



# **Minnesota Electronic Health Record (EHR) Incentive Program (MEIP)**

## **MEIP Attestation Basics**

Updated January 2016

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## Section 1: Guidance for Eligible Professionals (EP)

### 1.1 Prerequisites for EPs Part I: Preparation and Registration with CMS

Prior to Minnesota EHR Incentive Program (MEIP) enrollment and attestation, determine if you have the information necessary to complete the initial registration with the Centers for Medicare & Medicaid Services (CMS). Follow these steps to determine registration eligibility:

1. Determine if you are potentially eligible to participate in the MEIP. Use the [CMS Eligibility Tool](#) to find out.
2. Confirm you have an individual National Provider ID (NPI) valid for participation in the MEIP. Note: The NPI must be an active Individual rendering provider NPI, not a group NPI.
3. Confirm you are enrolled in Minnesota Health Care Programs (MHCP). The enrollment linked to your NPI must be active and in good standing. If you are not enrolled in MHCP, or you are not in good standing in MHCP, you will not be allowed by rule to participate in the program.

#### **What if I am not currently enrolled in MHCP or have questions about my enrollment standing?**

Complete your Minnesota Medicaid enrollment first, prior to participating in the MEIP. Contact [MHCP Provider Enrollment](#) at (651) 431-2700; Toll-free line at (800) 366-5411; Fax at (651) 431-7462.

4. Confirm your NPI is enrolled in the MHCP system as an eligible provider type.

According to the CMS Final Rule and described in the Medicaid EHR Incentive Program and the Minnesota State Medicaid HIT Plan, eligible provider types for the Medicaid EHR Incentive Program are:

- Physicians
- Dentists
- Certified nurse-midwives
- Nurse practitioners. This includes clinical nurse specialists who meet the federal and MN state plan definition of nurse practitioners.
- Physician assistants practicing in federally qualified health centers (FQHCs), rural health centers (RHCs) or tribal or urban facilities which is led by a Physician Assistant.
- Optometrists

#### **What if I am not currently enrolled as an eligible provider type in MHCP?**

Complete a full enrollment with MHCP. This process includes validation of current certifications and licenses. Contact [MHCP Provider Enrollment](#) at (651) 431-2700; Toll-free line at (800) 366-5411; Fax at (651) 431-7462.

5. Confirm your electronic health record system is certified by the Office of the National Coordinator (ONC) for Health Information Technology. If you are currently adopting, implementing, upgrading, or actively using an EHR system, verify your EHR system is certified by ONC by performing a search on the [ONC EHR Certification](#) site.

#### **What if I do not have my EHR certification number at this time?**

Visit the ONC EHR certification site, search the site using the product name, vendor name or the certified health product list (CHPL) product number to verify the EHR certification number. You will be required to validate this number in the MEIP portal during your enrollment and attestation in order to meet program eligibility requirements and achieve payment.

6. Confirm your Payment Assignment  
Enter a payee during CMS registration. By rule, you may assign payment to yourself or to another entity such

as a facility or group. In order for the desired payee to be communicated from the CMS Registration and Attestation (R&A) system to MEIP, the following information is required:

- a. The payee NPI and payee tax identification number (TIN) or social security number (SSN) identified by you at the time of *CMS EHR Incentive Program registration* must be enrolled in MHCP. The payee NPI and payee TIN or SSN must match the MHCP enrollment data.

**Note:** When assigning a payee during CMS registration, enter an NPI and TIN for the clinic or an NPI and TIN or SSN for yourself. Do *not* enter a *clinic's* TIN and an *EP's* NPI. The payee information will not appear in MEIP if this occurs.

- b. The desired payee must have an active MHCP enrollment in good standing. If the payee NPI and payee TIN or SSN do not match an enrollment with MHCP, or the payee NPI and payee TIN or SSN matches an enrollment with MHCP which is not in good standing, the payee selection will not be allowed in MEIP during the attestation process.

#### **What can I do if my payee NPI and TIN combination is not known to MHCP?**

The provider may do one of the following:

- Choose a new payee NPI and payee TIN or SSN which is currently enrolled in MHCP; or
- Request the payee associated with the payee NPI and payee TIN or SSN complete a full enrollment in MHCP. Contact MHCP Provider Enrollment at (651) 431-2700; Toll-free line at (800) 366-5411; Fax at (651) 431-7462.

#### **What if my payee NPI and payee TIN or SSN is currently enrolled in MHCP, but is not in an active status or good standing?**

The provider may do one of the following:

- Choose a new payee NPI and payee TIN or SSN which is currently enrolled and in good standing in MHCP; or
- The payee may contact MHCP to discuss the standing of their enrollment. If you are currently enrolled but have questions about your enrollment standing, contact MHCP Provider Enrollment at (651) 431-2700; Toll-free line at (800) 366-5411; Fax at (651) 431-7462.

Note: Finalize MHCP enrollment with DHS and registration for the Medicaid incentive program at the CMS Registration & Attestation site before entering a MEIP attestation. The provider will not be able to complete the MEIP attestation process required to achieve payment until this process is finalized.

7. Registration transfer for participation in the MEIP  
Register for participation in the MEIP at the [CMS EHR Incentive Registration](#) website. If CMS accepts the registration, CMS will transfer your registration to the MEIP the next day. Registration transfers occur 7 days a week.

## **1.2 Prerequisites for EPs Part II: Preparing, Enrolling & Attesting for MEIP**

Upon receiving the CMS registration receipt, confirm the MHCP enrollment matches your registration NPI that is:

- Found in the MHCP system; and
- In good standing and not sanctioned in the MHCP system; and
- A provider type eligible to participate in the MEIP.

#### **How do I get help if an issue is found with my MHCP enrollment?**

For help with your MHCP enrollment, contact [MHCP Provider Enrollment](#) at (651) 431-2700; Toll-free line at (800) 366-5411; Fax at (651) 431-7462.

## How do I get help for questions related to MEIP enrollment?

For help with MEIP enrollment, contact the MEIP Business Services staff at [MN.Support@MN-MEIP.com](mailto:MN.Support@MN-MEIP.com) or call (855)-676-0366.

After successful registration with CMS and transfer of the registration profile, you will receive an email from the MEIP portal notifying you of MEIP's receipt of the registration information from the CMS R&A system and providing attestation access instructions.

1. Gather and prepare documentation that will be needed during the MEIP enrollment and attestation process. *Appendix A: MEIP Guidance on Supporting Documentation* provides prepayment supporting documentation information that you will be prompted to upload in support of your enrollment and attestation.

Note: Some prepayment supporting documents are required while others are situational. During your initial attestation submission, do NOT upload any documentation containing protected health information (PHI). If a prepayment verification requires additional supporting documentation which may include PHI, you will be contacted by Business Services staff or Department of Human Services (DHS) staff to submit more detail.

2. Complete your attestation in the MEIP. Providers will be required to enter responses to questions and attest to the following types of data:
  - a. Are you attesting as a pediatrician?
  - b. Are you attesting as part of an FQHC, RHC, tribal or urban facility?
  - c. Are you attesting as part of a group? If you choose to attest as part of a group, review and update your provider affiliations with MHCP. This allows MEIP to validate your patient volume and location history. MHCP Provider Enrollment staff require you use either the [Individual Practitioner – MHCP Provider Profile Change Form \(DHS-3535\)](#) or the [Organization – MHCP Provider Profile Change Form \(DHS-3535A\)](#) listed in the Enrollment Applications and Agreements section on the [MHCP Enrolled Providers](#) page to keep provider affiliations current. Use these forms to notify Provider Enrollment of any changes.
  - d. Confirm the payee selection
  - e. Attest to Medicaid patient volume (as described in the next section)
  - f. Validate the EHR certification number
  - g. Attest to meaningful use criteria, if necessary. See section 3. Meaningful Use Attestations for more information.
  - h. Sign the Legal Notice confirming attested data
  - i. Upload certified EHR system ownership documentation
  - j. Confirm and submit your attestation as complete
  - k. Acknowledge and agree with the terms of the Legal Notice

3. Prepayment review

Based on Minnesota EHR Incentive Program policy, every provider attestation receives a prepayment verification. You may be required to upload additional information to support the data entered during attestation.

