Washington State Health Care Authority
HEALTH INFORMATION TECHNOLOGY

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- CMS EHR Help desk: 1-888-734-6433 option #1
- CMS account security: 1-866-484-8049 option #3
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Clinical Data Repository

Web portal is now open for viewing data

Since July the CDR web portal has been open for viewing by all licensed processionals including physical and behavioral health providers and their delegates.

If your organization would like to begin using this service, please contact OneHealthPort.

If you are an organization that has been using the CDR web portal and want to share feedback, please contact HIT at healthit@hca.wa.gov.

Some things to remember:

- All organizations viewing CDR data must be HIPAA Covered Entities and must have a signed HIE Participation Agreement with OneHealthPort.
- Only staff with a need to view individual client level data (as determined by their manager and configured by their internal IT access staff) are allowed in the CDR. This is similar to how your organization grants EHR access.

- Providers may view CDR data regardless of whether or not they are currently submitting Continuity of Care Documents (CCDs).
- Organizations with less than four providers are exempt from submitting CCDs until July 1, 2019.
- Organizations using the CDR will not incur training costs from OneHealthPort or HCA, and users can complete training in one hour or less. Reference materials are available on OneHealthPort's website.

Several providers, using different EHR systems, have CCD submission success rates in the 90 percent range. Currently, the CDR contains the following information:

- Eligibility data for 2.2 million Medicaid managed care lives
- Over two years of clinically relevant claims (medical, dental and pharmacy) for virtually all these lives
- Nearly 7 million clinical records (CCDs) overall!

The User Acceptance Testing domain is open and ready for testing for those that have not completed CDR onboarding. OneHealthPort continues working with vendors to assist remaining providers to complete their onboarding activities.

Community Activities

OneHealthPort has been conducting clinical usability sessions with providers to refine use cases and gather additional feedback.

HIT has concluded one-on-one meetings with all Managed Care Organizations to better understand use cases for CDR data.

Representatives from HIT will be in attendance at the 2019 State of Reform Health Policy Conference in January.

HIT is also making plans to present topics on the CDR and behavioral health integration at the following events in 2019: the Washington Health Care Association Winter Conference, the Washington Rural Health Association's Northwest Rural Health Conference and the Washington Council for Behavioral Health's conference.

SUPPORT Act

The Health Care Authority (HCA) is working closely with our federal partners to determine the impacts of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), which was signed into law in late October. The SUPPORT Act is designed to provide federal, state, and local government and law enforcement agencies tools and resources to combat the nation's opioid epidemic. Section 6001 of the SUPPORT Act provides incentive payments to behavioral health providers for adoption and use of certified EHRs. HCA is initiating conversations with Centers for Medicare and Medicaid Innovation (CMMI) and the Office of the National Coordinator to gain insights into the scope and requirements

for this program and to determine whether and how we can make these funds available to behavioral health providers across Washington. We expect to be able to provide more information in the coming months as these conversations continue at both the federal and state level.

Electronic Health Record Incentive Program

2017 attestation deadline extension

Due to various system issue that are affecting attestations, we extending the 2017 MU attestation deadline to **December 14, 2018**. Your patience is appreciated as our vendor works on these various issues.

PFS Final Rule

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (PFS) Final Rule. This rule includes changes to the Medicaid Promoting Interoperability Program, as well as for the Quality Payment Program (QPP) and Merit-based Incentive Payment System (MIPS).

Medicaid Promoting Interoperability Program (beginning on page 813)

- **eCQM Policies for PY 2019** (beginning on page 815)
    - The list of available eCQMs for EPs in 2019 was aligned with the list of eCQMs available for Eligible Clinicians

under MIPS in 2019. Those eCQMs can be found on the CMS website.

- In 2019, EPs who are returning meaningful users must report on a one year eCQM reporting period for and first-time meaningful users must report on a 90 day eCQM reporting period.
- EPs are required to report on any six eCQMs related to their scope of practice.
- In addition, Medicaid EPs are required to report on at least one outcome or high-priority measure. If there are no outcome or high priority measures relevant to an EP's scope of practice, they may report on any six relevant measures.

