

# Medicaid Electronic Health Record Incentive Program Rulebook

Division 165



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**OREGON HEALTH AUTHORITY**  
**DIVISION OF MEDICAL ASSISTANCE PROGRAMS**  
**DIVISION 165**

**Medicaid Electronic Health Record Incentive Program**

Update Information (most current Rulebook changes)

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# Medicaid Electronic Health Record Incentive Program

## Rulebook

### Update Information

July 22, 2011

The Division of Medical Assistance Programs updated this Rulebook to reflect the adoption of OAR 410-165-0060, effective July 22, 2011.

The Division adopted the Medicaid Electronic Health Record (EHR) Incentive Program effective July 1, 2011, having received approval from the Centers for Medicare and Medicaid Services (CMS). However OAR 410-165-0060 was delayed due to clarification from CMS in section (2) (b) (C) and Table 165-0060-1 related to the eligibility criteria for patient volume requirements of eligible professionals practicing in Federally Qualified Health Centers and Rural Health Clinics. The Division determined this to be a substantive change requiring the need to re-file the rule with the Secretary of State and allow a new Public Comment Period to end July 18 giving the public opportunity to comment on the rule change.

All program rules reflect the agency authority change from the Department of Human Services (DHS) to the Oregon Health Authority (Authority) and the subsequent statutory reference updates.

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

## **410-165-0000 Basis and Purpose**

(1) Oregon Administrative Rules (OAR) chapter 410, division 165, govern the Oregon Health Authority (Authority), Division of Medical Assistance Programs (Division), Medicaid Electronic Health Record (EHR) Incentive Program. The Medicaid EHR Incentive Program provides incentive payments to eligible providers participating in the Medicaid program who adopt, implement or upgrade, or successfully demonstrate meaningful use of certified EHR technology and who are qualified by the program.

(2) The Medicaid EHR Incentive Program is implemented pursuant to:

(a) The American Reinvestment and Recovery Act of 2009, Pub. L. No. 111-5, section 4201;

(b) The Centers for Medicare and Medicaid Services (CMS) federal regulation 42 CFR Part 495 (2010) pursuant to the Social Security Act sections 1903(a)(3)(F) and 1903(t);

(c) The Division's General Rules Program, OAR chapter 410, division 120;

(d) The Authority's General Rules Program, OAR chapter 943, division 120; and

(e) The Department of Human Services' Administrative Services Division and Director's Office Provider Rules, OAR chapter 407, division 120.

Statutory Authorization: ORS 413.042

Statutes Implemented: ORS 409.010, 413.042 & 414.033

7-1-11

## **410-165-0020 Definitions**

For the purposes of the Medicaid Electronic Health Record (EHR) Incentive Program Oregon Administrative Rules (OAR), chapter 410, division 165, the following definitions apply:

(1) Acceptance documents -- Written evidence supplied by a provider to demonstrate that the provider met Medicaid EHR Incentive Program eligibility criteria or participation requirements according to standards specified by the Oregon Health Authority's (Authority) Division of Medicaid Assistance Programs.

(2) Acute care hospital -- A healthcare facility, including but not limited to a critical access hospital, with a Centers for Medicare and Medicaid Services' (CMS) certification number (CCN) that ends in 0001-0879 or 1300-1399; and where the average length of patient stay is 25 days or fewer.

(3) Adopt, implement or upgrade:

(a) Acquire, purchase, or secure access to certified EHR technology;

(b) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or

(c) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology.

(4) Certified EHR technology -- As defined in 42 CFR 495.4 (2010) and 45 CFR 170.102 (2010 and 2011) per the Office of the National Coordinator for Health Information Technology EHR certification criteria.

(5) Children's hospital -- A separately certified hospital, either freestanding or hospital-within hospital that has a CCN that ends in 3300–3399; and predominantly treats individuals under 21 years of age.

(6) Dentist -- As defined in OAR 410-120-0000; and as defined in 42 CFR 440.100.

(7) Eligible hospital -- An acute care hospital with at least 10% Medicaid patient volume or a children's hospital.

(8) Eligible professional -- A physician; a dentist; a nurse practitioner, including a nurse-midwife nurse practitioner; or a physician assistant practicing in a Federally Qualified Health Center (FQHC) led by a physician assistant or a Rural Health Clinic (RHC), that is so led by a physician assistant, and meets patient volume requirements described in OAR 410-165-0060.

(9) Eligible provider -- Eligible hospital or eligible professional.

(10) Encounter:

(a) For an eligible hospital either may apply:

(A) Services rendered to an individual per inpatient discharge; or

(B) Services rendered in an emergency department on any one day;

(b) For an eligible professional, services rendered to an individual on any one day.

(11) Enrolled provider -- A hospital or health care practitioner who is actively registered with the Authority pursuant to OAR 407-120-0320.

(12) Entity promoting the adoption of certified EHR technology – An entity, designated by the Authority, that promotes the adoption of certified EHR technology by enabling: oversight of the business, operational and legal issues involved in the adoption and implementation of certified EHR technology; or the exchange and use of electronic clinical and administrative data between participating providers, in a secure manner, including but not limited to maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by eligible providers.