4. Payment

The Minnesota EHR Incentive Program attempts to process payments within 45 days after the commencement of the prepayment review. The processing clock will begin with the start of a prepayment verification and will be reset if additional supporting documentation is requested by Business Services staff. Processing payments within 45 days after the initiation of the prepayment review is a target; the actual payment timing may vary based on provider responsiveness to prepayment review inquiries as well as the general program attestation

activity. To minimize delays, we encourage program participants to complete and submit attestations as early as possible based on program stage and the associated reporting windows.

Payments will be disbursed by DHS on a bi-weekly basis and will appear as a gross adjustment on your [remittance advice](#).1.3 Medicaid Patient Volume Calculation for EPs.

### **1.3 Medicaid Patient Volume Calculation for EPs**

This section provides clarification on the process used by MEIP to calculate Medicaid patient volume (MPV) based on the programs that meet the definitions for eligible encounters in the federal regulations.

#### **What is considered an encounter for the purposes of reporting patient volume in MEIP? What is considered a Medicaid encounter?**

In the most basic terms, an encounter is a visit to a professional in which the professional sees the patient. All encounters that fall into the reporting period constitutes the denominator.

Medicaid patient encounters are services provided on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero pay claims and encounters with patients in Title XXI funded Medicaid expansion. The Medicaid encounters that fall into the same reporting period are considered the numerator.

#### **Can all Medicaid encounters be included in the numerator?**

No, programs partially or fully funded by the Federal government can be included. State-only funded programs cannot be included in the numerator. The Minnesota health care programs include:

- Medical Assistance
- MinnesotaCare
- Minnesota Family Planning Program
- Home and community-based waiver programs
- Medicare Savings Programs

Visits that occur for participants actively enrolled in the following fee-for-service programs can be included in the MPV numerator:

- MA (Medicaid)
- EH (Medicaid coverage of certain noncitizens for emergency medical conditions)
- FF (federally funded demonstration; MinnesotaCare for parents and adult caretakers)
- LL (federally funded demonstration; MinnesotaCare for pregnant women and children)
- FP (federally funded demonstration; family planning services only)
- QM (Medicare Part A & B premiums and cost sharing)
- SL (Medicare Part B premiums)
- WD (Medicare Part A premiums)

Visits that occur for participants actively enrolled in the following managed care programs can be included in the MPV numerator:

- MA12 – Prepaid Medical Assistance Program
- MA20 – Prepaid Medical Assistance Program
- MA17 – Special Needs Basic Care (SNBC Integrated Medicare)
- MA19 – Special Needs Basic Care (SNBC PIN Non-integrated Medicare)
- MA37 – Special Needs Basic Care (SNBC Non-integrated Medicare)
- MA30 – Minnesota Senior Care Plus (MSC+)
- MA35 – Minnesota Senior Care Plus (MSC+)
- MA02 – Minnesota Senior Health Options (MSHO)

- MinnesotaCare Basic Plus Two (parents & adult caretakers with income  $\leq 275\%$  FPL)
- MinnesotaCare Basic Plus (parents and adult caretakers with income  $\leq 275\%$  FPL)
- MinnesotaCare Expanded (MinnesotaCare for children under age 21 and pregnant women)
- MinnesotaCare Expanded (MinnesotaCare for adults without children up to 250% FPL)

Note: The EHR or practice management system identifies managed care program participants from patient records to accurately reflect patient encounters in this category.

In addition to the programs above, certain eligible provider types can include visits that occur under two additional programs. Physician assistants practicing predominantly in a FQHC, RHC, Tribal or urban facility can choose to include visits that occur for participants actively enrolled in the following programs:

- Children's Health Insurance Program (CHIP)
- Services provided on a sliding scale or that were uncompensated

### **Should I attest to individual patient volume or use the group or proxy methodology?**

You determine whether to attest using the individual or group methodology. While the final rule grants the freedom to attest as an individual, the organization that employs you is frequently the one that is aware of the MEIP, determines whether the organization will participate in the MEIP and communicates their plans to you. It is up to you to accept the organization's plan of action, attest on your own or choose not to participate.

### **Calculating patient volume**

To calculate the patient volume follow these steps (the steps are explained in detail below):

1. Determine source of patient volume
2. Determine your reporting period
3. Calculate your total patient encounters (the denominator)
4. As a subset of the total patient encounters, calculate your Medicaid patient encounters (the numerator)
5. Divide Medicaid patient encounters by the total patient encounters. The result is the MPV %.

#### **Step 1. Determine source of patient volume**

Steps 1 through 4 can occur at the same time or in a different order, depending on which sequence works best for you. To determine your source of patient volume, you have the option to attest as an individual reporting only your patient volume from one location or from multiple locations. You also have the option to attest as part of a group, combining patient volume from all professionals across the entire clinic. Many organizations have a plan in place to attest in a certain way. The final rule gives each eligible professional the ability to choose.

#### **Step 2. Determine your reporting period**

**Individual reporting period.** If you choose to attest as an individual, your next step is to review your patient volume history at every location you have provided services and determine which 90-day period meets or exceeds the required MEIP Medicaid patient volume percentage. You may have only one or you could have many to choose from. This requirement can be met by reporting on one location. You can also meet this requirement by combining your patient volume across multiple locations. Select any representative continuous 90-day period in the most recent continuous 12-months preceding your attestation or any continuous 90-day period in the calendar year preceding the payment year for which you are attesting.

Next, query your EHR or practice management system to determine a 90-day period that satisfies the minimum Medicaid patient volume (20% for pediatricians for a reduced payment, 30% for all others and for pediatricians who can meet the higher minimum). If more than one period is available, consider using a reporting period that will not conflict with a reporting period you might consider using later to report the next MEIP program year.

If you are employed by an FQHC, RHC or Tribal or urban facility, you have the option to include or exclude CHIP, sliding scale and uncompensated encounters. If you can meet or exceed the Medicaid patient volume requirement without including these encounter types, it is optional to inquire further about additional encounters.

**Group reporting period.** The patient volume requirement can also be met by combining the patient volume for all professionals within the selected group structure for a 90-day period. Work with your organization's meaningful use lead staff person to coordinate the group's patient volume calculation. Select any representative continuous 90-day period in the most recent continuous 12-months preceding the attestation(s) or any continuous 90-day period in the calendar year preceding the payment year for which you are attesting.

If you are attesting as part of a group, consider the following:

- Group as defined under MEIP is a unique pair of Federal Tax Identification Number (TIN) and National Provider Identifier (NPI). *Appendix B MEIP Individual and Group Patient Volume Form* provides a template for providers to account for the patient volume of all professionals employed by the group. This form was developed to be used as a tool if you are looking for guidance.
- All Medicaid encounters performed as part of the group are included for every practitioner in the group (for both the numerator and denominator counts), regardless of whether the practitioner is eligible for the incentive program or chooses not to participate.
  - For example, if you choose not to participate in the group but the organization attests as a group, the encounters you generated at that location are used in the numerator and denominator calculations for that particular group. You cannot use those encounters for calculating volumes for another practice or individually if the group has already included them in their volume calculation.
- One TIN can have multiple practice locations
- Multiple groups can attest under one TIN

If you are the first to attest to group volume, you are responsible to enter the reporting period, the group name and the group volume (numerator and denominator). Each subsequent person in the group to attest will select the group they are attesting with, attest to information provided by the first person in the group and provide other required information pertaining to their attestation.

If you are employed by an FQHC, RHC, tribal or urban facility, the group as a whole decides to include or exclude CHIP, sliding scale and uncompensated encounters (also known as needy patient encounters). If the group can meet or exceed the Medicaid patient volume requirement without including these encounter types, you do not need to add them. The members in the group must follow the same reporting methodology.

After these considerations, query your EHR or practice management system to determine a 90-day period that satisfies the minimum Medicaid patient volume (20% for pediatricians for a reduced payment, 30% for all others and for pediatricians who can meet the higher minimum). If more than one period is available, consider using a reporting period that will not conflict with a reporting period you or your group might consider using later to report the next MEIP program year.

