

**COMMONWEALTH OF PENNSYLVANIA**  
**DEPARTMENT OF HUMAN SERVICES**  
**OFFICE OF MEDICAL ASSISTANCE PROGRAMS (OMAP)**  
**HEALTH INFORMATION TECHNOLOGY (HIT)**  
**STATE MEDICAID HEALTH INFORMATION TECHNOLOGY PLAN (SMHP)**



**pennsylvania**  
**DEPARTMENT OF HUMAN SERVICES**

**APRIL 2015**

## VERSION CONTROL

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## Introduction

### Introduction

Pennsylvania's Medical Assistance (MA) Program is administered by the Department of Human Services (the Department). Within the Department, the Office of Medical Assistance Programs (OMAP), along with other agencies, is leading the development of the State Medicaid Health Information Technology Plan (SMHP), and the implementation of the Medical Assistance, Health Information Technology (HIT) initiatives.<sup>1</sup> The SMHP describes the Department's administrative process and vision for the next five years relative to implementing the Medicaid provisions contained in Section 4201 of the American Recovery and Reinvestment Act (ARRA). The SMHP is an evolving document and will be updated as needed to reflect the program's status.

### SMHP and Stage 2 Final Rule Update Published September 2012

The Department has reviewed the updated Final Rule to assess programmatic impacts. Through this analysis the Department has identified the appropriate mechanisms to implement the required changes. The changes will impact communications, operational processes and the Medical Assistance Provider Incentive Repository (MAPIR) system. The SMHP has been updated to reflect compliance with the Final Rule update however; many of the changes identified in the Final Rule Update do not alter the Department's general methodology for implementing the EHR incentive program. A summary of the changes and how the Department will specifically respond is included in Appendix VIII. The summary identifies: the updated Final Rule requirements, the programmatic areas impacted, the programmatic response and the implementation timeframe.

### SMHP and 2014 CEHRT Flexibility Final Rule Published September 2014

The Department reviewed the 2014 CEHRT Flexibility final rule to assess programmatic impacts and through this analysis, the Department has identified a plan to communicate the changes as well as to ensure the rule requirements can be validated. The changes will impact communications, operational processes and the MAPIR system. A summary of the Department's plan is included in Appendix IX. This summary identifies the updated Final Rule requirements, the programmatic areas impacted, the programmatic response and the implementation timeframe.

### 2015 SMHP Revision

Since the Department submitted its initial SMHP, the utilization of CEHRT has increased significantly in the Commonwealth of PA. Based on the changes in the health IT landscape and the need to set a strategy for Health IT in the next five years, the Department is revising its SMHP that will identify an updated to-be landscape as well as make changes to administer the EHR Incentive Program. This includes aligning with ONC/National Strategy, including consumer engagement, improving the success of providers in meeting MU phases, incorporating MITA principles, and supporting care coordination. The Department met on March 3, 2015 to establish new HIT goals on strategic planning for the next five years.

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<sup>1</sup> The term Medical Assistance is used in Pennsylvania for the Medicaid program and will be used interchangeably with Medicaid throughout this document.

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### OMAP's Vision for HIT and the Medical Assistance EHR Incentive Program

OMAP's vision and strategy for implementing HIT initiatives, including the Medical Assistance EHR Incentive Program, is to position Pennsylvania as a leader among state Medical Assistance programs in the use of electronic health care information to improve the quality and cost-effectiveness of service delivery for Medical Assistance consumers. The Department understands the impact that HIT can have on patient health outcomes and improving efficiency and continuity of care delivery. The Department also recognizes that EHR adoption alone is not sufficient. Providers (hospitals, physicians, and other eligible professionals) must become Meaningful Users of EHR technology which includes measuring and improving patient outcomes and exchanging health information with the Department, stakeholders, and each other. The Department's Medical Assistance HIT Vision is:

***To improve the quality and coordination of care by connecting providers to patient information at the point of care through the Meaningful Use of EHRs and electronic health information exchange.***

The Department's goals include increased quality, better coordination of care, and enhanced awareness of the benefits of the Department's HIT program. The implementation of EHRs and electronic health information exchange (eHIE) is a significant challenge, bringing together clinical, operational, regulatory and technical aspects of health care delivery but the Department is committed to addressing this challenge. Implementation of EHR Meaningful Use, more robust health information exchange as well as other HIT projects such as electronic Clinical Quality Measures, reflects the Department's longstanding goal of improving patient care, quality outcomes and program effectiveness.

The Department will educate stakeholders about the role of HIT in improving the quality and coordination of health care services delivered to consumers and will actively encourage the adoption of HIT. The Department's goals include:

- **Increased Quality** – Better information obtained via enhanced health information exchange will support better clinical decisions by providers and increase the probability of quality outcomes. Developing electronic reporting of quality measures will improve the efficiency of data collection and allow for a more timely application of rapid cycle quality improvement.
- **Increased Coordination** – Eliminating duplicative services and administrative inefficiency results in better care coordination for consumers and often decreases the overall cost of care while improving outcomes.
- **Increased Awareness** – Education enables providers and consumers to understand the benefits of HIT adoption and the importance of exchanging health information for patients and caregivers.

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- **System Redesign** – Data capture and analysis provides opportunities to enhance and improve current quality initiatives for both providers and consumers and allows the Department to assess the effectiveness of existing programs and identify gaps in care. Enhanced HIE will also enable the Department to move towards payment reform and redesign of health care delivery.

As is described throughout this document, the timely exchange of health information is essential to promoting Pennsylvania's HIT goals. Act 121 of 2012 created the Pennsylvania eHealth Partnership Authority (the Authority). This independent agency of the state government is tasked with coordinating public and private efforts to establish and maintain statewide electronic health information exchange (eHIE). The Authority continues the work of the Pennsylvania eHealth Collaborative described in Pennsylvania's previous SMHP plan. The Department closely collaborates with the Authority to promote alignment between Department initiatives and strategies and the Authority's efforts.

The Department and the Authority work collaboratively on activities that support Medical Assistance and are focused on ensuring that Pennsylvania's eHIE strategies effectively align with Meaningful Use objectives and the Department's long-term quality vision. In return, the Department helps to support the Authority in obtaining some of the funding necessary to make eHIE a reality through CMS IAPDs. The Department also helps guide Authority activities through participation of the Secretary of Human Services who maintains a permanent seat on the Authority's Board of Directors.

In 2014, the Authority developed a three-year strategic and operational plan (available on the Authority's website at [www.paehealth.org](http://www.paehealth.org)). The proposed Authority activities described in Section B and C of this SMHP align with that strategic and operational plan.

### **EHR Incentive Program Administration**

The Department initiated a HIT Executive Committee (the Committee) which is convened by the HIT Coordinator of the Medical Assistance Health Information Technology Initiative (MA HIT Initiative) with executive leadership provided by the Office of Medical Assistance Programs' (OMAP) Deputy Secretary, Chief Operating Officer, and Chief Medical Officer. The HIT Executive Committee consists of senior staff from the following OMAP and Office of Administration bureaus:

- Bureau of Data and Claims Management (BDCM)
- Bureau of Policy, Analysis, and Planning (BPAP)
- Bureau of Fee-for-Service Programs (BFFSP)
- Bureau of Managed Care Operations (BMCO)
- Office of the Clinical Quality Improvement (OCQI)
- Bureau of Program Integrity (BPI) – Office of Administration

The HIT Executive Committee has been meeting in large and small teams regularly since February 2010 to make sure the project remains focused and in line with Pennsylvania's goals. The Committee worked

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together to develop the SMHP and to develop the MAPIR. MAPIR is the state-level information system for the EHR Incentive Program that both tracks and acts as a repository for information related to payment, applications, attestations, oversight functions, and to interface with the Centers for Medicare & Medicaid Services (CMS) Registration and Attestation (R&A) System. The 13 state Collaborative will continue to develop the award winning MAPIR system to include Meaningful Use Stage 3 and other functionality such as an automated audit and appeal NLR transactions.

The MA Health Initiative and the MAPIR Operations Team that administers and oversees the EHR Incentive Program will continue to meet to discuss and resolve program issues and report project performance to the HIT Executive Committee.

In addition to the HIT Executive Committee, the Department actively engages and collaborates with other state agencies, CMS and other partners such as the Regional Extension Centers (RECs). The Department continues to convene the HIT Interagency Steering Committee which brings partners from across Commonwealth agencies together to discuss the Department's HIT strategy, including the Medical Assistance EHR Incentive Program and coordination across programs. Members of the HIT Interagency Steering Committee include all members of the HIT Executive Committee and representatives from:

- Secretary of the Department of Human Services
- Department of Human Services Communications
- Department of Human Services Office of Legislative Affairs
- Bureau of Information Systems
- Office of Medical Assistance Programs
- Office of Child Development and Early Learning
- Office of Long Term Living
- Office of Mental Health and Substance Abuse Services
- Department of Health
- Department of Corrections
- Department of Aging
- Department of Insurance
- Department of Labor & Industry
- Pennsylvania eHealth Partnership Authority

The Medical Assistance Advisory Committee (MAAC), composed of external stakeholders (providers and consumers), advises the Department on issues of policy development and program administration. It includes various workgroups, including the MAAC HIT workgroup which was formed in July 2009. The MAAC HIT workgroup meets once per month and presents and discusses information about the Department's HIT activities. The MAAC HIT workgroup was consulted on the initial submission of the SMHP and the Department will continue to consult the MAAC HIT workgroup in the development of

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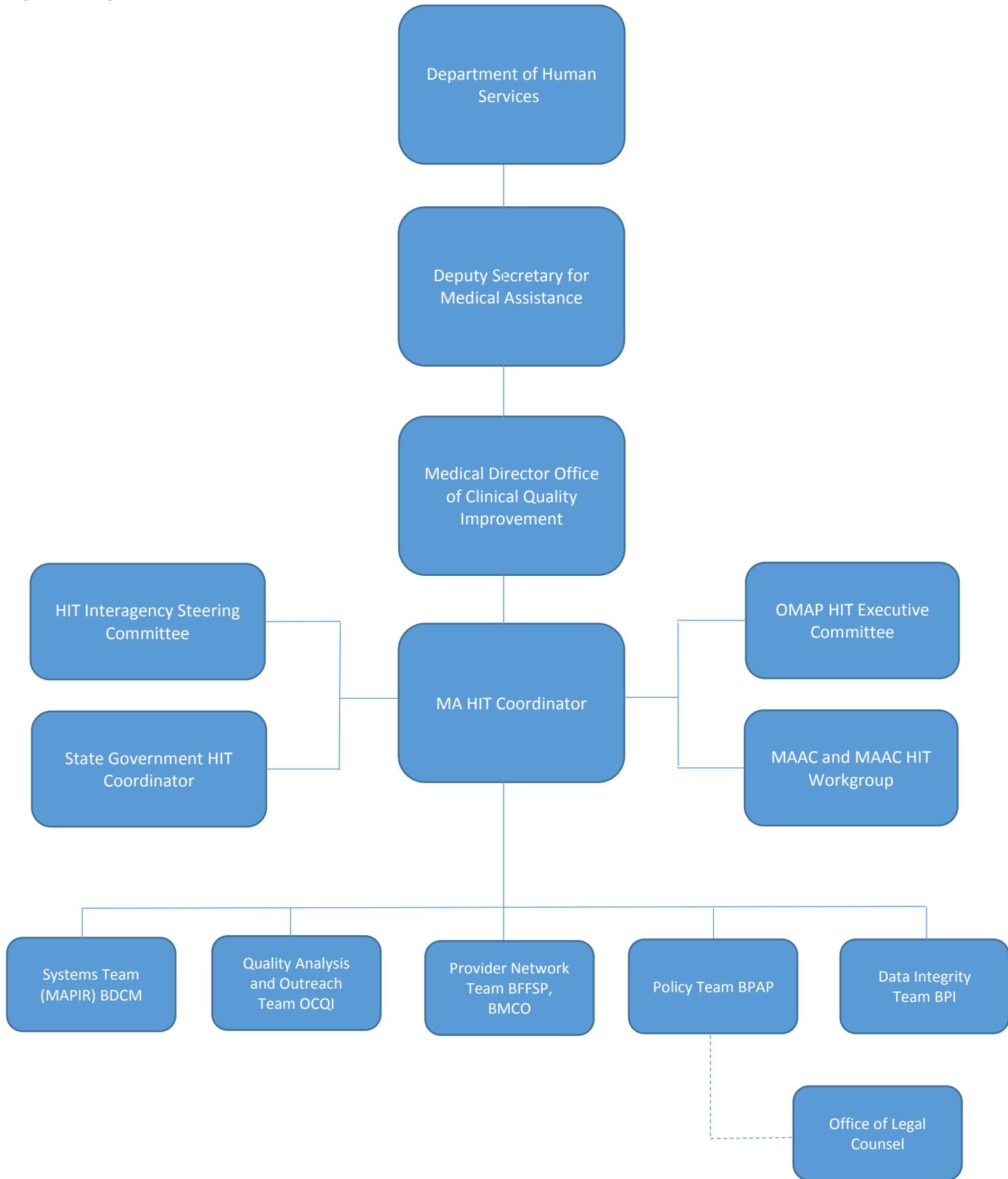
future versions of the SMHP prior to submitting to CMS. The Department also engages our Consumer Subcommittee on the value of EHR's to MA beneficiaries.

The Public Health Gateway Executive Committee is composed of the Governor's Office, the Department, the Department of Health, the Authority, and the Pennsylvania Health Care Cost Containment Council (PHC4). This committee sets strategic direction for establishing a gateway for effective exchange of health information between the public and private sectors.

The organizational structure for the HIT Executive Committee, HIT Interagency Steering Committee, and the OMAP teams that support the Medical Assistance EHR Incentive Program design and implementation process, is shown below in Figure 1. 1.

## Introduction

Figure 1. Organizational Structure



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The Bureau of Data and Claims Management (BDCM) is leading the effort to leverage the Commonwealth's work on the MAPIR system across multiple states as part of the MAPIR Collaborative. The MAPIR Collaborative is currently a partnership between the Department and 12 other state Medicaid agencies (Arkansas, Connecticut, Delaware, Florida, Georgia, Indiana, Kansas, Massachusetts, Oregon, Rhode Island, Vermont, and Wisconsin) with the potential to add more states to the Collaborative. This Collaborative coordinates efforts in designing a single EHR incentive payment application that leverages data to and from the state MMIS systems. The MAPIR Collaborative participants also share financial responsibility among all participating states. The Collaborative will continue to coordinate and develop solutions for Meaningful Use attestation changes such as incorporating flexibility options and Stage 3 MU, operational needs such as additional National Level Repository (NLR) transaction to support Audit and appeal reporting and other issues as they are identified.

### **The MA HIT Initiative and Administering the Medical Assistance EHR Incentive Program**

The MA HIT Initiative and MAPIR operation team lead activities related to the EHR incentive program. The MA HIT Initiative will continue to collaborate with the agencies and offices represented by the HIT Interagency Steering Committee, the State HIT Coordinator, and multi-state collaborations.

The MA HIT Initiative and MAPIR Operations Coordinators will manage day-to-day operations and coordinate with bureau staff members who are assigned to the Medical Assistance EHR Incentive Program as subject area liaisons. Additionally, the MA HIT Initiative team has program staff to perform the following tasks:

- Provider support in regards to the EHR Incentive Program application process.
- Outreach and communications to educate and update key stakeholders such as professional associations as well as directly with providers on the Medical Assistance EHR Incentive Program.
- Monitor efficiencies of the EHR Incentive Program, while preventing or addressing fraud and abuse through pre- and post-pay audit processes.
- Data analysis to measure performance / quality measurement and effectiveness of the Medical Assistance EHR Incentive Program and pursuance of an EHR Initiative under the purview of the Chief Medical Officer.
- Assist with development, statewide participation, and monitoring interfaces and exchanges between provider EHR systems and the Department for Meaningful Use data via the Public Health Gateway.

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- Facilitate the collection and review clinical trends including standard and ad hoc reports on clinical measures (related to Meaningful Use, Children’s Health Insurance Program Reauthorization Act (CHIPRA), and other special projects).

The MA HIT Initiative Coordinator coordinates the review of quality measure reports, requests follow-up analyses, and identifies and addresses clinical issues. The MA HIT Initiative team through the Office of Clinical Quality Improvement (OCQI) leads clinical quality projects and works with OMAP bureaus to implement these initiatives. Data is accessed by multiple users simultaneously to facilitate prompt program evaluation and intervention of problem areas. For example, OCQI analyzes the data and identifies trends for further analysis. The Chief Medical Officer then recommends program interventions that could be facilitated by the OMAP bureaus for outreach, e.g., Bureau of Managed Care Organizations (BMCO) as they relate to MCOs or by the Bureau of Fee-For-Service Programs (BFFSP). Conversely, BMCO and BFFSP conduct data analysis or trending for participating MCOs and fee-for-service providers and make data requests to OCQI.

MAPIR Operations is continuing to coordinate with the states involved in the MAPIR Collaborative as they develop and implement the MAPIR system to administer and make EHR incentive e payments. Additionally, MAPIR Operations team reviews applications and supports MAPIR system development for all stages of Meaningful Use attestation collection. The disaster recovery plan for the MAPIR system is included in the MMIS (PROMISe) recovery plan.

The MA HIT Initiative and MAPIR Operations Coordinators will also work with HIT Liaisons across the Department to resolve issues that affect or require expertise from the other bureaus in the Department. These liaisons will be staffed primarily to support, develop, monitor, and administer varying components of the EHR incentive program and EHR adoption. Figure 2 on the following page illustrates the structure of the program operations.



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### Overview of the SMHP

This SMHP defines the Department's approach to administering the EHR incentive payments and proposes advancement opportunities. For the Commonwealth of Pennsylvania's SMHP, the Department defines its vision and process for implementing, administering and overseeing key aspects of the program and describes the Roadmap that will take the Department from the present/prior to the EHR Incentive Program ("As-Is") to the Department's future HIT vision ("To-Be").

Section A, the State's HIT "As-Is" Landscape, describes where we are in 2015 and what we have accomplished related to the projections in the 2010 SMHP. The Department reviewed and utilized the results of the environmental scan and assessment that was conducted as part of the Department's planning efforts. Through continuous surveys, discussions with key provider groups through the Best Practices Focus Group, and through "listening sessions" conducted across the Commonwealth, the Department was able to determine the current extent of EHR adoption by practitioners and hospitals and their readiness and willingness to participate in the EHR Incentive Program. Surveys continue to be conducted to determine the progression that has occurred since 2010 in regard to EHR adoption. The original baseline survey results have been summarized for Section A and the longer narrative moved to Appendix II. Updates to the EHR adoption survey are described in Section A and also in Section E as part of reporting progress on the HIT Roadmap.

Section B, the State's HIT "To-Be" Landscape, describes the Department's vision for health information technology and health information exchange. The Department works closely with the Authority and will continue to collaborate going forward. The Department also discusses plans for the MMIS and Medicaid IT Architecture (MITA) system changes as they relate to administering the incentive program, making payments, and collecting and analyzing the data that will become available once Meaningful Use is in place, e.g., clinical quality measures.

Section C, the State's Implementation Plan, describes the processes the Department employs to ensure that eligible professionals and hospitals have met Federal and State statutory and regulatory requirements for the EHR Incentive Program. As part of the planning process the Department has created a process flow (Appendix III) that follows providers through every stage of the incentive payment program process from educating providers about the program from encouraging them to first apply with CMS and then apply in MAPIR. The process flow also describes how providers are approved for payment and informed that they will receive a payment. Finally, oversight mechanisms and the process for receiving future payments are described along with the process for educating, informing and providing technical assistance to providers to ensure they remain in the incentive program and become Meaningful Users.

Section D, the State's Audit Strategy, describes the audit, controls and oversight strategy for the State's EHR Incentive Program. Many of the controls employed are based on system edits and checks within the MAPIR system. The MAPIR system will allow providers to apply for the EHR Incentive Program and make all required attestations. The system reviews will generate a list of applications pending for further

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review. MA HIT Initiative and MAPIR Operations will work with BPI and other agencies and offices around the Commonwealth to address fraud and abuse.

Section E is the State's HIT Roadmap, which describes the strategic plan and tactical steps that the Department took and continues to take to successfully implement the EHR Incentive Program and its related HIT and eHIE goals and objectives. This includes the annual benchmarks, which can be measured for each programmatic goals related to provider adoption, quality, and the administrative processes. This section describes the measures, benchmarks, and targets that will serve as clearly measurable indicators of progress in achieving overall program goals.

In addition to this introduction and Sections A through E, this document includes a number of appendices. Appendix I includes a glossary of terms and acronyms to help the reader throughout the document; Appendix II describes the baseline landscape assessment conducted in support of the Department's first SMHP submission; Appendix III describes Medical Assistance HIT Initiative electronic resources that describe the EHR Incentive Program for providers and other stakeholders; Appendix IV describes Pennsylvania's Medical Assistance EHR Incentive Program process in a diagram; Appendix V includes an example of the Department's approved hospital incentive payment calculation; Appendix VI includes the Department's Electronic Quality Improvement Projects (EQUIPS) initiative templates; Appendix VII includes letters of support from the Commonwealth's State HIT Coordinator, the Commonwealth's Department of Health, the PA eHealth Authority and PA REACH Regional Extension Center Initiative; Appendix VIII addresses Stage 2 Regulations; and Appendix IX addressed 2014 Certified EHR Flexibility Rules.

## Section A: The State’s “As-Is” HIT Landscape

### Section A: The State’s “As-Is” HIT Landscape

This section provides an overview of the Department’s existing HIT resources, including the results of Pennsylvania’s environmental scan and assessment and a summary of the results of the EHR surveys conducted in 2010. This section includes responses to each of the questions listed in the CMS SMHP Template and listed below in Figure A.1.

**Figure A.1: Section A Questions from the CMS State Medicaid HIT Plan (SMHP) Template**

Please describe the State’s “As Is” HIT Landscape:
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,

## Section A: The State's "As-Is" HIT Landscape

Please describe the State's "As Is" HIT Landscape:

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.

## Section A: The State’s “As-Is” HIT Landscape

### ***Current EHR Adoption by Practitioners and Hospitals (Response to Question #1)***

The “As-Is” HIT landscape assessment describes findings from a number of data sources to describe the extent of EHR adoption by practitioners and hospitals. The Department has historically used multiple surveys to collect data. These surveys included: the Pennsylvania Medical Society in 2005, a second targeted survey that the Department sent in the summer of 2010 through a web-based tool, a survey completed by the Authority, additional provider web-based surveys and a survey within the MAPIR system. The survey conducted in 2010 was designed to provide specificity about the types of EHRs in use in Pennsylvania and the methodology for distributing the survey targeted Medical Assistance practitioners, many from large health systems that are early EHR adopters. The survey administered by the Hospital Health System Association of Pennsylvania (HAP) focused on hospital adaption and EHR usage and the survey administered by the Authority focused on the Health Information Organization goals and projections.

In addition to the practitioner surveys, the Department also conducted a survey of Federally Qualified Health Centers (FQHCs) because many of the practitioners in FQHCs are eligible for Medical Assistance EHR incentive payments. To assess hospital EHR adoption, the Department reviewed findings from survey data collected by the HAP. These results provide a baseline for EHR adoption before the launch of the EHR Incentive Program. These results are described in more detail in Appendix II as part of the Baseline Landscape Assessment.

As part of the annual Uniform Data System (UDS) reporting required of all FQHCs, starting in 2011, FQHCs reported the status of EHR implementation, functionality and utilization to report clinical UDS data.

**Table A.1: FQHC HIT Adoption Status**

Year	Total FQHCs Reporting	EHR Available at All Sites for All Providers	EHR Limited to Some Sites or Some Providers	Total FQHCs with EHR Installed	No EHR Installed %	No EHR Installed number of FQHCs
2011	35	54.3%	20%	74.3%	25.7%	9
2012	40	77.5%	15%	92.5%	7.5%	3
2013	40	85%	12.5%	97.5%	2.5%	1

For 2013, 36 FQHCs answered: Yes. Providers are receiving Meaningful Use incentive payments from CMS due to their use of health center’s EHR system; and 4 FQHCs answered: Not yet, but providers at my health center plan to apply to receive Meaningful Use incentive payments from CMS in the coming year.

The Department also used information on HIT adoption from the 2012 Physician Survey, which is collected as part of licensure renewal by county. The response rate to this survey of was nearly 90 percent with over 46,715 surveys returned. While the data is not specific to Medical Assistance, the

## Section A: The State's "As-Is" HIT Landscape

majority of physicians – over 85 percent – provide direct patient care to Medicaid patients. The 2012 Physician Survey provides the following information on HIT adoption by all physicians across the Commonwealth:

- Do you use IT to obtain information about treatment alternatives or recommended guidelines? 91 percent of respondents answered “yes.”
- Do you use IT to generate reminders for you about preventive services? 51 percent of respondents answered “yes.”
- Do you use IT to access medical records, patient notes, medication lists or problem lists? 90 percent of respondents answered “yes.”
- Do you use IT for clinical data and image exchanges with other physicians? 76 percent of respondents answered “yes.”
- Do you use IT for clinical data and image exchanges with hospitals and laboratories? 74 percent of respondents answered “yes.”
- F) Do you use IT to send patient prescriptions to pharmacies? 63 percent of respondents answered “yes.”

The data collected as part of the initial SMHP submission served as the baseline by which progress towards EHR adoption in Pennsylvania will be measured. Based on an update in the CMS Final Rule on the definition of an encounter, we understand that our initial baseline is a little low. Due to the nature of the calculations, we were unable to determine an accurate new baseline so we are still using the initial baseline. The Department has set performance improvement targets as part of the HIT Roadmap in Section E.

### ***Access to Broadband Internet (Response to Question #2)***

Access to bandwidth internet is a concern in many parts of Pennsylvania including the middle of the state and the northern tier. There has been significant dollars and work invested to identify areas of need and offer solutions. The results of the EHR adoption survey conducted in 2010 show that the highest percentage of respondents have DSL connections (over 37 percent), with T-1 and cable as the next highest choices.

In fiscal year 2006-2007, the Pennsylvania Medical Society was awarded a Broadband Outreach and Aggregation Fund (BOAF) grant to begin the first phase of a multi-phase project to assess the broadband connectivity of physicians and other healthcare community partners. Branded “ConnectTheDocs,” these efforts were coordinated with the Pennsylvania Department of Health and the Governor’s Office to

## Section A: The State's "As-Is" HIT Landscape

ensure alignment with broader HIT policies and objectives. The Phase I connectivity assessment survey identified not only a statewide interest but specific regions of Pennsylvania with an immediate need/desire for broadband procurement.

The Commonwealth was the recipient of three broadband infrastructure grants as part of the Department of Commerce, National Telecommunications and Information Administration (NTIA), American Reinvestment and Recovery Act funding. The Keystone Initiative for Network Based Education and Research received a \$99.7 million broadband infrastructure grant (with an additional \$29 million applicant-provided match) to create the Pennsylvania Research and Education Network (PennREN). The network expects to expand broadband Internet access and directly connect 60 critical community anchor institutions in 39 counties across south and central Pennsylvania. PennREN will enhance healthcare delivery, research, education, workforce development, and public safety by delivering broadband.

The second NTIA grant was to the Executive Office of the Commonwealth of Pennsylvania. This \$28.8 million broadband infrastructure grant (with an additional \$7.2 million applicant-provided match) will be used to increase broadband Internet connection speeds for community anchor institutions and underserved areas isolated by difficult, mountainous terrain in northern Pennsylvania.

The third NTIA grant was awarded to Zito Media Communications II, LLC in the amount of \$6.1 million. The Northeastern Ohio and Northwestern Pennsylvania Fiber Ring Project intends to create a 382-mile fiber ring with 10 gigabits of capacity through Northeastern Ohio, and the counties of Erie, Crawford, and Mercer counties in Northwestern Pennsylvania. The project plans to deploy 342 miles of new fiber and 40 miles of leased fiber to directly connect an estimated 60 community anchor institutions, including hospitals, schools, public safety agencies, colleges, and libraries. These projects have been completed and are currently closed.

### ***FQHCs and HRSA Funding (Response to Question #3)***

In December 2014 the Health Resources and Services Administration (HRSA) awarded funds to recognize health center quality improvement achievements and invest in ongoing quality improvement activities. Health centers received awards in four categories: health center quality leaders; national quality leaders; clinical quality improvers; and Electronic Health Record reporters.

Electronic Health Record reporters received funding if they used EHRs to report clinical quality measure data on all of their patients to the Uniform Data System (UDS).

In Pennsylvania, 12 FQHCs received this funding recognition. The awards totaled \$180,000.

In 2013 and 2014 two health center controlled networks, the Health Federation of Philadelphia and the Public Health Management Corporation received funding to advance the adoption, implementation, and optimization of HIT; to support the Meaningful Use of certified EHR at participating health centers; and to support quality improvement with optimal use of HIT.

## Section A: The State’s “As-Is” HIT Landscape

**Table A.2: FQHC Grants to Pennsylvania Health Centers as of March 2015**

Facility	Location	Amount
Public Health Management Corp.	Philadelphia	\$ 798,630
Health Federation of Philadelphia	Philadelphia	\$ 800,000
Total		\$ 1,598,630

On December 9, 2009, President Obama announced nearly \$600 million in American Recovery and Reinvestment Act (ARRA) awards to support major construction and renovation projects at 85 community health centers nationwide and to help networks of health centers adopt EHR and other HIT systems. The awards were expected to not only create new job opportunities in construction and health care but also help provide care for more than half a million additional patients in underserved communities. The following table lists the Pennsylvania facilities receiving funding under this program.

**Table A.3: ARRA HIT Grants to Pennsylvania Health Centers as of March 2015**

Facility	Location	Amount
Community Integrated Services Network of Pennsylvania	Wormleysburg	\$1,400,001
Health Federation of Philadelphia	Philadelphia	\$377,169
Total		\$1,777,170

### ***Veterans Administration (VA) or Indian Health Services (Response to Question #4)***

There are no known Indian Health Services clinical facilities currently operating in Pennsylvania. The Department worked with the VA to calculate that there are nine VA Medical Centers (hospitals) and 35 VA Community-Based Outpatient Clinics in Pennsylvania. As with other VA clinics across the country, Pennsylvania Veterans Affairs clinics and hospitals use the Computerized Patient Record System (CPRS) for patient records. A completely paperless patient record, CPRS is the patient record component of the Veterans Health Information Systems and Technology Architecture (VistA).

Electronic patient records are established for every veteran upon entrance into the VA health system. Electronic records are available from 1998 to present. CPRS uses a standard interface so that a VA clinic or hospital in one part of the state can access patient records in another part of the state.

When a patient enters the VA health system from a non-VA provider, their paper records are scanned into an electronic record. The electronic record contains an image of the original, and the information from the original is transformed into data that can be used by a practitioner within the VA health system.

CPRS records are accessible (can be read) remotely within VA. If a patient is in the system of a particular VA hospital, a provider can access the records via a remote data key and can read the Veteran’s record

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of every place that Veteran was seen within VA. However, only hard-copy or imaged patient records (on CD-ROM) can be provided to non-VA practitioners.

CPRS supports quality improvement through evidence based medicine. Via a process called "Clinical Reminders," a practitioner is notified that a patient is due for routine or chronic evaluations. Clinical decision making is supported through the Healthcare Effectiveness Data and Information Set (HEDIS) measures as well as other performance clinical metrics pertinent to the Veteran population, so a practitioner can perform specified disease related exams, order appropriate tests, screenings, or schedule follow-up appointments.

### ***Stakeholder Engagement in Existing HIT/E Activities (Response to Question #5)***

The Department has engaged with numerous stakeholder groups regarding current and proposed HIT and eHIE activities including the design and development of the EHR Incentive Program. There is a great deal of interest in the EHR Incentive Program and over the past five years, the Department has fielded numerous questions from providers, consumer advocates, other state agencies, and other stakeholders. The Department maintains a communication strategy with consistent messages and multiple venues for information distribution that help to raise practitioner awareness, participation, and retention in the incentive program and have them continue to be Meaningful Users. To ensure that all educational materials are accurate and communicate a uniform message, the Department continues to develop provider education and outreach materials in coordination with the other bureaus and offices in the Department; the Authority; CMS; Regional Extension Centers (REC), PA REACH EAST and PA REACH West; ONC, PA Dental Society, PA Medical Society, Rehabilitation and Community Provider Association, HAP, the Best Practices Focus Group and others.

The Department continues to update its website for the EHR Incentive Program with tools and information for providers and other stakeholders. An interactive map is located on the main page of the PA Incentive program website at <http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/index.htm>. This map allows providers and stakeholders to determine what payments have been made to professionals and hospitals. The website offers contact information for e-mailing specific questions and on-going updates via a listserv. The Department has reviewed the materials developed by CMS and placed a link to the CMS materials on its website along with links to other resources. The Department has presented numerous webinars on the EHR Incentive Program which includes information on how to apply through Medical Assistance Provider Incentive Program (MAPIR) using the Meaningful Use flexibility options for program year 2014, how to calculate patient volume, hospital payment calculations, and program monitoring and oversight. Other key areas on the website include: Meaningful Use, Public Health Registry Information Sheet, Auditing documentation, eHealth Pod Pilot program and various templates.

The Department works regularly with our MCO partners to ensure their understanding of the HIT program so they can inform their providers about any changes or updates. By ensuring the

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implementation and use of EHR and electronic exchange of health information, the MCO's will benefit as well with more timely access to clinical information to improve care coordination in addition to quality measurement enhancement in a goal of use of EHR data.

As part of the communications process and strategy, the Department continues to meet with practitioner groups such as the Pennsylvania Medical Society, the Pennsylvania Association of Community Health Centers, the Pennsylvania Chapter of the American Academy of Pediatrics, the Pennsylvania Academy of Family Physicians, Rehabilitation and Community Providers Association and the Hospital Association of Pennsylvania. The Department meets with a Best Practices Focus Group on a regular basis. This group includes key provider groups and stakeholders in Pennsylvania. The information gathered from this group is then shared with other providers and hospitals.

Quality Insights/PA REACH continues to collaborate with the Department to identify Medicaid providers in need of help to adopt and meaningfully use EHRs. To date, 1344 Medicaid providers have signed an agreement with PA REACH. Of that, 1166 have attested to A/I/U, and 1013 have received Stage 1 Year 1 MU. PA REACH continues to identify ways to assist Medicaid providers in Behavioral Health, Community Health Centers, and long term post- acute care. PA REACH is now testing newly developed eCQMs for Stage 3 feasibility, validity, and reliability and has offered to extend similar services for the Department as they identify CQMs to be reported from EHRs. In December, 2014, PA REACH agreed to assist any Medicaid providers wishing to participate in a reporting pilot to the Department. PA REACH also assists practices with PCMH recognition, and to date 71 practices have achieved NCQA recognition. Five PA REACH staff have also received Certified Content Expert (CCE) certification from NCQA. Quality Insights/PA REACH has received a four year grant from PA DOH to assist practices to use EHRs to improve diabetes, hypertension, and obesity through funding from the CDC's Million Hearts program.

The Authority has also developed a robust stakeholder community consisting of over 400 individuals that include clinicians, academics, advocates, health information technology professionals, healthcare industry business leaders, and state and local government leaders. The Authority routinely leverages this stakeholder power through committees and workgroups to build consensus approaches to various eHIE related challenges. Given that there is significant overlap between the Authority's stakeholder community and the Medicaid community, the Department and Authority coordinate on stakeholder engagement.

This coordination helps the Department and Authority in leveraging one another's stakeholder efforts, and ensures continuity and consistency in what private sector partners hear from both agencies. It also helps to avoid stakeholder fatigue that could otherwise result from overlapping engagement on very similar issues.

### ***Current Relationships with HIT/E Entities (Response to Question #6)***

The Department collaborates with the Authority, the PA REACH East and PA REACH West Regional Extension Centers, FQHCs, and ONC to maintain a real-time understanding of the HIT and eHIE initiatives

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underway in each of these areas and others as they are identified. The Department believes that this collaboration will allow the Department to meet Medical Assistance practitioner needs to demonstrate Meaningful Use and to achieve the Department's long-term quality vision.

The Department is collaborating with the HealthChoices MCOs, and the Regional Extension Centers to create educational opportunities on EHR adoption, implementation, upgrade, and Meaningful Use of EHRs and support ongoing distribution of these materials to eligible professionals and hospitals.

Quality Insights, dba PA REACH, worked in collaboration with the Authority and the Department to assist 892 providers to implement DIRECT licenses in late 2012. PA REACH provided on site assistance to ensure that the test was successful. Additionally, PA REACH was funded by the Department through Navigant for a 6 month pilot to test the exchange of CCDs in between Behavioral Health and Hospital systems. PA REACH was able to assist 2 BH sites to exchange CCDs with 2 different health systems.

### ***Current eHIE Organizations in Pennsylvania (Responsive to Question #7)***

The Department is working with the Authority and other eHIE organizations in Pennsylvania to support and promote the exchange of health information between medical providers.

There are at least seven operational private sector health information organizations (HIOs) and at least six operational private sector health information service providers (HISPs) operating in Pennsylvania. These organizations provide eHIE services to healthcare providers, facilities, and payers. The work conducted by the Pennsylvania eHealth Collaborative, and later by the Authority has sought to facilitate complementary public-private cooperation in establishing eHIE in the Commonwealth rather than competition between the public and private sectors. It has also served to facilitate collaboration between competing private sector organizations that would not, and for antitrust reasons could not collaborate without facilitation by a government agency like the Authority.

St Luke's University Health Network was the first HIO to complete the Authority certification and become an operational member of the Pennsylvania Patient and provider Network (P3N - see also response to question #9). Up to six additional HIOs are anticipated to complete certification and connection to P3N by the end of 2015 or early in 2016. These include (in alphabetical order):

- ClinicalConnect HIE (sponsored by University of Pittsburgh Medical Center and other western Pennsylvania hospital systems)
- HealthShare Exchange (HSX) of Southeastern Pennsylvania (sponsored by Independence Blue Cross and a coalition of hospital systems in the Philadelphia area)
- Keystone Health Information Exchange (sponsored in part by Geisinger Health System and also a certified HISP)
- Lancaster General Health
- MaxMD (also a certified HISP)
- Tapestry Health Information Exchange (sponsored by Highmark Blue Cross Blue Shield).

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The Authority conducts an annual survey of HIOs that examines many aspects including what eHIE functions they enable, what types of provider they serve, where they operate geographically, what technical and policy standards they have adopted, and more. Full results of these surveys are available on the Authority's website at [http://www.paehealth.org/images/2014\\_HIO\\_Survey\\_Results\\_FINAL.pdf](http://www.paehealth.org/images/2014_HIO_Survey_Results_FINAL.pdf).

Some highlights include:

- All of the HIOs noted above meet or soon will meet the Authority's requirement for certification that an HIO enable exchange across unaffiliated organizations.
- Operational adoption of most eHIE functions and capabilities is increasing, and all the above HIOs report operational ability to exchange discharge summaries.
- Many HIOs offer capabilities for participation in their HIOs by organizations that do not have eHIE-enabled EHR systems.
- All HIOs offer query-based exchange
- At least four different HIOs are available to healthcare providers in every county in the Commonwealth.

Additional Pennsylvania organizations are considering formation of an HIO, but have not yet decided whether to create their own HIO or join one of the organizations noted above.

Certified HISPs operational in Pennsylvania include Allied HIE, DataMotion, KeyHIE, MRO Corp., Secure Exchange Solutions, and MaxMD. More information regarding these certified HISPs is available on the Authority's website at [www.paehealth.org](http://www.paehealth.org).

### ***Role of MMIS in Current HIT/E Environment (Response to Question #8)***

The current MMIS seeks to meet the Service Oriented Architecture (SOA) requirements of MITA and future HIT upgrades. The Department's fully complies with standards as required under Title II, subtitle F, sections 261 through 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191; the Medicaid Enterprise Certification Toolkit; the ASC X12 Version 5010/National Council for Prescription Drug Programs (NCPDP) Version D.0; and the International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) standards, as required by Federal Register Vol. 74, No. 11 / Friday, January 16, 2009 / Rules and Regulations. The Department is responsible for the SMHP. The State has a number of projects being facilitated by the HIT Coordinator. One project includes the eCQM Pilot project. Providers are sending eCQMs to the Department and these are collected and compiled and apply the appropriate information into the MAPIR application. The Department expects to work with its MMIS vendor to implement SMHP and eHIE when these initiatives interface with the MMIS Enterprise.

