Ohio | Department of Medicaid

Frequently Asked Questions (FAQs)

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Registration and Enrollment

Q 1. What is MPIP?
A: MPIP is Ohio's Medicaid Promoting Interoperability Program (formerly known as the Medicaid Provider Incentive Program). MPIP provides incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade (AIU) to or demonstrate Meaningful Use (MU) of certified Electronic Health Record (EHR) technology.

Provider Registration

Q 2. How does an eligible professional (EP) register for and enroll in MPIP to receive an incentive payment?
A: Program Year 2016 was the last year that an EP could receive their first incentive payment and remain eligible to continue the program in subsequent years. Returning applicants may log directly into the MPIP system. All eligible professionals can enroll in MPIP at https://www.ohiompip.com/OHIO/enroll/logon.

First time Ohio applicants (EP that previously received an incentive payment from another state EHR incentive program) will be required to update their registration information with CMS at https://ehrincentives.cms.gov/hitech/login.action. Upon successfully updating the registration with CMS, eligible professionals will receive an email from the Ohio MPIP system inviting them to enroll in MPIP.

Eligible Providers will be required to enroll with MPIP and attest to all program requirements (i.e. patient volume) each year they seek any remaining incentive payments.

Q 3. How does an eligible hospital register and enroll in MPIP to receive an incentive payment?
A: After FFY 2016 an eligible hospital must have received an incentive payment in the previous year to remain eligible in subsequent years.

Returning applicants may log directly into the MPIP system. All eligible hospitals will submit their Medicaid attestation through the MPIP provider portal at https://www.ohiompip.com/OHIO/enroll/logon.

All Eligible Hospitals will be required to enroll with MPIP and attest to all program requirements (i.e. patient volume) each year they seek an incentive payment.

Q 4. As a returning MPIP applicant, do I need to re-register with CMS?
A: A returning applicant will only need to update their registration with CMS if any of the eligible provider's information (i.e. demographics, payee information) has changed since the previous program year. If the registration information has changed, the EP should first update their information at the CMS registration website at https://ehrincentives.cms.gov/hitech/login.action. Once the information has been updated with CMS, MPIP will receive the updates and invite the eligible provider to return to MPIP.

If the eligible provider's registration information has not changed since the previous program year, the eligible provider may enroll for the current program year in MPIP by going directly to the MPIP provider portal at https://www.ohiompip.com/OHIO/enroll/logon.

Before beginning the MPIP attestation, please take a look at the tip sheets for Meaningful Use that are available on the MPIP Resource Page.

Provider Eligibility

Eligibility—Eligible Professionals

Q 5. Who are considered Eligible Professionals?
A: Eligible Professionals include:

- Physicians (MD or DO)
- Optometrists
- Dentists
- Ohio Advanced Practice Nurses (Certified Nurse Practitioner (CNP), Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA) and Certified Nurse Specialists (CNS))
- Physician Assistants (PA) practicing through an FQHC or RHC that is so-led by a PA.

Eligible professionals must be an Ohio Medicaid Provider with an active Ohio Medicaid Provider Agreement and meet other program specific requirements.

Q 6. Can a hospital-based Eligible Professional participate in MPIP?
A: Eligible Professionals may not be hospital-based. An Eligible Professional who furnishes 90% or more of their covered professional services in sites of service identified by the codes used in the HIPAA standard transaction as an inpatient hospital (POS 21) or emergency room (POS 23) setting in the year preceding the program year is considered to be hospital-based.

The only instance where a hospital-based provider may be eligible for MPIP is when an eligible professional who meets the definition of a hospital-based professional but who can demonstrate to MPIP that they fund the acquisition, implementation, and maintenance of certified EHR technology (CEHRT), including supporting hardware and interfaces needed for Meaningful Use 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).

Q 7. Can an Eligible Professional practicing through an FQHC or RHC participate in MPIP?
A: Yes. As long as the provider meets the definition of an "eligible professional" and meets other program specific requirements, they may be eligible to participate in MPIP.

As a reminder eligible professionals include: Physicians (MD or DO), Optometrists, Dentists, Ohio Advanced Practice Nurses, and Physician Assistants (PA) practicing through an FQHC or RHC that is **"so-**

led" by a PA. **"So-led"** refers to a scenario in which a PA is the primary provider in a clinic (for example, when there is a part- time physician and the PA is full time, the PA will be considered as the primary provider); when the PA is a clinical or Medical director at a clinical site or practice; or when a PA is an owner of an RHC.