### **Step 3. Calculate your total patient encounters**

Note the following when calculating your total patient encounters:

- After you select your reporting period, count all encounters for this period within your detailed query results. If you are attesting with group volume this step would be the same but repeated for each EP associated with the group then combined or your query results already include all practitioners in the group.
- Identify and remove all duplicate encounters during the reporting period. Multiple visits by an individual to the same rendering provider on one day only count as one encounter. However, multiple visits by an individual to different rendering providers on one day can be counted separately.
- Determine if the query includes services provided to out-of-state recipients. You decide whether it is helpful to include out-of-state encounters to meet the minimum Medicaid patient percentage. Inclusion of out-of-state recipients to meet the patient encounter thresholds will require additional supporting documentation.
- Determine if services provided in a hospital and at an emergency department (ED) are included in the result. EP services provided within a hospital or ED setting with place of service (POS) 21 - Inpatient Hospital or POS 23 - ED **are** included in your patient volume.
- Save the detailed query result in case it is requested as part of the prepayment verification process or if you

need to support your attestation as part of a post payment audit.

#### Step 4. Calculate your Medicaid patient encounters

After you have a total patient volume count, locate the Medicaid encounters by identifying the MHCP fee-for-service and managed care encounters from the total patient volume or perform a separate query. Note the following when determining what Medicaid encounters are included in the count:

- If the patient was eligible for Medicaid at the time of the encounter, the encounter is included in the Medicaid count whether the encounter was billed to Medicaid or not
- Services provided to the patient and paid for through State-only funded programs are **not** included in the Medicaid encounter count
- Services provided to Medicaid patients and paid zero by Medicaid are included
- Each of the services provided to Medicaid patients but billed to Medicaid as a singular global billing are unique encounters and are included in the Medicaid encounter count

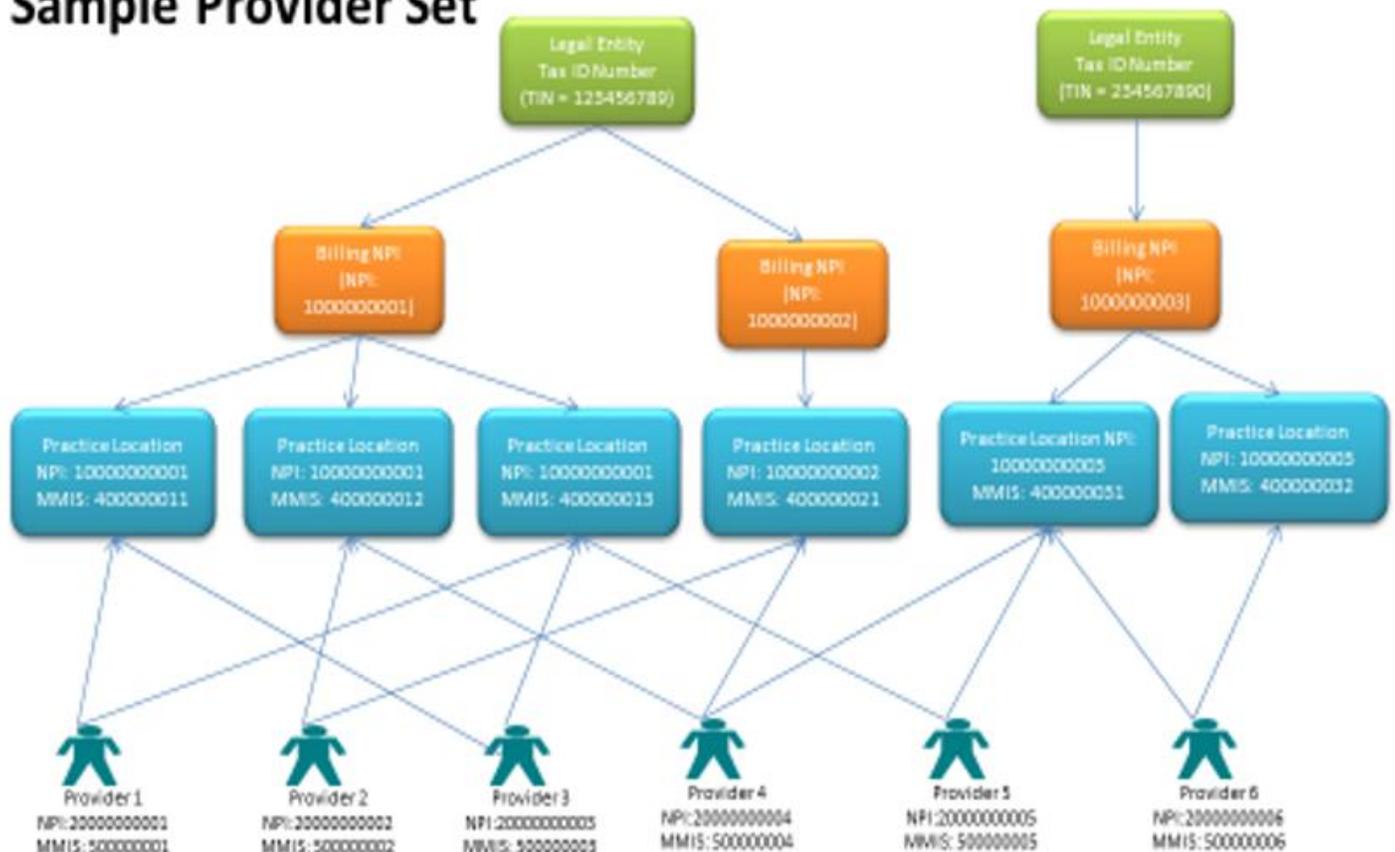
Example A. Provider Attestation Options below illustrate how one EP often has more than one path to potential eligibility. Provider 4, for example, can attest as an individual using encounters from one or more of these employer combinations:

- TIN = 123456789, Billing NPI = 1000000001, Practice Location MMIS = 400000012
- TIN = 123456789, Billing NPI = 1000000002, Practice Location MMIS = 400000021
- TIN = 234567890, Billing NPI = 1000000003, Practice Location MMIS = 400000031

Provider 4 can also choose to attest as part of a group patient volume attestation at one of the three practice locations above, exclusively.

