rule

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

- Attest to MU with Medicare
- Attest to MU with Medicaid
- Apply for, and be granted a hardship exemption. (See below)

Resources

For more information on EP payment adjustments, view the "Payment Adjustments and Hardship Exceptions Tip sheet for EPs," and the "How Payment Adjustments Affect Providers Tip sheet," 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 the following links:

General Information:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html.

Instructions:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipException2016_EP_Instructions.pdf

Individual Hardship Application:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipException2016_EP_Application.pdf

Multiple EPs Hardship Application:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/HardshipException2016_EP_Application_MultipleNPIs.pdf

The completed application and all supporting documentation must be attached to an email and sent to ehrhardship@provider-resources.com

As a last resort, this application and all supporting documentation can be submitted via fax to **814-456-7132**

Note: The following hardship applications indicate "Medicare"; CMS has instructed Medicaid EPs to use the same application.

Important dates for hardship exception can be found in the table above titled, "Timeline for Eligible Professionals (other than Hospital-Based) to avoid Payment Adjustment".

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 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	

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: 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. 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 can switch between programs only once after receiving their first incentive payment and the switch must occur prior to 12/31/2014 at 11:59PM (This has been extended to March 20, 2015 at 11:59PM EST). 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. When an EP switches programs, they are "placed in the payment year they would have been in had they begun in – and remained in – the program to which they switched."

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.