Q 8. Can an Eligible Professional enroll and receive incentive payments in both MPIP and the Medicare Promoting Interoperability Program during the same payment year?

A: Beginning in 2018, the Medicare EPs are now considered eligible clinicians and a part of the Quality Payment Program (QPP). For eligible clinician information please visit https://qpp.cms.gov/

Q 9. Can an Eligible Professional switch from the Medicare Promoting Interoperability Program to MPIP?

A: The last year for an Eligible Professional to switch to the Medicaid Promoting Interoperability Program from Medicare was at the close of Program Year 2014. Eligible professionals who were able to switch to MPIP from Medicare were placed in the same corresponding payment year.

Eligibility—Eligible Hospitals

Q 10. What is an eligible hospital?

A: An eligible hospital must be one of the following:

- Acute Care Hospital where the average length of stay is 25 days or fewer (length of stay will be calculated on FFY); have a CMS Certification Number (CCN) with the last four digits in the series 0001-0879 or 1300-1399 (critical access hospitals and cancer hospitals are included in the definition of acute care hospitals and will be eligible for the Medicaid hospital incentive insofar as they meet the requirements under an acute care hospital); or
- Children's Hospital that 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.

Q 11. Can eligible hospitals participate in both MPIP and Medicare QPP Program?

A: Yes. Eligible hospitals that meet all of the following qualifications may be 'Dually-Eligible' for both MPIP and the Medicare EHR Incentive Program:

1. Be a sub-section (d) hospital in the 50 U.S. States or the District of Columbia;
2. Have a CMS Certification Number ending in 0001-0879; and
3. Have at least 10% Medicaid patient volume.

Dually-Eligible Hospitals (DEHs) should select "Both Medicare & Medicaid" when registering for the program with CMS. DEHs must complete their Medicare attestation via the QualityNet system prior to submitting their Medicaid attestation. An auto-generated email will be sent to the DEH once they are able to enroll for the program year in MPIP.

Patient Volume

Patient Volume—General

Q 12. Why is my patient volume adjusted by an SCHIP factor?
A: SCHIP is no longer used in patient volume calculations.

Q 13. Can out-of-state encounters be used to calculate patient volume?
A: Yes. Eligible professionals and eligible hospitals may use out-of-state Medicaid encounters when calculating patient volume. If an eligible professional or eligible hospital includes out-of-state encounters in their numerator, they must also include all out-of-state encounters in their denominator for the same representative time period. Eligible professionals and eligible hospitals are required to provide documentation to support the use of out-of-state encounters.

Medicaid Patient Volume—Eligible Professionals

Q 14. What are the patient volume requirements for eligible professionals?
A: Eligible professionals 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.

For the purposes of MPIP eligibility determination, a **Pediatrician** is 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 either the American Board of Pediatrics (ABP), the American Osteopathic Board of Pediatrics (AOBP), the American Board of Surgery, the American Board of Radiology or the American Board of Urology or a current, in good standing, pediatric subspecialty certificate recognized by the American Board of Medical Specialties.

Q 15. How do eligible professionals calculate patient volume?
A: Eligible professionals can calculate patient volume in one of two ways:

- Divide the total Medicaid patient encounters in any representative, continuous 3-month period, beginning on the first day of the month, in the calendar year (CY) preceding the eligible professional's program year by the total patient encounters in the same 3-month period; or
- Divide the total Medicaid patient encounters in any representative, continuous 3-month period, beginning on the first day of the month, in the full 12 months before the eligible professional's attestation by the total patient encounters in the same 3-month period.

For the purposes of calculating patient volume, a **Medicaid encounter** means 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.

When calculating Medicaid patient volume, consider the following:

- At least one clinical location used in the calculation of patient volume must have CEHRT during the program year for which the eligible professional is attesting.
- "Medicaid Programs" refer to traditional and HMO Medicaid plans. For the purposes of calculating patient volume, patients may have Medicaid listed as either primary or secondary insurance.

Needy Individual Patient Volume—Eligible Professionals

Q 16. Who is eligible to use Needy Individual Patient Volume?
A: An eligible professional practicing predominantly through an FQHC or RHC must have a minimum 30% patient volume attributable to needy individuals.

An eligible professional **"practices predominantly"** through an FQHC or RHC 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 an FQHC or RHC.

