2019 Stage 3 Tip Sheet for Eligible Professionals

Effective Program Year 2017, per CMS Final Rule, the Medicaid Promoting Interoperability Program (MPIP) will remain available for continued participation to Eligible Professionals that have received at least one payment. Payments may be from either Ohio MPIP or another State Medicaid Promoting Interoperability Program. Payments must have been made during Program Year 2016 or prior.

This checklist provides a detailed overview of Ohio's MPIP system for returning EPs and may be used as a guide to gather the information required to successfully complete Stage 3 attestation in Program Year 2019.

MPIP Enrollment

Before you begin, has the EP had any pertinent information such as payee designation change since the previous attestation?

If YES:

the EP should first update their registration information with the CMS Registration and Attestation System by visiting https://ehrincentives.cms.gov/hitech/login.action. Once the information has been updated with CMS, MPIP will receive the updates and invite the EP to enroll for the program year. Please allow for an overnight update to occur before returning to the MPIP Provider Portal to complete your attestation.

If NO:

the EP may enroll for the current program year with MPIP by proceeding to the MPIP Provider Portal at

https://www.ohiompip.com/OHIO/enroll/logon.

Password Reset

Eligible professionals will be required to input all the following information to successfully reset their password:

- National Provider Identification Number (NPI)
- Last 4-digits of TIN (EPs use the last four digits of SSN)
- Email address on file
- Full 10-Digit CMS Registration ID

IMPORTANT: To update the email address on file or retrieve your CMS registration ID, please return to the CMS Registration & Attestation System. CMS Registration ID's are unique to each provider and should be kept in a safe place. Eligible Professionals will need this information to successfully reset their password and to complete attestation submission. For security purposes, MPIP Operations staff will only have access to the last four digits of an EP's CMS registration ID.

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Step One: Provider Registration Verification

The following questions will be asked to help EPs determine their program eligibility:

Are you a hospital-based provider? *(Select **"Yes"** if you meet the following definition).*

- An EP who furnishes 90% or more of their Medicaid covered professional services in an inpatient hospital (POS 21) or emergency room (POS 23) setting during the previous calendar year (CY 2018).

Hospital-based providers may still be eligible for MPIP if they meet both of the following requirements:

- Fund the acquisition, implementation, and maintenance of Certified EHR Technology (CEHRT), including supporting hardware and interfaces needed for MU without reimbursement from an eligible hospital **and**
- Use the CEHRT in the inpatient or emergency department (ED) of a hospital (instead of the eligible hospital's CEHRT).

The hospital-based exclusion does not apply to an EP practicing predominantly through a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

Are you attesting as a Pediatrician? (*Patient volume between 20% - 30% attributable to individuals enrolled in a Medicaid program).*

- For purposes of MPIP only, a pediatrician refers to a medical doctor, who diagnoses, treats, examines, and prevents diseases and injuries in children. Attesting pediatricians must hold a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) degree and hold a current, in good-standing board certification in pediatrics through the American Board of Pediatrics, the American Board of Surgery, the American Board of Radiology, the American Board of Urology, the American Osteopathic Board of Pediatrics, or a current, in good standing, pediatric subspecialty certificate recognized by the American Board of Medical Specialties.

Do you practice predominantly in an FQHC/RHC? *(Minimum patient volume of 30% attributable to needy individuals which includes Medicaid enrolled or sliding scale).*

- An EP "practices predominantly" when the clinical location for over 50% of his or her total patient encounters over a period of 6 months within the most recent calendar year or, within the 12-month period preceding attestation, occurs at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

Select your Patient Volume Attestation Method

- Individual – The EP is attesting using individual patient encounters
- Group/Clinic – The EP is attesting as a member of a group/clinic using patient volume attributable to a group. (*If attesting as a group, please refer to the **Group Patient Volume** tip sheet available*

on the MPIP Resources Page at https://medicaid.ohio.gov/Provider/MedicaidProviderIncentiveProgram/MPIPResources).