As with MMIS and MITA systems and related activities, the Department will adhere to the seven conditions and standards described in the CMS guidance updated May 2011. The Department will

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purchase MMIS and MITA systems and upgrades in relation to the Medical Assistance EHR Incentive Program and MAPIR that meet the following conditions and standards:

1. Modularity
2. MITA
3. Industry standards
4. Leverage
5. Business results
6. Reporting
7. Interoperability

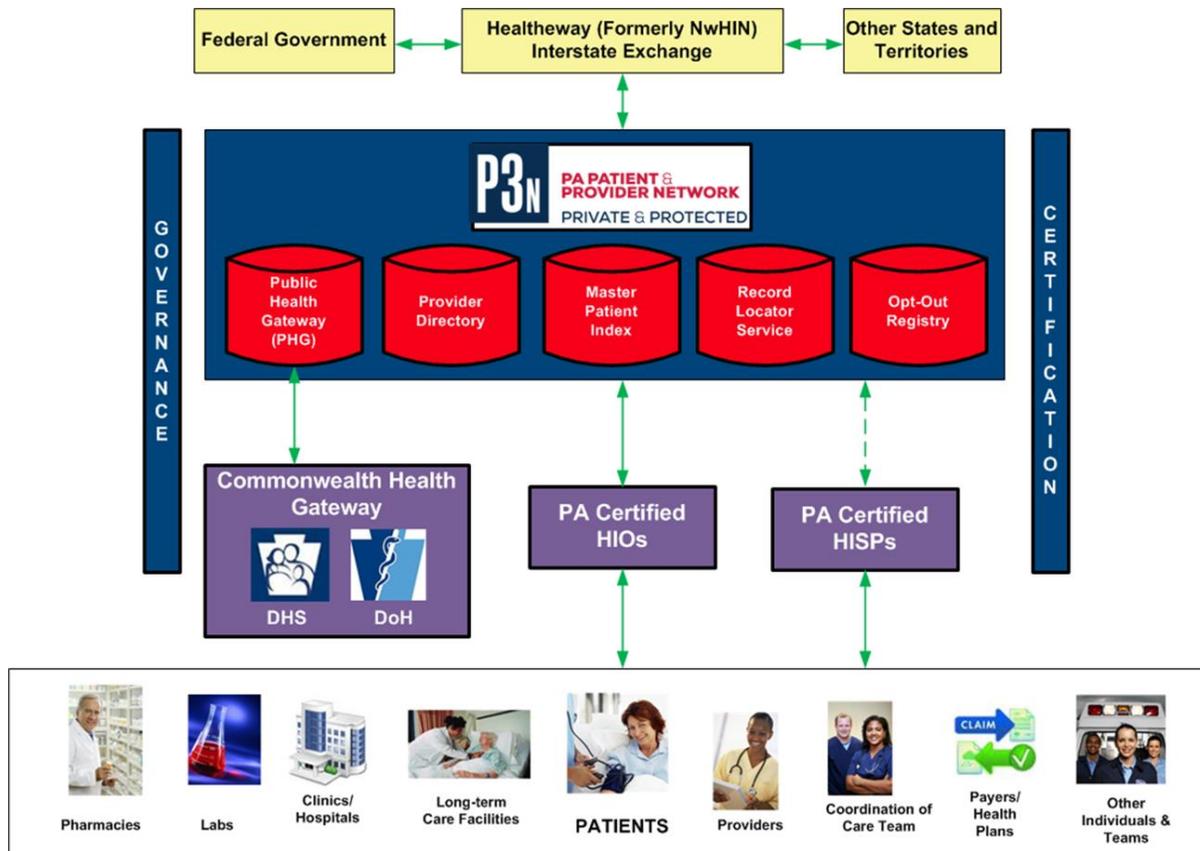
### ***Current Pennsylvania Activities to Implement eHIE and EHR (Response to Question #9)***

The exchange of health information remains a barrier for practices in PA. Quality Insights, dba PA REACH previously enabled 892 providers to implement Direct. However until mid-2014, there was no directory of DIRECT addresses made available for providers to securely exchange information. Many providers voice frustration at not being able to find the addresses for providers or entities that they commonly refer patients for care. PA REACH has been continuing to provide the link to the State White Pages, and work with vendors to try and facilitate DIRECT messaging. PA REACH is working with HSX in SE PA to expand the number of DIRECT licenses, and to encourage the exchange of hospital discharge information that is made available through HSX. We are also working to connect community based organizations that provide nutritional or self-management support for patients with diabetes and hypertension with PCPs to try and close the referral loop for these encounters.

The following picture illustrates the current operational model for statewide eHIE in Pennsylvania:

**Figure A.2: Current Operational Model for Statewide eHIE**

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P3N Architecture and Connection to the Trust Community – 3/18/2014



The Authority provides governance (through facilitated consensus building) over eHIE. The policy and technical decisions that emerge from the governance processes are incorporated into certification programs for HIOs and HISPs. While Pennsylvania law does not require any organization to acquire Authority certification, such certification is required if an organization wishes to participate in the state-wide network and receive grant funding offered by the Authority from time to time. Part of the certification program includes a set of uniform legal agreements that ensure that any HIO need execute only a single set of agreements with the Authority, and any healthcare organization need only sign a single set of agreements with a single HIO in order to allow any participant in any certified HIO to perform eHIE with any other participant of any certified HIO.

A highlight example of Authority governance efforts in the policy arena is the white paper, “Ensuring Privacy and Security of Health Information Exchange in Pennsylvania”, developed and published in 2014 in cooperation with the Pennsylvania eHealth initiative (available at [http://www.paehi.org/files/live/Privacy\\_WhitePaper\\_2014\\_FINAL.pdf](http://www.paehi.org/files/live/Privacy_WhitePaper_2014_FINAL.pdf)) An example of a current governance topic that is being facilitated by the Authority covers super protected data. Pennsylvania is a “HIPAA Plus” state, meaning that there are laws in the Commonwealth more stringent than the national standard, especially with regards to mental health, substance abuse, and HIV/AIDS. The Authority’s efforts are not only aimed at determining consensus-based strategies for how these types of

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information should be addressed in eHIE within the Commonwealth, they are also aimed at determining legal or regulatory changes required, or technical solutions, to enable interstate eHIE.

The Authority operates a thin-layer of technical services to support interoperability between certified HIOs. This includes a master patient index to manage cross-community patient identity, an opt-out registry to record patient choice for eHIE in accordance with Act 121, a state-level provider directory, and a record locator service to facilitate clinical document exchange on behalf of those HIOs. Of note, the Authority's MPI was seeded and is updated with information that includes information provided by the Department.

The combination of governance, certification, and interoperability technology is called the Pennsylvania Patient and Provider Network (P3N). Individual HIOs may opt for Authority mediated clinical document exchange, called XDS, or may simply use the identity management and consent portions of the P3N technology layer. In the latter case, called XCA, the Authority can tell a requesting HIO which other organizations have an association with a given patient since those other organizations will have also registered the patient in the P3N MPI. XCA participants then exchange clinical documents directly with one another, again with the P3N providing any documents for HIOs using XDS. P3N became operational in August, 2014 for XDS participants and is expected to be operational for XCA participants in mid-2015.

The last piece of the P3N is the Public Health Gateway, or PHG. PHG enables a single point of connection from any private sector P3N participant to registries maintained by the Department and Pennsylvania's Department of Health. This technology was successfully tested in proof-of-technology mode at the end of 2014. Operational connections to the electronic lab reporting registry, cancer registry, immunization registry, syndromic surveillance registry, and eCQM registry will phase in by September 2015.

The P3N has been designed and implemented with particular attention to ensuring that participating providers can leverage it to meet Meaningful Use objectives.

The Authority was initially funded primarily under ONC's State HIE Cooperative Agreement program with a \$17.1M grant. Since the expiration of that program, the Authority has operated primarily using state appropriated funding. In December, 2014, the Authority's Board approved a sustainability plan that will move the Authority towards funding that aligns with the organizations' public-private partnership nature, with a goal of at least half of core operational funding to be provided from fees on participating HIOs by early 2018.

Meanwhile, the Authority also seeks funding through grants and private donations. Such funds are used to accelerate eHIE development both by the Authority and via grants from the Authority by the certified HIOs and HISPs. One example is a federal fiscal year 2014-2015 IAPD 90/10 grant from CMS via the Department. This grant is being used to complete the build-out of PHG and also to offer grants to certified HIOs to support their onboarding to the P3N and the onboarding of EHR Incentive Program participating hospitals and physicians to the HIOs. Section B of this document describes additional planning for the Department and the Authority to leverage IAPD funding over the next five years.

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Even as the Authority seeks to complete HIO certification and onboarding, and complete PHG build-out, the Authority is working with other states, particularly those bordering Pennsylvania, to enable interstate eHIE. As noted earlier, a major portion of this effort involves identifying and addressing policy differences between the states, in addition to technical interoperability.

A final major area of concentration for the Authority is patient and provider education regarding eHIE, and patients' rights to opt-out under Pennsylvania law.

For additional information on recent Authority activities, please visit the Authority's 2014 Annual Report, available on the Authority's website at

[http://www.paehealth.org/images/PAeHPA\\_2014\\_Annual\\_Report\\_FINAL.pdf](http://www.paehealth.org/images/PAeHPA_2014_Annual_Report_FINAL.pdf)

### ***The Department's Relationship with State Government HIT Coordinator (Response to Question #10)***

The Department collaborates with the Executive Director of the Authority who held the State Government HIT Coordinator role as part of the ONC State HIE Cooperative Agreement Program. The Executive Director of the Authority, the Director for PA REACH meet bi-weekly with the Department's HIT Coordinator to discuss any updates to progress with HIE, barriers, and potential collaborative projects. In addition to their regular meeting schedule, the Department and the Executive Director also meet jointly on a biweekly schedule with the Regional Extension Center and on a monthly basis with the Department of Health, PA Medical Society, Hospital and Healthsystem Association of Pennsylvania, and Pennsylvania Healthcare Cost Containment Council. These collaborative efforts supplement the extensive stakeholder engagement processes of the Authority's standing committees and the Department's advisory community. A letter of support from the Executive Director of the Authority is provided in Appendix VII of this document.

### ***Current Department Activities Likely to Influence EHR Incentive Program (Response to Question #11)***

The Department has a number of initiatives and activities underway that may influence the EHR Incentive Program, for example, the Department is currently working on issues related to health care reform and Medical Assistance patient eligibility. The Department is also engaged in activities to improve quality and performance. The Commonwealth is implementing a plan to increase Medicaid participation. This plan has the potential to increase patient volume and allow more providers to participate in the incentive program. The Department is currently examining ways to coordinate the following initiatives with the EHR Incentive Program:

- The Department is working closely with the Department of Health to help providers meet public health Meaningful Use requirements related to reporting to and interfacing with the immunization registry, cancer reporting registry, syndromic surveillance system, and electronic lab reporting. Additionally, the Department, the Department of Health, and the Authority are collaborating to implement PHG, which will provide a single point of connection from any

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private sector P3N participant to the above mentioned registries maintained by Pennsylvania's Department of Health and the Clinical Quality Measure repository maintained by the Department. These efforts are described in more detail in Section C.

- The Department has a pay-for-performance program for the MCOs in HealthChoices, the Department's mandatory managed care program. The Department will evaluate how the EHR clinical quality measures are aligned with the HEDIS quality measures and with the pay-for-performance initiative. The Department's long-term goal is to reduce the number of paper chart audits for the current pay-for-performance and HEDIS measures through the implementation of electronically reported measures, and through the ability to leverage eHIE. The Department passes through funding to the MCOs for a provider pay for performance program. One of the mandatory requirements of the MCOs is that they establish provider incentives to electronically submit quality measures for HEDIS reporting.
- The Department, through the HealthChoices MCOs is participating in various medical home models. A key component of all medical home initiatives is the use of EHRs and health information exchange to make sure that providers have the right information for the right patient at the point of care. The Department, DOH and the Authority are collaborating with one another and with other state-level initiatives to introduce health delivery and payment reform, such as the state's SIM effort, to ensure eHIE being developed under the Authority's governance is prepared to support evolving models.
- The Department provides childhood nutrition and weight management services which reimburse providers for initial and on-going assessments; individual, family, and group weight management counseling; and nutritional counseling. The Department anticipates that the EHR Incentive Program will assist in obtaining high quality body mass index (BMI) data that can be used for healthy weight surveillance activities that track changes in BMI prevalence and for developing quality data driven interventions that can be used to evaluate the impact of child obesity prevention interventions.
- An additional key initiative the Department provides services for is tobacco cessation. The Department provides reimbursement to providers who provide tobacco cessation counseling services. In addition, all tobacco cessation medications are covered through the FFS or MCO pharmacy benefits. EHRs and HIT will improve both tobacco screening and cessation intervention rates in patients for all practice providers.
- The Department is recommending that its managed care providers implement a Transition of Care initiative to ensure continuity of care transition for patients discharged from a hospital to home or other care settings. The use of EHRs will provide key information that supports continuity of care efforts as well as avoid complications and readmissions. The use of eHIE will assist in communication between all providers involved in a patient's care. For all patients,

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especially the medically complex and fragile, the ability for both primary care providers and specialists to communicate effectively will have positive impacts on both health outcomes and quality of life for our Medical Assistance recipients. HSX, the major HIO in Southeastern Pennsylvania has operationalized transition of care information exchange between providers in 2014. The Department participated in an eHealth Pod Pilot program designed to increase Meaningful Use participation in Behavioral Health providers by supporting their transitions of care requirements.

- The Department has worked with the Authority to develop IAPD requests to support continuing development of eHIE in Pennsylvania in order to support ability of EHR Incentive Program participants' ability to meet Meaningful Use requirements. In federal fiscal year 2014-15, this included \$10.7 million to support an Authority grant to certified HIOs to assist them in connecting to the P3N and in onboarding EHR Incentive Program participating hospitals and physicians. It also included \$1.7 million to support build out of the PHG by the Authority, the Department, and the Department of Health. As described in Section B of this document, the Department intends to continue to work with the Authority to leverage federal funding to enhance eHIE in support of the EHR Incentive Program.
- Another area that may influence the EHR Incentive Program is the activities around the \$9.8 million dollar CHIPRA grant awarded in 2010. Since 2010, the Department worked in three categories related to quality improvement through the adoption of numerous electronic health record improvements. Category A focused on evaluating the use of evidence-based quality measures in the delivery of children's health care. This is being advanced by the collection of eCQMs which will collect and store data related to the Clinical Quality Measures. The basis of Category B was to promote the use of health information technology in children's health care delivery through the development of web based point of care assessment tools that address developmental delay, autism, Attention Deficit Hyperactivity Disorder (ADHD), adolescent depression and suicide risk, and maternal depression screening. Category D implemented and evaluated the impact of a model format pediatric electronic health record on the quality and cost of children's healthcare. See the answer to question 15 below for more information.

### ***Recent Relevant Changes to State Laws and Regulations (Response to Question #12)***

Passed unanimously, Act 121 of 2012 created the Pennsylvania eHealth Partnership Authority (the Authority). This independent agency of the state government is tasked with coordinating public and private efforts to establish and maintain statewide electronic health information exchange (eHIE). The Authority continued the work of the Pennsylvania eHealth Collaborative described in Pennsylvania's previous SMHP plan. The Department closely collaborates with the Authority to promote alignment between Department initiatives and strategies and the Authority's efforts. Act 121 also established that Pennsylvania citizens may opt-out of eHIE and requires the Authority to establish and maintain a consent registry and process.

## Section A: The State's "As-Is" HIT Landscape

***Pennsylvania Drug Monitoring Program (PDMP)*** - Pennsylvania intends to update and enhance the PDMP by improving the monitoring of the appropriate drug orders. This program is important for improving quality care initiatives.

There are new provider enrollment and screening requirements. The Affordable Care Act at Federal regulations at 42 CFR 455.410 and 455.450 requires that all participating providers be screened according to their categorical risk level, upon initial enrollment and upon re-enrollment or revalidation of enrollment. This will cause a misalignment with records, delays, and potential appropriate disenrollment of providers or provider locations that correlate to historical HIT incentive and MU records already created and synchronized with the R & A. It is important to note that the Provider Enrollment and Screening Provisions of the Affordable Care Act (ACA) requires all MA providers to be revalidated/re-enrolled and re-screened from a freshly submitted provider enrollment application for each site-of-service (in MA this is known as Service Location) at least every five years. The first deadline for a full revalidation of the MA provider network is due on March 24, 2016 and automatically set for every five years on the anniversary of their submission date. Prior to this provision, providers were able to voluntarily update their file on their own schedule and only when changes occurred, which was typically not done unless there was a direct impact to the provider therefore we expect many changes to ensue as a result of the first deadline.

**Patient Centered Medical Home (PCMH) Council-** Act 198 of 2014 directs the Department to form a PCMH Council that will advise the Department on payment and health care delivery reform including payment mechanisms for PCMH activities, expanding the use of telemedicine, and enhanced HIE that ensures better coordination of care.

### ***HIT/E Activities Crossing State Lines (Response to Question #13)***

Pennsylvania includes several geographic areas with considerable cross-border healthcare activity. The Department and the Authority has initiated discussions with most bordering states to explore:

- What information can be shared?
- What are the timeframes for sharing information?
- What types of agreements need to be in place to share information?
- What potential challenges exist to these collaborative arrangements?

The Department and the Authority plans to engage states beyond the bordering states once plans for connections with bordering states solidify.

## Section A: The State's "As-Is" HIT Landscape

The Department will continue to reach out to its neighboring states to validate encounters and licensure and provider state switches.

### ***Current Interoperability Status of State Immunization Registry and Public Health Surveillance Reporting (Response to Question #14)***

There are four different applications being administered through the Commonwealth which serves to collect electronic data related to immunizations and surveillance. Managed by the Pennsylvania Department of Health, the Pennsylvania Statewide Immunization Information System (PA-SIIS) is a statewide immunization registry that collects vaccination history information. It was developed to achieve complete and timely immunization for all people, particularly in the age group most at risk, birth through two years of age. Pennsylvania is considering the opportunity to partner with New Jersey, New York, Delaware, Maryland, and West Virginia in the future. The Department is also working on a project with the Pennsylvania Department of Health to implement agreements that formalize the partnership between the agencies to support Meaningful Use of the immunization registry and Public Health Surveillance Reporting.

The Commonwealth of Pennsylvania uses Health Monitoring System's EpiCenter system to conduct state-wide syndromic surveillance. The system currently collects emergency department (ED) visit data from 80% of the EDs in the state. Access to the secure system is limited to Pennsylvania public health officials and hospital epidemiologists.

The Pennsylvania National Electronic Disease Surveillance System (PA-NEDSS) establishes a near real-time, secure communication link between laboratories, hospitals, individual medical practices, and the Pennsylvania Department of Health. Physicians, laboratories, and hospitals that report disease and the public health investigators who investigate disease and outbreaks are the users of PA-NEDSS.

The Pennsylvania Cancer Registry (PCR) is a statewide data system responsible for collecting information on all new cases of cancer diagnosed or treated in Pennsylvania. The PCR has had statewide data collection since 1985. The PCR is part of the National Program of Cancer Registries (NPCR) administered by the Centers for Disease Control and Prevention (CDC). Through this program, the CDC provides funding for states, such as Pennsylvania, to enhance their existing registry to meet national standards for completeness, timeliness and data quality. This registry can be considered another registry for the EHR Incentive program.

The Department, the Department of Health, and the Authority are collaborating to implement PHG, which will provide a single point of connection from any private sector P3N participant to the immunization registry, cancer reporting registry, syndromic surveillance system, and electronic lab reporting registries maintained by Pennsylvania's Department of Health and the Clinical Quality Measure repository maintained by the Department.

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### *Transformation Grant or a CHIPRA HIT Grant (Response to Question #15)*

Pennsylvania was awarded a CHIPRA Quality Demonstration Grant on February 22, 2010. During the five-year life of the grant Pennsylvania received a total of \$9,777,361 in funding. Pennsylvania's demonstration was a collaborative effort including the Department, Department of Health and Insurance Department. In addition to collaboration between various departments and agencies, the Commonwealth also worked with various health systems. The demonstration was divided into the following three categories:

Category A – Testing and reporting on the pediatric core measures of quality: Pennsylvania worked with seven health systems that provide pediatric care to focus on improving the quality of care through the adoption of health information technology. All seven grantees were able to electronically extract and report quality measure data to the Department.

Category B – Promoting the use of HIT in children's healthcare delivery: Pennsylvania worked to improve the quality and coordination of care for children with special health care needs who are covered by Medical Assistance and Children's Health Insurance Program (CHIP). This was accomplished by leveraging HIT to maximize the early identification of children with developmental delay, behavioral health issues and those with complex medical conditions so their care can be closely coordinated with the Primary Care Provider (PCP) medical home, appropriate medical specialists and child serving social agencies.

Category D – Demonstrating the impact of the CMS model format pediatric electronic health record: The Department and its partners worked with St. Christopher's Hospital for Children to collaborate with four other health systems to create a team to implement and evaluate the impact of a model format pediatric EHR template provided by CMS and AHRQ. Large portions of the model format focused on the ability to share data across care systems. Because the Commonwealth did not yet have a Health Information Exchange that was operable across the entire state, the five grantees working on this project were unable to complete some of the format requirements. However, they were able to begin preparing their EHR systems for the eventual use of statewide data exchange mechanisms that will be brought forth by the HIT program.

CHIPRA was able to prepare the grantee health systems for the future of healthcare being shaped by the HIT program. By the mid-point of the CHIPRA grant every grantee had heard of the Meaningful Use program but they weren't sure what it meant for their health systems. As they began to alter their EHRs to electronically pull quality data and appropriately format the data for electronic transmission to the Department, the grantees began to understand how CHIPRA was preparing them for the future.

CHIPRA was also a mechanism to prove that a certified EHR wasn't always ready to accomplish complicated tasks presented by the grant. Many certified EHRs required vendor adjustments to capture specific data fields in a discrete manner or to generalize the data capture method so that a variety of systems (clinical, billing, etc.) could share information within a health system.

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The Department is at the end of the CHIPRA grant and is confident in saying CHIPRA has brought much knowledge of the HIT program and its requirements to the seven grantee health systems and their associated EHR vendors. In the beginning the Department felt that CHIPRA was driving knowledge of the HIT program, but by the end health systems were very aware of the HIT expectations being placed on them and often the HIT program began pushing the implementation of some CHIPRA requirements.

Within the HIT program, the Department has capitalized on the CHIPRA experience to tailor outreach efforts, identify solutions that will enhance the provider's ability to meet proposed Meaningful Use criteria and strategies for implementing and encouraging the adoption of EHRs.

Pennsylvania submitted and was awarded a 1.5 million dollar State Innovations Model (SIM) grant. In 2014 we unsuccessfully submitted an implementation grant however Pennsylvania is continuing to work towards another implementation submission. <http://innovation.cms.gov/initiatives/state-innovations/>

## Section B: The State’s HIT “To-Be” Landscape

### Section B: The State’s HIT “To-Be” Landscape

This section responds to each of the questions listed in the CMS State Medicaid HIT Plan Template and provides an overview of the Department’s “To-Be” landscape as it implements the Medical Assistance EHR Incentive Program and moves towards achieving its HIT and eHIE vision.

**Figure B.1: Section B Questions from the CMS State Medicaid HIT Plan (SMHP) Template**

Please describe the State’s “To Be” HIT Landscape:
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 Locator 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.

\* May be deferred if 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 to note if plans are known to include any of the listed functionalities/business processes.

\*\* May be deferred.

## Section B: The State's HIT "To-Be" Landscape

### *The Department's HIT Vision (Response to Question #1 and 4)*

This section provides an overview of the Department's vision of how the adoption and Meaningful Use of HIT and the exchange of health information will be used to support the Department's overarching goal to improve the quality and coordination of care by connecting providers to patient information at the point of care.

On March 17, 2010, the Department's executive leadership met to discuss the initial 5-year vision for HIT. Department stakeholders reconvened on March 3, 2015 to reflect on this vision and identify new strategic goals. The short-term goals have evolved as the program continues, but one thing remains constant: The Department's long term vision is to improve the quality and coordination of care delivered to Medical Assistance consumers. The Department recognizes the significance and value of HIT and eHIE to reaching broader care quality and care coordination goals.

The Department's goals identified to guide the next five years are:

- **Increase Quality of MA Services** – Afford providers' access to better, more timely information at the point of service to support clinical decisions, increase quality of patient care, and reduce unnecessary costs.
- **Increase Coordination among DHS Programs and External Stakeholders**– Eliminate duplicative services and administrative inefficiency and align resources to improve care coordination for consumers.
- **Increase Awareness** – Educate providers and consumers on the benefits of being a Meaningful User of HIT; Educate providers on the changes and the benefits of the program, the importance of beginning to participate by December 31, 2016 and to continue their participation in the incentive program.
- **Redesign Systems** – Keep MAPIR and systems infrastructure current to meet evolving program requirements and business needs, including scanning the environment to adopt the data capture and analysis tools necessary to enhance and improve current quality initiatives for both providers and consumers and to meet the CMS updated requirements. Enhanced HIE will also enable the Department to move towards payment reform and redesign of health care delivery.

Reaching these goals is an incremental process, the foundation of which is the adoption, Meaningful Use and timely exchange of health information. Adoption begins with implementing an EHR system then becoming a Meaningful User of the EHR technology thus sharing information with the consumer and other providers to improve overall healthcare to the consumer. The following text provides additional detail on the vision for the To-Be state by highlighting the key infrastructure and programmatic features

## **Section B: The State's HIT "To-Be" Landscape**

necessary to enable the overall vision. Tactical steps and implementation milestones are presented in further detail in Section E: The State's Roadmap.

### **Increase Quality of MA Services**

By providing health information to providers, MCOs and consumers, the Department seeks to identify coverage and quality gaps in a manner that results in efficient and effective care and improved health outcomes for the MA population.

The Department currently uses claims data, MCOs data and quality reporting and cost data to monitor and improve its programs. By collecting electronic Clinical Quality Measures (eCQMs) and housing them in a repository which can be linked to other data the Department will have a more comprehensive picture of its consumers. The Department will work with PCH4 around sharing the electronic data.

By leveraging EHR and eHIE for the more rapid collection and sharing of eCQMs, the MCOs and providers will be able to make more informed decisions on care needs. In addition the data will drive payment reform efforts.

### **Increase Coordination of Care and Sharing of Data**

Pennsylvania's goal is to coordinate care in a manner that leads to more efficient, cost-effective care. Achieving this vision requires alignment across Department bureaus as well as coordination across the Commonwealth's agencies and initiatives.

We expect advancing coordination to entail working closely with the eHealth Authority to improve the flow of data between external stakeholders and leveraging the MMIS planning and MITA process to strengthen alignment within the Department. Ultimately, Pennsylvania plans on a bidirectional flow of data; not just providers and MCOs pushing data to the Department, but the Department pushing data out to MCO and providers such as accountable care organizations (ACOs). The bi-directional flow of data will give providers a more complete view of their patient's care, so that providers can see the full continuum of care. This flow of data to large health systems/ACOs will enable them to manage the health care needs of an attributable population.

Furthermore, Pennsylvania plans to leverage HIT and eHIE to better coordinate the care of vulnerable populations including, but not limited to, children in the Commonwealth's child welfare system, children screened for developmental delays, individuals, both disabled and elderly, receiving home and community based waiver services and individuals transitioning in and out of the Commonwealth's correctional system.

### **Increase Awareness**

The Department plans to continue its current efforts to educate providers and consumers on the benefits of using EHRs and being Meaningful Users of HIT. Additionally, the Department plans to create a secure patient portal that will allow MA members to view their MA EHR and other health coverage

## Section B: The State's HIT "To-Be" Landscape

information and to link that information to the best ways to manage and improve their health conditions.

### Redesign Systems

A guiding principle for the Department's MITA strategy, which is to increase awareness, quality and coordination in public health coverage programs, is well-aligned with the broad HIT to be vision identified above. Keeping the Department's MAPIR system and other infrastructures current to meet evolving program requirements and business needs is essential to achieve that strategy. Within the coming five years the Department plans to:

- Enhance data capture and analysis capabilities for providers including ACOs, MCOs and the Department.
- Leverage software that supports robust care management.
- Develop and implement the capability to push/pull Healthcare information such as claims based data, eCQMs, and care plans across multiple waiver and special needs programs such as long term living services, community based waivers, child welfare, and early intervention.

### ***The Department's MMIS System Architecture and EHR Incentive Program System (Response to Questions #2, 3, and 4)***

The Department is in the process of re-evaluating and enhancing current Medical Assistance agency service operations in light of the EHR Incentive Program, including an enhancement of the MMIS architecture to support the exchange of healthcare encounter data. The Department anticipates that many of the current administrative processes will remain intact; for example, provider enrollment, claims processing, etc. The Department leverages the current MMIS financial system to make Medical Assistance provider HIT incentive payments using MAPIR. As a requirement during the re-procurement process, the MMIS system will need to be able to continue to interface with MAPIR. The Department will discuss working with the Authority to expand and make routine submissions from the Department to the P3N MPI and provider directories, and then working with both the Authority and other agencies to identify opportunities to leverage P3N to reduce administrative redundancy in state government.

All MMIS system development related to HIT must be coordinated with federal initiatives, especially in regard to changes associated with TMSIS, ICD-10, the Patient Protection and Affordable Care Act, and the development of the MITA "To-Be" model for Pennsylvania. As with MMIS and other MITA systems and related activities, the Department will adhere to the seven conditions and standards described in the CMS guidance updated May 2011. The Department will purchase MMIS and MITA systems and upgrades in relation to the Medical Assistance EHR Incentive Program and MAPIR that meet the following conditions and standards:

1. Modularity
2. MITA
3. Industry standards

## Section B: The State's HIT "To-Be" Landscape

4. Leverage
5. Business results
6. Reporting
7. Interoperability

MITA is transforming the design, operations, and costs associated with running an MMIS.

The Department envisions that in five years HIOs will be used to transport quality measures to allow the Department to analyze the impact of HIT on health outcomes and medical costs for Medical Assistance and other programs. The current MMIS system includes a Provider Portal whereby providers are able to perform such functions as claims entry, claims inquiry, ePrescribing via SureScripts, remittance advice downloads, eligibility inquiries, and updates to certain elements of provider enrollment.

Part of the MMIS enterprise uses two Enterprise Service Buses in the IT environment. The Commonwealth has standardized two Enterprise Service Buses for the MMIS enterprise: WebMethods for applications that require high-transaction throughput or process large amounts of data, and BizTalk for smaller applications whose workflow requirements and interaction with third party products are better suited to that technology. The Master Provider Index and Master Client Index each use these applications. In the next five years the goal is to make additional applications accessible via internet portals including prior authorization/ referral entry and maintenance.

The Department will continue to update the MAPIR system to administer the Meaningful Use portion of the incentive program. The MAPIR system has the capability to capture AIU and Stage 1, Stage 2, and flexibility Meaningful Use attestations, and will be enhanced for Stage 3 MU attestations once these requirements are defined by CMS. The Department will continue to look to CMS for guidance and will follow CMS's lead as it develops standards for Medicare Meaningful Use data.

The Department is also exploring the feasibility of integrating the DIRECT Project with MAPIR. The DIRECT Project (DIRECT) develops specifications for a secure, scalable, standards-based way to establish universal health addressing and transport for participants (including providers, laboratories, hospitals, pharmacies and patients) to send encrypted health information directly to known, trusted recipients over the Internet. The Department is utilizing the DIRECT messaging system to collect CQM submissions. The Department will continue to leverage the Authority's certified HISP trust community in DIRECT-related activities.

The Department will, in concert with the Authority, closely monitor activities occurring at the federal level and work with the Authority to develop necessary connections to federal level entities as requirements for such connections come to light, and as capabilities at the federal level mature.

### **Medical Assistance Provider Incentive Repository (MAPIR)**

The Department will lead the continued development of the MAPIR system as part of the MAPIR Collaborative to interface with CMS to exchange information and prevent duplicate payments,

## **Section B: The State's HIT "To-Be" Landscape**

determine eligibility for incentive payments, receive and track AIU and Stage 1, 2, and 3 Meaningful Use attestations, and trigger Medical Assistance incentive payments via the MMIS system ongoing.

### ***HIE and Department Governance (Response to Question #4)***

The administrative structure currently in place for the Department's EHR incentive program's planning and development efforts continues to evolve in manner that will allow the Department to achieve its HIT and eHIE goals and objectives. The Department's five-year vision includes the Meaningful Use of EHRs by all eligible professionals and hospitals with an emphasis on measuring and improving quality of care. A large part of this vision relies on Pennsylvania providers' use of eHIE. Section E provides more detail on proposed initiatives aimed at increasing eHIE Meaningful Use.

In order to achieve these goals, the Department will continue to pursue the infrastructure (hardware, software), resources (staff and funding), and agreements (legal, data sharing, privacy) necessary to participate in eHIE and leverage its functionality as part of the Department's HIT and eHIE vision. The Department holds a permanent seat on the Authority's Board of Directors and routinely participates in the Authority's stakeholder committee work.

By following the various HIT initiatives across the Commonwealth, the Department and Authority will be able to capitalize on existing structures to reduce duplication efforts. Collaborating with the RECs, FQHCs, and ONC will also assist in with this effort. Please see Figure A2 on page25.

### ***The Department's Role in Encouraging HIT Adoption and Ongoing Provider Outreach and Education (Response to Questions #5 and 7)***

The Department will continue to work in collaboration with other statewide efforts to further inform Medical Assistance providers about opportunities available to them for HIT adoption via the Medical Assistance HIT incentive program. The Department will work with CMS, ONC, the REC, and MCO's to collaborate and leverage existing resources, e.g., distribute CMS and ONC-approved materials rather than creating new materials.

In order for the Department to reach their goals, it is important to determine the status of the provider's EHR status. This can be done with a thorough Environmental Scan. The Department will work with CMS and the tools being developed to create an effective environmental scan. The Department is considering utilizing an outside source to implement and analyze the results of this survey.

The Department's communication goals will be to inform providers about:

- The Department's HIT Goals and Vision with emphasis on increasing quality through adoption of certified EHR and transforming care through HIT
- Eligibility criteria:

## Section B: The State's HIT "To-Be" Landscape

- Registering with the R&A
- Gathering data on Medical Assistance patient volume
- Unique criteria for various provider types
- Choosing Medicare or Medical Assistance
  
- General discussions on the payment structures (Year 1, Year 2, etc.)
  - Discussion on various strategies regarding Meaningful Use and incentives for providers to participate early in the program
  - Share information on adopt, implement or upgrade stages in connection with Year 1
  - Share information on Meaningful Use, continue to update based on CMS guidance
  - Describe impact of MU on quality of care and increased patient engagement
  
- Discussion on the payment structure and amounts
  
- Overview of the MAPIR system changes and user interface
  
- Education and outreach to encourage the adoption and Meaningful Use of federally-certified EHRs
  
- Explain auditing program and requirements
  
- Educate and communicate requirements and acceptable documentation for the auditing process
  
- Promote patient engagement in order to reach MU requirements and improve quality of care

The Department will tailor outreach and communication methods based on the nature of the issue and the volume of providers or stakeholders with these concerns. The Department will continue to utilize Quick Tips, website information, updates to provider materials, weekly listserv emails, and in-person and virtual training sessions. CMS and ONC will continue to initiate communication strategies on the Medical Assistance EHR Incentive Program and eHIE. The Department will also continue to coordinate with ONC, CMS, and the Authority on timing and messaging.

The Department anticipates their provider communications efforts can be coordinated with outreach efforts directed by CMS, the ONC, the Authority and others. The Department also anticipates working closely with the RECs to benefit from lessons they have learned and to work collaboratively with HealthChoices MCOs, ACOs, MAXIMUS (The Department's MCO, enrollment broker and others) to further relay their messages to providers and consumers. The Department sees great value in continuing to present a uniform message via many routes to providers to maximize exposure and increase impact. The Department will use information gathered through various EHR and HIT adoption surveys to gauge current HIT adoption among Medical Assistance providers and hospitals eligible for

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EHR incentives, and this information along with information from the RECs, the MAAC HIT workgroup and other resources will allow the Department to tailor their outreach strategy.

While the Department expects to conduct in-person outreach sessions to providers with regards to the EHR Incentive Program, it also will continue to provide detailed information on enhancements to its existing HIT website.<sup>2</sup> Currently, the Department provides a direct link and log-in message for providers as they enter the MMIS provider internet portal to direct them to new opportunities. The Department will also continue to work with vendors to add content on their provider portals to direct providers to information concerning the incentive program.

Throughout the years, the Department has released Medical Assistance bulletins describing Pennsylvania's Medical Assistance EHR incentive program; which included a description of, program requirements, eligible provider types, the R&A, program oversight, and the application and attestation process, Meaningful Use and Stage 2. The information in the Medical Assistance Bulletin was supplemented by information on the program's website. This included information on the following items:

- Where HIT information is located on website and how to register with listserv for latest information?
- What is the Medical Assistance EHR incentive program (per CMS) and what are the Pennsylvania-specific program requirements? (Medical Assistance EHR Incentive Program Resources, Appendix III)
- Preparing to attest for Medical Assistance incentive payment
- What is the R&A? How do providers access the R&A?
- What is Meaningful Use and what are the requirements?
- Auditing information and what is acceptable documentation for audits.
- Public Health Registry information and contact information.
- Details on the eHealth pod pilot project

The Department recognizes that the outreach and education process will need to be continuously reviewed and refined along the way as Federal and Commonwealth rules change and also in response to provider comments and questions that are maintained in the Department's inquiry database. The

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<sup>2</sup> <http://www.pamahealthit.org>

## Section B: The State's HIT "To-Be" Landscape

Department will use feedback gathered from providers and also through the Best Practices Focus Group, the Medical Assistance Advisory Committee (MAAC) and the MAAC's HIT workgroup.

In addition to materials that explain the Medical Assistance EHR incentive program, the Department sees the importance of providing educational and technical assistance materials on implementation, upgrade, and Meaningful Use of EHRs to providers. The Department will work with its partners and the Federally-funded National HIT Research Center (AHRQ) and Healthit.gov to gather existing materials that describe model practices and provide background and technical assistance on adoption, implementation, upgrade, and Meaningful Use of EHRs. The Department has leveraged the CMS Innovation Center provides information on the effective use of Health IT.

Similarly, the Department will work with the Authority to develop materials that encourage adoption of eHIE via participation with an Authority certified HIO. The Department and Authority will also leverage feedback received from provider onboarding efforts financed through the onboarding grants discussed earlier in this document to help educate providers on how to prepare for and effectively implement eHIE connections with minimal disruption. As success stories emerge from providers who have enabled eHIE, the Department will work with the Authority to communicate these stories to the broader provider community.

To encourage the adoption of EHRs, the Department will also be highlighting other opportunities available to Medical Assistance providers through partnerships that the Department has established with other entities to help defray provider costs, e.g., behavioral health and long-term living providers as described below. These partnerships will help reach all Medical Assistance providers, including those who may not meet the eligibility criteria for the incentive payment such as long term care and behavioral health providers. The participation of providers in eHIE – whether or not those providers meet the incentive program eligibility criteria – will further assist in meeting the Department's quality goals and developing the complete EHR. Communication will target providers as well as HealthChoices partners in order to increase the use of eHIE transport mechanisms within the Commonwealth.

For ongoing outreach and education, the Department will have a variety of resources for identifying provider issues. The Department will utilize the information they collect to develop additional resources as needed. The initial responses from the surveys noted above and information providers enter in MAPIR will provide insight about providers' current stage of HIT adoption. Many of the Department's materials will focus on issues unique to providers pending their HIT adoption status and the time they are entering the program. In addition, the Department uses provider inquiry data (primarily from telephone calls to program staff and emails received in the Department's EHR program support center) to track common issues or concerns that might be best addressed via Medical Assistance Bulletins, website content, listserv communications, webinar sessions, or other direct provider education sessions.

The Department is planning pilot programs and other activities that will leverage existing Department initiatives and help Medical Assistance providers to adopt EHRs and also help to promote eHIE. The

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Department's planned initiatives will help educate providers on how EHRs can be used to gather and report data (in some cases data required by the Department) and hopes that providers will be able to electronically exchange this information with the Department through DIRECT and PHG. All of these initiatives are in the planning phases at this time but we will submit additional details in future SMHP and I-APD submissions when we are ready to move forward.

- In an effort to enhance quality and reporting of Obstetrics and Gynecological services the Department is developing a pilot related to the Obstetrical Needs Assessment (OBNA) Form. The form is currently underutilized. The Department is working with the MCOs who have invested Adult Quality Measurement grant funds to develop electronic solutions. The ultimate goal is for the EHR data to auto populate the OBNA "form" and the form to be electronically available via a provider and/or patient portal for all appropriate health care team members to access the information. Information would be shared in a bi-directional manner.
- The Department is also considering how to collect and improve information sharing with health professionals that primarily provide services within elementary and secondary schools. Many schools are already participating with Innerlinks which is a system that health professionals utilize to store health information gathered in a school. The Department would like to facilitate sharing of this information perhaps through DIRECT so that the children's complete health record would be available to the school health professionals as well as the children's primary care providers. Inner links is also planning data exchange with our HealthChoices MCOs.
- The Department is currently considering how to provide technical assistance on Federally-certified EHR and HIT adoption to behavioral health and long-term care Medical Assistance providers. These providers are not currently eligible for the EHR Incentive Program but play a vital role in the overall healthcare system for Medical Assistance clients. Therefore the Department believes it is critical to engage and assist these providers as other Medical Assistance providers, the Department, and the Commonwealth move towards EHR and eHIE adoption. The Department is reviewing the EHR and HIT technical assistance grants recently awarded by the recent Substance Abuse and Mental Health Services Administration (SAMHSA) to community health centers that are working to integrate primary care and behavioral health services to determine if this program can serve as a model. The Department participated in an eHealth Pod Pilot program designed to increase Meaningful Use participation in Behavior Health providers by supporting their transitions of care requirements.
- The Department is also planning to align the pay-for-performance measures with the adult and pediatric measures included as part of the Patient Protection and Affordable Care Act (referred to as the ACA), and CHIPRA reauthorization respectively.

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### *Leveraging Related Funding Resources (Response to Questions #6 and 9)*

The HITECH Act of the ARRA and other healthcare reform initiatives have provided numerous opportunities for providers, hospitals, clinics, health systems and all involved in the delivery of healthcare to benefit from various funding opportunities that either allow for the adoption, implementation or upgrade of EHRs or support quality initiatives where HIT is used in meaningful ways. As the Department plans to further its HIT/HIE goals, it is also considering how these other resources and funding streams can be coordinated to further drive the success of this initiative.

