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PERMANENT ADMINISTRATIVE RULES

Oregon Health Authority, Health Systems Division: Medical Assistance Programs	410
Agency and Division	Administrative Rules Chapter Number
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Adopted on	
08/01/2016	
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RULE CAPTION

EHR IP Rule Updates Following Federal Rule Update

Not more than 15 words

RULEMAKING ACTION

ADOPT:

AMEND:
410-165-0000,410-165-0020,410-165-0040,410-165-0060,410-165-0080,410-165-0100,410-165-0120,410-165-0140

REPEAL:
410-165-0000(T),410-165-0020(T),410-165-0040(T),410-165-0060(T),410-165-0080(T),410-165-0100(T),410-165-0120(T),410-165-0140(T)

RENUMBER:

AMEND & RENUMBER:

Stat. Auth.: ORS 413.042, 414.033

Other Auth.:

Stats. Implemented: ORS 413.042

RULE SUMMARY

The Division needs to amend these rules because the Centers for Medicare and Medicaid Services (CMS) released a final rule that specifies criteria that eligible professionals (EPs) and eligible hospitals must meet in order to participate in the Medicaid Electronic Health Record (EHR) Incentive Programs. Updates to the Oregon Administrative Rules align with these changes. The CMS final rule became effective on December 15, 2015, and impacts providers for program years 2015 and later. There are also minor clarifications to wording throughout the rule.

Authorized Signer	Printed Name	Date
Karen Wheeler	Karen Wheeler	12/15/16

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410-165-0000

Basis and Purpose

(1) These rules (OAR chapter 410, division 165) govern the Oregon Health Authority (Authority), Health Systems Division, Medical Assistance Programs (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 CMS federal regulation 42 CFR Part 495 (2015), the effective date is December 15, 2015;

(b) For all sections and references in these rules that refer to CMS federal regulation 42 CFR Part 495 (2014), the effective date is October 1, 2014;

(c) 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;

(d) 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.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 414.033

410-165-0020

Definitions

The following definitions apply to OAR 410-165-0010 through 410-165-0140:

(1) “Acceptance documents” means written evidence supplied by a provider demonstrating that the provider met Medicaid EHR Incentive Program eligibility criteria or participation requirements according to standards specified by the Division.

(2) “Acute care hospital” means 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” means:

(a) Acquire, purchase, or secure access to certified EHR technology capable of meeting meaningful use requirements;

(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) “Attestation” means a statement that:

(a) Is made by an eligible provider or preparer during the application process;

(b) Represents that the eligible provider met the thresholds and requirements of the Medicaid EHR Incentive Program; and

(c) Is made under penalty of prosecution for falsification or concealment of a material fact.

(5) “Certified EHR technology” has the meaning given that term in 42 CFR 495.302 (2010, 2012, and 2014), 42 CFR 495.4 (2010, 2012, and 2015), 42 CFR 495.6 (2014), 42 CFR 495.20 (2015), and 45 CFR 170.102 (2010, 2011, 2012, 2014, and 2015).

(6) “Children’s hospital” means a separately certified hospital, either freestanding or a hospital within a hospital that predominantly treats individuals under 21 years of age and that:

(a) Has a CCN that ends in 3300–3399; or

(b) Does not have a CCN but has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program as a children’s hospital.

(7) “Dentist” has the meaning given that term in OAR 410-120-0000 and 42 CFR 440.100.

(8) “Eligible hospital” means an acute care hospital with at least 10 percent Medicaid patient volume or a children’s hospital.

(9) “Eligible professional” means a professional who:

(a) Is a physician, dentist, nurse practitioner, nurse-midwife nurse practitioner, or physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is so led by a physician assistant;

(b) Meets patient volume requirements described in OAR 410-165-0060; and

(c) Is not a hospital-based professional.

(10) “Eligible provider” means an eligible hospital or eligible professional.

(11) “Encounter” means:

(a) For an eligible hospital:

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

(B) Services rendered to an individual in an emergency department on any one day.

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

(12) “Enrolled provider” means a hospital or health care practitioner who is actively registered with the Authority pursuant to OAR 943-120-0320.

