



**The Ohio Health
Information Partnership**

QUESTIONS AND ANSWERS ABOUT THE MEDICAID EHR INCENTIVE PROGRAM FOR ELIGIBLE PROFESSIONALS

Fact Sheet

Q&AS ABOUT THE OHIO MEDICAID PROVIDER INCENTIVE PROGRAM

What is MPIP?

MPIP is the Medicaid Provider Incentive Program established by the state of Ohio and the federal government to reimburse certain Medicaid providers for adopting, implementing or upgrading (A/I/U) to a certified electronic health record (EHR) system.

What does Adopt/Implement/Upgrade (A/I/U) mean?

“Adopt, implement, or upgrade” means:

- ✚ Install or begin using certified EHR technology that has the capability to meet meaningful use requirements; or
- ✚ Expand the functionality of certified EHR technology to meet meaningful use requirements at the practice site, including staffing, maintenance and training; or
- ✚ Upgrade from existing EHR technology to certified EHR technology per the Office of the National Coordinator of HIT (ONC) EHR certification criteria.

ELIGIBILITY

Who are the Medicaid professionals eligible to draw down the incentives for adopting, implementing or upgrading to a certified electronic health record (EHR) system?

To be eligible, a professional must be an enrolled Ohio Medicaid provider with an active Ohio Medicaid Agreement and meet other program specific requirements. Eligible Professionals (EP) include: physicians (MD or DO), dentists, certified nurse midwives, nurse practitioners, and physician assistants (PA) practicing through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is so-led by a PA.

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("So-led" refers to cases where: 1) a PA is the primary provider in a clinic (e.g., when there is a part-time physician and the PA is full time, the PA is considered the primary provider); 2) when the PA is a clinical or Medicaid director at a clinical site or practice; or 3) when a PA is an owner of an RHC.)

For the purposes of MPIP eligibility determination, a pediatrician is a medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children.

To qualify for the Medicaid incentive program at the 20 percent Medicaid patient volume level, a pediatrician must hold a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) 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).

If the pediatrician meets a 30 percent Medicaid patient volume, then he or she does not need to demonstrate board certification.

Can a "hospital-based" provider qualify for the Medicaid EHR incentives?

An Eligible Professional cannot be hospital-based for any year that he or she is seeking payment.

An EP is hospital-based if:

- ✦ 90 percent or more of his or her Medicaid encounters are furnished in an inpatient hospital setting (billed as POS 21) or an Emergency Department (billed as POS 23)
- ✦ And these encounters occur in the calendar year prior to the payment year (e.g., if wishing to qualify for 2011 incentives, then the 2010 claims would be considered when determining hospital-based exclusion).

This exclusion does not apply to the Medicaid EP who qualifies as practicing predominantly in an FQHC or RHC.



MPIP FOR ELIGIBLE PROFESSIONALS

Are EPs practicing through an FQHC or RHC eligible? When is a Physician Assistant considered to be an eligible professional for the MPIP program?

As long as a professional practicing through an FQHC or RHC meets the definition of an “eligible professional” and meets other program specific requirements, he or she may be eligible to participate in MPIP.

CALCULATING MEDICAID PATIENT VOLUME

What are the patient volume requirements specific to EPs?

- ✧ The minimum Medicaid patient volume is 30 percent (20 percent for pediatricians).
- ✧ If a pediatrician meets the 20 percent Medicaid patient volume requirement, then he or she will be eligible for two-thirds (2/3) of the full Medicaid EHR incentive payment (i.e., \$42,500).
- ✧ If a pediatrician meets the 30 percent Medicaid patient volume requirement, he or she will be eligible to receive the full Medicaid EHR incentive reimbursement, (i.e., \$63,750).
- ✧ EP Patient Volume is derived by dividing the total Medicaid patient encounters (fee-for-service and managed care encounters) in any continuous 90-day period in the preceding calendar year by the total patient encounters in the same 90-day period.
- ✧ A Medicaid encounter means services rendered to an individual on any one day where Medicaid paid for part or all of the service; or Medicaid paid all or part of the individual’s premiums, copayments and cost-sharing.



What are the patient volume requirements for EPs in a group practice?

