Your Bridge to Health IT Resources

Updated 2017 Medicaid EHR Incentive Program Requirements For Eligible Providers (EP)

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ICAHN Illinois Critical Access Hospital Network

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Illinois Health Information Technology Regional Extension Center (ILHITREC)

SUPPORT PROVIDED BY ILHITREC:

The Illinois Health Information Technology Regional Extension Center (ILHITREC), under contract with the Illinois Department of Health and Family Services (HFS), is providing education, outreach, EHR, and Meaningful Use support to Medicaid providers for the Electronic Health Record Medical Incentive Payment Program (eMIPP). Contact us at info@ILHITREC.org; Phone: 815-753-5900; Fax: 815-753-7278.

ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Speaker Biographies

Lauren Wiseman, MSN, RN-BC

Lauren Wiseman is the Clinical Services Manager for Communities of Illinois Health Information Exchange. She works with participating healthcare organizations providing clinical project management, promoting effective adoption of HIE and providing Meaningful Use support with ILHITREC as a Clinical Informatics Specialist. She is an active member of the Health Information Management and Systems Society (HIMSS) and the American Nurses Association (ANA). Lauren holds the ANCC board certification in Nursing Informatics and CPHIMS.

Kerri Lanum, MS

Kerri Lanum is a Clinical Informatics Specialist at ILHITREC. She is an expert in the design and implementation of innovative technologies to support physician and nursing practice workflows. She is certified in eClinicalWorks, Epic Care Ambulatory and Healthy Planet EMR Products. She has been the lead for Quality programs including Meaningful Use, PQRS, HEDIS and ACO projects. She has a passion for educating providers and medical office staff on how to track their quality data to improve patient care. Kerri is an active member of the Medical Group Management Association (MGMA) and Health Information Management and Systems Society (HIMSS).

Disclaimer

- **The target audience of this presentation is Eligible Providers, but some references will be made related to Eligible Hospitals.**
- This webinar is based on official guidance provided by the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC), experiences from ILHITREC, and other Regional Extension Centers.
- This presentation was prepared as a tool to assist providers enrolled in the EHR Incentive Program administered by CMS. The ultimate responsibility for compliance, submission and response to any remittance from CMS rests with the provider. Medicare policy changes frequently. It is highly recommended that providers and their designee review rules and regulations frequently.
- The focus of this presentation is **2017 Reporting Requirements of the Medicaid EHR Incentive Program for Eligible Providers.** The content applies to the Medicaid EHR Incentive Program through CMS and the ONC.

Acronyms

- CQM-Clinical Quality Measure
- eCQM- Electronic Clinical Quality Measure
- EHR-Electronic Health Record
- EP- Eligible Professional
- MIPS- Merit Based Incentive Payment System
- MU-Meaningful use
- NQF- National Quality Forum
- QPP-Quality Payment Program
- QRDA- Quality Reporting Document Architecture

Learning Objectives

- Review Important Program Information
- Discuss updated 2017 requirements released in the IPPS Final Rule
- Review 2017 Required Objective and Clinical Quality measures
- Review program timeline and important dates
- Share FAQs

*IMPORTANT PROGRAM INFORMATION

- ✓ The Medicaid EHR Incentive Program continues through 2021.
- ✓ There are no payment adjustments in the Medicaid EHR Incentive Program.
- ✓ EPs who meet program requirements can continue to attest to their state Medicaid agencies to receive yearly incentive payments.
- ✓ The incentive payment is a fixed amount for each year of participation.
- ✓ EPs can receive incentive payments for six years nonconsecutively. EPs who began the program in 2016 must participate consecutively to receive the full payment amount over six years.
- ✓ (AIU) Adopt, Implement or Upgrade – 1st Year of Participation- **No longer an option for 2017.**
- ✓ The **Medicare** EHR Incentive program has been replaced with MACRA/MIPS.
- ✓ MIPS does **NOT** replace the Medicaid EHR Incentive Program.
- ✓ If a provider plans to participate in the Medicaid EHR Incentive Program through their state and they are also a Medicare Part B clinician who is eligible for MIPS, they will also need to participate in the MIPS program to avoid a negative MIPS payment adjustment to their Medicare Part B payments.