(13) Federal fiscal year (FFY) -- October 1 to September 30.

(14) Federally Qualified Health Center (FQHC) -- As defined in OAR 410-120-0000.

(15) Group -- A clinic as defined in OAR 407-120-0100.

(16) Hospital-based -- An eligibility criterion that excludes an eligible professional from participating in the Medicaid EHR Incentive Program when an eligible professional furnishes 90 percent or more of the eligible professional's Medicaid covered services in a hospital emergency room (place of service code 23), or inpatient hospital (place of service code 21) in the calendar year (CY) preceding the payment year.

(17) Individuals receiving Medicaid -- Individuals served by an eligible provider where the services rendered would qualify under the Medicaid encounter definition.

(18) Meaningful EHR user-- An eligible provider that, for an EHR reporting period for a payment year, demonstrates (in accordance with 42 CFR 495.8) meaningful use of certified EHR technology by meeting the applicable objectives and associated measures in 42 CFR 495.6 and as prescribed by 42 CFR Part 495.

(19) Medicaid encounter:

(a) For an eligible hospital either may apply:

(A) Services rendered to an individual per inpatient discharge where Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid for part or all of the service; or Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid all or part of the individual's premiums, copayments, or cost-sharing; or

(B) Services rendered in an emergency department on any one day where Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid for part or all of the service; or Medicaid (or a Medicaid demonstration project approved under the

Social Security Act section 1115) paid all or part of the individual's premiums, copayments, and cost-sharing;

(b) For an eligible professional either may apply:

(A) Services rendered to an individual on any one day where Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid for part or all of the service; or

(B) Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) paid all or part of the individual's premiums, copayments, and cost-sharing.

(20) National Provider Identifier -- As defined in 45 CFR Part 160 and OAR 410-120-0000.

(21) Needy individual -- Individuals served by an eligible professional where the services rendered qualify under the needy individual encounter definition.

(22) Needy individual encounter -- Services rendered to an individual on any one day where:

(a) Medicaid or Children's Health Insurance Program (CHIP) (or a Medicaid or CHIP demonstration project approved under the Social Security Act section 1115) paid for part or all of the service;

(b) Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under the Social Security Act section 1115) paid all or part of the individual's premiums, copayments, or cost-sharing;

(c) The services were furnished at no cost, and calculated consistent with 42 CFR 495.310(h); or

(d) The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

(23) Nurse practitioner -- As defined in OAR 410-120-0000; and as defined in 42 CFR 440.166.

(24) Panel -- A managed care panel, medical or health home program panel, or similar provider structure with capitation or case assignment that assigns patients to providers.

(25) Payment year --

(a) The CY for an eligible professional; or

(b) The FFY for an eligible hospital.

(26) Pediatrician -- A physician who predominately treats individuals under 21.

(27) Physician -- As defined in OAR 410-120-0000; and as defined in 42 CFR 440.50.

(28) Physician assistant -- As defined in OAR 410-120-0000; and as defined in 42 CFR 440.60.

(29) Practices predominately -- An eligibility criterion to permit use of needy individual patient volume that applies when more than 50 percent of an eligible professional's total patient encounters over a period of six months in the calendar year preceding the payment year occur at an FQHC or RHC.

(30) Preparer -- A person authorized by a provider to act on behalf of the provider to complete an application for a Medicaid EHR incentive via an electronic media connection with the Authority.

(31) Provider Web Portal -- The Department of Human Services' web site that provides a secure gateway for authorized providers to apply for the Medicaid EHR Incentive Program.

(32) Qualify -- The Medicaid EHR Incentive Program determines an eligible provider meets the eligibility criteria and participation requirements to receive a Medicaid EHR incentive payment for the payment year.

(33) Rural Health Clinic (RHC) -- A clinic located in a rural and medically underserved community, designated as an RHC by CMS.

Payment by Medicare and Medicaid to an RHC is on a cost-related basis for outpatient physician and certain non-physician services.

(34) So led – When an FQHC or RHC has a physician assistant who is:

(a) The primary provider in the clinic;

(b) A clinical or medical director at the clinical site of practice; or

(c) An owner of the RHC.

Statutory Authorization: ORS 413.042

Statutes Implemented: ORS 409.010, 413.042 & 414.033

7-1-11

## **410-165-0040 Application**

(1) An eligible provider must apply to the Medicaid Electronic Health Record (EHR) Incentive Program each year that the eligible provider seeks an incentive payment. In order to apply, an eligible provider must:

(a) Register with the Centers for Medicare and Medicaid Services (CMS) for each payment year;

(b) Apply to the Oregon Medicaid EHR Incentive Program after registering with CMS for each payment year; and

(c) Attest, and ensure that the eligible provider's preparer attests, that:

(A) The information submitted is true, accurate, and complete; and

(B) Any falsification or concealment of a material fact may be prosecuted under federal and state laws;

(d) Maintain, for a period of no less than seven years from the date of completed application, complete, accurate, and unaltered copies of all acceptance documents associated with all data transmissions and attestations. The information maintained must include, at a minimum documentation to support:

(A) The adoption, implementation, or upgrade of certified EHR technology including, but not limited to the purchase agreement or contract;

(B) Demonstration of meaningful use for the year corresponding to the payment year;

(C) Patient volume for the year corresponding to the payment year; and

(D) The eligible hospital's payment calculation data including, but not limited to Medicare cost reports.

