Staged for Success: 2019 Participation in the Medicaid Promoting Interoperability Program

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Agenda

▲ Program Basics
▲ Eligibility Criteria
▲ 2019 Program Requirements
▲ Stage 3 Objectives and Measures
▲ Deep Dive on Health Information Exchange and Public Health Reporting
▲ Resources
▲ Questions
Medicaid Promoting Interoperability Program...some basics

▲ In early 2018, CMS changed the name from the EHR Incentive Program (aka Meaningful Use) to the Medicaid Promoting Interoperability (PI) Program

▲ Not to be confused with the QPP/MIPS Promoting Interoperability performance category
  − Separate, parallel programs...similar name but now vastly different

▲ Medicaid PI will continue through 2021

▲ Incentives = $8,500/provider per year, but had to start participation no later than 2016

▲ No penalties for not participating (voluntary program)

▲ Stage 3 measures required in 2019; no longer able to attest to “Modified Stage 2” after 2018

▲ 2015 Edition CEHRT is mandatory for program participants in 2019
  − Ensure EHR is upgraded no later than Oct 3, 2019 (last 90 day reporting period begins)
  − Must be using 2015 technology on day 1 of reporting period and version must be ONC certified by last day
Program Eligibility – Provider Types

Eligible Professionals (EPs) (aka Program Participants) must be Michigan Medicaid providers who practice in the State and belong to one of the following provider types:

- Physicians
  - Medical Doctor (M.D.)
  - Doctor of Osteopathic Medicine (D.O.)
- Dentists (D.D.S. or D.M.D.)
- Optometrists (O.D.)
- Nurse Practitioners (NP)
- Certified Nurse-Midwives (CNM)
- Physician Assistants (PA) practicing in a PA-led Federally Qualified Health Center (FQHC) or a PA-led Rural Health Clinic (RHC)
Program Eligibility – Medicaid Patient Volume

▲ Must demonstrate a minimum 30% patient volume attributable to encounters with Michigan Medicaid enrolled patients
- For pediatricians, option for minimum patient volume of 20% to receive 2/3 incentive payment
- Note: Mid-level providers do not meet the program’s definition of a “pediatrician”

▲ Eligibility Reporting Period- A continuous 90-day reporting period during which the EP demonstrates that he or she has maintained an adequate Medicaid patient volume to be eligible for the Medicaid Promoting Interoperability Program. This continuous 90-day reporting period is within one of the two following time frames:
- **Prior Twelve Months**: This option is defined as the prior 365 days from the date of EP attestation/registration
- **Prior Calendar Year**: This option is defined as January 1st through December 31st of the prior calendar year to the program year of participation. Example: When attesting to program year 2018, the Prior Calendar Year would be January 1, 2017 through December 31, 2017
- Note: These options, once the attestation period opens, create a “dead zone” of unusable eligibility dates [Example: if attesting on 3/21/20, then 1/1/19 - 3/20/19 is neither “prior 12 months” nor “prior calendar year”]

▲ Eligibility Using Group Encounter Data (aka Group Proxy Option)
2019 Medicaid PI Program Requirements

Stage 3 Objectives Required
- (8) Objectives with (20) associated measures
- Minimum 90 day reporting period (90-365 days) [can be different from Eligibility Reporting Period]

Report on (6) clinically relevant Electronic Clinical Quality Measures (eCQMs)
- [New] Matching MIPS requirements, (1) must be an Outcome measure
  - If no applicable Outcome measure is available, report at least one High Priority measure
  - If no clinically relevant Outcome or High Priority measures are available, report on any (6) relevant eCQMs
- Minimum 90 day reporting period if EP is a first time attester (A/I/U does not count)
- For those who have demonstrated MU in a prior year, full year (365 days) of eCQM data is required
  - NEW MANDATE: Must be submitted electronically via “CQMRR” (See slide 27 for details)
Eligible Professional Stage 3 Objectives & Measures

(1) **Protect Patient Health Information** – Protect electronic protected health information created or maintained by the certified electronic health record technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.

(2) **Electronic Prescribing** – Generate and transmit permissible prescriptions electronically.

(3) **Clinical Decision Support** – Implement clinical decision support interventions focused on improving performance on high-priority health conditions.