Clinics or group practices will be permitted to calculate patient volume at the group practice or clinic level, but only in accordance with all of the following limitations [42 CFR 495.306 (h)]:

- ✦ The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP;
- ✦ There is an auditable data source to support the clinic's or group practice's patient volume determination;
- ✦ All EPs in the group practice or clinic use the same methodology for the payment year;
- ✦ The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and
- ✦ If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

Who enrolls a group practice/clinic?

Designated Group Enrollers: To attest as part of a group practice or clinic, a designated group enroller (GE) must be the first person to enroll in MPIP.

A designated GE is defined as the eligible professional (EP) within the group that the group practice or clinic has appointed to select all EPs within that group practice/clinic that will participate in MPIP to receive an incentive payment.

A Group Enroller will determine if each member of the group identified meets the following two conditions:

- ✦ Has a valid, current Medicaid provider agreement, and 2) Has rendered and billed Medicaid for at least one Medicaid covered service with a date of service in the 90-day period associated with the calculation of Patient Volume (PV), and has been reimbursed for that service.

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- ✧ If both of these conditions are not met for all members of the group practice/clinic, the group practice/clinic will be precluded from using the group proxy patient volunteers and the EPs within the group practice/clinic will need to apply for MPIP as individuals, or as members of another group practice/clinic.
- ✧ If both conditions are met for all members of the group practice/clinic, the GE will need to upload information to support the attested PV of all Medicaid practitioners used in the group proxy PV calculation. This will include the name and Medicaid Tax ID# (TIN) of each Medicaid practitioner of the group practice/clinic.
- ✧ All EPs must determine individually if they will seek MPIP payment as a member of the eligible group practice/clinic or separately. EPs of an eligible group practice/clinic may apply individually or as a member of another eligible group practice/clinic.
- ✧ The GE must confirm in writing from the EP that each EP in the group practice/clinic is consenting to apply as a member of that group practice/clinic.
- ✧ The GE must upload evidence of that consent. If any EP member of the group practice/clinic does not consent to apply as a member of the practice/clinic but will allow the group practice/clinic to use their encounters towards the group's proxy PV, the GE must upload evidence of that consent. In this instance, the non-participating EP member cannot use those encounters toward their individual PV or for any other group practice/clinic. If any EP within the group practice/clinic does not provide the GE with written consent to use their encounters, the GE may not enroll the group practice/clinic.
- ✧ EPs remaining in the group practice/clinic will be prevented from using a group practice/clinic proxy PV and will need to apply for MPIP as individuals or as members of another group practice/clinic.

How is EP patient volume calculated for an EP practicing predominantly through an FQHC or RHC?

EPs that practice predominantly through an FQHC or RHC must have a minimum 30 percent patient volume of needy individuals.

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Needy Patient Volume is calculated by dividing the total needy individual patient encounters in any representative, 90-day period in the preceding calendar year by the total patient encounters in the same 90-day period.

For the purposes of determining patient volume:

- ✦ “Practices Predominantly” refers to an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a six-month period occurs through an FQHC or an RHC;
- ✦ “Needy Individuals” are those individuals covered by Medicaid including the State Children’s Health Insurance Program (SCHIP), who are furnished uncompensated care by the provider or individuals furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay; and
- ✦ “A needy patient encounter” means services rendered to an individual on any one day where Medicaid (including SCHIP) paid for part or all of the service, Medicaid (including SCHIP) paid all or part of the individual’s premiums, co-payments, and cost-sharing, or services were furnished at no cost; and calculated as being uncompensated or charity care, or services were paid for at a reduced cost based on a sliding scale and determined by the individual’s ability to pay. If an EP is using services calculated as uncompensated care instead of charity care, the EP must downward adjust to eliminate bad debt from uncompensated care.

Why is the Medicaid patient volume being adjusted by an SCHIP factor?

For EPs (except for EPs predominantly practicing in FQHC/RHC) and EHs (except for Childrens Hospitals) in counties with children covered by virtue of Title XXI of the Social Security Act, MPIP will make the SCHIP adjustment to patient volume in compliance with the federal requirement that only individuals covered by Medicaid be included in the calculation of the patient volumes for the Medicaid EHR Incentive Payment Program.