(2) An eligible provider may submit to Oregon the acceptance documents to support attestation at application.

(3) The Medicaid EHR Incentive Program reviews the completed application and the documentation provided to determine if the eligible provider qualifies for an incentive payment:

(a) The information provided may be subject to verification by the program;

(b) The Medicaid EHR Incentive Program determines if the eligible provider's information complies with the eligibility criteria and participation requirements;

(c) The program notifies the eligible provider about the incentive payment determination;

(d) The Oregon Health Authority (Authority) may reduce the incentive payment to pay off debt if an eligible provider or incentive payment recipient owes a debt under a collection mandate to the state of Oregon. The incentive payment is considered paid to the eligible provider even when part or all of the incentive may offset the debt. The Authority may not reduce the incentive payment amount for any other purpose unless permitted or required by federal or state regulation; and

(e) The Authority distributes 1099 forms to the tax identification number designated to receive the Medicaid EHR incentive payment.

Statutory Authorization: ORS 413.042

Statutes Implemented: ORS 409.010, 413.042 & 414.033

7-1-11

## **410-165-0060 Eligibility**

For the purposes of the Medicaid Electronic Health Record (EHR) Incentive Program Oregon Administrative Rules, chapter 410, division 165, there are three categories of eligibility criteria, which include criteria for a professional, a professional practicing predominately in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC), and a hospital:

(1) A professional, as listed in Table 165-0060-1, must meet the Medicaid EHR Incentive Program criteria each year to be eligible for a Medicaid EHR incentive payment for the payment year:

(a) The professional types who are eligible for the Medicaid EHR Incentive Program are:

(A) A physician;

(B) A dentist; and

(C) A nurse practitioner, including a nurse-midwife nurse practitioner;

(b) To be eligible for an incentive payment, an eligible professional must, at a minimum:

(A) Meet and follow the scope of practice regulations, as applicable for each professional as defined in 42 CFR Part 440;

(B) Meet the following certified EHR technology and meaningful use requirements for the corresponding payment year:

(i) First payment year: Adopt, implement, or upgrade certified EHR technology; and

(ii) Subsequent payment years: Demonstrate meaningful use as prescribed by 42 CFR 495.8 and meet the corresponding meaningful use criteria for the payment year as prescribed by 42 CFR 495.6;

(C) Not be hospital-based; and

(D) Meet one of the following criteria:

(i) Have a minimum of 30 percent patient volume attributable to individuals receiving Medicaid; or

(ii) Have a minimum of 20 percent patient volume attributable to individuals receiving Medicaid, and be a pediatrician;

(c) An eligible professional must calculate patient volume, as listed in Table 165-0060-2, by using:

(A) The patient volume calculation method of:

(i) Patient encounter; or

(ii) Patient panel that may only be used when all of the following apply:

(I) The patient panel is appropriate as a patient volume calculation method for the eligible professional; and

(II) There is an auditable data source to support the patient panel data;

(B) The patient volume of the:

(i) Eligible professional; or

(ii) Group that may only be used when all of the following apply:

(I) The group's patient volume is appropriate to use in the patient volume calculation for the eligible professional;

(II) There is an auditable data source to support the group's patient volume data;

(III) All eligible professionals in the group must use the same patient volume calculation method for the payment year;

(IV) The group uses the entire practice or clinic's patient volume, including non-eligible providers who are billing, rendering and ancillary providers, and does not limit patient volume in any way; and

(V) If an eligible professional works inside and outside of the group, then the patient volume calculation includes only those encounters associated with the group, and not the eligible professional's outside encounters;

(C) To calculate Medicaid patient volume using the patient encounter calculation method based on:

(i) The eligible professional's patient volume, the eligible professional must divide the total Medicaid encounters of the eligible professional in any representative, continuous 90-day period in the preceding calendar year by the total patient encounters of the eligible professional in the same 90-day period; or

(ii) The group's patient volume, the eligible professional must divide the total Medicaid encounters of the group in any representative, continuous 90-day period in the preceding calendar year by the total patient encounters of the group in the same 90-day period;

(D) To calculate Medicaid patient volume using the patient panel calculation method based on:

(i) The eligible professional's patient volume, the eligible professional must divide the total Medicaid patients assigned to the eligible professional's panel in any representative, continuous 90-day period in the preceding calendar year when at least one Medicaid encounter took place with the Medicaid patient in the preceding calendar year plus the eligible professional's unduplicated Medicaid encounters in the same 90-day period by the total patients assigned to the eligible professional's panel in that same 90-day period with at least one encounter taking place with the patient during the preceding calendar year plus all of the unduplicated patient encounters of the eligible professional in the same 90-day period; or

(ii) The group's patient volume, the eligible professional must divide the total Medicaid patients assigned to the group's panel in any

representative, continuous 90-day period in the preceding calendar year when at least one Medicaid encounter took place with the Medicaid patient in the preceding calendar year plus the group's unduplicated Medicaid encounters in the same 90-day period by the total patients assigned to the group's panel in that same 90-day period with at least one encounter taking place with the patient in the preceding calendar year plus all of the unduplicated patient encounters of the group in the same 90-day period.

