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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Update Rules Governing Payment for the Medicaid EHR Incentive Program

EFFECTIVE DATE: 03/08/2019

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RULES:
410-165-0000, 410-165-0040, 410-165-0080, 410-165-0100, 410-165-0140

AMEND: 410-165-0000

RULE TITLE: Basis and Purpose

NOTICE FILED DATE: 01/11/2019

RULE SUMMARY: The Division needs to amend these rules as new federal legislation from the Centers for Medicare and Medicaid Services (CMS) and updates to Oregon's Medicaid State Plan Amendment affect how providers are eligible for the Medicaid EHR Incentive Program. These rules include changes for the 90-day EHR reporting period in 2018-2019.

RULE TEXT:
(1) These rules (OAR chapter 410, division 165) govern the Oregon Health Authority (Authority), Health Systems Division (Division), Medicaid Electronic Health Record (EHR) Incentive Program. The Medicaid EHR Incentive Program provides incentive payments consistent with federal law concerning such payments to eligible providers participating in the Medicaid program who adopt, implement, 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, 2012, 2014, and 2015) 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 Provider Rules, OAR chapter 943, division 120.
(3) The following retroactive effective dates apply to these rules:
(a) For all sections in these rules that refer to pediatric optometrists, the effective date is July 1, 2016;
(b) For rule 410-165-0080 that refers to:
(A) CMS federal regulation 42 CFR Part 495 (2016), the effective date is January 1, 2017;
(B) CMS federal regulation 42 CFR Part 495 (2017), the effective date is October 1, 2017;

(C) CMS federal regulation 42 CFR Part 495 (2018), in the FY 2019 Hospital Inpatient PPS Final Rule, sections 495.4, 495.24, 495.40, and 495.100, the effective date is October 1, 2018;
(D) CMS federal regulation 42 CFR Part 495 (2018) in the CY 2019 Medicare Physician Fee Schedule Final Rule, sections 495.4 and 495.24, the effective date is January 1, 2019.
(c) For all sections in these rules that refer to naturopathic physicians, the effective date is May 2, 2017;
(d) For eligible hospitals, except for sections and references in these rules applicable under section (3)(a) or (b) above, the effective date is October 1, 2013, which is also the start date for program year 2014;
(e) For eligible professionals, except for sections and references in these rules applicable under section (3)(a) or (b) above, the effective date is January 1, 2014, which is also the start date for program year 2014;
(f) For rule 410-165-0060 that refers to the grace period for program year 2017, the effective date is February 5, 2018.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.033

AMEND: 410-165-0040

RULE TITLE: Application

NOTICE FILED DATE: 01/11/2019

RULE SUMMARY: The Division needs to amend these rules as new federal legislation from the Centers for Medicare and Medicaid Services (CMS) and updates to Oregon's Medicaid State Plan Amendment affect how providers are eligible for the Medicaid EHR Incentive Program. These rules include changes for the 90-day EHR reporting period in 2018-2019.

RULE TEXT:

(1) An eligible provider shall apply to the program each program year that the eligible provider seeks an incentive payment. To apply, an eligible provider or preparer shall:

(a) Register with CMS;

(b) After registering with CMS, follow the steps as outlined on the website at https://www.oregon.gov/oha/HPA/OHIT-MEHRIP/pages/index.aspx to apply to the program within the grace period for each program year:

(A) For program years 2011 and 2012, the following applies:

(i) For a first-year application, the grace period is 60 days;

(ii) For all subsequent years, the grace period is 90 days.

(B) For program year 2013, the grace period is 90 days;

(C) For program year 2014, the following applies:

(i) For eligible hospitals, the grace period ends on January 31, 2015;

(ii) For eligible professionals, the grace period ends on May 31, 2015.

(D) For program year 2015, the following applies:

(i) For eligible providers who are attesting for adopt, implement, or upgrade defined in section (3), the grace period ends on March 31, 2016;

(ii) For eligible hospitals that are attesting for meaningful use through CMS for the Medicare EHR Incentive Program and for the Medicaid EHR Incentive Program, the grace period ends on March 31, 2016;

(iii) For eligible professionals who are attesting for meaningful use described in OAR 410-165-0080, the grace period ends on August 31, 2016;

(iv) For eligible hospitals that are children's hospitals defined in OAR 410-165-0020 that are attesting for meaningful use described in OAR 410-165-0080 through the Medicaid EHR Program, the grace period ends on December 31, 2016.

(E) For program year 2016, the following applies:

(i) For eligible hospitals, the grace period ends on March 31, 2017;

(ii) For eligible professionals that are not naturopathic physicians, the grace period ends on May 31, 2017;

(iii) For naturopathic physicians, the grace period ends on July 31, 2017.