- **Program Year 2021 Policies** (beginning on page 827)
  - In 2021 all EPs will have 90 day reporting periods for MU and eCQM to allow states to meet the statutory deadline of December 31, 2021 for all incentives to be paid. We note that we received many comments from states about 2020 the reporting period, which we will take into account in future rulemaking.
  - October 31, 2021 is the default deadline for attestations, but states may set an earlier deadline to ensure that payments can be issued. That

deadline must be included in an SMHP and approved by CMS BEFORE December 31, 2020.

- **Meaningful Use Policies** (beginning on page 832)
    - The threshold for Stage 3 Objective 6, Measure 1 (View, Download, Transmit) and Measure 2 (Secure Messaging) was set at 5% for the remainder of the Medicaid PI Program
    - The requirement that only EPs in urgent care settings can use the Syndromic Surveillance measure to meet the Objective 8 (Public Health) was removed.

For more information on these provisions, please join the Quality Improvement Through Health IT Community of Practice on December 13 and the Audit CoP on November 29. We will also discuss the regulation on an upcoming All States call.

For more information on the QPP and MIPS policies for Medicare Eligible Clinicians, see the CMS press release.

We want to take this opportunity to reiterate our guidance on the following FAQ:

Question: The eCQM specifications are updated each year. Which year(s) specifications can/should a state accept from providers?

Answer: Vendors are not required to update CEHRT each year to the latest specifications in

order to remain certified (for more information see https://www.healthit.gov/faq/42-question-06-13-042-1). Therefore, it is possible that Medicaid providers will have CEHRT that produce eCQMs specified to a variety of versions. States should always be able to accept the most recent version for each eCQM and must also allow providers to report on older versions (electronically or through attestation), if that is what their CEHRT is able to produce.

For example, CMS146 (Appropriate Testing for Children with Pharyngitis) was updated to version 5 in 2017 for 2018 reporting. Because the earliest version of the eCQM that 2014 Edition CEHRT could be certified with is 2012 (CMS146v1), states must accept manual attestation from providers using 2014 Edition CEHRT who are able to produce CMS146v1-CMS146v5. Note that each of these versions has one numerator and one denominator and therefore the logic in the state's attestation system would not need to vary. States may, but are not required to, gather information from providers about which version of the eCQM their CEHRT produces and they are reporting. If a state is collecting eCQMs electronically, the state must be able to collect the latest version (CMS146v5) and may choose how many previous versions they wish to collect. For example, a state may decide that the previous two years of specifications will still provide useful data and therefore collect CMS146v3-CMS146v5 electronically, but providers whose 2014 Edition CEHRT can only produce CMS146v1-CMS146v2 would have to attest manually. Note that the earliest eCQM

specifications that 2015 Edition CEHRT could have been certified to is 2016.

Note that for QPP, CMS requires the most recent published specifications applicable to the reporting period to be used. The eCQM specifications for Eligible Professionals and Clinicians published on the eCQI Resource Center in May 2017 and the applicable addendum published in September 2017 must be used for the 2018 reporting period.

Electronic Health Record Incentive payments

EPs

Paid for Year 1 = 6,938 ($146,795,030)
Paid for Year 2 = 3,244 ($27,426,684)
Paid for Year 3 = 2,267 ($19,221,339)
Paid for Year 4 = 1,515 ($12,832,172)
Paid for Year 5 = 788 ($6,678,169)
Paid for Year 6 = 233 ($1,977,667)

EHs

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

Grand total = $361,991,300

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About the Health Care Authority (HCA)

The Washington State Health Care Authority (HCA) is committed to whole-person care, integrating physical health and behavioral health services for better results and healthier residents.

HCA purchases health care for more than two million Washington residents through Apple Health (Medicaid), the Public Employees Benefits Board (PEBB) Program, and, beginning in 2020, the School Employees Benefits Board (SEBB) Program. As the largest health care purchaser in the state, we lead the effort to transform health care, helping ensure Washington residents have access to better health and better care at a lower cost.

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