

§ 495.368

42 CFR Ch. IV (10–1–14 Edition)

provider is licensed to practice in multiple States, or paid within more than one area of a State.

(2) Subject to §495.332, the State must have a process in place to assure that Medicaid EHR incentive payments are made without reduction or rebate, have been paid directly to an eligible provider or to an employer, a facility, or an eligible third-party entity to which the Medicaid eligible provider has assigned payments.

(3) Subject to §495.332, the State must have a process in place to assure that that Medicaid EHR incentive payments are made for no more than 6 years; that no EP or eligible hospital begins receiving payments after 2016; that incentive payments cease after 2021; and that an eligible hospital does not receive incentive payments after FY 2016 unless the hospital received an incentive payment in the prior fiscal year.

(4) Subject to §495.332, the State must have a process in place to assure that only appropriate funding sources are used to make Medicaid EHR incentive payments.

(5) Subject to §495.332, the State must have a process in place to assure that Medicaid EHR incentive payments are not paid at amounts higher than 85 percent of the net average allowable cost of certified EHR technology and the yearly maximum allowable payment thresholds.

(6) Subject to §495.332, the State must have a process in place to assure that for those entities promoting the adoption of EHR technology, the Medicaid EHR incentive payments are paid on a voluntary basis and that these entities do not retain more than 5 percent of such payments for costs not related to certified EHR technology.

(7) Subject to §495.332, the State must have a process in place to assure that any existing fiscal relationships with providers to disburse the incentive through Medicaid managed care plans does not exceed 105 percent of the capitation rate, in order to comply with the Medicaid managed care incentive payment rules at §438.6(c)(5)(iii) of this chapter and a methodology for verifying such information.

(8) The State must not request reimbursement for Federal financial par-

ticipation unless all requirements of this subpart have been satisfied.

[75 FR 44565, July 28, 2010, as amended at 75 FR 81887, Dec. 29, 2010]

§ 495.368 Combating fraud and abuse.

(a) *General rule.* (1) The State must comply with Federal requirements to—

(i) Ensure the qualifications of the providers who request Medicaid EHR incentive payments;

(ii) Detect improper payments; and

(iii) In accordance with §455.15 and §455.21 of this chapter, refer suspected cases of fraud and abuse to the Medicaid Fraud Control Unit.

(2) The State must take corrective action in the case of improper EHR payment incentives to Medicaid providers.

(b) *Providers' statements regarding submission of documentation containing falsification or concealment of a material fact on EHR incentive payment documentation.* For any forms on which a provider submits information necessary to the determination of eligibility to receive EHR payments, the State must obtain a statement that meets the following requirements:

(1) Is signed by the provider and contains the following statement: "This is to certify that the foregoing information is true, accurate, and complete. I understand that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws."

(2) Appears directly above the claimant's signature, or if it is printed on the reverse of the form, a reference to the statements must appear immediately preceding the provider's signature.

(3) Is resubmitted upon a change in provider representative.

(4) Is updated as needed.

(c) *Overpayments.* States must repay to CMS all Federal financial participation received by providers identified as an overpayment regardless of recoupment from such providers, within 60 days of discovery of the overpayment, in accordance with sections 1903(a)(1), (d)(2), and (d)(3) of the Act

and part 433 subpart F of the regulations.

(d) *Complying with Federal laws and regulations.* States must comply with all Federal laws and regulations designed to prevent fraud, waste, and abuse, including, but not limited to applicable provisions of Federal criminal law, the False Claims Act (32 U.S.C. 3729 *et seq.*), and the anti-kickback statute (section 1128B(b) of the Act).

§ 495.370 Appeals process for a Medicaid provider receiving electronic health record incentive payments.

(a) The State must have a process in place consistent with the requirements established in § 447.253(e) of this chapter for a provider or entity to appeal the following issues related to the HIT incentives payment program:

- (1) Incentive payments.
- (2) Incentive payment amounts.
- (3) Provider eligibility determinations.
- (4) Demonstration of adopting, implementing, and upgrading, and meaningful use eligibility for incentives under this subpart.

(b) Subject to paragraph (a) of this section, the State's process must ensure the following:

- (1) That the provider (whether an individual or an entity) has an opportunity to challenge the State's determination under this part by submitting documents or data or both to support the provider's claim.
- (2) That such process employs methods for conducting an appeal that are consistent with the State's Administrative Procedure law(s).

(c) The State must provide that the provider (whether individual or entity) is also given any additional appeals rights that would otherwise be available under procedures established by the State.

(d) This section does not apply in the case that CMS conducts the audits and handles any subsequent appeals under § 495.312(c)(2) of this part.

[75 FR 44565, July 28, 2010, as amended at 77 FR 54161, Sept. 4, 2012]

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/IID AND CERTAIN NFs IN THE MEDICAID PROGRAM

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