Patient volume Pre-Approval

- ✓Have a minimum 30% Medicaid patient volume*
- ✓Have a minimum 20% Medicaid patient volume, and be a pediatrician*
- ✓Practice predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) and have a minimum 30% patient volume attributable to needy individuals

Patient volume Pre-Approval

- ✓ Contact Mecky Lang @ hfs.ehrincentive@Illinois.gov
  Provide the following information:
  TIN =
  Group or individual numbers?
  Provider type: (physician, hospital, dentist)
  Date Range (either from 2016 or previous 12 months from today's date)=
  Straight Medicaid (only traditional Medicaid & All Kids) =
  Medicaid Managed Care =
  Total Encounters for all payees =

Patient volume Pre-Approval

- ✓ Do NOT include encounters for immunizations only, blood pressure checks, etc
- ✓ Link for list of CPT codes for encounters that should be counted

http://www.ilhitrec.org/ilhitrec/EHRincentive.shtml

*This list is not all-inclusive

Updated 2017 Program Requirements

IPPS Final Rule passed August 3rd, 2017. Changes for EPs include:

Requirements BEFORE the Final Rule	Current Requirements per the Final Rule
One Calendar year of CQM data required unless it is your first year of participation. 90 day reporting period only allowed if you submit electronically.	90 day reporting period for Clinical Quality measures regardless of submission method
Nine Clinical Quality Measures required to report across 3 of the NQF domain categories	Six Clinical Quality Measures required to report aligning with MIPS requirements
2015 EHR certification required for 2018	2014, 2015 and/or a combination of 2014/2015 EHR certification for 2018
Stage III required for all providers in 2018	Stage III OPTIONAL in 2018
One Full Calendar year of measure reporting required for 2018	90 day reporting period for Objective and CQM's in 2018

Changes to Objectives Beginning in 2017- Modified Stage 2

2016 Requirements	2017 requirements
Patient Electronic Access, VDT- 1 patient	Patient Electronic Access, VDT- **>5%**
Secure electronic messaging- 1 patient	Secure electronic messaging- **>5%**
Alternate exclusions available	Alternate exclusions **NOT** available

Changes to Objectives Beginning in 2017-Modified Stage 2

- **OBJECTIVE 8 measure 2 – Patient Electronic Access, View, Download and Transmit:**

  For an EHR reporting period in 2017, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.

- **OBJECTIVE 9- Secure Electronic Messaging**

  For an EHR reporting period in 2017, for more than 5 percent of 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 the patient-authorized representative) during the EHR reporting period.

Modified Stage 2 Objectives for Eligible Providers 2017

Objective Measures	Modified Stage 2
Objective 1: Protect Patient Information	Perform Security Risk Analysis
Objective 2: Clinical Decision Support	5 rules related to 4 CQM's
Objective 3: CPOE meds/labs/rads	60%/30%/30%
Objective 4: E-Prescribing	50%
Objective 5: Health Information Exchange	10% < 100 referrals per reporting period exclusion
Objective 6: Patient Education	10%
Objective 7:Medication Reconciliation	50%
Objective 8: Patient Electronic Access	50% Access >5% VDT
Objective 9: Secure Electronic Messaging	>5%
Objective 10: Public Health Reporting	Report on 2 options

Link to Objective Measure specifications

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_ModifiedStage2.pdf

Information Blocking Attestation Beginning 2017 Attestation Year

Item	Statement
Statement 1 **Information Blocking**	A health care provider must attest that it did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.
Statement 2 **Information Blocking**	A health care provider must attest that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times: (1) Connected in accordance with applicable law; (2) compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170; (3) implemented in a manner that allowed for timely access by patients to their electronic health information (including the ability to view, download, and transmit this information); (4) implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated health care providers, and with disparate certified EHR technology and vendors.
Statement 3 **Information Blocking**	A health care provider must attest that it responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.
Statement 4 **SPPC**	A health care provider must attest that it acknowledges the requirement to cooperate in good faith with ONC direct review of its' health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received.
Statement 5 **SPPC**	A health care provider must attest that if requested, it cooperated in good faith with ONC direct review of its' health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the health care provider in the field.
Statement 6 **SPPC OPTIONAL**	A health care provider must attest that it acknowledges the option to cooperate in good faith with ONC-ACB surveillance of its' health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received.
Statement 7 **SPPC** **OPTIONAL**	A health care provider must attest that if requested, it cooperated in good faith with ONC-ACB surveillance of its' health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating capabilities as implemented and used by the health care provider in the field.

Information Blocking Attestation Beginning 2017 Attestation Year

The Department of Health and Human Services is working to identify and stop instances of information blocking. You can help by reporting complaints about information blocking to us via **http://www.healthIT.gov/healthITcomplaints**.

Objective 10: Public Health Reporting

Measure 3: Specialized Registry Reporting: There are no certification and standards criteria specified in the ONC 2014 Edition EHR Technology Criteria objective:
To meet the measure, the EPs would need to electronically submit data specifications, and vocabularies required by the specialized registry. This is maintained by Public Health Agencies or other national organizations like the CDC/NCHS.

Potential Suggestions:

Suggestion 1: Electronic submission to Prescription Drug Monitoring Program (PMP)
Suggestion 2: Illinois Cancer Registry if the provider treats or diagnose cancer conditions
Suggestion 3: Electronic submissions to CDC/National Center for Health Statistics (NCHS). Specifically, the National Ambulatory Medical Care Survey and the National Hospital Medical Care Survey.
Suggestion 4: Professional Organizations EPs are members of and submit data to electronically.

