Washington State Health Care Authority
HEALTH INFORMATION TECHNOLOGY

# Electronic Health Records Incentive Payment Program (EHR) updates

## Program Name Change

CMS is renaming the EHR Incentive Programs to the Promoting Interoperability (PI) Programs. Washington does not plan on following the name change however, you will see reference to it in most of our documents. For more information please visit the CMS website.

## Assign Late Payments

This temporary policy is to allow Groups to attest for Providers for the 2017 payment year if they are no longer employed by the group on 10/4/17 or later. Meaningful Use (MU) information was collected on this EP during the reporting period in 2017.

The group has to communicate with the new employer and EP and the agreement is for the previous group to receive the EP's payment. A signed EP agreement to assign payment for this year is on-file and uploaded into the eMIPP attestation.

### In this issue



### Need help?

**Clinical Data Repository (CDR):**

- CDR resource page
- Readiness steps with OHP
- Email HCA
- Email OHP

**Electronic Health Records (EHR):**

- EHR resource page
- ProviderOne help
- CMS EHR Help desk: 1-888-734-6433 option #1
- CMS account security: 1-866-484-8049 option #3
- CMS listserv

This allows for 2017 attestations only, due to the late deployment of eMIPP for the 2017 payment year.

## Audit Reminder

After a provider receives payment for the Washington State Medicaid EHR Incentive program, there is the possibility of a post-payment audit. All providers participating in the EHR Incentive Program are required to maintain all supporting documents, including any EHR screen shots, for a minimum of six years. It is a good time to re-evaluate your documentation process to ensure you are ready in case of an audit.

## 2018 Clinical Quality Measure (CQM) Guidance

CQMs are tools that help measure and track the quality of health care services provided by eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) within our health care system. This slide deck provides guidance on 2018 CQMs.

## From CMS: Submit a Hardship Application by July 1, 2018

As a result of the American Recovery and Reinvestment Act of 2009, the Centers for Medicare & Medicaid Services mandates that payment adjustments be applied to Medicare eligible hospitals and critical access hospitals (CAHs) that are not meaningful users of certified electronic health record technology under the EHR Incentive

Programs (now called the Promoting Interoperability (PI) Programs).

Eligible hospitals and CAHs may be exempt from Medicare penalties if they can show that demonstrating meaningful use would result in a significant hardship. To be considered for an exemption and avoid a payment adjustment, health care providers must complete a hardship exception application and provide proof of hardship. If approved, the hardship exception is valid for only one payment year.

Here are additional details for submitting the 2019 Eligible Hospital Hardship Exception Application:

• The deadline for eligible hospitals to submit application is July 1, 2018.

• The completed application and all support documentation must be attached to an email and sent to ehrhardship@cms.hhs.gov.

• All hardship exception determinations will be returned via email from ehrhardship@cms.hhs.gov to the email address provided on the application.

## Clarification of CMS Meaningful Use Guidance

Based on a number of questions from states, CMS would like to clarify guidance regarding Supporting Providers with the Performance of CEHRT (SPPC).

Eligible professionals (42 CFR §495.40(a)(2)(H)) and eligible hospitals (42 CFR §495.40(b)(2)(H)) are required to make certain attestations regarding Supporting Providers with the Performance of CEHRT (SPPC) to be a meaningful user. There are

two parts to this attestation—paragraph (1) regards ONC Direct Review; paragraph (2) concerns ONC Surveillance.

(H) Supporting providers with the performance of CEHRT (SPPC). To engage in activities related to supporting providers with the performance of CEHRT, the EP—

(1) Must attest that he or she:

(i) Acknowledges the requirement to cooperate in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and

(ii) If requested, cooperated in good faith with ONC direct review of his or her 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 EP in the field.

(2) Optionally, may also attest that he or she:

(i) Acknowledges the option to cooperate in good faith with ONC-ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received; and

(ii) If requested, cooperated in good faith with ONC-ACB surveillance of his or her 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 EP in the field.

There is a difference between the two policies. Participation in Direct Review (if requested) is required to be a meaningful user, but participation in surveillance is optional.

In both cases, because the provider is attesting after the year in question they are attesting to:

1) Their acknowledgement of the policy, whether or not they actually received (past tense) a request to participate.

2) Their actual participation based on a request received (past tense):

a. Participation is required for Direct Review

b. Participation is optional for Surveillance

We cannot ask providers to prospectively promise that they will in the future participate in either action, because being a meaningful user is optional and tied to a single performance year reported subsequent to that year. Therefore, they could choose not to participate and not be a meaningful user the following year.

In addition to the participation in surveillance being optional CMS does not require them to even answer the second question(s), which is why it has the "optionally" in the regulation text. In other words, it is not only optional to participate in surveillance,

it is also optional to attest to the policy. Whereas it is required to participate in Direct Review (or have documented a reasonable reason why you cannot) and required to attest to the policy.

On a practical level, the state's attestation system should work in the following manner: the provider must answer question 1 (checking either 1.a, or 1.a and 1.b); the provider may answer question 2 (checking either 2.a, or 2.a and 2.b). If 1 is answered, they do not have to answer question 2 to move on to the next page in the system or to have their submission accepted.

Please note that this is different than the Information Blocking attestation at 42 CFR § 495.40(a)(2)(I) and (b)(2)(I). More information about that attestation can be found here.

# EHR stats

## Hospitals

Year 1 = 88 ($63,781,127)
Year 2 = 81 ($36,102,305)
Year 3 = 77 ($29,081,024)
Year 4 = 64 ($18,095,783)

## EPs

Year 1 = 6,938 ($146,795,030)
Year 2 = 3,215 ($27,180,184)
Year 3 = 2,232 ($18,923,839)
Year 4 = 1,476 ($12,500,672)
Year 5 = 729 ($6,176,669)
Year 6 = 187 ($1,586,667)

## Grand total = $360,223,300

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