#### Example A. Provider Attestation Options

### Sample Provider Set

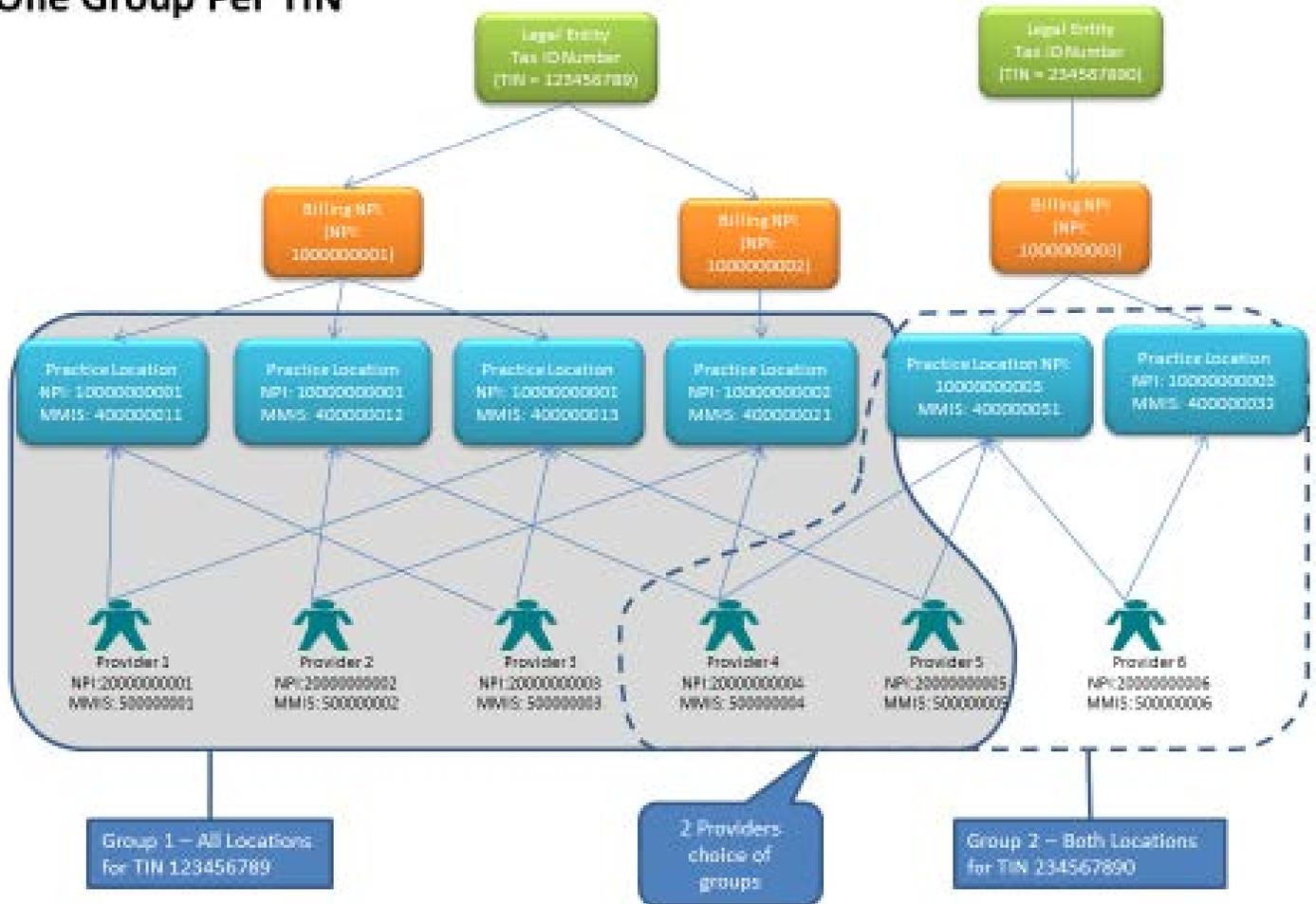


Example B. Provider Group Attestation Options illustrates which attesting providers could attest using a group

methodology. For example, the dark grey area shows if organization with TIN 123456789 attests using the group methodology then providers 1-3 only have the option to attest using the group methodology under that umbrella and the organization would be required to also report providers 4 and 5's encounters. Providers 4 and 5 have two group options to choose: with the providers in the dark grey area or with Provider 6.

### Example B. Provider Group Attestation Options

#### One Group Per TIN



#### Step 5. Divide Medicaid patient encounters from your total encounters

To calculate MPV percentage, use the following calculation:

Medicaid encounters divided by total patient encounters times 100; or

$$\frac{\text{Medicaid Patient Encounters}}{\text{Total Patient Encounters}} \times 100$$

When you attest to your individual patient volume in the MEIP portal:

- Select Individual Attestation
- Select Medicaid or FQHC, RHC, tribal or urban facility patient volume
- Select Practice Location. Providers select one or all of the locations where the encounters occurred.
- Select & Return to continue

When you attest to your group patient volume in the MEIP portal:

- Select Group Attestation

- Select Medicaid or FQHC/RHC/Tribal or urban facility patient volume and enter Group TIN
- Select Practice Location
- The first member to create the group will select one or all of the locations where the encounters occurred
  - The first group member will create the group by entering the reporting period and group attestation in Step 1 of the application
- If the provider is joining the group, the EHR Group ID column will show an ID at the location(s) where a group has been created
- The first member will select whether out-of-state encounters are to be included

## Section 2: Guidance for Eligible Hospitals

### 2.1 Prerequisites Part I: Preparation and Registration with CMS

Prior to registration in the MEIP, determine if the eligible hospital (EH) has the information necessary to complete the initial registration with CMS and eventual enrollment in the MEIP. Follow these steps to determine registration eligibility:

1. Determine if the EH is potentially eligible to participate in the MEIP. The EH can use the [CMS Eligibility Tool](#) to find out if it qualifies for MEIP.
2. Confirm the EH has an NPI valid for participation in the MEIP.
3. Confirm the EH is enrolled with MHCP. The enrollment linked to the EH's NPI must be active and in good standing. If the EH is not enrolled in MHCP, or the EH is not in good standing in MHCP, the EH will not be allowed by rule to participate in the program.

#### **What if the EH is not currently enrolled in MHCP or has questions about the enrollment standing?**

Complete your Minnesota Medicaid enrollment first, prior to participating in the MEIP. Contact [MHCP Provider Enrollment](#) at (651) 431-2700; Toll-free at (800) 366-5411; Fax at (651) 431-7462.

4. Confirm your NPI is enrolled in the MHCP system as an Eligible Provider Type.  
According to the CMS Final Rule for the Medicaid EHR Incentive Program and the Minnesota State Medicaid HIT Plan, EHs for MEIP are those whose last four digits of their CMS Certification Number (CCN) fall into one of the following ranges:
  - 0001-0879 for acute care hospitals
  - 1300-1399 for critical access hospitals
  - 3300-3399 for children's hospitals

#### **What if I am not currently enrolled as an eligible provider type in MHCP?**

Complete a full enrollment with MHCP. This process includes validation of current certifications and licenses. Contact [MHCP Provider Enrollment](#) at (651) 431-2700; Toll-free at (800) 366-5411; Fax at (651) 431-7462.

5. Confirm your electronic health records system is certified by the Office of the National Coordinator (ONC) for Health Information Technology (HIT). If you are currently adopting, implementing, upgrading, or using an electronic health records system you can determine if your system is certified by ONC by performing a search on the ONC EHR Certification Search website.

#### **What if I do not have my EHR Certification Number at this time?**

Visit the ONC EHR certification site, search the site using the product name, vendor name or the certified

health product list (CHPL) product number to verify the EHR certification number. You will be required to validate this number in the MEIP portal during your enrollment and attestation in order to meet program eligibility requirements and achieve payment.

6. Confirm your Payment Assignment

By rule, the EH is required to assign payment to the EH TIN. In order to assign payment for MEIP, the following is required:

- a. The Payee NPI and Payee TIN, identified by the Provider at the time of *CMS EHR Incentive Program registration*, must be enrolled in MHCP. The Payee NPI and Payee TIN must match exactly to the MHCP Enrollment data.
- b. The enrollment linked to your payee must be active and in good standing. If the Payee NPI and Payee TIN do not match an enrollment with MHCP, or the Payee NPI and Payee TIN match an enrollment with MHCP which is not in good standing, the payee selection will not be allowed for MEIP.

**What can I do if my Payee NPI and TIN combination is not known to MHCP?**

Request the Payee associated with the Payee NPI and Payee TIN combination complete a full enrollment in MHCP. Contact [MHCP Provider Enrollment](#) at (651) 431-2700; Toll-free at (800) 366-5411; Fax at (651) 431-7462.

**What can I do if my Payee NPI and Payee TIN combination is currently enrolled in MHCP, but is not in an active status or good standing?**

Contact MHCP to discuss the standing of your enrollment. If you are currently enrolled, but have questions about your enrollment standing, contact [MHCP Provider Enrollment](#) at (651) 431-2700; Toll-free at (800) 366-5411; Fax at (651) 431-7462.

Note: A provider may register with CMS for program participation prior to finalizing MHCP Payee Enrollment; however, the provider will not be able to complete the MEIP attestation process required to achieve payment until this information is finalized.

7. Registration transfer for participation in the MEIP

Register for participation in the MEIP at the [CMS EHR Incentive Registration](#) website. If accepted, CMS will send your registration to the MEIP the next day. Registrations are processed by CMS and Minnesota 7 days a week.

## 2.2 Prerequisites Part II: Preparing, Enrolling & Attesting for MEIP

Upon receiving your CMS registration confirmation, confirm the MHCP enrollment matches your registration NPI and your registration NPI is:

- Found in the MHCP system,
- In good standing and not sanctioned in the MHCP system and
- A provider type eligible to participate in the MEIP

**How do I get help if an issue is found with my program MHCP enrollment?**

For help, contact [MHCP Provider Enrollment](#) at (651) 431-2700; Toll-free at (800) 366-5411; Fax at (651) 431-7462.

**How do I get help for questions related to MEIP enrollment?**

For help, contact the MEIP help desk at [MN.Support@MN-MEIP.com](mailto:MN.Support@MN-MEIP.com) or call 855-676-0366.

After successful registration with CMS and transfer of the registration profile, you will receive an email from the MEIP portal which provides MEIP attestation access instructions. From there you will:

1. Gather and prepare documentation for the MEIP enrollment and attestation process. *Appendix A: MEIP Guidance on Supporting Documentation* provides prepayment supporting documentation options that you will be prompted to upload in support of your enrollment and attestation.