(2) To be eligible for a Medicaid EHR incentive payment for the payment year, a professional practicing predominately in an FQHC or an RHC, as listed in Table 165-0060-1, must meet the Medicaid EHR Incentive Program professional eligibility criteria each year, by meeting either the above section (1) of this rule or by meeting the following FQHC- and RHC-specific criteria:

(a) The professional types who are eligible for the Medicaid EHR Incentive Program are:

(A) A physician;

(B) A dentist;

(C) A nurse practitioner, including a nurse-midwife nurse practitioner; and

(D) A physician assistant practicing in an FQHC or RHC that is so led by a physician assistant;

(b) To be eligible for an incentive payment, an eligible professional must, at a minimum:

(A) Meet and follow the scope of practice regulations, as applicable for each professional as prescribed by 42 CFR Part 440;

(B) Meet the following certified EHR technology and meaningful use requirements for the corresponding payment year:

(i) First payment year: Adopt, implement, or upgrade certified EHR technology; and

(ii) Subsequent payment years: Demonstrate meaningful use as prescribed by 42 CFR 495.8 and meet the corresponding meaningful use requirements for the payment year as prescribed by 42 CFR 495.6; and

(C) Have a minimum of 30 percent patient volume attributable to needy individuals;

(c) An eligible professional must calculate patient volume, as listed in Table 165-0060-3, by using:

(A) The patient volume calculation method of:

(i) Patient encounter; or

(ii) Patient panel that may only be used when all of the following apply:

(I) The patient panel is appropriate as a patient volume calculation method for the eligible professional; and

(II) There is an auditable data source to support the patient panel data;

(B) The patient volume of the:

(i) Eligible professional; or

(ii) Group that may only be used when all of the following apply:

(I) There is an auditable data source to support the group's patient volume data;

(II) All eligible professionals in the group must use the same patient volume calculation method for the payment year;

(III) The group uses the entire practice or clinic's patient volume, including non-eligible providers who are billing, rendering and ancillary providers, and does not limit patient volume in any way; and

(IV) If an eligible professional works inside and outside of the group, then the patient volume calculation includes only those encounters associated with the group, and not the eligible professional's outside encounters;

(C) To calculate needy individual patient volume using the patient encounter calculation method based on:

(i) The eligible professional's patient volume, the eligible professional must divide the total needy individual encounters of the eligible professional in any representative, continuous 90-day period in the preceding calendar year by the total patient encounters of the eligible professional in the same 90-day period; or

(ii) The group's patient volume, the eligible professional must divide the total needy individual encounters of the group in any representative, continuous 90-day period in the preceding calendar year by the total patient encounters of the group in the same 90-day period;

(D) To calculate needy individual patient volume using the patient panel calculation method based on:

(i) The eligible professional's patient volume, the eligible professional must divide the total needy individual patients assigned to the eligible professional's panel in any representative, continuous 90-day period in the preceding calendar year with at least one encounter taking place with the needy individual patient in the preceding calendar year plus unduplicated needy individual encounters in the same 90-day period by the total patients assigned to the eligible professional's panel in that same 90-day period with at least one encounter taking place with the patient in the preceding calendar year plus all unduplicated patient encounters of the eligible professional in the same 90-day period; or

(ii) The group's patient volume, the eligible professional must divide the total needy individual patients assigned to the group's panel in any representative, continuous 90-day period in the preceding calendar year when at least one encounter took place with the needy

individual patient in the preceding calendar year plus unduplicated needy individual encounters of the group in the same 90-day period by the total patients assigned to the group's panel in that same 90-day period with at least one encounter taking place with the patient during the preceding calendar year plus all unduplicated patient encounters of the group in the same 90-day period.

(3) An eligible hospital must meet the Medicaid EHR Incentive Program criteria each year to be eligible for a Medicaid EHR incentive payment for the payment year:

(a) The hospital types that are eligible for the Medicaid EHR Incentive Program are:

(A) A children's hospital; and

(B) An acute care hospital;

(b) To be eligible for an incentive payment, an eligible hospital must, at a minimum:

(A) Meet the certified EHR technology and meaningful use requirements for the corresponding payment year:

(i) First payment year: Adopt, implement, or upgrade certified EHR technology; and

(ii) Subsequent payment years: Demonstrate meaningful use as prescribed by 42 CFR 495.8 and meet the corresponding meaningful use criteria for the payment year as prescribed by 42 CFR 495.6; and

(B) Meet one of the following:

(i) Be an acute care hospital with at least a 10 percent Medicaid patient volume; or

(ii) Be a children's hospital that is exempt from meeting a patient volume threshold;

(c) An eligible acute care hospital must calculate patient volume by dividing the total eligible hospital Medicaid encounters in any representative, continuous 90-day period in the preceding federal fiscal year by the total encounters in the same 90-day period.

