Oregon Medicaid EHR Incentive Program (Promoting Interoperability Program)
2018 Webinar
Frequently Asked Questions

Topics	Questions	Answers
Attestation – general	Who should I contact if I need help?	For **general questions** about eligibility or the program, you can contact the Medicaid EHR Incentive Program: Medicaid.EHRIncentives@dhsoha.state.or.us or 503-945-5898. For **questions specific to your EHR** and its functionality or reporting, contact someone in your IT department or your EHR vendor directly. For **help with understanding how to meet Meaningful Use and for assistance submitting your attestation**, contact Oregon's Medicaid Meaningful Use Technical Assistance Program (OMMUTAP): OMMUTAP@ochin.org or 503-943-2500. OMMUTAP is a program that offers technical assistance to support Medicaid providers in their efforts to implement, upgrade, and effectively use Electronic Health Records (EHR). These services are offered at no cost to the provider or the clinic.
	The program year 2018 attestation is due 3/31/19 – is it only for the Meaningful Use (MU) objectives, or does it include electronic Clinical Quality Measures (eCQMs) as well?	The MU objectives and eCQMs must both be submitted by 3/31/19, because they are part of the attestation.
	What is the deadline for program year 2018? Will it continue to be 3/31 as in prior years?	Yes. The deadline to submit program year 2018 attestations is 3/31/19.
	If we need help determining which stage we need to attest to, who can help with that?	It's determined primarily by the capability of your Certified EHR Technology (CEHRT): • **2014 Edition CEHRT** - Modified Stage 2 only • **2014/2015 combination CEHRT** - Modified Stage 2 or Stage 3. Speak with someone in IT or your vendor to determine if your CEHRT is set-up to capture Stage 3 Objectives and Measures. • **2015 Edition CEHRT** - Modified Stage 2 or Stage 3

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	Can some providers be in Modified Stage 2 while others are in Stage 3?	It is unlikely that different providers at the same clinic would report on different stages. This is because your stage of meaningful use is largely determined by the CEHRT edition your practices utilizes. However, to be sure, speak with someone in IT or contact your vendor.
	Has Oregon decided what they will do if the Proposed IPPS rule for 2019 is upheld? Will Oregon adopt the changes for the Medicaid EHR Incentive Program?	On August 2, 2018 the Centers for Medicare & Medicaid Services (CMS) issued updates to Fiscal Year (FY) 2019 Medicare payment policies and rates under the Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule. The final rule changes set a new performance-based scoring methodology under the Medicare Promoting Interoperability Program for hospitals, and gave states the option to adopt this new scoring methodology. Oregon will not have any hospitals attesting in program year 2019, so we will not be affected by this change. **This change does not affect eligible professionals attesting to the Medicaid EHR Incentive Program (Medicaid Promoting Interoperability Program).**
	When registering an Eligible Professional (EP), can you clarify when an OHP 3035 form is needed, vs. OHP 3113?	Our Provider Enrollment Services are the experts for all issues regarding registering with the Oregon Health Authority. Their processes are always subject to change to better meet the needs of our providers. For any questions related to registering an EP please contact them at 800-422-5047 or by email at Provider.enrollment@state.or.us.
	When will you begin paying 2017 attestations? The challenge we've had in the past couple years is that payment processing has extended into the following year, making it difficult to have sufficient time to submit the next year's attestations before the deadline.	We are currently processing and paying program year 2017 attestations and are working on attestations that were submitted March 2018. We understand this concern and appreciate that it can be difficult to make 2018's deadline if your 2017 attestation has not been paid yet. We will do the best we can to process and pay all attestations in a timely manner, so you are provided sufficient time to submit your 2018 attestations. To help us make the process as efficient as possible, we ask that you ensure you have uploaded all required documentation with your 2017 attestation, and that if corrections need to be made, that you complete them within 30 days of our staff contacting you. If you have any questions, please contact the program staff: Medicaid.EHRIncentives@dhsoha.state.or.us or 503-945-5898.
	Where can I view these slides or the presentation?	We send the slides to each registered webinar participant immediately following the webinar and upload the recorded webinar to our website within two weeks of the presented webinar. Please check our site: MedicaidEHRIncentives.Oregon.gov/