CMS FAQ: https://questions.cms.gov/faq.php?faqId=11988

CMS: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/CentralizedRepository-.html

Objective 10: Public Health Reporting

Measure 3: Specialized Registry Reporting

Specialized Registry exclusion question - If you have selected an exclusion to the Specialized Registry measure, an additional question will require an answer. The question will require the attester to verify that they have: (1) checked with the state/jurisdiction to determine if there is an available specialized registry maintained by a public health agency or (2) checked with specialty societies with which they are affiliated to determine if the society maintains a specialized registry.

There will be a yes and no option. If they select no, an error popup screen will be displayed (either immediately or during the save process), notifying the attester that they must comply with this requirement.

Clinical Quality Measures

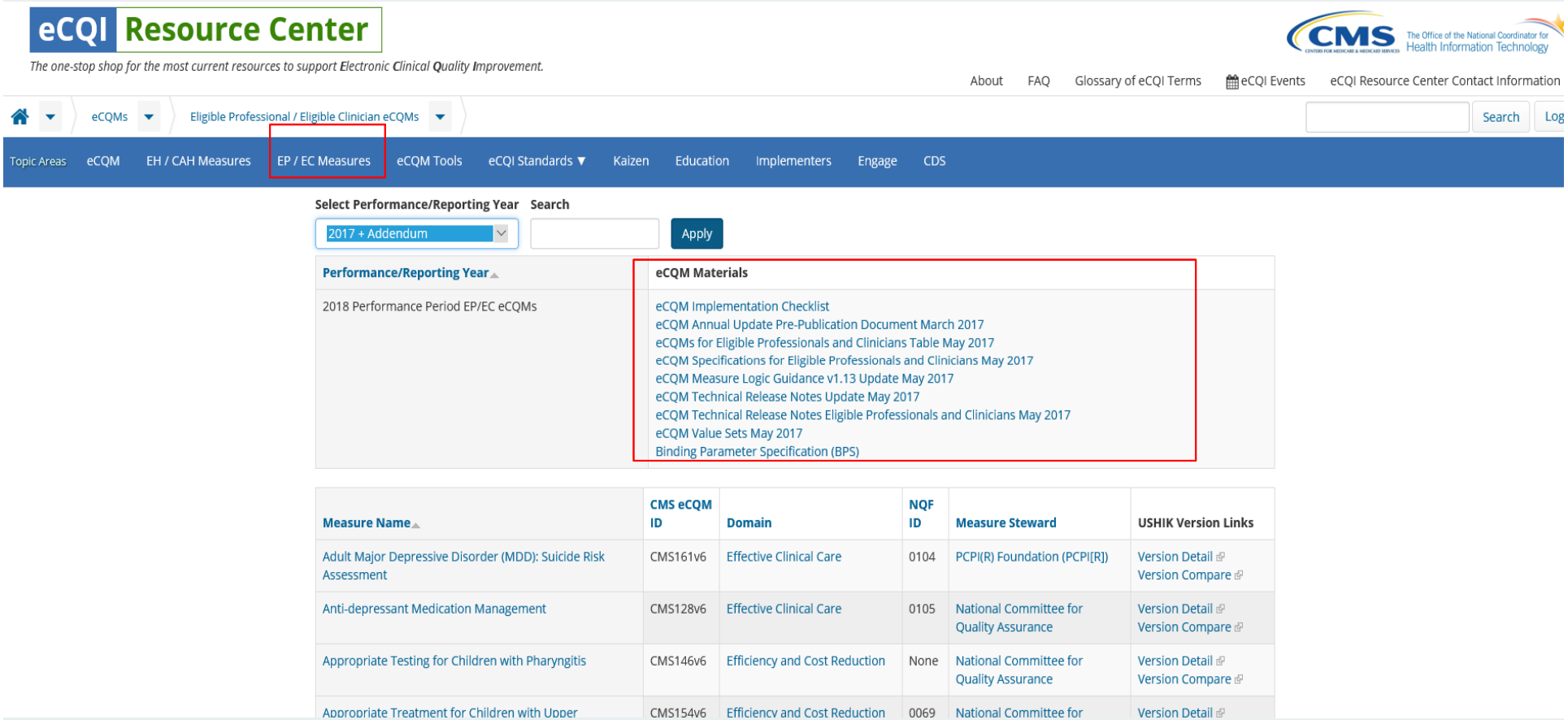
- EPs must select 6 approved Clinical Quality measures.
- For the EHR reporting period in 2017, providers will attest to any continuous 90-day period of CQM data regardless of submission method.
- Submission methods available are electronically submitting via a QRDA file format or manually entering numerator and denominators at the time of attestation.

