Crosswalk for changes to State Medicaid HIT Plan (SMHP)

February 14, 2011

Section	Type of Change	Rational for Change
Scope	**Delete:** States to administer the incentive payments provided for under such section with three activities to be done under the direction of the SMA. Such administrative match is contingent on the State demonstrating to the satisfaction of the Secretary that it meets the following three requirements: **Replace with**: Section 4201 of the ARRA provides 90% FFP HIT Administrative match for three activities to be done under the direction of the SMA: **Delete:** 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 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 HIT planning initiatives supported by the HHS Office of the National Coordinator and others, including assets needed in support of the SMHP future goals* **Replace with:** We are particularly interested in how the States plan to go about making the provider incentive payments (100% FFP), how they will monitor them, and how the SMAs' plans will dovetail with other State-wide HIE planning initiatives and Regional Extension Centers supported by the Office of the National Coordinator for HIT (ONC) and other programs. Please be sure to indicate in the SMHP what activities the SMA expects will be included in a HITECH Implementation –APD or a MMIS APD so that CMS can crosswalk the SMHPs to their corresponding funding request documents. If a State has already begun work on their SMHP, they should consider how it lines up with the content in this draft template	Provide clarity and specifics
Time Frame	**Revised:** The SMHP time horizon is five years, although States may discuss their plans beyond that, 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. We expect that States will want to revise their SMHPs over time, particularly for initiatives to encourage the adoption of certified EHR technology.	
(New) Required vs Optional Content	**Add:** We recognize that not every element of the SMHP is of equal weight and priority-level in order to implement the EHR Incentive Program at the barebones minimum. We have flagged the questions which a State may choose to defer for a later iteration. For example, some States may not be ready to take on activities in 2011 to promote EHR adoption and HIE among Medicaid providers but are fully planning to be able to make EHR incentive payments to the right providers, under the correct circumstances in the first year of the program.	Further guidance
Delete: SECTION A: Activities Necessary to .Administer 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. **Replace with:** SECTION A: The State's "As-Is" HIT Landscape: This information should be a result of the environmental scan and assessment conducted with	**Delete:** 1. Met the relevant provider enrollment eligibility criteria including: ✓ Not hospital-based for EPs (expect 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 their 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. Meaningfully 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 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.	To provide further definition of requirements (Section A-C)

the CMS HIT P-APD funding; or was available to the SMA through other means (e.g., was part of the ONC HIE cooperative agreement planning and assessment activities or other HIT/E assessments).	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. **Replace with:** 1. What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State's providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of provider? Does the SMA have data on EHR adoption by types of provider (e.g. children's hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)? 2. To what extent does broadband internet access pose a challenge to HIT/E in the State's rural areas? Did the State receive any broadband grants? 3. Does the State have Federally-Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe. 4. Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe. 5. What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized? 6. * Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc) of these activities? 7. Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? ** How extensive is their geographic reach and scope of participation? 8. Please describe the role of the MMIS in the SMA's current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how. 9. What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use? 10. Explain the SMA's relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program. 11. What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years? 12. Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please	

	describe. 13. Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe. 14. What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)? 15. If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description. * May be deferred. ** The first part of this question may be deferred but States do need to include a description of their HIE(s)' geographic reach and current level of participation.	

Delete:
SECTION B: Activities Necessary to Conduct 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:
 	
Replace with:
SECTION B: The State's "To-Be" HIT Landscape
	Delete:
	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.	
	Replace with: 1. Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc. 2. *What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locater Service? 3. How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)? 4. Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA's HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies. 5. What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology? 6. ** If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption? 7. ** How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology? 8. ** How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program? 9. If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.? 10. Does the SMA anticipate the need for new or State	

	legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe. Please include other issues that the SMA believes need to be addressed, institutions that will need to be present and interoperability arrangements that will need to exist in the next five years to achieve its goals. * This question may be deferred if the timing of the submission of the SMHP does not accord with when the long-term vision for the Medicaid IT system is decided. It would be helpful though to note if plans are known to include any of the listed functionalities/business processes. ** May be deferred.	
Delete: SECTION C: Activities Necessary to Pursue Initiatives to Encourage the Adoption of Certified EHR Technology to Promote Health Care Quality and the Exchange of Health Care Information. **A. "As-Is" Landscape** Narrative Discussion	**Delete:** *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, HIT and EHR technology adoption over the next five years? Please describe. How will these existing assets be leveraged to achieve provider adoption?	
Delete: **B. "To-Be" Landscape** Narrative Discussion	**Delete:** 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. ***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.	
Delete: **C. Roadmap** Annual Measurable Targets Tied to Goals	**Delete:** 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.	
Replace with: **SECTION C: Activities Necessary to Administer and Oversee the EHR Incentive Payment Program** **The State's Implementation Plan:** Provide a description of the processes the SMA will employ to ensure that eligible professional and eligible hospital have met Federal and State statutory and regulatory requirements for the EHR	**Replace with:** 1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers? 2. How will the SMA verify whether EPs are hospital-based or not? 3. How will the SMA verify the overall content of provider attestations? 4. How will the SMA communicate to its providers regarding their eligibility, payments, etc? 5. What methodology will the SMA use to calculate patient volume? 6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals? 7. How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement?	

Incentive Payments.	6. How will the SMA verify *adopt, implement or upgrade* of certified electronic health record technology by providers?	
	7. How will the SMA verify *meaningful use* of certified electronic health record technology for providers' second participation years?	
	8. Will the SMA be proposing any changes to the MU definition as permissible per rule-making? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden.	
	9. How will the SMA verify providers' use of *certified electronic health record technology*?	
	10. How will the SMA collect providers' meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term and a different approach for the longer-term?	
	11. * How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?	
	12. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?	
	13. What IT systems changes are needed by the SMA to implement the EHR Incentive Program?	
	14. What is the SMA's IT timeframe for systems modifications?	
	15. When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)?	
	16. What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to mainframe interface or another means)?	
	17. What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc?	
	18. Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD?	
	19. What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?	
	20. What will the SMA establish as a provider appeal process relative to: a) the incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and meaningful use certified EHR technology?	
	21. What will be the process to assure that 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?	
	22. What is the SMA's anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)?	
	22. What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate?	
	23. What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and	

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<td>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?

24. What will be the process to assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans does not exceed 105 percent of the capitation rate per 42 CFR Part 438.6, as well as a methodology for verifying such information?

25. What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs' 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?

26. What will be the role of existing SMA contractors in implementing the EHR Incentive Program – such as MMIS, PBM, fiscal agent, managed care contractors, etc.?

27. States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:

- The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support)
- The status/availability of certified EHR technology
- The role, approved plans and status of the Regional Extension Centers
- The role, approved plans and status of the HIE cooperative agreements
- State-specific readiness factors

*May be deferred</td>
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<td>**New:**

SECTION D: The State's Audit Strategy

The State's Audit Strategy: Provide a description of the audit, controls and oversight strategy for the State's EHR Incentive Payment Program.</td>
<td>**New:**
What will be the SMA's methods to be used to avoid making improper payments? (Timing, selection of which audit elements to examine pre or post-payment, use of proxy data, sampling, how the SMA will decide to focus audit efforts etc):

1. Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.

2. How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?

3. Describe the actions the SMA will take when fraud and abuse is detected.

4. Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.

5. Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?* (i.e. probe sampling; random sampling)

6. **What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight</td>
<td>Describe audit controls & oversight</td>
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	process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc)? 7. Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated? * The sampling methodology part of this question may be deferred until the State has formulated a methodology based upon the size of their EHR incentive payment recipient universe. ** May be deferred	
(NEW) Section E: The State's HIT Roadmap **The State's HIT Roadmap:** Annual Measurable Targets Tied to Goals	New: 1. *Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there. 2. What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type? 3. Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario. 4. Discuss annual benchmarks for audit and oversight activities. CMS is looking for a strategic plan and the tactical steps that SMAs will be taking or will take successfully implement the EHR Incentive Program and its related HIT/E goals and objectives. We are specifically interested in those activities SMAs will be taking to make the incentive payments to its providers, and the steps they will use to monitor provider eligibility including meaningful use. We also are interested in the steps SMAs plan to take to support provider adoption of certified EHR technologies. We would like to see the SMA's plan for how to leverage existing infrastructure and/or build new infrastructure 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 providers and/or partners. * Where the State is deferring some of its longer-term planning and benchmark development for HIT/E in order to focus on the immediate implementation needs around the EHR Incentive Program, please clearly note which areas are still under development in the SMA's HIT Roadmap and will be deferred.	Describes annual measureable targets tied to goals.