Maryland State Medicaid HIT Plan

Version 1.0

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Introduction

1. Purpose

The State Medicaid Health Information Technology Plan (SMHP) describes the activities Maryland will be engaged in over the next five years relative to implementing Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA). These activities will fall into three main areas:

1. *Administering the incentive payments* to eligible professionals (EPs) and hospitals (EHs);
2. *Conducting adequate oversight of the program*, including tracking meaningful use by providers; and
3. *Pursuing initiatives to encourage the adoption of certified electronic health record (EHR) technology* to promote health care quality and the exchange of health care information.

This document will describe how Maryland intends to:

- Administer the EHR incentive payments to eligible providers
- Monitor EHR incentive payments to eligible providers
- Coordinate all ongoing health IT (HIT) initiatives including: the Medicaid EHR Incentive Program, statewide health information exchange (HIE) initiatives and Regional Extension Centers (REC) supported by the Office of the National Coordinator for Health Information Technology (ONC) and other programs

The SMHP consists of the following main sections:

- Section A: Maryland's "As-Is" HIT Landscape
- Section B: Maryland's "To-Be" HIT Landscape
- Section C: Maryland's Medicaid EHR Incentive Program Implementation Plan
- Section D: Maryland's Audit Strategy
- Section E: Maryland's HIT Roadmap

This is the public version of Maryland's SMHP. It does not contain detailed information about the State's audit strategy (Section D). This version may be different from the version(s) officially submitted to CMS; thus, this document is not the State's official approach to administering and overseeing the Maryland Medicaid EHR Incentive Program. If you need confirmation about any aspect of the State's program as described in these pages, please email MarylandEHR@dhmh.state.md.us.

1.1 Overview of the SMHP

The Department of Health and Mental Hygiene (DHMH) will administer the State's Medicaid EHR Incentive Program. DHMH developed this SMHP and is also responsible for developing the Implementation Advanced Planning Document (I-APD). This SMHP describes Maryland's approach to administering and monitoring the EHR Incentive Program.

The Maryland Department of Health and Mental Hygiene (DHMH) convened an EHR Planning and Implementation Committee (the Committee) to begin planning for the EHR Incentive Program. These meetings began in January 2010 when the Committee aided in the completion of Maryland's Planning – Advanced Planning Document (P-APD). Since then, the Committee has made significant progress in developing its processes for administering and overseeing the EHR Incentive Program.

This document describes Maryland's vision and process for implementing, administering and overseeing key aspects of the program and describes the Roadmap that will take Maryland from the present or prior to the EHR Incentive Program ("As Is") to the future HIT vision ("To Be"). The sections of the SMHP are structured as follows:

Section A, the State's HIT "As Is" Landscape, describes the current extent of EHR adoption by professionals and hospitals and their readiness and willingness to participate in the EHR Incentive Program. This section also describes other aspects of the State's HIT landscape including coordination with other organizations on HIT.

Section B, the State's HIT "To Be" Landscape, describes Maryland's vision for HIT and HIE. DHMH works closely with the Maryland Health Care Commission (MHCC), which in turn works closely with the Chesapeake Regional Information System for our Patients (CRISP) – the State's designated Health Information Exchange (HIE). These parties will continue to collaborate going forward. In this section, DHMH 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 DHMH will employ 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 DHMH has created a process flow that follows providers through every stage of the incentive payment program process from educating providers about the program to encouraging them to register at the Medicare and Medicaid EHR Incentive Program Registration and Attestation System (R&A) and apply in the Electronic Medicaid Incentive Payment Program, also known as eMIPP. 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 Medicaid EHR Incentive Program. Many of the controls employed are based on system edits and checks within eMIPP. The eMIPP system will allow providers to apply for the incentive program and make all required attestations. The system edits and checks will generate lists of providers denied for the incentive payment program or pended for further review. Maryland will leverage existing Medicaid program integrity resources and other program integrity agencies and offices around the State to address fraud and abuse.

Section E is the State's HIT Roadmap, which describes the strategic plan and tactical steps that DHMH will take to successfully implement the EHR Incentive Program and its related HIT and HIE 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 indicators of progress in achieving overall program goals.

1.2 About this Document

The SMHP will be a "living" document and will be reviewed and updated annually. Revisions will be submitted to the Centers for Medicare and Medicaid Services (CMS) for its approval. The most current approved version will be available at both the Maryland Health Care Commission (MHCC) website: http://mhcc.maryland.gov/electronichealth/hie.html and the Maryland Medicaid EHR Incentive Program website: http://www.dhmh.state.md.us/mma/ehr/index.html. Viewers will be encouraged to comment on future changes.

1.3 Public Input

The State solicited public input and stakeholder engagement on the development of the Medicaid EHR incentive program as part of discussions related to HIE and HIT in Maryland and as part of the regularly scheduled Medicaid meetings with stakeholders and advocates. Comments will be accepted on an ongoing basis. Comments should be directed to MarylandEHR@dhmh.state.md.us with the subject of *SMHP Comment*. The SMHP is a living and breathing document and appropriate comments will be responded to and incorporated into subsequent versions of the SMHP or as part of Medicaid operations as appropriate.

Section A: Maryland "As-Is" HIT Landscape

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 the data? Does it provide specificity about the types of EHRs in use by your State's providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? 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 your State's rural areas? Did your 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 your State have Veterans Administration or Indian Health Services 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 your State, what is their governance structure and is the SMA involved? How extensive is the geographic reach and scope of participation?

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

Please describe the State's "As-Is" HIT Landscape (cont.):

8. Please describe the role of the MMIS in your current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plan 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 to achieve meaningful use?

10. Explain the SMA's relationship to the State HIT Coordinator and how the activities planned under the Office of the National Coordinator (ONC)-funded HIE cooperative agreement and the RECs (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 your State was awarded an HIT-related grant, such as the Transformation Grant or a CHIPRA HIT grant, please include a brief description.

Overview

Maryland has a number of advantages for implementing health information technology (health IT or HIT), e.g., the presence of early innovators and strong state leadership in the Health Information Exchange (HIE). Hospitals and other health care providers are actively engaged in efforts to expand HIT throughout Maryland. The State's collaborative nature, diverse population, and relatively small size (roughly 5.7 million in 2009 according to the U.S. Census Bureau) have made it convenient for stakeholders from around the state to meet regularly to explore options for expanding HIT, and to develop policies to protect the exchange of electronic health information. Maryland is rich in geographic and cultural diversity that includes rural and inner city areas and diverse minority populations. Maryland is also home to a diverse health care community; including three Veteran Affairs (VA) medical centers; five VA clinics; and numerous nursing homes, long term care facilities, and Federally Qualified Health Centers (FQHCs).

Maryland is considered a leader in adopting HIT. Over the last five years, the state has placed considerable emphasis on advancing HIT and engaging stakeholders in planning and implementation activities. The state has a long tradition of hospital-hospital and hospital-government collaboration on projects, including the award-winning Maryland Patient Safety Center. Located in the State are three prominent regional medical systems (Johns Hopkins, MedStar, and the University of Maryland), several local hospitals belonging to national hospital systems, and a number of independent community hospitals. The three regional medical systems of Johns Hopkins, MedStar, and the University of Maryland are the founding organizations in the Chesapeake Regional Information System for our Patients (CRISP), which is a not-for-profit organization that serves as the state-designated entity in partnership with the State of Maryland to build the statewide health information exchange (HIE) and it also serves as the Regional Extension Center (REC) in Maryland.