(4) Table 165-0060-1

(5) Table 165-0060-2

(6) Table 165-0060-3

Statutory Authorization: ORS 413.042

Statutes Implemented: ORS 409.010, 413.042 & 414.033

7-22-11

**Table 165-0060-1 Eligible professional eligibility criteria comparison**

| Table 165-0060-1                                      |  |  |
|---|--|--|
| Eligible professional eligibility criteria comparison |  |  |
|   | Eligible professional eligibility criteria (see section 1 of this rule):   | Eligible professional FQHC- and RHC-specific eligibility criteria (see section 2 of this rule):  |
| <b>Practice Location</b>                              | Cannot be hospital-based   | Must practice predominately in an FQHC or RHC  |
| <b>Eligible Professional Types</b>                    | <ol style="list-style-type: none"> <li>1. Physician</li> <li>2. Dentist</li> <li>3. Nurse Practitioner (including a Nurse-Midwife Nurse Practitioner)</li> </ol> | <ol style="list-style-type: none"> <li>1. Physician</li> <li>2. Dentist</li> <li>3. Nurse Practitioner (including a Nurse-Midwife Nurse Practitioner)</li> <li>4. Physician Assistant practicing in an FQHC or an RHC that is so led by a physician assistant</li> </ol> |
| <b>Patient Volume Minimum</b>                         | 30% Medicaid patient volume, except 20% for Pediatricians  | 30% Needy Individual patient volume  |

**Table 165-0060-2 Patient volume calculation choices for an eligible professional**

| Table 165-0060-2  |  |  |
|---|--|--|
| Patient volume calculation choices for an eligible professional<br>(using the eligibility criteria in section 1 of this rule)   |  |  |
|   | Individual calculation   | Group calculation  |
| Patient Encounter   | $\frac{\text{Eligible Professional's Medicaid patient encounters}^*}{\text{Eligible Professional's total patient encounters}^*}$   | $\frac{\text{Group's Medicaid patient encounters}^*}{\text{Group's total patient encounters}^*}$   |
| Patient Panel   | $\frac{\text{Eligible Professional's assigned Medicaid patients}^* \text{ with at least one encounter in the prior calendar year} + \text{Eligible Professional's unduplicated Medicaid patient encounters}^*}{\text{Eligible Professional's assigned total patients}^* \text{ with at least one encounter in the prior calendar year} + \text{Eligible Professional's total unduplicated Medicaid patient encounters}^*}$ | $\frac{\text{Group's assigned Medicaid patients with at least one encounter}^* \text{ in the prior calendar year} + \text{Group's unduplicated Medicaid patient encounters}^*}{\text{Group's assigned total patients}^* \text{ with at least one encounter in the prior calendar year} + \text{Group's total unduplicated Medicaid patient encounters}^*}$ |
| <p>*For the selected representative, continuous 90-day period in the preceding calendar year.</p> <p>**Unduplicated: a patient counted as assigned to a provider that also had an encounter should only be counted once in the calculation.</p> |  |  |

**Table 165-0060-3 Patient volume calculation choices for an eligible professional who practices predominantly in an FQHC or an RHC**

| Table 165-0060-3  |  |  |
|---|--|--|
| Patient volume calculation choices for an eligible professional who practices predominantly in an FQHC or an RHC (using the FQHC- and RHC-specific eligibility criteria in section 2 of this rule)  |  |  |
|   | Individual calculation   | Group calculation  |
| Patient Encounter   | $\frac{\text{Eligible Professional's Needy Individual patient encounters}^*}{\text{Eligible Professional's total patient encounters}^*}$   | $\frac{\text{Group's Needy Individual patient encounters}^*}{\text{Group's total patient encounters}^*}$   |
| Patient Panel   | $\left( \begin{array}{l} \text{Eligible Professional's assigned Needy Individual patients}^* \text{ with at least one encounter in the prior calendar year} \\ + \\ \text{Eligible Professional's unduplicated Needy Individual patient encounters}^* \end{array} \right)$ | $\left( \begin{array}{l} \text{Group's assigned Needy Individual patients with at least one patient encounter}^* \text{ in the prior calendar year} \\ + \\ \text{Group's unduplicated Needy Individual patient encounters}^* \end{array} \right)$ |
|   | $\left( \begin{array}{l} \text{Eligible Professional's assigned total patients}^* \text{ with at least one encounter in the prior calendar year} \\ + \\ \text{Eligible Professional's total unduplicated Needy patient encounters}^* \end{array} \right)$                 | $\left( \begin{array}{l} \text{Group's assigned total patients}^* \text{ with at least one patient encounter in the prior calendar year} \\ + \\ \text{Group's total unduplicated Needy patient encounters}^* \end{array} \right)$                 |
| <p>*For the selected representative, continuous 90-day period in the preceding calendar year.</p> <p>**Unduplicated: a patient counted as assigned to a provider that also had an encounter should only be counted once in the calculation.</p> |  |  |

## **410-165-0080 Meaningful Use**

(1) An eligible provider must demonstrate being a meaningful Electronic Health Record (EHR) user as prescribed by 42 CFR 495.4 and 42 CFR 495.8.