Two specific areas where the Department will be working closely to coordinate funding resources are with FQHCs who have received funding via HRSA and other HIT-related grants the state has been awarded as defined in Section A.

#### **HRSA Funding for FQHCs**

The purpose of the HRSA Health Center Controlled Networks (HCCN) funding is to advance the adoption and implementation of Health Information Technology (HIT) and to support quality improvement in health centers. HCCN grants will also support the adoption and Meaningful Use of electronic health records (EHRs) and technology-enabled quality-improvement strategies in health centers.

In 2013 and 2014 two health center controlled networks (HCCNs), the Health Federation of Philadelphia and the Public Health Management Corporation received HRSA funding to advance the adoption, implementation, and optimization of HIT; to support the Meaningful Use of certified EHR at participating health centers; and to support quality improvement with optimal use of HIT. The HCCNs also provide technical assistance closely matched to center-identified HIT and QI needs determined through initial and ongoing needs assessment.

**Table B.1: HRSA Health Center Controlled Networks (HCCN) Funding**

Facility	Location	Amount
Public Health Management Corp.	Philadelphia	\$ 798,630
Health Federation of Philadelphia	Philadelphia	\$ 800,000
Total		\$ 1,598,630

#### **CHIPRA Funding**

As discussed in Section A, Pennsylvania has been awarded a CHIPRA Quality Demonstration grant. The state received a total of \$9.8 million over a five year period. Many of the quality and HIT goals for the CHIPRA grant are consistent with those for the Medical Assistance EHR incentive program. The goals for the CHIPRA quality demonstration grant include extracting quality data, using health information exchange to improve care coordination, and identifying a model pediatric electronic health record format. The CHIPRA quality demonstration grant is on a more aggressive timeline than the Medical Assistance incentive program, which will allow the Medical Assistance incentive program to leverage

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CHIPRA grant experiences. The Department is working on both initiatives which will allow an opportunity to capitalize on the CHIPRA experience to tailor outreach efforts, identify solutions that will enhance the provider’s ability to meet proposed Meaningful Use criteria and strategies for implementing and encouraging the adoption of EHRs.

The Department sees an opportunity for learning from the development of the pediatric EHR format, to enhance relationships with public and private partners for development of customized EHRs for Long-Term Living and Behavioral Health. The Department can also utilize the systems and templates developed for the pediatric EHRs for all Medical Assistance participants and providers. Through the CHIPRA initiative, the Department will be electronically extracting and reporting quality measures from the model format pediatric electronic health record. The Department will have a system in place to capture these core measures, assess their impacts on quality and can use the analyses to assist CMS in defining the core measures for pediatric Meaningful Use.

### State Innovation Model (SIM) Plan Funding

The Commonwealth has received grants through the State Innovation Model (SIM) Initiative, which provides federal funding and technical support to assist states plan, design, and test new healthcare reform models. [http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Center%20for%20Medicare%20and%20Medicaid%20innovation%20\(CMMI\)/Pages/default.aspx#.VQr-YVXD-70](http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Center%20for%20Medicare%20and%20Medicaid%20innovation%20(CMMI)/Pages/default.aspx#.VQr-YVXD-70). In total, the Commonwealth received two grants in the last two years. In 2013, the Commonwealth received a \$1.5 million Model Design Round One award from the Center for Medicare and Medicaid Innovation to develop its Pennsylvania State Health Care Innovation Plan. The Innovation Plan discusses the state’s strategy to improve its infrastructure in order to ensure quality health care, lower costs, and improve population health.

The HIT strategy discussed in the Innovation Plan centers on building its current infrastructure to support performance data that is transparent and standardized for providers, patients, and payers. Furthermore, the Commonwealth also seeks to improve its telemedicine infrastructure to improve access to care in underserved and rural areas. The Plan also aims to leverage the state’s activities in adopting EHRs and building connections for statewide health record transmission to improve performance data collection, analysis, and reporting. In December 2014, the Commonwealth received a Model Design Round Two award totaling \$3 million, which will assist the state to refine and advance the development of its Innovation Plan.

**Table B.2: State Innovation Model Funding**

CMMI Model Design Award	Amount
Round One	\$1,560,135
Round Two	\$3,000,000
Total	\$4,560,135

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The Department intends to align with future SIM planning efforts to ensure the efficient use of federal resources.

### ***Addressing the Unique Needs of Special Populations (Response to Question #8)***

EHR technology can be used to address the unique, complex and special healthcare needs of Medical Assistance recipients as well as address racial and ethnic healthcare disparities. These populations may have the most to gain from successful EHR and eHIE adoption. HIT that adequately captures and exchanges appropriate medical information in real-time is essential for providing effective and appropriate healthcare to populations with unique needs. For patients with complex healthcare needs, this could include exchanging healthcare information with all providers, social agencies and the patient to coordinate and manage complex conditions. Also, to address and reduce racial and ethnic disparities, it is first necessary to identify these disparities so that interventions can be developed and improvements tracked.

As part of this SMHP planning effort, the Department is focusing on the following populations:

- Those individuals in need of long term care services, in medical institutional setting or in the community, can benefit from EHR adoption and Meaningful Use that will result in better care coordination between long term care providers, those providing acute/primary care services and case managers. There are several initiatives whose goal is to link up nursing home sand get these providers on-boarded into eHIE.
- Those individuals with behavior health conditions, especially for those treated by high volume behavioral health providers in behavioral health homes.
- Children placed in out-of-home care through the foster care system, who may have health conditions requiring ongoing treatment as well as to identify those health conditions that may result from trauma or from being placed out of their homes. The goal is to provide these children and youth with better care coordination and higher quality care.

Over the past six years our HealthChoices MCOs have identified (through HEDIS oversampling of 14 measures) that disparities exist within certain geographic areas for diabetes care, obstetrical care, and hypertension. Many of these geographic areas are served by high volume health system providers that are eligible for EHR incentive payments. Through the use of EHR extraction in the future, our providers and MCOs will be better able to identify and develop interventions that quickly close the gaps in care that result in disparate care.

The Department is currently engaged in many efforts to include these populations as part of planning efforts. There are two primary efforts where the Department is proactively engaged in collaborative planning efforts to address these groups. First, the Department continues to engage the HIT

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Interagency Steering Committee that includes participants from Office of Children, Youth and Families (OCYF), Office of Long Term Living (OLTL), Office of Mental Health and Substance Abuse (OMHSAS) and others. The Department's vision and strategy is to facilitate collaboration between the EHR Medical Assistance incentive and other Offices and Departments to address the needs of populations and providers not included in the EHR incentive program, e.g., for mental health and substance abuse and long-term care. While the majority of the providers in these settings are not eligible for incentive payments and the Department is not requesting 90/10 HIT funds for providers not eligible for EHR incentive payments; the Department's vision is to expand the use of EHR and HIE to these providers and populations so that they can also realize the positive impacts on care coordination, clinical outcomes, and increased continuity of care.

As part of the HIT Interagency Steering Committee, the Department is using a tool to identify a subset of the Medical Assistance population that has special healthcare needs. The Department is addressing and defining the unique needs of these groups to identify specific ways in which HIT can address these needs and improve quality of care. The Department also seeks feedback from the HIT workgroup of the MAAC to understand this population and identify how HIT adoption and eHIE can best support the Department's quality goals. The MAAC includes advocacy groups as well as consumers with disabilities and special health care needs.

In addition to these opportunities, to learn from other stakeholders and offices about the benefits and challenges the HIT initiative will have for these populations, the Department also expects their involvement in the CHIPRA grant will help the Department better address the quality of care of pediatric populations. Category B of the grant involves electronic screening and referral tracking of children with developmental delay, behavioral health conditions and other special needs.

### ***The Need for Additional Legislation (Response to Question #10)***

The Authority is engaging stakeholders to identify recommendations on how best to address barriers to exchange related to "super protected data" (mental health, substance abuse, and HIV/AIDS). Any solutions must effectively balance the continuing imperative to protect privacy and security of patient's information with the benefits patients can reap from eHIE. The Department will monitor and participate in these discussions. Should this effort result in recommendations to Pennsylvania's current "HIPAA Plus" legislation, the Department will work with the Authority to ensure it can endorse such recommendations, and then work with legislators as required on resulting legislative efforts.

The Department will also be closely identifying and monitoring legal, social, and political barriers that may limit the exchange of healthcare data, e.g., exchanging healthcare data for minors and patients receiving mental health and substance abuse services, and exchanging information on HIV/AIDS. This includes exchanging information for electronic prescribing purposes, e.g., the Generic Equivalency Law requires that the words "Brand Medically Necessary" be handwritten on a prescription so Medical Assistance ePrescribing will not allow these drugs to be electronically prescribed. The Department will

## Section B: The State’s HIT “To-Be” Landscape

work closely with the Authority to understand these barriers and to pose solutions that will allow for the exchange both for Medical Assistance recipients and for all Pennsylvanians.

## Section C: The State’s Implementation Plan

This section responds to each of the questions listed in the CMS SMHP Template and provides an overview of the activities the Department will undertake to administer and oversee the Medical Assistance EHR Incentive Payment Program.

**Figure C.1: Section C Questions from the CMS SMHP Template**

Describe the methods OMAP employs and what activities OMAP will undertake to administer and oversee the Medicaid EHR Incentive Program:
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?
6. How will the SMA verify <i>adopt, implement or upgrade</i> of certified electronic health record technology by providers?
7. How will the SMA verify <i>Meaningful Use</i> 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 <i>certified electronic health record technology</i> ?
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 Registration and Attestation System (R&A)?
16. What is the SMA’s plan for accepting the registration data for its Medicaid providers from the CMS R&A system (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?

## Section C: The State’s Implementation Plan

Describe the methods OMAP employs and what activities OMAP will undertake to administer and oversee the Medicaid EHR Incentive Program:
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.)?
23. 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?
24. 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 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?
25. 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?
26. 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?
27. 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.?
28. States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:

The HIT Executive Committee created a process flow for the Medical Assistance EHR incentive payment process that takes the Department, eligible professionals, hospitals, and the MMIS system from start to finish. Please refer to Appendix III for this process flow. The process flow outlines the Department’s process for administering and overseeing the Medical Assistance EHR Incentive Payment Program. In the narrative below, the Department describes each step and indicates which step(s) of the process flow help to respond to each CMS template question. The term “providers” is used to refer to both eligible professionals and eligible hospitals unless otherwise noted.

In this section, as with the other sections, the Department is requesting enhanced 90/10 match for all activities unless otherwise noted. In response to question 21 in section C of the CMS template, the Department has established a process with its budget office that helps the Department to closely monitor program costs and help to ensure that the EHR incentive program costs are not comingled with enhanced MMIS match. Expenditures and other program information are projected and reported as

## Section C: The State's Implementation Plan

required on the CMS-37 and CMS-64. This includes the costs associated with the eligibility and payment system described below, the Medical Assistance Provider Incentive Repository (MAPIR).

Please note that some of the process issues are also described further in other sections, e.g., oversight issues are addressed in Section D and program performance measurement is addressed in Section E.

### ***Step 1: The Department conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, and 27)***

The Department is responsible for communicating with providers about enrolling in the Medical Assistance incentive program and performs the following:

- Informs providers of the EHR Incentive Program and the requirements for participation including the application process, patient volume and Meaningful Use requirements for Stages 1, 2 and 3
- Coordinates with the Regional Extension Centers (RECs) and other resources to provide technical assistance and information related to EHR adoption, implementation, upgrade, and Meaningful Use of EHRs
- Informs providers about how to begin the enrollment process and maintain registration information with the CMS Registration and Attestation System (R&A)
- Informs providers that they will be asked for a National Provider Identifier (NPI) when they register with the R&A and are encouraged to get an NPI if they do not already have one, e.g., providers who practice predominantly in a health center
- Informs providers that, to participate in the incentive program, they must be participating Medical Assistance providers (the Department cannot conduct proper oversight, or reclaim overpayments if they are not enrolled) Since the incentive program includes providers who do not normally enroll in MA, these providers are encouraged to enroll in MA and the Department works directly with enrollment to confirm participation

In order to communicate this information to providers, the Department has developed communications tools and presentations that educate and inform providers and key stakeholders about the program. The Department released a series of Medical Assistance Bulletins (MABs) to describe Pennsylvania's Medical Assistance EHR Incentive Program; including: program requirements, eligible provider types, the R&A, program monitoring & oversight, the application, and attestation and audit processes. The Department holds webinars to discuss key topics and to provide a walk-thru of the MAPIR system prior to a key release. In addition to the Medical Assistance Bulletins, the Department developed and published Provider Quick Tips, Provider Manuals for both hospitals and professionals, and Remittance Advice banner messages to address such topics as:

## Section C: The State's Implementation Plan

- Location of HIT information on the Department's website and how to register with the Department's listserv that the Department uses to make announcements and provide information on a weekly basis;
- Medical Assistance incentive payment process and links– the R&A, getting an NPI, requirements to be a Medical Assistance-enrolled provider, registering with the MMIS Provider Portal, pre- and post-pay review updates and updates as needed ;
- Inform provider how to begin the application process with Pennsylvania Medical Assistance once they have successfully registered at the R&A as well as the importance of providing an email address at the R&A and two email addresses in the MAPIR application for communication purposes; and
- Continue to issue messages and other materials to inform providers of changes to the application and attestation process in the six years of participation including multiple stages of Meaningful Use attestations and flexibility options.

As part of the communications process and strategy, the Department will continue to meet with provider groups both through the MAAC HIT workgroup and individually. These groups include the Pennsylvania Medical Society, the Pennsylvania Association of Community Health Centers, the Pennsylvania Chapter of the American Academy of Pediatrics, the Pennsylvania Academy of Family Physicians, and the Hospital and Health System Association of Pennsylvania.

In addition, Pennsylvania's Regional Extension Center (REC) was approved for federal funds under ARRA in April 2010, and the Department is collaborating with the REC to perform Medical Assistance provider outreach and education activities. For example, the REC held a series of regional meetings to educate providers about the EHR Incentive Program in which the Department and the REC discussed the EHR Incentive Program and how to access the technical support of the REC. As part of the Department's work with the CHIPRA grant program, the REC had also been engaged with CHIPRA grantees to assist when needed with their EHR implementations.

From the inception of the program until the end of 2014, the Department disbursed more than \$143,947,681 in incentive payments to 9,072 Eligible Professionals and \$161,297,790 to 332 Eligible Hospitals totaling \$305,245,471. Payment amounts are updated weekly for professionals and hospitals and available at [www.PAMAHealthIT.org](http://www.PAMAHealthIT.org) . There continues to be a great deal of interest in the EHR Incentive Program and the Department continues to field numerous questions from providers, consumer advocates, other state agencies, and other stakeholders. Many of the questions raised to the Department are a result of misinformation, conflicting information, or a simple lack of information; hence it is important that we continue to work with CMS and ONC to minimize the opportunity for misinformation as well as inconsistent information. The Department believes that a communications

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plan with consistent messages and multiple venues for information distribution helps to raise provider awareness, understanding, participation, and helps to retain providers in the incentive program and have them continue to be Meaningful Users. To ensure that all educational materials are accurate and communicate a uniform message, the MA HIT Initiative operations team has developed and will continue to update and/or approve provider education and outreach materials in coordination with the other bureaus and offices in the Department, the REC, CMS, and ONC, and others.

In terms of materials related to adoption and Meaningful Use of EHRs adoption the Department will continue to work with its partners such as the RECs and the Federally-funded National HIT Research Center to gather existing materials and tools that describe model practices and provide background and provide technical assistance on adoption, implementation, upgrade, and Meaningful Use of EHRs. Team members from the Department attend Community of Practice calls and review materials available on the CMS Technical Assistance website to keep up-to-date on CMS guidance and to distribute the most recent information to providers and stakeholders.

In addition to the materials and partner entities described above, providers are able to obtain information about the Pennsylvania EHR Incentive program via the Department website, the Pennsylvania's MMIS provider internet portal, and through the Department's EHR support center. The Department developed an EHR support center to allow providers and other stakeholders to pose questions about the Medical Assistance EHR Incentive Program. An inquiry database was designed to track and report information about EHR Incentive Program-related inquiries, e.g., reasons, provider information, and resolution. We have created over 5400 Inquiries since the inception of the database. These inquiries include multiple contacts per inquiry and there may be additional inquiries that were responded to but not entered into the database. The information the Department is gathering from provider inquiries e.g., to gain a sense of how many providers will continue to apply for payments, will help with future administration of the EHR incentive program. The Department has also developed survey tools to assess the ease in using MAPIR and provider understanding of the EHR Incentive Program.

In the case of materials for Medical Assistance recipients, the Department is coordinating with CMS and ONC as part of their efforts to educate recipients. The Department participates on the Authority Communications Workgroup which is helping to develop a communications strategy for providers, patients, and payers on the value of eHIE and to address privacy and security concerns. The Department also continues to engage the members of the MAAC to review and provide feedback on the materials as they relate to consumers. The Department has created a Best Practices Focus Group that meets regularly to discuss important program topics and then share the information with the other providers and hospitals. The Department has also designed a Provider Experience Day where representatives from key organizations come to the office to test the MAPIR system prior to an important release. This group provides feedback that is then shared with other provider groups and hospitals.

***Step 2: Providers enroll in the CMS Registration and Attestation System (R&A) (Response to Questions #1, 16, 17)***

## Section C: The State's Implementation Plan

Before the provider can apply to participate in the program and receive their first EHR incentive payment, the provider must enroll at the R&A. The goal of the R&A is to ensure that there are no duplicate or improper payments resulting from providers switching among state Medical Assistance EHR Incentive Programs or between Medical Assistance and Medicare (applies only to eligible professionals; hospitals however can receive both Medical Assistance and Medicare incentive payments). The Department created the **MAPIR** system in collaboration with a number of other state Medicaid agencies to interface with the R&A. There are currently 13 states participating in the MAPIR Collaborative. The R&A collects from providers the types of information listed below:

- NPI: National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System)
- CCN: Provider number (for hospitals)
- Payee NPI: National Provider Identifier of the entity receiving payment (EPs)
- Payee TIN: Taxpayer Identification Number that is to be used for payment
- Personal TIN: Personal Taxpayer Identification Number (EPs)
- Program Option: Eligible Professional's choice of program to use for incentives. Valid values include Medicare or Medical Assistance. For hospitals, a selection of Dually Eligible is available.
- State: The selected State for Medical Assistance participation
- Provider Type: Differentiates types of providers as listed in HITECH legislation
- Email address of applicant
- Certified EHR Technology number (optional)

The R&A also interfaces with other sources of provider information including the Medicare Exclusions Database which helps to identify providers who are ineligible due to exclusions or sanctions.

Providers are not required to go back to the R&A in order to receive future payments. However, providers may go back to the R&A and update their information. When providers update their R&A information MAPIR will receive and updated B6. The updated B6 will be evaluated to ensure the provider is still eligible to participate in the program. In the event the provider cancels their R&A information MAPIR receives a cancel B6 transaction and the provider may not apply for future incentive payments.

The Department will issue outreach materials to make sure that providers are aware of the process for applying for incentive payments in payment years 2 and beyond.

Pennsylvania will allow a 90-day grace period or attestation tail, for hospitals and professionals; after the end of the federal fiscal year for hospitals and calendar year for professionals. The grace period may be expanded due to program requirements. In such cases the state will supply CMS with reasoning for an extended grace period. Upon approval by CMS the state will communicate with all provider and change the grace period in MAPIR.

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### ***Step 3: The R&A provides information to the Department through MAPIR interfaces about providers who have applied for the incentive program (Response to Questions #14, 18, 20)***

Step 3 describes the Pennsylvania Medical Assistance EHR Incentive Program application process. Applicants must register with CMS at the CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System (also known as the R&A) website (<https://ehrincentives.cms.gov/hitech/login.action>) to apply for and receive their first EHR incentive payment. For future payments, providers do not need to register at the R&A unless the information that they initially provided at the R&A has changed. When providers change information the updated information will be sent by CMS via the NLR to MAPIR. In the event the provider cancels their registrant CMS will again use the NLR to notify the state and MAPIR will change the provider to ineligible.

The Department, and in particular the Bureau of Data and Claims Management, designed MAPIR to track and act as a repository for information related to payment, applications, attestations, auditing, appeals, oversight functions, and to interface with CMS' R&A. The MAPIR system is used to process most of the stages of the provider application process including:

- Interfaces to the R&A
- Provider Applicant Verification
- Provider Applicant Eligibility Determination
- Provider Applicant Attestation
- Provider Application Payee Determination
- Application Submittal Confirmation/Digital Signature
- Payment Determination (including R&A confirmation)
- Payment Generation

The Department designed MAPIR to gather information from existing sources on the provider during the application process in a manner that reduces burden for the applicant. The Pennsylvania Medical Assistance EHR Incentive Program Eligible Professional Provider Manual and Eligible Hospital Provider Manual are resources designed by the Department for providers who wish to learn more about the Pennsylvania Medical Assistance EHR Incentive Program including detailed information and resources on eligibility and attestation criteria, as well as instructions on how to apply for incentive payments. The provider manuals also provide information on how to apply to the program via the Medical Assistance Provider Incentive Repository (MAPIR), which is the Department's web-based EHR Incentive Program application system. As the program evolved since inception, MAPIR has been enhanced to meet the new program requirements. MAPIR has been enhanced to accept 2013 Meaningful Use measures, 2014 stage 1 and stage 2 and finally the Program Year 2014 flexibility changes.

The MAPIR application was added to the existing MMIS Enterprise architecture. Providers can access MAPIR through Pennsylvania's secure MMIS provider internet portal, PROMISe™: <https://promise.dpw.state.pa.us/portal/>. To access MAPIR via the PROMISe™ internet portal, the user

## Section C: The State's Implementation Plan

must first be an enrolled Medical Assistance provider. To enroll as a Medical Assistance provider, applicants must complete the Medical Assistance enrollment process.

Additionally, once a provider incentive application is approved for payment, payments are generated through the financial system. This allows the Department to leverage current financial transactions, including payment via check or EFT, remittance advice notifying the provider of payment, and 1099 processing. Communication via file transfer protocol (FTP) is performed with the R&A.

In addition to the provider interface, MAPIR has interfaces which Department staff use to review and process provider applications and attestations. For example, Department users are able to attach notes to the MAPIR application, attach documents to provider records, track application and decision status, disseminate provider correspondence via email and generate reports. In addition, providers have access to current and completed applications in MAPIR.

Each year additional funding has been used to enhance MAPIR to meet CMS and other regulatory requirements. To date, MAPIR has been enhanced quarterly to meet new NLR transaction requirements, Meaningful Use measures changes in Program Year 2013 and Program Year 2014, the annual update to CQMs and the Program Year 2014 Flexibility changes. Additional funding will be required to maintain the quarterly NLR updates, the NPRM for Program Year 2015, Stage 3 Meaningful Use Measures, annual CQM updates and unknown future changes.

The initial costs of developing the business requirements for MAPIR were included in the P-APD and the Department submitted both MMIS and HITECH sections of the I-APD for the MAPIR implementation costs. The MMIS section of the I-APD included Pennsylvania's share of the costs of the "core" MAPIR system that all states in the MAPIR Collaborative use and also Pennsylvania's costs for the "custom" Pennsylvania-specific MAPIR features. Each state in the MAPIR Collaborative splits the total costs of developing the MAPIR core system and applies for 90 percent enhanced match from CMS for their share. The custom interfaces that need to be implemented by each state are also be reimbursed at 90 percent federal match. Implementation costs associated with federal fiscal years 2015 and 2016 system modifications are described in Appendix A of the HIT I-APD.

## Section C: The State's Implementation Plan

### ***Step 4: MAPIR runs edits on information from R&A to determine which providers to contact for the application process (Response to Questions #1, 15, 16)***

Not all applications received by CMS via the NLR will meet the incentive program requirements. Those providers that do not meet program requirements are placed on a report and are not allowed immediate access to MAPIR. A MAPIR report is reviewed and the providers are advised the reason they do not have access to MAPIR. Providers that do not meet eligibility requirements will be asked to go back and re-apply at the R&A. For example, providers must be enrolled as Medical Assistance providers without disqualifying sanctions or exclusions in order to qualify for the EHR Incentive Program. Providers who are not enrolled are required to enroll with Medical Assistance prior to accessing MAPIR, (see response to Question #3 above). Information on the Department's website ([www.PAMAHealthIT.org](http://www.PAMAHealthIT.org)) instructs providers that they must be enrolled and how to do so. Likewise, enrolled providers that do not meet the eligible provider type (Physician, Dentist, Hospital, etc.) on the MMIS enrollment file cannot access MAPIR and are directed to the Department for assistance.

Upon receiving information from the R&A, MAPIR performs format edits (e.g., Tax ID is numeric and nine digits, CMS Certification Number is six digits, State code is PA, program type is Medical Assistance/Medicaid, duplicate checking) in addition to determining whether the provider is on the MMIS Provider file.

Upon enrollment, provider data is compared to State and Federal databases including, but not limited to Pa Department of State and Department of Health license files, the Social Security Administration's (SSA) Death Master File (DMF), Office of Inspector General (OIG) and General Services Administration's (GSA) sanctions through the OIG System of Award Management (SAM) Excluded Parties List System (EPLS) and the MED Exclusions database which includes the OIG List of Excluded Individuals and Entities (LEIE) as well as the monthly thereafter (currently in the process of implementing automated monthly checks) as well as the CMS Provider Enrollment, Chain and Ownership System (PECOS) database. If applicable sanctions are discovered, the provider is not permitted to enroll or would be appropriately dis-enrolled and therefore prevented from completing a MAPIR application or HIT incentive payment processing.

If the enrolled provider has a valid logon ID and provider type, MAPIR performs an automated check based on the NPI number associated with the logon ID or any service locations associated with that logon ID to find a match on an R&A record. If a match is found, the provider has been verified and can begin the application process, but if no match is found then the provider is placed on a MAPIR report and is contacted as necessary to resolve the reason why the provider cannot access MAPIR.

If a provider does not pass the MAPIR eligibility requirements, then the application is placed on a MAPIR report called the 'Mismatch Report.' The report is reviewed for possible actions as listed below:

- Refers providers back to the R&A for errors on data provided at the R&A, e.g., incorrect Payee Tax-ID;

## Section C: The State's Implementation Plan

- Refers non-participating Medical Assistance providers to the Office of Medical Assistance Provider Enrollment for assistance with program enrollment;
- Resolves discrepancies between the provider type entered at the R&A and the provider type stored in the MMIS, e.g., non-HITECH provider type in MMIS as well as NPI/Payee Tax-ID combinations that are not present in the MMIS.
- Assists providers in completing enrollment applications, enrolling/participating in Pennsylvania Medical Assistance; and,
- Ensures that providers have valid pay-to and fee assignments on the Pennsylvania Medical Assistance provider file that align with the information from the R&A.

If eligibility requirements are passed, then the provider proceeds to Step 5. If eligibility requirements are not passed then the provider will be contacted to explain the reason for the suspension (e.g., provider not enrolled, etc.) and who to contact to discuss corrective action. The Department will work with those whose applications have been suspended to make every effort to resolve inconsistencies and errors before cancelling the application.

If the provider passes the MAPIR eligibility requirements in Step 4, applicants will be able to refer to information on the Department's website about how to access the MAPIR application through the PROMISE™ Provider Portal. Providers who do not pass the eligibility requirements in Step 4 will not be able to access MAPIR. There is educational material and information on how to access MAPIR available on the Department's website (including Quick Tips) and on Pennsylvania's MMIS provider internet portal. The Department's EHR support center responds to inquiries about the EHR Incentive Program and triages inquiries as appropriate, e.g., to the Department's website or to subject matter experts to make sure those questions are answered accurately, consistently, and in a timely manner.

### ***Step 5: Providers submit application in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, and 26)***

Providers may obtain information about the application process via the Department's EHR support center, the Department's website, the weekly ListServ messages, webinars, provider experience days, best practices focus groups and other education and outreach materials. The Department has developed accompanying guides for the MAPIR system to walk applicants through the application and attestation process. The accompanying guides explain that eligible professionals must attest to Medicaid patient volume by using the individual methodology or group proxy methodology. The Department verifies that EPs are currently and actively seeing Medical Assistance recipients (or needy individuals if the EP practices predominately in a FQHC or RHC) by reviewing claims history for the EP. MAPIR has the capability to suspend and deny applications based on system logic and has been

## Section C: The State's Implementation Plan

enhanced to meet eligibility updates. After the application is submitted by the provider, MAPIR accesses PROMISE™ and determines the number of claims or encounters for the volume period the provider entered on their application. In addition, MAPIR runs a program to check for hospital-based place of service indicators. This data is then used to validate the providers' eligibility. Providers not meeting volume eligibility are contacted via email to supply additional information. Based on provider supplied documents a decision is made if the provider has met the applicable program requirements.

The Department also uses the Pennsylvania Medicaid Hospital Cost Reports as a primary data source when evaluating an EH's incentive payments because the reports align with the incentive calculation data elements as well as the required timeframes described in the initial and updated Final Rules. The Department assists providers with the application process through the use of provider manuals that can be found on the Department's website. These provider manuals include MAPIR screen shots and there are "hover bubbles" within the MAPIR application that a provider can hover on to obtain additional instructions and information during the application process. For example, there are hover bubbles over the patient volume questions to describe the requirement and how to complete this section. Providers also receive notifications while in MAPIR that alert them if they enter invalid values in a field or do not complete a required field.

MAPIR captures the information submitted during the application and attestation process. MAPIR is designed to allow user applicants to save the partially-completed application, exit the system, and return later to complete the form. If a record is suspended in MAPIR, the provider is instructed to contact the MA Health Initiative team for assistance, in order to resume the application process. The eligible professional and eligible hospital provider manuals give a more detailed explanation of the MAPIR application process. The provider manuals can be found here at [www.PAMAHealthIT.org](http://www.PAMAHealthIT.org) under the MAPIR resources section. Please see Appendix III for additional information.

### ***Step 6: The Department reviews pended provider application and attestation and determines eligibility or addresses reasons for suspension (Response to Question 22)***

The MAPIR system includes a series of "hover bubbles" and validation messages to help applicants submit a complete and accurate application. Both hover bubbles and validation messages are configurable and have been updated to meet new program requirements. As applicants move through the various screens, MAPIR displays key information about completing each tab through information pages which display details about what is needed to complete the fields in the tab and guidance on what to include in the response. The provider manuals provide screen-by-screen guidance on applying in MAPIR.

Once the provider has completed the application and attestation, MAPIR provides a list of applicants that have completed the MAPIR application and the Department uses this list to begin the pre-payment eligibility determination review process. Applicants can withdraw their applications and attestations through cancelling the application at the R&A or by aborting the application in MAPIR up to the point when the Department sends the applicant's information to the R&A for an EHR incentive payment.

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MAPIR Operations reviews applications submitted in MAPIR to review volume eligibility, validate that provider has adopted, implemented, upgraded to or is meaningfully using an EHR system that is a certified product, and hospital incentive amount prior to making incentive payment. If an issue with the application is identified in the pre-payment eligibility process, an inquiry is sent to the MA HIT initiative staff who notify the designated applicant contact via an email that includes the issue that has been identified and information on how to contact the EHR support center to resolve the issue.

The Department's goal is to review applications, any additional information, and make a decision about applicant's eligibility, within six weeks of receiving an application. However, the process of working with providers on suspended applications and the high volume periods we experience, it will take longer than six weeks. Department team members communicate with providers by phone and email as necessary to direct applicants to education materials and to resolve any issues.

Initially the Department manually processed applications, but the application process has been improved. A report of all pending application data elements are downloaded weekly into an Excel spreadsheet. The spreadsheet is designed to review data elements in the application to ensure minimum requirements are met. The Department then reviews each application and reaches out to the provider for more information or to initiate the payment process. A historical database of the application review is maintained.

Once the Department has reviewed the application and gathered additional information, the provider either receives notification that his/her application has been approved and proceeds to step 10, or move to step 7 in the case of a denial.

### ***Step 7: The Department denies provider's application (Response to Questions #1, 22)***

Once the review is complete, the Department sends email correspondence via MAPIR to providers who do not appear to be eligible for an incentive payment indicating a "finding" of not eligible which describes the reason why the provider does not appear eligible and describes appeal rights. Providers have up to 33 days to file an appeal with the Bureau of Hearings and Appeals. The applicant is directed to send a copy of the appeal to the EHR Incentive Program. The Department informs CMS of the denial and provides a reason code for each denial. Appeals related to this program are processed like all other provider appeal issues.

Providers have the right to appeal certain Department decisions related to the Medical Assistance EHR Incentive Program. Examples of appeal reasons include, but are not limited to, the following:

- Applicant is determined ineligible for the EHR Incentive Program;
- Applicant has received an overpayment for the EHR Incentive Program; or,
- Appeal of incentive payment amount, (e.g., pediatrician or hospital payment).

## Section C: The State's Implementation Plan

### ***Step 8: Provider application clears MAPIR system edits and MAPIR generates approval email with program information to provider (Response to Question #4)***

MAPIR displays the entire completed application, including confirmation of information entered at the R&A, for confirmation by the applicant prior to the application being submitted.

MAPIR displays instructions for printing the summary information along with Department contact information regarding application inquiries. MAPIR also generates correspondence to the provider indicating that the application is complete and pending final review with the R&A, and the provider is notified of the payment status. Providers have access to all of their applications that have been processed in Pennsylvania's MAPIR system.

### ***Step 9: MAPIR interfaces list of providers who pass edits to CMS' R&A for final confirmation (Response to Questions #1)***

Payments cannot be made until the application is error free and submitted to the R&A for final duplicate and sanction/exclusion verification. Once the Department informs the R&A that a payment is ready to be made and CMS approves the payment, the R&A "locks" the record so that the provider cannot switch programs or states before the payment is issued.

### ***Step 10: The Department sends approval email to provider with program and payment information (Response to Question #4)***

MAPIR sends correspondence via email to the provider applicant notifying the provider that the application has been approved, and an EHR incentive payment will be issued to the provider or assignee. The correspondence includes information about the estimated timing of the payments.

### ***Step 11: MMIS issues payment and MAPIR submits payment information to the R&A (Response to Questions #24, 25)***

MAPIR issues a remittance advice and makes the incentive payment using a gross adjustment. A unique gross adjustment reason code is generated and payments are processed with the weekly Medical Assistance Financial Cycle. The payment method (paper, electronic funds transfer (EFT)) is driven by the information used for claims payment on the provider enrollment file. A remittance advice provides information on the incentive payment that has been made. Upon completion of the payment cycle, the MMIS returns payment data to MAPIR. MAPIR generates a payment transaction including pay information to the R&A on a weekly basis). The provider applicant/payee (to whom the payment is assigned) combination must be valid in the MMIS in order to make payment.

The Department payment schedules are consistent with program regulations are discussed in more detail in the provider manuals located at [www.PAMAHealthIT.org](http://www.PAMAHealthIT.org) under the MAPIR resources section.

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Using the MAPIR system in combination with establishing processes for reviewing applications and attestations and generating reports showing the status of a given application allows the Department to make timely provider incentive payments. The Department anticipates making payments to EPs within 30 days of their application approval date and within five weeks of the application completion date for hospitals depending on whether or not additional outreach to the hospital, or information from the hospital, is necessary to approve application.

### ***Step 12: Post-payment oversight and outreach activities (Response to Question #3, 6 – 8, 26)***

As described in the above steps, the MAPIR system reviews eligibility requirements which help the Department conduct payment oversight at the point of application and attestation. Section D describes the Department's proposed post-payment oversight activities in detail, but, in short, the Department's oversight efforts focus on two distinct areas: 1.) provider eligibility through pre-payment auditing, 2.) post-payment auditing to ensure proper payment, adoption, implementation and upgrade, and Meaningful Use of certified EHRs.

The Department has identified areas of risk in the eligibility determination process and is using this information to design studies and application and payment reviews that will help to mitigate the risk of making an improper payment. For example, the Department is conducting regular audit studies to review information submitted in attestation forms and from other areas, e.g., validating the use of a certified product, Meaningful Use information, patient volume, FQHC/RHC predominantly practice attestations, and assignment of payments. The Department understands the programmatic risks of improper payments and will continue to conduct measures and studies to mitigate these risks.

### ***Step 13: Ongoing technical assistance for adoption, implementation, upgrade and Meaningful Use of EHR (Response to Questions #8, 9)***

Given the history of suboptimal EHR implementations across the nation, the Department is aware that having the incentive payments may motivate providers to begin the adoption process, but the incentive payments alone are not sufficient for successful Adoption, Implementation, Upgrade and Meaningful Use of certified EHRs. Using the same communications strategy as described in Step 1, the Department is considering collaborating with partners and organizations that can provide technical assistance and other resources to educate providers about the EHR Incentive Program and also to provide technical assistance and information on EHR Adoption, Implementation, Upgrade, and Meaningful Use of certified EHRs.

In addition to reviewing providers who return for additional payments, the Department will generate reports of providers who do not apply for year 2 and beyond incentive payments and target these providers for technical assistance through the REC or other means. Encouraging providers to return for future payments and thus become Meaningful Users is an important goal for the Department and will be included as a program evaluation metric in Section E.

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For example, PA REACH has collaborated closely with the Department's OMAP HIT Coordinator for over 4 years to ensure that providers could run reports to verify that they have the 30% volume (20% for pediatricians). Staff is on site with EPs to produce the reports needed for the core and menu reporting requirements. PA REACH has cooperated with the Department to work with practices to provide any audit documentation, for those identified for audit. Many times, questions and issues arise related to MU. The Department and PA REACH have worked closely together to answer provider questions, address eligibility issues, and work together to resolve issues. The REC has a reciprocal relationship with the Department for dissemination of information. The OMAP HIT Coordinator will include pertinent REC information in the OMAP weekly email, and the REC includes information regarding the Medicaid incentive program in its weekly e-blast to its REC providers. The Executive Director and Director participate in the Best Practices group meetings, and share information gained during those meetings with staff and providers around the state. Going forward, we will continue to work closely with the Department to support new initiatives. The Executive Director also participates with the OMAP HIT Coordinator in a monthly meeting with key stakeholders around the State. The REC will be applying for a no cost extension (NCE) from ONC, and has already asked the Department to identify Behavioral Health sites and PCPs that may be in need of assistance implementing and meaningfully using EHRs through April 2016. The OMAP Coordinator provides regular reports for AIU to the REC to help and identify potential sites for assistance.

### ***Step 14: Notification of Meaningful Use requirements for Year 2 and beyond (Response to Questions #10 – 12)***

There have been significant changes to the program since the inception in 2011. Because of the frequent changes to the program a MAPIR Change Management Committee and Workgroup has been formed. The CMC and workgroup consist of other member states of the collaborative. Both groups meet weekly to review proposed and new CMS requirements. Changes to MAPIR are developed to meet new requirements. Since inception there have been many changes including; Stage, Flexibility, CQMs, MU Requirements and more.

In addition, the Department is working in partnership with the Authority and REC to identify the correct point in the EHR adoption process to start a conversation with the provider regarding eHIE. Ultimately, the Department will notify the Authority of providers who reach this milestone. The Authority will then reach out to provide information regarding eHIE and offer assistance to the provider in selecting an HIO that aligns with their requirements, preferably an HIO that received onboarding grant money to build an interface to the EHR system being used by this provider. The Authority will also inform both the provider and their selected HIO of any incentive or subsidy programs currently available to help enroll the provider in the HIO.

### ***Step 15: Meaningful Use payment request or renewal (Response to Questions #9, 12, 13)***

The Department will allow eligible professionals to attest to Meaningful Use after the first program year (2011) and will accept hospital Meaningful Use attestations if these hospitals are dually eligible for

## Section C: The State's Implementation Plan

Medical Assistance and Medicare EHR incentive programs and are deemed Meaningful Users under Medicare by CMS. The Department has been continually enhanced since the inception of the program. Additionally, the updated MAPIR system includes the most recent list of federally-certified EHR systems to ensure that providers continue to acquire and use federally-certified systems. The MAPIR system performs a real time call out to ONC to ensure the provider is using a certified EHR system. Then, providers are required to show proof of ownership of a certified EHR system that matches their application prior to payment.

In the first two years of the EHR Incentive Program, the Department anticipated that MAPIR would be sufficient to collect and store the information needed to process eligibility and make payments. The Department anticipated that it would need to build or contract for a new data store in future years as the Meaningful Use criteria progresses past attestations and requires more sophisticated data fields and storage volume to process clinical quality measures. This is being done with the Super Extract report currently. In addition to leveraging eHIE, the Department also hopes to leverage the resources and knowledge from its CHIPRA grant. The Department's CHIPRA grant has three components:

1. **Testing and reporting on the pediatric core measures of quality:** The Department will work with seven health systems that provide pediatric care to focus on improving the quality of care through the adoption of health information technology.
2. **Promoting the use of HIT in children's healthcare delivery:** The Department will work to improve the quality and coordination of care for children with special health care needs who are covered by the Medical Assistance and CHIP programs through the use of HIT.
3. **Demonstrating the impact of the CMS model format pediatric EHR:** The Department will work with five health systems to implement and evaluate the impact of a model format pediatric EHR provided by CMS and AHRQ.

There are numerous ways to leverage the CHIPRA grant activities and resulting lessons learned to promote EHR adoption and Meaningful Use. For example, the seven CHIPRA grantees have electronically extracted and reported quality data from the CMS/AHRQ pediatric core measures to the Department. The Department is planning to leverage the information exchanged through the P3N to facilitate this process of extraction and reporting and take those lessons learned to providers in the EHR Incentive Program. In addition, the CHIPRA model format pediatric EHR will be used to understand the necessary functionalities to use HIT to improve children's health. Lessons learned from the pediatric EHR testing will be available to all EHR system vendors which may enhance EHR functionality. Providers will also have an easier time meeting Meaningful Use if EHR systems have better functionality; in this case, better functionality will allow Pennsylvania Medical Assistance providers to meaningfully use EHRs for children and improve patient outcomes and care.