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	For new providers who cannot attest for the Medicaid EHR Incentive Program, do we need to attest for Medicare to avoid the penalty?	Only physicians who bill the Medicare Physician Fee Schedule for patient services are subject to a Medicare payment adjustment for not meeting meaningful use. Medicaid health care providers who are only eligible to participate in the Medicaid EHR Incentive Program are not subject to payment adjustments. For more information, go to: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html The Medicare EHR Incentive Program has concluded; however, the Merit-based Incentive Payment System (MIPS) may be an option for you. For more information, go to: https://qpp.cms.gov/mips/overview. For MIPS technical assistance, go to: https://healthinsight.org/qpp
	We can't submit our 2018 attestations until January 2019, correct?	Yes, that is correct. The attestation period will be January – March 2019. Providers will be notified if there are any changes to the dates.
Eligibility	Does it matter if the attesting provider is a hospitalist or an ED provider?	Yes. To qualify for the Medicaid EHR Incentive Program (Medicaid Promoting Interoperability Program), the provider cannot be hospital-based. If the provider has more than 90% of his/her patient encounters occur in a hospital or ED setting, he/she is not eligible for this program.
	Can you apply for the Medicaid EHR Incentive Program (Medicaid Promoting Interoperability Program) if you didn't apply and receive a payment in 2017?	Yes. Participation for eligible professionals does not have to be done in consecutive years. As long as you have participated and received a payment at least once between 2011 and 2016, you are eligible to apply again until you reach six years of participation, or until the program's final year (2021). 2016 was the last year providers could begin the program, so if you have not participated in 2016 or prior, you are not eligible to apply now.
	I have a provider who has participated in the Medicaid EHR Incentive Program staff for the last few years; she is leaving our clinic before the end of 2018 – can I still attest for her?	Yes. The provider needs to have been employed at the attesting clinic for **one** of the following: 1) During the patient volume period; 2) During the EHR reporting period; or 3) At the time the attestation is completed. **Note**: The Medicaid EHR Incentive Program will not mediate situations where multiple clinics are attempting to attest for the same provider.

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	Can we still attest for adopt, implement, upgrade (AIU) in 2018, or is the program closed to new providers?	AIU is no longer an available attestation option. 2016 was the last year EPs could begin the program and submit an AIU attestation. Only EPs who have previously attested to the Medicaid EHR Incentive Program by 2016 can participate in subsequent years.
Meaningful Use Objectives and Measures	What patient population should be included in the MU objectives – is it just Medicaid patients?	No. MU objectives include actions related to all patients, not just Medicaid patients. Some objectives require the count for unique patients, while other objectives require the count for all patient encounters during the 90-day EHR reporting period.
	Is the Security Risk Analysis (SRA) for the EHR, provider, or the office computer?	The SRA must address how your practice protects electronic protected health information (ePHI). That involves addressing several areas, including the office computer, your EHR, and individual users' access to ePHI. To meet *Objective 1 – Protect Patient Health Information*, you must conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process. Please see the Security Risk Analysis Tip Sheet for more information. If you are attesting for multiple providers from the same clinic, it is acceptable to submit one SRA for all your providers, as long as the SRA represents assessed risks for the entire clinic/organization where each attesting provider practices.
	If we have already conducted a 2018 SRA, but then mid-2018 switch to a different CEHRT, do we need to conduct a new SRA?	Yes. Conducting an SRA is required when CEHRT is adopted in the first reporting year. In subsequent reporting years, or **when changes to the practice or electronic systems occur**, a review must be conducted. Please see the Security Risk Analysis Tip Sheet for more information.
	Can you explain what is involved with Objective 0?	Objective 0 refers to the series of statements/questions located on your attestation collectively known as the "Prevention of Information Blocking Attestation." These statements/questions are a result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Quality Payment Program final rule that require participants of the Medicare and Medicaid EHR Incentive

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		Programs (Promoting Interoperability Programs) to show that they have not knowingly and willfully limited or restricted the compatibility or interoperability of their certified electronic health record (EHR) technology. Objective 0 is not a CMS term; it is the name Oregon and several other states are using to identify these required statements/questions on the attestation. If you are an EP, eligible hospital, or critical access hospital participating in the Medicare and Medicaid EHR Incentive Programs you must attest to the Prevention of Information Blocking Attestation. For more information, please see the Prevention of Information Blocking Attestation Fact Sheet.
	We attested in 2016 to MU Modified Stage 2; for 2018, is our EHR reporting period 90 days, or a full year?	For 2018, the EHR reporting period is any continuous 90 days in 2018, regardless of meaningful use stage.
	Can we attest to a full year of MU, not just 90 days?	Yes. Please contact our office before you attest to 2018, as this will require a special process: Medicaid.EHRIncentives@dhsoha.state.or.us or 503-945-5898.
	Some of our reports are custom-built by our vendor to capture the data. Will this type of report suffice?	Your CEHRT must include the capability to electronically record the numerator and denominator and generate a report including the numerator, denominator, and resulting percentage for all percentage-based MU measures. However, the MU measures do not specify that this capability must be used to calculate the numerators and denominators. Providers may use a separate, non-certified system to calculate numerators and denominators and to generate reports on the measures. Furthermore, as long as the CEHRT has not been modified to adversely affect the technology's capabilities to perform as it did when it was tested and certified, it is acceptable for providers to modify their CEHRT to meet local health care delivery needs. Please refer to the CMS FAQs below for more guidance: CMS FAQ #3063 CMS FAQ #3073 CMS FAQ #3601