(2) An eligible provider must satisfy meaningful use objectives and measures as prescribed by 42 CFR 495.6. The state of Oregon has an exception that requires an eligible provider to satisfy the objective “Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice” as part of the core requirements for Stage 1:

(a) If an eligible hospital is deemed to be a meaningful EHR user by Medicare for a payment year, then the eligible hospital is automatically deemed to be a meaningful EHR user for the Medicaid EHR Incentive Program for the same payment year;

(b) An eligible hospital deemed to be a meaningful EHR user by Medicare for a payment year does not have to meet Oregon’s exception to qualify for the Medicaid EHR incentive payment for the same payment year.

Statutory Authorization: ORS 413.042

Statutes Implemented: ORS 409.010, 413.042 & 414.033

7-1-11

## **410-165-0100 Participation and Incentive Payments**

(1) An eligible provider applying for a Medicaid Electronic Health Record (EHR) incentive payment must meet the Medicaid EHR Incentive Program eligibility criteria and participation requirements for each year that the eligible provider applies to qualify for an incentive payment:

(a) An eligible provider must meet the eligibility criteria for each payment year of:

(A) Type of eligible provider;

(B) Patient volume minimum; and

(C) Certified EHR technology requirements for the first payment year and meaningful use requirements for the subsequent payment years;

(b) An eligible provider must meet the participation requirements for each payment year including:

(A) Be an enrolled Medicaid provider with the Oregon Health Authority's (Authority) Division of Medical Assistance Programs (Division);

(B) Provide up to date provider information to the Division;

(C) Possess an active professional license and comply with all licensing statutes and regulations within the state where the eligible provider practices;

(D) Possess an active Provider Web Portal account;

(E) Be able to receive electronic funds transfer from the Authority; and

(F) Comply with all applicable Oregon Administrative Rules (OAR), including chapter 407, division 120, chapter 410, division 120, and chapter 943, division 120;

(c) An eligible professional may reassign the entire amount of the incentive payment to:

(A) The eligible professional's employer with which the eligible professional has a contractual arrangement allowing the employer to bill and receive payments for the eligible professional's covered professional services;

(B) An entity with which the eligible professional has a contractual arrangement allowing the entity to bill and receive payments for the eligible professional's covered professional services; or

(C) An entity promoting the adoption of certified EHR technology.

(2) An eligible professional must follow the Medicaid EHR Incentive Program participation conditions including an eligible professional must:

(a) Receive an incentive payment from only one state for a payment year;

(b) Only receive an incentive payment from either Medicare or Medicaid for a payment year, but not both;

(c) Not receive more than the maximum incentive amount of \$63,750 over a six-year period; or the maximum incentive of \$42,500 over a six-year period if the eligible professional qualifies as a pediatrician who meets the 20 percent patient volume minimum and less than the 30 percent patient volume;

(d) Participate in the Medicaid EHR Incentive Program:

(A) Starting as early as calendar year (CY) 2011, but no later than CY 2016;

(B) Ending no later than CY 2021;

(C) For a maximum of six years; and

(D) On a consecutive or non-consecutive annual basis;

(e) Be allowed to switch between the Medicare and Medicaid EHR Incentive Program only one time after receiving at least one incentive payment, and only for a payment year before 2015.

(3) Payments are disbursed to an eligible professional on a rolling basis following verification of eligibility for the payment year:

(a) An eligible professional is paid an incentive amount for the corresponding payment year for each year of qualified participation in the Medicaid EHR Incentive Program;

(b) The payment structure is as follows for:

(A) An eligible professional qualifying with 30 percent minimum patient volume:

(i) The first payment year incentive amount is \$21,250; and

(ii) The second, third, fourth, fifth, or sixth payment year incentive amount is \$8,500; or

(B) An eligible pediatrician qualifying with 20 percent, but less than 30 percent minimum patient volume:

(i) The first payment year incentive amount is \$14,167; and

(ii) The second, third, fourth, fifth, or sixth payment year incentive amount is \$5,667.

(4) An eligible hospital must follow the Medicaid EHR Incentive Program participation conditions including that the eligible hospital:

(a) Receives a Medicaid EHR incentive payment from only one state for a payment year;

(b) May participate in both the Medicare and Medicaid EHR Incentive Programs if the eligible hospital meets all eligibility criteria for the payment year for both programs;

(c) Participates in the Medicaid EHR Incentive Program:

(A) Starting as early as federal fiscal year (FFY) 2011 but no later than FFY 2016;

(B) Ending no later than FFY 2021;

(C) For a maximum of three years;

(D) On a consecutive or non-consecutive annual basis for federal fiscal years prior to FFY 2016; and

(E) On a consecutive annual basis for federal fiscal years starting in FFY 2016;

(d) A multi-site hospital with one Centers for Medicare and Medicaid Services' Certification Number is considered one hospital for purposes of calculating payment.