A.1.a What is the current extent of EHR adoption by practitioners and by hospitals?

Physicians

To understand the current EHR environment, Maryland conducted two environmental scans: 1.) a preliminary survey done by selecting current Medicaid providers with patient volumes close to that required for EHR Incentive Program participation (see Appendix A) and, 2.) one done with P-APD funds through a vendor to achieve more detailed estimates (see Appendix B).

Maryland has roughly 16,141 physicians in active practice. These physicians treat patients in approximately 5,965 practices (2009 physician data). The number of primary care physicians is

nearly 3,796 and the number of primary care practices is around 2,012. Physician EHR adoption in Maryland parallels the nation at approximately 24 percent and that number is closer to 20 percent for Medicaid-only providers. However, many of these EHRs do not have clinical decision support, computerized physician order entry (CPOE), e-prescribing, or results receipt and delivery functionalities. Approximately 70 percent of active physicians accept Medicaid patients and about 20 percent have adopted an EHR. The table depicts Maryland physicians, Medicaid, and EHR adoption.

Table A.1 – Physician EHR Use

Physicians	Number of Physicians (#)	EHR Adoption (#)	Overall EHR Adoption (%)	Practices (#)	Practices that have an EHR (#)	Practice EHR Adoption %
Medicaid	11,449	2,677	23.38	3,777	722	19.12
Non-Medicaid	4,692	927	19.76	2,188	297	13.57
Total	**16,141**	**3,604**	**22.33**	**5,965**	**1,019**	**17.08**

The primary purpose of the environmental scan conducted as part of the HIT P-APD activities, was to assess EHR adoption, provider likeliness to apply for the Medicaid EHR Incentive Program, and support needed to achieve meaningful use. The environmental scan was designed to identify how many providers might apply for the incentive, the extent of current and future EHR use among responding practices, and the concerns about EHR implementation among practices that do not currently have an EHR system in place. Surveys were sent to 297 Medicaid physicians and responses were received from 103 physicians, which is a fairly high response rate.

A full copy of the survey findings is available in Appendix B. Physicians responding to the environmental scan reported an EHR adoption rate of approximately 37 percent. Environmental scan results indicate about 50 percent of physicians that adopted an EHR also reported using the EHR for three or more years. Environmental scan findings indicate approximately 52 percent of physicians that have not adopted an EHR plan to adopt an EHR within two years. Approximately 45 percent of physicians in the environmental scan were undecided about EHR adoption.

Hospitals

To estimate the use of HIT among Maryland hospitals, the Maryland Health Care Commission (MHCC) conducted a series of surveys, the most recent of which was completed in August 2010. For details on the most recent survey, see Appendix C. Maryland has approximately 46 acute

care hospitals and most hospitals have some level of HIT in their facility. This varies from a fully functional EHR to a limited EHR that may only be used in a few departments. According to the survey conducted in 2010, EHR adoption is reported at around 81 percent with varying functionality:

- 55 percent are fully implemented
- Nearly 68 percent have CPOE
- Roughly 79 percent have electronic medication administration record
- Approximately 57 percent have bar code medication administration
- Nearly 43 percent use infection surveillance software
- Almost 28 percent e-prescribe to a community pharmacy

The ability to share health information electronically with community providers improves care coordination by delivering information to the provider when it matters most – at the point of care. About 50 percent of hospitals reported exchanging some patient information electronically with providers in their service area. As of this SMHP version, five hospitals are connected to the statewide HIE and about 18 are at varying stages of connectivity; all 46 acute care hospitals in Maryland are expected to be connected to the statewide HIE in 2012.

A.1.c Types of EHRs in use by the State's providers

Based on results from a survey conducted in 2009-2010 (See Appendix A), GE Centricity is the most-frequent company cited from which providers purchased their EHR systems (n=5; 38 percent). Other companies include Allscripts and E-Clinical Works. There does not appear to be a dominant EHR system in use. Of the software purchased, the most frequent included Centricity (n=4; 11 percent). Similarly, 83 percent of providers report a unique vendor implemented their EHR. The most common vendor, Allscripts, implemented seven (24 percent). It is unknown at this time the types of EHRs used by non-Medicaid providers.

A.1.d Is it specific to just Medicaid or an assessment of overall statewide use of EHRs?

Primarily, DHMH has focused on the Medicaid and hospital population when estimating EHR adoption rates. However, a Maryland Board of Physicians licensure survey conducted by the

MHCC in 2008-2009 found that roughly 23 percent of providers in the state had adopted an EHR.[1]

A.1.e Data and estimates on eligible providers broken out by types of provider

Within practice types, about 26 percent of community health centers have plans to implement an EHR (n=39). When only non-urban centers are considered, this percentage drops to 7.69 (n=26). Only about 11 percent of non-hospital dental providers have plans (n=18), 33 percent of non-hospital based pediatricians (n=48) and 43 percent of non-hospital based physicians (n=75).[2]

A.1.f Does the SMA have data on EHR adoption by types of provider (e.g. children's hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)?

To estimate EHR adoption rates by provider types, DHMH performed an MMIS query of Medicaid providers who may meet the federal criteria for EHR incentives as defined by ARRA. Providers deemed potentially eligible based on patient volume estimates received a survey, the results of which are available in Table A.3. The full results of the survey are available in Appendix A.

FQHCs have the highest percentage of practices within their provider type using an EHR. At the time of the survey, CCHIT was the only EHR certifying body. Overall, a majority of practices with EHRs had CCHIT certified technology.

[1] See: Maryland Health Information Technology State Plan FY 2011- FY2014. Accessed at: http://mhcc.maryland.gov/electronichealth/hit_state_plan/HITStatePlan.pdf on June 6, 2011.

[2] See Appendix A.

Table A.3 – Percent EHR, Certification, and Use Within Provider Type

	EHR (%)	CCHIT Certified (%)	EHR Use (%)
Acute care hospitals	33.33 (3)	100.00 (1)	100.00 (1)
Community Health Centers	4.88 (41)	50.00 (2)	50.00 (2)
Federally Qualified Health Centers	66.67 (12)	87.50 (8)	75.00 (8)
Non-Hospital Based Dental Providers	14.29 (21)	100.00 (2)	100.00 (2)
Non-Hospital Based Pediatricians	20.00 (60)	54.55 (11)	83.33 (12)
Non-Hospital Based Physicians	21.88 (96)	50.00 (20)	89.47 (19)

