

**IL HIE Medicaid Work Group
Meeting Notes
July 23, 2012**

Attendees (by phone):

Dave Barnes	Department of Healthcare and Family Services (HFS)
Janet Barrett	OSF Healthcare
Pat Borrowdale	Pediatric Health Associates
Kelly Carter	Illinois Primary Health Care Association
Connie Christen	Department of Healthcare and Family Services (HFS)
Peter Ingram	Sinai Health System
Mike Koetting	Department of Healthcare and Family Services
John Lekich	Office of Health Information Technology
Mary McGinnis	Office of Health Information Technology
Renee Perry	Department of Healthcare and Family Services
Cathy Potter	Southern Illinois University Health Care
Mary Ring	Illinois Critical Access Hospital Network
Amanda Schmidt	University of Chicago Medicine
Direndia Shackelford	Advocate Physician Partners
Matt Werner	Academic Medical Centers
Lori Williams	Illinois Hospital Association

1. Electronic Health Records/Provider Incentive Program Status Update

- **Payments to date (7/20/12):**
1,221 Eligible Professionals (EPs) - \$25,733,760
26 Eligible Hospitals (EHs) - \$44,929,475
Total to date: \$70,663,235

Approved:
3 EPs - \$63,750
8 EHs - \$2,179,813

Renee Perry reported that the payments to date amounts have not changed since the last call. However, 3 EP and 8 EH payments for just over \$2M were just approved and will be sent soon. 1,374 EPs and 76 EHs are in the work queue. **Cathy Potter** asked for the number of payments in the work queue by payment year and Renee said that she will provide that for the next call.

2. Pre-payment Audit Process

- *Groups vs. Individuals*
 About 900 of the 1,374 EPs who submitted their attestations as a group will be handled differently. As discussed before, EPs can count the Medicaid patient volume of other physicians in their practice so that they can reach the required 30% Medicaid patient volume amount required to receive the incentive payment. A new email and a form with more detailed information are being sent to all EPs who attested by group. It will ask for their National Provider Numbers (NPIs) for each physician so that their patient volume can be counted.

For the remaining physicians who have attested, additional audit methodologies being developed will be sent for approval from the Centers for Medicare and Medicaid Services (CMS). HFS will implement the new audit strategies as soon as they are approved.

3. Payment Year 2 – Meaningful Use

- *DRAFT Screen Mock-Ups*

As discussed before, the mock ups of the screens were sent in April to CMS for approval.

Educational materials will be developed for providers in addition to having informational webinars regarding Meaningful Use.

Hospitals that attested to the Meaningful Use measures with Medicare do not have to attest again for Medicaid. CMS sends their attestation information to HFS. Screens that address Medicaid patient volume calculation will be included for dual-eligible hospitals.

Each EP is required to meet all of the 15 core objectives and five of the ten menu set objectives. There are three core clinical quality measures and three additional clinical quality measures that the provider will choose from on the list of 38 that they will need to meet. A screen for each objective will have to be built. Hospitals are required to meet 14 of the core objectives, five of the menu set objectives and 15 clinical quality measures. Exclusion criteria will be included.

At least 80% of unique patients' data from the providers reporting period are required to be in that providers certified electronic health system or they do not qualify for Meaningful Use. Renee will find out if that applies to hospitals.

Peter asked that work group members send comments on the screen mock ups to Renee with Meaningful Use Screens in the subject line.

Meeting adjourned. The next call is schedule on August 6.