(4) **Computerized Provider Order Entry** – Use computerized provider order entry for medication, laboratory, and diagnostic imaging orders directly entered by any licensed health care professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

(5) **Patient Electronic Access to Health Information** – The eligible professional (EP) provides patients (or patient authorized representative) with timely electronic access to their health information and patient-specific education.

(6) **Coordination of Care through Patient Engagement** – Use CEHRT to engage with patients or their authorized representatives about the patient’s care.

(7) **Health Information Exchange** – The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

(8) **Public Health and Clinical Data Registry Reporting** – The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.
Objective 7:

Health Information Exchange (HIE)
# Objective 7: Health Information Exchange

| Objective: | The eligible professional (EP) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT). |
| Measure(s): | Providers must attest to all (3) measures and must meet the thresholds for at least (2) measures to meet the objective:  
  • **Measure 1** – For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care:  
    (1) Creates a summary of care record using CEHRT; and  
    (2) Electronically exchanges the summary of care record  
  • **Measure 2** – For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient’s EHR an electronic summary of care document.  
  • **Measure 3** – For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets:  
    (1) Medication: Review of the patient’s medication, including the name, dosage, frequency, and route of each medication.  
    (2) Medication Allergy: Review of the patient’s known medication allergies.  
    (3) Current Problem list: Review of the patient’s current and active diagnoses. |
| Threshold(s): |  
  • **Measure 1**: > 50%  
  • **Measure 2**: > 40%  
  • **Measure 3**: > 80% |
### Objective 7: Health Information Exchange

#### Numerator(s):
- **Measure 1**: The number of transitions of care and referrals in the denominator where a summary of care record was created using certified EHR technology and exchanged electronically.
- **Measure 2**: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the certified EHR technology.
- **Measure 3**: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.

#### Denominator(s):
- **Measure 1**: Number of transitions of care and referrals during the PI reporting period for which the EP was the transferring or referring provider.
- **Measure 2**: Number of patient encounters during the PI reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.
- **Measure 3**: Number of transitions of care or referrals during the PI reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.

#### Exclusion(s):
- **Measure 1**: A provider may exclude from the measure if any of the following apply:
  1. Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the Promoting Interoperability (PI) reporting period.
  2. Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period may exclude the measures. (Note: no counties in MI qualify)
- **Measure 2**: A provider may exclude from the measure if any of the following apply:
  1. Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.
  2. Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measures.
- **Measure 3**: Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.

Continued on next slide
HIE Measure 2: Excluding Patients from the Denominator Calculation

From the HIE Measure Specification Sheet:

▲ For the purposes of defining the cases in the denominator for Measure 2, we stated that what constitutes “unavailable” and, therefore, may be excluded from the denominator, will be that an EP:

- Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; **and**
- The EP either:
  - Queried at least one external source via HIE functionality and did not locate a summary of care for the patient, or the provider does not have access to HIE functionality to support such a query, or
  - Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider’s geographic region and not available within the EP’s EHR network as of the start of the EHR reporting period.

▲ The Michigan Medicaid Promoting Interoperability Team has determined that “HIE functionality supporting query for summary of care documents was not operational in the provider’s geographic region” for 2019 reporting

- If the ability to query for a SoC/CCDA is not available within your EHR, you can skip this step in 2019
- MiHIN’s “MIDIGATE” will be available in early 2020 to satisfy this requirement for 2020 PY reporting
Additional Information on HIE Objective

▲ For Measure 2, a record cannot be considered incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for EP use within the EHR
  – CMS does not strictly define “incorporate”, leaving how this is done to the EP (and/or technology) to decide

▲ For Measure 3, the process may include both automated and manual reconciliation to allow the receiving EP to work with both the electronic data provided with any necessary review, and to work directly with the patient to reconcile their health information

▲ For Measure 3, if no update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record

▲ Non-medical staff may conduct reconciliation under the direction of the EP so long as the EP or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant clinical decision support alert
Objective 8:

Public Health and Clinical Data Registry Reporting
### Objective 8: Public Health and Clinical Data Registry Reporting