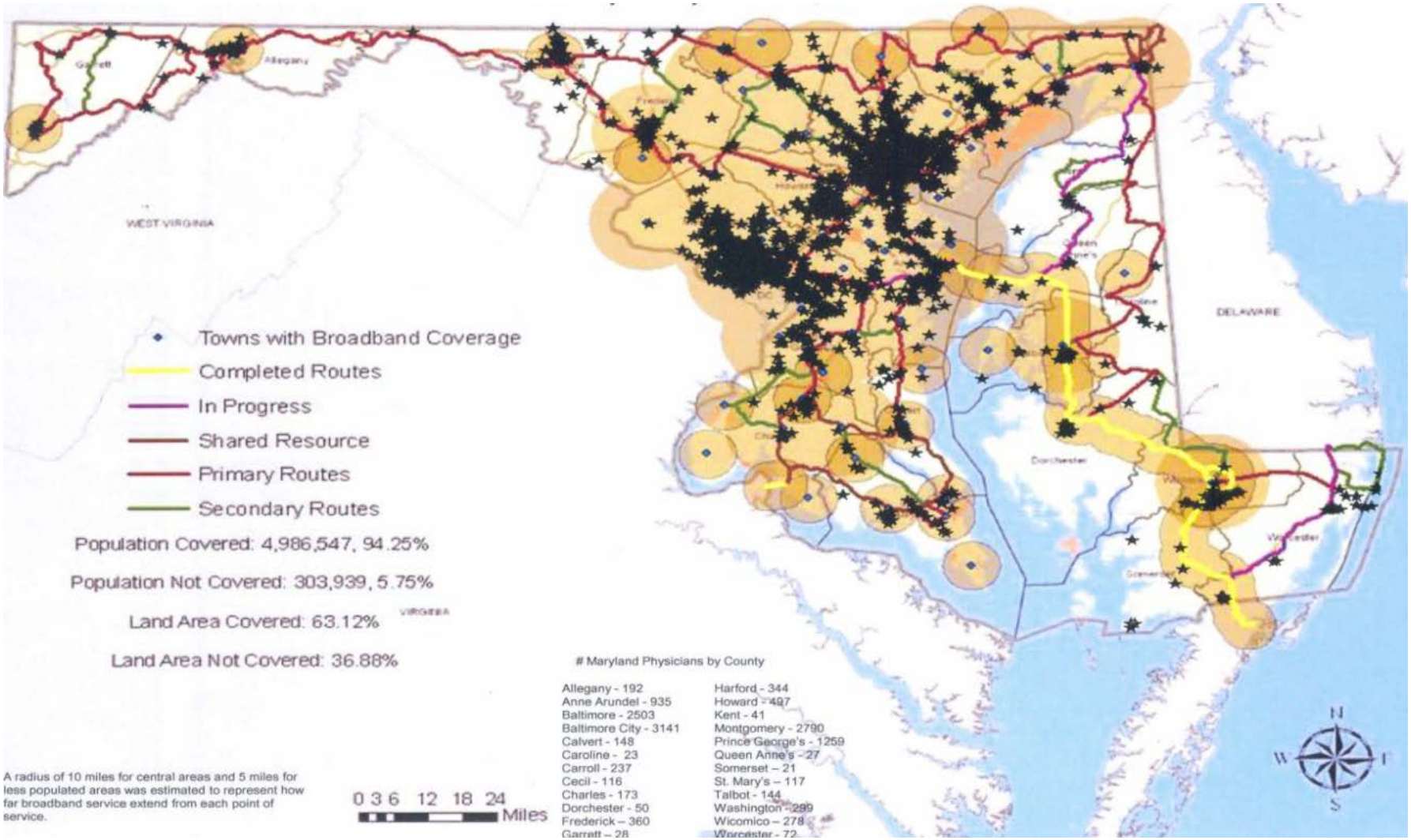
Note: (n)

A.2.a To what extent does broadband internet access pose a challenge to HIT/E in the State's rural areas?

Relative to most states, Maryland has a fairly extensive broadband infrastructure.[3] In November 2009, the U.S. Department of Commerce's National Telecommunications and Information Administration announced that Maryland was one of seven states to receive funding under HITECH. Maryland received about $1.5 million for broadband data collection and mapping activities over a two-year period and almost $480,000 for broadband planning activities over a five-year period, bringing the total grant award to approximately $2 million. Maryland recognizes that broadband access is essential to achieving increased EHR adoption and connecting practices to the statewide HIE. Nearly all physician practices have access to broadband and roughly 94 percent of the state's populations are covered by broadband. Generally speaking, the lack of broadband coverage in rural areas of the state is considered to be minimal. The maps below outline existing broadband capabilities in the state and include physicians and physician practices.

[3] Supra, fn. 1.

Figure A.2 – Estimated Broadband Coverage and Physicians



A.2.b Did the State receive any Broadband grants?

In November 2009, the Department of Commerce's National Telecommunications and Information Administration announced that Maryland was one of seven states to receive funding under HITECH. Maryland received about $1.5 million for broadband data collection and mapping activities over a two-year period and almost $480,000 for broadband planning activities over a five-year period, bringing the total grant award to approximately $2 million.

A.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.

Maryland's FQHCs are recipients of funding to advance HIT from the Health Resources Services Administration (HRSA). Most recently, HRSA funded the Community Health Integrated Partnership (CHIP) with about $1M to advance EHRs. In 1996, nine regional community health centers joined together to address a shared challenge—the growing economic and regulatory issues that tested their ability to offer accessible, high quality, and affordable health care to the state's uninsured and low-income residents. As an agent of change to address these issues, CHIP was formed as a nonprofit Health Center Controlled Network (HCCN) that provides services for quality improvement, operational and clinical management, revenue enhancement, and health IT to its members. About three years ago, CHIP launched an EHR initiative in eight of the state's 16 FQHCs. These FQHCs represent 57 delivery sites throughout rural, suburban, and urban Maryland.

A.4 Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.

The VA in Maryland has deployed VistA as their EHR solution. The Baltimore and Perry Point VA Medical Centers, in addition to the Baltimore VA Rehabilitation & Extended Care Center, and five community-based outpatient clinics all work together to form a comprehensive health care delivery system for Maryland veterans. Connecting public programs to the statewide HIE is an essential part of demonstrating the vision and future of meaningful use to achieve measureable improvements in health care quality, safety, and efficiency. Discussions of VA connectivity with the statewide HIE will result in Use Case development in the near future. The strategy that will be deployed consists of utilizing the statewide HIE's system architecture team and equivalent individuals connected with VA clinics to perform a detailed evaluation of the technology that is in place and required to support data sharing.

A.5 What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?

Almost five years ago, Maryland began the process of planning for HIT/E by engaging numerous stakeholders to address fundamental policy and technology issues. The support and broad collaboration among the stakeholders was an essential first step in enabling the state to implement HIT/E and continues to be crucial to implement HIT/E in Maryland. Stakeholder engagement includes support from payers, providers, consumers, and employers. The table below represents the wide-range of stakeholders that have supported Maryland's HIT/E efforts.

Figure A.3 – Stakeholders

HIT/E Policy Development:
AARP of Maryland
ACLU of Maryland
American Heart and Stroke Association Mid-Atlantic Affiliate
Anne Arundel Medical Center
Asian Pacific American Chamber of Commerce
Baltimore Washington Medical Center
British American Auto Care
CareFirst Blue Cross Blue Shield of Maryland
Community Health Integrated Partnership
Genesis Healthcare
Hebrew Home of Greater Washington
Higher Ground, Inc.
Kosson Care
The League for People with Disabilities
M&T Bank
Maryland Hispanic Chamber of Commerce
Mid-Atlantic Association of Community Health Centers
National Network to End Domestic Violence
The National Society of Allied Health
Primary Care Coalition of Montgomery County
Washington County Health Systems

Key Health Systems and Long Term Care Providers:
The Erickson Foundation
Erickson Retirement Communities, LLC
Johns Hopkins Health System Corporation
Johns Hopkins Medicine
MedStar Health, Inc.
University of Maryland Medical System, Inc.