Select Patient Volume Location

Based on the patient volume attestation method selected, the EP will be required to select a Patient Volume Location. Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an EP's sites of practice however, at least one of the locations must be equipped with Certified EHR Technology (CEHRT).

- Individual attestation method – Select from a list of practice locations based on the individual EP or payee TIN in the State MMIS including practices the EP may be associated with.
- Group attestation method – Select from a list of the group/clinic practice location(s) within the State MMIS the EP is associated with to create a group or join an existing group.

NOTE: Practice locations are based on the practice NPI and Medicaid ID combination. If there are numerous locations that use the same NPI and Medicaid ID then only one location will appear for selection.

Select your Payee Medicaid ID

Verify the payee information is correct based on NPI and Medicaid ID entered during the CMS registration process and select your Payee Medicaid ID.

NPI and TIN combinations must match what appears on the payee's Ohio Medicaid agreement. If you are unable to select a payee Medicaid ID, first visit the Ohio Medicaid Information Technology System (MITS) at https://ssopro.mits.medicaid.ohio.gov/prosecure/authtam/login to verify the information that appears on the Medicaid agreement. If updates are necessary, you will need to return to the CMS Registration & Attestation system to review and correct the entered payee NPI and TIN. Please allow an overnight update before returning to the MPIP provider portal. If problems persist, please contact MPIP Operations at 1-877-537-6747.

Update Point of Contact Information

EPs will have the opportunity to update point of contact information within the MPIP system such as email address and phone number.

Step Two: Medicaid Patient Volume Determination

For each year of program participation, an EP must meet one of the following patient volume requirements:

- A minimum patient volume of 30% attributable to individuals enrolled in a Medicaid program;
- A minimum patient volume of 20% attributable to individuals enrolled in a Medicaid program and be a Pediatrician; or

- A minimum patient volume of 30% attributable to needy individuals and practice predominantly through an FQHC/RHC.

Select Patient Volume Reporting Period

The patient volume reporting period consists of any continuous 3-month period, beginning on the first day of the month. EPs will select their reporting period from the preceding calendar year (2018) or from within the most recent full 12-month period*

*The available 12-months to select a 3-month reporting period is determined by the date of attestation.

Start Date:_____ End Date:_____

Out-of-State Encounters

Were out-of-state encounters included in the EP's patient volume calculation? (Yes or No)
If yes, you will need to select which states or territories and include applicable Medicaid encounters.

Patient Volume Attestation

The following are considered Medicaid encounters for EPs:

- Services rendered to an individual on any one day where Medicaid paid for part or all of the service;
- Services rendered to an individual on any one day where Medicaid paid for part or all of the individual's premiums, co-payments, and cost sharing; or
- Services rendered to an individual on any one day where the individual was enrolled in a Medicaid program at the time the billable service was provided.

EPs practicing predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) may include Needy encounters in addition to their Medicaid encounters to meet the required patient volume threshold. Needy encounters include:

- Encounters furnished at no cost & calculated as being uncompensated care (minus bad debt) or charity care
- Encounters paid for based on a sliding scale

Medicaid encounters may include individuals enrolled in a traditional or Medicaid HMO program where Medicaid is the primary or secondary payer. Additionally, encounters for both the patient volume numerator and denominator should be based on per patient per day.

Total Medicaid patient encounters: _____
Total Patient encounters: _____

Supporting Documentation: EPs will have the opportunity to upload any patient volume reports on the Document Upload page following the completion of Step 4 on the MPIP attestation.

Step Three: Meaningful Use (Promoting Interoperability)

CMS, the overseeing agency of the Medicare and Medicaid EHR Incentive Programs, is dedicated to improving interoperability and patients' access to health information. To better reflect this focus, the Medicare and Medicaid EHR Incentive Programs have been renamed to the Promoting Interoperability (PI) Programs. Please note that this tip sheet may still reference Meaningful Use (MU).

