Strategies to Meet 2017 Meaningful Use Measures

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) and in partner with ICAHN and CIHIE, 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.

ILLINOIS DEPARTMENT OF Healthcare and Family Services

ICAHN Illinois Critical Access Hospital Network

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Speaker Biographies

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 **the discussion of strategies to meet 2017 Meaningful Use measures.** 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 2017 Requirements for Pre-approval of Patient Volume

Review 2017 Reporting Requirement Changes in the Final Rule

Review Strategies for Meeting:

- -Patient Electronic Access
- -Secure Electronic Messaging
- -Health Information Exchange
- -Specialized Registry Reporting

*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-REQUIRED

- ✓ 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- REQUIRED

- ✓ 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) =
(count ALL encounters where straight Medicaid is the primary, secondary, or tertiary coverage)
Medicaid Managed Care =
Total Encounters for all payees =

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

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

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

Objective 5: Health Information Exchange

Measure: EP transitions or refers their patient to another setting of care or provider of care that:

(1) uses CEHRT to create a summary of care record, and

(2) electronically transmits such summary to a receiving provider for more than 10% of transitions of care and referrals.

*Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than **100** times during the reporting period.*

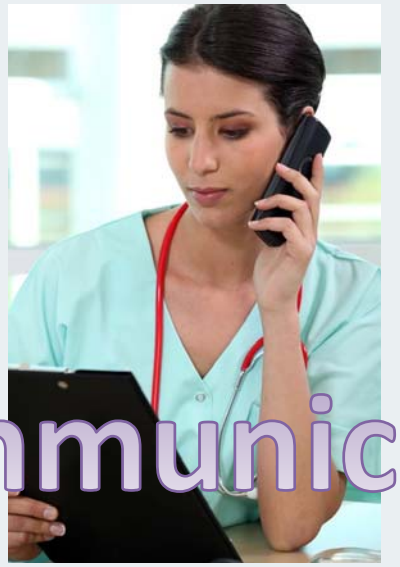
Objective 5: Health Information Exchange

Strategies:

- Obtain **Direct Addresses** from referring partners who also use a certified EHR

b.wells@direct.aclinic.org – Example of a direct address

~~drsmith@gmail.com~~ -NOT a direct address



Communication

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NIU Northern Illinois University

Objective 5: Health Information Exchange

Strategies:

- Work with an HIE

cihie | Communities of Illinois Health Information Exchange

Contact Information:
Lauren Wiseman MSN, RN-BC, Clinical Services Manager
Communities *of* Illinois Health Information Exchange
MOBILE 309.285.8085 x4 / FAX 309.692.0492

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 8: Patient Electronic Access

Measure 1: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information.

Measure 2: More than 5% of unique patients seen by the

EP during the reporting period view, download, or transmit their health information to a third party.

Exclusions: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures; or the EP practices in a county with less than 4 Mbps broadband.

Objective 8: Patient Electronic Access

Strategies:

- ✓ 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.
- ✓ Sign patient up and log them in at their visit

Objective 8: Patient Electronic Access

Success Stories:

*Pediatric Practice 3 providers- 0-65% in one month

Key strategy- Team work

*Internal Medicine provider 75% elderly population- 100% patient portal access

Key strategies- Team work, provider engagement, verifying current e-mail address as part of their demographics, mobile app

Objective 9: Secure Electronic Messaging

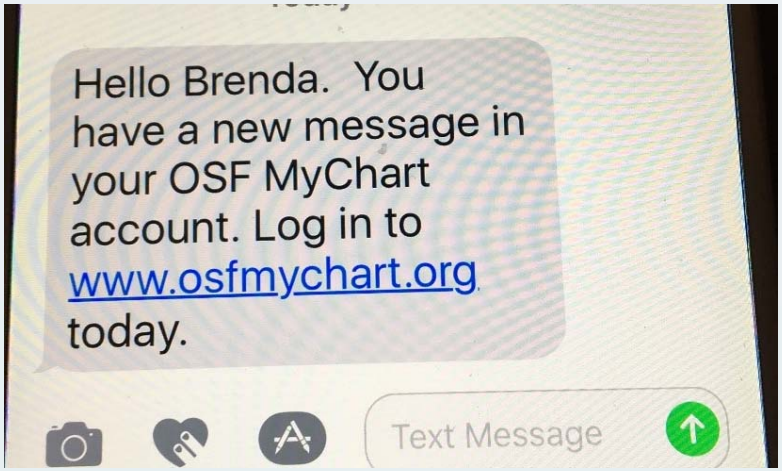
Measure: More than 5% of unique patients seen by the EP during the reporting period, a secure message was sent using the electronic messaging function to the patient, or in response to a secure message sent by the patient during the reporting period.

Exclusions: An EP has no office visits during the reporting period, or the EP practices in a county with less than 4 Mbps broadband.

Objective 9: Secure Electronic Messaging

Strategies:

- ✓ EMR specific workflow
- ✓ Provider engagement
- ✓ Bulk Messaging
- ✓ Text messages
- ✓ Calling patients to respond to messages



Objective 9: Secure Electronic Messaging

Success Stories:
Rural Health Clinic- Primary Care with 8 providers
-has had high turnover with 4 different Managers in less than 3 years.
-Have dramatically increased their percentages for all providers and are on track to meet this measure by the end of the year
Key Strategy- Taking the time. Managers sat down with each provider and figured out exactly how many patients they would need to send messages to in order to meet the measure and sent those messages and added on a couple more just to make sure they had enough.

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: 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.

Objective 10: Public Health Reporting

Measure 3: Strategies

- ✓ Check with other registries you work with and confirm they are certified by CMS to serve as a specialized registry
- ✓ Actively participating but forgot to register by deadline

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

This list is NOT All-inclusive

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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ILLINOIS HEALTH INFORMATION TECHNOLOGY
REGIONAL EXTENSION CENTER

Contact Information:

Kerri Lanum
klanum@niu.edu

Brenda Simms
bsimms@niu.edu

Lauren Wiseman
lwiseman@cihie.org

Carrie Galbraith
cgalbraith@icahn.org

ILHITREC
info@ILHITREC.org
(815) 753-5900
http://www.ILHITREC.org

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