The Department is also working closely with the Department of Health and the Authority to help providers meet, via the PHG, public health Meaningful Use requirements related to reporting to and

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interfacing with the immunization registry, syndromic surveillance system, and electronic lab reporting. The Departments of Human Services and Health will:

- Assist providers to meet Meaningful Use requirements;
- Identify and quantify level of support needed to help “on-board” providers to immunization registry, syndromic surveillance system and electronic lab reporting;
- Identify providers that have submitted information electronically to immunization registry, syndromic surveillance system and electronic lab reporting and;
- Identify and publicize list of EHR systems.

***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 payment) without any deduction or rebate? (Response to Questions #23)***

When an Eligible Professional registers at the CMS R&A website, the EP chooses who should receive the payment. When the R&A details are sent to PA, the information is matched against our MMIS (PROMISE™) System. If the EP assigned the payment to another entity, then there needs to be an active fee assignment to that entity in order to proceed with that application.

Payments cannot be made until the application is error free and the D-16 NLR transaction is submitted to the R&A for final duplicate and sanction/exclusion verification. Once the Department informs the R&A that a payment is ready to be made and CMS approves the payment, the R&A “locks” the record so that the provider cannot switch programs or states before the payment is issued.

If at any time during the application process, the Fee Assignment becomes inactive, the application process will automatically stop. The process will not continue again until the Fee Assignment becomes active again.

Pennsylvania's MMIS (PROMISE™) makes the incentive payment using a gross adjustment and issues a remittance advice to the provider or assigned payee. A unique gross adjustment reason code is generated and payments are processed with the weekly Medical Assistance Financial Cycle. The payment method (paper, electronic funds transfer (EFT)) is driven by the information used for claims payment on the provider enrollment file. A remittance advice provides information on the incentive payment that has been made. Upon completion of the payment cycle, the MMIS returns payment data to MAPIR. MAPIR generates a payment transaction including pay information to the R&A on a weekly basis). The provider applicant/payee (to whom the payment is assigned) combination must be valid in the MMIS in order to make payment.

The full payment will show on the remittance advice and will be made. The only time that an EHR incentive payment would be reduced is if the EP has public debts under a collection mandate.

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Also, per the guidance from CMS, we follow this guideline in response to the provision requiring that the incentive be paid “without deduction or rebate” allowing us to offset mandatory public debt collection (e.g., wage garnishment and claims overpayments) with the incentive. Per CMS: The requirement that the incentives be passed to providers without deduction or rebate refers to requiring that the State not use the incentive payment to pay for its own program administration or to fund other State priorities. However, where there are public debts under a collection mandate, CMS considers the incentive as paid to the provider, even when part or all of the incentive may offset public debts. States should apply the same process that they use for other payments to providers in order to recoup public debts.

***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 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?  
(Response to Questions #24)***

When an Eligible Professional registers at the CMS R&A website, the EP chooses who should receive the payment. When the R&A details are sent to PA, the information is matched against our MMIS (PROMISE™) System. If the EP assigned the payment to an entity, then there needs to be an active fee assignment to that entity in order to proceed with that application.

The provider, through their EHR incentive program attestation, confirms that he or she is receiving the EHR incentive payment as the payee or assigned the incentive payment voluntarily to the selected payee and that the provider has a contractual relationship that allows the assigned employer or entity to bill for the providers services

Payments cannot be made until the application is error free and submitted to the R&A for final duplicate and sanction/exclusion verification. One of the components of the pre-pay process is to validate the EP and/or EH is either Adopting, Implementing, Upgrading or Meaningfully Using a Certified EHR System. As part of the pre-pay process, documentation is required to validate that a Certified EHR System is being (or is in the process of being) utilized with the understanding the incentive money is used to off-set costs incurred with this system. The review process does not proceed until the appropriate documentation has been received.

Once the Department informs the R&A that a payment is ready to be made and CMS approves the payment, the R&A “locks” the record so that the provider cannot switch programs or states before the payment is issued.

If at any time during the application process, the Fee Assignment becomes inactive, the application process will automatically stop. The process will not continue again until the Fee Assignment becomes active again.

Pennsylvania's MMIS (PROMISE™) makes the incentive payment using a gross adjustment and issues a remittance advice to the provider or assigned payee. A unique gross adjustment reason code is

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generated and payments are processed with the weekly Medical Assistance Financial Cycle. The payment method (paper, electronic funds transfer (EFT)) is driven by the information used for claims payment on the provider enrollment file. A remittance advice provides information on the incentive payment that has been made. Upon completion of the payment cycle, the MMIS returns payment data to MAPIR. MAPIR generates a payment transaction including pay information to the R&A on a weekly basis). The provider applicant/payee (to whom the payment is assigned) combination must be valid in the MMIS in order to make payment.

Also, per the guidance from CMS, we follow this guideline in response to the provision requiring no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption **Q: EHR Incentive Programs] What safeguards are in place to ensure that Medicaid electronic health record (EHR) incentive payments are used for their intended purpose? A:** Like the Medicare EHR incentive program, neither the statute nor the CMS Stage 1 final rule dictate how a Medicaid provider must use their EHR incentive payment. The incentives are not a reimbursement and are at the providers' discretion, similar to a bonus payment. For more information about the Medicare and Medicaid EHR Incentive Program, please visit <http://www.cms.gov/EHRIncentivePrograms>.

Keywords: FAQ9959 (FAQ2711)

***What will be the process to assure that there are fiscal arrangements with the providers to disburse incentive payments through Medicaid managed care plans does not exceed 105% of the capitation rate per 42 CFR Part 438.6 as well as a methodology for verifying such information? (Response to Questions #25)***

When the final approval is received from CMS, Pennsylvania's MMIS (PROMISe™) makes the incentive payment using a gross adjustment and issues a remittance advice to the provider or assigned payee. A unique gross adjustment reason code is generated and payments are processed with the weekly Medical Assistance Financial Cycle. The payment method (paper, electronic funds transfer (EFT)) is driven by the information used for claims payment on the provider enrollment file. A remittance advice provides information on the incentive payment that has been made. Upon completion of the payment cycle, the MMIS returns payment data to MAPIR. MAPIR generates a payment transaction including pay information to the R&A on a weekly basis). The provider applicant/payee (to whom the payment is assigned) combination must be valid in the MMIS in order to make payment. The payments are not done through the Medicaid Managed Care Plans therefore we do not have controls in place to make sure the payment does not exceed 105% of the capitation rate.

***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? (Response to Questions #26)***

Providers may obtain information about the application process via the Department's EHR support center, the Department website, and other education and outreach materials. The Department has developed accompanying guides for the MAPIR system to walk applicants through the application and attestation process. The accompanying guides explain that eligible professionals must attest to

## Section C: The State's Implementation Plan

Medicaid patient volume by using the individual methodology or group proxy methodology. The group proxy methodology is only appropriate for Medical Assistance enrolled providers who do not exclusively see only Medicare, Commercial or self-pay patients and therefore are currently and actively seeing Medical Assistance recipients. The Department will verify that EPs are currently and actively seeing Medical Assistance recipients (or needy individuals if the EP practices predominately in a FQHC or RHC) by reviewing claims history for the EP. MAPIR has the capability to suspend and deny applications based on system logic. The Department is utilizing existing Commonwealth data sources to validate information submitted by providers prior to making an incentive payment such as meeting patient volume threshold and hospital based status. The Department will consider hospital based EP's eligible for an incentive should they meet the requirements outlined in the updated final rule (September 4, 2012). The process for the hospital based EPs to use for consideration for an incentive is described at [www.pamahealthit.org](http://www.pamahealthit.org). The Department also uses the Pennsylvania Medicaid Hospital Cost Reports as a primary data source when evaluating an EP's incentive payments because the reports align with the incentive calculation data elements as well as the required timeframes described in the initial and updated Final Rules. The Department assists providers with the application process through the use of provider manuals that can be found on the Department's website. These provider manuals include MAPIR screen shots and "hover bubbles" within the MAPIR application that a provider can hover on to obtain additional instructions and information during the application process. For example, there are hover bubbles over the patient volume questions to describe the requirement and how to complete this section. Providers also receive notifications while in MAPIR that alert them if they enter invalid values in a field or do not complete a required field.

Pennsylvania's MMIS (PROMISE™) makes the incentive payment using a gross adjustment and issues a remittance advice to the provider or assigned payee. A unique gross adjustment reason code is generated and payments are processed with the weekly Medical Assistance Financial Cycle. The payment method (paper, electronic funds transfer (EFT)) is driven by the information used for claims payment on the provider enrollment file. A remittance advice provides information on the incentive payment that has been made. Upon completion of the payment cycle, the MMIS returns payment data to MAPIR. MAPIR generates a payment transaction including pay information to the R&A on a weekly basis). The provider applicant/payee (to whom the payment is assigned) combination must be valid in the MMIS in order to make payment.

The Department payment schedules are consistent with program regulations are discussed in more detail in the provider manuals located at [www.PAMAHealthIT.org](http://www.PAMAHealthIT.org) under the MAPIR resources section.

***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 (Response to Questions #28)***

The Department is responsible for projecting the processes/education needed to address assumptions and timing of program updates.

## Section C: The State's Implementation Plan

- **Role of CMS:** The Department in conjunction with the 13 state collaborative, utilizes the CMS NLR when determining eligibility, during the entire application process, during the payment process, for post-payment processes and for the adjustment process. Providers are referred to the CMS Help Desk for issues specific to the Medicare EHR Incentive program and the Department will utilize the CMS Help Desk occasionally to assist a provider.
- **Status/Availability of Certified EHR Technology:** Based on the CMS Flexibility Rule, MAPIR was updated in January 2015 to allow providers to utilize the 2011 or 2011/2014 combination certification. After surveying the providers participating in the Medicaid EHR Incentive program, it was clear the 2014 Certified EHR systems were not fully implemented or able to provide the data the providers needed to attest to program year 2014. The Department provided guidelines and tools to the providers to assist them in understanding the flexibility rule and how it might benefit. The Department continues to monitor the provider participation and what Certified System is being utilized.
- **Role of the Regional Extension Center:** The Department continues to have meetings with PA Reach twice a month. PA Reach continues to work with the Medicaid providers and assisting them with meeting Meaningful Use. The Department also utilized PA Reach to be the liaison when there are questions and/or issues that arise with a provider that PA Reach is working with. The Department refers providers to PA Reach and they in turn encourage providers to participate in the EHR Incentive program.
- **Role/approved plans and status of the HIE cooperative agreements:** The Department works directly with the PA eHealth Partnership Authority (the Authority) on a number of HIE projects and a number of projects that are being proposed for the upcoming years. The Authority has received funding through the PA IAPD for On-boarding and Public Health Gateway projects that are being implemented in 2015. These projects and a number of new projects will continue to build on the relationship and to improve HIE tremendously in Pennsylvania.
- **State-specific readiness factors:** The Department continues to ensure the state funds and resources needed to support Pennsylvania's EHR Incentive Program and lead the 13 state MAPIR Collaborative is committed in the Commonwealth's budget.

## Section D: The State's Audit Strategy

### Section D: The State's Audit Strategy

This section responds to each of the questions listed in the CMS State Medicaid HIT Plan Template and provides an overview of OMAP's audit, controls and oversight strategy for the Department's EHR Incentive Program.

**Figure D.1: Section D Questions from the CMS State Medicaid HIT Plan (SMHP) Template**

<b>What will be the SMA's methods used to avoid making improper payments? (Timing, selection of which audit elements to examine pre or post payment, use of proxy payment, sampling, how the SMA will decide to focus audit efforts, etc.)</b>
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 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?

### ***Methods for detecting fraud and abuse, and monitoring payments (In response to Question # 1 and Question # 2)***

### **CMS Principles for Auditing and the Department's Review Criteria**

CMS provides basic principles for states to follow regarding their state's monitoring and auditing program. The keys to structuring concrete oversight operations are:

- Catch the obvious
- Focus on substantial non-compliance
- Employ smart risk-profiling
- Find the balance between cost of oversight and total incentive payment
- Find the balance between hi-tech and hands-on approaches
- Maximize existing/third party data sources where appropriate

## Section D: The State’s Audit Strategy

The Department is required to provide information to CMS outlining the processes and methodologies that it will use to ensure that payments are being made to the right provider, for the right reason. The Department’s oversight efforts will focus on two distinct areas: 1.) provider eligibility through pre-payment auditing, 2.) post-payment auditing to ensure proper payment, adoption, implementation and upgrade, and Meaningful Use of certified EHRs. For each of two areas, Table D.1 provides examples of criteria that the Department reviews and discusses examples of oversight efforts throughout this section. This has been updated based on the lessons learned from the three audit cycles already completed and in response to correspondence with our federal partners.

**Table D.1: Sample Provider Review Criteria by Oversight Area**

	Sample Criteria
<b>Provider eligibility through pre-payment auditing</b>	<ul style="list-style-type: none"> <li>• Provider is licensed, enrolled and participating Medical Assistance provider.</li> <li>• Provider is registered in CMS’ Registration &amp; Attestation System (R&amp;A).</li> <li>• Provider is choosing the Medical Assistance Program.</li> <li>• Provider meets hospital-based provider definition or meets criteria to claim hospital-based exclusion (professionals only).</li> <li>• Provider provides a continuous 90-day Medical Assistance encounter period in the previous hospital fiscal year (hospitals) or previous calendar year (professionals)</li> <li>• Provider meets Medical Assistance patient volume thresholds through comparison to Commonwealth’s claims data and cost reports.</li> <li>• Provider follows the Department’s Medical Assistance patient volume methodology, e.g., group practice or individual volume calculations</li> <li>• EPs practicing predominantly in FQHCs and RHCs meet relevant patient volume thresholds and rules.</li> <li>• EP is not participating in another state’s Medical Assistance EHR incentive program or the Medicare EHR Incentive Program</li> <li>• Provider meets non-sanctioned requirements.</li> <li>• Provider attests to multiple program eligibility requirements including that there was no coercion when assigning payments, if relevant.</li> <li>• Provider attests to adopt, implement, upgrade or Meaningful Use.</li> </ul>

	Examples of High Risk Areas for Review
<b>Post-payment auditing of high risk areas to ensure adoption, implementation and upgrade, and Meaningful Use of certified EHRs</b>	<ul style="list-style-type: none"> <li>• Providers with significant out-of-state Medical Assistance patient volume.</li> <li>• Providers with Medical Assistance sanctions from date of payment to at least one year prior.</li> <li>• All providers with Medical Assistance volume slightly above the minimum threshold.</li> <li>• Provider meets requirements for adopt, implement or upgrade, where applicable.</li> <li>• Provider meets the criteria for the appropriate stage of Meaningful Use, where applicable.</li> <li>• Pediatricians must meet the Department’s EHR Incentive Program definition of a pediatrician due to their ability to qualify for an incentive payment at a lower</li> </ul>

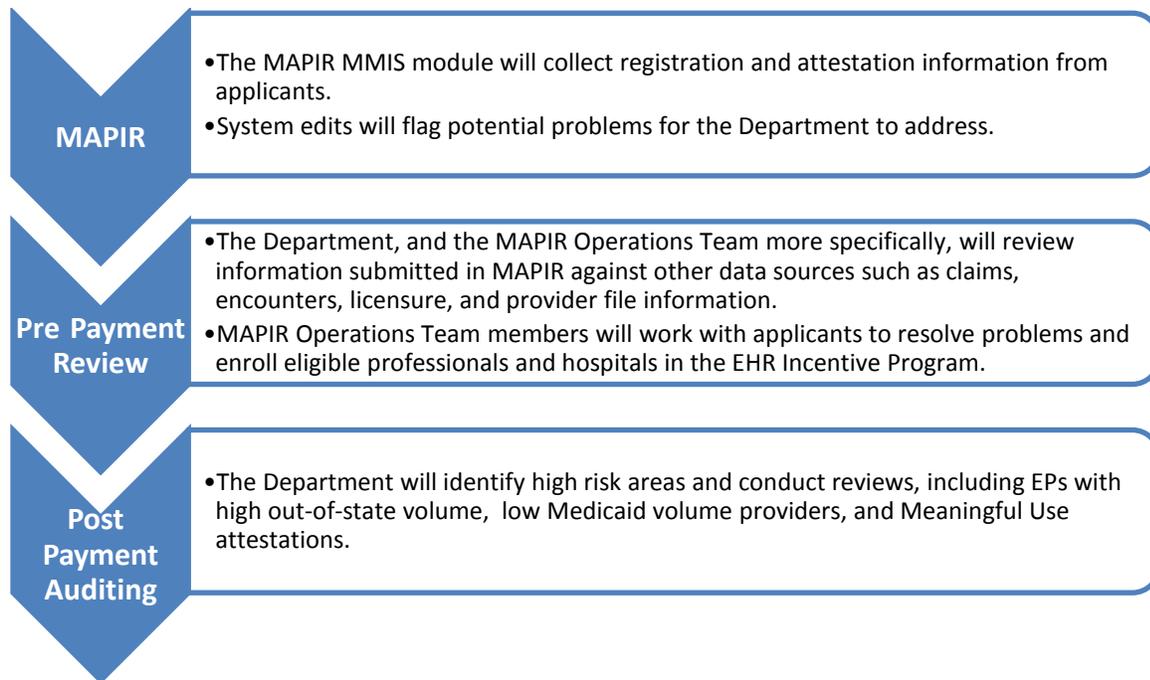
## Section D: The State’s Audit Strategy

	<p>patient volume threshold</p> <ul style="list-style-type: none"> <li>• Dentists; due to limited options for certified EHR systems.</li> <li>• Physician Assistants in a Physician Assistant-led FQHC/RHCs</li> <li>• Meaningful Use report outliers</li> </ul>
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### Overall Strategy

The Department has developed a multi-layered approach to auditing that is summarized in Figure D.2 below and is described in greater detail throughout this section.

**Figure D.2: Audit Process**



### Medical Assistance Provider Incentive Repository (MAPIR) Review Elements

The MA HIT Initiative and MAPIR Operations team is responsible for coordinating provider oversight for Pennsylvania’s Medical Assistance EHR Incentive Program. The MAPIR Operations team relies on information submitted through MAPIR that is verified against provider information maintained in the MMIS. Section C describes the MAPIR registration and attestation process. Information such as licensure, patient volumes through claims verification, and provider costs data is reviewed by the Bureaus of Fee-for-Service Programs (BFFSP) and the Bureau for Data and Claims Management. The MAPIR Operations team will review information submitted by providers as they apply in MAPIR.

## Section D: The State's Audit Strategy

Once the provider completes the R&A registration process, the system serves to provide information to MAPIR. The R&A sends provider registration information to the Department on a daily and weekly basis. MAPIR automatically checks for eligible providers and notifies these providers through an automated "welcome" email. Instances where providers are found to be ineligible by MAPIR's comparison to the MMIS provider file, the HIT support team performs outreach to the provider to identify the issue with the provider and works with them to demonstrate program eligibility to gain access to the EHR Incentive Program MAPIR application.

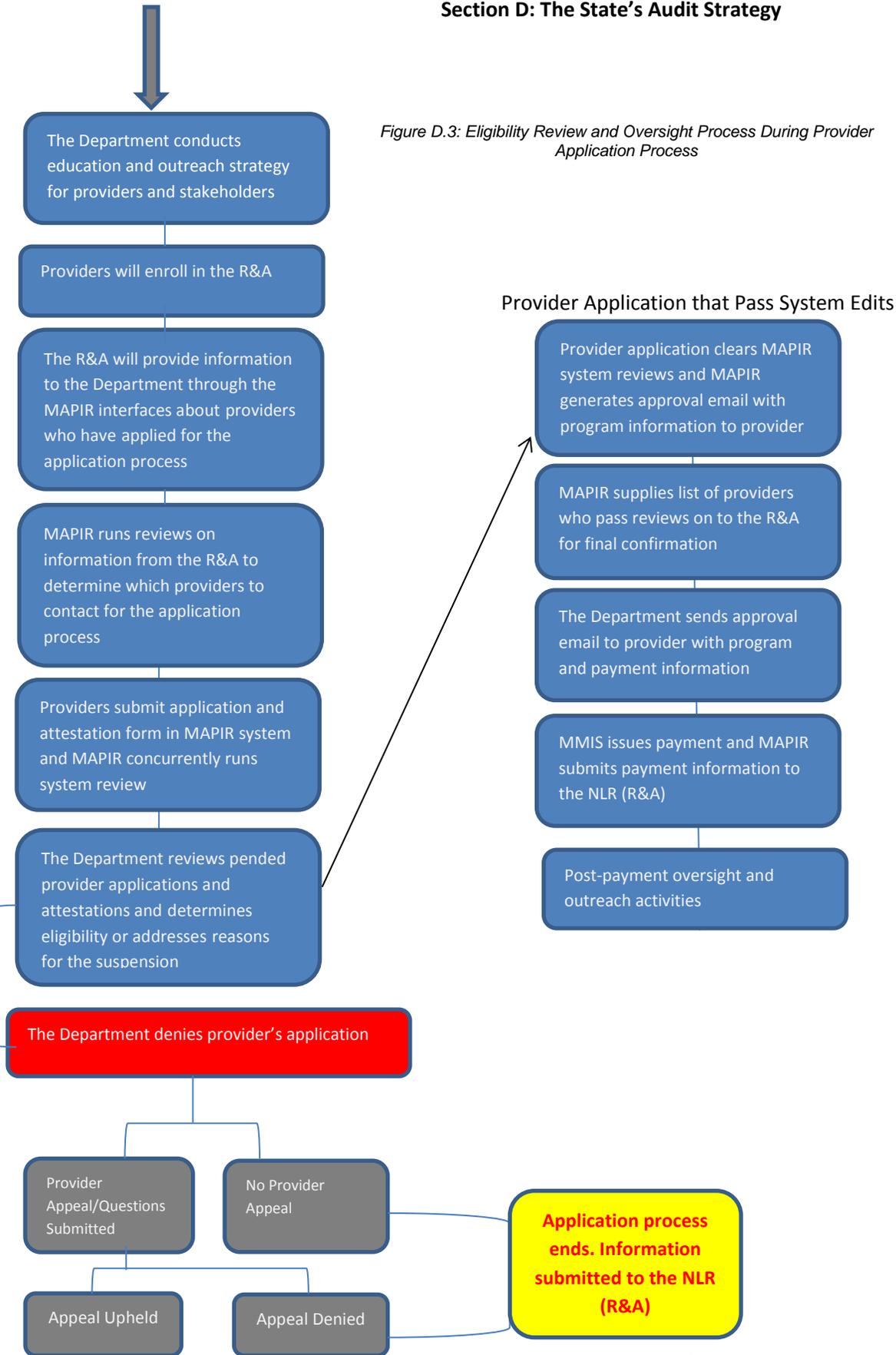
Provider applications are submitted through MAPIR, which not only serves as a public-facing digital application tool, but as a pre-payment audit instrument for the MA HIT Initiative and MAPIR Operations teams. MAPIR collects all information related to provider payment, applications, attestations and oversight functions, and interfaces with CMS' R&A. The information submitted during the MAPIR application process that is checked by the Department HIT team is described below:

- Patient volume matched to claims and encounters in MMIS
- Hospital-based encounters reviewed
- Hospital-based exclusion documentation reviewed
- Provider type checked against provider file
- All hospital information checked – cost reports, etc.
- Documentation that validates EHR system is certified

The HIT Executive Committee identified the system reviews that MAPIR will use to assess provider applicants as they apply for incentive payments. These reviews provide information at multiple points in the application process and against information submitted to the R&A and will thus help to reduce the need to recoup funds from providers who are not eligible (Section C outlines recoupment process). The steps in the eligibility review and oversight process are described in Figure D.3 below.

## Section D: The State's Audit Strategy

Figure D.3: Eligibility Review and Oversight Process During Provider Application Process

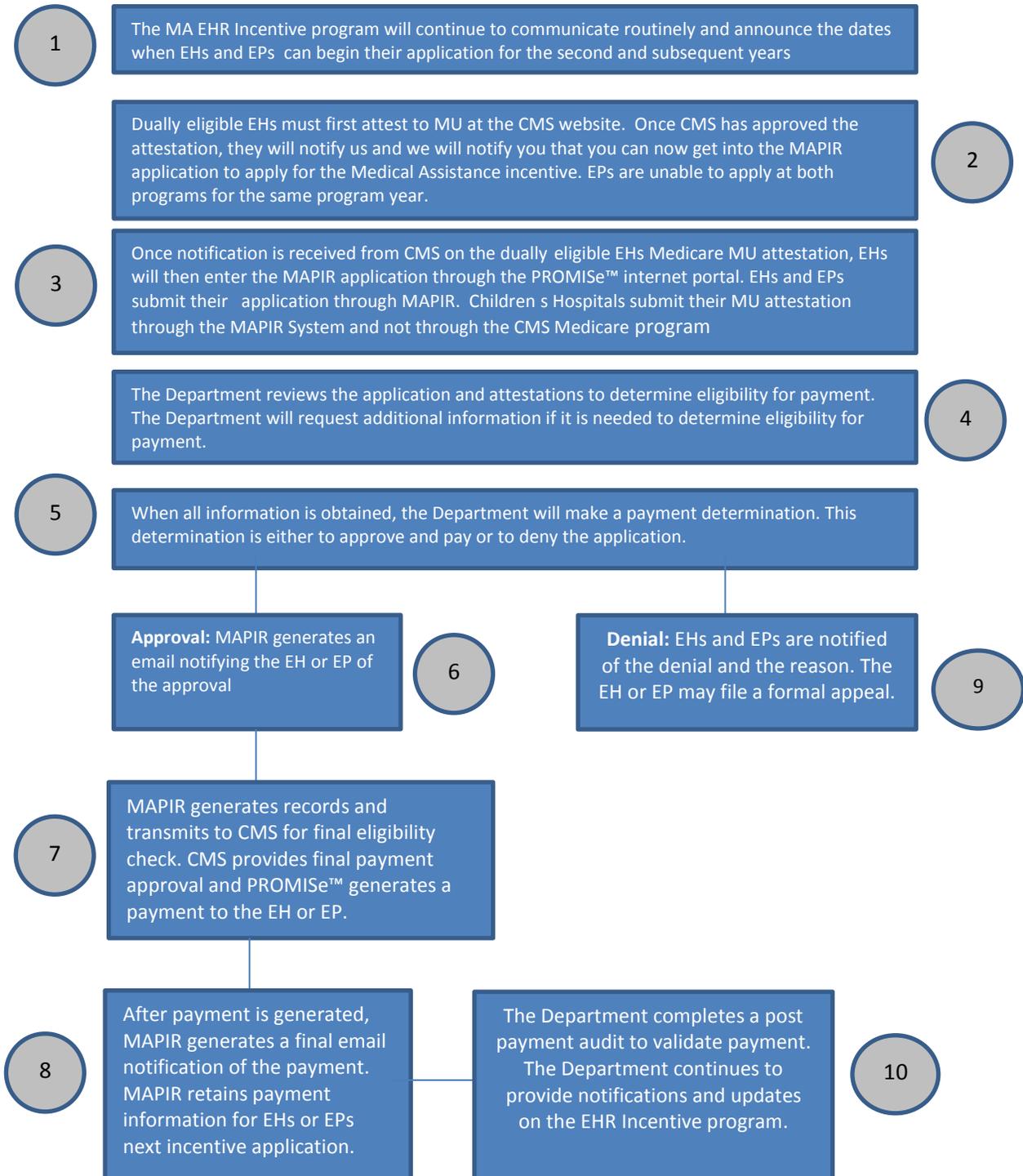


\*Providers include Eligible Professionals & Eligible Hospitals as defined by the EHR Incentive Program rules.

**CMS** - Centers for Medicare & Medicaid Services  
**MAPIR** – Medical Assistance Provider Incentive Repository  
**R&A** – Medicare and Medicaid EHR Incentive Program Registration and Attestation System  
**The Department** – Pennsylvania Department of

## Section D: The State's Audit Strategy

**Years 2 - 6** Once an EH or EP has registered at the CMS R&A site it is not necessary to re-register UNLESS the CCN, NPI, TIN or Payee details have changed



## Section D: The State's Audit Strategy

### ***Program Oversight: Organizational Structure (Response to Question #1, Question #7 and Question #3)<sup>3</sup>***

MAPIR Operations, under the MA HIT Initiative, is chiefly responsible for implementing both the pre- and post-payment auditing strategy, including identifying overpayments and detecting fraud and abuse in the EHR Incentive Program. By reviewing required data fields on the application prior to payment and by risk profiling providers for the post-payment audit, fraud or abuse is closely monitored and overpayments are recouped and returned within specified timeframes. A contractor located in MAPIR Operations performs the audit. This contractor is part of the HIT Executive Committee and participates in daily operations. The BPI Liaison developed the auditing strategy in coordination with the HIT Executive Committee. The auditing strategy has been updated as the EHR Incentive Program has progressed and based on lessons learned throughout the life of the program. The Department is also considering contracting for additional assistance with monitoring Meaningful Use attestations. Regarding auditing of hospitals Meaningful Use attestations the Department designates CMS to conduct all audits and appeals of eligible hospitals' Meaningful Use attestations, which binds the Department to the audit and appeal findings. Therefore, the Department will perform any necessary recoupments, which includes returning the funds to CMS, arising from the audits that determine the hospital was not a meaningful EHR user. The results of any adverse CMS audits would be subject to the CMS administrative appeals process and not the state appeals process.

During the pre-payment audit, providers work with MA Health Initiative Operations on a one-on-one basis when necessary to make sure attestations and payments are correct. During the post-payment audit, providers are placed into risk review categories (as discussed in figure D.2). Overpayments are either recouped in accordance to federal timeline standards or during the reconciliation process at the beginning of the subsequent program year. In the case where abuse is identified after the payment is processed, MA HIT Initiative and MAPIR Operations will refer the issue to the Department's Office of Administration, Bureau of Program Integrity (BPI). Note: Abuse is characterized as an unintentional mistake, while fraud consists of an event that was knowingly and willingly incorrect, and that was purposely executed to obtain a benefit.

Once the Department has reviewed the application and any additional information it has gathered on the audit elements, or has been obtained from the provider that was deemed necessary to complete its review determination, the Department will notify the provider via email correspondence that their application has been denied for those who do not appear to be eligible for the EHR Incentive Program.

If a provider does not respond to the preliminary findings correspondence, or if the provider is found ineligible, then the Department will send a final determination correspondence which will include information about the appeal process. The Department will also inform CMS of the denial and provide a

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<sup>3</sup> Once Section C: Administration is complete, compare these responses to information provided in Section C and cross-reference as appropriate.

## Section D: The State's Audit Strategy

reason code for each denial, and informs BPI of all final denials. The Department's goal is to review applications, any additional information, and make a decision about applicant's eligibility within six weeks of receiving an application. During peak periods when the volume of applications is higher, it may be longer than six weeks. Providers must respond to requests for additional information in a timely manner and we request that initially responses are submitted within 30 days. However, the process of working with providers on suspended applications may take longer and failure to respond in a reasonable time period may result in applications exceeding the six week processing period.

Providers will have the right to appeal certain Department decisions related to the Medical Assistance EHR Incentive Program. Examples of appeal reasons include, but are not limited to, the following:

- Applicant is determined ineligible for the EHR Incentive Program due to sanctions;
- Applicant volume of Medical Assistance encounters do not meet the minimum threshold for an incentive payment; and,
- Appeal of incentive payment amount, (e.g., pediatrician payment).

Appeals related to this program will be processed like all other provider appeal issues. Providers should submit appeals to the Department's Bureau of Hearings and Appeals.

For providers passing all of the application and attestation steps, MAPIR will generate a preliminary approval. The preliminary approval will trigger MAPIR to send information to the R&A System to verify that providers are still eligible for payment, e.g., provider has not (since date of submission of Pennsylvania application) received a payment from another state or in the case of EPs from Medicare and that the provider has not had a sanction or exclusion levied against him/her. Only after all these steps are passed will an incentive payment be made.

Once the incentive payments are made, the MA HIT Initiative and MAPIR Operations teams will work with BPI to provide program oversight as discussed above.

### **Collecting Overpayments**

MAPIR is used to store and track records of incentive payments for all participating providers. Once an overpayment is identified, MAPIR will be used to determine the amount of payments that have been made and which must be returned by providers. When overpayments are identified, the Department initiates the payment recoupment process and communicates with CMS on repayments. The Department will request that providers submit recoupment payments by check; if a provider fails to submit a payment by check within 90 calendar days of the notice to return the EHR incentive payment, the Department will generate an accounts receivable to offset payment of future claims to recoup the EHR Incentive Program overpayments. Federal law requires the Department to return overpayments within 365 days of identification.

## Section D: The State's Audit Strategy

The Department has a system in place for tracking recoupment of overpayments from providers. MAPIR will allow for tracking and reporting overpayments specific to EHR provider incentive payments. Tracking, collecting, and returning overpayments are measures that will be monitored on an ongoing basis as described in Section E, the Roadmap that describes benchmarks and program measures. The Department has developed a weekly report in MAPIR that will be reviewed to determine the status of recoupment of overpayments.

After the recoupment process, fraud cases are forwarded to The Department's Office of Administration, Bureau of Program Integrity (BPI). BPI is comprised primarily of healthcare professionals responsible for identifying and deterring fraud, abuses, and other non-compliance with MA policy. They refer cases to the appropriate enforcement agency to ensure that the provider is reviewed for their actions in all programs associated with the Medical Assistance program.

The HIT Initiative has one staff person solely dedicated to the EHR Incentive Program audit strategy. The Auditing Lead is assigned to work with MA HIT Initiative on program integrity studies and to address issues that arise for the EHR incentive payment program.

The appeals process described in Section C for the EHR Incentive Program will be used in any instances when a provider wishes to appeal a finding of an improper payment.

### ***Methods for Avoiding Improper Payments (Response to Questions #1, #4 and #5)***

The Department will implement multiple mechanisms, studies and processes as part of its program oversight approach to avoid making improper payments and identify and recoup any overpayments. Below are the Department's planned approaches.

### **Application Review Process / Office of Inspector General Audit Elements**

The Department currently uses existing federal and state data sources as part of its ongoing Medical Assistance oversight activities. As described above, MAPIR Operations utilizes the MAPIR system to determine provider eligibility, and capture attestation information including EHR status (Adopt, Implement, Upgrade), and make payments. Information submitted by providers that is reviewed during the application process includes:

- CMS registration
- Confirmation that the hospital or professional is choosing Pennsylvania's Medical Assistance EHR Incentive Program
- Provider type eligibility including hospital-based providers
- Sanction issues
- Attestation time periods are within required parameters
- Patient volume

## Section D: The State's Audit Strategy

- Licensure verification
- Valid EHR Certification number
- Hospital Cost data

The Department's Bureau of Data and Claims Management (BDCM), in conjunction with the multi-state collaborative, has programmed extensive system checks and edits to enhance the Department's oversight capability. These edits will flag potential errors or issues in a provider's MAPIR application, e.g., when new R&A data is interfaced with MAPIR data and MAPIR identifies inconsistencies or changes in provider selection of state or from Medical Assistance to Medicare. Having MAPIR enables the Department to operationalize many of these checks as part of our review process which helps to identify potential concerns in real-time rather than relying on retrospective review of the Department's enrollment and payment records. The MAPIR Operations team verification process is further described in an internal operations manual.

See Table D.2 for the EHR Incentive Program Requirements and the Pennsylvania review process in the context of the findings of the Office of the Inspector General report on Medical Assistance EHR Incentive Programs.<sup>4</sup> All elements are reviewed in part prior to payment. However, the Department will also continue its review of application information as part of the post-payment audit.

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<sup>4</sup> U.S. Department of Health and Human Services Office of Inspector General, Office of Evaluations and Inspections, "Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight, OEI-05-10-00080," July 15, 2011.

## Section D: The State’s Audit Strategy

**Table D.2: EHR Incentive Program Requirements and the Pennsylvania Review Process**

EHR Incentive Program Requirements Analyzed	
Requirement	Review Protocol
Practitioners must be one of the permissible practitioner types	Providers who are not a permissible provider type (physician, pediatrician, dentist, CRNP, midwife, or physician assistant in a so led FQHC/RHC) cannot access the MAPIR application to apply for the EHR Incentive Program.
Practitioners and hospitals must be licensed to practice in the State	Each provider’s license is checked prior to initial Medical Assistance enrollment to ensure that he or she has a valid license to practice. There is an automated process in place to check in-state EP licenses on a monthly basis against our license file to ensure that these providers continue to be actively licensed. If they are not actively licensed then they are not enrolled in the Medical Assistance program and not eligible for an EHR Incentive Program. In addition, hospitals are reviewed during the Medical Assistance enrollment process to verify that the hospital is actively licensed. This check is automated. If a provider is not MA enrolled they cannot receive an incentive payment.
Practitioners and hospitals must not be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State	If a provider is not MA enrolled they cannot receive an incentive payment. Prior to enrolling any provider, we perform system checks to ensure that they have not been precluded in addition to checking state-specific preclusions. Any existing providers found to be precluded are closed. We are looking for ways to further automate these processes.
Practitioners must have at least a 30% Medical Assistance patient volume (or 20% for pediatricians) if they are not practicing predominantly in an FQHC or RHC	Medical Assistance claims history is used to validate the Medical Assistance encounter (EP) reported by the provider on an incentive application. When the reported volume cannot be reasonably verified the application is pended for additional review. The provider is contacted and asked to supply documentation to support the reported volumes.
Practitioners must have at least a 30% needy individual patient volume if they are practicing predominantly in an FQHC or RHC	We have requested that each FQHC / RHC provide supporting information for their needy encounters that includes signed attestation by CEO / Executive Director. We allow documentation from the billing system and data submitted to HRSA to support patient volume attestations.
Hospitals must have at least 10% Medical Assistance patient volume (acute care hospital only) and Calculating Hospital EHR Incentive Payments Over Four Years	We have taken the strongest possible defense regarding validation of data towards threshold criteria as well as payment methodology. Cost report data is vetted by the in-house accountants. Information is verified with each facility to maintain integrity in cost reporting. Multiple data sources (Medical Assistance data, Medicare cost report data, claims, and PHC4 information) are reviewed, but a higher weight is given to internal cost reporting.

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EHR Incentive Program Requirements Analyzed	
Requirement	Review Protocol
	Hospitals with Medical Assistance patient volume greater than 10 percent are approved for payment. To determine that the volume threshold is met claims and encounter reviewed prior to payment.
Practitioners must not be hospital-based	Medical Assistance claims history is used to verify if a provider is hospital based. Providers who are found to have over 90% of their submitted claims with an Inpatient or Emergency place of service (POS 21 or 23) are flagged for additional review. The provider is contacted and asked to supply additional information which shows the provider performs less than 90% of his or hers service in an Inpatient or Emergency Room setting.
If practitioner is a PA, he or she must practice in a PA-led FQHC or RHC	Physician assistants applying for the incentive payment will be required to provide supporting documentation to validate the so-led criteria prior to being able to enroll with Medical Assistance and therefore prior to applying to EHR Incentive Program.
Practitioners and hospitals must adopt, implement, upgrade or Meaningful Use a certified EHR technology	Each provider must obtain a valid CMS EHR Certification Number through the ONC. During the application process each provider must enter a valid EHR Certification Number in MAPIR. MAPIR performs a real time verification of the EHR Certification Number through the ONC. Providers who enter an invalid EHR Certification Number are not allowed to submit an application. Providers are required to provide supporting documentation such as bill of sales or copies of contracts to prove their Adoption, Implementation, Upgrade or Meaningful Use of a Certified EHR System. Information supplied by the provider is uploaded into MAPIR and permanently attached to the provider's application. Additionally, the MAPIR application provides the capability for the provider to indicate service location(s) where they are utilizing EHR technology.
Payment re-assignment	Eligible professionals are unable to complete MAPIR application if there is an invalid payee assignment as outlined in the Final Rule. The applicant must also attest that the re-assignment was made voluntarily.
Must have an average length of stay of 25 days or less (acute care hospital only)	Each hospital attests to this standard within application and will be part of post payment review that all hospitals will undergo.

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### Risk Profiling and Post-Payment Sampling

The Department is currently manually sorting by provider type, Adoption, Implementation, Upgrade, or Meaningful Use, patient volume, and other information fields submitted in MAPIR, so that the Department can prioritize reviews and identify post-payment high risk categories. The Department is working towards downloading all MAPIR data into a data warehouse that can automatically generate reports from the submitted application data. The Department has developed a review process/workflow that identifies elements that will be verified post-application and post-payment.

Risk profiling begins with identification of application type and the methodology used to identify Medical Assistance patient volume. Applications are reviewed by category: 1.) eligible professional individual patient volume methodology, 2.) eligible professional group patient volume methodology, and 3.) eligible hospitals. The Department found that conducting different risk profiling for hospitals and professionals is more efficient for deterring fraud and abuse and enforcing the requirements in the Final Rule than performing audits on a broad-based sample from all applications.

Performing post-payment audits on high risk categories or populations allows for the Department to narrow its focus on areas that may need more attention (e.g. minimum threshold requirements submitted). These high risk categories are identified in the "Post-payment auditing to ensure Adoption, Implementation and Upgrade, and Meaningful Use of certified EHRs" section of figure D.1. Each of these high risk categories is accompanied with functioning audit parts – the elements within these categories that are reviewed. Audit element examples can be seen below, along with further information provided in the provider manual located at [www.PAMAHealthIT.org](http://www.PAMAHealthIT.org).