Beginning with the MU reporting period in calendar year 2019, all participants in the Medicaid Promoting Interoperability Program are required to use 2015 Edition CEHRT. The 2015 Edition CEHRT **did not** have to be implemented on January 1, 2019. However, the functionality must be in place by the first day of the EHR reporting period and the product must be certified to the 2015 Edition criteria by the last day of the EHR reporting period. In many situations the product may be deployed but pending certification.

Select PI Meaningful Use Reporting Period

The MU reporting period for Program Year 2019 is a minimum of any continuous 90-days between January 1 and December 31, 2019. (Refer to page 12 for eCQM reporting details).

Practice Location Details

EPs are required to list each of their practice locations to verify that at least 50% of their total patient encounters occur at sites equipped with Certified EHR Technology. EPs will be prompted to provide the following information for each location.

EHR Solution Details

EPs must identify if a location is equipped with Certified EHR Technology and enter applicable Certified EHR Technology (CEHRT) detail for that location.

Is the location equipped with certified EHR technology? _____

Total number of the patient encounters that occurred at the location: _____

Total Encounters for Meaningful Use: *[CMS defines] patient encounters as any encounter where a medical treatment is provided and/or evaluation and management services are provided, except a hospital inpatient department (Place of Service 21) or a hospital emergency department (Place of Service 23). Patient encounters in ambulatory surgical centers (Place of Service 24) would be included for the purpose of this definition. This includes both individually billed events and events that are globally billed, but are separate encounters under our definition. For more information, see CMS FAQ #3065 and #3215.*

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If the practice location is equipped with Certified EHR Technology, the EP will be required to enter the applicable CMS EHR Certification ID for each location.

CEHRT ID used to attest to Meaningful Use Objectives: _____

CEHRT ID used to attest to Meaningful Use eCQMs (If different than MU): _____

To obtain the CMS EHR Certification ID specific to the EHR software in use, please contact your EHR vendor or visit the Certified Health IT Product List available at: https://chpl.healthit.gov/#/resources/cms-lookup.

If the CMS EHR Certification ID has changed as a result of an upgrade or change in EHR vendor for example, the EP will be required to upload supporting documentation after completing Step 4. Refer to the **MPIP Supporting Documentation** tip sheet available on the MPIP Resources Page for additional guidance.

Stage 3 Meaningful Use

Stage 3 requirements consist of 8 objectives and measures including one consolidated public health measure. The table on the following pages outline Stage 3 Meaningful Use (PI) Objectives and Measures for EPs in 2019.

NOTE: Eligible professionals should consult with their EHR vendor for information on obtaining the data needed to report on Meaningful Use objectives and measures.

For additional details regarding Stage 3 Objectives and Measures for EPs please refer to the CMS 2019 Specification Sheets at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_2019.pdf

Protect Patient Health Information	
Objective	Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.
Measure	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.
Electronic Prescribing (eRx)	
Objective	Generate and transmit permissible prescriptions electronically.

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Measure	More than 60 percent of all permissible prescriptions written by the eligible professional (EP) are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).
Exclusions	Any EP who: (1) Writes fewer than 100 permissible prescriptions during the Promoting Interoperability (PI) reporting period; or (2) Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her PI reporting period.
Clinical Decision Support	
Objective	Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.
Measures	An EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusions. **Measure 1**: Implement five CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an EPs scope of practice or patient population, the CDS interventions must be related to high-priority health conditions. **Measure 2**: Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
Exclusion	**Measure 2**: Any EP who writes fewer than 100 medication orders during the EHR reporting period.
Computerized Provider Order Entry (CPOE)	
Objective	Use CPOE for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
Measures	An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions. **Measure 1** – More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Measure 2** – More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. **Measure 3** – More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