Q 17. How is patient volume calculated for eligible professionals using Needy Individual Patient Volume?
A: Eligible professionals practicing predominantly through an FQHC or RHC can calculate needy individual patient volume in one of two ways:

- Divide the total needy individual patient encounters in any continuous 3-month period, beginning on the first day of a month, in the preceding calendar year (CY), by the total patient encounters in the same 3-month period; or
- Divide the total needy individual patient encounters in any continuous 3-month period, beginning on the first day of a month, in the full 12 months before the eligible professional's attestation, by the total patient encounters in the same 3-month period.

For the purposes of calculating needy individual patient volume, a **Needy Individual encounter** means 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, 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.

When calculating Needy patient volume, consider the following:

- At least one clinical location used in the calculation of patient volume must have CEHRT during the program year for which the eligible professional is attesting.
- "Medicaid Programs" refer to traditional and HMO Medicaid plans. For the purposes of calculating patient volume, patients may have Medicaid listed as either primary or secondary insurance.
- 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 debt.

Group Patient Volume Proxy—Eligible Professionals

Q 18. What are the patient volume requirements for eligible professionals in a group practice?
A: Group practices must meet one of the three patient volume requirements referenced in Q14. For detailed information on using the group patient volume proxy, please see the **Group Patient Volume** tip sheet available on the MPIP Resources Website.

Medicaid Patient Volume—Eligible Hospitals

Q 19. What are the patient volume requirements for eligible hospitals?
A: Eligible hospitals must meet one of the following patient volume requirements:

- A minimum patient volume of 10% attributable to individuals enrolled in a Medicaid program;
- Children's Hospitals are exempt from the patient volume requirement.

Q 20. How do eligible hospitals calculate patient volume?
A: Eligible hospitals can calculate patient volume in one of two ways:

- Divide the total Medicaid encounters in any representative, continuous 3-month, beginning on the first day of the month, during the previous calendar year (CY) by the total encounters in the same 3-month period; or
- Divide the total Medicaid encounters in any representative, continuous 3-month period, beginning on the first day of the month, in the 12 months before the hospital's attestation by the total encounters in the same 3-month period.

For the purposes of calculating patient volume, a **Medicaid encounter** means 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/or cost-sharing;
- The individual was enrolled in a Medicaid program at the time the billable service was provided.

When calculating Medicaid patient volume, consider the following:

- Medicaid Programs refer to traditional and HMO Medicaid plans. For the purposes of calculating patient volume, patients may have Medicaid listed as either primary or secondary insurance.

Incentive Payments

Incentive Payment Amounts

Q 21. How much can an eligible professional receive in MPIP incentive payments?
A: Eligible professionals may receive up to $63,750 in incentive payments over a six-year period ($21,250 in the first year, and $8,500 for up to five subsequent years).

Pediatricians attesting to greater than 20% but less than 30% patient volume are limited to $42,500 over a six-year period ($14,167 in the first year and $5,667 for up to five subsequent years). Pediatricians with 30% Medicaid patient volume may be eligible to receive the maximum incentive payment amount. Pediatricians can qualify for MPIP at either 20% or 30% Medicaid patient volume and there is no sliding scale between 20% and 30%.

As long as an eligible professional meets all necessary requirements to qualify for an incentive payment, they will receive the federally specified incentive payment amount, regardless of the purchase or implementation costs of their EHR system.

Q 22. How much can an eligible hospital receive in MPIP incentive payments?
A MPIP follows a 7-step calculation to arrive at the Aggregate EHR amount. In summary, the aggregate EHR incentive amount is the total amount the hospital could receive in Medicaid payments over a theoretical four years of the program. It is the product of two factors: 1) The overall EHR amount and 2) The Ohio Medicaid Share.

A onetime payment calculation will be completed during payment year one and the total payment will be distributed over four payment years. In payment year one, the payment will be 40% of the total, 30% in payment year two, 20% in payment year three and 10% in payment year four.

As long as an eligible hospital meets all necessary requirements to qualify for an incentive payment, they will receive the federally specified incentive payment amount, regardless of the purchase or implementation costs of their EHR system.

Note: If an eligible hospital switches to an EHR incentive program in a different state, then the total incentive payments they receive over all payment years of the program cannot exceed the aggregate EHR incentive amount calculated by the State they began with.

Incentive Payment Schedule/Frequency and Issuance

Q 23. When, and how often, are payments made for eligible professionals?

