Ohio | Medicaid Provider Incentive Program

MPIP Commonly Used Terms

Eligibility

Acute Care Hospital: a hospital where the average length of stay is less than 25 days (calculated on the federal fiscal year (FFY)) and has a Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN) with the last four digits in the series 0001-0879 or 1300-1399. Cancer hospitals and critical access hospitals (CAH) are included with the definition of an acute care hospital.

Adopt, Implement and Upgrade (AIU)

- **Adopt:** to acquire, purchase or secure access to certified electronic health record (EHR) technology capable of meeting meaningful use (MU) requirements.
- **Implement:** to install or begin using certified electronic health record (EHR) technology (*must prove actual installation)*
- **Upgrade:** to improve the functionality of certified electronic health record (EHR) technology capable of meeting MU requirements at the practice site or upgrading current EHR technology to certified EHR technology.

Children's Hospital: is separately certified and is either a freestanding hospital or a hospital-within-a hospital that has a CMS certification number (CCN) that has the last 4 digits in the series 3300-3399; or 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; and predominantly treats individuals under 21 years of age.

Dually Eligible Hospital: a Subsection (d) hospital in the U.S. or District of Columbia and has a Centers for Medicare and Medicaid Services (CMS) Certification Number (CCN) ending in 0001-0879. Dually eligible hospitals may be eligible for **BOTH** MPIP and the Medicare EHR incentive payment program.

Hospital-Based: an eligible professional is hospital based if 90% or more of their covered professional services are furnished in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital or ER setting in the year preceding the payment year. The hospital-based exclusion does not apply to an eligible professional practicing predominantly through a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC).

Nonhospital-Based: an eligible professional who meets the definition of a hospital-based eligible professional, but who can demonstrate that they 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).

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

Practices Predominantly: if more than 50% of an eligible professional's total patient encounters over a period of 6 months in the most recent CY or within the 12-month period preceding attestation occur through a FQHC/RHC, they are considered to practice predominantly at an FQHC/RHC and the eligible professional has the option to use needy individual patient volume.

This information is not intended to replace, change or obsolete any provisions of the published federal regulations at 42 CFR Part 495 or the Ohio Administrative Code department rules.

MPIP Commonly Used Terms

Patient Volume

Eligible Professionals
Calculation: total Medicaid patient encounters in any representative continuous 90-day period in the calendar year (CY) preceding the eligible professional's payment year, or in the 12 months before the eligible professional's attestation; divided by the total patient encounters in the same 90-day period.

Medicaid Encounter: services rendered to an individual on any one day where:

- Medicaid paid for part or all of the service;
- Medicaid paid all or part of the individual's premiums, co-payments, and cost-sharing;
- The individual was enrolled in a Medicaid program at the time the billable service was provided.

Needy Individual Patient Volume Calculation: total needy individual patient encounters in any continuous 90-day period, in the preceding calendar year (CY), or in the 12 months before the eligible professional's attestation; divided by the total patient encounters in the same 90-day period.

Needy Individual Encounter: services rendered to an individual on any one day where:

- Medicaid or CHIP paid for part or all of the service.
- Medicaid or CHIP paid all or part of the individual's premiums, co-payments, or cost-sharing.
- The individual was enrolled in a Medicaid program at the time the billable service was provided.
- The services were furnished at no cost.
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

Note: *If uncompensated care is used, eligible professionals will be required to downward adjust the uncompensated care figure to eliminate bad debt data. Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future. Providers should use cost reports, or other auditable records, to identify bad debts.*

Eligible Hospitals
Calculation: total Medicaid encounters in any representative continuous 90-day period, in the fiscal year preceding the hospitals' payment year or in the 12 months before the hospital's attestation; divided by the total encounters in the same 90-day period.

Medicaid Encounter: services rendered to an individual (per inpatient discharge or in the emergency department) on any one day where:

- Medicaid paid for part or all of the service.
- Medicaid paid all or part of the individual's premiums, co-payments, and/or cost-sharing.
- The individual was enrolled in a Medicaid program at the time the billable service was provided.

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MPIP Commonly Used Terms

Meaningful Use

Eligible Professionals
Unique Patient: if a patient is seen by an eligible professional more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure.

Eligible Hospitals
Unique Patient*:* if a patient is admitted to an eligible hospital's inpatient or emergency department (POS 21 or 23) more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure.

Note: *All meaningful use measures relying on the term "unique patient" relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period.*