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Audits	How often do audits happen? How are providers selected for audit?	Post-payment audits are conducted for each program year. Providers selected for audits are selected one of two ways: 1) random selection; 2) flagged as high risk during due to certain criteria. For more information, contact the program auditor, Jenni Claiborne: Medicaid.EHRIPAudits@dhsoha.state.or.us
Electronic Clinical Quality Measures	Do we still have the option of using a 90-day eCQM reporting period, or are we required to use a full year?	If you are attesting to meaningful use for the first time (that is, prior to program year 2018, you have only received an AIU payment), then your eCQM reporting period is any continuous 90 days in calendar year 2018. If you have already achieved meaningful use in a prior year, then your eCQM reporting period for 2018 is a full year.
	What is the eCQM reporting period for Stage 3? For Modified Stage 2? Do both stages require electronic reporting?	For 2018, the eCQM reporting period is a full year, regardless of which stage you are attesting to. The only exception would be for EPs reporting their first year of meaningful use. For first time meaningful users, the eCQM reporting period is any continuous 90 days in calendar year 2018. For more information, see: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CQM_Table.pdf For 2018, all participants of Oregon's Medicaid EHR Incentive Program will submit their eCQMs to the CQMR, either via QRDA from CEHRT, or using the CQMR Excel template.
	Are zero denominators still allowed for eCQM reporting?	Yes. Please see CMS FAQ #12356 for more information.
	Since the eCQM reporting for 2018 is to include a full 12 months, if we have a provider who leaves before the end of 2018, would we just submit eCQMs for the portion of the year that he/she worked for us,	The CMS guidance states that if an EP practices at multiple locations, he/she should combine data for eCQMs across locations where possible. However, if different practice locations choose to report on different eCQMs, then the EP should report on eCQMs from the location with the greatest number of patient encounters. Furthermore, there is no requirement that an EP works 12 months to qualify for the Medicaid EHR Incentive Program; therefore, if an EP only works at a clinic for three months, then retires or goes on

	or does he/she become ineligible with the full 12 months of eCQM data?	leave, the eCQM data for the time he/she was working would be what you would report for the 12-month eCQM reporting period. For more information, see the Guide for Eligible Professionals Practicing in Multiple Locations.
	Do we have to submit our eCQMs via the Clinical Quality Metrics Registry (CQMR)?	Yes. Starting in program year 2018, eCQMs will no longer be manually entered in MAPIR with your attestation. Instead, from MAPIR, you will be directed to a link to the CQMR, where you will submit your eCQM data using your choice of an Excel template or a QRDA III file. If you submit your eCQMs using the Excel template method, you will still need to upload your eCQM report from your CEHRT with your attestation in MAPIR.
	Will the CQMR be the same as MAPIR in the fact that I can be an administrator for all our providers?	Yes. You will be able to set up your account to submit eCQMs in the CQMR on behalf of multiple providers.
	Will the eCQM information be publicly reported?	Transitioning to the CQMR does not change OHA's approach to public reporting. OHA does not plan to publicly report individual EP eCQM data. For CCO incentive measures, CCO performance will continue to be publicly reported as in previous years. CCO metrics reports are posted here: https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Pages/HST-Reports.aspx
	If we are using two different CEHRTs in 2018 due to a transition, how will we need to report our eCQMs? Can we upload two different QRDA III files, or can we just manually combine in an excel spreadsheet?	Manually combining and submitting the eCQMs in the Excel template is the simplest option in this situation.

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	For Stage 3 reporting, eCQMs have to be submitted via a QRDA III file; currently at our organization, the QRDA file that we generate is done at the group/TIN level. Would the state accept one QRDA file (that has numerous providers' data in it) for our individual EP attestations, or does the state expect a unique QRDA file that is specific to only the EP who is reporting? Regarding individual EP or eCQM reporting, does a unique QRDA file have to be generated for each EP, or can there be one file with many providers in it?	Please note that QRDA III submission is accepted but is not required for 2018 for Oregon EPs. Oregon will accept either attestation or QRDA III reporting of eCQMs. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CQM_Table.pdf To do QRDA III reporting, you need a QRDA III report for each EP, although you are welcome to submit those reports in a zip file if that approach is convenient for you. A group report QRDA III file (like you'd use for MIPS and CPC+), however, does not meet the program requirements for the Medicaid EHR Incentive Program, which require reporting at the individual EP level.