STATE MEDICAID HIT PLAN (SMHP)

(Note: This template represents what we believe is likely to be included in an SMHP, based upon the provisions in section 4201 of ARRA. However, readers should be aware that the agency intends to engage in notice and comment rulemaking in order to implement the incentives program authorized by section 4201. Therefore, the contents and requirements of this initial SMHP are likely to change after publication of a final rule, and States' plans will need to be modified accordingly.)

PURPOSE: The SMHP should describe the State's Medicaid incentive program and how it will integrate current and planned Medicaid HIT assets and ft within the larger State HIT/HIE roadmap.	***SCOPE:*** Section 4201 of the ARRA provides 90% FFP HIT Administrative match for States to administer the incentive payments provided for under such section. Such administrative match is contingent on the State demonstrating to the satisfaction of the Secretary that it meets the following three requirements: 1. *It is using the funds provided for the purposes of administering the incentive payments* to eligible professionals and hospitals, including tracking of meaningful use by providers; 2. *It is conducting adequate oversight of the program*, including. tracking meaningful use by providers; and 3. *It is pursuing initiatives to encourage the adoption of certified EHR technology* to promote health care quality and the exchange of health care information. The SMHP should address all <u>three</u> areas. We have subdivided the last section ("initiatives to encourage the adoption of certified EHR technology") into three additional subsections: As-Is, To-Be and SMHP Roadmap. *We are particularly interested in how the States anticipate, based upon a preliminary review of the Recovery Act, that they will make and monitor provider incentive payments, , and how the SMAs' plans will dovetail with other State-wide HIE planning initiatives supported by the HHS Office of the National Coordinator and others, including assets needed in support of the SMHP future goals.*

TIME FRAME*:* The SMHP time horizon is the next five years through 2014, although States may discuss their plans beyond 2014, if appropriate. We understand States have a better understanding of their current, near-term needs and objectives, and that plans will change over time. For this reason, we will expect to receive annual updates, as well as as-needed updates, to keep CMS informed of the SMHP as it evolves, and States' ability to meet their targets over the next five years.

SECTION A:	*Administering Incentive Payments to Eligible Professionals (EPs) and Hospitals*
While CMS intends to engage in rulemaking in order to implement section 4201, States can conduct a review of the Recovery Act and determine how they believe they will administer the incentive payments provided for under such section. This includes specific actions for defining and verifying EPs' (physicians, dentists, nurse practitioners, certified nurse midwives, and certain physician assistants), as well as acute care and children's hospitals' eligibility for payments, It also includes actions for processing payments and ensuring against duplicative incentive payments for those professionals eligible under both the Medicare and Medicaid programs.	1. Met the relevant provider enrollment eligibility criteria, including: ✓ Not hospital-based for EPs (except for those EPs practicing predominantly in an FQHC or RHC). ✓ Medicaid patient volume ✓ Use of certified EHR technology ✓ Satisfactorily demonstrated meeting Meaningful Use requirements. 2. Successfully adopted, implemented, or upgraded to certified electronic health record technology during their first year of program participation (for those EPs and hospitals that have not met the MU requirements in Year 1). 3. Commenced utilization of the certified electronic health record . 4. Meaningful use of certified EHR technology, potentially including the reporting of clinical quality measures. 5. The systems that will be used to establish EP and hospital eligibility as well as to communicate with CMS to ensure no duplicate payment of incentives between Medicaid and Medicare. 6. How EP and hospital questions regarding eligibility for the program will be addressed, such as through call centers or other means. 7. Modifications necessary to the MMIS or other systems to coordinate, track and account for the incentive payments. 8. Any potential plans to create a provider appeals process for disputes regarding: a) incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and meeting meaningful use requirements.

SECTION B: Conducting Adequate Oversight of the Program, Including Tracking Meaningful Use by Providers	
Provide a description of the methodologies and/or processes the SMA anticipates it will employ to ensure adequate oversight regarding:	1. Methodologies used to verify: ✓ Use of certified EHR technologies ✓ Meaningful use of information, potentially including the reporting of clinical quality measures. 2. Methodologies to verify that provider information conveyed to the State is accurate and verifiable. Provider information may include information such as NPIs, information on efforts to adopt, implement or upgrade to EHR technology, or information on meaningful use of such technology. States would determine whether they anticipate EPs and hospitals conveying such information via attestations or through other means. 3. If the measures for meaningful use become more stringent over time, States should explain how they would assure systems can accommodate different requirements depending upon the year the EP or hospitals begin receiving incentive payments. 4. All Federal funding, both for the 100 percent incentive payments, as well as the 90 percent HIT administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS FFP re: ✓ No amount higher than the 100% FFP incentive to be claimed by EPs/hospitals. ✓ EPs may not claim the incentive payment from more than one program (Medicaid or Medicare but not both) (Note: Hospitals may claim payment of incentives from both Medicaid and Medicare consistent with the requirements in Section 4201 and subsequent regulations). ✓ Medicaid provider payments are paid directly to such provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate. ✓ Medicaid payments paid to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such a payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption , as described in the Statute. ✓ All hospital calculations and hospital payment incentives are made consistent with the Statute and regulation, as well as a methodology to verify such information.

