CPCA
California Primary Care Association

Health Care Access for All

CPCA Meaningful Use Boot Camp
October 22, 2014
Parking Lot Q&A

1) **Can you explain "Stage 1 vs Year 1; Stage 2 vs Year 2"?**
   - With focus on the Medi-Cal EHR Incentive Program (that has slight differences from the Medicare EHR Incentive Program)
     - Year 1 is most often "AIU", Adopt Implement, Upgrade, $21,250 incentive
     - Each EP must attest to at 2 years at each state. Therefore, we differentiate between Stage 1 Year 1, Stage 1 Year 2, Stage 2 Year 1, Stage 2 Year 2

2) **Explain 2014 Changes to me.**
   - This entails a lot. 2014 CEHRT requirement, changes to some measures, the commencement of Stage 2 (if an EP has completed at least 2 years of Stage 1), changes to how menu measures work. We will cover in details with a few slides coming up.

3) **If attesting to MU for the first time in 2015, does it have to be for a 90 day (reporting period) or a full year?**
   - No matter the year, an EP's first year attesting to MU is for a 90 day reporting period

4) **Can you define or explain patient engagement?**
   - Some MU measures require a degree of patient participation, having the patients actually use health information technology (data). As HIT professionals and health centers that have embraced the use of EHRs, we must educate our patient population on the value of logging in and connecting with their health information. We will review the MU measures that require patient engagement later in this presentation.

5) **To Open Door presenter: Did you use volunteers to help register your patients for the portal?**
   - While at the time of publishing this document, a response was not in hand from Open Door. However, it is known that some community health centers have had college student volunteers work their wait room / intake rooms, having those students assist patients to register for their patient portal.

6) **How do we engage patients without emails?**
   - This question is often asked. To assist EPs in being meaningful users, we all must find ways to continue to grow the use of health information use – be it via patient portals, health information exchanges, clinic based kiosks, mobile technology (smart phones, aps), etc.
   - It is recommended to work with your EHR Vendor on their software requirements regarding email addresses.

7) **View Download Transmit (VDT). There are a couple of measures, some with "and", some with "or". Please explain.**
    - ❖ Measure 1 (2014+ Stage 1 and Stage 2): More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, with the ability to view, download, **and** transmit to a third party.
    - ❖ Measure 2 (Stage 2 only): More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.
    - ❖ This topic will be covered during the MU Boot Camp follow up webinar.
8) **Do we need to provide account numbers for the patients who are in the numerator and denominator of each measure?**
    - ❖ No. MU measures are reported as aggregate data, CMS is not looking for patient specific information. For example, when attesting to the Core measure on recording demographics, you will enter something like 297/301, and that is all!

9) **For patient portal messaging measure, does the patient requesting an appointment through the portal count?**
    - ❖ Be sure to know the difference between Stage 2 Core Measure 7 Patient Electronic Access, and Core Measure 17 Secure Messaging
    - ❖ No. A patient accessing their portal account for scheduling will most likely not satisfy their having "viewed, downloaded or transmitted" their online health information nor will it satisfy having sent a secure message – because they have only scheduled an appointment, they have not logged in to address these specific MU steps
    - ❖ Check this with your EHR Vendor!!!

10) **In MU2, the Problem List measure was moved into the Summary of Care measure. Is there a standard documentation requirement for the problem list, i.e. icdio / snomed?**
    - ❖ Per the measure's specification sheet (see link to Core 15 on the resources page):
        - ❖ Data incorporation. Electronically incorporate the following data expressed according to the specified standard(s): Problems. At a minimum, the version of the standard specified in § 170.207(a)(3)
        - ❖ IHTSDO SNOMED CT® International Release July 2012 (incorporated by reference in § 170.299) and US Extension to SNOMED CT® March 2012 Release (incorporated by reference in § 170.299).

11) **While in the SLR, should Group Accounts lock when selecting "Save" at Step 3 or 4?**
    - ❖ CalHIPSO is working with DHCS on a response (Nov 2014)

12) **Is the SRA sufficient if you only made an assessment, or do you need to fill in the gaps as well? For both Stage 1 and Stage 2.**
    - ❖ SRAs can easily cover their own Boot Camp or webinar, summary information from their specification sheets:
        - ❖ Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.

- Stage 2: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.

13) **Regarding the portal. If the patient is offered a security token to sign up and they do not follow-through, does this count towards the numerator?**
    - It might – depending upon (but not limited to) your clinic's policies (and interpretation of the rules) and your EHR. However, at the end of the day, not exactly the intent behind the parts of meaningful use that are looking to increase patient engagement.