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<thead>
<tr>
<th>Objective:</th>
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<td>The eligible professional (EP) is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice.</td>
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<th>Measure(s):</th>
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<td>An EP must satisfy (2) measures for this objective (which can be the same measure twice). If the EP cannot satisfy at least two measures, they may take exclusions from all measures they cannot meet.</td>
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<tr>
<td>• <strong>Measure 1</strong>: Immunization Registry Reporting: The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).</td>
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<td>• <strong>Measure 2</strong>: Syndromic Surveillance Reporting: The EP is in active engagement with a PHA to submit syndromic surveillance data from an urgent care setting.</td>
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<td>• <strong>Measure 3</strong>: Electronic Case Reporting: The EP is in active engagement with a PHA to submit electronic case reporting of reportable conditions.</td>
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<td>• <strong>Measure 4</strong>: Public Health Registry Reporting: The EP is in active engagement with a PHA to submit data to a public health registry.</td>
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<td>• <strong>Measure 5</strong>: Clinical Data Registry Reporting: The EP is in active engagement to submit data to a Clinical Data Registry.</td>
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<th>Threshold(s):</th>
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<td>• Measures 1-5: Yes/No/Exclusions</td>
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<th>Numerator(s):</th>
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<td>N/A</td>
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What does it mean to be Actively Engaged?

▲ Active Engagement (AE) Options =

- **Option 1 – Completed Registration to Submit Data:** The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows clinicians to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Clinicians who have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

- **Option 2 – Testing and Validation:** The EP is in the process of testing and validation of the electronic submission of data. EPs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that EP not meeting the measure.

- **Option 3 – Production:** The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.
**Immunization Registry Reporting**

▲ YES/NO: The EP must attest YES to being in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

- **EXCLUSIONS:** An EP may take an exclusion if any of the following apply:
  - Clinician does not administer immunizations to any of the populations for which data is collected by their jurisdiction’s immunization registry or IIS during the EHR reporting period;
  - Clinician practices in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - Clinician practices in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the EHR reporting period.

▲ **In Michigan:** [Michigan Care Improvement Registry (MCIR)]

▲ **Must** be actively engaged for bi-directional connection (aka QBP – Query by Parameter)
  - Unidirectional active engagement (any option) in a prior year no longer meets program requirements
  - MCIR requires participants to in “Production” with unidirectional feed (VXU) prior to accepting registration for QBP
  - For 2019 only, State will accept documentation of registration attempt as AE Option 1

▲ To register for QBP, send email request to [MDHHS-MU-MCIRHelp@michigan.gov](mailto:MDHHS-MU-MCIRHelp@michigan.gov) (AE Option 1)
Syndromic Surveillance Reporting

▲ YES/NO: The EP must attest YES to being in active engagement with a PHA to submit syndromic surveillance data.

– EXCLUSIONS: An EP may take an exclusion if any of the following apply:
  ▪ Clinician is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction’s syndromic surveillance system;
  ▪ Clinician practices in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs/ECs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  ▪ Clinician practices in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs/ECs as of six months prior to the start of the EHR reporting period.

▲ In Michigan: Michigan Syndromic Surveillance System (MSSS)
▲ MSSS only accepts Syndromic Surveillance data from Hospital ERs and Urgent Care locations
  – Primary care offices which have “after hours” urgent care-like services do not count
▲ Vast majority of MI EPs qualify for measure exclusion
Electronic Case Reporting

▲ YES/NO: The EP must attest YES to being in active engagement with a PHA to submit case reporting of reportable conditions.

– EXCLUSION: A Michigan EP may take an exclusion if the following applies:
  ▪ Clinician does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction’s reportable disease system during the EHR reporting period

▲ In Michigan: Michigan Disease Surveillance System (MDSS)

▲ Criteria for Electronic Case Reporting

– Data Originating from Eligible Hospitals and Eligible Professionals
  Michigan’s Public Health Code requires that all health provider encounters that result in identification of reportable communicable diseases get reported to the local health authorities. Details about mandatory reporting can be found at www.michigan.gov/cdinfo.