(F) For program year 2017, the following applies:

(i) For eligible hospitals, the grace period ends on March 31, 2018;

(ii) For eligible professionals, the grace period ends on May 31, 2018;

(G) For program year 2018, the grace period ends on April 30, 2019;

(H) For program years 2019 and 2020 the grace period is 90 days;

(I) For program year 2021, the grace period does not apply. Information regarding program year 2021 application deadlines shall be established by the program.

(c) Attest that:

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

(B) They understand that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

(d) Maintain for a minimum of 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 shall include at a minimum documentation to support:
(A) The financial or legal obligation for 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 program year;
(C) Patient volume for the year corresponding to the program year; and
(D) The eligible hospital's payment calculation data including, but not limited to, Medicare cost reports.
(2) An eligible provider shall submit the acceptance documents referred to in section (1)(d)(A) when the eligible provider is attesting for a payment for the adoption, implementation, or upgrade to certified EHR technology or when new certified EHR technology is acquired. If the eligible provider is an eligible hospital seeking its first-year payment, it shall submit the acceptance documents referred to in section (1)(d)(D).
(3) The Program reviews the completed application and the acceptance documents to determine if the eligible provider qualifies for an incentive payment:
(a) The Program shall verify the information in the application;
(b) The Program shall determine if the eligible provider's information complies with the eligibility criteria and participation requirements;
(c) The Program shall notify the eligible provider about the incentive payment determination;
(d) The 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 law; and
(e) The Authority shall distribute 1099 forms to the tax identification number designated to receive the Medicaid EHR incentive payment.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.033

AMEND: 410-165-0080

RULE TITLE: Meaningful Use

NOTICE FILED DATE: 01/11/2019

RULE SUMMARY: The Division needs to amend these rules as new federal legislation from the Centers for Medicare and Medicaid Services (CMS) and updates to Oregon's Medicaid State Plan Amendment affect how providers are eligible for the Medicaid EHR Incentive Program. These rules include changes for the 90-day EHR reporting period in 2018-2019.

RULE TEXT:

(1) An eligible provider shall demonstrate being a meaningful EHR user as prescribed by 42 CFR 495.4 (2010, 2012, 2015, 2016, 2017, and 2018), 42 CFR 495.6 (2010, 2012, and 2014), 42 CFR 495.8 (2010, 2012, and 2014), 42 CFR 495.20 (2015), 42 CFR 495.22 (2015, 2016, and 2017), 42 CFR 495.24 (2015, 2016, 2017, and 2018), and 42 CFR 495.40 (2015, 2016, 2017, and 2018):

(a) For eligible providers demonstrating meaningful use under the program in Stage 1 prior to December 15, 2015, to comply with 42 CFR 495.8, the State of Oregon requires the 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;"

(b) For eligible hospitals:

(A) If CMS deems an eligible hospital to be a meaningful EHR user for the Medicare EHR Incentive Program for a program year, the eligible hospital is automatically deemed to be a meaningful EHR user for the program for the same program year;

(B) An eligible hospital deemed to be a meaningful EHR user by CMS for a program year does not have to meet the requirements specified in section (1)(a) for the program for the same program year.

(2) As prescribed by 42 CFR 495.4 (2010, 2012), the following meaningful use EHR reporting periods shall be used by eligible providers that are demonstrating meaningful use to the program for:

(a) Program years 2011, 2012, and 2013:

(A) Eligible professionals:

(i) For the first time, either:

(I) Any continuous 90-day period in the calendar year; or

(II) The calendar year.

(ii) For a subsequent time: the calendar year.

(B) Eligible hospitals:

(i) For the first time, either:

(I) Any continuous 90-day period in the federal fiscal year; or

(II) The federal fiscal year.

(ii) For a subsequent time, the federal fiscal year.

(b) Program year 2014:

(A) Eligible professionals, either:

(i) Any continuous 90-day period in calendar year 2014; or

(ii) Any of the following 3-month periods:

(I) January 1, 2014 through March 31, 2014;

(II) April 1, 2014 through June 30, 2014;

(III) July 1, 2014 through September 30, 2014; or

(IV) October 1, 2014 through December 31, 2014.

(B) Eligible hospitals, either:

(i) Any continuous 90-day period in federal fiscal year 2014; or

(ii) Any of the following 3-month periods:

(I) October 1, 2013 through December 31, 2013;
(II) January 1, 2014 through March 31, 2014;
(III) April 1, 2014 through June 30, 2014; or
(IV) July 1, 2014 through September 30, 2014.
(3) As prescribed by 42 CFR 495.4 (2015, 2016), the following meaningful use EHR reporting periods shall be used by eligible providers that are demonstrating meaningful use to the program for:
(a) Program year 2015, prior to December 15, 2015:
(A) Eligible professionals attesting for the first year, either:
(i) Any continuous 90-day period in the calendar year; or
(ii) The calendar year.
(B) Eligible professionals attesting for a subsequent year, the calendar year;
(C) Eligible hospitals attesting for the first year, either:
(i) Any continuous 90-day period in the federal fiscal year; or
(ii) The federal fiscal year.
(D) Eligible hospitals attesting for a subsequent year, the federal fiscal year.
(b) Program year 2015, on or after December 15, 2015, any continuous 90-day period in the calendar year;
(c) Program year 2016 before January 1, 2017:
(A) The first year, either:
(i) Any continuous 90-day period in the calendar year; or
(ii) The calendar year.
(B) A subsequent year, the calendar year.
(d) Program year 2016 after January 1, 2017:
(A) Any continuous 90-day period in the calendar year; or
(B) The calendar year.
(4) As prescribed by 42 CFR 495.4 (2017, 2018), the following meaningful use EHR reporting periods shall be used by eligible providers that are demonstrating meaningful use to the program for:
(a) Program year 2017 before October 1, 2017:
(A) The first year, either:
(i) Any continuous 90-day period in the calendar year; or
(ii) The calendar year.
(B) A subsequent year:
(i) Any continuous 90-day period in the calendar year; or
(ii) The calendar year for meaningful use objectives; and
(iii) A calendar year for the Clinical Quality Measures.
(b) Program year 2017 on or after October 1, 2017:
(A) Any continuous 90-day period in the calendar year; or
(B) The calendar year.
(c) Program year 2018, 2019, and 2020:
(A) The first year, either:
(i) Any continuous 90-day period in the calendar year; or
(ii) The calendar year.
(B) A subsequent year:
(i) Any continuous 90-day period in the calendar year; or
(ii) The calendar year for meaningful use objectives; and
(iii) A calendar year for the Clinical Quality Measures.
(d) Program year 2021: Any continuous 90-day period in the calendar year that ends before the application deadline specified in OAR 410-165-0040(1)(b)(I).

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 414.033, ORS 413.042

AMEND: 410-165-0100

RULE TITLE: Participation and Incentive Payments

NOTICE FILED DATE: 01/11/2019

RULE SUMMARY: The Division needs to amend these rules as new federal legislation from the Centers for Medicare and Medicaid Services (CMS) and updates to Oregon's Medicaid State Plan Amendment affect how providers are eligible for the Medicaid EHR Incentive Program. These rules include changes for the 90-day EHR reporting period in 2018-2019.

RULE TEXT:

(1) To qualify for an incentive payment, an eligible provider shall meet the Program eligibility criteria and participation requirements for each year the eligible provider applies:

(a) An eligible provider shall meet the eligibility criteria for each program year of:

(A) Type of eligible provider;

(B) Patient volume minimum; and

(C) Certified EHR technology adoption, implementation, or upgrade requirements in the first year of participation and meaningful use requirements in subsequent years, or meaningful use requirements in all years of participation.

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

(A) Be an enrolled Medicaid provider with the Division;

(B) Maintain current provider information with 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) Have an active Provider Web Portal account;

(E) Ensure the designated payee is able to receive electronic funds transfer from the Authority; and

(F) Comply with all applicable Oregon Administrative Rules, including 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 whom 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 shall follow the Program participation conditions and requirements. The eligible professional shall:

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

(b) Only receive an incentive payment from either Medicare or Medicaid for a program 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 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 Programs only one time after receiving at least one incentive payment and only for a program year before 2015.

(3) The Authority shall disburse payments to the eligible professional following verification of eligibility for the program year:

(a) An eligible professional is paid an incentive amount for the corresponding program year for each year of qualified participation in the Program;
(b) The payment structure is as follows for:
(A) An eligible professional qualifying with 30 percent minimum patient volume:
(i) The first payment incentive amount is $21,250; and
(ii) The second, third, fourth, fifth, or sixth payment 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 incentive amount is $14,167; and
(ii) The second, third, fourth, or fifth payment incentive amount is $5,667;
(iii) The sixth payment incentive amount is $5,665.
(c) The deadline for the Authority to disburse payments to eligible professionals is December 31, 2021.
(4) An eligible hospital shall follow the Medicaid EHR Incentive Program participation conditions including requirements that the eligible hospital:
(a) Receives a Medicaid EHR incentive payment from only one state for a program year;
(b) May participate in both the Medicare and Medicaid EHR Incentive Programs only if the eligible hospital meets all eligibility criteria for the program year for both programs;
(c) Participates in the Program:
(A) Starting as early as program year 2011 but no later than program year 2016;
(B) Ending no later than program year 2021;
(C) For a maximum of three years;
(D) On a consecutive or non-consecutive annual basis for program years prior to program year 2016; and
(E) On a consecutive annual basis for program years starting in program year 2016.
(d) A multi-site hospital with one CMS CCN is considered one hospital for purposes of calculating payment.
(5) The Authority shall disburse payments to the eligible hospital following verification of eligibility for the program year. An eligible hospital is paid the aggregate incentive amount over three years of qualified participation in the Program:
(a) The payment structure as listed in Table 165-0100-1 is as follows:
(A) The first payment incentive amount is equal to 50 percent of the aggregate EHR amount;
(B) The second payment incentive amount is equal to 40 percent of the aggregate EHR amount; and
(C) The third payment incentive amount is equal to 10 percent of the aggregate EHR amount.
(b) The aggregate EHR amount is calculated as the product of the “overall EHR amount” times the “Medicaid Share” as listed in Table 165-0100-2. The aggregate EHR 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) For initial amounts calculated in program years 2011 or 2012, the discharge-related amount is $200 per discharge for the 1,150th through the 23,000th discharge, based upon the total discharges for the eligible hospital (regardless of source of payment) from the hospital fiscal year that ends during the federal fiscal year (FFY) prior to the FFY year that serves as the first payment year. No discharge-related amount is added for discharges prior to the 1,150th or any discharges after the 23,000th;
(II) For initial amounts calculated in program year 2013 or later, the discharge-related amount is $200 per discharge for the 1,150th through the 23,000th discharge, based upon the total discharges for the eligible hospital (regardless of source of payment) from the hospital fiscal year that ends before the FFY that serves as the first payment year. No

discharge-related amount is added for discharges prior to the 1,150th or any discharges after the 23,000th;
(III) 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 hospital's average annual rate of growth; negative rates of growth shall 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 or coordinated 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 either of 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 shall 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 shall 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 subparagraph (B)(ii)(II) in this section, that amount is deemed to be 1.
(6) The aggregate EHR amount is determined by the state from which the eligible hospital receives its first incentive payment. If a hospital receives incentive payments from other states in subsequent years, total incentive payments received over all payment years of the program can be no greater than the aggregate EHR amount calculated by the state from which the eligible hospital received its first incentive payment.
(7) Table 165-0100-1. [Table not included. See NOTE.]
(8) Table 165-0100-2. [Table not included. See NOTE.]
(9) Table 165-0100-3. [Table not included. See NOTE.]

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.033

Table 165-0100-1

Incentive Payment Schedule for an Eligible Hospital

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 shall meet eligibility criteria and participation requirements for each payment year.				

Table 165-0100-2

Initial Amount for an Eligible Hospital (calculated for each theoretical payment year)

	Hospitals with ≤ 1,149 discharges during the payment year	Hospitals with ≥ 1,150 ≤ 23,000 discharges during the payment year	Hospitals with ≥ 23,001 discharges during the payment year
Base Amount	$2,000,000	$2,000,000	$2,000,000
Discharge-Related Amount*	$0	$200 x (n – 1,149) (n is the number of discharges during the payment year)	$200 x (23,001 – 1,149)
*Adjusted by average annual rate of growth	Average of most recent three years annual rate of growth in total discharges		
Total Initial Amount	$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

Theoretical Year:	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Initial amount =	(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)
Medicare share =	1	1	1	1
Transition factor =	1.00	0.75	0.50	0.25
Total Yearly EHR amount:	(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)
Overall EHR Amount =	**Sum of the 4 Yearly EHR Amounts**			
Multiply Overall EHR Amount by				
Medicaid share =	(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) / (Estimated total # of inpatient-bed days for the eligible hospital during that period)	multiply by	(Estimated total amount of the eligible hospital's charges during that period minus charity care) / (Estimated total amount of the eligible hospital's charges during that period including charity care)	
equals				
Aggregate EHR Amount (product of the Overall EHR Amount and Medicaid Share)				

AMEND: 410-165-0140

RULE TITLE: Oversight and Audits

NOTICE FILED DATE: 01/11/2019

RULE SUMMARY: The Division needs to amend these rules as new federal legislation from the Centers for Medicare and Medicaid Services (CMS) and updates to Oregon's Medicaid State Plan Amendment affect how providers are eligible for the Medicaid EHR Incentive Program. These rules include changes for the 90-day EHR reporting period in 2018-2019.

RULE TEXT:

(1) A provider who qualifies for a Medicaid Electronic Health Record (EHR) incentive payment under the Program is subject to audit or other post-payment review procedures pursuant to OAR 943-120-1505.

(2) The Authority and the Department of Human Services may recover overpayments from the person or entity who received an incentive payment from the Program.

(3) As authorized in 42 CFR 495.312, the Authority designates CMS to conduct audits on hospitals' meaningful use attestations through program year 2014. For program year 2015 and later, the Authority and the Department of Human Services shall conduct these audits.

(4) 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 943-120-1505.

STATUTORY/OTHER AUTHORITY: ORS 413.042

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.033