Clinical Quality Measures Removed for 2017

- **ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range CMS179v5**
- **Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer CMS140v5**
- **Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients CMS141v6**
- **Diabetes: Low Density Lipoprotein (LDL-C) Control (< 100 mg/dL) CMS163v5**
- **Hemoglobin A1c Test for Pediatric Patients CMS148v5**
- **HIV/AIDS: Medical Visit CMS62v5**
- **HIV/AIDS: RNA Control for Patients with HIV CMS77v5**
- **Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control (<100 mg/dL) CMS182v6**
- **Preventive Care and Screening: Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test Performed CMS61v6**
- **Preventive Care and Screening: Risk-Stratified Cholesterol -Fasting Low Density Lipoprotein (LDL-C) CMS64v6**
- **Use of Appropriate Medications for Asthma CMS126v5**

Clinical Quality Measures 2017 Updated Specifications

https://ecqi.healthit.gov/



Technical Requirements for eCQM Reporting

- Measure data needs to be in QRDA III file format if submitting electronically
- QRDA III Implementation guide https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/eCQM_QRDA_EC.pdf

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Stage 3 Meaningful Use

Objective Measures	Modified Stage 2	Stage 3
Objective 1: Protect Patient Information	Perform Security Risk Analysis	No change
Objective 2: Clinical Decision Support	5 rules related to 4 CQM's	No change
Objective 3: CPOE meds/labs/rads	60%/30%/30%	60%/60%/60%
Objective 4: E-Prescribing	50%	60%
Objective 5: Health Information Exchange	10% < 100 referrals per reporting period exclusion	50% send summary of care/40% receive summary of care for new patients/Clinical info reconciliation for new patients 80%
Objective 6: Patient Education	10%	Removed and Incorporated into the electronic access
Objective 7: Medication Reconciliation	50%	removed
Objective 8: Patient Electronic Access	50% Access >5% VDT	85%/ Patient electronic access to pt. education material 35%
Objective 9: Secure Electronic Messaging	>5%	Changed to Coordination of care 5% messaging, 5% VDT, 5% patient entered info incorporated into CEHRT
Objective 10: Public Health Reporting	Report on 2 out of 3 options	Report on 2 out of 5 measures

Stage 3 measure specifications

Reporting Periods

2017

- All participants may use any 90-day period for both Objective and Clinical Quality Measures

2017

- MACRA/MIPS Medicaid participants that bill Medicare “Fee for Service” while in the Medicaid Incentive Program will participate in both programs

2018

-All participants may use any 90 day period for both Objective and Clinical Quality Measures

Participation Timeline

2016

Attest to Modified Stage 2
(Some alternate exclusions remain for providers)

Last Year to Register and Attest to Begin Medicaid Participation in the program and receive an incentive.

2017

Attest to either Modified Stage 2 **or** full version of Stage 3

AIU no longer an option

2018

Attest to either Modified Stage 2 **or** full version of Stage 3

FAQ

Do I have to attest to Modified Stage 2 or Stage 3 in 2017?

Providers have the **option** to attest to either Modified Stage 2 or Stage 3 in 2017. If they choose to attest to Stage 3 their EHR has to meet the 2015 certification standards or a combination of 2014 and 2015 standards that would not prohibit them from meeting the stage 3 measures. Stage 3 will continue to be OPTIONAL for 2018.

FAQ

If I attest successfully for Medicaid Meaningful use in 2017 will I avoid the Medicare penalty for 2019?

NO, If you bill Medicare Fee for Service and meet the eligibility requirements you now must participate in the new Quality Payment Program either through the MIPS or Advanced APM tracks to avoid the Medicare payment penalties.

FAQ

Are we allowed to participate in both the Medicaid EHR Incentive program and the new Quality Payment program?

If you bill both Medicare and Medicaid, and meet the minimum eligibility requirements for each program then **Yes** you can participate in both programs.

FAQ

If I have a new provider join our practice, how do I register them for the program?

Unless your provider has already registered for the program in prior years, they are not eligible to participate in the program. 2016 was the last year to register to be eligible to participate in the Medicaid EHR Incentive program

FAQ

How can I get more patients to sign up and use the patient portal?

- ✓ Implement sign up process into standard workflow
- ✓ Explain to patients the benefits of the portal
- ✓ Create policies around portal usage
- ✓ Train staff on use and benefits of portal and how to assist patients with resetting password, navigating site, etc.

Additional References

- Final Rule – Modification 2015 -2017
  - https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-25595.pdf
- CMS EHR Incentive Program
  - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html
- CMS FAQs
  - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html
- 2017 Requirements
  - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2017ProgramRequirements.html
- IDPH Public Health Objectives
  - https://murs.illinois.gov/
  - https://questions.cms.gov/faq.php?faqId=11988

Questions?

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