- Adoption, Implementation, Upgrade, and Meaningful Use: Acceptable documentation including receipts and leases
- Group provider information and all NPIs associated with applications and payments (group patient volume methodology only)
- Volume matches payment according to threshold requirements and provider type
- Hospital-based (eligible professionals only)
- Verification of pediatric training – pediatricians must meet Pennsylvania's definition through proof of training and/or board certification

In the case of auditing and validating out-of-state Medical Assistance patient volume, the Department conducts targeted reviews on providers with high out-of-state volume. In conjunction with CMS, the Department is participating in conversations at the "Medicaid HITECH TA Portal," more specifically, with multiple states that are part of the "Auditing Community of Practice." Participation in this multi-state collaborative ensures proper auditing practice alignment and allows for sharing of emerging best practices to be presented. Additionally, the Department did have initial conversations with New Jersey, Delaware, Maryland and Ohio about developing agreements to review out-of-state information although this is currently not being done and the providers are responsible for validating their volume.

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**Audits and provider incentive payments:** The MA HIT Initiative audits providers to verify they are meeting adopt, implement, upgrade and Meaningful Use of certified EHRs. Verifying attestation data in the first year is particularly important as providers are receiving their largest payments in the first program year. Provider incentive payments are stored and tracked in MAPIR. Through MAPIR's interface with the R&A, the MA HIT Initiative team is able to determine if new information exists (following receipt from the R&A) that indicates a payment should or should not be made in future program years, (e.g., provider switches to Medicare or switches to another state's Medical Assistance EHR Incentive Program). At the end of each audit, the Department's audit report serves as a cumulative report to Department executives and CMS.

**Meaningful Use – CMS guidance:** The MA HIT Initiative's Meaningful Use portion of the Program will take direction from CMS. The Department will follow the backbone of auditing methods that are provided in addition to the PA audit strategy approved by CMS.

The Department implemented a three-tiered audit approach. The first tier consists of "red flagging" applications for instances such as data outliers and intelligent analytics. Data trending and benchmark analysis assist with this. The Department is performing this type of process in the beginning of the pre-payment audit for review for things such as volume thresholds, sanctions, hospital-based and AIU. This practice assists with performing this similar audit for Meaningful Use. The second tier consists of secondary data sources. The Department is currently leveraging existing claims data and cost reports during the pre-payment and post-payment audit, and the experience assists with performing this type of process for Meaningful Use. The third tier consists of various risk categories identified as potential indicators of poor business practices or the need to additional technical assistance. This approach results in direct contact with the provider. The Department has established and continues to improve outreach functions within its existing pre-payment and post-payment audit processes.

The past-practices and lessons learned from these areas will assist with meeting Meaningful Use audit standards. Based on the most recent guidance from CMS, the Department captures Meaningful Use information from providers as follows:

- Request an explanation of how the certified EHR technology is being used in a meaningful manner (e.g., e-prescribing).
- Request an explanation of the how the certified EHR technology is electronically exchanging health information to improve the quality of care.
- Request the organization to attest to the Clinical Quality Measures prescribed by CMS.
- Request proof of passing CMS Core Set Objectives.
- Request proof of completing CMS Menu Set Objectives.

When a provider has not met the criteria, the Department will refer the provider for technical assistance and will require a corrective action plan to address non-compliance to either rectify the situation or to

## Section D: The State's Audit Strategy

recoup the incentive funds. The Department will instruct all EPs and EHs (including CAHs) to keep documentation supporting their demonstration of Meaningful Use for 6 years.

### Reviews for Additional Incentive Payments

Providers are not required to participate in the program in consecutive years, so the renewal process is designed to track when the provider requests a second or subsequent incentive payment. The review process will be reviewed in MAPIR and will incorporate reviews of:

- Continued provider eligibility, e.g., continued participation as a Pennsylvania Medical Assistance provider, check for sanctions, licensure
- Variance in patient volume calculations
- Updated information at the R&A
- Meaningful Use criteria
- New provider information, (e.g., provider's practice closure or move)

### *Reduce provider burden and maintain integrity and efficacy of oversight process (In response to Question #6)*

#### Use of Other Department Information Systems to Enhance Program Oversight Capabilities

In addition to MAPIR, the Department will use other sources of data to monitor the program and verify information submitted by providers in the application process and in future years as providers request additional incentive payments.

- **Claims Data Systems:** Data from the MMIS, the DPW Data Warehouse and the Fraud and Abuse Detection System will supplement information gathered through MAPIR. For example, in-state Medical Assistance patient volume numerators could be checked against claims data.
- **Health Information Organizations (HIOs):** Through the HIE model the Authority, is facilitating the Department will have access to other data that will help with ongoing oversight and monitoring of Meaningful Use. The Department anticipates expanding its relationship with the Authority and the capabilities of the PHG to using the data collected from HIEs monitor future components of Meaningful Use and to help gather the clinical data required under Meaningful Use. Utilizing as well as information to support these attestations and
- **Other Agency Registries:** The Department is collaborating with appropriate contacts of other agencies to assess monitoring capabilities specifically as it relates to Meaningful Use measures. Appropriate agreements will be drafted to create inter-agency working relationships.
- **Exclusion and Debarment Databases:** The Department will regularly review Commonwealth and federal systems not included in the R&A, such as the State's MediCheck list, the National

## **Section D: The State's Audit Strategy**

Provider Data Base (NPDB) and the Office of the Inspector General's (OIG's) List of Excluded Individuals/Entities (LEIE).

### **Continued Education and Technical Assistance Before and During the Application Process**

The Department has developed and made available resources to providers to educate them about the application process. The Department developed a comprehensive communications strategy that identifies events, communication channels, materials, content, and audiences. The Department released a series of Medical Assistance Bulletins (MABs) to describe EHR Incentive Program; including: program requirements, eligible provider types, the R&A, program monitoring and oversight, the application, and attestation, audit processes and Meaningful Use stages. In addition to the Medical Assistance Bulletins, the Department developed and published Provider Quick Tips, provider manuals for both hospitals and professionals, and Remittance Advice banner messages. These resources are available at [www.PAMAHealthIT.org](http://www.PAMAHealthIT.org) and announced to professional associations as well as through the program's listserv. Please see Appendix III for additional resources.

### **Evolving Audit Strategy**

The Department will continue to evolve its auditing strategy. Lessons learned as the Department continues to conduct post-payment auditing reviews had made it necessary to modify existing audit practices and create new high risk categories with audit elements. Additionally, as providers become more familiar with state and Federal auditing processes, both strategies will need to evolve to make sure that the protocols are still effectively identifying fraud, abuse, and overpayments.

The Department has implemented a programmatic audit to evaluate the effectiveness, and efficiency of the Medical Assistance EHR Incentive Program. The programmatic audit confirms that program processes are being followed, that the information obtained is satisfactory, and defines adjustments to program processes which may be needed.

The Department hopes to create an efficient EHR Incentive Program auditing and oversight strategy by using the audit protocols discussed in this document and will continuously look for new methods to enforce program regulations and to assist providers with program compliance.

## Section E: The State’s Roadmap

### Section E: The State’s Roadmap

This section provides an overview of the Department’s HIT Roadmap for achieving its’ HIT and eHIE vision. The following section includes responses to each of the questions listed in the CMS SMHP as described in Figure E.1 below.

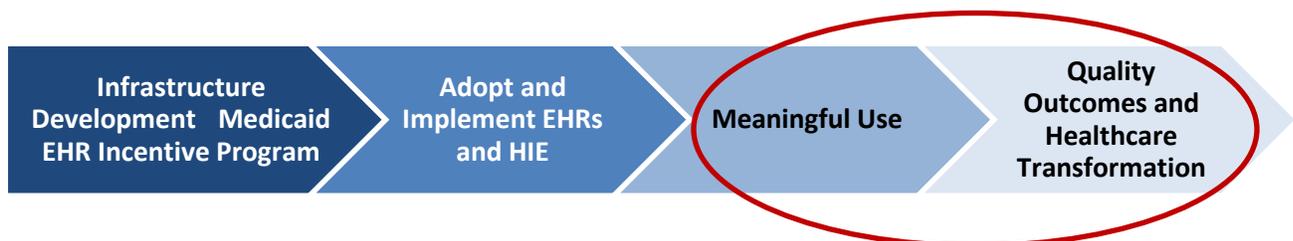
**Figure E.1: Section E Questions from the CMS State Medicaid HIT Plan (SMHP) Template**

Please describe the SMA’s HIT Roadmap:
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.

#### ***Medical Assistance Agency Five-Year Roadmap (Response to Question #1)***

The Department’s Roadmap discusses strategies for moving beyond the current state of HIT adoption and Meaningful Use to achieving a critical mass of providers who have adopted EHRs and who are exchanging data via an HIO so as to improve the quality and coordination of care for Medical Assistance recipients. The Department recognizes that the Roadmap must be flexible in order to respond to the ever-changing health care landscape, help providers to continue to participate in the incentive program, help providers achieve Meaningful Use, and foster long-term involvement and information exchange. As first predicted in the 2010 SMHP, Department’s HIT / eHIE overall Roadmap extends beyond a 5 year discussion. As represented in Figure E.2 below, over time the Department’s strategy has progressed through phases. Based on the Department’s current projections of HIT adoption and Meaningful Use rates (described in Section A), the Department anticipates that the revised 5-year roadmap will be heavily focused on promoting the Meaningful Use of HIT/HIE, coordinating with stakeholders to effectively leverage available clinical data to improve health care outcomes, and continuing to evolve infrastructure to meet continually changing program and business needs.

**Figure E.2: Phases of the Department’s HIT Strategy**



## Section E: The State’s Roadmap

As Figure E.2 illustrates from left to right, the Department’s initial efforts were focused on developing infrastructure both internal to the Department and with providers through the EHR Incentive Program. The Department then worked with providers through resources such as the REC, to help move providers into adoption and implementation and make progress towards Meaningful Use. The Department used the data submitted by providers to evaluate clinical practices and performance and supply feedback to providers to help them continue to evolve in their use of HIT so as to gain the maximum benefit of HIT and the EHR Incentive Program. The first three phases were essential steps towards achieving the Department’s long-term goal of improving the value (quality and cost) of health care services. The Department continues to evolve its strategy to advance the third and fourth phases on the Roadmap.

***Annual benchmarks for each of the SMA’s goals that will serve as clearly measurable indicators of progress along this scenario (Response to Question 3)***

The Department continues to evolve its strategy to advance the third and fourth phases on the Roadmap. With the revised HIT goals in mind, the Department identified the following strategies and milestones to move beyond simply promoting HIT adoption and use and progress against larger quality improvement goals.

**Table E.1. 2015-2020 HIT Goals, Strategies and Milestones**

Goal	Strategy	Short term Milestones	Long term Milestones
<b>1. Increase Quality of MA Services</b>	<ul style="list-style-type: none"> <li>• Integrate with payment reform effort</li> <li>• Better leverage MCO contract to support Meaningful Use</li> <li>• Leverage EHR and HIE, so that providers can push quality metrics (HEDIS, eCQM, CHIPRA quality measures, MA adult core metrics, etc.) to the Department to allow for the quick and efficient measurement of quality</li> <li>• Push same metrics to MCOs, reducing the need for the large number of chart reviews, to identify care gaps and intervene to speed up the QI cycle.</li> <li>• While there is some overlap of eCQM/ Meaningful Use metrics with Medicaid Adult Core measures and CHIPRA measures, PA plans to explore more overlap with these other quality measure sets. However, initially</li> </ul>	<ul style="list-style-type: none"> <li>• Develop a plan that maps eCQM to HEDIS measures used by OMAP with payment reform and then pilot a limited set of measures with specific providers to determine the effectiveness and accuracy of this collection method</li> <li>• After reviewing leading practices in other states for leveraging MCO contracts to support meaningful use and after extensive discussions with the MCOs, the next iteration of the MCO contract will be updated in a manner that best implements this strategy.</li> <li>• Pilot for early adopters focused on a smaller set of eCQMs.</li> </ul>	<ul style="list-style-type: none"> <li>• Use eCQMs to supplant current HEDIS collection and reporting process</li> <li>• Implement process that leverages EHR and HIE to allow for the push by providers (and MCOs) of all quality metrics (HEDIS, eCQM, CHIPRA, Medicaid Adult Core, etc.)</li> <li>• State will push eCQMs to PHC4.</li> <li>• Ob needs assessment form will be collected electronically and shared between OMAP, MCOs and providers.</li> </ul>

## Section E: The State's Roadmap

Goal	Strategy	Short term Milestones	Long term Milestones
	<p>Pennsylvania will focus on a smaller subset of eCQMs (10 to 12) to pilot collection process with early adopters, even if redundant with CPT codes, to measure outcomes, not process.</p> <ul style="list-style-type: none"> <li>• Department will work to push eCQMs through the Public Health Gateway to the PHC4 to support independent analysis and public reporting of regional healthcare quality.</li> <li>• Push same eCQM/ QRDA1 information to HealthChoices MCOs to facilitate more efficient HEDIS data collection.</li> <li>• Automate the process of collecting data from the MCO OB needs assessment form, which allows plans to report on other OB care metrics, with a plan to extract this information from the EHR and push the data to the MCOs.</li> <li>• With MCOs state also provides funds for their provider Pay for Performance programs. In future, the plan is to incent providers to push even more quality data (eCQMs) to OMAP and MCOs.</li> </ul>	<ul style="list-style-type: none"> <li>• Automate MCO OB needs assessment form in manner that extracts information from this form into the EHR and pushes this data to the MCOs.</li> </ul>	<ul style="list-style-type: none"> <li>• Incentivize providers and MCOs to collect and report quality data electronically.</li> </ul>
<p><b>2. Increase Coordination of Care and Sharing of Data</b></p>	<ul style="list-style-type: none"> <li>• Pennsylvania's goal is to coordinate care in a manner that leads to more efficient, cost-effective care that helps MCOs, ACO/Health systems, and providers assist patients in navigating the health care delivery system.</li> <li>• Continue to align with eHealth Authority priorities.</li> <li>• Strengthen coordination with MMIS planning and align with MITA process.</li> <li>• OMAP plans on a bidirectional flow of data; not just providers and MCOs pushing data to OMAP, but OMAP pushing data out to MCOs</li> </ul>	<ul style="list-style-type: none"> <li>• Continue to collaborate with the eHealth Authority to onboard EPs and hospitals with HIOs and connect HIOs to P3N. Continue to refine policies on protected health information.</li> <li>• Implement more robust use of HIE between DHS, MCO, and providers for children in the child welfare system.</li> <li>• Implement more robust use of HIE (including appropriate care plan</li> </ul>	<ul style="list-style-type: none"> <li>• Implement bi-directional flow of quality data from and to providers, health systems/ACOs, and managed care plans.</li> <li>• Implement client portal.</li> <li>• Implement appropriate health information exchange of claims data, quality data and care plans for HCBW/LTC programs, Child Welfare and Early</li> </ul>

**Section E: The State’s Roadmap**

Goal	Strategy	Short term Milestones	Long term Milestones
	<p>and providers including health systems and ACOs.</p> <ul style="list-style-type: none"> <li>• Develop a provider/patient portal so both can see quality care gaps.</li> <li>• OMAP plans to push out appropriate claims and quality information so that providers can see the full continuum of care provided to their patients.</li> <li>• DHS plans to implement more robust data sharing across multiple Offices for foster care children, especially those in out-of-home care, including more intensive care management data (physical health, behavioral health, trauma care, etc.). This information will be pushed to single county authorities managing children’s social needs and to the MCOs managing their health care. An automated method for identifying care gaps will create better health and social outcomes.</li> <li>• Ensure that children screened by medical and other providers for developmental delays and autism have appropriate referral and follow-up by OCDEL and their early intervention providers. Appropriate electronic sharing of medical data and care plans will ensure that the loop is closed between medical providers, parents and the early intervention providers.</li> <li>• In the area of long term care, especially home and community based waiver programs, an electronic data record will be developed and utilized to share care plans, Medicaid and Medicare claims data and eQMs for better care coordination between the HCBW agency,</li> </ul>	<p>sharing) between DHS/OMAP/OCDEL/OMHSAS, MCOs, medical providers and early intervention providers for children referred and evaluated for developmental delay and autism.</p> <ul style="list-style-type: none"> <li>• Align MMIS/MITA planning to implement more robust electronic enrollment and electronic utilization management/prior authorization processes.</li> <li>• Continue to develop and test the Public Health Gateway in order to use it for currently defined unidirectional information flow but anticipate/ plan for future bidirectional use cases described in the strategy column.</li> <li>• Continue internal DHS multi-Office planning to implement HIE strategies that better coordinate information flow across program Offices and their respective providers.</li> </ul>	<p>Intervention to appropriate providers.</p> <ul style="list-style-type: none"> <li>• Incorporate use of HIE in care planning for individuals entering and leaving correctional facilities operated by counties and the state.</li> <li>• Efficiently streamline electronic enrollment and utilization management processes. Develop HIE that facilitates provider ability to move towards payment and health delivery reform (ACOs, PCMH, and episode of care payments).</li> </ul>

## Section E: The State's Roadmap

Goal	Strategy	Short term Milestones	Long term Milestones
	<p>provider team, and case managers.</p> <ul style="list-style-type: none"> <li>• Use of appropriate health information exchange to better manage the health care for individuals transitioning between the state and county corrections system and Medicaid to improve long term health outcomes, lower recidivism and more efficiently care manage this population.</li> </ul>		
<p>3. <b>Increase Awareness</b></p>	<ul style="list-style-type: none"> <li>• Educate providers and consumers on the benefits for being a Meaningful User of HIT.</li> <li>• Increase Patient engagement.</li> </ul>	<ul style="list-style-type: none"> <li>• Review current consumer and provider educational efforts and determine how best to modify the information or communication modes/methods to improve understanding of the benefits of HIT Meaningful Use.</li> <li>• Working with consumer, provider, advocacy and other experts in the field of patient engagement, develop the requirements for a patient portal that actively engages consumers.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop and implement a patient portal with strict security access rules that allows patients to view their electronic health information in a manner that engages their attention. This may include allowing links to web-based information about managing health conditions for favorable health outcomes.</li> <li>• Enhance the portal to include access to other MA data (EOMB, demographics, etc.) to allow individuals to actively engage.</li> </ul>
<p>4. <b>Redesign Systems</b></p>	<ul style="list-style-type: none"> <li>• Guiding principle for OMAP coming out of the MITA SS-A is to increase awareness, quality and coordination in public health coverage programs.</li> <li>• Keep systems infrastructure current to evolving program requirement and business needs.</li> </ul>	<ul style="list-style-type: none"> <li>• Complete a feasibility study to determine if implementing popHealth tool (or a similar tool) would further progress towards MA HIT goals</li> <li>• Develop an automated process for Medicaid fee reporting</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporate CQM and MU data into MMIS</li> <li>• Implement a more effective business intelligence strategy to make the MA HIT data both accessible and meaningful to both MA and</li> </ul>

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Goal	Strategy	Short term Milestones	Long term Milestones
	<ul style="list-style-type: none"> <li>• Enhance data capture and analysis capabilities.</li> <li>• Meet or exceed system readiness for latest CMS guidance.</li> <li>• OMAP has Intensive Care Management Unit that utilizes care management software. Part of the plan within system redesign is to further leverage software to do care management possibly across multiple Office programs. This will help Pennsylvania to improve the level of MITA Maturity and assure program accountability across multiple waivers.</li> <li>• Develop and implement the capability to push/pull care plans, eQCMs and claims data to MCOs, single county authorities, and providers such as health systems/ ACOs.</li> </ul>	<ul style="list-style-type: none"> <li>• Batch reporting</li> <li>• Implement the automated collection of CQM (eCQM)</li> <li>• NCR changes</li> </ul>	<p>MA partners (OCDEL, counties, etc.)</p> <ul style="list-style-type: none"> <li>• Based upon the outcome of the PopHealth feasibility, implement that (or a similar tool) that best meets PA MA HIT goals.</li> <li>• Leverage HIE to facilitate payment and health delivery reform.</li> </ul>

## Section E: The State's Roadmap

### Advancing eHIE

The following presents the five-year roadmap for specific eHIE-related activities to be undertaken by the Authority in collaboration with the Department, other Pennsylvania government agencies, certified HIOs and HISPs, and other Authority stakeholders:

- **On Boarding** – The Authority plans to continue to promote ever widening exchange of health information within PA by continuing to support and supplement (using continued IAPD funding if possible) onboarding of EHR Incentive Program participating providers to HIOs and HIOs to P3N. These programs do not only require HIOs to build technical connections, but require that HIOs assist providers in integrating eHIE into their workflows and provide training and “go-live” support. Both HIOs and providers accepting onboarding funds are required to provide lessons-learned to the Authority and the Department. These lessons will be aggregated and made available to encourage ongoing improvement in the onboarding and eHIE adoption process. These additional steps increase the probability that the funds spent on onboarding will help to generate continuing use of eHIE and thus increase the probability that eHIE will help to transform healthcare delivery and yield cost savings and quality improvement.

The Department in conjunction with the Authority plans to request IAPD ongoing funding to support the onboarding program initiated using IAPD funds in 2015. Given that eHIE can only reach its full potential with participation by providers across the entire healthcare delivery spectrum, the Authority also intends to seek sources of funding, possibly including IAPD, to support similar onboarding programs for non-EHR Incentive Program participating providers, starting with long term care facilities (LTC) and home health agencies.

There will for the foreseeable future be some providers who have not been able to adopt EHR technology that can be fully integrated with eHIE. The Department and Authority feel that it would be a mistake to leave these providers entirely out of the eHIE revolution. Most of the Pennsylvania HIOs currently provide some means for such providers to request information from their networks, usually via an internet-based portal. The Authority will encourage HIOs to further extend these capabilities to include rudimentary abilities for non-EHR enabled providers to nonetheless contribute information to eHIE, and to develop portals that are tailored to supporting the workflow needs of particular provider segments to enhance usability and encourage adoption.

Assuming the availability of funds, the Department and Authority intend to continue to support onboarding incentive programs. The Department will work with the Authority to identify specific annual target goals for percentages of particular provider types to be onboarded over the coming five years.

- **Public Health Gateway** – Year one of the SMHP planning period will include making the connections to DHS and DOH bi-directional to permit providers to access these valuable resources. In order to take advantage of the re-usable framework being built in the initial Public

## Section E: The State's Roadmap

Health Gateway (PHG) implementation, PHG will be also be enhanced in year one to facilitate the collection of additional DHS and DOH public health data, such as birth and death registries data submissions. The PA Health Care Cost Containment Commission (PHC4) will be connected to PHG as an additional state agency, receiving copies of health care quality related data such as Electronic Clinical Quality Measures (eCQMs), enhancing the quality and cost analyses provided by that agency.

In year two of the SMHP planning period, the Department will work with the Authority to introduce PHG enhancements that should provide healthcare providers more streamlined health information reporting, improved care coordination, and reduced administrative costs, and will allow PHG connected state agencies to support broader health improvement objectives. To that end, additional state (and sometimes local government) agencies, consuming, utilizing and/or providing healthcare related information will be added to PHG in future years. The order in which agencies are added will be developed through conversation with the various agencies, but the five-year plan should incorporate the following:

- Department of Corrections (DOC) to support transitions and coordination of care,
- Department of Aging to support care coordination and administrative functions,
- Child Welfare Services and/or county-level organizations to support care coordination and administrative functions,
- OCDEL to support care coordination and administrative functions,
- Department of Education (PDE) and/or county-level school system to enable P3N access by school nurses for both care and administrative purposes (i.e. immunization verification),
- Department of Military and Veterans Affairs (DMVA) to support transitions and coordination of care

Additional possibilities, again with timeframes uncertain, include offering feedback on eCQM derived reports back to providers, and leveraging PHG to streamline Department of State (DOS) processes related to provider credentialing. Note that in all cases, the work associated with expanding PHG includes not only technical work, but also legal analysis and agreements, policy work, operations and workflow, and communications. Where appropriate, the Department may seek IAPD funding to support PHG-related efforts.

For each enhancement to PHG, the Department will work with the Authority and the involved agency or agencies to develop specific adoption and utilization targets, and/or cost savings or quality improvement goals, and then measure progress against those targets and goals. Where linkages currently exist to some degree between public and private sector organizations, the Department and the Authority will work with the involved agency to develop and implement a roadmap to transition one-to-one connections to use of the PHG.

- **MPI Enhancements** – The Authority maintains a master patient index (MPI) to manage patient identity across participating HIOs and agencies. The MPI was seeded with information from the DHS PA Medicaid Master Client Index and the DOH Immunizations Registry Patent

## Section E: The State's Roadmap

Demographics. In year one of the SMHP period, the Authority will work with the Department and the Department of Health to operationalize routine periodic updates from these sources to the MPI. This will both improve P3N MPI patient matching and enhance bi-directional exchange via the PHG.

The Authority will enhance the MPI to create the capability to link patients, providers, and care coordination organizations such as patient centered medical homes (PCMHs) and Accountable Care Organizations (ACOs) or *other emerging models*, to show care delivery and payment relationships. Providers who are connected to Health Information Organizations (HIOs), which are connected to P3N, could utilize this index to assist in generating alerts related to clinically relevant events. This functionality will initially be piloted with the PA Medicaid MCO, along with at least one HIO and ACO. The Authority will develop a plan to expand this functionality to all P3N users and eventually all PA operating care coordination organizations in subsequent years.

The Department and the Authority also proposes an effort among state agencies to identify the various patient identity management efforts occurring across state agencies and determination of possible actions to streamline or even consolidate these efforts to increase efficiency and reduce taxpayer costs. Planning for this possible state government-wide patient identity management consolidation will likely commence in year two of the SMHP period, with implementation occurring in SMHP years three to five.

- **Provider Directory Enhancements** – The P3N Provider Directory is currently updated monthly from the National Plan and Provider Enumeration System (NPPES), the PA Department of State (DOS), and the PA Department of Health (DOH). The P3N Provider Directory will be enhanced to create a clearer reconciliation and correlation between these data sources. This will provide for more accurate, complete and timely provider related data in the P3N Provider Directory, making it a comprehensive source of truth for health care providers in PA. This effort is likely to be completed in SMHP year one. No provider directory enhancements have been identified for later SMHP years.
- **Advanced Directives Planning and Pilot** – In the SMHP period, the Authority will conduct work, including facilitated stakeholder discussions, to determine how P3N can improve the sharing of advanced directives (ADs) and physician orders for life sustaining treatment (POLSTs). It is possible that the Authority will create a centralized repository within P3N that allows patients and providers to register these documents so they will be available to all network participants. Assuming such a repository is required, the Authority will conduct an AD / POLST sharing pilot leveraging Medicaid recipients and providers in SMHP years two and three. The pilot would be followed by a technology review and revision process to improve the scalability and usability of the system, followed by a secondary pilot with a larger community of patients and providers. The ultimate goal is to provide this functionality to all patients and P3N participating providers in PA.

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- **Patient Portal** – The Authority maintains a patient portal that permits Pennsylvania citizens to manage their opt-out and opt-back-in consent decisions with regard to sharing of clinical information across the P3N. Assuming the AD/POLST work described above does result in a P3N AD/POLST registry, the provider portal will be enhanced to allow consumers to manage these documents.

Starting in year two of the SMHP period, the Department will engage in discussions with the Authority and with other effected stakeholders to identify additional possibilities to enhance the P3N patient portal. These may include:

- Provision of provider quality information produced by DHS, DOH, and/or PHC4
- Consent for secondary uses of clinical information, such as public health initiatives or academic studies
- Patient contribution of information to P3N, especially objective device-derived information (i.e. Bluetooth enabled scales, glucometers, etc.)
- Single-point accounting of disclosures

In all cases, decisions on enhancements to the patient portal will be informed through consumer and provider surveys to help ensure that limited resources are not spent on developing functionality that is not demanded by users.

- **Interstate Connections** – Healthcare is not constrained by state borders. The Department and the Authority's strategic plans includes efforts to establish interstate eHIE, starting with the six states bordering Pennsylvania, and then progressing to other states with substantial shared patient populations. The Authority is now commencing an analysis to better understand technical eHIE models and services, and legal and policy aspects and variances in these other states. This effort, combined with currently ongoing outreach efforts to these other states, will permit the Authority to develop a roadmap for pairwise interstate connection (PA-DE; PA-NJ; PA-NY, etc.).

The Department will work with the Authority to encourage emphasis on those cross-border connections that have the largest impact on Medicaid populations. The Department will also reach out to its sister departments in these other states, in order to ensure similar working relationships between those departments and their individual state-level eHIE efforts as the Department has with the Authority.

- **Community Resource Registry** – A longer-range vision to enhance the value of eHIE in Pennsylvania is to leverage the P3N or other eHIE technology to actively engage community resources into care coordination efforts where appropriate. This could improve patient welfare and potentially improve patient health, by allowing providers and care coordinators access to near-real-time information about community services that may be available to their patients, such as access to food banks, housing assistance and shelters, transportation to and from medical encounters, substance abuse or other support groups, and social service. This could also include ability to create appointments or referrals, again in near-real-time to these services.

## Section E: The State’s Roadmap

The Department and Authority expect to start conversations around this type of registry in the second year of the SMHP period. As with the patient care associations index described in the MPI section above, we anticipate that this functionality will initially be piloted with the PA Medicaid MCO, along with at least one HIO and ACO. The Authority will develop a plan to expand this functionality to all P3N users and eventually all PA operating care coordination organizations in subsequent years

### ***OMAP’s Expectations for Provider EHR Adoption Over Time and Annual Benchmarks (Response to Questions #2)***

Aside from the EHR adoption goals, the Department’s goals for the Pennsylvania EHR Incentive Program were initially structured around the three critical paths: 1.) provider participation, 2.) infrastructure development, and 3.) Meaningful Use. The Department described its goals and strategies in 2010; Table E.2 below presents some results from the last five years in.

**Table E.2: The Department’s Goals and Strategies for the EHR Incentive Program**

Goal	Strategy	2010 2014 Results
Increase provider participation in the EHR incentive program	The Department will employ outreach and education strategy	<ul style="list-style-type: none"> <li>• Four EHR program related webinars. In post-MAPIR survey 58% of respondents indicated that they had attended Department training (through end of July 2011 – n=410).</li> <li>• Weekly program updates to over 800 listserv subscribers.</li> <li>• Website updated with MAPIR provider manual, FAQs other resources</li> </ul>
Retain majority of enrolled providers in future years, in particular, retain providers between adoption, implementation, upgrade and Meaningful Use	The Department will employ outreach and education strategy	<ul style="list-style-type: none"> <li>• In post-MAPIR survey 100% of respondents indicated they plan to attest to Meaningful Use in 2012 (through end of July 2011 – n=410)</li> </ul>
Provide resources to support increases adoption stage rating for all Medical Assistance providers	The Department will employ outreach and education strategy and collaborate with the Regional Extension Centers	<ul style="list-style-type: none"> <li>• In post-MAPIR survey 25% of respondents indicated in they need additional technical assistance (through end of July 2011n=410).</li> <li>• In post-MAPIR survey 88% of respondents indicated that have taken steps to meet MU standards (through end of July 2011 n=410).</li> </ul>

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Goal	Strategy	2010 2014 Results
Track usage of eHIE services through the Authority and increase the percentage of providers exchanging data to support the Department's overarching eHIE goals	The Department will collaborate with the Authority, specifically on incentive programs to onboard providers to the P3N	<ul style="list-style-type: none"> <li>18/19 respondents indicated in post-MAPIR survey that knew of or had some knowledge of eHIE</li> </ul>
Measure and improve provider satisfaction with the EHR incentive program including satisfaction with the application process and with the assistance provided by the Department	Develop provider satisfaction surveys, e.g., screens at the end of MAPIR with satisfaction questions	<ul style="list-style-type: none"> <li>18/19 respondents indicated in post-MAPIR survey that MAPIR application was not difficult</li> <li>16/19 respondents indicated in post-MAPIR survey that they completed application in 30 minutes or less.</li> </ul>
Increase number of providers who meet Meaningful Use at various stages	Develop interventions to help increase number of providers meeting Meaningful Use e.g., collaborate with the RECs. The Department is also considering requiring providers who participate in health home/medical home to meet Meaningful Use criteria	As of March 16, 2015, there has been \$148,791,271 paid to 9,369 EPs and \$167,772,924 paid to 365 EHs. Of these payments, 5,499 of EPs received payments for AIU and 2,650 unique EPs received payments for MU. There were 1,167 EPs and 74 EHs who received payments for meeting Stage 2 MU.
Improve provider performance on clinical quality measures and objectives	Develop metrics and tracking mechanisms for Meaningful Use reporting and develop interventions to improve results of clinical quality measures and objectives	OMAP has aggregated initial submission of eQMs (QRDA3 level) and identified which eQMs are most likely to be reported by providers. Aggregated results have been collated to see which measures offer an opportunity across the program for the most improvement.

The Department is continuing to refine this roadmap to customize the approach to infrastructure development to address the unique needs and challenges facing providers. As discussed in Section A, professionals and hospitals are at varying levels of EHR adoption and familiarity with HIT. The Department does not fully understand the functionality of the systems that providers are using and anticipates that functionality may change significantly when providers move towards using federally-certified EHR systems. The Department will continue to collect information on the levels of EHR and eHIE adoption, including information on system functionality and progress towards achieving Meaningful Use of certified EHRs.

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Critical to this long-term pathway is defining provider requirements and expectations for achieving Stage 3 of Meaningful Use and beyond. Moving providers who currently have not adopted HIT to Meaningful Use will likely be tied to the provider's perception of sustainability and ability to meet Meaningful Use criteria. The Department's strategy will involve providers in the EHR Incentive Program and to help them evolve in their participation over time. Efforts to clear these hurdles and involve providers in HIT adoption include but are not limited to:

- **Outreach-** As previously noted in Section C, the Department has many provider outreach efforts planned to maximize Medical Assistance provider HIT adoption and sustained participation in the EHR Incentive Program. The Department is using the data that is collected through multiple provider surveys and through outreach to provider associations and other stakeholders. This information will be used to shape the Department's EHR Incentive Program and align outreach and oversight functions in relation to these baseline measures. Over time, the Department also plans to use the MAPIR system and the provider statistics, captured during the application process, to further assess and statistically monitor provider adoption levels and ongoing outreach and technical assistance needs. The MAPIR system will also provide valuable statistics on when an application is suspended for further review to help the Department target outreach efforts.

The Department will analyze and modify the program based on the key issues or challenges for successful enrollment and will regularly outreach to providers to improve success in the program. In all outreach efforts, the Department's emphasis will be to make sure that providers understand that the Department's ultimate goal is to improve quality of care. The EHR Incentive Program is driven by the need to develop the necessary infrastructure to support a more sophisticated means of exchanging data on medical services to save and improve lives and contain costs.

- **Collaboration-** The Department will continue to work in collaboration with other HIT and eHIE initiatives to maximize the existing resources and to ensure an accurate and consistent message regarding the Medical Assistance incentive program is delivered to providers. As previously mentioned, to move providers who currently operate without - HIT to adopt and participate, these providers will have to recognize the clinical value, cost effectiveness and sustainability of HIT. Participation in the incentive program will certainly be seen as a means to offset costs. However, if providers are uncertain of their ability to meet Meaningful Use criteria, they will initially require guidance on which solution will best serve them in meeting the incentive program requirements. The Department will collaborate with Regional Extension Centers, the Authority, medical societies, associations, and others to help disseminate research and model practices on benefits and functionality to promote long-term sustainability. The Department recognizes the importance of engaging consumers and will continue to engage consumers as part of the MAAC.
- **Innovations-** The Department will also work with providers to identify innovative solutions to HIT adoption and how to most effectively adopt and use HIT and meet program requirements

## Section E: The State's Roadmap

and Meaningful Use. Future provider surveys, provider outreach, and further refinement of the current HIT adoption levels will assist the Department in developing solutions that maximize Meaningful Use of HIT for all Medical Assistance providers (those in the incentive program and those who are not).

As providers move from the AIU stage to the MU stage, the Department will be working closely with ONC, and the Authority to provide innovative solutions that support providers' ability to meet these criteria. The Department will be closely monitoring the final rules for Meaningful Use and working with the Authority and the Department's internal data stores to further evaluate clinical and administrative operational plan as it relates to sustaining providers through the life of the Pennsylvania EHR Incentive Program. Given that the Meaningful Use (MU) criteria is subject to change in years 3 and beyond of the program, the Department will continue to evaluate this process and modify data collection and analyses tools as necessary.

Helping providers maximize the benefits of this program and sustain their involvement is critical to the long-term success of the model. The Department is also looking for ways to leverage the experiences of "MUVers." MUVers, as defined by the Office of the National Coordinator, are Meaningful Use Vanguard providers, or providers who are already meeting the requirements of Meaningful Use and demonstrating that they can improve outcomes and quality of care through the use of EHRs and eHIE. MUVers are identified by the Regional Extension Centers (RECs) and so far the RECs have identified over 800 MUVers. The Department will work with the REC to identify and leverage lessons learned from MUVers in Pennsylvania. MUVers are expected to:

- Build momentum for Meaningful Use
- Identify challenges to meeting Meaningful Use
- Assist with the development of tools
- Highlight model practices
- Help to pilot and test Meaningful Use requirements

As the Department works with providers moving them through the Meaningful Use stages, the Department will begin to move towards outcomes and evaluation. The Department will begin to assess quality improvements using the Meaningful Use data, evaluate changes in utilization and service patterns in relation to HIT stages and begin utilizing more advanced features of the Authority.

At the inception of the program in 2011, the Department determined that there were potentially 4,600 Eligible Professionals who could participate in the MA EHR Incentive program based on being able to meet the 30% MA patient volume requirement. Since then the Program has reached and exceeded that goal. This is due to several changes. First, the 2012 Final Rule updated the definition of an encounter to include patients eligible for MA and not just paid encounters. Second, the Program has also seen an increase of new providers who have just started their medical career and are participating in the incentive program through their practice. As of March 16, 2015, there have been 5,700 unique Eligible Professionals and 141 out of the 159 Pennsylvania Eligible Hospitals that have participated in the Pennsylvania MA EHR Incentive program

In projecting for the next 5 years, the Department anticipates that there will continue to be an increase in participation due to the Medicaid Expansion program which may allow new providers and hospitals to meet the 30% patient volume requirement (10% for hospitals except Children's hospitals) and begin participation in the program. Two important components of the Final Rule that need to be considered:

## Section E: The State's Roadmap

First, neither EPs nor EHs are able to begin participating in the MA EHR Incentive program after 12/31/16 so we will not have any new participants after that time period. Second, currently EPs are no longer allowed to switch between the Medicare and Medicaid EHR Incentive programs, so we will not see an increase of providers switching between programs.

In regards to the Meaningful Use part of the program, we are currently in the grace period for program year 2014 applications and are now seeing an increase in applications due to the implementation of the Flexibility Rule. We anticipate that this will increase until the end of our grace period which is June 30, 2015 for EPs. One challenge in determining the continued increase in MU participation is the lack of knowledge about the upcoming two Notice of Proposed Rulemaking (NPRM) rules that will be released and most likely will have an impact on participation in the future. Another challenge for the providers is being able to meet the Stage 2 measures. Even though EPs and EHs are finalizing and/or utilizing a 2014 Certified EHR system, many are still not able to meet the Stage 2 requirements. As of March 16, 2015 only 73 EPs and 74 EHs have been able to successfully attest to Stage 2 MU. This may change with the 2 new NPRMs CMS is releasing soon. Furthermore, we understand the challenges with certain provider types in being able to participate in the EHR Incentive program. These provider types include dentists and behavioral health providers. We are working directly with these groups but currently these are more challenging and preventing us from attaining a higher percentage of MU participation.

Based on the above summary, Tables E.2 and E.3 below provide information on the Department's future adoption and Meaningful Use goals through the next five years.

**Table E.3: EHR Adoption Rate Goals for Medical Assistance Providers, 2015-2019**

**NOTE:** As of 3/16/15 we had 5,499 Unique Providers attest to AIU and 141 Unique Hospitals attest to the MA EHR Incentive program

	2015	2016	2017	2018	2019
EP	5774	6063	n/a	n/a	n/a
EH	142	144	n/a	n/a	n/a

**Table E.4: EHR Meaningful Use Rate Goals for Medical Assistance Providers, 2015-2019**

**NOTE:** As of 3/16/15 there were 2,650 unique EPs who have received MU payments and the potential target is 6,063 (see chart above). Below is the % toward the goal of 6,063 that we would like to reach.

	2015	2016	2017	2018	2019
EP	60% (3,638)	70% (4,244)	80% (4,826)	90% (5,457)	95% (5,760)

In addition to increasing participation in the program, we are also preparing goals in anticipating the participation in Health Information Exchange and utilizing a Health Information Organization to share information. Although we do not have an exact measure currently of how many providers are participating with an HIO, we know it is low. Our goal for the next 5 years is to have 100% participation with the EHs who are participating in the MA EHR Incentive program and 80% participation with the EPs. We understand that the costs may be prohibitive to some of the EPs so that will limit the participation. We are also planning on working with the Authority to be able to allow those EPs to participate in the exchange of data through a HIO.

### ***Annual Benchmarks for Audit and Oversight Activities (Response to Question 4)***

## Section E: The State's Roadmap

As Sections C and D describe, the MAPIR system is being designed to facilitate monitoring and oversight during application, attestation, post-payment, and during the renewal process. As described in Section D both eligible professionals and eligible hospitals will be reviewed, but hospitals payments will be reviewed more closely before issuing the payment since the payments are much larger. Some examples of annual benchmarks that will be captured through MAPIR and other oversight activities include:

- Number of reviews conducted by the Department. EHR incentive payment reviews will be incorporated into other reviews;
- 100 percent of overpayments recouped within one year for the categories described in Section D;
- Number of technical assistance referrals made and resolved; and,
- Special studies and findings, e.g., patient volume reviews, assignment of payments consensual.