HIT/E Advisor Organizations
Adventist Healthcare
Atlantic General Hospital
Bon Secours
Calvert Memorial
CareFirst
Carroll Hospital Center
Children's National Medical Center
Columbia Medical Practice
Erickson Retirement Communities
Frederick Memorial Healthcare System
Greater Baltimore Medical Center
Genesis Physician Services
Green Spring Internal Medicine, LLC
Healthcare for the Homeless
Holy Cross Hospital
Johns Hopkins University
LifeBridge Health
Maryland Hospital Association
MedChi, The Maryland State Medical Society
MedStar Health
Maryland Medical Group Management Association
Peninsula Regional Medical Center
Peter M. Schissler, M.D., P.A.
St. Agnes Hospital
St. Joseph Medical Center
University of Maryland Medical System
Western Maryland Health System

HIT/E Planning Organizations
Advanced Radiology
Advocates for Children and Youth
Aetna
AIDS Legislative Council
American Cancer Society
Atlantic General Hospital
Audacious Inquiry
Baltimore City Medical Society
Baltimore Medical System
Braddock Hospital
Bravo Health
Calvert Memorial Hospital
Carroll Hospital Center
Catonsville Diagnostic Imaging
Chesapeake Eye Center
Chester River Hospital Center
Civista Medical Center
Constellation Energy Group
Delmarva Foundation
Delta Dental Plans Association
Doctors Community Hospital
Dorchester General Hospital
Edward W. McCready Memorial Hospital
EPIC Pharmacies
Franklin Square Hospital
Garrett County Memorial Hospital
Good Samaritan Hospital of Maryland
Harbor Hospital
Harford Memorial Hospital
Healthcare for All
Howard County General Hospital
James Lawrence Kernan Hospital
Johns Hopkins Bayview Medical Center
Johns Hopkins Community Physicians
Johns Hopkins Urban Health Institute
Kelly and Associates
Kodak Dental Systems
Laboratory Corporation of America
Laurel Regional Hospital
Legal Aid Bureau
Maryland General Hospital
Maryland Hospital Association
Matria Health Care
MedStar Health VNA
Memorial Hospital & Medical Center of Cumberland
Memorial Hospital at Easton
Mercy Medical Center
Mid-Atlantic LifeSpan
Montgomery County Medical Society
Montgomery General Hospital
Montgomery Internal Medicine Association
Northwest Hospital Center
Primary Care Coalition of Montgomery County
Prince George's Hospital Center
Shady Grove Adventist Hospital
Shepherd's Clinic
Shepherd Pratt Health System
Sinai Hospital of Baltimore
Southern Maryland Hospital Center
St. Agnes Healthcare
St. Mary's Hospital
Suburban Hospital
Union Hospital of Cecil County
Union Memorial Hospital
United Healthcare Mid-Atlantic
University Physicians, Inc.
Upper Chesapeake Medical Center

A.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?

The Maryland Department of Health and Mental Hygiene, through the Office of Planning, works closely with the state-designated HIE and Regional Extension Center (REC), both of which are overseen by CRISP, and the State's public health office, the Infectious Disease and Environmental Health Administration (IDEHA).

The Director of the Office of Planning holds a seat on the HIE Policy Board, the responsibilities of which include, although are not limited to, the development and recommendation of policies for privacy and security of protected information exchanged through a health information exchange operating in Maryland. In addition, the Office of Planning has initiated meetings with CRISP to better understand how and if administrative funds for the EHR Incentive Program can support health information exchange. The Office of Planning is working with the REC to expand their outreach efforts to provide assistance to Medicaid providers potentially eligible for the EHR Incentive Program. By leveraging CRISP's involvement in HIT and HIE infrastructure and expansive provider outreach program for the REC program, DHMH hopes to both reach a large number of providers without having to duplicate current outreach activities while also improving the uptake of HIE connectivity.

Understanding that both Medicare and Medicaid providers and hospitals participating in the EHR Incentive Program must work through the State Public Health Agency to fulfill public health meaningful use requirements, the Office of Planning holds standing meetings with IDEAH staff. Both the Office of Planning and IDEAH attend the CDC Meaningful Use Nationwide calls, and hold meetings following these calls to discuss issues related to the EHR Incentive Program. To help prepare the Public Health Agency for the production of submitted public health data, DHMH has built in funding in the State's I-APD.

A.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?

Five years ago the MHCC began the process of planning the implementation of a statewide HIE by engaging numerous stakeholders to address the fundamental policy issues and plan a course of action. State legislation passed in 2009 required the MHCC to designate a multi-stakeholder group to implement the statewide HIE; CRISP was selected based upon the breadth of stakeholders and their response to the state's RFA. The statewide HIE makes possible the appropriate and secure exchange of data, facilitates and integrates care, creates efficiencies, and improves outcomes. MHCC's efforts are targeted towards developing a widespread and sustainable HIE that supports the meaningful use definition that qualifies providers for CMS incentive payments. This strategy also supports state public health programs to ensure that

public health stakeholders prepare for HIE and mobilize clinical data needed for consumer engagement and health reform in Maryland.

The statewide HIE will support high quality, safe, and effective health care; make certain that data is exchanged privately and securely; ensure transparency and stakeholder inclusion; support connectivity regionally and nationally; achieve financial sustainability; and serve as the foundation for transforming health care in Maryland. The HIE architecture will be capable of connecting approximately 47 acute care hospitals and 7,914 physician practices throughout Maryland. The infrastructure will support the meaningful use requirements and eventually connect with other HIEs regionally and nationally. The governance of the statewide HIE will guide the development of the five domains that support the grant program, establish the policies governing the exchange, and determine Use Case implementation. The statewide HIE will provide a mechanism for authorized individuals to perform sophisticated analytics and reporting for public health, bio-surveillance, and other appropriate secondary uses of data.