– Capability to Submit Electronic Case Reports in the Standard Format
  A national standard has been developed for certified electronic health record technology (CEHRT) to generate an Electronic Initial Case Report (eICR) as described in the HL7 CDA® R2 Implementation Guide: Public Health Case Report, Release 2 – US Realm – the Electronic Initial Case Report (eICR).
  ▪ Translation: If your EHR is not certified for Electronic Case Reporting, EP cannot use this measure (claim exclusion)
Is the “Specialized Registry” I used in 2018 a PHR or CDR in 2019?

▲ **Public Health Registry (PHR)** – “are those administered by, or on behalf of, local, state, territorial, or national public health agencies.” (i.e. Governmental Entity)

▲ **Clinical Data Registry (CDR)** – “are administered by, or on behalf of, other non-public health agency entities”. Further, the National Quality Registry Network defines clinical data registries as those that record information about the health status of patients and the health care they receive over varying periods of time. (i.e. Non-Governmental Entity)

www.federalregister.gov/d/2015-25595/p-1239
Public Health Registry Reporting

▲ YES/NO: The EP must attest YES to being in active engagement with a PHA to submit data to public health registries.

– EXCLUSIONS: An EP may take an exclusion if any of the following apply:
  • Clinician does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period;
  • Clinician practices in a jurisdiction for which no PHA is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  • Clinician practices in a jurisdiction where no PHA for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.

▲ In Michigan: Michigan Automated Prescription System (MAPS), Michigan Cancer Surveillance Program (MCSP), Michigan Birth Defects Registry (MBDR) – EPs, Michigan Birth Registry (MBR), Newborn Screening (NBS)

– Note: Michigan's Dental Registry (MiDR) cannot be used in the Medicaid PI Program in 2019 as it does not currently use a valid “specified standard” for data transmission. OK for use in MIPS PI. (see slide 22)

– Similar to Electronic Case Reporting, if EHR is not certified for Cancer reporting, cannot engage registry

▲ Nationally: CDC National Health Care Surveys Registry
Clinical Data Registry Reporting

▲ YES/NO: The EP must attest YES to being in active engagement to submit data to a CDR.

– EXCLUSIONS: An EP may take an exclusion if any of the following apply:
  ▪ Clinician does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the EHR reporting period;
  ▪ Clinician practices in a jurisdiction for which no CDR is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  ▪ Clinician practices in a jurisdiction where no CDR for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.
  ▪ NOTE: “Jurisdiction” is often national with CDRs

▲ Example: Prime Registry (American Board of Family Medicine)

– For additional examples: National Institutes of Health List of Registries

▲ To be valid for use, registry must:

– Publicly declare readiness to accept electronic data at least 6 months prior to the start of the program performance year and be able to accept electronic submissions (*manual data entry into a website does not count*)
– Be able to support the registration, onboarding and production processes
– Be able to provide documentation to clinician as evidence of active engagement
Potential PI Stage 3 Issue with former Specialized Registries

Vital Information Which Only Applies to Medicaid PI/MU Participants:

▲ From the Medicaid PI Measure Specification Sheet *(DOES NOT APPLY TO MIPS PARTICIPANTS)*

- “For Measure 4, an EP may count a specialized registry (such as prescription drug monitoring) if the EP achieved Active Engagement Option 3 in a prior year under the applicable requirements of the PI Programs for that year.”

- “For Measures 4 and 5, if the PHA or CDR does not use a specified standard, it must use another standard specified in 170.205 to meet the measure. For example, the transmission could be in the form of a Consolidated Clinical Document Architecture (C-CDA) per 170.205(a)(4), or Quality Reporting Document Architecture (QRDA) per 170.205(h)(2).”

  ▪ **Translation for Measure 4:** If the registry is a PHR, does not use a standardized method/language for the transmission of data, and you did not attest to being in Active Engagement Option 3 – Production in a prior program year, it CANNOT be used in the Medicaid Promoting Interoperability Program to meet Stage 3 requirements.

  ▪ **Translation for Measure 5:** If the registry is a CDR and does not use a standardized method/language for the transmission of data, it CANNOT be used in the Medicaid Promoting Interoperability Program to meet Stage 3 requirements.