(13) “Entity promoting the adoption of certified EHR technology” means an entity designated by the Authority that promotes the adoption of certified EHR technology by enabling:

(a) Oversight of the business and operational and legal issues involved in the adoption and implementation of certified EHR technology; or

(b) 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.

(14) “Federal fiscal year (FFY)” means October 1 to September 30.

(15) “Federally Qualified Health Center (FQHC)” has the meaning given that term in OAR 410-120-0000.

(16) “Grace period” means a period of time or specified date following the end of a program year when an eligible provider may submit an application to the Medicaid EHR Incentive Program for that program year.

(17) “Hospital-based professional” means a professional who furnishes 90 percent or more of 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 program year, but does not include a professional practicing predominantly at a FQHC or RHC.

(18) “Individuals receiving Medicaid” means individuals served by an eligible provider where the services rendered would qualify under the Medicaid encounter definition.

(19) “Meaningful EHR user” means an eligible provider that meets the criteria set forth in OAR 410-165-0080.

(20) “Medicaid encounter” means:

(a) For an eligible hospital applying for program year 2011 or 2012:

(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 hospital applying for program year 2013 or later, either:

(A) Services rendered to an individual per inpatient discharge where the individual was enrolled in Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) or Children’s Health Insurance Program (CHIP) if part of a state’s Medicaid expansion (does not apply to Oregon’s as it is designated as a separate CHIP state) at the time the billable service was provided; or

(B) Services rendered in an emergency department on any one day where the individual was enrolled in Medicaid (or a Medicaid demonstration project approved under the Social Security Act section 1115) or Children’s Health Insurance Program (CHIP) if part of a state’s Medicaid expansion (does not apply to Oregon’s as it is designated as a separate CHIP state) at the time the billable service was provided.

(c) For an eligible professional applying for program year 2011 or 2012, either:

(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.

(d) For an eligible professional applying for program year 2013 or later, services rendered to an individual on any one day where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under the Social Security Act section 1115) or Children's Health Insurance Program (CHIP) if part of a state's Medicaid expansion (does not apply to Oregon's as it is designated as a separate CHIP state) at the time the billable service was provided.

(21) "National Provider Identifier" has the meaning given that term in 45 CFR Part 160 and OAR 410-120-0000.

(22) "Needy individual" means individuals served by an eligible professional where the services rendered qualify under the needy individual encounter definition.

(23) "Needy individual encounter" means:

(a) For an eligible professional applying for program year 2011 or 2012, services rendered to an individual on any one day where:

(A) Medicaid or 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) (2010); or

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

(b) For an eligible professional applying for program year 2013 or later, services rendered to an individual on any one day where:

(A) The services were rendered to an individual enrolled in a Medicaid program or a Medicaid demonstration project approved under the Social Security Act section 1115 or CHIP at the time the billable service was provided;

(B) The services were furnished at no cost and calculated consistently with 42 CFR 495.310(h) (2010); or

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

(24) “Nurse practitioner” has the meaning given that term in OAR 410-120-0000 and 42 CFR 440.166.

(25) “Panel” means a managed care panel, medical or health home program panel, or similar provider structure with capitation or case assignment that assigns patients to providers.

(26) “Patient volume” means:

(a) For eligible hospitals, the proportion of Medicaid encounters to total encounters expressed as a percentage;

(b) For eligible professionals who do not meet the definition of “practices predominantly,” the proportion of Medicaid encounters to total encounters expressed as a percentage;

(c) For eligible professionals who meet the definition of “practices predominantly,” the proportion of needy individual encounters to total encounters expressed as a percentage.

(27) “Pediatrician” means a physician who predominantly treats individuals under the age of 21.

(28) “Physician” has the meaning given that term in OAR 410-120-0000 and 42 CFR 440.50.

(29) “Physician assistant” has the meaning given that term in OAR 410-120-0000 and 42 CFR 440.60.

(30) “Practices predominantly” means an eligibility criterion to permit use of needy individual patient volume. An eligible professional practices predominantly if:

(a) For program year 2011 or 2012, more than 50 percent of an eligible professional’s total patient encounters over a period of six months in the calendar year preceding the program year occur at an FQHC or RHC;

(b) For program year 2013 and later, more than 50 percent of an eligible professional’s total patient encounters occur at an FQHC or RHC:

(A) During a six-month period in the calendar year preceding the program year; or

(B) During a six-month period in the most recent 12 months prior to attestation.