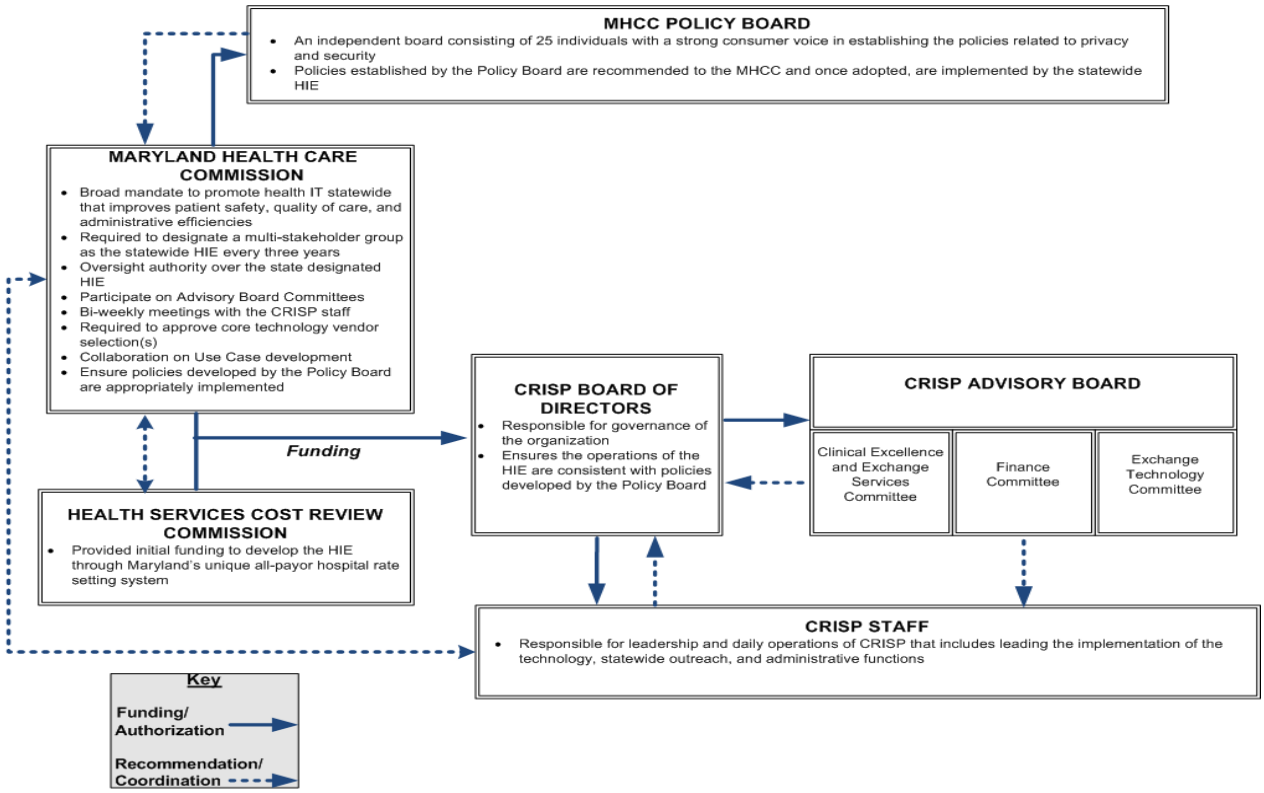
The statewide HIE will consist of a hybrid approach that combines a federated or distributed model, keeps the data at its source facilities or with providers, and uses the HIE as the conduit for sharing. In general, the HIE provides a roadmap for properly routing information to the appropriate location. The HIE will maintain a central master patient index (MPI) and a separate registry (Registry) of the record's location within the system. The design also includes the use of a HRB/PHR that is controlled by the consumer, which does not use MPI or Registry. The hybrid model also allows the centralization of records when directed by consumers. This does not constitute a centralized record, but rather directory information that allows records to be identified and located throughout the distributed system. The hybrid model used in Maryland is less threatening to participants and individual consumers because it is less disruptive to existing, trusted relationships between individuals and their care providers, and raises fewer regulatory issues in today's privacy and security focused regulatory environment. A disadvantage of a hybrid approach is the absence of a single database that can be queried for a variety of health services research, public health reporting, and post marketing surveillance purposes. This disadvantage can be minimized by efficient queries to the statewide HIE, long retention times on edge servers, and special purpose databases with privacy protections suspect to the statewide HIEs controls and data sharing policies. A single HRB associated with the statewide HIE can also deliver robust resource to monitoring capability together with consumer control.

The successful development and implementation of the statewide HIE will be defined by how beneficial health information is in improving quality, reducing health care costs, and improving health outcomes. The infrastructure of the statewide HIE ensures flexibility so that the organization can respond to market changes and eventually connect providers throughout the

State. The technological design of the statewide HIE is based on federally-endorsed standards and integration protocols that bridge proprietary boundaries. The incremental approach to building the statewide HIE ensures sustainability for a core set of services within about five years. Should additional services beyond the core services be identified by the stakeholder community or the legislature, the need for additional funding to support the development of these services would be required. At this time, no additional action on the part of the legislature is required to align funding with the ARRA.

Maryland is considered to be a leader in adopting health IT. Over the last six years, the state has placed considerable emphasis on advancing health IT and engaging stakeholders in planning and implementation activities. The existing governance structure of the statewide HIE represents a sound model for ensuring that all providers meet the meaningful use requirements. The statewide HIE developed an integrated governance approach involving key stakeholders in addressing clinical, technical, and financial aspects of the HIE. The governance model includes a Board of Directors; an Advisory Board, which is organized into four committees, and an independent Policy Board.

Figure A.4 – HIE Governance Model



HIE Connectivity

In July 2010, the Health Information Technology Forum (Forum) brought together elected officials, media, and more than 200 hospital representatives to discuss information sharing and care coordination. The Forum included Governor Martin O'Malley, Lieutenant Governor Anthony Brown, and then Secretary of the Department of Health and Mental Hygiene John Colmers, along with the *Health Information Technology Forum* (Forum) at Sinai Hospital in Baltimore with the hospital Chief Executive Officers (CEOs) and other senior level executives from Maryland's acute care hospitals. State leaders stressed the value of the HIE and the significance of sharing information between places of care and coordinating efforts across different providers. They also mentioned that electronic health information will become even more important in an era of personalized medicine and accountable care. The Governor, Lieutenant Governor, and Secretary encouraged the CEOs to sign a Letter of Intent (LOI) conveying their hospital's intent in connecting to the statewide HIE. The statewide HIE received a signed LOI from each of the acute care hospitals in September. Hospitals selected one of four timeframes for connecting (see Table 1 for the *Timeframes Specified by Hospitals for Connecting to the HIE*).

Table A.3 –Timeframes Specified by Hospitals for Connecting to the HIE

Timeframe for HIE Connectivity	Percent of Hospitals
Early (6 months)	38
Mainstream (6-12 months)	23
Deferred (12-18 months)	22
Late (18-24 months)	17

Efforts to connect providers to the statewide HIE have centered on hospitals, since they are considered large suppliers of data, and will then proceed to connect ambulatory care practices. The Montgomery County hospitals were the first to begin connecting to the statewide HIE; most of these hospitals as well as Quest Diagnostics, LabCorp, RadNet, and American Radiology are connected to the HIE. The statewide HIE anticipates connecting ambulatory care providers beginning in 2011 and expects to have all hospitals connected within two years. Providers connecting to the statewide HIE will be able to exchange data as specific services are made available through the exchange. The statewide HIE has an ambitious schedule to implement services over the next six months.

DHMH hopes to use the ease of the HIE to encourage providers to connect in order to submit public health data to the State. By partnering with CRISP, DHMH will be able to clearly convey this message and provide the technical assistance to aid in connection in the near future.

A.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.

Maryland state government has several IT systems in place help to manage the health care environment. Many providers are already required to submit multiple files for secondary uses by public health officials for monitoring and reporting purposes. The primary Medicaid IT system is Medicaid Management Information System (MMIS). The MMIS manages operational responsibilities associated with the management of Maryland Medicaid Program.

The State Immunization registry and public health surveillance reporting database are two examples of databases that can be populated through the statewide HIE. Maryland's immunization registry is ImmuNet operated by the Center for Immunization at the DHMH. The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) is a web-based syndromic surveillance system designed for the early detection of disease outbreaks, suspicious patterns of illness, and public health emergencies. Discussions are currently underway to integrate ImmuNet into the statewide HIE. Data in the Immunization registry and ESSENCE is through a push model from the provider to Medicaid. The goal is to centralize the flow of these data through the statewide HIE; a Use Case is anticipated in mid-2011.