**Note:**

Some prepayment supporting documents are required, while others are situational. During your initial attestation submission, do NOT upload any documentation containing protected health information (PHI). If a prepayment verification requires additional supporting documentation which may include PHI, you will be contacted by Business Services staff or DHS staff to submit more detail.

2. Determine incoming MEIP participation year. Review your EH's enrollment with and participation in the Medicare and Medicaid EHR incentive programs. If you are enrolled and receiving claim payments from Medicare and Medicaid you may have already participated in one or both of the EHR incentive programs.
  - If you have received prior EHR incentive program payment from the Medicare EHR incentive program and the Medicaid EHR incentive program, review the most recent participation year and final rule direction to determine your next stage of meaningful use. If you are participating in both the Medicare and Medicaid programs as a Dually-Eligible Hospital, you must complete your Medicare attestation prior to starting the Medicaid attestation, unless it is your first year and you have not completed an attestation in either program system. During this first year, you can elect to attest to Adopt, Implement or Upgrade (AIU) in the MEIP prior to completing the Medicare attestation.
3. Confirm Payee designation. As part of the CMS EHR Registration process, the Hospital Payee is, by default, the Hospital NPI and Hospital TIN used at the time of registration. Unlike Eligible Professionals, hospitals may not designate their payments to other Medicaid professionals or entities. Payments will be made to the Medicaid Hospital Enrollment which matches the hospital's registration NPI and TIN.

MEIP requires the attesting hospital confirm the payee NPI and TIN as part of the attestation process. This will help ensure the appropriate Medicaid payee receives the EHR Incentive payment if the hospital is determined eligible for an EHR Incentive payment.

4. Attest to Patient Discharge Volume. The CMS EHR Incentive Program Final Rule requires acute care and critical access hospitals to meet a 10% Medicaid discharge volume in order to participate in the program. Children's hospitals have a 0% Medicaid discharge volume requirement. Refer to section 2.3 Medicaid Patient Volume Calculation for EHs for more information.
5. Confirm EHR Certification Number. Enter your Certified EHR Number during the attestation process. The number is validated real-time against the Office of the National Coordinator (ONC) Certification database.
6. Payment Calculation Attestation. The CMS EHR Incentive Program Final Rule documents the payment calculation to be used by Medicaid states. MEIP payments are made to hospitals which have been determined to be eligible to participate in the Minnesota Medicaid program.

EHs should consider the following:

- A multi-site hospital with one CCN is considered one hospital for purposes of attestation and payment
- Use an auditable data source, such as the latest Medicare cost report and Minnesota-specific hospital annual report (HAR), to complete the EHR Incentive Payment Calculation attestation
- Use your HAR when necessary
- If you only have one year of data, use the first year data and enter zeroes for the other years. Then, as the years progress, update the worksheet
- Review your worksheet amounts every year, attest to the same amounts if these are still correct and adjust them if they have changed
- If your facility was involved in a merging of two facilities and has had to submit cost reports in six month increments during this period of change, go back to the first full 12-month report for year one

To calculate your total hospital payment, access and download the MEIP Hospital Calculation worksheet link found on the [MEIP Eligible Hospitals](#) page. The worksheet identifies the Medicare Cost Report data and HAR fields used to verify hospital payment attestation data. The [MEIP Hospital Calculation Sample](#) provides EHs with an example of a completed EH EHR incentive payment worksheet. *Appendix C Sample MEIP Hospital Calculation* provides an attached example of the completed MEIP EH worksheet.

7. Select enrollment year. Program year 2016 is the last year that an EH can submit their first Medicaid EHR Incentive Program attestation. The following tables can assist the decision:
  - a. *Appendix D: MEIP First Enrollment and Attestation Month* provides the Payment Year options based on when the EH has submitted the CMS R&A registration and the month they are performing their attestation in MEIP.
  - b. *Appendix E: MEIP Hospital Fiscal Year Start* provides the time period to be used for discharge volumes, charges and inpatient days in the MEIP incentive payment calculation based on the desired first payment year.

Note: If you are enrolling for program year 2016 or later, the program year changed to a calendar year to be in sync with the EP program year.

To determine the discharge-related amount for the three subsequent payment years that are included in determining the overall EHR amount, the number of discharges will be based on the annual growth rate for the hospital over the current and most recent three years of available data. Per a CMS.gov outreach document, “For the first payment year, data on hospital discharges from the hospital fiscal year that ends during the federal fiscal year prior to the hospital fiscal year that serves as the first payment year will be used as the basis for determining the discharge-related amount.”

8. Prepayment review

Based on Minnesota EHR Incentive Program policy, every provider attestation will go through a prepayment verification. You may be required to upload additional information to support the data entered during attestation.

9. Payment

The Minnesota EHR Incentive Program attempts to process payments within 45 days after the commencement of the prepayment review. The processing clock will begin with the start of a prepayment verification and will

be reset if additional supporting documentation is requested by Business Services staff. Processing payments within 45 days after the initiation of the prepayment review is a target; the actual payment timing may vary based on provider responsiveness to prepayment review inquiries as well as the general program attestation activity. To minimize delays, we encourage program participants to complete and submit attestations as early as possible based on program stage and the associated reporting windows.

## 2.3 Medicaid Patient Volume Calculation for EHs

This section provides clarification on the process used by MEIP to calculate MPV based on the programs that meet the definitions for eligible encounters in the federal regulations.

MEIP's definition of EH patient encounters is in accordance with the final rule which describes an EH encounter as, "...services rendered to an individual per inpatient discharge or on any one day in the emergency room where Title XIX Medicaid or another state's Medicaid program paid for part or all of the service, their premiums, co-payments, and/or cost-sharing." Per federal regulations, children's hospitals are not required to meet any Medicaid patient-volume percentage and do not provide information on patient encounters. Minnesota has created a hospital incentive calculation template which is available on our EHR Incentive website.

Acute care hospitals, critical access hospitals and children's hospitals count each inpatient discharge and ED visit as an encounter for the purposes of calculating their Medicaid patient encounters.

### Can all Medicaid encounters be included in the numerator?

No, programs partially or fully funded by the Federal government can be included. State-only funded programs cannot be included in the numerator. The Minnesota health care programs include:

- Medical Assistance
- MinnesotaCare
- Minnesota Family Planning Program
- Home and community-based waiver programs
- Medicare Savings Programs

Discharges and ED visits that occur for participants actively enrolled in the following fee-for-service programs can be included in the MPV numerator:

- MA (Medicaid)
- EH (Medicaid coverage of certain noncitizens for emergency medical conditions)
- FF (federally funded demonstration; MinnesotaCare for parents and adult caretakers)
- LL (federally funded demonstration; MinnesotaCare for pregnant women and children)
- FP (federally funded demonstration; family planning services only)
- QM (Medicare Part A & B premiums and cost sharing)
- SL (Medicare Part B premiums)
- WD (Medicare Part A premiums)

Visits that occur for participants actively enrolled in the following managed care programs can be included in the MPV numerator:

- MA12 – Prepaid Medical Assistance Program
- MA20 – Prepaid Medical Assistance Program
- MA17 – Special Needs Basic Care (SNBC Integrated Medicare)
- MA19 – Special Needs Basic Care (SNBC PIN Non-integrated Medicare)
- MA37 – Special Needs Basic Care (SNBC Non-integrated Medicare)
- MA30 – Minnesota Senior Care Plus (MSC+)

- MA35 – Minnesota Senior Care Plus (MSC+)
- MA02 – Minnesota Senior Health Options (MSHO)
- MinnesotaCare Basic Plus Two (parents & adult caretakers with income  $\leq 275\%$  FPL)
- MinnesotaCare Basic Plus (parents and adult caretakers with income  $\leq 275\%$  FPL)
- MinnesotaCare Expanded (MinnesotaCare for children under age 21 and pregnant women)
- MinnesotaCare Expanded (MinnesotaCare for adults without children up to 250% FPL)

### **Which professionals do I include in the count?**

All Medicaid encounters performed during the reporting period are included in the EH count.