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Exclusions	**Measure 1**: Any EP who writes fewer than 100 medication orders during the EHR reporting period. **Measure 2**: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. **Measure 3**: Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.
Patient Electronic Access to Health Information	
Objective	The eligible professional (EP) provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.
Measures	An EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusions: **Measure 1** – For more than 80 percent of all unique patients seen by the EP: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's certified electronic health record technology (CEHRT). **Measure 2** – The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the EHR reporting period.
Exclusions	**Measure 1 and Measure 2**: A provider may take an exclusion for either measure, or both, if either of the following apply: (i) He or she has no office visits during the EHR reporting period. (ii) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period.
Coordination of Care through Patient Engagement	
Objective	Use certified electronic health record technology (CEHRT) to engage with patients or their authorized representatives about the patient's care.
Measures	EPs must attest to all three measures and must meet the thresholds for at least two measures to meet the objective:

	Measure 1: More than 5 percent of all unique patients (or their authorized representatives) seen by the eligible professional (EP) actively engage with the EHR made accessible by the EP and either— (1) View, download or transmit to a third party their health information; or (2) Access their health information through the use of an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the EP's CEHRT; or (3) A combination of (1) and (2) **Measure 2**: More than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative. **Measure 3**: – Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the PI reporting period.
Exclusions	Measure 1, 2 and 3: An EP may take an exclusion for any or all measures if either of the following apply: (i) He or she has no office visits during the EHR reporting period, or; (ii) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period may exclude the measure.
Health Information Exchange (HIE)	
Objective	The eligible professional (EP) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).
Measures	EP's must attest to all three measures and must meet the threshold for at least two measures to meet the objective. **Measure 1** – For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) Electronically exchanges the summary of care record

	Measure 2 – For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she into the patient's EHR an electronic summary of care document. **Measure 3** – For more than 80 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies. (3) Current Problem list. Review of the patient's current and active diagnoses.
Exclusions	**Measure 1** – An EP may take an exclusion if either or both of the following apply: (1) He or she transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the EHR reporting period. (2) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period. **Measure 2** – An EP may take an exclusion if either or both of the following apply: (1) The total of transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period. (2) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. **Measure 3** – An EP may take an exclusion if the total of transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.

Stage 3 Public Health Reporting

Eligible professionals must satisfy two measures in order to meet the objective. If the EP cannot satisfy at least two measures, they may take exclusions from all measures they cannot meet.

For current reporting information pertaining to the Ohio Department of Health, please visit https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/promoting-interoperability/welcome-to

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For additional details regarding the Stage 3 Public Health Objective and Measures for EPs please refer to the CMS 2019 Specification Sheet https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEP_2019_Obj8.pdf

Public Health Reporting	
Objective	The eligible professional (EP) is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice
Measures	**Measure 1:** Immunization Registry Reporting: The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). **Measure 2:** Syndromic Surveillance Reporting: The EP is in active engagement with a PHA to submit syndromic surveillance data. **Measure 3:** Electronic Case Reporting: The EP is in active engagement with a PHA to submit case reporting of reportable conditions. **Measure 4:** Public Health Registry Reporting: The EP is in active engagement with a PHA to submit data to public health registries. **Measure 5:** CDR Reporting: The EP is in active engagement to submit data to a CDR
Exclusions	**Measure 1:** An EP may take an exclusion if any of the following apply: (1) He or she does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or IIS during the EHR reporting period; (2) He or she practices in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) He or she practices in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the EHR reporting period. **Measure 2:** An EP may take an exclusion if any of the following apply: (1) He or she is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; (2) He or she practices in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or

	(3) He or she practices in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs as of six months prior to the start of the EHR reporting period. **Measure 3:** An EP may take an exclusion if any of the following apply: (1) He or she does not diagnose or directly treat any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period; (2) He or she practices in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) He or she practices in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the EHR reporting period. **Measure 4:** An EP may take an exclusion if any of the following apply: (1) He or she does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period; (2) He or she practices in a jurisdiction for which no PHA is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) He or she practices in a jurisdiction where no PHA for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period. **Measure 5**: An EP may take an exclusion if any of the following apply: (1) He or she does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the EHR reporting period; (2) He or she practices in a jurisdiction for which no CDR is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) He or she practices in a jurisdiction where no CDR for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.