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The adjustment to Patient Volume will be a reduction equal to the value of the lesser of the statewide average percent of children covered by virtue of Title XXI (i.e., 2 percent), or the percent of children in the county represented by the EP. This calculation is performed by the system and requires no input from the provider other than the provider selecting the county in which they predominantly practice.

PROGRAM REGISTRATION

How does an Eligible Professional register and enroll to receive incentive payments?

- ✦ An EP must begin the registration process by first registering with Centers for Medicare and Medicaid Services (CMS) using the National Level Repository (NLR). The NLR is the federal database used to capture and verify basic provider information for Medicare and Medicaid. The website for registering with CMS is: http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp
- ✦ To successfully register with the NLR, an EP must have: a National Provider Identifier (NPI), an active account in the National Plan and Provider Enumeration System (NPPES) and a Payee Tax Identification Number (TIN). Information on obtaining an NPI and registering in the NPPES system can be found at: http://www.cms.gov/NationalProvIdentStand/03_apply.asp#TopOfPage
- ✦ To complete registration for the Medicaid EHR incentive program, providers must enroll in MPIP using the following link: <http://jfs.ohio.gov/OHP/HIT%20Program.stm> The Ohio Medicaid registration can occur the day after the CMS NLR national registration.
- ✦ Prior to enrolling in MPIP, the provider must be a registered Ohio Medicaid provider and have an active Ohio Medicaid Provider Identification Number. This number is needed during the MPIP enrollment process. For detailed information, see "Prerequisites for Eligible Professionals to Participate in MPIP." The link for Medicaid provider enrollment is: <http://www.odjfs.state.oh.us/forms/interfind.asp?formnum=06750>

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How does a Nurse Practitioner (NP) register for Medicaid EHR incentives?

A Nurse Practitioner registers using the same procedures as any other eligible Medicaid provider listed above. If the NP is not able to register in the CMS NLR (see Question 9), it may be because the NP is billing under the practice's NPI # and not his/her own NPI #. In this case, the NP should register for a unique NPI using the steps outlined above, then contact the MPIP program at MPIP@jfs.ohio.gov to determine what documentation needs to be submitted that can be used to calculate the NP's Medicaid patient volume.

What proof must be shown to demonstrate that an EP has adopted, implemented or upgraded (A/I/U) to a certified EHR system?

A practitioner can demonstrate that an EHR system is certified and the practitioner has adopted/implemented/upgraded the system by uploading a copy of a: 1) Purchase order; 2) Contract; or 3) EHR software license to the Medicaid incentive program website during registration for the incentives.

MEDICAID EHR INCENTIVE PAYMENTS

How much can an eligible professional receive in Medicaid EHR incentives?

Eligible Professionals can receive \$63,750 over a six-year period (\$21,250 in the first year, and \$8,500 per year for up to five subsequent years).

An EP who is a pediatrician with a patient volume of less than 30 percent, but meets the patient volume requirement of at least 20 percent, will receive \$42,500 (\$14,167 in the first year and \$5,667 in the subsequent years). Pediatricians meeting the 30 percent patient volume threshold will be eligible to receive the maximum incentive payment of \$63,750, distributed under the same procedure as other EPs listed above.

As long as an EP meets all necessary requirements to qualify for incentive payments, he or she will receive the maximum federally specified incentive payment amount, regardless of the purchase or implementation costs of the EHR system.

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When and how often will EP payments be made?

For the full Medicaid incentives, payments to EPs will extend over six years. EPs may receive payments in non-consecutive years. Eligible Professionals may receive first-year payment as early as 2011 but no later than 2016.

Payments after the first payment year may continue for a maximum of five (5) years. No payments will be made after Calendar Year 2021. Medicaid eligible professionals may receive an incentive payment from only one state in any given payment year.

How are payments issued?

Payments will be made by the state of Ohio to the taxpayer identification number (TIN) selected by the EP at the time of the CMS NLR registration. Each year of eligibility, a single consolidated annual incentive payment will be made to the EP.

Payments for the first year will be made on a rolling basis as soon as the state has verified that the EP has met the required criteria for A/I/U. After the first year, the EP must demonstrate meaningful use for the applicable EHR reporting periods (that is, 90 days for the first Meaningful Use year and a full Calendar Year for EPs for subsequent years).

Payments are made via electronic fund transfer (EFT).



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