### **Calculating patient volume**

To calculate the patient volume follow these steps (the steps are explained in detail below):

1. Determine source of patient volume
2. Determine your reporting period
3. Calculate your total patient encounters (the denominator)
4. As a subset of the total patient encounters, calculate your Medicaid patient encounters (the numerator)
5. Divide Medicaid patient encounters by the total patient encounters. The result is the MPV %.

#### **Step 1. Determine source of patient volume**

Steps 1 through 4 can occur at the same time or in a different order, depending on which sequence works best for you. To determine your source of patient volume, all Medicaid encounters performed during the reporting period within the facility are included in the EH count.

#### **Step 2. Determine your reporting period**

Review your patient volume history at your facility and determine which 90-day period meets or exceeds the MEIP Medicaid patient volume percentage. The reporting period has been any 90-day consecutive period in the previous federal fiscal year. As of December 15, 2015, the reporting period for 2016 attestations and beyond is by calendar year. You may have only one reporting period or you could have many to choose from. Select any representative continuous 90-day period in the most continuous 12-months preceding your attestation or any continuous 90-day period in the calendar year preceding the payment year for which you are attesting.

Next, query your EHR or practice management system to determine a 90-day period that satisfies the minimum Medicaid patient volume (10% for acute care and critical access hospitals, 0% for children's hospitals). If more than one period is available, consider using a reporting period that will not conflict with a reporting period you might consider using later to report the next MEIP program year.

#### **Step 3. Calculate your total patient encounters**

After you have selected your reporting period, count all encounters for this period within the detailed query results. Note the following when calculating your total encounters:

- Identify and remove all duplicate encounters during the reporting period. Multiple ED visits by an individual to the same rendering provider on one day only counts as one encounter. However, multiple ED visits by an individual to *different* rendering providers on one day can be counted separately.
- Determine if the query includes services provided to out-of-state recipients. You can choose to include out-of-state encounters to meet the minimum Medicaid patient percentage, if needed.
- Save the detailed query result in case it is requested as part of the prepayment verification process or if you are selected for a post payment audit.

#### **Step 4. Calculate your Medicaid patient encounters**

After you have a total patient volume count, locate the Medicaid encounters by identifying the MHCP fee-for-service and managed care encounters from the total patient volume or perform a separate query. Note the following when

determining what Medicaid encounters are included in the count:

- If the patient was eligible for Medicaid at the time of the encounter, the encounter is included in the Medicaid count whether the encounter was billed to Medicaid or not
- Services provided to the patient and paid for through State-only funded programs are **not** included in the Medicaid encounter count
- Services provided to Medicaid patients and paid zero by Medicaid are included
- Each of the services provided to Medicaid patients but billed to Medicaid as a singular global billing are unique encounters and are included in the Medicaid encounter count

MHCP will consider EH encounter queries in accordance with the following rules:

- If a person has an Emergency Department (ED) visit and no inpatient stay on a given day, the ED is one encounter
- If a person has an inpatient stay but no ED visit, the inpatient discharge is one encounter
- If a person goes to an ED and is admitted to an inpatient stay where the DISCHARGE from that inpatient stay is any day FOLLOWING, the ED visit is TWO encounters
- If a person has an inpatient stay and is discharged and goes to the ED on the same day as the discharge to the same provider, that will be counted as ONE encounter
- Contiguous inpatient stays from the same provider are merged and counted as ONE encounter
- The measurement span includes one month prior and one month after the actual measurement year to evaluate inpatient discharge dates
- Inpatient discharge must occur between the start and end dates of the measurement span to be included as an encounter

#### **Step 5. Divide Medicaid patient encounters from your total encounters**

To calculate MPV percentage, use the following calculation:

$$\frac{\text{Medicaid discharges} + \text{Medicaid ED visits}}{\text{Total discharges} + \text{total ED visits}}$$

### **Section 3: Meaningful Use Attestations**

EPs attesting to year one of MEIP participation have the option to attest to either AIU or may attest to Stage one, year one of meaningful use. See section 1.2 for more information on AIU attestations.

All EPs, Medicaid-only EHs and dual eligible EHs attesting to meaningful use should review the MEIP meaningful use documents on the MEIP site to determine which stage to report. Changes in the final rule have modified which stage to report depending on the program year.

### **Section 4: Appendices**

## Appendix A - MEIP Guidance on Supporting Documentation

Category	Document Options	Required/Situational
<b>Adopt, Implement, Upgrade</b>	AIU Other	<b>Required – first year only.</b> In the first year, providers will be required to upload at least one form of AIU documentation. This documentation must clearly show the relationship between: (1) the certified EHR vendor, (2) the entity that adopted, implemented or upgraded to the system, and (3) the licensed user. See also the EHR Solution.
	Contract	
	Purchase Order, Invoice or Receipt	
<b>Reconsideration</b>	Reconsideration Request – Supporting Documentation	<b>Situational.</b> This documentation type would only be used if a provider is requesting a reconsideration of an initial payment decision.
<b>Appeal</b>	MEIP Appeal Form	<b>Situational.</b> This documentation type would only be used if a provider is filing a formal appeal of a payment decision.
<b>Prepayment Verification</b>	Prepayment Verification Documentation	<b>Situational.</b> This documentation type would only be used if a provider has been asked for additional documentation during a prepayment desk audit.
<b>Post Payment Audit</b>	Post Payment Audit Documentation	<b>Situational.</b> This documentation type would only be used if a provider has been asked for additional documentation during a post payment audit.
<b>EHR Solution</b>	EHR Contract	<b>Required – second year and beyond.</b> Providers will be required to upload at least one form of EHR solution documentation in year two and beyond. This documentation must clearly show the relationship between: (1) the certified EHR vendor, (2) the entity using the system, and (3) the licensed user. This document is especially important when the contract has been renewed, or the provider has changed vendors or switched to a more current certified EHR technology (CEHRT) version.
	EHR Other	
	EHR Purchase Order	
	EHR Software License	
<b>Group</b>	Group Attestation Document	<b>Situational.</b> Providers attesting using a group Medicaid Patient Volume (MPV) will be required to upload documentation listing the EPs, whether they intend to attest as part of the group, and documenting their acknowledgment and approval to include their patient volume included in the group. The <a href="#">MEIP EP Individual and Group Patient Volume Form</a> available on the MEIP Reference Material website provides an optional template for providers to account for all professionals employed by the group.
	Individual and Group Patient Volume Documentation	
	Group Other	
	Group Volumes Supporting Documentation	

Category	Document Options	Required/Situational
Legal Notice	Disagreed with Legal Notice	<b>Situational.</b> This document is automatically generated and uploaded to the provider's file if the provider indicates that they disagree with the legal notice.
	Signed & Affirmed Legal Notice	<b>Required.</b> This document is automatically generated and uploaded to the provider's file when they electronically sign the legal notice. Providers are offered the opportunity to print a copy of this document for their records upon attestation.
Meaningful Use	MU Other	<b>Situational.</b> If a provider is attesting for meaningful use, they may use this option to upload any related documentation in support of their MU attestation. For detailed information on MEIP MU supporting documentation visit the <a href="#">MEIP website</a> .
Patient Volume	Hospital Based	<b>Situational.</b> Providers may be required to upload documentation in support of their Medicaid patient volume. This is required in the following situations: <ul style="list-style-type: none"> <li>• Providers are including out-of-state encounters, zero paid encounters, Not Billed Encounters or Global billing encounters not billed in their MPV attestation. Documentation of out-of-state encounters should specify the number and state in which the encounters occurred.</li> <li>• The attested patient volume numerator is significantly lower or higher than the EP patient volume accounted for at DHS.</li> </ul>
	Patient Encounter	
	Patient Volumes Other	
	Out of State Volume	
Payment	EH Average Length of Stay	<b>Situational.</b> Hospitals will be required to submit documentation relevant to their payment calculation. Categories are also available in the event that an EP would need to upload any payment related documentation.
	EH Charity Expenses Supporting Documentation	
	EH Discharge Documentation	
	EH Schedule Adjustment	
	EH Medicaid Share	
	EH Cost Report or HAR	
	EP Adjustment	
	Payment Other	
Pediatrician Attestation	Pediatrician Certification	<b>Situational.</b> When a pediatrician attests to Medicaid patient volume between 20% and 29%, the pediatrician is required to upload documentation in support of their pediatrician attestation. Per MN Statute, 62J.495 Subd. 8 (f) "Pediatrician" means a physician who is certified by either the American Board of Pediatrics or the American Osteopathic Board of Pediatrics.