A: An eligible professional may receive a first-year incentive payment as early as 2011 and payments after the first payment year may continue for a maximum of five years. Eligible professionals may receive incentive payments in non-consecutive years and the last year for eligible professionals to receive a first-year payment is 2016. Incentive payments are usually made four to six weeks after successful attestation in MPIP. Eligible professionals may receive one payment per program year.

Q 24. When, and how often, are payments made for eligible hospitals?
A: An eligible hospital may receive a first-year incentive payment as early as 2011 and payments issued after the first payment year may continue for a maximum of three years. Prior to program year 2016, payments may be made to an eligible hospital on a non-consecutive, annual basis. After program year 2016, an eligible hospital may not receive an incentive payment unless it received an incentive payment in the prior program year (i.e. an eligible hospital must receive an incentive payment in program year 2016 in order to receive an incentive payment in program year 2017). Incentive payments are usually made four to six weeks after successful attestation in MPIP. Eligible hospitals may receive one payment from MPIP per program year.

Q 25. How are payments issued?
A: A single consolidated annual incentive payment will be made to the Taxpayer Identification Number (TIN) selected at the time of CMS registration, through the State financial system. Payments will be made on a rolling basis as soon as the state has verified and confirmed that the eligible professional or eligible hospital has met the required criteria for AIU or has demonstrated Meaningful Use. Incentive payments are usually made four to six weeks after successful attestation in MPIP. An eligible professional or eligible hospital may view the status of their MPIP payment in the MPIP system. No payments will be made after 2021 when the Medicaid Promoting Interoperability Program ends.

Reassignment of Payment

Q 26. Can an eligible professional reassign their incentive payments?
A: Yes. Eligible professionals may use their own payee information or reassign the payment to an employer or entity that has a contractual agreement with the eligible professional allowing the employer or entity to bill and receive payment for their professionally covered services. The employer or entity for which payment is reassigned must be an Ohio Medicaid Provider with an active Ohio Medicaid Provider Agreement.

Assignment of the incentive payment must be consistent with applicable Medicaid laws, rules and regulations, including without limitation, those related to fraud, waste and abuse. Election to re-assign payment must be made at the time of CMS registration and requires a payee Tax Identification Number (TIN) and a payee National Provider Identifier (NPI).

Medicare Payment Adjustments

Q 27. Who is subject to the Medicare Payment Adjustments?
A: Eligible professionals and eligible hospitals that have the option to participate in either MPIP or the

Medicare Promoting Interoperability Programs may be subject to a Medicare Payment Adjustment unless they are meaningful users of Certified EHR Technology. Medicaid eligible professionals and hospitals that can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

For more information about Medicare payment adjustments, please visit the CMS Promoting Interoperability (PI) Programs website at:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html.

Supporting Documentation

Q 28. What are the requirements for auditable data sources?
A: Eligible professionals and eligible hospitals will be required to maintain documentation that verifies their attestation for no less than seven years following the last day of the calendar year in which a payment related to the attestation has been received. In the event of an active audit, eligible professionals and eligible hospitals will be required to maintain documentation until the audit and any appeal of the audit is resolved.

Certified EHR Technology

Q 29. What is Certified EHR Technology (CEHRT)?
A: Certified EHR Technology means a product is consistent with the guidelines established by the Office of the National Coordinator of Health Information Technology (ONC). In order to qualify for an MPIP incentive payment, eligible professionals and eligible hospitals are required to select and implement only Certified EHR products consistent with the ONC guidelines.

Q 30. What is a CMS Certification ID?
A: During attestation, MPIP requires each eligible professional and eligible hospital to provide a CMS EHR Certification ID that identifies the Certified EHR Technology being used to demonstrate Meaningful Use. This unique alpha-numeric CMS EHR Certification ID can be obtained by entering the Certified EHR Technology's product information at the Certified Health IT Product List (CHPL) on the ONC website: https://chpl.healthit.gov/#/search

NOTE: The ONC CHPL Product Number issued to your vendor for each certified product is different than the CMS EHR Certification ID. Only a CMS EHR Certification ID obtained through the CHPL will be accepted during attestation.

Frequently Asked Questions (FAQs)

Payment Year 1

Q 31. What are the requirements for payment year 1?
A: Per CMS Final Rule MPIP is now closed to any new participants. Program Year 2016 was the last year that an EP could receive their first incentive payment and remain eligible to continue the program in subsequent years.