- See next slide for a decision tree which may help you make sense of this
Public Health Registry vs Clinical Data Registry Decision Tree

• Methodology the State of MI Medicaid PI team will use in 2019+ to validate registries
## Summary of MDHHS Sponsored Public Health Options

<table>
<thead>
<tr>
<th>Public Health Measure</th>
<th>System Name</th>
<th>Available Since</th>
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<tbody>
<tr>
<td>Immunization Registry Reporting</td>
<td>Michigan Care Improvement Registry (MCIR)</td>
<td>January 1, 2011 (Receive Immunization data)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>January 1, 2016 (Receive and Respond to Queries for Immunization Histories and Forecasts)</td>
</tr>
<tr>
<td>Syndromic Surveillance Reporting</td>
<td>Michigan Syndromic Surveillance System (MSSS)</td>
<td>August 1, 2013</td>
</tr>
<tr>
<td>Public Health Registry Reporting – Cancer Case Reporting</td>
<td>Michigan Cancer Surveillance Program (MCSP)</td>
<td>March 1, 2014</td>
</tr>
<tr>
<td>Public Health Registry Reporting – Birth Defect Reporting</td>
<td>Michigan Birth Defects Registry (MBDR)</td>
<td>March 1, 2014</td>
</tr>
<tr>
<td>Public Health Registry Reporting – Pediatric Oral Health Reporting</td>
<td>Michigan's Dental Registry (MiDR)</td>
<td>February 1, 2016</td>
</tr>
<tr>
<td>Electronic Case Reporting</td>
<td>Michigan Disease Surveillance System (MDSS)</td>
<td>January 1, 2018</td>
</tr>
</tbody>
</table>
So what must program participants do prior to claiming a Public Health measure exclusion?

At a minimum, clinician must:

1. Determine if the registries offered by a Public Health Agency (PHA) in their “jurisdiction” (which may be state- or national-level depending on the registry) are relevant to the provider’s scope of practice
   - State-Level: See slide 24 for MDHHS sponsored options
   - National-level (example): CDC National Health Care Surveys Registry
   - If clinically relevant and technologically capable, achieve active engagement with the registry

2. Determine if a medical society with which the provider is affiliated endorses or sponsors a registry valid for use in these regulatory programs
   - If clinically relevant and technologically capable, achieve active engagement with the registry

3. If no public health registry determination can be made in the previous steps, clinician may claim measure exclusions for (1) or perhaps both required measures
How Does Claiming an Exclusion Work in Meeting the Objective?

△ Medicaid Promoting Interoperability Program

- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP needs to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of available measures is less than two, the EP can meet the objective by meeting all of the remaining available measures and claiming the applicable exclusions. Available measures are ones for which the EP does not qualify for an exclusion.
New eCQM data submission requirements – “CQMRR”

▲ Effective 1/1/19, EPs are **required** to submit via CQMRR (Clinical Quality Measure Reporting and Repository Service) [pronounced “Skimmer”]

▲ CQMRR submission to MiHIN (Michigan Health Information Network) validates data format and passes eCQM file to CHAMPS/eMIPP for PI attestation

▲ Phases out manual quality measure submission process

▲ Moves toward goal of “report once” capability (one data submission, multiple programs)

▲ To submit 2020 CQM data, EP will need “QRDA 3” file from EHR (either Indiv or Group level)

▲ See 2018 [State of MI announcement](https://www.michigan.gov/2018-06-29-000045-0-690573-1-1142738-0-524771-.aspx) on this requirement

▲ Self-register (and test files) at: [https://healthdirectories.force.com/QMI/s/login/SelfRegister](https://healthdirectories.force.com/QMI/s/login/SelfRegister)

▲ For EPs who cannot submit eCQMs via CQMRR, former manual data entry option will be available through “Enable Web” or “Break the Glass” request/approval
  - Send email to MDHHS-EHR@michigan.gov
  - Explain why EP/Group is requesting manual CQM data entry, the relevant CEHRT ID #, and information about any troubleshooting that has taken place, if applicable
Resources

▲ Federal Registration Website: https://ehrincentives.cms.gov/hitech/login.action
▲ Michigan Medicaid Promoting Interoperability Program Website: https://michiganhealthit.org/
▲ CQMRR Website: https://healthdirectories.force.com/QMI/s/login/
Questions?

www.mceita.org
(888) 642-4347

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