<b>FQHC, RHC, tribal or urban facilities Attestation</b>	PA So-Led Documentation	<b>Situational.</b> Providers may upload documentation in support of their PA-So-Led attestation. Page 44483 of the <a href="#">Final Rule</a> clarifies the CMS definition of Physician Assistant (PA) 'so-led'. The <a href="#">MEIP PA So-Led Form</a> is available on the MEIP Reference Material website for providers to attest to being employed in a so-led facility.
<b>Additional Documentation</b>		For detailed information on MEIP eligibility and meaningful use supporting documentation visit the <a href="#">MEIP website</a> .

## Instructions for Appendix B. MEIP EP Individual and Group Volume Worksheet

### Purpose

Appendix B. was written in response to the provider community requesting a patient volume calculation template. This template can be modified to fit the need of the provider and is not considered official DHS direction or a binding agreement. This document may be requested by DHS during the prepayment verification or post payment audit processes to validate members of the group.

### Key

TIN – Reporting the Tax Identification Number (TIN) of the organization is useful when collecting a complex set of patient volume

From Date – The starting date of your patient volume reporting period

To Date – The last date of your patient volume reporting period

Medicaid Provider Name – Name of the professional reporting patient volume. When used as an individual EP reporting tool, each row would record the same Medicaid Provider Name. When used as a group Medicaid patient volume tool, each row would record every professional that provided an encounter during the reporting period.

Individual NPI – National Provider Identifier (NPI) of the professional

Location NPI – NPI of the location where encounters were provided

Total Medicaid Encounters (Numerator) – The number of Medicaid encounters that occurred during the reporting period. This includes paid encounters, encounters billed but paid zero and encounters during which the patient was eligible for Medicaid but encounter was paid in full by another payer or encounters that were billed to Medicaid and denied for reasons other than eligibility.

Total Encounters (Denominator) – The number of all encounters that occurred during the reporting period. This includes Medicaid encounters reported in the numerator and encounters provided to non-Medicaid patients.

Group Use Only, Attesting with Group (Y/N) – This field indicates whether the professional listed will be attesting with the group (Y) or if the professional has chosen to either attest separately under another group, individually, is not eligible or chooses not to attest (N). Note: A professional’s patient volume can be used as part of a group IF the patient volume has not already been used by the professional under an individual attestation.

Group Use Only, Professional contacted/agreed to include patient volume in the group (Y/N) – This field indicates whether the professional was contacted and agreed to have their patient volume included in the group (Y) or if the group was not in contact with the professional (N). The purpose of this field is to minimize confusion between the professional and the group location and is not binding in any way.

Appendix B. MEIP EP Individual and Group Patient Volume Worksheet							
TIN:		From Date (mm/dd/yy)		To Date (mm/dd/yy)		Group Use Only	
	Medicaid Provider Name	Individual NPI	Location NPI	Total Medicaid Encounters (Numerator)	Total Encounters (Denominator)	Attesting with Group (Y/N)	Professional contacted/agreed to include patient volume in the group (Y/N)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
<b>Total</b>							

Example A. Individual EP Patient Volume Collection

Appendix B. MEIP EP Individual and Group Patient Volume Worksheet							
TIN: 9876543210		From Date (mm/dd/yy)	1/1/2014	To Date (mm/dd/yy)	3/31/2014	Group Use Only	
	Medicaid Provider Name	Individual NPI	Location NPI	Total Medicaid Encounters (Numerator)	Total Encounters (Denominator)	Attesting with Group (Y/N)	Professional contacted/agreed to include patient volume in the group (Y/N)
1	Smith	1111111111	9999999999	9	30		
2	Smith	1111111111	8888888888	1	12		
3	Smith	1111111111	7777777777	18	60		
4	Smith	1111111111	6666666666	2	14		
5	Smith	1111111111	5555555555	27	90		
6							
7							
8							
9							
10							
11							
12							
13							
14							
<b>Total</b>				<b>54</b>	<b>180</b>		

When an EP’s patient volume includes encounters from multiple locations, the EP can choose to report all or select patient volume from select location(s) to meet the minimum patient volume. In Example A. the provider does not meet the minimum 30% patient volume if all locations are selected. By choosing to report location rows 1, 3 and 5, the EP patient volume is 30% and the patient volume meets the minimum percentage.

Example B. One Location Group Patient Volume Collection

Appendix B. MEIP EP Individual and Group Patient Volume Worksheet							
TIN: 9876543210		From Date (mm/dd/yy)	1/1/2014	To Date (mm/dd/yy)	3/31/2014	Group Use Only	
	Medicaid Provider Name	Individual NPI	Location NPI	Total Medicaid Encounters (Numerator)	Total Encounters (Denominator)	Attesting with Group (Y/N)	Professional contacted/agreed to include patient volume in the group (Y/N)
1	Smith	1111111111	9999999999	9	30	Y	
2	Yang	2222222222	9999999999	1	12	Y	
3	Allen	3333333333	9999999999	18	60	Y	
4	Xiong	4444444444	9999999999	2	14	Y	
5	Jones	5555555555	9999999999	27	90	Y	
6	Larsen	6666666666	9999999999	62	87	Y	
7							
8							
9							
10							
11							
12							
13							
14							
<b>Total</b>				119	293		

When an EP chooses to attest to group volume all patient encounters are required to be reported from one or more locations that share the same Tax Identification Number (TIN). In Example B., Doctors Yang and Xiong are not eligible if they each attest using individual volume but as a group the Medicaid patient volume is equal to 40%. When attesting as a group, the group must include all volumes for the locations that are included in the group.

Example C. Multiple Location Group Patient Volume Collection

Appendix B. MEIP EP Individual and Group Patient Volume Worksheet							
TIN: 9876543210		From Date (mm/dd/yy)	1/1/2014	To Date (mm/dd/yy)	3/31/2014	Group Use Only	
	Medicaid Provider Name	Individual NPI	Location NPI	Total Medicaid Encounters (Numerator)	Total Encounters (Denominator)	Attesting with Group (Y/N)	Professional contacted/agreed to include patient volume in the group (Y/N)
1	Smith	1111111111	9999999999	9	30	Y	Y
2	Yang	2222222222	9999999999	1	12	Y	Y
3	Allen	3333333333	9999999999	18	60	N	Y
4	Xiong	4444444444	9999999999	2	14	Y	Y
5	Jones	5555555555	8888888888	27	90	Y	Y
6	Larsen	6666666666	7777777777	62	87	Y	Y
7							
8							
9							
10							
11							
12							
<b>Total</b>				119	293		

In Example C., the EPs share the same TIN 9876543210 but their encounters carry across multiple locations. If the group chose to attest using only encounters from Location NPI 9999999999, the EPs would not meet the minimum 30% Medicaid patient volume at 26%. By including patient volume from location NPIs 8888888888 and 7777777777 (which share the same TIN with 9999999999), the group Medicaid patient volume increases to 40%. It should also be noted that while Dr. Allen chose not to attest using her volume from location NPI 9999999999, her volume must be included in the group volume to meet the all in group volume reporting requirement.