Clinical Quality Measures (eCQMs)

Per the 2019 Physician Fee Schedule (PFS) Final Rule, Medicaid EPs who are returning must report on a one-year eCQM reporting period, and first-time meaningful users must report on a 90-day eCQM reporting period.

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EPs are required to report on any six eCQMs related to their scope of practice. In addition, Medicaid EPs are required to report on at least one outcome measure. If no outcome measures are relevant to that EP, they must report on at least one high-priority measure. If there are no outcome or high priority measures relevant to an EP's scope of practice, they must report on any six relevant measures.

EPs may choose to upload eCQM data files or enter data manually via the MPIP provider portal. Please consult with your EHR vendor for information on obtaining the data needed to report eCQMs.

eCQMs for EPs in 2019 continue to remain aligned with eCQMs for Eligible Clinicians under MIPS. The list of eCQMs can be found at https://ecqi.healthit.gov/eligible-professional-eligible-clinician-ecqms

Step Four: Payment Schedule

The table below shows the Ohio MPIP payment amount you could receive based on your current payment year.

Payment Year	Eligible Professionals	Eligible Professionals Attesting as Pediatrician
1 – Closed to new participants	$21,250.00	$14,167
2	$8,500.00	$5,667.00
3	$8,500.00	$5,667.00
4	$8,500.00	$5,667.00
5	$8,500.00	$5,667.00
6	$8,500.00	$5,667.00
Total	$63,750.00	$42,500.00

Document Upload

The MPIP System will determine the supporting documentation you will be required to upload prior to submitting your attestation. You may also choose to upload additional documentation to support your attestation during this step. The **MPIP Supporting Documentation** tip sheet (available on the MPIP Resources Page) will provide guidance on acceptable forms of documentation.

Document Upload Policy: Please ensure that documents you are uploading do not contain protected health information (PHI) unless specifically requested as part of the document requirements.

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Enrollment Summary and MPIP Payment Status

Eligible professionals will have the opportunity to review their enrollment prior to submitting as well as the option to download enrollment data to a PDF. Eligible professionals will be asked to review attestation statements and confirm by selecting “Agree & Continue”.

EPs must sign the legal notice by entering the full name of the Authorizing Official and re-enter the EP’s full 10-digit CMS Registration ID. Upon signing the Legal Notice and selecting "Agree and Continue," MPIP will take the EP to the "Submit Enrollment" screen. The EP should review the enrollment summary and then select "Confirm & Submit" to send the application for processing.

Congratulations! Attestation in the MPIP system is complete. Once the MPIP application is successfully submitted, the EP’s enrollment status will change from “In Progress” to “Submitted for Review” or “Payment Pending.” Please note that modifications to the enrollment are prohibited if the enrollment status is listed as "Submitted for Review" or “Payment Pending.”

Check Your Email

MPIP will be sending you e-mails throughout the enrollment process indicating your current status in the program (e.g., registration updates received from CMS, confirming enrollment in MPIP, payment status, etc.). These notifications are sent from an unmonitored mailbox from MPIP (do-not-reply@mail.ohiompip.com). Please do not respond to this mail box. All e-mails should be sent to MPIP@medicaid.ohio.gov. Please be sure to add both e-mail addresses to your address book and/or to your “trusted sender” list to ensure you receive important messages from MPIP.

Additional Resources and Contact Information

MPIP Provider Portal: https://www.ohiompip.com/OHIO/enroll/logon
MPIP Resources Page: https://medicaid.ohio.gov/Provider/MedicaidProviderIncentiveProgram

MPIP Operations staff are available Monday through Friday from 8:00 AM to 4:00 PM EST.
Email: MPIP@medicaid.ohio.gov
Phone: 1-877-537-6747