14) **Where is the best resource to find the most updated measure specifications and changes?**
    - CMS, http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html., then selecting from the left hand navigation column "2013 Definition Stage 1 of Meaningful Use", "2014 Definition Stage 1 of Meaningful Use" or "Stage 2"
    - CPCA's MU Boot Camp resources! http://cpca.org/index.cfm/health-center-resources/meaningful-use/meaningful-use-boot-camp/

15) **If we choose not to participate in MU under the CMS EHR Incentive Program, are we subject to Medicare Penalty if we bill Medicare Part B?**
    - If the EP is eligible for the Medicare EHR Incentive Program, yes.
    - To elaborate, PAs and NPs are not eligible for the Medicare EHR Incentive Program. Therefore, if they are not meaningful users, their Medicare Part B claims will not be subject to a payment adjustment
    - MDs, DOs, and DDSs are eligible for the Medicare EHR Incentive Program. Therefore, if the EP is not a meaningful user and does have Part B claims, those claims are subject to a payment adjustment.

16) **Our internal prescription faxes goes out on a fax line and comes back in and gets printed to a printer in our internal pharmacy. Our pharmacists have access to NextGen EHR to see medications entered by provider. Does this meet eRx measure?**
    - Faxing is analog technology, not electronic (structured) data, also not bi-directional.
    - It is recommended that you look into your NextGen's e-prescribing capabilities as well as your MU reports to see if you are able to meet the eRx measure via your current work flow.

17) **We went live on Aug 17, 2014 with 2014 CEHRT. Until then it was all 2011 CHERT. If we use reporting period Oct – Dec 2014 can we go for 2011 CEHRT for attestation or should it be 2011-2014 Combo period?**
    - This question is in regards to 2014 CEHRT Flexibility
    - If you are able to demonstrate (and document) that you were not able to fully implement on your 2014 CEHRT (due to vendor delays) between your date of upgrade (Aug 2014) through (or at least partially through) the Oct – Dec reporting period, you can exercise the option for flexibility.

- The easiest path to follow is to select a 90 day reporting period prior to your August upgrade to 2014 CEHRT (i.e. May – June – July) wherein your certified EHR number (CHPL) would be 2011 only.
- Second suggest path is to select a 90 day reporting period that includes at least 1 day prior to your Aug 2014 upgrade (i.e. if your upgrade was the weekend of August 2nd/3rd, use Aug 1st thru Oct 29th (or Aug 1 – Oct 31) as your reporting period wherein your certified EHR number (CHPL) would be 2011/2014 Combination
- Third path might require CMS review, as they have stated that if an EP wants to flex to 2013 Stage 1 Definition but was on 2014 CEHRT for their entire reporting period (in this case Oct 1 – Dec 31) then CMS would review on a case-by-case basis. This path will most likely be easier to pursue in the SLR than the NLR due to differences in the way the systems are programmed.

18) Is SNOMED required for 2014 MU or is ICD-9 okay?

- CalHIPSO believes that the answer is "ICD-9 is okay". However, it is advised that you look at the measures on a case by case basis. The specification sheets created by CMS have technical specifications, or certification requirements, at the end of each of sheet.

19) Do the payment adjustments apply to FQHCs when billing for Medicare Part B claims is via individual provider's NPI for diagnostic tests?

- FQHCs typically bill as a facility and should not expect payment adjustments on Medicare Part B claims (as they are not billed on individual EP NPIs). However, if an FQHC does bill Part B claims on individual NPIs, such as diagnostic tests, they should expect to see payment adjustments if the EP is not a meaningful user.

20) If patient declines our offer for patient portal or does not have an email address and we document this in our system, does it count for numerator for this measure?

- See number 13 above.

21) Is there an Opt Out for portal?

- See on our resource page CMS' Spotlight on Patient Electronic Access:
  - **Stage 1 and Stage 2 Measure #1: Providers with Patients who Opt-Out**
    A patient can choose not to access their health information, or "opt-out." Patients cannot be removed from the denominator for opting out of receiving access. If a patient opts out, a provider may count them in the numerator if they have been given all the information necessary to opt back in without requiring any follow up action from the provider, including, but not limited to, a user ID and password, information on the patient website, and how to create an account.

22) EHR Vendors are telling us that after 2014 or after Stage 1 (or both) that even if participating in Medicaid EHR Incentive Program (Medi-Cal for California), that the reporting period must be 90 days.

- Be sure to question your Vendors if they are speaking about Medicare EHR Incentive Program reporting period. Medi-Cal 90 day reporting periods are always any continuous 90 days, that do not crossover a calendar year end, not restricted to calendar quarters.

23) Has a workflow study been conducted for time/FTE needed for attestation?

- Not that we are aware of. Excellent question and many of the discussions had during the MU Boot Camp showed that an analysis such as this would benefit Community Health Centers. While far from a study, this topic will be included in an MU presentation to health center CFOs later this month.

24) We have an HIE in our county. The HIE is complaining about the cost of interoperability/connectivity between the EHR and the HIE. How did IEHIE overcome this?

- Response provided by IEHIE: I'm not sure that we have. What we have done is that we use a 3rd party vendor for the Ambulatory EMR side which allows us to have a fixed interface cost that we then roll into our fees. The reality is, the cost to interface is the single greatest cost in the HIE.

25) How to engage your County and partners to begin/join an HIE?

- Soft responses, more ideas than concrete guidance: Join yourself and share the benefits you are seeing for being part of an HIE. Encourage your peers. Collaborate. Join a Practice Transformation Network. Needed for MU…