**Appendix B. MEIP EP Individual and Group Patient Volume Worksheet**

TIN:		From Date (mm/dd/yy)		To Date (mm/dd/yy)		Group Use Only	
	Medicaid Provider Name	Individual NPI	Location NPI	Total Medicaid Encounters (Numerator)	Total Encounters (Denominator)	Attesting with Group (Y/N)	Professional contacted/agreed to include patient volume in the group (Y/N)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
<b>Total</b>							

## Appendix C. MEIP Hospital Calculation Sample

### MEIP Hospital Incentive Payment Calculation Worksheet Version 1.1

Last updated: 11/06/2012

#### Step 1: Calculate growth rate

	Total Discharges <small>(Source1: CMS-2552-10 Medicare Cost Report Worksheet S-3, Part I, col. 15, line 14) OR (Source2: CMS-2552-96 Medicare Cost Report Worksheet S-3, Part I, Col. 15, Line 12)</small>	Previous Year	Difference	Previous Year	Percent Change	Years of Data	Average Growth Rate
Year 1 (Federal Fiscal (FF) Year prior to payment year))	18,015	18,131	(116)	18,131	-0.006397882		
Year 2 (1st Previous FF Year)	18,131	17,297	834	17,297	0.048216454		
Year 3 (2nd Previous FF Year)	17,297	16,773	524	16,773	0.031240684		
Year 4 (3rd Previous FF Year)	16,773					0.073	2.44%

#### Step 2: Calculate initial payments

	Total Discharges	Average Growth Rate	Adjusted Discharges	Allowed Discharges <small>(max=21,850)</small>	Discharges Rate	Discharge Cost	Base Amount	Transition Factor	Initial EHR Payment
Year 1	18,015	0	18,015	16,865	\$200	\$3,373,000	\$2,000,000	1	\$5,373,000
Year 2	18,015	2.44%	18,454	17,304	\$200	\$3,460,744	\$2,000,000	0.75	\$4,095,558
Year 3	18,454	2.44%	18,903	17,753	\$200	\$3,550,625	\$2,000,000	0.50	\$2,775,313
Year 4	18,903	2.44%	19,363	18,213	\$200	\$3,642,695	\$2,000,000	0.25	\$1,410,674
								<b>Overall EHR Amount:</b>	<b>\$13,654,544.48</b>

Note: There is no discharge allowance for discharges less than 1,150 and more than 23,000 (23,000 - 1,150 = 21,850).

#### Step 3: Calculate Medicaid share

	Total Charges <small>(Source1: CMS-2552-10 Medicare Cost Report Worksheet C, Part I, col. 8, line 200) OR (Source2: CMS-2552-96 Medicare Cost Report Worksheet C, Part I, Col. 8, Line 101)</small>	Charity Care Charges* <small>(Source1: HAR line 0762) OR (Source2: CMS-2552-10 Medicare Cost Report Worksheet S-10, col. 3, line 20) OR (Source3: CMS-2552-96 Medicare Cost Report Worksheet S-10, Line 30 minus HAR 0621)</small>	Total Charges	% of Noncharity Charges	Total Inpatient Days <small>(Source1: CMS-2552-10 Medicare Cost Report Worksheet S-3 part I, col. 8, line 1, 2 + lines 8-12) OR (Source2: CMS-2552-96 Medicare Cost Report Worksheet S-3, Part I, Col. 6, Line 1, 2 +lines 6-10)</small>	Adjusted Inpatient Days	Medicaid Inpatient Days FFS**	Medicaid Inpatient Days MC***	Adjusted Inpatient Days	Medicaid Share
Current Yr	\$939,854,524.00	\$44,821,846.00	\$939,854,524	0.95	97,530	92,879	8,889	20,309	92,879	31.44%

#### Step 4: Calculate aggregate amount

	Overall EHR Amount	Medicaid Share	Aggregate EHR Amount
Current Yr	\$13,654,544	31.44%	\$4,292,534.96

#### Step 5: Apply MN hospital incentive payout schedule

	Aggregate EHR Amount	Payout Percentage	Annual Incentive Payment
Year 1	\$4,292,535	50%	\$2,146,267.48
Year 2	\$4,292,535	40%	\$1,717,013.98
Year 3	\$4,292,535	10%	\$429,253.50
			<b>\$4,292,534.96</b>

#### MEIP Hospital Calculation Worksheet footnotes

\* **Charity Care Charges** - If bad debt is present, remove it. The HAR line 0762 value should not include bad debt. The CMS-2552-10 Medicare Cost Report Worksheet S-10, col. 3, line 20 value should not include bad debt. To calculate net Charity Care using the CMS 2552-96 form, subtract the HAR Report 0621 Bad Debt amount from the CMS-2552-96 Medicare Cost Report Worksheet S-10, Line 30 amount (an Uncompensated amount and not exclusive to Charity Care).

\*\* **Medicaid Inpatient Days FFS** - To calculate net value, SUBTRACT Managed Care (MC) patient days, Medicaid eligible days for which no payment was received and nursery days after discharge from CMS-2552-10 Medicare Cost Report Worksheet S-3 part I, col. 7, line 1 + lines 8-12 or CMS-2552-96 Medicare Cost Report Worksheet S-3, Part I, Col. 5, line 1 +lines 6-10.

\*\*\* **Medicaid Inpatient Days MC** - To calculate net value, SUBTRACT Medicaid Fee-For-Service (FFS) secondary payer patient days, Medicaid eligible days for which no payment was received and nursery days after discharge from CMS-2552-10 Medicare Cost Report Worksheet S-3 part I, col. 7, line 2 or CMS-2552-96 Medicare Cost Report Worksheet S-3, Part I, Col. 5, Line 2.

**Requirement:** Hospitals are required to use their CMS approved cost report. If a CMS approved cost report is not used then supporting documentation will be required. Hospitals are to use their MN Hospital Annual Report (HAR) when necessary.

## Appendix D. MEIP First Enrollment and Attestation Month

V First Enrollment	JAN 2016	FEB 2016	MAR 2016	APR 2016	MAY 2016	JUN 2016	JUL 2016	AUG 2016	SEP 2016	OCT 2016	NOV 2016	DEC 2016	JAN 2017
DEC 2015 or earlier	2015 or 2016	2016	2016	2016	2016	2016	2016	2016	2016 or 2017				
JAN 2016		2015 or 2016	2015 or 2016	2015 or 2016	2015 or 2016	2016	2016	2016	2016	2016	2016	2016	2016 or 2017
FEB 2016			2015 or 2016	2015 or 2016	2015 or 2016	2016	2016	2016	2016	2016	2016	2016	2016 or 2017
MAR 2016				2015 or 2016	2015 or 2016	2016	2016	2016	2016	2016	2016	2016	2016 or 2017
APR 2016					2015 or 2016*	2016	2016	2016	2016	2016	2016	2016	2016 or 2017
MAY 2016						2016	2016	2016	2016	2016	2016	2016	2016 or 2017
JUN 2016							2016	2016	2016	2016	2016	2016	2016 or 2017
JUL 2016								2016	2016	2016	2016	2016	2016 or 2017
AUG 2016									2016	2016	2016	2016	2016 or 2017
SEP 2016										2016	2016	2016	2016 or 2017
OCT 2016											2016	2016	2016 or 2017
NOV 2016												2016	2016 or 2017
DEC 2016													2016 or 2017
JAN 2017													
FEB 2017													
MAR 2017													

\* CMS EHR incentive program year 2015 registrations open from Jan 5, 2016 through May 30, 2016.

## Appendix E - MEIP Hospital Fiscal Year Start

Hospital Fiscal Year Start	2015 Payment Year <sup>1,2</sup>	2016 Payment Year <sup>2</sup>
January	January 1, 2014 - December 31, 2014	January 1, 2015 - December 31, 2015
February	February 1, 2013 - January 31, 2014	February 1, 2014 - January 31, 2015
March	March 1, 2013 - February 28, 2014	March 1, 2014 - February 28, 2015
April	April 1, 2013 - March 31, 2014	April 1, 2014 - March 31, 2015
May	May 1, 2013 - April 30, 2014	May 1, 2014 - April 30, 2015
June	June 1, 2013 - May 31, 2014	June 1, 2014 - May 31, 2015
July	July 1, 2013 - June 30, 2014	July 1, 2014 - June 30, 2015
August	August 1, 2013 - July 31, 2014	August 1, 2014 - July 31, 2015
September	September 1, 2013 - August 31, 2014	September 1, 2014 - August 31, 2015
October	October 1, 2013 - September 30, 2014	October 1, 2014 - September 30, 2015
November	November 1, 2013 - October 31, 2014	November 1, 2014 - October 31, 2015
December	December 1, 2013 - November 30, 2014	December 1, 2014 - November 30, 2015

<sup>1</sup> – Beginning with PY 2015, the Stage 2 Final Rule synchronizes the attestation PY for all providers. EHs, CAHs and EPs will be aligned with the calendar year (Jan 1 – Dec 31).

<sup>2</sup> – For PY 2015 only, EHs can select an MU reporting period using any 90 day period between Oct 1, 2014 - Dec 31, 2015. Starting 2016 and forward, the EH/CAH MU reporting period must be entirely within the calendar year, Jan 1 – Dec 31.