SECTION C: *Encouraging the Adoption of Certified EHR Technology* to Promote Health Care Quality and the Exchange of Health Care Information.	
A. "As-Is" Landscape Narrative Discussion	***Goals/Objectives:*** To what extent are Health Information Technology and Health Information Exchange (HIT and HIE) activities currently underway, including but not limited to Electronic Health Record (EHR) technology adoption, in your Medicaid enterprise? 1. ***Stakeholders***: What parts of your program are currently engaged in these activities and what is the extent of their involvement? With what other entities do you have HIE relationships, and what is the nature of these activities? 2. ***MMIS/MITA***: Please describe the role of your Medicaid Management Information System/Medicaid IT Architecture (MMIS/MITA) in your current HIE environment relative to your provider community, Medicaid clients, and trading partners. 3. ***Provider EHR Adoption***: What steps are you planning to take in 2009 to use the provider incentives under Section 4201 to achieve your goals? How will you know which providers are eligible? That they are using certified EHRs? That they will be able to meet the draft Meaningful Use criteria? Please describe in detail. 4. ***ONC's State HIT Coordinator/Governance***: What structures are currently in place to facilitate HIT/HIE and EHR adoption currently? What role does the Medicaid agency play? Who else is currently involved? Explain your relationship to the State HIT Coordinator. 5. ***Other***: What other activities do you currently have underway that will likely influence the direction of HIT, HIE and EHR technology adoption over the next five years? Please describe. How will these existing assets be leveraged to achieve provider adoption?
B. "To-Be" Landscape Narrative Discussion	***1. Goals/Objectives***: Looking forward to 2014, what specific goals and objectives do you expect to achieve? Be as specific as possible; e.g., 100% of all Medicaid-participating acute care and children's hospitals, primary care physicians and nurse practitioners will meet the Meaningful Use criteria (as currently proposed), 75% of all dentists, and 50% of all nurse midwives by 2014. ***2. MITA/Enterprise Architecture:*** What will your system architecture look like by 2014 to support achieving the 2014 goals and objectives? Web portals? Enterprise Service Bus? How will your providers interface with your program? With other medical professionals? With their patients? ***3. ONC's State HIT Coordinator/Governance***: Given what you know about governance structures currently in place, what should be in place by 2014 in order to achieve your goals and objectives? While we do not expect you to know the specific organizations will be involved, etc., we would appreciate your discussing this in the context of what is missing today that you think would need to be in place five years from now to ensure EHR adoption and meaning use of EHR technologies.

B. "To-Be" Landscape Narrative Discussion (Continued)	***4. Other***: Please feel free to discuss other issues you believe need to be addressed, institutions that will need to be present and interoperability arrangements that will need to exist by 2014 to achieve your goals.
C. Roadmap Annual Measurable Targets Tied to Goals	1. Provide CMS with a graphical as well as narrative pathway that clearly shows where your Medicaid agency is starting from (As-Is) today, where you expect to be five years from now (To-Be), and how you plan to get there. What are the key milestones, dependencies and risks? 2. How will you measure your program? What methodologies do you intend to use to establish a baseline and period remeasurements of adoption? *In short, CMS is looking for a strategic plan, and the tactical steps that SMAs will be taking (to the extent they are known), as well as those SMAs believe will need to be taken in the future, to achieve your goals. We are specifically interested in those activities SMAs will be taking to make the incentive payments to your providers, and the steps they will use to monitor provider eligibility including meeting Meaningful use criteria on an annual basis for accuracy and timeliness. We also are interested in the steps SMAs plan to take to support provider uptake of EHR technologies and the infrastructure the SMA, working with others, will create, build or adopt to foster HIE between Medicaid's trading partners within the State, with other States in the area where Medicaid clients also receive care, and with any Federal data bases SMAs believe useful in this regard.*