These findings will be reported in the CMS audit database.

## Appendix I: Glossary of Terms and Acronyms

### Appendix I: Glossary of Terms and Acronyms

The matrix below provides a glossary of terms and acronyms that are frequently used in discussions about the Department of Human Services' HIT initiative.

Term	Acronym	Definition
<b>Technology</b>		
<b>Health Information Technology</b>	HIT	<ul style="list-style-type: none"> <li>• Allows comprehensive management of medical information and its secure exchange between health care consumers and providers</li> <li>• Application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data and knowledge for communication and decision-making</li> </ul>
<b>Electronic Medical Record</b>	EMR	<ul style="list-style-type: none"> <li>• The legal record created in hospitals and ambulatory environments that is the source of data for an electronic health record (EHR)</li> <li>• A record of clinical services for patient encounters in a single provider organization; does not include encounter information from other provider organizations</li> <li>• Created, gathered, managed and consulted by licensed clinicians and staff from a single provider organization who are involved in the individual's health and care</li> <li>• Owned by the provider organization</li> <li>• May allow patient access to some results information through a portal, but is not interactive</li> </ul>

## Appendix I: Glossary of Terms and Acronyms

<b>Electronic Health Record</b>	EHR	<ul style="list-style-type: none"> <li>• A subset of information from multiple provider organizations where a patient has had encounters</li> <li>• An aggregate electronic record of health-related information for an individual that is created and gathered cumulatively across multiple health care organizations, and is managed and consulted by licensed clinicians and staff involved in the individual’s health and care</li> <li>• Connected by a Health Information Exchange (HIE)</li> <li>• Can be established only if the EMRs of multiple provider organizations have evolved to a level that can create and support a robust exchange of information</li> <li>• Owned by patient</li> <li>• Provides interactive patient access and ability for the patient to append information</li> </ul>
Term	Acronym	Definition
<b>Personal Health Record</b>	PHR	<ul style="list-style-type: none"> <li>• Electronic, cumulative record of health-related information for an individual in a private, secure and confidential manner</li> <li>• Drawn from multiple sources</li> <li>• Created, gathered, and managed by the individual</li> <li>• Integrity of the data and control of access are the responsibility of the individual</li> </ul>
<b>Electronic Health Information Exchange</b>	eHIE	<ul style="list-style-type: none"> <li>• The sharing of clinical and administrative data across the boundaries of health care institutions and providers</li> <li>• The mobilization of healthcare information electronically across organizations within a region, community or hospital system</li> <li>• Provides capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged</li> <li>• Goal is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable patient-centered care</li> </ul>

## Appendix I: Glossary of Terms and Acronyms

<b>Pennsylvania eHealth Partnership Authority</b>	the Authority	<ul style="list-style-type: none"> <li>• Independent state agency created by Act 121 of 2012 to coordinate eHIE development efforts across the Commonwealth, build and maintain the ability for patients to opt-out of eHIE, and educate providers and the public about eHIE. The Authority is governed by a public-private Board of Directors which includes a permanent seat for the Secretary of Human Services.</li> </ul>
<b>Health Information Organization</b>	HIO	<ul style="list-style-type: none"> <li>• A private sector organization that enables eHIE for providers, patients, and/or payers</li> <li>• Standard terminology adopted in Pennsylvania to distinguish the action of eHIE from the organizations that enable eHIE.</li> <li>• The Authority maintains a certification program for HIOs. Certification is free and voluntary, but required for participation in the P3N and in Department/Authority administered eHIE-related grant and incentive programs.</li> </ul>
<b>Health Information Service Provider</b>	HISP	<ul style="list-style-type: none"> <li>• An organization that provides DIRECT services for providers, patients, and/or payers.</li> <li>• The Authority maintains a certification program for HISPs. Certification is free and voluntary, but required for participation in Department/Authority administered DIRECT-related grant and incentive programs.</li> </ul>
<b>Pennsylvania Patient and Provider Network</b>	P3N	<ul style="list-style-type: none"> <li>• The combination of governance, legal, and technical services offered by the Authority to establish state-wide interoperability amongst HIOs and HISPs.</li> <li>• Includes the PHG.</li> <li>• HIOs pay fees in order to participate in P3N</li> </ul>
<b>Public Health Gateway</b>	PHG	<ul style="list-style-type: none"> <li>• A part of P3N that enables single-pathway communication between the public and private sectors in Pennsylvania.</li> <li>• As of 2015 includes submissions from providers to the Department’s eCQM repository, and to the Department of Health’s Immunization, Cancer, Electronic Lab Reporting, and Syndromic Surveillance registries.</li> </ul>
<b>CMS Registration and Attestation System (R&amp;A)</b>	R&A	<ul style="list-style-type: none"> <li>• A repository that will be available to states to help avoid duplication of payments to providers participating in the EHR Provider Incentive Program</li> <li>• Information the repository is proposed to store includes provider registration information, Meaningful Use attestations and incentive payment information</li> </ul>

## Appendix I: Glossary of Terms and Acronyms

<b><i>CMS Documentation Requirements for Provider Incentive Program<sup>5,6</sup></i></b>		
<b>Planning Advanced Planning Document</b>	PAPD	A plan of action, and any necessary update documents, that requests FFP and approval to accomplish the planning necessary for a State agency to determine the need for and plan the acquisition of HIT equipment or services or both and to acquire information necessary to prepare a HIT implementation advanced planning document (IAPD) or request for proposal to implement the State Medicaid HIT Plan (SMHP)
<b>State Medicaid Health Information Technology Plan</b>	SMHP	<ul style="list-style-type: none"> <li>• Document that describes a state’s current and future HIT activities in support of the Medicaid EHR incentive program</li> <li>• Purpose is to identify the “As-Is” state and “To-Be” (target) state of a state’s Medicaid business enterprise and to align business areas and processes in the user community</li> <li>• Development of an SMHP provides states an opportunity to analyze and plan for how EHR technology, over time, can be used to enhance quality and health care outcomes and reduce overall health care costs</li> </ul>
<b>Implementation Advanced Planning Document</b>	IAPD	<ul style="list-style-type: none"> <li>• A plan of action, and any necessary update documents, that requests FFP and approval to acquire and implement the proposed SMHP services or equipment or both</li> </ul>

<sup>5</sup> To receive FFP for administering an EHR provider incentive program, a state must develop a HIT PAPD, an SMHP and a HIT IAPD to describe its process to implement and oversee the EHR incentive program. They will help states to construct an HIT roadmap to develop the systems necessary to support providers in their adoption and Meaningful Use of certified EHR technology.

<sup>6</sup> The APD process allows states to update their APD when they anticipate changes in scope, cost, schedule, etc. States may add tasks to the contract which they identified after the HIT PAPD was written and as they worked on tasks included in the original submission. This is a complex initiative that will most likely result in an “as needed” and “annual” update to the original scope of work.

## Appendix I: Glossary of Terms and Acronyms

<i>Other</i>		
<b>Children’s Health Insurance Program Reauthorization Act</b>	CHIPRA	<ul style="list-style-type: none"> <li>• Provides grant funding for demonstration programs</li> <li>• Pennsylvania awarded grant funds for initiative to link geographically diverse health systems across the Commonwealth with a common pediatric EHR and pediatric survey tool with the goal to better meet needs of children with critical medical needs, to target resources provided in the child serving system and to ensure children are properly screened and referred to providers offering them the appropriate care</li> </ul>
<b>Health Information Technology for Economic and Clinical Health Act</b>	HITECH	<ul style="list-style-type: none"> <li>• Act that provides for funding opportunities to advance health information technology</li> </ul>
<b>Electronic Quality Improvement Project</b>	EQUIP	<ul style="list-style-type: none"> <li>• Project developed and designed in collaboration with providers to assist in the improvement of services to consumers while allowing the providers to demonstrate Meaningful Use</li> </ul>
<b>Medicaid Information Technology Architecture</b>	MITA	<p>Both a framework and an initiative:</p> <ul style="list-style-type: none"> <li>• National framework to support improved systems development and health care management for the Medicaid enterprise</li> <li>• Initiative to establish national guidelines for technologies and processes that enable improved program administration for the Medicaid enterprise, and which includes an architecture framework, models, processes and planning guidelines for enabling State Medicaid enterprises to meet common objectives with the framework while supporting unique local needs</li> </ul>
<b>Regional Extension Centers</b>	REC	<ul style="list-style-type: none"> <li>• Entities that have received grants funds to offer technical assistance, guidance, and information to support and accelerate health care providers’ efforts to become Meaningful Users of EHRs</li> <li>• Originally designed to ensure primary care clinicians who need help are provided with an array of on-the-ground support to meaningfully use EHRs</li> <li>• Entities will provide training and support services to assist doctors and other providers in the adoption and Meaningful Use of EHR systems</li> <li>• Part of the Health Information Technology Extension Program authorized through the HITECH Act</li> </ul>

## Appendix II: Baseline Landscape Assessment

### Appendix II: Baseline Landscape Assessment

#### Surveys of Practitioners – 2005 and 2010

In June and July of 2005, the Pennsylvania Medical Society and Quality Insights of Pennsylvania surveyed over 2,800 Pennsylvania medical practices to assess current and prospective use of EHR systems in the Commonwealth. Results of the survey found that only 14 percent of the medical practices (below the national average of 17 percent in 2005) had implemented EHR systems; 12 percent of respondents were in the process of implementing a system. The survey segmented responses by primary care, surgical specialist and medical specialist and found that surgical specialists were the most likely to have a current EHR system in place. Based on results of the survey, the estimated growth rate of EHR systems ranged from 0.25 percent to 0.75 percent of practices per month. Survey respondents cited costs of EHR as the key barrier to implementation. However practices with EHRs reported positive rating on their ability to serve patients more effectively and safely.

The Department surveyed practitioners in August and September 2010 to gauge the current extent of EHR adoption among Medical Assistance practitioners and targeted the survey practitioners potentially eligible for Medical Assistance EHR incentive payments. The survey was conducted via web-based tool. The link to the survey was sent to practitioners through the following contacts:

Pennsylvania Chapter American Academy of Pediatricians

HealthChoices Managed Care Organizations to distribute to providers

Gold Star providers through the Unison Health Plan – high volume Medical Assistance providers

Access Plus providers (primary care case management providers)

Conducting the survey through a web-based tool allowed for quick turnaround with surveyed practitioners. The survey was targeted to high volume Medical Assistance practitioners; many affiliated with large institutions or participate with HealthChoices MCOs, in the group referred to as “PA-surveyed Medical Assistance practitioners.” Many of these practices have started to implement an EHR but have not attained full functionality and who may be affiliated with health systems that have already invested in HIT infrastructure and are therefore further along.

The web-based survey tool and use of provider associations will also allow the Department to repeat the survey easily in the future. However, the Department recognizes that there is response bias in that respondents who are comfortable responding over the internet may be more likely to be comfortable with EHR systems and therefore may be more likely to be EHR adopters. There is also response bias in that many of the responses represented early adopters such as the Geisinger Health System. The survey findings describe the potential response bias which will be addressed by repeating this methodology in future years to have comparable results with which to compare the current results. The Department is planning to conduct more targeted surveys or focus groups for practitioners who are not comfortable with responding via a web-based survey in the future.

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According to survey results, 267 respondents started the survey and 131 respondents successfully completed the survey. The Department anticipates that office managers or other representatives would complete on behalf of the practitioners in their offices and asked questions to determine the number of practitioners each survey represented. The survey responses represent 2,294 practitioners as described in Table II.1 below.

Table II.1: Practitioner Breakdown

Practitioner Type	Count	Percent of Total
Pediatrician*	594	26%
Primary Care Physicians	420	18%
Specialists	1,124	29%
Other – Eligible	12	1%
Other – Non-Eligible	144	6%
Total	2,294	

\* Of the 594 Pediatricians, 38 were identified as Pediatric Specialists

Table II.2 provides a breakdown of the physical location of the practitioner.

Table II.2: Practitioner Location

Location	Count	Percent of Responses (Rounded)
Rural	1,098	48%
Urban	1,196	52%
Total	2,294	

According to survey results, 60 percent of the respondents in the PA-surveyed Medical Assistance practitioner group indicated that they currently use an EHR software package within their practice/clinic.

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The largest percentage of respondents began their system implementations in 2009. Also, these figures do not describe the level of implementation. The 60 percent adoption rate is believed to be a sampling bias that overrepresented adoption in Pennsylvania for the reasons described above; web-based survey that was targeted to high-volume Medical Assistance practitioners with many of the responses coming from large health system practitioners and other groups that are likely to be early EHR adopters.

Table II.3 below provides a break-out of the period for when practitioners plan to participate in the PA Medical Assistance HIT incentive program. More than half of the responses indicated that they plan to participate in the PA Medical Assistance HIT incentive program beginning in 2011 or 2012.

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Table II.3: Anticipated Date of Initial Participation

Electronic Health Records	Count	Percent
2011	62	47%
2012	10	8%
2013	5	4%
2014	1	<1%
2015	0	0%
2016	0	0%
Unanswered	53	40%
Total	131	

Table II.4 below provides a break-out of the EHR functionality used by practitioners. Many of the responses indicate the use of clinical documentation and medical history and problem list functionality. Almost half of respondents indicated that their systems have the necessary functionality for clinical documentation, documenting medical history and problem lists, electronic prescribing and physician order entry.

Table II.4: EHR Functionality Used by Practitioners

Function	Count	Percent of Responses (Rounded)*
Clinical Documentation	72	55%
Medical History	69	53%
Problem Lists	68	52%
Electronic Prescribing	61	47%
Physician Order Entry	61	47%
Reporting (Quality Measures)	46	35%
Decision Support	34	26%

## Appendix II: Baseline Landscape Assessment

Discharge Planning	28	21%
Exchange with Other Systems	25	19%
Total	464	

\* Based on 131 respondents who completed the survey

Table II.5 below provides a break-out of the usage of computerized systems. The table includes the percentage of respondents who indicated that they had the functionality below and used the functionality. For example, almost all respondents who have patient problem lists, patient allergy lists, patient medications, and clinical notes or care plans, use this functionality.

Table II.5: Usage of Computerized Systems By Percent (Rounded)

Electronic Health Records	Yes	No	Unsure	Do Not Use	Use Some of the Time	Use Most or All the Time	Not Applicable
Patient problem lists	99%	1%	0%	1%	7%	92%	0%
Patient allergy lists	100%	0%	0%	1%	1%	97%	0%
Patient medication lists	97%	3%	0%	3%	3%	95%	0%
Viewing Lab results?	84%	12%	4%	4%	18%	70%	8%
Viewing Imaging results	63%	36%	1%	17%	15%	47%	21%
Clinical notes or care plans?	93%	6%	1%	3%	6%	89%	3%
Care gap reminders for guideline-based interventions and/or screening tests?	58%	30%	12%	13%	22%	44%	21%
Public health reporting?	12%	57%	31%	45%	5%	11%	40%

Table II.6 below provides a break-out of the systems that are connected to the EHR. Labs and pharmacies have the highest rate of connectivity.

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Table II.6: EHR Connections

Connections	Count	Percent of Responses* (Rounded)
Lab(s)	46	35%
Pharmacy	42	32%
Hospital(s)	29	22%
Other clinic(s)	22	17%
Digital Radiology	17	13%
Emergency Department(s)	14	11%
HP/PROMISE™	1	1%
Total	171	

\* Based on 131 respondents who completed the survey

Table II.7 provides an overview of health information exchange (HIE) practitioner participation rates. The low percentage of participation in an HIE highlights the goals of Meaningful Use to improve quality, safety, efficiency, and reduce health disparities by using computerized physician order entry, e-prescribing, and maintaining an active medication list and up-to-date problem list of current and active diagnoses.

Table II.7: Health Information Exchange Participation

	Yes	No
Participates in HIE	5%	95%
Practice currently provides health information electronically to patients	22%	78%
If currently does not provide electronic health information plans to provide electronic health information to patients	74%	26%

## Appendix II: Baseline Landscape Assessment

in the future		
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Successful implementation of an EHR system requires funding, adequate staffing, training, and leadership. The Department estimates that there are approximately between 4,500 and 4,600 eligible Medical Assistance practitioners. The MA HIT Initiative is well positioned to encourage provider Adoption, Implementation, Upgrading, and Meaningful Use.

### Survey of Federally Qualified Health Centers

PACHC has not conducted an EHR implementation survey since 2010. As mentioned before, FQHCs report the status of EHR implementation, functionality and utilization to report clinical Uniform Data System data in the UDS report. That report does not go to the level of reporting the number and/or type of practitioner utilizing an EHR.

The UDS does ask if providers at the health center are Meaningful Users of HIT.

As part of the annual Uniform Data System (UDS) reporting required of all FQHCs, starting in 2011, FQHCs reported the status of EHR implementation, functionality and utilization to report clinical UDS data.

Year	Total FQHCs Reporting	EHR Available at All Sites for All Providers	EHR Limited to Some Sites or Some Providers	Total FQHCs with EHR Installed	No EHR Installed %	No EHR Installed – number of FQHCs
2011	35	54.3%	20%	74.3%	25.7%	9
2012	40	77.5%	15%	92.5%	7.5%	3
2013	40	85%	12.5%	97.5%	2.5%	1

For 2013, 36 FQHCs answered: Yes. Providers are receiving Meaningful Use incentive payments from CMS due to their use of health center’s EHR system; and 4 FQHCs answered: Not yet, but providers at

## Appendix II: Baseline Landscape Assessment

my health center plan to apply to receive Meaningful Use incentive payments from CMS in the coming year.

In April 2010, the Department sent a survey inquiring about EHR implementation status to every health center in Pennsylvania. The Department received responses from all but one health center.<sup>7</sup>

According to survey results, 44 percent of health center practitioners in Pennsylvania have either fully implemented or are in the process of implementing an EHR system.<sup>8</sup> A larger percentage (26 percent) responded that they were in the process of implementing EHR rather than having a fully implemented EHR (18 percent).

Tables II.8 and II.9 below provide detail total number of practitioner types at health centers that have either fully implemented or are in the process of implementing EHR. The category “Practitioner” refers to physicians and specialists, the category “Mid” refers to mid-levels providers such as midwives and certified registered nurse practitioners, and “Dentists” is dentists only.

Table II.8: Health Centers with EHR Fully Implemented

Health Center	FT Practitioner	PT Practitioner	FT Mid	PT Mid	FT Dentist	PT Dentist	Total
East Liberty	22	0	1	1	1	1	26
Esperanza	14	0	2	1	2	0	19
Family Practice and Counseling	0	1	17	3	7	0	28
Keystone Rural Health Center	35	4	10	0	5	0	54
Mathilda Theiss	3	0	0	0	0	0	3
Public Health Management	2	0	17	0	0	0	19
Spectrum	8	5	0	2	0	0	15
Squirrel Hill	3	2	1	0	0	0	6

<sup>7</sup> Types of health centers include FQHCs, FQHC Look-Alikes, Hospital-Based RHCs, Independent, Not-For-Profit RHCs, and Independent, For-Profit RHCs

<sup>8</sup> Practitioner types include Full-Time Physicians (9a), Part-Time Physicians (9b), Full-Time Midwives (10a), Part-Time Midwives (10b), Full-Time Dentists (11a) and Part-Time Dentists (11b).

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Washington Phys. Services	3	0	1	0	0	0	4
Totals	90	12	49	7	15	1	174
Percent with full EHR Implementation	17.96%	11.21%	27.07%	31.82%	12.40%	7.69%	18.41%

Table II.9: Health Center with EHR Implementation in Process

Health Center	FT Practitioner	PT Practitioner	FT Mid	PT Mid	FT Dentist	PT Dentist	Total
Centerville	22	6	3	0	2	2	35
Chespenn	11	2	1	0	3	0	17
Delaware Valley	21	0	2	1	7	0	31
Hamilton	13	1	3	0	4	1	22
NEPA	2	0	4	0	0	0	6
North Penn Comprehensive	10	0	3	0	0	0	13
Northside Christian	6	0	3	0	0	1	10
Primary Health Network	43	27	17	0	10	2	99
Conneaut Valley	7	1	4	1	0	0	13
Totals	135	37	40	2	26	6	246
Percent "In Process" of implementing	26.95%	34.58%	22.10%	9.09%	21.49%	46.15%	26.03%

Total - "Fully Implemented" or "In Process"	225	49	89	9	41	7	420
Percentage "Fully	44.91%	45.79%	49.17%	40.91%	33.88%	53.85%	44.44%

## Appendix II: Baseline Landscape Assessment

Implemented" or "In Process"							
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Table II.10 below provides a break-out of the practitioner types by type of center for those health centers that responded to the Department’s survey. Of the 945 practitioners represented by health centers responding to the survey, a majority of practitioners work in either a -FQHC (755) or a FQHC look-alike (139) and the majority of practitioners were classified as full-time physicians (501).

Table II.10: Number of Practitioners by Type of Health Center

Type of Health Center	FT Phys (9a)	PT Phys (9b)	FT Mid (10a)	PT Mid (10b)	FT Dent (11a)	PT Dent (11b)	Total
FQHC	379	82	159	21	102	12	755
FQHC Look-Alike	103	9	10	0	17	0	139
Hospital-Based RHC	13	16	9	1	1	1	41
Independent Not-For-Profit Rural Health Center	3	0	2	0	1	0	6
Independent For-Profit Rural Health Center	3	0	1	0	0	0	4
<b>Total</b>	<b>501</b>	<b>107</b>	<b>181</b>	<b>22</b>	<b>121</b>	<b>13</b>	<b>945</b>

### Department Surveys

Beginning in 2011, the Department created and released a number of surveys focusing on Meaningful Use, Stage 2, eCQMs, the Flexibility Rule and MAPIR. Below are the responses to a few of the key questions from these surveys.

This question captured the reason why eligible providers or eligible hospitals were compelled to implement an Electronic Health Record.

Table II. 11: Reasons to Implement an Electronic Health Record (EHR)

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Reasons to Implement (EHR)	Count	Percent of Total
EHR Incentive Program	59	74.68%
Health Information	21	26.58%
Medical Home Accreditation	11	13.92%
Ease of Use	2	27.85%
Other –	25	31.65%
<b>Total</b>	<b>79</b>	

\*\*Other being the second highest this was an open ended question. Providers

are looking forward to embracing the change in technology enhancements in the healthcare industry. This implementation will allow more accuracy on patient records and increase the quality and access to care which two of the three main issues are in our healthcare system today

Table II.12 2011 Knowledge Base of the Health Information Exchange (HIE)

Health Information Exchange (HIE)	Count	Percent of Total
No Knowledge of (HIE)	9	11.39%
Heard of (HIE)	38	48.10%
Know of (HIE)	32	40.51%
<b>Total</b>	<b>79</b>	

The eQCM Reporting survey from July 2014, had 85 respondents started the survey and 85 respondents successfully completed the survey. The Department anticipates that office managers or other representatives would complete this MAPIR Follow-Up Survey. This survey was automatically sent to all providers after an application was completed in the MAPIR system. The survey responses represent 85 practitioners as described in the tables below.

Table II. 13 Familiarity with the Electronic Clinical Quality Measures (eQCM) reporting

Health Information Exchange (HIE)	Count	Percent of Total
Knowledgeable of (eQCM)	66	77.65%

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Not Knowledgeable of (eCQM)	19	22.35%
Total	85	

Table II. 14 Manual vs. Electronic Submission of CQM Preferences

Manual vs. Electronic Submission	Count	Percent of Total
Manual	3	5.56%
Electronic Submission	43	79.63%
Undecided	8	14.81%
Total	54	

\*\*\* 31 people have skipped this question

Table II. 15 Concerns About (eCQM)

Concerns about (eCQM)	Count	Percent of Total
Cost	15	29.41%
Lack of Staff/Resources	30	58.82%
Security	13	25.49%
Technical Inability	22	43.14%
None	11	21.57%
Total	51	

\*\*\* 7 people have skipped this question

Survey of Hospitals

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In 2009, the American Hospital Association (AHA) distributed surveys to Pennsylvania hospitals to assess the level of HIT adoption throughout the state. The surveys were sent out in May 2009 and collected data through August. Overall there was a 72 percent response rate from Pennsylvania hospitals and a 73 percent response rate from all Pennsylvania general acute care (GAC) hospitals. The significant response from the survey gives more weight to the trends and responses. The results from the survey are as follows:

*General Acute Care Hospitals* - Of the GAC hospitals surveyed, 63 percent have at least begun to implement an -EHR- system, and 49 percent of the hospitals have an almost basic EHR system or better.

*All Pennsylvania Hospitals* - As of August 2009, 85 percent of Pennsylvania hospitals have patient demographics implemented in their electronic clinical documentation. Nursing notes and Medication lists exist in electronic form in 38 percent and 54 percent of Pennsylvania hospitals, respectively. However, 31 percent of hospitals are considering implementing physician notes but do not have the resources to add them to the electronic documentation.

Within the Pennsylvania hospitals, 54 percent do not share patient level clinical data through an HIE. Forty-six percent of hospitals share clinical data with ambulatory practitioners outside their hospital health system compared to 9 percent of hospitals who share their data with other hospitals outside their health system.

In 2010, the AHA sent out another HIT survey to all Pennsylvania hospitals and had a 73 percent response rate. The results from the survey are as follows:

Of the nine priority practitioners surveyed, 89 percent have partially or fully implemented an EHR system.<sup>9</sup>

Eighty-eight percent of the practitioners are exchanging clinical information with in-system hospitals and ambulatory practitioners, but 44 percent do not have an HIE framework in place. Subsequently, only 22

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<sup>9</sup> The nine priority providers identified for this survey are: Hospital of the University of Pennsylvania, Lancaster General Health, Lehigh Valley Hospital, Pinnacle Health System, Robert Packer Hospital, Thomas Jefferson University Hospital, University of Pittsburgh Medical Center/Presbyterian, Wellspan Health/York Hospital, and Williamsport Hospital and Medical Center

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percent actively participate in HIE, and only 11 percent share more than clinical data with hospitals and ambulatory practitioners outside their health system.

In 2002, the Children's Hospital of Pittsburgh of UPMC implemented a Children's EHR, which has been successful in providing instantaneous access to the child's full record, managing quality by enabling Children's to mine discrete data — not scanned forms — for trends and patterns in patient care and caregiver behaviors and improving the diagnosis and treatment of pediatric disease through analysis of the collected data. Children's achievement in EHR adoption has been recognized by the Healthcare Information and Management Systems Society (HIMSS) as a facility that has achieved Stage 7 adoption, which only 0.7 percent of the surveyed facilities were able to achieve by 2009. Children's EHR has achieved the following operational efficiencies:

Practitioners place more than 94 percent of all orders directly into the electronic record, reducing the potential for human error by eliminating handwritten and verbal orders.

Eliminates time-consuming processes such as the search for paper records, and the faxing and/or delivery of paper records between nursing units and departments.

Eliminates the need to ask for the same information from the patient or parent.

Mobile, wireless computers allows nurses, physicians to spend less time charting at the nurse's station and more time at the patient's bedside.

Gives caregivers real-time access to critical patient information, such as the types of care and medications that a patient received.

Gives caregivers immediate access to lab and radiology reports as well as online access to medication formularies and medical references so that caregivers have this potentially lifesaving information before making a decision.

Provides information needed for regulatory and compliance standards.

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Allows pediatric interns, residents and fellows to train with state-of-the-art technology.

The entire EHR is securely available at the bedside and from anywhere in the world.

In addition, four facilities within the UPMC Health System (Magee-Women's Hospital, UPMC Presbyterian, UPMC - St. Margaret and UPMC Mercy) as well as Doylestown Hospital and St. Clair Memorial Hospital have been recognized by HIMSS to have achieved Stage 6 adoption, or achieved EMR capabilities which include physician documentation, full clinical decisions support systems and a full complement of Picture Archive and Communication Systems (PACS) to provide medical images to physicians via an intranet and displaces all film-based images.

In 2014, the American Hospital Association released their Health IT Survey. The completed surveys were submitted to the AHA in late-2014 and early-2015 (Survey Closed March 6, 2015). There were 109 responses that represent 69 percent of the 159 Pennsylvania GAC hospitals. The respondents are representative of all PA GAC hospitals based on size, region, and system affiliation (i.e., stand-alone vs. part of a multi-hospital system). Below are some of the relevant results from this survey.

1. Does your hospital currently have a computerized system which allows for:

	(1)	(2)	(3)	(4)	(5)	(6)
<i>(Fully implemented means it has completely replaced paper record for the function.)</i>	<b>Fully Implemented</b>	<b>Fully Implemented in at least one Unit</b>	<b>Beginning to Implement in at least one Unit</b>	<b>Have Resources to Implement in the next year</b>	<b>Do Not have Resources but Considering Implementing</b>	<b>Not in Place and Not Considering Implementing</b>
<b>Number out of 109 Responses</b>	<b>Across ALL Units</b>					
<b>Electronic Clinical documentation</b>						
Patient demographics	<b>107</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Physician notes	<b>54</b>	<b>35</b>	<b>4</b>	<b>9</b>	<b>7</b>	<b>0</b>

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	(1)	(2)	(3)	(4)	(5)	(6)
<i>(Fully implemented means it has completely replaced paper record for the function.)</i>	<b>Fully Implemented</b>	<b>Fully Implemented in at least one Unit</b>	<b>Beginning to Implement in at least one Unit</b>	<b>Have Resources to Implement in the next year</b>	<b>Do Not have Resources but Considering Implementing</b>	<b>Not in Place and Not Considering Implementing</b>
<b>Number out of 109 Responses</b>	<b>Across ALL Units</b>					
Nursing notes	<b>90</b>	<b>15</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>0</b>
Problem lists	<b>93</b>	<b>14</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>0</b>
Medication lists	<b>102</b>	<b>6</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Discharge summaries	<b>90</b>	<b>11</b>	<b>1</b>	<b>5</b>	<b>2</b>	<b>0</b>
Advanced directives (e.g. DNR)	<b>97</b>	<b>8</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>2</b>
<b>Results Viewing</b>						
Laboratory reports	<b>108</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Radiology reports	<b>108</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Radiology images	<b>102</b>	<b>2</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>0</b>
Diagnostic test results (e.g.						
EKG report, Echo report)	<b>101</b>	<b>5</b>	<b>2</b>	<b>1</b>	<b>0</b>	<b>0</b>
Diagnostic test images (e.g.						
EKG tracing)	<b>95</b>	<b>6</b>	<b>2</b>	<b>5</b>	<b>0</b>	<b>0</b>
Consultant reports	<b>86</b>	<b>11</b>	<b>2</b>	<b>7</b>	<b>3</b>	<b>0</b>

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<i>(Fully implemented means it has completely replaced paper record for the function.)</i>	(1)	(2)	(3)	(4)	(5)	(6)
<b>Number out of 109 Responses</b>	<b>Fully Implemented Across ALL Units</b>	<b>Fully Implemented in at least one Unit</b>	<b>Beginning to Implement in at least one Unit</b>	<b>Have Resources to Implement in the next year</b>	<b>Do Not have Resources but Considering Implementing</b>	<b>Not in Place and Not Considering Implementing</b>

**Computerized Provider Order Entry** (Provider (e.g., MD, APN, NP) directly enters own orders that are transmitted *electronically*)

Laboratory tests	<b>98</b>	<b>8</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>0</b>
Radiology tests	<b>100</b>	<b>6</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>0</b>
Medications	<b>99</b>	<b>8</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>0</b>
Consultation requests	<b>96</b>	<b>7</b>	<b>2</b>	<b>0</b>	<b>4</b>	<b>0</b>
Nursing orders	<b>99</b>	<b>6</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>0</b>

### Decision Support

Clinical guidelines (e.g. Beta blockers post-MI, ASA in CAD)	<b>89</b>	<b>10</b>	<b>5</b>	<b>1</b>	<b>3</b>	<b>0</b>
Clinical reminders (e.g. pneumovax)	<b>89</b>	<b>11</b>	<b>2</b>	<b>1</b>	<b>4</b>	<b>0</b>
Drug allergy alerts	<b>105</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>
Drug-drug interaction alerts	<b>104</b>	<b>3</b>	<b>0</b>	<b>1</b>	<b>0</b>	<b>0</b>
Drug-lab interaction alerts	<b>82</b>	<b>12</b>	<b>0</b>	<b>8</b>	<b>3</b>	<b>2</b>

## Appendix II: Baseline Landscape Assessment

	(1)	(2)	(3)	(4)	(5)	(6)
<i>(Fully implemented means it has completely replaced paper record for the function.)</i>	<b>Fully Implemented</b>	<b>Fully Implemented in at least one Unit</b>	<b>Beginning to Implement in at least one Unit</b>	<b>Have Resources to Implement in the next year</b>	<b>Do Not have Resources but Considering Implementing</b>	<b>Not in Place and Not Considering Implementing</b>
<b>Number out of 109 Responses</b>	<b>Across ALL Units</b>					
Drug dosing support (e.g. renal dose guidance)	<b>85</b>	<b>8</b>	<b>3</b>	<b>9</b>	<b>1</b>	<b>1</b>
<b>Bar Coding or Radio Frequency Identification (RFID) for Closed-loop Medication Tracking</b>						
Medication administration	<b>81</b>	<b>20</b>	<b>2</b>	<b>3</b>	<b>2</b>	<b>0</b>
Patient verification	<b>82</b>	<b>21</b>	<b>2</b>	<b>2</b>	<b>1</b>	<b>0</b>
Caregiver verification	<b>69</b>	<b>15</b>	<b>3</b>	<b>6</b>	<b>4</b>	<b>10</b>
Pharmacy verification	<b>70</b>	<b>18</b>	<b>2</b>	<b>5</b>	<b>3</b>	<b>7</b>
<b>Other Functionalities</b>						
Bar coding or Radio Frequency (RFID) for supply chain management	<b>48</b>	<b>16</b>	<b>3</b>	<b>6</b>	<b>20</b>	<b>13</b>
Telehealth	<b>24</b>	<b>37</b>	<b>12</b>	<b>11</b>	<b>11</b>	<b>13</b>
Ability to connect mobile devices (tablet, smart phone, etc.) to her	<b>69</b>	<b>14</b>	<b>9</b>	<b>4</b>	<b>6</b>	<b>5</b>

2. Does your hospital currently have a computerized system which allows for:

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<b>Electronic Clinical Documentation</b>	<b>Yes</b>	<b>No</b>	<b>Do Not Know</b>
Record gender/sex and date of birth	108	0	0
Record race and ethnicity	108	0	0
Record time and preliminary cause of death when applicable	103	2	2
Record preferred language for communication with providers of care	107	0	1
Record vital signs (height, weight, blood pressure, BMI, growth charts)	108	0	0
Record smoking status using standard format	108	0	0
Record and maintain medication allergy lists	108	0	0
Record patient family health history as structured data	101	6	1
Incorporate as structured data lab results for more than 40 percent of patients admitted to inpatient or emergency departments	108	0	0
<b>Population Health Management</b>	<b>Yes</b>	<b>No</b>	<b>Do Not Know</b>
Generate lists of patients by condition	106	1	1
Identify and provide patient-specific education resources	103	2	2
<b>Medication Management</b>	<b>Yes</b>	<b>No</b>	<b>Do Not Know</b>
Compare a patient's inpatient and preadmission medication lists	104	3	1
Provide an updated medication list at time of discharge	108	0	0
Check inpatient prescriptions against an internal formulary	101	4	3
Automatically track medications with an electronic medication administration record (eMAR)	105	2	1
Prescribe (eRx) discharge medication orders electronically	80	27	1

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### Number out of 109 Responses

	Yes	No	Do Not Know
<b>Care Summary Documents</b>			
Generate summary of care record for relevant transitions of care using Clinical Document Architecture (CCDA) format.	105	2	1
Include care teams and plan of care in summary of care record	101	3	5
Send summary of care records to an unaffiliated organization using a different certified EHR vendor	93	14	2
<b>Automated Quality Reporting</b>			
Automatically generate hospital-specific Meaningful Use quality measures by extracting data from an EHR without additional manual processes	92	16	1
Automatically generate Medicare Inpatient Quality Reporting program measures for a full Medicare inpatient update	64	29	15
Automatically generate physician-specific Meaningful Use quality measures calculated directly from the EHR without additional manual processes	87	18	3
<b>Public Health Reporting</b>			
Submit electronic data to immunization registries/information systems on an ongoing basis per Meaningful Use standards	104	5	0
Submit electronic data on reportable lab results to public health agencies on an ongoing basis per Meaningful Use standards	90	15	3
Submit electronic syndromic surveillance data to public health agencies on an ongoing basis per Meaningful Use standards	97	7	5
<b>Other Functionalities</b>			
Implement at least 5 Clinical Decision Support interventions related to 4 or more clinical quality measures	103	2	4
Conduct or review a security risk analysis and implement security updates as necessary	102	3	3

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### 3. Are patients treated in your hospital able to do the following:

	Yes	No	Do Not Know
View their health/medical information online	101	7	0
Download information from their health/medical record	91	16	1
Electronically transmit (send) transmission of care/referral summaries to a third party	80	24	4
Request an amendment to change/update their health/medical record	71	34	3
Request refills for prescriptions online	47	57	2
Schedule appointments online	46	58	3
Pay bills online	82	21	4
Submit patient-generated data (e.g., blood glucose, weight)	45	59	3
Secure messaging with providers	70	35	2

### Health Information Exchange Functionalities

#### 4. Which of the following patient data does your hospital electronically exchange/share with one or more of the provider types listed below? (Check *all* that apply)

	With Hospitals Inside of Your System	With Hospitals Outside of Your System	With Ambulatory Providers Inside of Your System	With Ambulatory Providers Outside of Your System	Do Not Know
Patient demographics	82	61	96	78	2
Laboratory results	107	80	61	98	0
Medication history	80	52	86	67	5
Radiology reports	78	54	99	82	1
Clinical/Summary care record in any format	79	66	94	76	3

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This next section asks further detail about sending and/or receiving summary care records.

5. When a patient transitions to another care setting or organization outside your hospital system, how does your hospital routinely send and/or receive a summary of care record? Check *all* that apply.

	Send	Receive	Do not know
Mail or fax	95	85	0
eFax using EHR	62	34	6
Secure messaging using EHR (via DIRECT or other secure protocol)	75	51	2
Provider portal (i.e., post to portal or download from portal)	61	35	5
Via health information exchange organization or other third party	53	41	9

When a patient transitions to or from another care setting or organization, does your hospital routinely electronically send and/or receive (NOT eFax) a summary of care record in a structured format (e.g. CCD) with the following providers? Check *all* that apply (across a row)

	Send	Receive	Do not know
Other Hospitals outside your system	50	27	16
Ambulatory Care Providers outside your system	65	26	9
Long-term Care Providers (inside or outside your system)	50	16	14
Behavioral Health Providers (inside or outside your system)	32	15	23

This next section asks other questions related to electronically sending or receiving data.

Does your EHR integrate any type of clinical information received electronically (not eFax) from providers or sources outside your hospital system/organization without the need for manual entry? *This could be done using software to convert scanned documents into indexed, discrete data that can be integrated into EHR.*

Yes, routinely 20    Yes, but not routinely 31    No 55    Do not know 3    NA 0

If yes, does your EHR integrate the information contained in summary of care records received electronically (not eFax) without the need for manual entry? *This could be done using software to convert scanned documents into indexed, discrete data that can be integrated into EHR.*

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Yes, routinely **13**    Yes, but not routinely **28**    No **9**    Do not know **1**    NA **0**

9a. Do providers at your hospital routinely have necessary clinical information available electronically from outside providers or sources when treating a patient that was seen by another health care provider/setting?

Yes **29 (27%)**    No **71**    Do not know **8**

9b. Do providers at your hospital query electronically for patients' health information (e.g. medications, outside encounters) from sources outside of your organization or hospital system?

Yes **48 (44%)**    No **41**    No, don't have capability **14**    Do not know **4**

10a. When a patient visits your Emergency Department (ED), do you routinely provide electronic notification to the patient's primary care physician?

Yes **69 (63%)**    No **34**    Do Not Know **4**    Do Not Have ED **0**

10b. If yes, are electronic notifications provided to primary care physicians below? (Check *all* that apply)

Inside System **68 (98.6%)**    Outside System **36 (52%)**    Do Not Know **0**

11. Please indicate your level of participation in a state, regional, and/or local health information exchange (HIE) or health information organization (HIO).

**60 (55.0%)** HIE/HIO is operational in my area and we are participating and actively exchanging data in at least one HIE/RHIO

**24 (22.0%)** HIE/HIO is operational in my area but we are not participating

**20 (18.3%)** HIE/HIO is not operational in my area

**3 (2.8%)** Do not know

12. Which of the following issues has your hospital experienced when trying to electronically (not eFax) send, receive or find (query) patient health information to/from other care settings or organizations?

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(Check *all* that apply)

**8 (7.3%)** We lack the capability to electronically send patient health information to outside providers or other sources

**16 (14.7%)** We lack the capability to electronically receive patient health information from outside providers or other sources

**55 (50.5%)** Providers we would like to electronically send patient health information to do not have an EHR or other electronic system with capability to receive the information

**62 (56.9%)** Providers we would like to electronically send patient health information to have an EHR; however, it often lacks the capability to receive the information

**37 (33.9%)** Many recipients of our electronic care summaries (e.g. CCDA) report that the information is not useful

**40 (36.7%)** Cumbersome workflow to send (not eFax) the information from our EHR system

**25 (22.9%)** Difficult to match or identify the correct patient between systems

**48 (44.0%)** Difficult to locate the address of the provider to send the information (e.g. lack of provider directory)

**31 (28.4%)** We have to pay additional costs to send/receive data with care settings/organizations outside our system

**3 (2.8%)** We don't typically share our patient data with care settings/organizations outside our system

### *EHR System and IT Vendors*

13. Does your IT Department currently support an infrastructure for two factor authentication (e.g. tokens or biometrics)?