(31) “Preparer” means an individual authorized by an eligible 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.

(32) “Program” means the Medicaid EHR Incentive Program.

(33) “Program year” means:

(a) The CY for an eligible professional;

(b) For an eligible hospital:

(A) The federal fiscal year for program years 2011 through 2014 and for program 2015 if the attestation date is before December 15, 2015;

(B) The CY for program year 2015 and later if the attestation date is on or after December 15, 2015.

(34) "Provider Web Portal" means the Authority's website that provides a secure gateway for eligible providers or preparers to apply for the Program.

(35) "Qualify" means to meet the eligibility criteria and participation requirements to receive a payment for the program year. The Program makes the determination as to whether an eligible provider qualifies.

(36) "Rural Health Clinic (RHC)" means 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.

(37) "So led" means 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.

Stats. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 414.033

410-165-0040

Application

(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, 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 and later, 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 and later, the grace period is 90 days.

(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.

Stats. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 414.033

410-165-0060

Eligibility

(1) There are three categories of eligibility criteria:

(a) Eligible professionals;

(b) Eligible professionals practicing predominately in a FQHC or RHC; and

(c) Eligible hospitals.

(2) To be eligible for a Medicaid EHR incentive payment for the program year, an eligible professional as listed in Table 165-0060-1 shall meet the Program criteria each year:

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

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

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

(i) First year of participation:

(I) Adopt, implement, or upgrade certified EHR technology; or

(II) Meet the definition of a Meaningful EHR user described in OAR 410-165-0020.

(ii) Subsequent years of participation, meet the definition of a Meaningful EHR user described in OAR 410-165-0020.

(C) Either not be a hospital-based professional or for program year 2013 or later meet the requirements that allow a reversal of a hospital-based determination. To be considered non-hospital-based in future program years after an initial reversal determination, the professional shall attest in each subsequent program year that the professional continues to meet the requirements. To meet the requirements, the professional shall do all of the following:

(i) Fund the acquisition, implementation, and maintenance of certified EHR technology, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital and use such certified EHR technology in the inpatient or emergency department of a hospital;

(ii) Provide documentation to the Program for review and approval for the program year and in accordance with OAR 410-165-0040;

(iii) Meet all applicable requirements to receive an incentive payment; and

(iv) If attesting to meaningful use, demonstrate using all encounters at all locations equipped with certified EHR technology, including those in the inpatient and emergency departments of the hospital.

(D) Meet one of the following criteria:

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

(ii) Be a pediatrician who has a minimum of 20 percent patient volume attributable to individuals receiving Medicaid.

(b) An eligible professional shall calculate patient volume as listed in Table 165-0060-2 by using the patient volume calculation method either of patient encounter or of patient panel. The patient panel volume calculation method may be used only when all of the following apply:

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

(B) There is an auditable data source to support the patient panel data.

(c) An eligible professional shall calculate patient volume as listed in Table 165-0060-2 by using either the patient volume of the eligible professional or the patient volume of the group. The patient volume of the group may be used only when all of the following apply:

(A) The group's patient volume is appropriate as a patient volume methodology calculation for the eligible professional;

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

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

(D) The group uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and

(E) 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.

(d) An eligible professional's patient volume must be calculated using one of the following methods:

(A) The patient encounter calculation method based on the patient volume of the eligible professional requires that:

(i) For program year 2011 or 2012, the eligible professional shall divide the total Medicaid encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period in the preceding calendar year; or

(ii) For program year 2013 and later, the eligible professional shall divide the total Medicaid encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period either in the preceding calendar year or in the twelve-month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

(B) The patient encounter calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional shall divide the group's total Medicaid encounters by the group's total patient encounters in any representative, continuous 90-day period in the preceding calendar year;

(ii) For program year 2013 and later, the eligible professional shall divide the group's total Medicaid encounters by the group's total patient encounters in any representative, continuous 90-day period either in the preceding calendar year or in the twelve-month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

(C) The patient panel calculation method based on the patient volume of the eligible professional requires that:

(i) For program year 2011 or 2012, the eligible professional shall:

(I) Add the total Medicaid patients assigned to the eligible professional's panel in any representative, 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the eligible professional's unduplicated Medicaid encounters rendered in the same 90-day period; and

(II) Divide the result calculated above in section (1)(d)(C)(i)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.