First time Ohio applicants (EP that previously received an incentive payment from another state EHR incentive program) will be required to update their registration information with CMS at https://ehrincentives.cms.gov/hitech/login.action. Upon successfully updating the registration with CMS, eligible professionals will receive an email from the Ohio MPIP system inviting them to enroll in MPIP.

Adopt, Implement, or Upgrade (AIU) Requirements

Q 32. What are the requirements for "Adopting, Implementing or Upgrading" to Certified EHR Technology?
A: The following definitions apply to adopting, implementing or upgrading (AIU) to CEHRT:

Adopt: to acquire, purchase or secure access to certified electronic health record (EHR) technology capable of meeting meaningful use (MU) requirements; or

Implement: Installing or commencing utilization of certified EHR technology capable of meeting Meaningful Use requirements; or

Upgrade: 1) Expanding the available functionality of certified EHR technology capable of meeting Meaningful Use requirements at the practice site, including staffing, maintenance, and training, or 2) Upgrading from existing EHR technology to certified EHR technology per the EHR certification criteria published by the ONC.

Eligible professionals and eligible hospitals will be required to report which certified product they adopted, implemented or upgraded to and upload supporting documentation that shows a financially and/or legally binding agreement (i.e. contract, EHR software license) in the MPIP system.

Meaningful Use

Meaningful Use—Overview

Q 33. What is the purpose of Meaningful Use (MU)?
A: Meaningful Use, now known as Promoting Interoperability, began as three categorized stages that build on each other. The purpose of Meaningful Use/Promoting Interoperability is to set the baseline for electronic data capturing and information sharing that can be built on during later stages. This baseline provides a starting point to measure how Certified EHR Technology is improving the quality, safety, and efficiency of healthcare services; reducing health disparities; engaging patients and families in their healthcare; improving care coordination; improving population and public health; and maintaining the privacy and security of patient information.

Q 34. Are the Meaningful Use measures for MPIP different than Medicare?
A: Medicaid Promoting Interoperability Objectives and measures are aligned with other CMS quality payment programs, including MIPS. For detailed information about objectives, measures and links to current specification sheets, please see the CMS Promoting Interoperability page at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Q 36. Where can I find more information about Public Health objectives?
A: For information on current public health objective policies, please visit the Ohio Department of Health (ODH) website at https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/promoting-interoperability/welcome-to

Meaningful Use—Reporting Periods

Q 37. What are the general Meaningful Use reporting periods for eligible professionals and eligible hospitals?

A: The table below depicts the current EHR Reporting Periods for eligible professionals and eligible hospitals. All EHR reporting periods must be from within the same calendar year as the program year. Dually-eligible hospitals are required to attest with Medicare first. If a DEH is a meaningful user under Medicare, they will be deemed a meaningful user for MPIP, if they meet all the other MPIP program requirements.

MPIP EHR Reporting Periods	
Adopt, Implement or Upgrade (AIU)	No reporting period
First Year-Meaningful Use	90-days
2018 & beyond - All stages of Meaningful Use	90-days*

**Note that EHR reporting periods continue to change as a result of CMS regulation updates that impact the Medicaid Promoting Interoperability Program. Please refer to the most current tip sheet for EP or EH attestation to determine current program year requirements.*

Meaningful Use- Reporting Requirements

Q 40. What are the general requirements for meeting Meaningful Use specific to eligible professionals?
A: At least 80% of unique patients must have their data contained in a certified EHR system during the EHR reporting period. Additionally, eligible professionals who work at multiple sites must have at least 50% of their total encounters take place at locations equipped with certified EHR technology.

Please refer to the latest program year tip-sheets for current reporting requirements.

Q 41. What are the general requirements for meeting Meaningful Use specific to eligible hospitals?

A: Eligible hospitals will be asked to select a method for determining ED patients included in the denominator for certain measures. Eligible hospitals may choose one of the following methods to be applied to all measures:

- **Observation Service Method**
  - Patients admitted to inpatient setting through the ED, and
  - Patients treated in the ED's observation unit (POS 22 and 23)
- **All ED Visits Method**
  - All ED visits (POS 23)

In addition, dually-eligible hospitals must attest to Medicare first. If a DEH is a meaningful user under Medicare, they will be deemed a meaningful user for MPIP if they meet all the other Medicaid program requirements.

Please refer to the latest program year tip-sheets for current reporting requirements.

Q 42. What is a unique patient?
A: Unique Patient (Eligible Professionals): 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.