(5) Payments are disbursed to an eligible hospital on a rolling basis following verification of eligibility for the payment year. An eligible hospital is paid the aggregate incentive amount over three years of qualified participation in the Medicaid EHR Incentive Program:

(a) The payment structure as listed in Table 165-0100-1 is as follows:

(A) The first payment year incentive amount is equal to 50% of the aggregate amount;

(B) The second payment year incentive amount is equal to 40% of the aggregate amount; and

(C) The third payment year incentive amount is equal to 10% of the aggregate amount;

(b) The aggregate EHR hospital incentive amount is calculated as the product of the "overall EHR amount" times the "Medicaid Share" as listed in Table 165-00100-2. The aggregate amount is calculated once, for the first year participation, and then paid over three years according to the payment schedule:

(A) The overall EHR amount for an eligible hospital is based upon a theoretical four years of payment the hospital would receive, and is the sum of the following calculation performed for each of such four years. For each year, the overall EHR amount is the product of the initial amount, the Medicare share and the transition factor:

(i) The initial amount as listed in Table 165-0100-3 is equal to the sum of the base amount, which is set at \$2,000,000 for each of the theoretical four years, plus the discharge-related amount, that is calculated for each of the theoretical four years:

(I) The discharge-related amount is \$200 per discharge for the 1,150<sup>th</sup> through the 23,000<sup>th</sup> discharge, based upon the total discharges for the eligible hospital (regardless of source of payment) from the hospital fiscal year that ends during the FFY prior to the fiscal year that serves as the first payment year. No discharge-related amount is added for discharges prior to the 1,150<sup>th</sup> or any discharges after the 23,000<sup>th</sup>;

(II) For purposes of calculating the discharge-related amount for the last three of the theoretical four years of payment, discharges are assumed to increase each year by the provider's average annual rate of growth; negative rates of growth must also be applied. Average annual rate of growth is calculated as the average of the annual rate of growth in total discharges for the most recent three years for which data are available per year.

(ii) The Medicare share that equals 1;

(iii) The transition factor, that equals:

(I) 1 for the first of the theoretical four years;

(II) 0.75 for the second of the theoretical four years;

(III) 0.5 for the third of the theoretical four years; and

(IV) 0.25 for the fourth of the theoretical four years;

(B) The Medicaid share for an eligible hospital is equal to a fraction:

(i) The numerator for the FFY and with respect to the eligible hospital is the sum of:

(I) The estimated number of inpatient-bed-days that are attributable to Medicaid individuals; and

(II) The estimated number of inpatient-bed-days that are attributable to individuals who are enrolled in a managed care organization, a pre-paid inpatient health plan, or a pre-paid ambulatory health plan administered under 42 CFR Part 438;

(ii) The denominator is the product of:

(I) The estimated total number of inpatient-bed-days with respect to the eligible hospital during such period; and

(II) The estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during such period;

(iii) In computing inpatient-bed-days for the Medicaid share, an eligible hospital may not include the following:

(I) Estimated inpatient-bed-days attributable to individuals that may be made under Medicare Part A; or

(II) Inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C;

(iv) If an eligible hospital's charity care data necessary to calculate the portion of the formula for the Medicaid share are not available, the eligible hospital's data on uncompensated care may be used to determine an appropriate proxy for charity care, but must include a downward adjustment to eliminate bad debt from uncompensated care data if bad debt is not otherwise differentiated from uncompensated care. Auditable data sources must be used; and

(v) If an eligible hospital's data necessary to determine the inpatient bed-days attributable to Medicaid managed care patients are not available, that amount is deemed to equal 0. In the absence of an eligible hospital's data necessary to compute the percentage of inpatient bed days that are not charity care as described under (B)(ii)(II) in this section, that amount is deemed to be 1.

(6) Table 165-0100-1

(7) Table 165-0100-2

(8) Table 165-0100-3

Statutory Authorization: ORS 413.042

Statutes Implemented: ORS 409.010, 413.042 & 414.033

7-1-11

## Table 165-0100-1 Incentive Payment Schedule for a Hospital

| <b>Table 165-0100-1</b>  |                             |                             |                             |                              |
|--|-----------------------------|-----------------------------|-----------------------------|------------------------------|
| <b>Incentive Payment Schedule for a Hospital</b>   |                             |                             |                             |                              |
| Actual Payment Year*   | Year 1                      | Year 2                      | Year 3                      | Total                        |
| Payment amount   | 50% of Aggregate EHR Amount | 40% of Aggregate EHR Amount | 10% of Aggregate EHR Amount | 100% of Aggregate EHR Amount |
| *Hospital must meet eligibility criteria and participation requirements for each payment year. |                             |                             |                             |                              |