To help administer the Medicaid EHR Incentive Program, Maryland is procuring "eMIPP", a technical solution that will interface with existing legacy MMIS and with the expected replacement system, based on Medicaid Information Technology Architecture Initiative (MITA) principles. Maryland's new MMIS is expected to be in place by September 2013 and is not expected to impact on the administration of the ARRA.

Maryland will use the eMIPP to provide for program registration and attestation. Using current State staff and contractor services, DHMH will be able to administer the incentive payments, track meaningful use by providers, and pursuing initiatives to encourage the adoption of certified EHR technology.

Medicaid IT Systems

In June 2010 the State of Maryland began an initiative to replace its almost 20 year old MMIS. The legacy system was bid as a transfer system in 1992 and was used for the claims processing needs of the State of Maryland with largely batch operations running on a mainframe processor. The legacy system will be replaced with a new MMIS system based on MITA 2.0 principles that includes imaging and workflow management and a robust business rules engine to aid in creating and managing flexible benefit plans. The MMIS has the ability to process all Medicaid claims and eliminate the duplicative adjudication of the Mental Hygiene

Administration, Developmental Disabilities Administration, and Dental claims. In addition, the MMIS system supports coordination of benefits, surveillance and utilization review, Federal and management reporting, and case management that supports commercial-off the- shelf solutions, call center, document management and customer relationship management activities.

New MMIS

Medicaid is at the beginning stages of implementing a new MMIS to replace the system that has been in place since 1992. The current legacy system is used for claims processing running in largely batch operations on a mainframe processor. The current technology will not support health care reform or, in the long term, the vision for health IT. The request for proposal that was released by Medicaid in May 2010 seeks to identify a vendor that can navigate the increasingly complex services, eligibility, and new regulations and find ways to ensure the state delivers the maximum value for the cost. Implementing a new MMIS system is a major undertaking for the state and is well timed to support the health IT initiates that are underway in the state. In each area, DHMH seeks to advance the MITA maturity level of the MMIS, to replace manual or inefficient processes with more efficient ones.

Figure A.5 – MMIS Process Flow

Web Portal

In order to provide quality customer service to Medicaid consumers, DHMH stakeholders, and other entities, DHMH will make use of a web portal for easy access to information about program benefits, eligibility, policy, processes, and reports, as well as the ability to communicate readily with DHMH. The MMIS web portal as a single gateway shall be an important tool and shall provide general and program specific information and links to other programs, applications, related agencies, and resources. The web portal has both secure and non-secure areas.

The MMIS system has a web-based Service Oriented Solution consistent with MITA guidelines that has online web capabilities for all users, including providers and recipients. The web portal includes the ability to view remittance and status reports; and submit and view the status of

service authorization requests via web screens for authorized providers and other users. The web portal allows providers to complete, submit, resubmit, modify, check status, view deficient documentation listings, save partial applications, dis-enroll, or cancel applications and updates.

A.9.a What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play?

Maryland's approach to governance is to create a coordinated governance model that emphasizes public/private partnerships. The HIE governance structure consists of the CRISP Board of Directors, the Advisory Board, and an independent Policy Board convened by the MHCC. The Board of Directors is comprised of members appointed by the respective founding member organizations. The Advisory Board is divided into four committees. While a strong provider representation on the Advisory Board guides the CRISP Board of Directors on the development and operation of the statewide HIE, a consumer focused Policy Board establishes the policies governing data sharing. This separation of responsibilities assures that policies that govern the exchange of electronic health information are consumer oriented (see Figure 1 for an illustration of the Maryland HIE Governance Structure).

In regards to DHMH specifically, DHMH is partnering with CRISP and the REC to better understand how to leverage Federal and State funds to support health information exchange and to provide a streamlined information and outreach strategy for all providers interested in adopting EHRs or connecting to the HIE. As described in A.6, DHMH is in the early collaboration stages of these efforts. Future iterations of the SMHP will provide updates to these meetings.

Board of Directors

The statewide HIE Board of Directors is the authoritative entity overseeing the operations of the statewide HIE. The Board of Directors considers the recommendations of the Advisory Board and ensures that the policies developed by the Policy Board are implemented. The governance structure of the statewide HIE is fairly consistent with those implemented by other HIEs nationally. The statewide HIE bylaws provide a mechanism to support changing the composition of the Board of Directors as long as these revisions do not have a significant impact on governance, best practices, or legal considerations, such as those for tax-exempt organizations.

Advisory Board

The statewide HIE operates under the guidance of an Advisory Board. The statewide HIE Advisory Board is organized into the following four committees - technology, finance, clinical excellence and exchange services, and small practice; each committee is comprised of approximately 10 to 15 members. Members are identified through a nomination process and

appointed by the Board of Directors. Most of the work done by the Advisory Board is accomplished at the committee level. The Advisory Board is tasked with making recommendations on matters such as the technology to support the core infrastructure, early Use Case implementation, and sustainability models.

The Policy Board

The Policy Board is comprised of approximately 25 members selected based upon their expertise, the breadth of stakeholder representation, and a strong consumer voice, which is essential to building trust among stakeholders. Ex-officio members of the Policy Board consist of representatives from CRISP and state government including Medicaid, the MHCC, and the HSCRC. The responsibilities of this Policy Board primarily include the development of policies for privacy and security (see Appendix E for the Policy Board Operating Guidelines). The MHCC will consider the policies developed by the Policy Board; the statewide HIE is required to implement policies adopted by the MHCC.

A.9.b 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?

The statewide HIE received $5.5 million in funding from the ONC under the HITECH Act to establish a regional extension center (REC) in Maryland. The goal of the REC is to help 1,000 priority primary care providers, as defined by the ONC, in Maryland with adopting EHRs and achieving the meaningful use requirements. In Maryland, the statewide HIE is also the Regional Extension Center (REC) and is a significant partner in encouraging EHR adoption among Maryland providers. The model that is being deployed relies on a group of Management Service Organizations (MSO) to promote physician adoption of EHRs and meeting the meaningful use requirements. Maryland developed the MSO model as a result of HB 706: Electronic Health Records – Regulation and Reimbursement[4]. HB 706 requires the Maryland Health Care Commission to certify MSOs that will offer centrally hosted EHRs instead of EHRs maintained at the practice. These MSOs became the implementation arm of the REC to get primary care providers to adopt and then meaningfully use certified EHRs. At a minimum, the MSOs must assist a combined total of 1,000 priority primary care providers with EHR adoption and provide support as they work toward meeting each stage of meaningful use. At the present time, roughly 22 MSOs are participating with the REC.

The REC relies on MSOs that have State Designation to address the challenges associated with provider adoption and upgrades to EHRs. These challenges include the cost and maintenance

[4] See: http://mhcc.maryland.gov/electronichealth/HouseBill706ArticleFINALV2-CTK051509-DS-Copy-Copy.pdf.

required for the technology, and the responsibilities that accompany the storage of electronic data privacy and security. The MHCC provides State Designation to MSOs that meet stringent criteria for privacy and security and have received national accreditation. Unlike the traditional EHR client-server model where the data and technology is hosted locally at the provider site, MSOs offer EHRs hosted in a centralized secure data center.

