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Ohio Administrative Code

Rule 5160-57-01 Medicaid provider incentive program (MPIP): program eligibility requirements and payment.

Effective: November 9, 2019

(A) The medicaid provider incentive program (MPIP) is Ohio's program implementing section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5, and the published regulations in 42 C.F.R. Part 495. Certain medicaid eligible professionals and hospitals are eligible to participate in MPIP. Funding for this program ends in 2021.

(B) An eligible professional participating in Ohio's MPIP program is a provider that meets eligibility requirements in 42 C.F.R. 495.304 (as in effect on October 1, 2018) and practices within his or her scope of practice as recognized under Ohio law for each type of professional. In addition, an advanced practice registered nurse (APRN) defined in rule 5160-4-04 of the Administrative Code with an appropriate scope of practice will be considered as an eligible provider for Ohio's MPIP program.

(C) Medicaid eligible hospitals participating in Ohio's MPIP program are subject to the program eligibility rules and regulations published in 42 C.F.R. Part 495 (as in effect on October 1, 2018).

(D) To be eligible for a year of participation in MPIP, each eligible professional and hospital must:

(1) Be an enrolled Ohio medicaid provider with an active Ohio medicaid provider agreement;

(2) Except for eligible hospitals, not have received an electronic health record (EHR) incentive payment within the current payment year from another state, MPIP, or the medicare EHR incentive payment program;

(3) Not have a current sanction or exclusion identified at the United States department of health and human services, office of inspector general, list of excluded individuals and entities, or the Ohio medicaid list of excluded providers.

(E) Patient volume requirements.

(1) Eligible professionals and hospitals participating in MPIP must meet annual patient volume requirements in accordance with 42 C.F.R. 495.304 (as in effect on October 1, 2018) with the exception of children's hospitals;

(2) Patient volume is calculated in accordance with the patient encounter methodology defined in 42 C.F.R. 495.306(c) (as in effect on October 1, 2018);

(F) Group practices or clinics patient volume proxy.

(1) A group practice or clinic will be permitted to calculate patient volume at the group practice or clinic level, but only in accordance with all of the limitations defined in 42 C.F.R. 495.306(h) (as in effect on October 1, 2018).

(2) Each group practice or clinic must confirm in writing and provide evidence of consent, in a manner specified by the Ohio department of medicaid (ODM) on the ODM website, www.medicaid.ohio.gov, from each eligible professional in the group practice or clinic that the eligible professional is consenting to one of the following:

(a) Attesting as a member of the group practice or clinic and permitting the group practice or clinic to use his or her encounters in the group practice or clinic patient volume proxy calculation; or

(b) Not attesting as a member of the group practice or clinic but will permit the group practice or clinic to use his or her encounters in the group practice or clinic patient volume proxy calculation.

(3) If an eligible professional is not attesting as a member of a group practice or clinic but will permit a group practice or clinic to use his or her encounters in the patient volume proxy calculation for the group practice or clinic, the non-participating eligible professional cannot use those encounters toward his or her individual patient volume calculation.

(4) If any eligible professional within the group practice or clinic does not provide written consent for the group practice or clinic to use his or her encounters in the patient volume proxy calculation for the group practice or clinic, the group practice or clinic is precluded from using a group practice

or clinic patient volume proxy.

(5) Supporting documentation must be provided for processing through the MPIP system of the attested patient volume proxy and include the medicaid encounters, total encounters, name and medicaid ID of all medicaid practitioners used in the group practice or clinic patient volume proxy calculation. This information shall be provided in a manner specified by ODM.

(6) Eligible professionals must be employed by the group practice or clinic at the time of attestation in order to use the group practice's or clinic's patient volume proxy.

(G) Encounters.

(1) Encounters are defined in accordance with 42 C.F.R. 495.306(e) (as in effect October 1, 2018).

(2) "Out-of-state encounters" are services rendered by an eligible professional or hospital to a non-Ohio resident and may be used for calculating patient volume.

(a) If out-of-state medicaid encounters are included in the numerator of the calculation to determine patient volume, all out-of-state encounters for the same representative period should be included in the denominator.

(b) Eligible professionals and eligible hospitals are required to provide documentation to support the use of out-of-state encounters and must report out-of-state encounters from each state separately through the MPIP system, in a manner specified by ODM.

(H) Meaningful use (MU).

(1) Eligible professionals and hospitals must:

(a) Meet all activities required to receive an incentive payment in accordance with 42 C.F.R. 495.314 (as in effect on October 1, 2018), in addition to all program eligibility requirements.

(b) Report which certified EHR technology they have adopted, implemented or upgraded to by

providing supporting documentation through the MPIP system at the time of registration and attestation, in a manner specified by ODM.

(c) Demonstrate that meaningful use objectives and measures are met, in accordance with 42 C.F.R. 495.40 (as in effect on October 1, 2018).

(2) Demonstration of MU is subject to review by both ODM and the centers for medicare and medicaid services (CMS).

(3) Dual eligible hospitals meeting MU criteria for the medicare EHR incentive program will be deemed meaningful users for MPIP, but will be required to meet MPIP program eligibility requirements.

(I) Incentive payments.

(1) MPIP incentive payments are calculated in accordance with 42 C.F.R. 495.310 and 42 C.F.R. 495.312 (as in effect on October 1, 2018). Payment will be disbursed to the payee tax identification number selected at the time of attestation.

(2) Eligible professionals and hospitals must meet all requirements set forth in this rule to be eligible for payment.

(3) Eligible professionals may reassign incentive payments in accordance with 42 C.F.R. 495.60(f) (as in effect on October 1, 2018) and other applicable federal and state medicaid laws, rules, and regulations.

(a) The employer or entity for which payment is reassigned must be an Ohio medicaid provider with an active Ohio medicaid provider agreement.

(b) In cases where eligible professionals are associated with more than one practice, the eligible professional must select one tax identification number to receive any applicable EHR incentive payment.

(J) Eligible hospital incentive payments.

(1) All data used to calculate the hospital EHR incentive payment amount must be provided through the MPIP system at the time of the eligible hospital's application and attestation.

(2) All eligible hospital calculations of the aggregate EHR hospital incentive payment made at the time of MPIP application are subject to review and may be adjusted based on review findings.

(3) An eligible hospital may be paid up to one hundred per cent of the calculated aggregate EHR incentive amount over a four-year period, if it meets all MPIP eligibility requirements: forty per cent in year one; thirty per cent in year two; twenty per cent in year three; and ten per cent in year four.

(4) An eligible hospital may not alter or modify data elements used to calculate the hospital EHR incentive payment after MPIP has processed an application for payment and payment has been disbursed for the payment year.

(K) Offsets, adjustments and recoupment of payment.

(1) MPIP payments are subject to offsets, adjustments and recoupments. These and other collection methods will be applied to the medicaid EHR incentive payments to reimburse or pay for medicaid overpayments, fines, penalties, or other debts owed by the provider or its assignee(s) to ODM, Ohio county or local governments, the United States department of health and human services, or any other federal agency.

(2) ODM will identify and recoup overpayments made under the incentive program that result from incorrect or fraudulent attestations, quality measures, cost data, patient data, or any other submission required to establish eligibility or qualify for a payment.

(3) Eligible professionals and eligible hospitals must report any suspected overpayments of an incentive payment to ODM within sixty days of its discovery.