Oregon Medicaid EHR Incentive Program
(aka Medicaid Promoting Interoperability Program)
Program Year 2019 Update Webinar
Frequently Asked Questions

Topic	Questions	Answers
General Questions about Attesting	Who should I contact if I need help on my attestation?	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.
	Where can I view these slides or the presentation?	Each webinar participant will receive the slides and FAQ after the webinar. All materials will be accessible on our website as well, including the recorded webinar: MedicaidEHRIncentives.Oregon.gov/
	Can a delegate of the provider attest on his/her behalf?	Yes. The provider may designate another person to submit his/her attestation. If the provider already has a Medicaid web portal account, then the administrator of that account would log in and designate a clerk to submit the attestation on his/her behalf. If the provider does not have a web portal account, they would need to contact Provider Services at 1-800-336-6016.
	What if I submitted my attestation, but then later when I check on it, I see it's in an "Incomplete" status?	This indicates that a change needs to be made to your attestation. An EHR Incentive Specialist will reach out to you by email with instructions on what to do next.
	Is it required for a provider to participate in the Medicaid EHR Incentive Program?	No, it is not a requirement for providers to participate in the Medicaid EHR Incentive Program (aka Medicaid Promoting Interoperability Program).
	Does a provider need to meet all the objectives to get the incentive payment?	Providers need to meet the criteria for all objectives or meet the exclusion criteria to qualify for the incentive payment.

	When will the 2019 Stage 3 Objectives and Measures be available?	These are now available on the CMS website. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_2019.pdf
	Does my patient volume timeframe have to be the same as my PI/EHR reporting period? For the patient volume spreadsheet, do I list all the patients seen during the patient volume timeframe?	No, your patient volume can be a different timeframe than your PI/EHR reporting period. For more information on patient volume, please see: https://www.oregon.gov/oha/HPA/OHIT-MEHRIP/Pages/Manuals.aspx For the pre-payment process, if we request a patient volume spreadsheet, we are verifying your patient volume numerator and need all the encounters (not just patients) included in the patient volume numerator (Medicaid encounters). The spreadsheet would only need the following fields: date of service, patient's Medicaid ID, amount billed if easily attainable, and if attesting as group patient volume, the rendering provider's NPI. Please note, an encounter is counted as one per patient, per provider, per day. Therefore, if a patient is seen by the same provider on three different days during the patient volume timeframe, that counts as three encounters. For a post-payment audit, you would need to provide a patient volume spreadsheet with all the encounters (Medicaid and non-Medicaid) that were included in the denominator.
Stage 3 Meaningful Use Objectives and Measures	Will we have the same public health registry options for 2019?	Currently there is no additional information provided that indicates any change in the public health registry options. However, for Stage 3 there are five measures to answer and you must meet at least two of the measures to meet the objective.
	Can I submit to Syndromic Surveillance?	For Stage 3 Syndromic Surveillance, Oregon Public Health is only ready to receive syndromic data from EPs practicing in urgent care settings https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/PREPAREDNESSSURVEILLANCEEPIDEMIOLOGY/ESSENCE/Pages/Meaningful-Use.aspx
	Can access by authorized delegates for a provider in the Prescription Drug Monitoring Program (PDMP) count toward the PDMP access requirement piece of the Public Health Registry Reporting measure?	Yes. According to Oregon Administrative Rule 333-023-0820 practitioners may authorize a delegate to access the PDMP on his/her behalf, but the delegate must have her/his own active system account.

	Does OHA have a security risk analysis template they suggest using?	Although we do not have a specific template to endorse, we know HITECH TA has an SRA tool available to providers at **no-cost**. ONC, in collaboration with the HHS Office for Civil Rights (OCR), developed a new version of the downloadable Security Risk Assessment Tool (SRA Tool). https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment
	Can you add specific language to the measures as to who is eligible to perform the tasks required in each measure? There seems to be a lot of confusion around who can send messages, run medication reconciliations, etc.	The Centers for Medicare and Medicaid Services (CMS) publish the specification sheets for the objectives and measures. States are not able to revise these. According to CMS FAQ 2771, "The Stage 3 Final Rule for the Medicare and Medicaid EHR incentive programs specifies that in order to meet the meaningful use objective for computerized provider order entry (CPOE), any licensed health care provider or a medical staff person who is a credentialed medical assistant or is credentialed to and performs the duties equivalent to a credentialed medical assistant can enter orders in the medical record, per state, local and professional guidelines. **The remaining meaningful use objectives do not specify any requirement for who must enter information.** https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/FAQ_EligibilityParticipation.pdf
	When I'm asked for a list of providers who submit to Public Health or Clinical Data Registry, where do I get that list?	The attesting clinic/provider creates that list of providers and NPIs; however, the list must be accompanied by a letter from the registry verifying the EP's active engagement.
	Why is the eCQM reporting period a full year and MU measures a 90-day reporting period?	Starting in Program Year 2018, CMS elected to change the eCQM reporting period for the Medicaid EHR Incentive participants to align with the corresponding performance period in MIPS for MIPS eligible clinicians.
	What is Electronic Case Reporting (eCR)?	Electronic Case Reporting (eCR) is one of the public health registries available to Oregon providers. It is the generation and transmission of case reports from an EHR to public health for review and action. To see the available public health registries, visit https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/HEALTHCAREPROVIDERSFACILITIES/MEANINGFULUSE/Pages/index.aspx?wp830=se:"electronic+case+reporting"

	We use the EHR for lab orders but not to receive the information. We do not do radiology orders. Do we meet the measure?	According to the 2019 CMS specification sheet for *Objective 4 – Computerized Provider Order Entry (CPOE)*: "The EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions." The exclusion criteria for Measure 3 is "Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period." For more information, see https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEP_2019_Obj4.pdf
	For secure messaging – if we are sending a message to a patient about something that needs to get done and when they last received it, and the message includes PHI, could we count that for MU?	There isn't a requirement stating when the message has to be sent to the patient within the 90-day EHR reporting period (before vs. after the office visit). However, in order for the message to count in the numerator, it must be clinical in nature and contain information regarding the patient's care. It cannot be administrative in nature (e.g. regarding billing, payment, insurance, and appointment scheduling).
	Has the metric changed so that if a medical assistant or nurse sends the secure message instead of the provider, it will still meet the metric for secure messaging?	No. According to the 2019 CMS Specification sheets: "Measure 2 includes provider-initiated communications (when a provider sends a message to a patient or the patient's authorized representatives), and provider-to-provider communications if the patient is included. **An EP can only count messages in the numerator when the EP participates in the communication** (e.g., any patient-initiated communication only if the EP responds to the patient. *Note*: *EPs are not required to respond to every message received if no response is necessary*." https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEP_2019_Obj6.pdf