The data is safeguarded through a network operating center that, by design, ensures high quality and uninterrupted service. MSOs enable physicians to access a patient's record wherever access to a high speed Internet connection exists. Remotely hosted EHRs enable providers to focus on practicing medicine rather than dedicating staff to support the application. The model in use in Maryland is expected to help all providers throughout the state meet the meaningful use requirements. The state anticipates modifying the State Designation criteria each year based on feedback it receives from the MSOs and evolving technology. Today, the criteria includes nearly 100 requirements that center around data protection, business practices, data center security, disaster recovery, and business continuity planning. The business model that was developed by the REC to rely on the services of the MSOs to increase EHR adoption is based on free market principles. The MSOs can market hosted EHR solutions across the state and a variety of other services that includes billing, workflow management, training, performance data monitoring, etc. Each time an MSO signs up a practice to participate with the MSO, they receive a payment from the REC and from the practice. The MSOs have a milestone schedule that enables them to earn an additional incentive for meeting the requirements. These requirements have been established in a way to ensure that practices meet the meaningful use requirements.[5]

To aid in promoting the EHR Incentive Program, Medicaid continues to partner with Maryland's Regional Extension Center (REC), CRISP. As is outlined in our I-APD, we plan to leverage the outreach activities already supported by the REC to include all EHR Incentive providers. Through this extension, DHMH will continue to participate in provider outreach calls and webinars hosted by the REC. Medicaid attends these calls to answer specific questions posed by providers interested in participating in the EHR Incentive Program. Medicaid has also invited the REC to speak to the Maryland Medicaid Advisory Committee (MMAC), a committee created to improve and maintain the quality of the State's Managed Care program by assisting Medicaid with the implementation, operation and evaluation of the program. The REC has also presented alongside Medicaid at the Public Health Officers Roundtable.

The REC's association with MHCC increases information sharing between these groups and Medicaid. All groups coordinate websites, with each hyperlinking to the other when

[5] More information on MSOs is available at http://mhcc.maryland.gov/electronichealth/mso/.

information on varying aspects of the program better contained on the other's website. For example, Medicaid contains programmatic information about the EHR Incentive Program, while the REC supplies assistance with indentifying EHR vendors, and the MHCC provides an online EHR Product Portfolio.

A.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.

The MHCC's Center for Health Information Technology (Center) Director, David Sharp, is the Maryland Government HIT Coordinator. MHCC is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access in a rapidly changing health care environment by providing timely and accurate information on availability, cost, and quality of services to policy makers, purchasers, providers and the public. The Center reports to the Secretary of the Department of Health and Mental Hygiene. The Center Director also oversees CRISP, Maryland's HIE and REC.

The Center Director is actively involved in HIT and HIE in Maryland and previously participated on the National Health Information Security and Privacy Collaboration, Adoption of Standard Policies Collaborative. The Center Director has worked with Medicaid in creating initial drafts of the SMHP and IAPD, and he is currently working with Medicaid to explore data sharing opportunities under the MITA transformation project and is actively involved with CMS as part of its EHR Demonstration Project. As the HIT Coordinator for Maryland, the Center Director also sits on the Steering Committee for the Community Health Integrated Partnership's (CHIP) Electronic Patient Record System Implementation project. CHIP provides roughly nine community health centers with the business expertise to achieve the shared goal of quality improvement in the care they deliver, and is a recipient of HIT funding from the Health Resources and Services Administration. The Center Director is an ex-officio member on the CRISP Advisory Board, a participant on the state Policy Board, and is actively involved with the state's medical society and hospital association.

DHMH plans to use the services of the REC to promote the adoption of EHR technology by leveraging their current outreach strategy to include all providers potentially eligible for the EHR Incentive Program. As discussed previously, DHMH is holding meetings with the REC and HIE to plan for cooperation with HIE adoption.

A.11.a 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?

CMS EHR Demonstration Project

Maryland is one of four states participating in the CMS EHR Demonstration Project (CMS project); the other states include Louisiana, Pennsylvania, and South Dakota. In Maryland, the

CMS project is studying EHR adoption in 255 small to medium-sized primary care physician practices. The MHCC provides physician practices with support in the evaluation of EHRs and educational material related to the adoption and meaningful use of EHRs. The CMS project began in June 2009 and continues through May 2014. The information gleaned from this Project will inform our EHR Incentive Program outreach strategy and materials.

ARRA Related Projects

Maryland has been successful in obtaining funding under the ARRA. These funds are intended to provide the necessary technical assistance for providers to become meaningful users of EHRs, coordinate the State's efforts with regard to the electronic exchange of health information, and provide the needed training and education to increase the health IT workforce. The table below describes the funding that has been received in Maryland.

Table A.4 – Maryland ARRA Funding

Project	Amount	Awardee	Purpose
State HIE Cooperative Agreement Grant Program	$9.3M	*Maryland Health Care Commission*	Build capacity for exchanging health information across the health care system
HIT Extension Program: Regional Centers Cooperative Agreement Program	$5.5M	*Chesapeake Regional Information System for our Patients*	A regional extension center established in Maryland for EHR adoption assistance to physicians
Program of Assistance for University-Based Training	$3.7M	*Johns Hopkins University School of Medicine*	Offer training programs for highly specialized health IT roles
Expand Health IT Capacity	$2.9M	*Community Health Integrated Partnership, Inc.*	Expand EHR technology in Federally Qualified Health Centers
Curriculum Development Centers Program	$1.8M	*Johns Hopkins University School of Nursing*	Development of graduate level programs for health IT
HIT Planning-Advanced Planning Document	$1.3M	*Maryland Medical Assistance Program (Medicaid)*	An award from CMS for state planning activities to implement the EHR incentive
Community College Consortia Program	$325K	*Baltimore County Community College*	Create non-degree health IT training programs with completion in six months or less
TOTAL	**$24.8M**		

Additional Funding Opportunities

Patient Centered Medical Home

The patient centered medical home (PCMH) is a model of practice where a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to consumers. On April 13th Governor Martin O'Malley signed a law entitled the *Patient Centered Medical Home Program*

(HB 929, 2010 legislative session). This law requires the establishment of a PCMH program that will provide care to nearly 200,000 consumers in Maryland. Under this program, reimbursement includes a care coordination payment plus opportunities for shared savings in addition to existing fee for service or capitation models. Adoption and meaningful use of an EHR and sharing electronic health information is vital to support a PCMH. Funding for the PCMH program supports the notion that additional funding is needed for primary care providers.

To better align the PCMH project with the EHR Incentive Program, the PCMH incorporates core and alternate core measures in the practice evaluation criteria.[6]

A.11.b Medicaid Activities Influencing the EHR Incentive Program

Medicaid supports the vision of using health IT to improve patient care, increase efficiency, and reduce health care costs. The implementation of a new MMIS system is not expected to negatively impact on the administration of the ARRA EHR incentives. In fact, Medicaid's strategy will ensure that a sound program is developed on top of the current and future MMIS and that the State's implementation strategy evolves with the improved MMIS. Medicaid recently conducted an environmental scan of Medicaid physicians to identify EHR adoption and meaningful use activities and assess leading implementation barriers. These barriers will inform outreach strategies and provider assistance. Medicaid also completed a feasibility assessment of the EHR Incentive Program. Available in Appendix C, the Assessment found that the EHR Incentive Program aligns with current HIT, MMIS, and MITA expansions within the State.