**Table 165-0100-2 Initial Amount for an eligible hospital**

| <b>Table 165-0100-2</b>   |  |  |   |
|---|--|--|---|
| <b>Initial Amount for an eligible hospital (calculated for each theoretical payment year)</b> |  |  |   |
|   | <b>Hospitals with ≤ 1,149 discharges during the payment year</b>             | <b>Hospitals with ≥ 1,150 ≤ 23,000 discharges during the payment year</b>      | <b>Hospitals with ≥ 23,001 discharges during the payment year</b> |
| <b>Base Amount</b>  | \$2,000,000  | \$2,000,000  | \$2,000,000   |
| <b>Discharge-Related Amount*</b>  | \$0  | \$200 x (n – 1,149)<br>(n is the number of discharges during the payment year) | \$200 x (23,001 – 1,149)  |
| <b>*Adjusted by average annual rate of growth</b>   | Average of most recent three years annual rate of growth in total discharges |  |   |
| <b>Total Initial Amount</b>   | \$2,000,000  | Between \$2,000,000 and \$6,370,400 depending on the number of discharges      | Limited by law to \$6,370,400                                     |

**Table 165-0100-3 Eligible hospital payment calculation**

| <b>Table 165-0100-3</b>                      |  |  |  |  |
|--|--|--|--|--|
| <b>Eligible hospital payment calculation</b> |  |  |  |  |
| <b>Theoretical Year:</b>                     | <b>Year 1</b>  | <b>Year 2</b>  | <b>Year 3</b>  | <b>Year 4</b>  |
| <b>Initial amount =</b>                      | (a base amount of \$2,000,000) + (Year 1 discharge-related amount) | (a base amount of \$2,000,000) + (Year 1 discharge-related amount x average annual rate of growth) | (a base amount of \$2,000,000) + (Year 2 discharge-related amount x average annual rate of growth) | (a base amount of \$2,000,000) + (Year 3 discharge-related amount x average annual rate of growth) |
| <b>Medicare share =</b>                      | 1  | 1  | 1  | 1  |
| <b>Transition factor =</b>                   | 1.00   | 0.75   | 0.50   | 0.25   |
| <b>Total Yearly EHR amount:</b>              | (Initial amount) x (Medicare share) x (Transition factor)          | (Initial amount) x (Medicare share) x (Transition factor)  | (Initial amount) x (Medicare share) x (Transition factor)  | (Initial amount) x (Medicare share) x (Transition factor)  |
| <b>Overall EHR Amount =</b>                  | <b>Sum of the 4 Yearly EHR Amounts</b>                             |  |  |  |

multiply **Overall EHR Amount** by

|                         |   |  |
|-------------------------|---|--|
| <b>Medicaid share =</b> | <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <b>Estimated # of inpatient-bed days attributable to Medicaid, including: fee-for-service, managed care, pre-paid inpatient health plan, or pre-paid ambulatory health plan</b> </div> |  |
|                         | <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <b>Estimated total # of inpatient-bed days for the eligible hospital during that period</b> </div>   | <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <b>Estimated total amount of the eligible hospital's charges during that period minus charity care</b> </div>     |
|                         | multiply by   | <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> <b>Estimated total amount of the eligible hospital's charges during that period including charity care</b> </div> |

equals

**Aggregate EHR Amount (product of the Overall EHR amount and Medicaid Share)**

## **410-165-0120 Appeals**

(1) The appeals process for the Medicaid Electronic Health Record (EHR) Incentive Program is pursuant to 42 CFR 495.370 and the Oregon Health Authority's (Authority) Provider Appeals Rules in the Oregon Administrative Rules (OAR) chapter 410, division 120.

(2) For purposes of OAR chapter 410, division 165, a provider who applies for a Medicaid EHR incentive payment may appeal a decision by the Medicaid EHR Incentive Program as outlined in the Authority's Division of Medical Assistance Programs' Provider Appeal Rules (OAR chapter 410, division 120). The provider's appeal must note the specific reason for the appeal, which must be due to:

- (a) An incentive payment;
- (b) An incentive payment amount;
- (c) A provider eligibility determination;
- (d) The demonstration of adopting, implementing or upgrading; or
- (e) Meaningful use eligibility.

Statutory Authorization: ORS 413.042

Statutes Implemented: ORS 409.010, 413.042 & 414.033

7-1-11

## **410-165-0140 Oversight and Audits**

(1) A provider who qualifies for a Medicaid Electronic Health Record (EHR) incentive payment under the Medicaid (EHR) Incentive Program is subject to audit or other post-payment review procedures as authorized in Oregon Administrative Rule (OAR) 407-120-1505.

(2) The Oregon Health Authority and the Department of Human Services have the authority to recover overpayments from the person or entity who received an incentive payment from the Medicaid EHR Incentive Program.

(3) The person or entity who received a Medicaid EHR incentive overpayment must repay the amount specified within 30 calendar days from the mailing date of written notification of the overpayment as prescribed by OAR 407-120-1505.

Statutory Authorization: ORS 413.042

Statutes Implemented: ORS 409.010, 413.042 & 414.033

7-1-11