(ii) For program year 2013 and later, the eligible professional shall:

(I) Add the total Medicaid patients assigned to the eligible professional's panel in any representative, 90-day period in either the preceding calendar year or during the 12-month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the eligible professional's unduplicated Medicaid encounters rendered in the same 90-day period; and

(II) Divide the result calculated above in section (2)(d)(C)(ii)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

(D) The patient panel calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional shall:

(I) Add the total Medicaid patients assigned to the group's panel in any representative, 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the group's unduplicated Medicaid encounters in the same 90-day period; and

(II) Divide the result calculated above in section (1)(d)(D)(i)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.

(ii) For program year 2013 and later, the eligible professional shall:

(I) Add the total Medicaid patients assigned to the group's panel in any representative, 90-day period in either the preceding calendar year or during the 12-month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the group's unduplicated Medicaid encounters that same 90-day period;

(II) Divide the result calculated above in section (1)(d)(D)(ii)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

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

(a) At a minimum, the eligible professional shall:

(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 year of participation:

(i) First year of participation:

(I) Adopt, implement, or upgrade certified EHR technology; or

(II) Meet the definition of a meaningful EHR user described in OAR 410-165-0020.

(ii) Subsequent years of participation, meet the definition of a meaningful EHR user described in OAR 410-165-0020.

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

(b) An eligible professional shall calculate patient volume as listed in Table 165-0060-3 by using the patient volume calculation method either of patient encounter or of patient panel. The patient panel volume calculation method may be used only when all of the following apply:

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

(B) There is an auditable data source to support the patient panel data.

(c) An eligible professional must calculate patient volume as listed in Table 165-0060-3 by using either the patient volume of the eligible professional or the patient volume of the group. The group's patient volume may be used only when all of the following apply:

(A) The group's patient volume is appropriate as a patient volume methodology calculation for the eligible professional;

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

(C) All eligible professionals in the group shall use the same patient volume calculation method for the program year;

(D) The group uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and

(E) If an eligible professional works inside and outside of the group, the patient volume calculation includes only those encounters associated with the group and not the outside encounters.

(d) An eligible professional's needy individual patient volume shall be calculated using one of the following methods:

(A) The patient encounter calculation method based on the eligible professional's patient volume:

(i) For program year 2011 or 2012, the eligible professional shall divide the total needy individual encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period in the preceding calendar year;

(ii) For program year 2013 and later, the eligible professional shall divide the total needy individual encounters by the total patient encounters that were rendered by the eligible professional in any representative, continuous 90-day period either in the preceding calendar year or in the12-month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

(B) The patient encounter calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional shall divide the group's total needy individual encounters by the group's total patient encounters in any representative, continuous 90-day period in the preceding calendar year;

(ii) For program year 2013 and later, divide the group's total needy individual encounters by the group's total patient encounters in any representative, continuous 90-day period either in the preceding calendar year or in the 12-month timeframe preceding the date of attestation. The eligible professional may not use the same 90-day timeframe to calculate patient volume in different program years.

(C) The patient panel calculation method based on the patient volume of the eligible professional requires that:

(i) For program year 2011 or 2012, the eligible professional shall:

(I) Add the total needy individual patients assigned to the eligible professional's panel in any representative, 90-day period in the prior calendar year, provided at least one Medicaid encounter took place with the patient in the preceding calendar year, to the eligible professional's unduplicated needy individual encounters rendered in the same 90-day period; and

(II) Divide the result calculated above in section (2)(d)(C)(i)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.

(ii) For program year 2013 and later, the eligible professional shall:

(I) Add the total needy individual patients assigned to the eligible professional's panel in any representative, 90-day period either in the preceding calendar year or during the 12-month timeframe preceding the attestation date, provided at least one Medicaid encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the eligible professional's unduplicated needy individual encounters rendered the same 90-day period;

(II) Divide the result calculated above in section (2)(d)(C)(ii)(I) by the sum of the total patients assigned to the eligible professional's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

(D) The patient panel calculation method based on the patient volume of the group requires that:

(i) For program year 2011 or 2012, the eligible professional shall:

(I) Add the total needy individual patients assigned to the group's panel in any representative, 90-day period in the prior calendar year, provided at least one needy individual encounter took place with the patient in the preceding calendar year, to the group's unduplicated Medicaid encounters in the same 90-day period; and

(II) Divide the result calculated above in section (2)(d)(D)(i)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the preceding calendar year, plus all of the unduplicated patient encounters in the same 90-day period.