Yes **59 (54.1%)**       No **48**       Do not know **2**

14. Do you possess an EHR system that has been certified as meeting federal requirements for the hospital objectives of Meaningful Use?

Yes **106 (97.2%)**       No **2**       Do not know **1**

15. On the whole, how would you describe your EMR/EHR system?

**27 (24.8%)** A mix of products from different vendors

**80 (73.4%)** Primarily one vendor

**2** Self-developed

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**16a. Which vendor below provides your primary inpatient EMR/EHR system? (Please check only one)**

*“Primary” is defined as the system that is used for the largest number of patients or the system in which you have made the single largest investment. Please answer based on vendor name rather than product.*

- 7** Allscripts/Eclipsys    
  **3** CPSI    
  **11** (10.1)Cerner    
  **19** (17.4%)NextGen  
 **23** (21.1%)Epic    
  **2** GE    
  **24** (22.0%) HMS    
  **1** Healthland  
 **1** McKesson    
  **4** Meditech    
  **0** QuadraMed    
  **2** Vitera/Greenway  
 **9** (8.3%)Siemens    
  **1** Self-developed  
 **2** eClinical Works  
 **0** Would prefer not to disclose

**16b. Do you use the same primary inpatient EHR/EMR system vendor (noted above) for your primary outpatient**

**EMR/EHR system?** *“Primary” is defined as the system that is used for the largest number of patients or the system in which you have made the single largest investment. Please answer based on vendor name rather than product.*

- 45** (41.3%) Yes    
  **61** No    
  **0** Do not Know    
  **4** NA

**17. Which vendor(s) below does your hospital directly use to electronically exchange patient health information?**

- 49** The same system as our primary inpatient EMR/EHR system (noted above)  
 **0** MedFX    
  **0** Intersystems    
  **0** Harris    
  **26** Surescripts  
 **7** Medicity    
  **1** Truven Analytics    
  **11** Mirth    
  **13** Relay Health  
 **9** Orion Health    
  **3** Alare    
  **2** Care Evolution    
  **1** Optom/Axolotl  
 **1** IBM    
  Covinst    
  **0** Sandlot    
  **1** ICA  
 **0** Browsersoft    
 **4** Microsoft    
 **2** Certify Data Systems  
 **6** Do not exchange patient health information electronically  
 **1** Would prefer not to disclose

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34 Other (please specify) (see below)

	Frequency	Percent	Valid Percent	Cumulative Percent
	76	69.7	69.7	69.7
Caradigm	1	.9	.9	70.6
Clinical Connect	1	.9	.9	71.6
Clinical Connect HIE	4	3.7	3.7	75.2
DrFirst, Secure Exchange Solutions	1	.9	.9	76.1
HSX	1	.9	.9	77.1
Iatric	2	1.8	1.8	78.9
Infor	2	1.8	1.8	80.7
KeyHIE	1	.9	.9	81.7
MedAllies	2	1.8	1.8	83.5
Valid MedAllies, KeyHIE	1	.9	.9	84.4
Medhost	1	.9	.9	85.3
Meditech LSS/MPM	1	.9	.9	86.2
Mobile MD	3	2.8	2.8	89.0
MobileMD	1	.9	.9	89.9
OpenLink	2	1.8	1.8	91.7
OpenLink, eGate	1	.9	.9	92.7
Par8o	1	.9	.9	93.6
PAR8O	1	.9	.9	94.5
Secure Exchange Solutions	5	4.6	4.6	99.1
Siemens MobileMD	1	.9	.9	100.0
Total	109	100.0	100.0	

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18. What changes, if any, are you planning for your primary inpatient EMR/EHR system within the next 18 months?

(Check *all* that apply)

- 2 (1.8%) Initial deployment
- 38 (34.9%) Major change in vendor
- 2 (1.8%) Change from enterprise architecture to best-of-breed
- 13 (11.9%) Change from best-of-breed to enterprise architecture
- 39 (35.8%) Significant additional functionalities
- 10 (9.2%) Do not know
- 32 (29.4%) No major changes planned

19. What is (are, or would be) the primary challenge(s) in implementing an EMR/EHR system that meets the federal requirements for Meaningful Use? (Please check all that apply)

- 64 (58.7%) Upfront capital costs/lack of access to capital to install systems
- 72 (66.1%) Ongoing cost of maintaining and upgrading systems
- 57 (52.3%) Obtaining physician cooperation
- 24 (22.0%) Obtaining other staff cooperation
- 35 (32.1%) Concerns about security or liability for privacy breaches
- 26 (23.9%) Uncertainty about certification requirements
- 41 (37.6%) Limited vendor capacity
- 46 (42.2%) Lack of adequate IT personnel in hospital to support implementation/maintenance
- 65 (59.6%) Challenge/complexity of meeting all Meaningful Use criteria within implementation timeframe

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**9 (8.3%) Other (specify) (SEE BELOW)**

**Other MU Challenge**

	Frequency	Percent	Valid Percent	Cumulative Percent
	101	92.7	92.7	92.7
Adverse effects on revenue if Meaningful Use is not met; i.e. penalties	2	1.8	1.8	94.5
Already at Stage 2	1	.9	.9	95.4
Changes that occur during the reporting period with poor communication	1	.9	.9	96.3
Valid Enterprise system which affects multiple hospitals	1	.9	.9	97.2
Meeting current - changes related to stage 3 are unknown	1	.9	.9	98.2
Patient cooperation for patient engagement	1	.9	.9	99.1
Vendor code not stable with upgrades	1	.9	.9	100.0
Total	109	100.0	100.0	

**20. Please indicate whether you have used electronic clinical data from the EHR or other electronic system in your hospital to: (Please check all that apply)**

**76 (69.7%) Create a dashboard with measures of organizational performance**

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- 70 (64.2%)** Create a dashboard with measures of unit-level performance
- 75 (68.8%)** Create individual provider performance profiles
- 52 (47.7%)** Create an approach for clinicians to query the data
- 60 (55.0%)** Assess adherence to clinical practice guidelines
- 51 (46.8%)** Identify care gaps for specific patient populations
- 67 (61.5%)** Generate reports to inform strategic planning
- 82 (75.2%)** Support a continuous quality improvement process
- 83 (76.1%)** Monitor patient safety (e.g., adverse drug events)
- 55 (50.5%)** Identify high risk patients for follow-up care using algorithm or other tools
- 6 (5.5%)** None of the above

### HIO Surveys

Since 2011, the Pennsylvania eHealth Partnership Authority has conducted surveys on health information organizations operating in the state to determine the current environment on HIO activities. In previous years, the survey results gave stakeholders a better understanding of current and anticipated activities. The surveys enable the Authority to scan the environment and continue its development of strategic and operational plans. In 2014, out of the 11 organization invited to participate, 7 organizations responded to the surveys.

Questions were asked for the following categories: Operations and Technology, Communications and Outreach, Finance, and Policy, Consent Management and Legal. Using the surveys, the Authority is able to collect new information and add to their knowledge base from previous, yearly responses. The report provides summaries of the results and, and if available, a comparison of survey results from the previous year.

### eHIE Functions Adoption

Regarding eHIE functions adoption, the survey asked the HIOs which functions have been implemented or planned to be implemented. The results show that operational adoption of the majority of eHIE functions and capabilities have increased among respondents from 2013 to 2014. The Authority notes that most organizations are consistent in their intentions in comparison to the previous year, or are anticipating to expand functionality. Moreover, several functions are planned for universal adoption

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including active care coordination, master patient index, order/lab results delivery, and role-based access control.

### Participating Providers

Participating Providers		
Participant Type	2013	2014
Payers	82%	57%
Hospitals	100%	100%
Ambulatory Surgery Centers	55%	86%
Long Term/Post Acute Care	73%	86%
Mental Health/Substance Abuse	64%	71%
Outpatient Cancer Treatment	73%	86%
Urgent Care Centers	64%	86%
Physical/Occupational Therapy	82%	86%
Community Clinic/FQHC	82%	100%
Other Ambulatory Practices*	100%	100%
Independent Imaging Centers	55%	71%
Independent Reference Labs	64%	71%
Ambulance/EMS Services	64%	71%
Home Health	73%	86%

HIOs were asked about the types of providers being connected and which types were being planned for future connections. From the table above, participation from providers has increased in all categories except for payers. The organizations also planned to expand the types of providers in their networks.

### Active Participation Rates

Participant Type	2013	2014
------------------	------	------

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Payers	1	4
Hospitals	44	83
Ambulatory Surgery Centers	2	2
Long Term/Post Acute Care	83	65
Mental Health/Substance Abuse	8	6
Outpatient Cancer Treatment	7	1
Urgent Care Centers	1	0
Physical/Occupational Therapy	1	2
Community Clinic/FQHC	2	6
Other Ambulatory Practices		417
Independent Imaging Centers	1	0
Independent Reference Labs	0	0
Ambulance/EMS Services	2	1
Home Health	28	29

In addition to the information on the status of current and future connections, HIOs provided the total number of active providers signed up to participate. The survey notes that, due to the smaller sample size of HIOs participating in the survey, the participation rates collected show a decline for most provider types. Despite fewer HIOs participating in the survey, a few of the providers still show increases in rates, (e.g. hospitals), which have increased their active participation significantly from 2013.

### Summary of Landscape Assessment Findings

As described in the findings above, hospitals and practitioners are all at varying rates of EHR adoption. The Department attempted in its original survey to gauge the level of adoption with respect to functionality but there is still a need for more information about functionality and progress towards meeting Meaningful Use. Table II.11 presents a summary of the adoption results which will serve as baseline measures going forward. This table highlights some of the differences in EHR adoption across the survey instruments for physicians and other practitioners. The physician adoption survey conducted

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by PMS in 2005 shows the lowest adoption rate but 5 years is a very long time for EHR adoption. Health centers show a significant number of responses indicating adoption.

**Table II.11: Percent of Providers Who Have Adopted or Will Adopt EHR Systems**

Year	Physician Adoption	Health Center Adoption Rate	PA Surveyed Medical Assistance Practitioners	Acute Care Hospital Adoption Rate
Baseline (year)	26% (2005)	44% (2009)	60% (2010)	63% (2009)

To provide context for the EHR statistics above, the Department provides national adoption rates in Table II.12 below. Several industry publications identify noted progress in the adoption rate over the last few years. As Meaningful Use standards are being developed for the HITECH Act, much depends on how the EHR system is measured and defined. Adoption rates vary based on whether the provider is implementing a fully functional system or a more basic level of service. For example, only 4.4 percent of the respondents reported using a fully functional system.

**Table II.12: National Estimates of EHR Adoption Rates**

Source	Practitioners	Adoption Rate
Ambulatory Practitioners		
2008 Harvard Medical School study <sup>10</sup>	Office-based physicians	17% using EHRs
CDC's 2009 National Ambulatory Medical Care Survey (preliminary results) <sup>11</sup>	U.S. physicians	~20.5% of U.S. physicians reported having basic EHR systems 6.3% reported having a fully

<sup>10</sup> DesRoches CM, et al "Electronic health records in ambulatory care -- a national survey of physicians" *New England Journal of Medicine* 2008; 359: 50-60 Published online June 18, 2008.

<sup>11</sup> Chun-Ju Hsiao, et al. Electronic Medical Record/Electronic Health Record Use by Office-based Physicians: United States, 2008 and Preliminary 2009. Electronic Medical Record/Electronic Health Record Use by Office-based Physicians: United States, 2008 and Preliminary 2009

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		functional system.
National Ambulatory Care Survey for 2008 <sup>12</sup>	Overall ambulatory practitioners	Overall >38% in 2008 Preliminarily 44% in 2009
Hospitals		
American Hospital Association <sup>13</sup>	All acute care hospitals	8.7% in 2008 using basic or comprehensive electronic records 11.9% in 2009

The practitioner survey conducted in August and September 2010 indicated queried practitioners to discuss various questions regarding their internet connectivity. Table II.13 provides a breakdown of the type of internet access that is available to the practitioner.

**Table II.13: Internet Access Availability**

Access Type	Count	Percent of Responses* (Rounded)
Dial Up	0	0%
DSL	45	34%
Cable	23	18%
Satellite	2	2%
T-1	30	23%
Fiber optic	9	7%
Other	12	9%
<b>Total</b>	<b>121</b>	

\* Based on 131 respondents who completed the survey

<sup>12</sup> *Ibid.*

<sup>13</sup> American Hospital Association and New England Journal of Medicine, June 18, 2008.

## Appendix II: Baseline Landscape Assessment

Table II.14 provides a breakdown of the type of internet access that is used to collect and exchange health information.

**Table II.14: Internet Access Used to Collect and Exchange Health Information**

Access Type	Count	Percent of Responses* (Rounded)
Dial Up	0	0%
DSL	45	34%
Cable	24	18%
Satellite	0	0%
T-1	26	20%
Fiber optic	10	8%
FiOS	0	0%
Other	10	8%
<b>Total</b>	<b>115</b>	

*\* Based on 131 respondents who completed the survey*

According to survey results, 16 percent of the respondents indicated that they plan to upgrade from DSL, Dial Up or a lower speed connection. Of these practitioners, 94 percent plan to upgrade within two years. Forty-four percent of respondents indicated that they do not need additional high speed internet access. Over 33 percent of the practitioners indicated that the cost of high speed internet access is an issue.

Adoption Baseline Update 2014

**The health information technology adoption and utilization data presented below are based upon measures publically reported by the US Department of Health and Human Services Office of the National Coordinator within the Health IT Dashboard.**

## Appendix II: Baseline Landscape Assessment

### Providers

Measure	PA	National	Last Updated
Provider Population Estimates			
<b>Total Number of Health Care Providers</b>	<b>34,777</b>	<b>716,592</b>	<b>2012</b>
<b>Number of Primary Care Providers</b>	<b>13,565</b>	<b>302,357</b>	<b>2012</b>
<i>Adoption of Basic EHRs among Office-based Providers</i>			
<b>Overall Physician Practices</b>	<b>42%</b>	<b>48%</b>	<b>2013</b>
<b>Primary Care Providers</b>	<b>40%</b>	<b>53%</b>	<b>2013</b>
<b>Rural Providers</b>	<b>19%</b>	<b>46%</b>	<b>2013</b>
<b>Small Practices</b>	<b>35%</b>	<b>41%</b>	<b>2013</b>
<i>Health Information Exchange: Office-based Physicians</i>			
<b>Percent of office-based physicians with capability to send orders for lab tests electronically</b>	<b>48%</b>	<b>53%</b>	<b>2013</b>
<b>Percent of office-based physicians with computerized capability to view lab results</b>	<b>79%</b>	<b>77%</b>	<b>2013</b>
<b>Percent of office-based physicians with EHR/EMR that can automatically graph a specific patient's lab results over time</b>	<b>48%</b>	<b>47%</b>	<b>2013</b>
<i>Patient Engagement: Office-based Physicians</i>			
<b>Percent of office-based physicians with capability to exchange secure messages with patients</b>	<b>44%</b>	<b>49%</b>	<b>2013</b>
<b>Percent of office-based physicians with capability to provide patients with clinical summaries for each visit</b>	<b>68%</b>	<b>68%</b>	<b>2013</b>

### Hospitals

## Appendix II: Baseline Landscape Assessment

Measure	PA	National	Last Updated
<i>Adoption of Basic EHRs</i>			
<b>Overall Hospital</b>	<b>53%</b>	<b>59%</b>	<b>2013</b>
<b>Rural Hospital</b>	<b>53%</b>	<b>53%</b>	<b>2013</b>
<b>Small Hospital</b>	<b>46%</b>	<b>53%</b>	<b>2013</b>
<i>Health Information Exchange: Capability to electronically share laboratory results</i>			
<b>with any provider outside their health system</b>	<b>65%</b>	<b>57%</b>	<b>2013</b>
<b>with hospitals outside their health system</b>	<b>34%</b>	<b>34%</b>	<b>2013</b>
<b>with ambulatory providers outside their health system</b>	<b>63%</b>	<b>52%</b>	<b>2013</b>
<i>Health Information Exchange: Providing patients with an E-Copy of their health information</i>			
<b>Copy of their EHR within 3 business days of the request</b>	<b>83%</b>	<b>87%</b>	<b>2013</b>
<b>Copy of their discharge instructions upon request</b>	<b>86%</b>	<b>79%</b>	<b>2013</b>
<i>Health Information Exchange: Capability to exchange clinical care summaries with outside providers</i>			
<b>with any provider outside their health system</b>	<b>51%</b>	<b>42%</b>	<b>2013</b>
<b>with hospitals outside their health system</b>	<b>27%</b>	<b>29%</b>	<b>2013</b>
<b>with ambulatory providers outside their health system</b>	<b>48%</b>	<b>37%</b>	<b>2013</b>

## Appendix III: Medical Assistance HIT Initiative Electronic Resources

### Appendix III: Medical Assistance HIT Initiative Electronic Resources

There are a number of resources available to assist providers with the Pennsylvania Medical Assistance EHR Incentive Program application process. These resources can be found at:

<http://www.PAMAHealthIT.org>. For example, there are webinars describing various aspects of the application and attestation process, and frequently asked questions. Also on the website is a patient volume calculator, Meaningful Use information, Frequently Asked Questions and an interactive map. These resources are described in more detail below.

#### **Pennsylvania EHR Incentive Program Provider Manuals**

The Pennsylvania Medical Assistance EHR Incentive Program Eligible Professional Provider Manual and the Eligible Hospital Provider Manual are resources for healthcare professionals who wish to learn more about the Pennsylvania Medical Assistance EHR Incentive Program including detailed information and resources on eligibility and attestation criteria, as well as instructions on how to apply for incentive payments. The Provider Manuals also provide information on how to apply to the program via the Medical Assistance Provider Incentive Repository (MAPIR), the Department's web-based EHR Incentive Program application system.

The best way for a new user to orient themselves to the EHR Incentive Program requirements and processes is to read through each section of the Provider Manual in its entirety, prior to starting the application process.

In addition to the provider manuals, there are also screen shots of all the pages in the MAPIR application for Stage 1 and Stage 2 applications. These will show the provider exactly what they will see when they complete the MAPIR application. These are updated whenever there is a major change in the MAPIR application.

In the event this provider manual does not answer your questions or you are unable to navigate MAPIR or complete the registration and application process, you should contact the Department by email at: [RA-mahealthit@state.pa.us](mailto:RA-mahealthit@state.pa.us).

#### **MAPIR Eligible Professional Provider Manual:**

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/p\\_011449.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/p_011449.pdf)

#### **MAPIR Eligible Professional 2014 Stage 1 Application Screen Shots:**

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c\\_087644.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_087644.pdf)

#### **MAPIR Eligible Professional 2014 Stage 2 Application Screen Shots:**

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c\\_087645.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_087645.pdf)

## Appendix III: Medical Assistance HIT Initiative Electronic Resources

### MAPIR Eligible Hospital Provider Manual:

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/p\\_011450.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/manual/p_011450.pdf)

### MAPIR Eligible Hospital 2014 Stage 2 Application Screen Shots:

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c\\_111843.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_111843.pdf)

### MA HIT Webinar Series:

- *Overview of Electronic Health Record (EHR) Incentive Program (January 26, 2011):*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_004130.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_004130.pdf)
- *Calculating Patient Volume Webinar (February 15, 2011):*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_004130.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_004130.pdf)
- *Attestations, Monitoring, and Documentation (March 22, 2011):*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_010932.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_010932.pdf)
- *Pennsylvania MAHITI Frequently Asked Questions Webinar (April 26, 2011):*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_011465.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_011465.pdf)
- *Meaningful Use Year 2:*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_011824.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_011824.pdf)
- *Champions Webinar:*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_011890.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_011890.pdf)
- *Meaningful Use Q&A Webinar:*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_012082.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_012082.pdf)
- *HIE Webinar*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/p\\_013218.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/p_013218.pdf)
- *Stage 2 Final Rule Webinar*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_014622.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_014622.pdf)
- *Stage 2 Part 2 Final Rule Webinar*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_022216.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_022216.pdf)
- *Meaningful Use FAQs and Best Practices*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p\\_031826.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/presentation/p_031826.pdf)
- *MA EHR Incentive Program Auditing Webinar*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/p\\_035643.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/p_035643.pdf)
- *Lessons Learned, Meaningful Use and Stage 2 Updates*  
[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c\\_081246.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/c_081246.pdf)

### Pennsylvania DPW MAHITI Frequently Asked Questions (FAQs):

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/mahitfaqs/index.htm>

### Eligible Professional Volume Calculator:

*This calculator will assist eligible professionals in estimating their Medical Assistance patient volume percentage.*

## Appendix III: Medical Assistance HIT Initiative Electronic Resources

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/maprovincentiverepos/eligibleprofessionalvolumecalculator/index.htm>

### **Eligible Hospital Volume Calculator:**

*This calculator will assist eligible hospitals in estimating their Medical Assistance patient volume percentage.*

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/maprovincentiverepos/eligiblehospitalvolumecalculator/index.htm>

### **Eligible Hospital Payment Calculator:**

*This calculator will assist eligible hospitals in estimating what their incentive payment might be.*

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/maprovincentiverepos/eligiblehospitalpaymentcalculator/index.htm>

### **Medical Assistance Provider Incentive Repository (MAPIR) Resources**

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/maprovincentiverepos/index.htm>

### **Medical Assistance Bulletins**

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/d\\_006036.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_006036.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/d\\_006041.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_006041.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/d\\_006069.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_006069.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/d\\_006068.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_006068.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/d\\_005812.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005812.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/d\\_005813.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005813.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/d\\_005950.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/d_005950.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/p\\_035883.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/p_035883.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/p\\_033882.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/p_033882.pdf)

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin\\_admin/p\\_033883.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/bulletin_admin/p_033883.pdf)

### **Quick Tips:**

[http://www.dhs.state.pa.us/cs/groups/webcontent/documents/communication/p\\_011495.pdf](http://www.dhs.state.pa.us/cs/groups/webcontent/documents/communication/p_011495.pdf)

### Appendix III: Medical Assistance HIT Initiative Electronic Resources

**Meaningful Use Information** – There is an entire section that includes documents, tip sheets, charts and links pertaining to Meaningful Use. This is a good resource for providers trying to attest to Meaningful Use.

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/meaningfuluse/index.htm>

**Frequently Asked Questions** – The Department has compiled and continues to update the Frequently Asked Questions on HIT website. These FAQs includes questions that the providers are asking and need to be shares with other providers. There is also a link to the CMS FAQ database as it is more comprehensive list. Here’s a link to the FAQ page:

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/mahitfaqs/index.htm>

**Interactive Map** – On the main page of the HIT website is an interactive map that will display the payments made for the Medical Assistance EHR Incentive program. This data can be displayed per provider type, per location, per attestation type (AIU or MU), etc. This has been extremely beneficial in providing information to those seeking it. This map is located at:

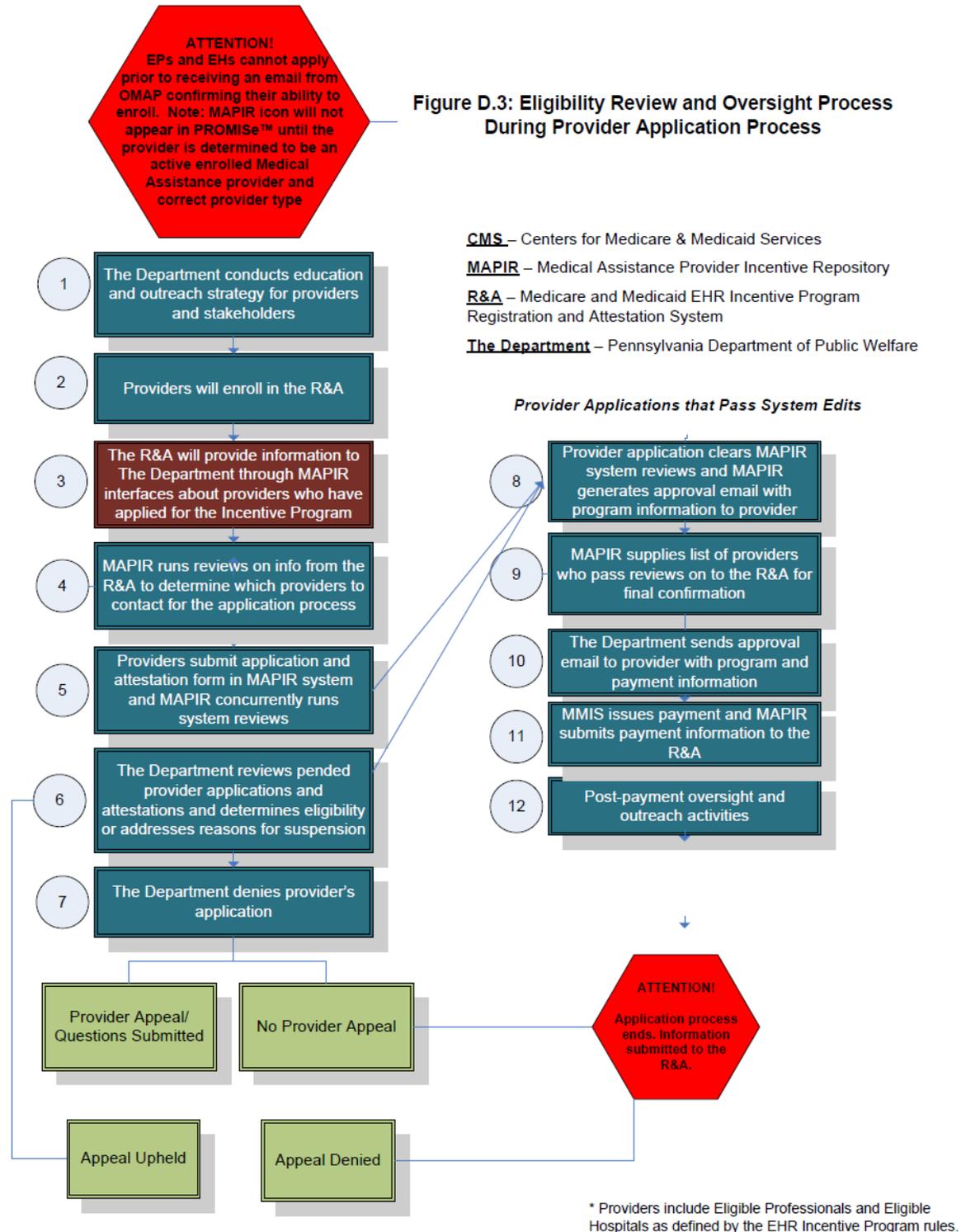
<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformationtechnologyinitiative/index.htm>

## Appendix IV: Medical Assistance EHR Incentive Program Process

### Appendix IV: Medical Assistance EHR Incentive Program Process

The figure below describes the overall application, registration, attestation, and monitoring process for the Medical Assistance EHR Incentive Program.

#### Year One Process Flow



## Appendix V: Hospital Incentive Payment Calculation Example

### Appendix V: Hospital Incentive Payment Calculation Example

The following tables outline the payment calculation process that will take place based on the required information provided by a hospital. Note: The hospital calculation is completed in the 1<sup>st</sup> payment year and calculates the payment for all 4 payment years. The hospital calculation is re-validated before each payment year. Hospitals update cost data if necessary during payment years 2 through 4.

Hospitals can also estimate their payments using the hospital payment calculator available on the Department’s website:

<http://www.dhs.state.pa.us/provider/healthcaremedicalassistance/medicalassistancehealthinformation/technologyinitiative/maprovincincentiverepos/eligiblehospitalpaymentcalculator/index.htm>

Fiscal Year	Total Discharges	Total # IP MCD Bed Days	Total IP Days	Total Charges - All Discharges	Total Charity Care - All Discharges
9/30/2009	115,000	47,469	189,985	\$1,188,756,696	\$56,452,000
9/30/2008	112,000				
9/30/2007	116,000				
9/30/2006	111,000				

**Step 1: Enter the end date of the last full facility fiscal year ending prior to the current program year the hospital is applying for.**

Hospital Fiscal Year	
9/30/2009	Entered Fiscal year
9/30/2008	Entered minus 1 – calculated
9/30/2007	Entered minus 2 – calculated
9/30/2006	Entered minus 3 – calculated

**Calculation 1: The previous three hospital fiscal years will be filled in.**

**Step 2: Fill in the overall facility discharges to cover each of these time periods.**

**Appendix V: Hospital Incentive Payment Calculation Example**

<b>Hospital Fiscal Year</b>	<b>Total Discharges</b>
9/30/2009	115,000
9/30/2008	112,000
9/30/2007	116,000
9/30/2006	111,000

**Calculation 2a: These figures will be used to determine the facility growth rate year over year:**

<b>Hospital Fiscal Year</b>	<b>Total Discharges</b>	<b>Yearly Growth Rate</b>
9/30/2009	115,000	2.7%
9/30/2008	112,000	-3.4%
9/30/2007	116,000	4.5%*
9/30/2006	111,000	

\*4.5% is the difference from FY 2006 to FY 2007

**Appendix V: Hospital Incentive Payment Calculation Example**

**Calculation 2b: The average of the yearly growth rate is the overall facility growth rate:**

	<b>Yearly Growth Rate</b>
	2.7%
	-3.4%
	4.5%
<b>AVERAGE</b>	1.2%

*\*Please note that a negative growth rate will also be applied to the facility*

**Step 3: Apply growth rate to the base number of discharges. Pennsylvania will be paying over 4 years.**

Reporting Year	Reported Discharges	Growth Rate	Calculated Discharges
Base Year	115,000		115,000
Year 2		1.2%	116,432
Year 3		1.2%	117,881
Year 4		1.2%	119,349

*\*116,432 is 1.24% times the self-reported 115,000 discharges*

**Calculation 3: As noted in green above, the initial discharge amount was increased by 1.2% each year.**

**Step 4: Determine eligible discharges. Only discharges between 1,149 and 23,000 are to be used in the equation.**

Reporting Year	Reported Discharges	Growth Rate	Calculated Discharges	Eligible Discharges
Base Year	115,000		115,000	21,851
Year 2		1.2%	116,380	21,851
Year 3		1.2%	117,777	21,851
Year 4		1.2%	119,190	21,851

*\* 21,851 is the discharges between 1,149 and 23,000*

**Calculation 4: Any volume below 1,149 is not included and any volume over 23,000 is also not included.**

**Step 5: Multiply the eligible discharges by \$200**

**Appendix V: Hospital Incentive Payment Calculation Example**

Reporting Year	Reported Discharges	Growth Rate	Calculated Discharges	Eligible Discharges	Eligible Discharge Payment
Base Year	115,000		115,000	21,851	\$4,370,200
Year 2		1.2%	116,380	21,851	\$4,370,200
Year 3		1.2%	117,777	21,851	\$4,370,200
Year 4		1.2%	119,190	21,851	\$4,370,200

**Step 6: Add the base year amount per payment year: \$2,000,000**

Reporting Year	Reported Discharges	Growth Rate	Calculated Discharges	Eligible Discharges	Eligible Discharge Payment + Base Amount (\$2,000,000)
Base Year	115,000		115,000	21,851	\$6,370,200
Year 2		1.2%	116,380	21,851	\$6,370,200
Year 3		1.2%	117,777	21,851	\$6,370,200
Year 4		1.2%	119,190	21,851	\$6,370,200

*Calculation 6: Add the base amount of \$2,000,000 to each payment year.*

**Step 7: Use Eligible Discharge Payment and Medicaid Transition Factor to create Overall EHR Amount**

Reporting Year	Eligible Discharge Payment	Medicaid Transition Factor **	Overall EHR Amount
Base Year	\$ 6,370,200	1	\$6,370,200
Year 2	\$ 6,370,200	0.75	\$4,777,650
Year 3	\$ 6,370,200	0.5	\$3,185,100
Year 4	\$ 6,370,200	0.25	\$1,592,550

*\*As defined by Federal Regulations*

*Calculation 7: Multiply the Eligible Discharge Payment by the Medicaid Transition Factor per payment year.*

**Step 8: Input the remaining self-reported information**

**Appendix V: Hospital Incentive Payment Calculation Example**

Total # IP MCD Bed Days	Total IP Days	Total Charges - All Discharges	Total Charity Care - All Discharges
47,469	189,985	\$ 1,188,756,696	\$ 56,452,000

*Calculation 8: N/A - self-reported data entry step.*

**Step 9: Calculate the Medicaid Share. This is used to weight Medicaid's impact on total bed days. It is considered a better metric than discharges since Medicaid patients generally have a higher illness burden.**

*Calculation 9a: Calculate the Non-Charity Care ratio by subtracting charity care from total charges and dividing by total charges*

Reporting Year	Total Charges - All Discharges	Total Charity Care - All Discharges	Non-Charity Care Ratio
Base Year	\$ 1,188,756,696	\$ 56,452,000	95.3%
Year 2	\$ 1,188,756,696	\$ 56,452,000	95.3%
Year 3	\$ 1,188,756,696	\$ 56,452,000	95.3%
Year 4	\$ 1,188,756,696	\$ 56,452,000	95.3%

*Calculation 9b: Calculate the Medicaid Bed Days share ratio:*

Reporting Year	Total # IP MCD Bed Days	Total IP Days	Medicaid Bed Days Ratio
Base Year	47,469	189,985	25.0%
Year 2	47,469	189,985	25.0%
Year 3	47,469	189,985	25.0%
Year 4	47,469	189,985	25.0%

*Calculation 9c: Divide the Medicaid Bed Days ratio by the Non-Charity Care Ratio:*

Reporting Year	Non-Charity Care Ratio	Medicaid Bed Days Ratio	Medicaid Share
Base Year	95.3%	25.0%	26.2%
Year 2	95.3%	25.0%	26.2%
Year 3	95.3%	25.0%	26.2%

**Appendix V: Hospital Incentive Payment Calculation Example**

Year 4	95.3%	25.0%	26.2%
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**Step 10: Multiply the Overall EHR Amount by the Medicaid Share:**

*Calculation 10: Multiply the Overall EHR Amount by the Medicaid Share:*

Reporting Year	Overall EHR Amount	Medicaid Share	MCD Aggregate EHR Incentive
Base Year	\$ 6,370,200	26.2%	\$1,670,988.67
Year 2	\$ 4,777,650	26.2%	\$1,253,241.50
Year 3	\$ 3,185,100	26.2%	\$835,494.33
Year 4	\$ 1,592,550	26.2%	\$417,747.17

*Calculation 10b: Sum the MCD Aggregate EHR Incentive:*

MCD Aggregate EHR Incentive
\$1,670,988.67
\$1,253,241.50
\$835,494.33
\$417,747.17
\$4,177,471.67*

*\*This represents the total amount that the facility is eligible to receive based upon self-reported information.*

## Appendix V: Hospital Incentive Payment Calculation Example

**Step 11: Apply distribution schedule for total MCD Aggregate EHR Amount over the 4 year period (Pennsylvania specific):**

<b>Reporting Year</b>	<b>Payment Percentage</b>	<b>Payment per Year</b>
Base Year	50%	\$2,088,735.84
Year 2	30%	\$1,253,241.50
Year 3	10%	\$417,747.17
Year 4	10%	\$417,747.17

**Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates**

**Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates**

Pennsylvania Department of Human Services  
**DRAFT BEHAVIORAL HEALTH EQUIP**  
 Link to Quality/Meaningful Use\*

**I. ASSESSMENT**

- |   |   |
|---|---|
| <p>a. Clinical Information: Lists: Problem/Medication/Allergy<br/>also Medication Reconciliation from Menu</p>  | <p>MU: EP Core Measure;</p>                       |
|   | Set   |
| Demographics  | MU: EP Core                                       |
| Vital Signs   | MU: EP Core                                       |
| <p>b. Weight : BMI/ BMI percentile<br/>Clinical Quality measure</p>   | <p>MU: Core measure; Core</p>                     |
|   | Proposed Adult measure                            |
| <p>c. Depression: Screening and Follow up Plan<br/>Anti-depressant Medication Management<br/>Quality; Proposed Adult</p>  | <p>Proposed Adult<br/>MU: Additional Clinical</p> |
| <p>d. Alcohol misuse: Screening, Brief Intervention, Referral<br/>for treatment. (SBIRT)</p>  | <p>Proposed Adult measure</p>                     |
| <p>e. Developmental Screening in the first 3 years of life</p>  | <p>CHIPRA</p>                                     |
| <p>f. Follow up care for children prescribed ADHD medications</p>   | <p>CHIPRA</p>                                     |
| <p>g. Bipolar I Disorder 2 : Annual assessment of weight or BMI,<br/>glycemic control and lipids</p>  | <p>Proposed Adult measure</p>                     |
| <p>h. Bipolar 1 Disorder C: Proportion of patients with bipolar I<br/>Disorder treated with mood stabilizer medications<br/>during the course of bipolar I disorder treatment</p> | <p>Proposed Adult measure</p>                     |
| <p>i. Schizophrenia 2: Annual assessment of weight/BMI,<br/>glycemic control, lipids</p>  | <p>Proposed Adult measure</p>                     |
| <p>j. Schizophrenia B: Proportion of schizophrenia patients with<br/>long-term utilization of antipsychotic medications</p>   | <p>Proposed Adult measure</p>                     |
| <p>k. Schizophrenia C: Proportion of selected schizophrenia<br/>Patients with antipsychotic polypharmacy utilization</p>  | <p>Proposed Adult measure</p>                     |
| <p>l. Smoking<br/>(13 and older); also Core Clinical Quality</p>  | <p>(3) MU: Core Measure</p>                       |
|   | Measure (18 and                                   |
| older); also Additional quality measure:  |   |
|   | Smoking/tobacco                                   |
| use cessation   |   |
|   | Proposed Adult measure                            |

## Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates

Pennsylvania Department of Human Services <b>DRAFT BEHAVIORAL HEALTH EQUIP</b> Link to Quality/Meaningful Use*	
m. Influenza Immunization for Patients ≥ 50 years Quality	MU: Alternate Clinical
n. Pneumonia Vaccination Status for Older Adults Quality measure	Proposed Adult measure MU: Alternate Clinical
o. Dental: Preventative Treatment services	P4P (2-21 years)
p. Annual monitoring for patients on persistent medications	Proposed Adult measure
q. Labs	MU: Menu set measure
r. Ambulatory Care: ED Visits	P4P (optional measure) Proposed Adult measure
s. Mental Health Utilization	Proposed Adult measure
<b>II. CLINICAL DECISION SUPPORT</b>	
a. Provider links to current treatment guidelines clinical decision support rule relevant to ( Evidenced-based guidelines) clinical priority along with the ability to	MU: Core Implement one  specialty or high  track.
<b>III. COORDINATION OF CARE</b>	
a. Clinical summaries for each office visit	MU Core measure
b. Exchange key clinical information	MU Core measure
c. Medication reconciliation	MU Menu set measure
d. Provide patients with electronic copy of health info	MU Core measure
e. Follow up after hospitalization for mental illness CHIPRA	Proposed Adult measure;
f. Link to DOH/Philadelphia DOH Immunization Registries	MU
g. Submit syndromic surveillance data to public health agencies	MU Menu set
h. E-prescribing	MU
<b>IV. ENGAGE PATIENT/FAMILIES</b>	
a. Text messages/ pop-up reminders	MU Menu set measure
b. Access to EHR	MU Menu set
c. Patient centered care plan	
d. Education/self-management	MU Menu set
e. CAHPS Survey	Proposed Adult measure
<b>V. TRANSITION OF CARE</b>	
a. Summary of Care Record	MU Menu set

**Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates**

Pennsylvania Department of Human Services  
**DRAFT BEHAVIORAL HEALTH EQUIP**  
 Link to Quality/Meaningful Use\*

b. Medication reconciliation

MU Menu set

Pennsylvania Department of Human Services

**J. ASSESSMENT**

- |  |  |   |
|--|--|---|
| <p>t. Clinical Information: Lists: Problem/Medication/Allergy<br/>also Medication Reconciliation from Menu</p> |  | <p>MU: EP Core Measure;<br/>Set</p>                 |
|  | <p>Demographics</p>                                    | <p>MU: EP Core</p>                                  |
|  | <p>Vital Signs</p>                                     | <p>MU: EP Core</p>                                  |
| <p>u. Weight : BMI/ BMI percentile<br/>Clinical Quality measure</p>  |  | <p>MU: Core measure; Core</p>                       |
|  |  | <p>Proposed Adult measure</p>                       |
| <p>v. Hypertension: BP management<br/>Clinical Quality measure</p>   |  | <p>MU: Core measure; Core</p>                       |
|  |  | <p>Proposed Adult measure</p>                       |
| <p>w. Diabetes: HbA1c testing<br/>measure</p>  |  | <p>P4P Optional measure<br/>Proposed Adult; P4P</p> |
|  | <p>HbA1c Control (&lt;8)</p>                           | <p>MU: Additional Clinical</p>                      |
|  | <p>Quality; P4P Optional measure</p>                   |   |
|  | <p>HbA1c Poor Control</p>                              | <p>MU: Additional Clinical</p>                      |
|  | <p>Quality</p>   |   |
|  | <p>Lipid</p>   | <p>MU: Additional Clinical</p>                      |
|  | <p>Quality; P4P Optional; Proposed Adult</p>           |   |
|  |  | <p>measure</p>                                      |
|  | <p>Eye Exam/Foot Exam/Urine Screen</p>                 | <p>MU: Additional Clinical</p>                      |
|  | <p>Quality</p>   |   |
|  | <p>Retinopathy: Presence/Absence/Level of Severity</p> | <p>MU: Additional Clinical</p>                      |
|  | <p>Quality</p>   |   |
|  | <p>BP Management</p>                                   | <p>MU: Additional Clinical</p>                      |
|  | <p>Quality</p>   |   |
| <p>x. Coronary Artery Disease : Drug therapy for lowering LDL<br/>Quality; Proposed Adult; P4P Optional</p>    |  | <p>MU: Additional Clinical</p>                      |
|  | <p>Beta Blocker Therapy for patients with prior MI</p> | <p>MU: Additional Clinical</p>                      |
|  | <p>Quality; Proposed Adult</p>                         |   |

**Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates**

Pennsylvania Department of Human Services <b>DRAFT CHRONIC CARE EQUIP</b> Link to Quality/Meaningful Use*		
	Oral Antiplatelet Therapy	MU: Additional Clinical
Quality		
y.	Congestive Heart Failure: ACE/ARB Therapy	MU: Additional Clinical
	Quality	
	Warfarin Therapy for Patients with AFib	MU: Additional Clinical
	Quality	
z.	Ischemic Vascular Disease: Complete Lipid Profile/LDL-C rates	Proposed Adult measure;
	MU Additional Quality measure	
	BP Management	MU: Additional Quality
	Use of Aspirin or another antithrombotic	MU: Additional Quality
aa.	Depression: Screening and follow up plan	Proposed Adult
	Anti depressant Medication Management	MU: Additional Quality;
	Proposed Adult	
bb.	Asthma: Assessment	Proposed Adult measure
	Treatment	MU: 2 Additional quality
	measures: Assessment and Asthma	
	Therapy	Pharmacologic
	Action Plans	
cc.	Smoking	(3) MU: Core Measure
	(13 and older); also Core Clinical Quality	
	older); also Additional quality measure:	Measure (18 and
	use cessation	Smoking/tobacco
dd.	Influenza Immunization for Patients ≥ 50 years	Proposed Adult measure
	Quality	MU: Alternate Clinical
ee.	Pneumonia Vaccination Status for Older Adults	Proposed Adult measure
	Quality measure	MU: Alternate Clinical
ff.	Dental: Preventative	P4P (2-21 yrs)
	Treatment services	
gg.	Labs	MU: Menu set measure
hh.	Ambulatory Care: ED Visits	P4P (optional measure) Proposed Adult measure

## Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates

Pennsylvania Department of Human Services <b>DRAFT CHRONIC CARE EQUIP</b> Link to Quality/Meaningful Use*	
ii. Annual Monitoring for Patients on Persistent Medications	Proposed Adult measure
<b>II. CLINICAL DECISION SUPPORT</b>	
b. Provider links to current treatment guidelines clinical decision support rule relevant to ( Evidenced-based guidelines) clinical priority along with the ability to	MU: Core Implement one specialty or high track.
<b>III. COORDINATION OF CARE</b>	
i. Clinical summaries for each office visit	MU Core measure
j. Exchange key clinical information	MU Core measure
k. Medication reconciliation	MU Menu set measure
l. Provide patients with electronic copy of health info	MU Core measure
m. Follow up after hospitalization for mental illness	Proposed Adult measure
n. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	MU: Additional Quality
o. Annual number of asthma patients 2-20 with one or more asthma related emergency room visits	
p. Link to DOH/Philadelphia DOH Immunization Registries	MU
q. Submit syndromic surveillance data to public health agencies	MU Menu set
r. E-prescribing	MU
<b>IV. ENGAGE PATIENT/FAMILIES</b>	
f. Text messages/ pop-up reminders	MU Menu set measure
g. Access to EHR	MU Menu set
h. Patient centered care plan	
i. Education/self-management	MU Menu set
j. CAHPS Survey	Proposed Adult measure
<b>V. TRANSITION OF CARE</b>	
a. Summary of Care Record	MU Menu set
b. Medication reconciliation	MU Menu set

**Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates**

Pennsylvania Department of Human Services  
**DRAFT OBSTETRICS CARE AND DELIVERY EQUIP**  
 Link to Quality/Meaningful Use\*

<b>K. ASSESSMENT</b>		
jj.	Clinical Information: Lists: Problem/Medication/Allergy also Medication Reconciliation from Menu	MU: EP Core Measure;
		Set
	Demographics	MU: EP Core
	Vital Signs	MU: EP Core
kk.	Submit common OBNA form electronically by trimester and payment Postpartum	Future EHR incentive
ll.	Timeliness of Prenatal Care	CHIPRA; P4P
mm.	Post Partum Care Adult Measure; P4P	CHIPRA; Proposed
nn.	Frequency of ongoing Prenatal Care	CHIPRA; P4P
oo.	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	MU: Additional Measure
pp.	Prenatal Care: Anti-D Immune Globulin	MU: Additional Measure
qq.	Percent of live births weighing less than 2500 grams	CHIPRA
rr.	Cesarean rate for nulliparous singleton vertex	CHIPRA
ss.	Appropriate Use of Antenatal Steroids	Proposed Adult Measure
tt.	Depression Screening	Proposed Adult Measure;
uu.	Smoking and Tobacco Use Cessation and older); also Core Clinical Quality  also Additional Quality Measure	MU: Core Measure (13  Quality Measure;  Proposed Adult Measure
vv.	Chlamydia Screening measure	CHIPRA; MU Additional
ww.	Labs measure	MU: Menu set
<b>II. CLINICAL DECISION SUPPORT</b>		
c.	Provider links to current treatment guidelines clinical decision support rule relevant to (ACOG) clinical priority along with the ability to track.	MU: Core Implement one  specialty or high
<b>III. COORDINATION OF CARE</b>		
s.	Clinical summaries for each office visit	MU Core measure

**Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates**

Pennsylvania Department of Human Services <b>DRAFT OBSTETRICS CARE AND DELIVERY EQUIP</b> Link to Quality/Meaningful Use*	
t. Exchange key clinical information	MU Core measure
u. Medication reconciliation	MU Menu set measure
v. Provide patients with electronic copy of health info	MU Core measure
w. Follow up after hospitalization for mental illness	Proposed Adult;
x. Anti-depression medication management Adult Measure	MU: Additional ; Proposed
<hr/>	
y. E-prescribing	MU Core
<hr/>	
<b>IV. ENGAGE PATIENT/FAMILIES</b>	
k. Text messages/ pop-up reminders	MU Menu set measure
l. Access to EHR	MU Menu set
m. Patient centered care plan	
n. Education/self-management	MU Menu set
o. CAHPS Adult Survey	Proposed Adult Measures
<hr/>	
<b>V. TRANSITION OF CARE</b>	
a. Summary of Care Record	MU Menu set
b. Medication reconciliation	MU Menu set

**Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates**

Pennsylvania Department of Human Services  
**DRAFT PEDIATRIC EQUIP**  
 Link to Quality/Meaningful Use\*

**L. ASSESSMENT**

xx. Clinical Information: Lists: Problem/Medication/Allergy also Medication Reconciliation from Menu	MU: EP Core Measure;  Set MU: EP Core MU: EP Core
Demographics	
Vital Signs	
yy. Weight : BMI/ BMI percentile clinical quality measure	CHIPRA; MU: Alternate
zz. Immunization : Childhood ; Adolescent clinical quality measure	CHIPRA; MU: Alternate
aaa. Well-Child Visits /Adolescent Well care	CHIPRA; P4P
bbb. Asthma: Assessment Treatment measures: Assessment and Asthma  Therapy Action Plans	CHIPRA: ER visits MU: 2 Additional quality  Pharmacologic  (3) MU: Core Measure
ccc. Smoking (13 and older); also Core Clinical Quality  older); also Additional quality measure:  use cessation	Measure (18 and  Smoking/tobacco
ddd. Developmental screen	CHIPRA
eee. Dental: Preventative Treatment services	(2) CHIPRA; P4P
fff. Pharyngitis quality measure	MU Additional clinical
ggg. Labs measure	MU: Menu set
hhh. Ambulatory Care: ED Visits (optional measure)	CHIPRA; P4P

**II. CLINICAL DECISION SUPPORT**

d. Provider links to current treatment guidelines clinical decision support rule relevant to (AAP, Bright Futures, validated screening tools, clinical priority along with the ability to track. Evidenced-based guidelines)	MU: Core Implement one  specialty or high
--	---

**Appendix VI: Electronic Quality Improvement Projects (EQUIPS) Templates**

Pennsylvania Department of Human Services  
**DRAFT PEDIATRIC EQUIP**  
 Link to Quality/Meaningful Use\*

<b>III. COORDINATION OF CARE</b>	
z. Clinical summaries for each office visit	MU Core measure
aa. Exchange key clinical information	MU Core measure
bb. Medication reconciliation	MU Menu set measure
cc. Provide patients with electronic copy of health info	MU Core measure
dd. Follow up after hospitalization for mental illness	CHIPRA
ee. Follow up for children prescribed ADHD medications	CHIPRA
ff. Child/Adolescent access to primary care practitioners	CHIPRA
gg. Annual number of asthma patients 2-20 with one or more asthma related emergency room visits	CHIPRA
hh. Link to DOH/Philadelphia DOH Immunization Registries	MU
ii. E-prescribing	MU
<b>IV. ENGAGE PATIENT/FAMILIES</b>	
p. Text messages/ pop-up reminders	MU Menu set measure
q. Access to EHR	MU Menu set
r. Patient centered care plan	
s. Education/self-management	MU Menu set
t. CAHPS Survey	CHIPRA
<b>V. TRANSITION OF CARE</b>	
a. Summary of Care Record	MU Menu set
b. Medication reconciliation	MU Menu set

## Appendix VII: Letters of Support

### Appendix VII – Letters of Support



3001 Chesterfield Place  
Charleston, West Virginia 25304  
Phone 304.346.9864  
Toll Free 1.800.642.8686  
Fax 304.346.9863  
www.wvmi.org

March 13, 2015

Fran McCullough  
Centers for Medicare and Medicaid Services  
The Public Ledger Building, Suite 216  
150 S. Independence Mall West  
Philadelphia, PA 19106

Jason McNamara  
Technical Director for Health IT  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Mr. McCullough and Mr. McNamara:

It is my pleasure to write this letter to express my support for Pennsylvania's State Medicaid Health IT Plan. Pennsylvania's HIT efforts positions our beneficiaries, providers, and the entire state to achieve the triple aim of better health, lower costs, and better population health status. Our Medicaid Health IT Plan reflects this commitment as we continue to seek innovative IT strategies to improve our Medicaid program.

Pennsylvania's vision involves ongoing efforts to not only increase HIT adoption and meaningful use but also the exchange of timely health information to improve quality of care, provider performance, and program administration. We believe that aligning the use of HIT and HIE is critical to maximizing value and realizing better health outcomes for our beneficiaries.

As both the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and the Regional Extension Center (REC), PA REACH, for Pennsylvania I look forward to working with the Centers for Medicare and Medicaid Services to achieve our Commonwealth's strategic vision.

Sincerely,

A handwritten signature in black ink that reads "John C. Wiesendanger".

John C. Wiesendanger  
Chief Executive Officer

## Appendix VII: Letters of Support



March 20, 2015

Fran McCullough  
Centers for Medicare and Medicaid Services  
The Public Ledger Building, Suite 216  
150 S. Independence Mall West  
Philadelphia, PA 19106

Jason McNamara  
Technical Director for Health IT  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Mr. McCullough and Mr. McNamara:

My name is Alix Goss, and I serve as Executive Director of the Pennsylvania eHealth Partnership Authority (Authority) and fulfilled Pennsylvania's State Health IT Coordinator role under the commonwealth's health information exchange cooperative agreement with the Office of National Coordinator (ONC). I am writing to express my support for Pennsylvania's State Medicaid Health IT Plan.

Pennsylvania's Act 121 of 2012 established the Authority to advance health information exchange in Pennsylvania. As part of this effort we have extensively engaged stakeholders to provide input and to help develop strategies and detailed recommendations that can best serve Pennsylvanians in establishing a connected health care system. The Department of Human Services, and especially their Medicaid unit, has and is participating with us and is an important strategic partner in this effort. Pennsylvania's health IT efforts position our beneficiaries, providers, and the entire state to achieve the triple aim of better health, lower costs, and better population health status. Our Medicaid Health IT Plan reflects this commitment as we continue to seek innovative IT strategies to build on existing investments to improve our Medicaid program.

We work very closely with Medicaid to align and effectively leverage our respective programmatic areas. To ensure collaboration, we meet routinely to assess our progress and discuss strategies that would be of mutual benefit. We also meet monthly with the Pennsylvania Medical Society, the Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Department of Health and the PA REACH (PA's Regional Extension Center) to identify issues and opportunities that we can collectively work on

Pennsylvania eHealth Partnership Authority  
613 North Street | 402-A Finance Bldg | Harrisburg, PA 17120 | 717.214.2490 | Fax 717.346.6772  
[www.pahealth.org](http://www.pahealth.org)

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***Improving your care through the exchange of health information***

## Appendix VII: Letters of Support

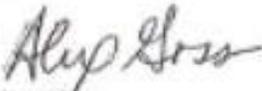
Fran McCullough and Jason McNamara

to advance health IT and health information exchange. Additionally, I meet monthly with Medicaid leadership and on a biweekly basis the Medicaid Health IT Coordinator and the Authority coordinate with PA REACH (Pennsylvania's regional extension center designated by ONC).

Pennsylvania's vision involves ongoing efforts to not only increase health IT adoption and meaningful use, but also the exchange of timely health information to improve quality of care, provider performance and reporting, and program administration. We believe that aligning the use of health IT and HIE is critical to maximizing value and realizing better health outcomes for our beneficiaries.

I look forward to working with the Centers for Medicare and Medicaid Services to achieve our commonwealth's strategic vision. I encourage your favorable consideration of Pennsylvania's Medicaid Health IT Plan. If I can be of any further assistance, please do not hesitate to let me know. You can reach me at [algoss@pa.gov](mailto:algoss@pa.gov) or (717) 346-1115.

Sincerely,



Alix Goss  
Executive Director  
Pennsylvania eHealth Partnership Authority  
Room 402A, Finance Building  
613 North Street  
Harrisburg, PA 17120

Appendix VII: Letters of Support



September 20, 2011

Fran McCullogh  
Centers for Medicare and Medicaid Services  
The Public Ledger Building, Suite 216  
150 S. Independence Mall West  
Philadelphia, PA 19106

Jessica Kahn  
Technical Director for Health IT  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard, Mail Stop S3-13-15  
Baltimore, MD 21244

Dear Ms. McCullogh and Ms. Kahn:

My name is Robert Torres and I currently serve as Pennsylvania's Health IT Coordinator. I write this letter in support of our state's Medicaid Health IT Plan. On July 27, 2011, Governor Corbett issued executive order 2011-04 establishing the Pennsylvania eHealth Collaborative to re-launch our efforts to advance health information exchange in Pennsylvania. As part of this effort, we have engaged over 100 stakeholders to provide input and to help develop recommendations that can best serve Pennsylvanians. Medicaid is participating with us and is an important partner in this effort.

We work very closely with Medicaid to align and effectively leverage our respective efforts. To ensure our collaboration, we meet routinely to assess our progress and discuss strategies that would be of mutual benefit. We also meet monthly with the Pennsylvania Medical Society, the Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Department of Health and the Regional Extension Center to identify issues and opportunities that we can collectively work on to advance health information technology and health information exchange.

I encourage your favorable consideration of Pennsylvania's Medicaid Health IT Plan. If I can be of any further assistance, please do not hesitate to let me know.

Sincerely,

A handwritten signature in cursive script that reads 'Robert Torres'.

Robert Torres  
Pennsylvania Health IT Coordinator

Appendix VII: Letters of Support



October 11, 2011

Fran McCullogh  
Centers for Medicare and Medicaid Services  
The Public Ledger Building, Suite 216  
150 S. Independence Mall West  
Philadelphia, Pennsylvania 19106

Jessica Kahn  
Technical Director for Health IT  
Centers for Medicare and Medicaid Services  
7500 Security Boulevard, Mail Stop S3-13-15  
Baltimore, Maryland 21244

Dear Ms. McCullogh and Ms. Kahn:

As the Executive Deputy Secretary of Pennsylvania's Department of Health (DOH), I am writing to offer full support to the Pennsylvania Department of Public Welfare, Office of Medical Assistance Program's (OMAP) collaborative efforts to advance the adoption and implementation of Electronic Health Records (EHRs) for eligible providers and hospitals in Pennsylvania.

The DOH works very closely with OMAP in areas of chronic disease, maternal health, and pediatric health. DOH operates several surveillance and public health reporting systems such as chronic and infectious disease reporting, lab surveillance, lead screening, metabolic disease screening, sickle cell surveillance, smoking cessation quit line, and the state wide immunization registry. These electronic systems are integral to public disease surveillance reporting and additionally are essential to Stage One Meaningful Use requirements for Medicaid and Medicare EHR incentive programs. We have worked very closely with OMAP to help high volume Medicaid providers in Pennsylvania get linked to many of these surveillance systems.

We fully support OMAP's submitted State Medicaid Health Information Technology Plan and look forward to ongoing collaboration with OMAP to advance the use of health information technology and exchange that will improve the lives of Pennsylvanians.

Sincerely,

A handwritten signature in black ink, appearing to read 'Michael Wolf'. The signature is written in a cursive, somewhat stylized font. A long, thin, curved line extends from the bottom right of the signature, possibly representing a flourish or a checkmark.

Michael Wolf, Executive Deputy Secretary  
Department of Health

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

**Appendix VIII - Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes					State Checklist				
Subject	Change	Applicable CFR Rule	Affected Providers		Effective Date	Target Date	Implementation Status	Activity	SMHP Location (if applicable)
			EP	EH					
Patient Volume	<b>Practicing Predominately Calculations:</b> Allow EPs to use a six-month period within the prior calendar year or preceding 12 month period from the date of attestation for the definition of practicing predominantly (more than 50% of the encounters). <u>States have some flexibility, but all approaches need approved by CMS.</u>	§495.302	X		1/1/13	1/1/13	Completed	Communications:  – Updated EP provider manual to reflect new standard  - Presented new standard in Listserv emails, webinars and FAQs (all available on program website) -Conducted two webinars discussing new requirement. - Added to posted tip sheet on website: <a href="http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/p_014610.pdf">http://www.dhs.state.pa.us/cs/groups/webcontent/documents/document/p_014610.pdf</a>	Introduction (Page 4) acknowledges changes as a result of the final rule update.
						1/1/13	Completed	Operations: Program maintains operation manual and has been documenting process changes in the manual.  - Updated process to validate post pay practice predominately standard now being 12 months preceding attestation, including changing outreach emails to clarify the timeframe that validation materials for practicing predominately must pertain.	Section C (Pages 49-65) refers providers to program website and on-line manuals for how specific changes are implemented.
						4/1/13	Completed	MAPIR: Walkthrough of MAPIR changes with CMS presented 11/15/12  - Updating information within MAPIR to reflect the new standard for practice predominately (e.g. hover bubbles)	Section D (Pages 66 – 81) discusses

Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist

Stage 2 Regulation Changes					State Checklist			
<p><b>Medicaid Enrolled Encounters:</b> Numerator to include service rendered on any one day to a Medicaid-enrolled individual, <i>regardless of</i> payment liability. Includes zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate CHIP programs (see below).</p>	§495.306	X	X	10/1/12 – EHS	1/1/13	Completed	<p>Communications:</p> <ul style="list-style-type: none"> <li>- Updated EP provider manual to reflect new standard for allowable encounters</li> <li>- Presented new standard in Listserv emails, webinars and FAQs (all available on program website)</li> <li>- Updated provider volume template and website calculator to address allowable encounter standard</li> <li>- Conducted two webinars discussing new requirements.</li> <li>- Posted tip sheet to website. <a href="http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_014610.pdf">http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_014610.pdf</a></li> </ul>	the general requirements of the program as it relates scope of the program’s audit plan. The specific methodology is separately from SMHP.
				1/1/13 – EPs				<p>Introduction (Pg.4) acknowledges changes as a result of the final rule update.</p> <p>Section C (Pages 49-65) refers providers to program website and on-line manuals for how specific changes are implemented.</p> <p>Section D (Pages 66 –</p>
					1/1/13	Completed	<p>Operations: Program maintains operation manual and has been documenting process changes in the manual.</p> <ul style="list-style-type: none"> <li>- Updated process to validate pre and post pay encounter standard. This includes updating reports to include allowable encounters as opposed to paid only.</li> <li>- Outreach emails were be updated to refer to new standard.</li> </ul>	

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes						State Checklist			
						4/1/13	Completed	<p>MAPIR</p> <p>-Walkthrough of MAPIR changes with CMS presented on: 11/15/12. Information screens and hover bubbles within MAPIR will present updated encounter requirements.</p>	81) discusses the general requirements of the program as it relates scope of the program's audit plan. The specific audit methodology is described in a separate document from the SMHP.
<p><b>CHIP Encounters:</b> Provider patient volume includes CHIP encounters in numerator <i>if part of Title XIX expansion or part of Title XXI expansion</i> (still cannot include CHIP stand-alone Title XXI encounters).</p>	<p>§495.306</p>	<p>X</p>	<p>X</p>	<p>10/1/12 – EHS</p>	<p>1/1/13 – EPs</p>	1/1/13	Completed	<p>Communications:</p> <p>– Updated EP provider manual to reinforce that CHIP is still only allowed for EPs that practice predominately at FQHC / RHC (due to Pennsylvania's CHIP being a standalone program)</p> <p>- Reinforced requirement in Listserv emails, webinars and FAQs (all available on program website – <a href="http://www.pamahealthit.org">www.pamahealthit.org</a>)</p> <p>- Conducted two webinars discussing new requirements.</p> <p>- Posted tip sheet to website. <a href="http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_014610.pdf">http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_014610.pdf</a></p>	<p>Introduction (Pg.4) acknowledges changes as a result of the final rule update.</p> <p>Section C (Pages 49-65) refers providers to program website and on-line manuals for</p>
						1/1/13	Completed	<p>Operations: Program maintains operation manual and has been documenting process changes in the manual. Process will remain largely unchanged since capacity exists to identify inclusion of CHIP for non FQHC / RHC EPs.</p>	

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes					State Checklist			
					4/1/13	Completed	MAPIR: Walkthrough of MAPIR changes with CMS presented on 11/15/12. Pennsylvania will reinforce CHIP not being allowable for non FQHC / RHC providers within MAPIR at appropriate points.	how specific changes are implemented.
								Section D (Pages 66 – 81) discusses the general requirements of the program as it relates scope of the program’s audit plan. The specific audit methodology is described in a separate document from the SMHP.
<b>Panel Methodology:</b>	§495.306	X	X	10/1/12 – EHS	N/A	N/A	In Pennsylvania the panel method is not an option for providers to use and there are currently no plans to implement the method. Reasons for not offering at this time include lack of consistency for how panels are assigned which creates inability to define an auditable data source. Providers have not requested panel be an option. Based on participation of providers and review of volume attestations the Department believes lack of panel method as an option is not creating a participation barrier.	If Pennsylvania would begin to use the panel method an SMHP amendment would be submitted
Change the period during which an encounter with a patient must take place from 12 months to 24 months to account for new clinical guidelines from the U.S. Preventive Health Services Task Force that allow greater spacing between some wellness				1/1/13 – EPs	N/A	N/A		
					N/A	N/A		

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes					State Checklist				
visits.									
<b>Provider, Panel and Needy Individual Patient Volume:</b> Allow the provider to have their patient volume reporting period to be any consecutive 90 day period within the prior calendar year or preceding 12 month period from the date of the attestation. <u>States have some flexibility, but all approaches need approved by CMS.</u>	§495.306	X	X	10/1/12 – EHS  1/1/13 – EPs	1/1/13	Completed	<p>Communications:</p> <ul style="list-style-type: none"> <li>- Conducted two webinars discussing new requirements.</li> <li>- Presented new standard in Listserv emails, webinars and FAQs (all available on program website)</li> <li>- Posted tip sheet to website. <a href="http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_014610.pdf">http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/p_014610.pdf</a></li> </ul>	<p>Introduction (Pg.4) acknowledges changes as a result of the final rule update.</p> <p>Section C (Pages 49-65) refers providers to program website and on-line manuals for how specific changes are implemented.</p> <p>Section D (Pages 66 – 81) discusses the general requirements of the program as it relates scope of the program’s audit plan. The specific audit</p>	
					1/1/13	Completed	<p>Operations: Program maintains operation manual and has been documenting process changes in the manual. Updates to process will include determining if 90 days selected by EP / EH provides program enough claim data (due to claim lags) for pre-pay validation purposes.</p>		
					4/1/13	Completed	<p>MAPIR: Walkthrough of MAPIR changes with CMS presented on 11/15/12</p>		

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes					State Checklist			
								methodology is described in a separate document from the SMHP.
<b>Exemption from Hospital Based Exclusion for EPs</b>	<b>Hospital Based Exclusion:</b> EPs who can demonstrate that the EP funds the acquisition, implementation, and maintenance of Certified EHR Technology, including supporting hardware and any interfaces necessary to meet Meaningful Use without reimbursement from an eligible hospital or CAH; and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT) are now eligible for EHR Incentive Payments.	\$495.5	X	1/1/13	1/1/13	Completed	Communications:  - Webinar discussed change.  - Process is outlined in EP provider manual, FAQs and listservs	Section C- Pre-pay (Pages 49-65)
					1/1/13	Completed	Operations: Program operations manual will include how professionals will notify program that wish to claim exclusion through MAPIR and program support center. The process will also identify standards professionals must use to validate exclusion claim.	Section D – Post pay (Pages 66 – 81)
					1/1/12	Completed	MAPIR: Updated information splash screens to explain to providers requirements	
<b>Hospital Changes</b>	<b>Children's Hospital Eligibility:</b> Revised definition of a children's hospital to also include any separately certified hospital, either	\$495.302	X	10/1/12	10/1/12	Completed	Communications:  - Presented in webinars  - Conducted outreach to specific hospitals that were identified as meeting the new definition once listing is made available	Section C – (Pages 49-65)

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Stage 2 Regulation Changes				State Checklist			
<p>freestanding or hospital within hospital that predominately treats individuals under 21 years of age; and does not have a CMS certification number (CCN) because they do not serve any Medicare beneficiaries but has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program.</p> <p><b>Hospital Calculation Change:</b> Hospitals that begin participation in 2013 and later can now use the most recent continuous 12 month period for which data are available prior to the payment year. Hospitals that began participation in the program prior to the Stage 2 Rule will not have to adjust previous calculations. Previously Medicaid eligible hospitals calculated the base year using a 12 month period ending in the Federal fiscal year before the hospital's</p>	\$495.310	X	10/1/12	TBD		<p>Operations:</p> <p>- Process may need updated to allow additional hospitals into MAPIR but the review of their application is not distinct from how other hospitals are reviewed. Manual process already established</p> <p>MAPIR: Determined the CCN range for newly eligible hospitals to update system capacity to allow hospitals access.</p>	
				Completed			
				1/1/13	Completed	<p>Communications – Presented new requirement and that data was aligned with auditable data source (e.g. Pennsylvania Cost Reports) Reinforced through Provider Manual, ListServ and FAQs</p>	Section C – (Pages 49-65)
				1/1/13	Completed	<p>Operations – Program updating process documentation to verify dates used for cost data in application are allowable and from an auditable source.</p>	
				10/1/12	Completed	<p>MAPIR – Information within system communicates new requirements and EHs could enter dates allowable by new requirement</p>	

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes				State Checklist		
fiscal year that serves as the first payment year.						
<b>Hospitals Switching States:</b> Allow a hospital to switch states from where they receive EHR incentive payments provided that both states work together to determine the remaining payments due to the hospital based on the aggregate incentive amount and incentive amounts already paid. The hospital will then assume the second state's payment cycle, less the money paid from the first state. States should consult with CMS before addressing this specific scenario.	§495.310	X	10/1/12	10/1/12	Completed	Communications: Addressed this through ad-hoc outreach once situation identified.
				1/1/13	Completed	Operations: Capacity exists to identify switch. Process will document that program will contact CMS to resolve issue with other state.
				10/1/12	Completed	MAPIR: System is used to identify switch and prevent hospital from completing application until able to communicate with other state.
<b>Dual Eligible Hospital Audits and Appeals:</b> States can have CMS conduct the MU audit and appeals for EHs provided that they: (1) designate CMS to conduct all audits and appeals of eligible hospitals' Meaningful Use attestations; (2) be bound by the audit and appeal	§495.370	X	10/1/12	10/1/12	Completed	Communications: Amended SMHP language and will reinforce through EH provider manual as well as listerv communications, webinars and FAQs
				10/1/12	Completed	Operations – Does not change operations because this confirms existing operational plan
				1/1/13	Complete	MAPIR – Reinforced how EHs will be audited and can appeal at appropriate points within MAPIR.

Section D  
(Pages 66 – 81)

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes						State Checklist				
		findings; (3) perform any necessary recoupments arising from the audits; and (4) be liable for any FFP granted the state to pay eligible hospitals that, upon audit (and any subsequent appeal) are determined not to have been meaningful EHR users. Results of any adverse CMS audits (for states that have made the election) would be subject to the CMS administrative appeals process and not the state appeals process.								
<b>Stage 1</b>	<b>C</b>	<b>CPOE Entered by CMAs:</b>	\$495.6	X	X	1/1/13 -	1/1/13	Completed	Communications – Presented new requirements in two webinars and posted tip sheet outlining changes to website. Reinforced who can do CPOE through FAQs, provider manuals and Listserv	Introduction (Pg.4) references changes from updated rule.
<b>MU</b>	<b>o</b>	The revised interpretation allows a credentialed medical assistant (CMA) to be considered a “licensed health care professional” for purpose of computerized provider order entry (CPOE). The CMA must still adhere to State, local and professional guidelines re order entry. Their credentialing would have to be obtained from an organization other than the employing						Operations – Capacity developed to capture measure requirements and review process to that information. Internal education of new requirement on-going.  MAPIR – System walkthrough with CMS scheduled for 11/15/12		
<b>Measures</b>	<b>e</b>						1/1/13	Completed		

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Stage 2 Regulation Changes				State Checklist			
organization.”							
<b>CPOE Alternate Measure:</b> More than 30% of the medication orders created by the provider during the EHR period are recorded using CPOE.				4/1/13	Completed		
<b>Generate &amp; Transmit eRX/New Exclusion</b> - If no pharmacy within organization & no pharmacy within 10 miles who accept electronic submissions.	\$495.6	X	4/1/13	1/1/13	Completed	Communications – Presented new requirements in two webinars and posted tip sheet outlining changes to website. Reinforcing exclusion through FAQs, provider manuals and Listserv  Operations – Capacity developed to capture measure requirements and review process to that information. Internal education of new requirement on-going.  MAPIR – System walkthrough with CMS held on 11/15/12	Section C (Pages 49-65) refers providers to Provider Manuals that are updated about specific requirements
				1/1/13	Completed		

Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist

Stage 2 Regulation Changes					State Checklist		
					4/1/13	Completed	
<p><b>Vital Signs Alternate Measure:</b> Also allow alternate measure for Vital: More than 50 percent of all unique patients seen by the provider during the EHR reporting period have blood pressure (<b>for patients age 3 and over only</b>) and height and weight (<b>for all ages</b>) recorded as structured data.</p> <p><b>Vital Signs/New Exclusion</b> Any provider who (1) Sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is</p>	§495.6	X	X	1/1/13 - EHS 4/1/13 - EPs	1/1/13	Completed	<p>Communications – Presented new requirements in two webinars and posted tip sheet outlining changes to website. Reinforced new requirement and exclusion through FAQs, provider manuals and Listserv</p> <p>Operations – Capacity developed to capture measure requirements and review process to that information. Internal education of new requirement on-going.</p> <p>MAPIR – System walkthrough with CMS held on 11/15/12</p>
	§495.6	X	X	1/1/13 - EHS 4/1/13 - EPs	1/1/13	Completed	
					4/1/13	Completed	

Section D references changes as result of updated rule

Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist

Stage 2 Regulation Changes					State Checklist			
excluded from recording blood pressure; (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.								but specific plan submitted independently to CMS.
<b>Clinical Information:</b> Electronic transmission of key clinical information: <i>Remove requirement</i>	§495.6	X	X	1/1/13 - EHS 4/1/13 - EPs	1/1/13	Completed	Communications – Presented new requirements in two webinars and posted tip sheet outlining changes to website. Reinforcing that requirement is removed through FAQs, provider manuals and Listserv  Operations – Capacity developed to capture measure requirements and review process to that information. Internal education of new requirement on-going.  MAPIR – System walkthrough with CMS held on 11/15/12	
					1/1/13	Completed		
					4/1/13	Completed		

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Stage 2 Regulation Changes					State Checklist		
<b>Report CQMs: No longer a Core Measure, now part of MU definition</b>	<i>n/a</i>	X	X	1/1/13 - EHS 4/1/13 - EPs	1/1/13	Completed	Communications – Presented new requirements in two webinars and posted tip sheet outlining changes to website. Reinforcing that CQM is no longer a standalone measure but still necessary to be a Meaningful User through FAQs, provider manuals and Listserv  Operations – Capacity developed to capture measure requirements and review process to that information. Internal education of new requirement on-going.  MAPIR – System walkthrough with CMS held on 11/15/12
					1/1/13	Completed	
					4/1/13	Completed	
<b>Exchange Key Clinical Info Electronically: Remove</b>	<i>n/a</i>	X	X	1/1/13 - EHS 4/1/13	1/1/13	Completed	Communications – Presented new requirements in two webinars and posted tip sheet outlining changes to website. Reinforcing that requirement is removed through FAQs, provider

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes						State Checklist		
	<i>requirement</i>				– EPs			<p>manuals and Listserv</p> <p>Operations – Capacity developed to capture measure requirements and review process to that information. Internal education of new requirement on-going.</p> <p>MAPIR – System walkthrough with CMS held on 11/15/12</p>
						1/1/13	Completed	
						4/1/13	Completed	
M e n u	<b>Immunizations:</b>	\$495.6	X	X	1/1/13 - EHs 4/1/13 – EPs	1/1/13	Completed	Communications – Presented new language in webinars and posted tip sheet outlining changes to website. Reinforcing in who can do CPOE through FAQs, provider manuals and Listserv
	<b>Reportable Labs:</b>	\$495.6			1/1/13			Operations – Capacity developed to capture measure requirements and review process to that information. Internal education of new requirement on-going.
	<b>Syndromic Surveillance:</b>	\$495.6	X	X	1/1/13 - EHs 4/1/13 – EPs			MAPIR – System walkthrough with CMS held on 11/15/12

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Stage 2 Regulation Changes			State Checklist		
	law and practice”		1/1/13	Completed	
			4/1/13	Completed	
<b>IAPD</b>	State must submit HIT updates <i>12 months from date of last CMS approved HIT IAPD</i>	§495.342	11/9/12	Completed	Updated SMHP language to reinforce point
<b>SMHP</b>	State should submit an update to their SMHP to notify CMS of the sections being updating and the changes being made. Does not need to be full SMHP update, but rather an amendment to the last submission.		11/9/12	Completed	This document will be added as an appendix to SMHP.
<b>State Audit</b>	States with approved audit strategies should update		4/30/1	In-progress	Program’s audit strategy reviewed and will be updated. Need to consider MAPIR system

**Appendix VIII: Stage 2 Regulations - 2013 State Medicaid Changes Checklist**

Stage 2 Regulation Changes		State Checklist	
<b>Strategies</b>	them to included changes to accommodate the previous Stage 1 and the 2013 Stage 1 changes.	5	updates when revising audit strategy.

**Appendix IX - 2014 Certified Electronic Health Record Flexibility Rule**

**Pennsylvania State Medicaid Health IT Plan Addendum for 2014 Certified Electronic Health Record Flexibility Rule**

The Pennsylvania Department of Human Services’ (the Department) Office of Medical Assistance Programs through the Medical Assistance Health Information Technology Initiative complies with federal regulations and guidance from the Centers for Medicare & Medicaid Services (CMS) to administer and oversee Pennsylvania’s Medical Assistance Electronic Health Record Incentive Program. This State Medicaid Health Information Technology Plan Addendum provides CMS with an overview of the Department’s plan to address the new requirements for Program Year 2014.

On September 4, 2014, CMS published a Final Rule, *Medicare and Medicaid Programs; Modifications to Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for 2014 and Other Changes to the EHR Incentive Program; and Health Information Technology: Revisions to Certified EHR Technology Definition and EHR Clarification Changes Related to Standards* to the Federal Register, or the 2014 CEHRT Flexibility Rule.

The Department completed a comprehensive analysis of the final rule to identify information, policy, process and technology impacts to the Pennsylvania Medicaid EHR Incentive Program. The following table contains a summary of the areas impacted as well as the plan to address the impacts for Program Year 2014.

**SMA Policy Changes**

- |                       |  |
|-----------------------|--|
| Policy Considerations | <ul style="list-style-type: none"> <li>• Developed policies and guidance on supporting documentation that relates to the Flexibility Rule (e.g. what is acceptable reasons that providers were unable to fully implement 2014 Edition CEHRT)</li> <li>• Reviewed and updated the pre-payment verification documentation requirements that will be needed from providers at time of attestation to support their ability to utilize flexibility options</li> <li>• Determined the documentation providers will need to provide to prove they their delay in implementation of 2014 Edition CEHRT availability is attributable to issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor.</li> <li>• Developed internal processing documentation for use by staff in applying changes necessary for the Flexibility Rule</li> </ul> |
|-----------------------|--|

**Provider Registration and Attestation**

- |                          |   |
|--------------------------|---|
| Systems / infrastructure | <ul style="list-style-type: none"> <li>• Reviewed and updated eligibility verification checklists by identifying what was submitted if provider claimed flexibility option and to ensure adoption Implementation or upgrade (AIU) attestations use 2014 Certified Electronic Health Record Technology (CEHRT)</li> <li>• Worked with MAPIR Collaborative members, internal program staff, and external vendor, HP, to design core systems changes including any screen changes required to determine the CEHRT verification process in the state Registration and Attestation system, MAPIR, to allow for attestations using the MU Flexibility Rule</li> <li>• Worked with internal program staff and external vendor, HP, to update custom related</li> </ul> |
|--------------------------|---|

## Appendix IX: 2014 Certified Electronic Health Record Flexibility Rule

state Registration and Attestation requirements and web portals changes to allow for attestations using the MU Flexibility Rule.

- Determine CEHRT verification process – included as part of MAPIR system update and verification checklists
- Per the MAPIR Collaborative Statement of Work, planned adequate time to beta test the core system changes to MAPIR and finalize all changes related to the Flexibility Rule in preparation of implementation in Pennsylvania’s production environment
- Determined that the attestation tail period needs to be extended due to the MAPIR system implementation date for Flexibility Rule as well as to adequately communicate with provider community about the changes
  - Received approval (email dated Oct. 17, 2015) for attestation tail extensions for Eligible Hospitals through March 31, 2015 and for Eligible Professionals through June 30, 2015
  - The extension of the attestation tails will be announced via listserv message to provider community as well as on program website.

### Outreach, Collaboration, Support

- |                   |  |
|-------------------|--|
| Provider Outreach | <ul style="list-style-type: none"><li>• Program has reviewed requirements with provider focus group as well as shared CMS resources with provider community</li><li>• Additional webinars will address program requirements as well as how system has changed to accommodate Flexibility rule requirements</li><li>• Coordinating outreach with Regional Extension Centers and stakeholder groups such as the Hospital and Healthsystem Association of PA, The Pennsylvania Medical Society, PA Association of Community Health Centers and others</li></ul> |
| Provider Support  | <ul style="list-style-type: none"><li>• Developed FAQs and talking points for SMA staff and vendors that field phone/email questions from providers regarding Flexibility Rule content, timing, and process issues</li><li>• Utilizing existing tracking mechanism for inquiries to identify patterns in knowledge gaps and update/design additional communications to address gaps</li></ul>  |

### Medicaid EHR Incentive Program Payment Administration

- |                 |   |
|-----------------|---|
| Fiscal Services | <ul style="list-style-type: none"><li>• Payment procedures will remain unchanged due to the Flexibility rule. If payments need to be recouped then they will follow same process. Reason for recoupment will be included in correspondence with provider and if related to flexibility rule then the appropriate section of rule will be referenced</li></ul> |
| Appeals         | <ul style="list-style-type: none"><li>• Providers will follow existing appeal process.</li></ul>  |

### Audit & Program Integrity

- |        |   |
|--------|---|
| Audits | <ul style="list-style-type: none"><li>• Updated post-payment audit procedures to incorporate requirements in the Flexibility Rule by updating checklist to review documentation that is necessary to validate provider’s attestation that delay in 2014 Edition CEHRT is attributable to the issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor which affected their 2014 CEHRT availability and resulted in the inability of a provider to fully implement 2014 Edition CEHRT.</li><li>• Evaluating if audit risk profile(s) need to be updated to reflect Flexibility Rule requirements. Need to see what providers are supplying and what they are attesting to for 2014.</li></ul> |
|--------|---|

### State-Based Performance Measures

- |           |  |
|-----------|--|
| Reporting | <ul style="list-style-type: none"><li>• Will utilize MAPIR data to track attestation as well as Health IT inquiry database to capture Eligible Professionals / Eligible Hospitals that have delayed implementing 2014 Edition CEHRT attributable to issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor.</li></ul> |
|-----------|--|