Unique Patient (Eligible Hospitals): 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.

Q 43. How does a Dually-Eligible Hospital meet Meaningful Use in MPIP?
A: Dually-Eligible Hospitals must first attest to Meaningful Use with Medicare via QualityNet. Once a DEH has successfully met Meaningful Use for the Medicare program, they will be deemed a meaningful user for MPIP. DEHs must enroll in MPIP each program year and meet program specific requirements.

Q 44. Can Meaningful Use be calculated on the group level for eligible professionals using the group patient volume proxy?
A: No. Meaningful Use cannot be calculated or averaged on the group level. MPIP incentive payments are made on an individual eligible professional basis, not by practice. Each eligible professional will need to demonstrate the full requirements of Meaningful Use in order to qualify for EHR incentive payments.

Q 45. How do I include patient information that is not contained in a certified EHR system?
A: To meet certain Meaningful Use objectives, eligible professionals and eligible hospitals may have the option of including individual patients who are not contained in the certified EHR system. CMS has

provided detailed information about how to report each Meaningful Use measure, including how to calculate the numerator and the denominator. Please see the CMS Meaningful Use specifications sheets for detailed information.

Q 46. When can an eligible professional or eligible hospital take an exclusion?
A: Eligible professionals and eligible hospitals may take an exclusion for an objective if an exclusion is offered and they meet the requirements for the exclusion. Not every Meaningful Use measure offers an exclusion and exclusions do not prevent a provider from achieving Meaningful Use.

Meaningful Use Reporting with Percent's

Q 47. How do you determine the numerator for Meaningful Use measures?
A: The numerator equals the number of actual patients that meet the measure and not just the Medicaid patients. The numerator is one of the following two types depending on the measure:

- All patients seen or admitted during the EHR reporting period that meet the measure such as, all patients that have an active medication list in the EHR; or
- A subset of patients seen or admitted during the EHR reporting period that met the measure or the total of the action taken.

Q 48. How do you determine the denominator for Meaningful Use measures?
A: The denominator equals all possible patients that could have met the measure and not just the Medicaid patients. When calculating a measure with percentages, the denominator should include the total possible population for each measure. The denominator is one of the following two types depending on the measure:

- All patients whether or not their records are kept using the EHR technology; or
- Only includes patients, or actions taken on behalf of those patients, whose records are kept using the EHR technology.

eClinical Quality Measures (CQMs)

Q 54. Where can I find more information on eCQM reporting?
A: eCQM specifications for eligible professionals are published on the eCQI Resource Center https://ecqi.healthit.gov/

Please refer to the latest program year tip-sheets for current reporting period requirements.

MPIP Appeals

Q 55. Can an MPIP determination be appealed?
A: Yes. If the MPIP system makes an adverse preliminary determination regarding an eligible professional's or eligible hospital's application or the eligible professional or eligible hospital does not

agree with the incentive payment amount, an eligible professional or eligible hospital may request for an informal review via the MPIP system by initiating an appeal, within 15 calendar days of the notification. Supporting documentation may also be submitted with the request.

Resources

CMS Promoting Interoperability Programs Registration System: This site is intended to update existing registrations only. Update include changes to payee designation, participation state and point of contact.
Link: https://ehrincentives.cms.gov/hitech/login.action

CMS Promoting Interoperability (PI) Homepage: Access to pertinent program dates, specification sheets and educational resources.
Link: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

MPIP Operations: Resource for Eligible Professionals and Hospitals participating with Ohio Medicaid Promoting Interoperability Program. Available Monday through Friday 8:00am until 4:00pm EST.
Email: MPIP@medicaid.ohio.gov
Toll Free Telephone: 1-877-537-6747

FAQs Removed and Archived

Q 35. CMS released the Stage 2 Final Rule in fall of 2012. Is the rule retroactive?
Q 38. What is the Payment Year 2014 ONLY Meaningful Use Reporting Periods for providers?
Q 39. Are there any additional reporting period scenarios that apply to dually eligible hospitals?
Q 49. What is the Stage 1 Meaningful Use criteria for eligible professionals and eligible hospitals?
Q 50. How does the CMS Stage 2 Final Rule impact Stage 1 Meaningful Use reporting?
Q 51. What is the Stage 2 reporting requirements and measures for eligible professionals?
Q 52. What is the Stage 2 reporting requirements and measures for eligible hospitals?
Q 53. How are the CQMs changing in 2014?