(ii) For program year 2013 and later, the eligible professional shall:

(I) Add the total needy individual patients assigned to the group's panel in any representative, 90-day period either in the preceding calendar year or during the 12-month timeframe preceding the attestation date, provided at least one needy individual encounter took place with the individual during the 24 months before the beginning of the 90-day period, to the group's unduplicated Medicaid encounters that same 90-day period;

(II) Divide the result calculated above in section (2)(d)(D)(ii)(I) by the sum of the total patients assigned to the group's panel in the same 90-day period, provided at least one encounter took place with the patient during the 24 months before the beginning of the 90-day period, plus all of the unduplicated patient encounters in the same 90-day period; and

(III) Not use the same 90-day timeframe to calculate patient volume in different program years.

(4) To be eligible for a Medicaid EHR incentive payment for the program year, an eligible hospital shall meet the Program criteria each year:

(a) To be eligible for an incentive payment, an eligible hospital shall meet the certified EHR technology and meaningful use requirements for the corresponding year of participation:

(A) First year of participation:

(i) Adopt, implement, or upgrade certified EHR technology;

(ii) Eligible hospitals that are children's hospitals shall meet the definition of a meaningful EHR user; or

(iii) Eligible hospitals that participate in both the Medicare and Medicaid EHR Incentive Programs shall demonstrate meaningful use under the Medicare EHR Incentive Program to CMS and be deemed a meaningful EHR user for the program year.

(B) Subsequent years of participation:

(i) Eligible hospitals that participate in both the Medicare and Medicaid EHR Incentive Programs shall demonstrate meaningful use under the Medicare EHR Incentive Program to CMS and be deemed a meaningful EHR user for the program year; or

(ii) Eligible hospitals that are children's hospitals shall meet the definition of a meaningful EHR user;

(b) If an eligible hospital is an acute care hospital, it shall calculate patient volume by dividing the total eligible hospital Medicaid encounters by the total encounters in any representative, continuous 90-day period:

(A) For program year 2011 and 2012, in the preceding federal fiscal year;

(B) For program year 2013 and later, either in the preceding federal fiscal year or in the 12-month timeframe preceding the attestation date. The eligible hospital may not use the same 90-day timeframe to calculate patient volume in different program years.

(5) Table 165-0060-1.

(6) Table 165-0060-2.

(7) Table 165-0060-3.

Stats. Auth.: ORS 413.042
Stats. Implemented: ORS 413.042, 414.033

Table 165-0060-1

Eligible professional eligibility criteria comparison

Practice Location	Eligible professional eligibility criteria (see section 1 of this rule):	Eligible professional FQHC-and RHC-specific eligibility criteria (see section 2 of this rule):
	Cannot be hospital-based	Shall practice predominantly in an FQHC or RHC
Eligible Professional Types	1. Physician 2. Dentist 3. Nurse Practitioner (including a Nurse-Midwife Nurse Practitioner)	1. Physician 2. Dentist 3. Nurse Practitioner (including a Nurse-Midwife Nurse Practitioner) 4. Physician Assistant practicing in an FQHC or an RHC that is so led by a physician assistant
Patient Volume Minimum	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 (using the eligibility criteria in section 1 of this rule)

	Individual calculation	Group calculation
Patient Encounter	(Eligible Professional's Medicaid patient encounters*) / (Eligible Professional's total patient encounters*)	(Group's Medicaid patient encounters*) / (Group's total patient encounters*)
Patient Panel	(Eligible Professional's assigned** Medicaid patients*) + (Eligible Professional's unduplicated *** Medicaid patient encounters*) / (Eligible Professional's total assigned patients*) + (Eligible Professional's total unduplicated *** patient encounters*)	(Group's assigned Medicaid patients with at least one encounter**) + (Group's unduplicated *** Medicaid patient encounters*) / (Group's assigned total patients*) + (Group's total unduplicated *** patient encounters*)

*If applying in program years 2011 or 2012, include encounters in any representative, continuous 90-day period in the preceding calendar year. If applying in program year 2013 or later, include encounters in any representative, continuous 90-day period either in the preceding calendar year or in the 12-month timeframe preceding the attestation date.

**If applying in program years 2011 or 2012, include assigned patients who have had at least one encounter in the prior calendar year. If applying in program year 2013 or later, include assigned patients who have had at least one encounter in the 24 months that occurred prior to the start date of the selected representative, continuous 90-day period.

***Unduplicated: A patient should not be counted more than once in totaling assignments and encounters. In other words, if a patient is assigned to a panel for an eligible professional or a group, that patient should be counted only once in the calculation of the total assigned patients and the total unduplicated patient encounters.

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	(Eligible Professional's Needy Individual patient encounters*)	(Group's Needy Individual patient encounters*)
	(Eligible Professional's total patient encounters*)	(Group's total patient encounters*)
Patient Panel	(Eligible Professional's assigned** Needy Individual patients*) + (Eligible Professional's unduplicated *** Needy Individual patient encounters*)	(Group's assigned** Needy Individual patients*) + (Group's unduplicated *** Needy Individual patient encounters*)
	(Eligible Professional's assigned** total patients*) + (Eligible Professional's total unduplicated *** patient encounters)	(Group's assigned** total patients*) + (Group's total unduplicated *** patient encounters*)

* If applying in program years 2011 or 2012, include encounters in any representative, continuous 90-day period in the preceding calendar year. If applying in program year 2013 or later, include encounters in any representative, continuous 90-day period either in the preceding calendar year or in the 12-month time period preceding the attestation date.

**If applying in program years 2011 or 2012, include assigned patients who have had at least one encounter in the prior calendar year. If applying in program year 2013 or later, include assigned patients who have had at least one encounter in the 24 months that occurred prior to the start date of the selected representative, continuous 90-day period.

*** A patient should not be counted more than once in totaling assignments and encounters. In other words, if a patient is assigned to a panel for an eligible professional or a group, that patient should be counted only once in the calculation of the total assigned patients and the total unduplicated patient encounters.

410-165-0080

Meaningful Use

(1) An eligible provider shall demonstrate being a meaningful EHR user as prescribed by 42 CFR 495.4 (2010, 2012, and 2015), 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), 42 CFR 495.24 (2015), and 42 CFR 495.40 (2015):

(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, and 2015), the following meaningful use EHR reporting periods shall be used by eligible providers that are demonstrating meaningful use to the Program:

(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.

(c) 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.

(d) On or after December 15, 2015, for program year 2015, any continuous 90-day period in the calendar year;

(e) For program year 2016 and subsequent years, the following applies to eligible providers attesting for:

(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.

Stats. Auth.: ORS 413.042
Stats. Implemented: ORS, 413.042, 414.033

410-165-0100

Participation and Incentive Payments

(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, fifth, or sixth payment incentive amount is $5,667.

(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.

(8) Table 165-0100-2.

(9) Table 165-0100-3.

Stats. Auth.: ORS 413.042
Stats. 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)				

410-165-0120 Appeals

(1) The appeals process for the Program is governed by 42 CFR 495.370 and the Authority's Provider Appeals Rules in chapter 410, division 120.

(2) Pursuant to 42 CFR 495.312 and 42 CFR 495.370, the Authority may have CMS conduct the audits and handle any subsequent appeals of whether eligible hospitals are meaningful EHR users.

(3) A provider who applies for a Medicaid EHR incentive payment may appeal the Program's decision. Appeals are governed by the Division's Provider Appeal Rules OAR chapter 410, division 120. The provider's appeal shall note the specific reason for the appeal, due to one or more of the following issues:

(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 other than a meaningful use eligibility issue where CMS handles the appeal, as provided in section (2) of this rule.

Stats. Auth.: ORS 413.042
Stats. Implemented: ORS, 413.042, 414.033

410-165-0140

Oversight and Audits

(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 and the Department of Human Services may designate CMS to conduct audits on hospitals' meaningful use attestations.

(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.

Stats. Auth.: ORS 413.042

Stats. Implemented: ORS 413.042, 414.033