A.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.

The Maryland legislature recognized that changes in state law may be required to support the private and secure exchange of patient information. Changes in state laws that are necessary to provide for the effective operation of an HIE are required to be recommended to the state legislature. These recommendations include: define in statute an HIE and qualified HIE; clarify that making data available through the HIE is not considered to be a disclosure under existing state law; establish liability protections for the exchange and providers that participate in the HIE; and require HIEs that are non-commonly owned, such as a hospital or health system, to adhere to the exchange policies recommended by the Policy Board.

[6] See: http://mhcc.maryland.gov/pcmh/documents/PCMH%20Prog%20Partic%20Agmt%20050411.pdf.

In the 2011 Session, HB 736, Electronic Health Records – Incentives for Health Care Providers – Regulations[7], provided more information on the State's EHR Incentive program for state-regulated payors. Although the regulations for this program are currently under review and will be described in later iterations of the SMHP when they become available, it is likely that these additional incentives will increase the adoption and meaningful use of EHRs by Maryland providers.

A.13.a Are there any HIT/E activities that cross state borders?

Maryland has participated in discussions with neighboring states about HIT and HIE and is in talks with neighboring states about coordinating monitoring efforts. Maryland is also interested in participating in a learning and implementation collaborative with our fellow CMS Region III states.

A.13.b Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe.

Due in large part to its relatively small size and its shared contiguous borders with Pennsylvania, Delaware, Washington DC, Virginia, and West Virginia, Maryland likely experiences a significant crossing of State lines by Medicaid beneficiaries to access health services. Although there is no easy way to calculate Maryland Medicaid beneficiaries' access to provider services across state lines, the Health Services Cost Review Commission (HSCRC) estimates that in CY 2010 around two percent of all Maryland Hospital visits (inpatient and outpatient) were provided for Medicaid beneficiaries with primary addresses from surrounding states. And in the same calendar year, 7.4 percent of all hospital visits by Maryland Medicaid patients were provided in out-of-state hospitals.

A.14 What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)?

DHMH, CRISP, and IDEHA is in the process of assessing the feasibility of direct EHR provider connection with these systems and the impact this may have on increasing the adoption of the HIE. Currently, Maryland can accept point-to-point electronic submission of public health data via a secure FTP. While Maryland will accept public health measures via this method, we hope to encourage the use of the HIE for public health data submission once the Department is fully connected to the HIE.

[7] See: http://mlis.state.md.us/2011rs/chapters_noln/Ch_533_hb0736T.pdf.

Public Health Systems

Maryland has a long history of using health IT to improve public health issues. Maryland employs the National Electronic Disease Surveillance System (NEDSS) for legally-mandated infectious disease reporting, including electronic reporting from laboratories. In addition, Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) is a syndromic surveillance system developed for early detection of infectious disease outbreaks at military treatment facilities. Finally, Maryland employs an electronic immunization registry known as ImmunNet. These systems have been continually improved over the years and provide an excellent base to build the new meaningful use requirements on. Data in NEDSS, ESSENCE, and ImmuNet is currently through a push model from the provider to DHMH. The goal is to centralize the flow of these data through the statewide HIE. Full connectivity between the State and the HIE is anticipated by Fall of 2011.

NEDSS

The Maryland Code Annotated, Health-General § 18-201, § 18-202 and § 18-205 and Code of Maryland Regulations (COMAR) 10.06.01 mandate that certain infections and other conditions be reported to local health departments and to DHMH. Since 2007, most of those reports have been entered into and maintained in NEDSS. For these purposes, Maryland uses the NEDSS Base System (NBS) which was developed by CDC and is employed by at least 30 other states in addition to Maryland. NBS is a secure, web-based system that serves to support the electronic processes involved in notifiable disease surveillance and analysis as well as transmission of surveillance data securely between local health departments, DHMH, and CDC. In production currently is NBS version 4.1. NEDSS is capable of and receives electronic reports directly from clinical laboratory information systems ("electronic laboratory reporting"). While the Department prefers Logical Observation Identifiers Names and Codes (LOINC), there is no Electronic Lab Reporting (ELR) regulation requiring it, unless submissions follow meaningful use guidelines. Over time, the Department expects submissions to standardize. Currently, Maryland NEDSS receives electronic reports from two major national laboratories (Mayo Medical Laboratories and Lab Corp), and will soon receive electronic reports from several other large laboratories. Existing electronic laboratory reporting requires one-to-one connections between the reporting laboratories and DHMH; however, such reporting could potentially be performed more efficiently from laboratories through the statewide HIE to DHMH.

ESSENCE

The field of biosurveillance involves monitoring measures of diagnostic activity for the purpose of finding early indications of disease outbreaks. By providing early notification of potential outbreaks, the aim is to provide public health officials the opportunity to respond earlier and

thus more effectively. DHMH uses ESSENCE for the early detection of public health emergencies. Initially, 15 acute care hospitals in the National Capital Region and Baltimore Metro Region of the state were sending emergency department data to ESSENCE. In 2007, Maryland Governor Martin O'Malley introduced a homeland security initiative that outlined 12 Core Goals for A Prepared Maryland. One of the core goals is to improve biosurveillance so that every region in Maryland has access to a real-time, 24/7 statewide biosurveillance system. To accomplish this goal, Medicaid began the expansion of ESSENCE to incorporate data from all acute care hospitals in the state. ESSENCE has incrementally expanded its capabilities through a series of targeted project implementations, adding the following data sources: hospital emergency department visits, poison control center data, over the counter medication sales, thermometer sales, prescription antiviral sales, and prescription antibacterial sales.

Figure A.7 – Percent (%) of Maryland Coverage by ESSENCE Data Source According to Year

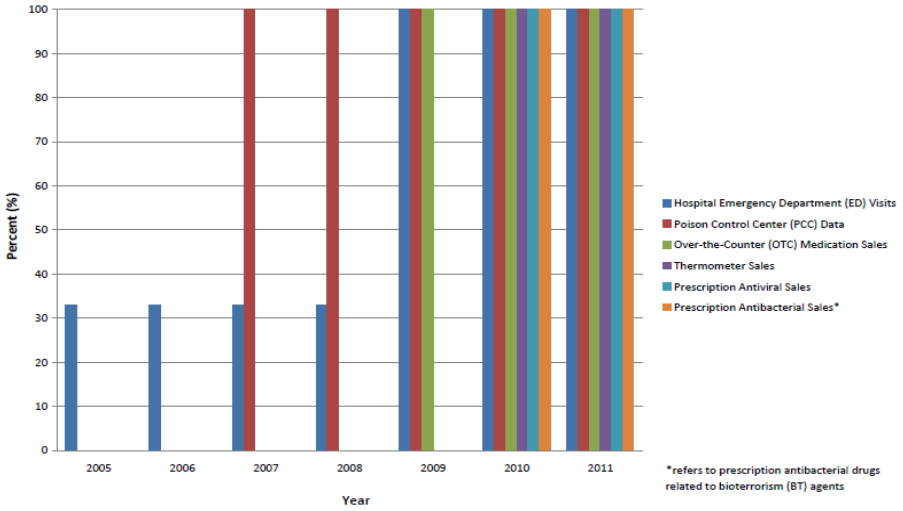
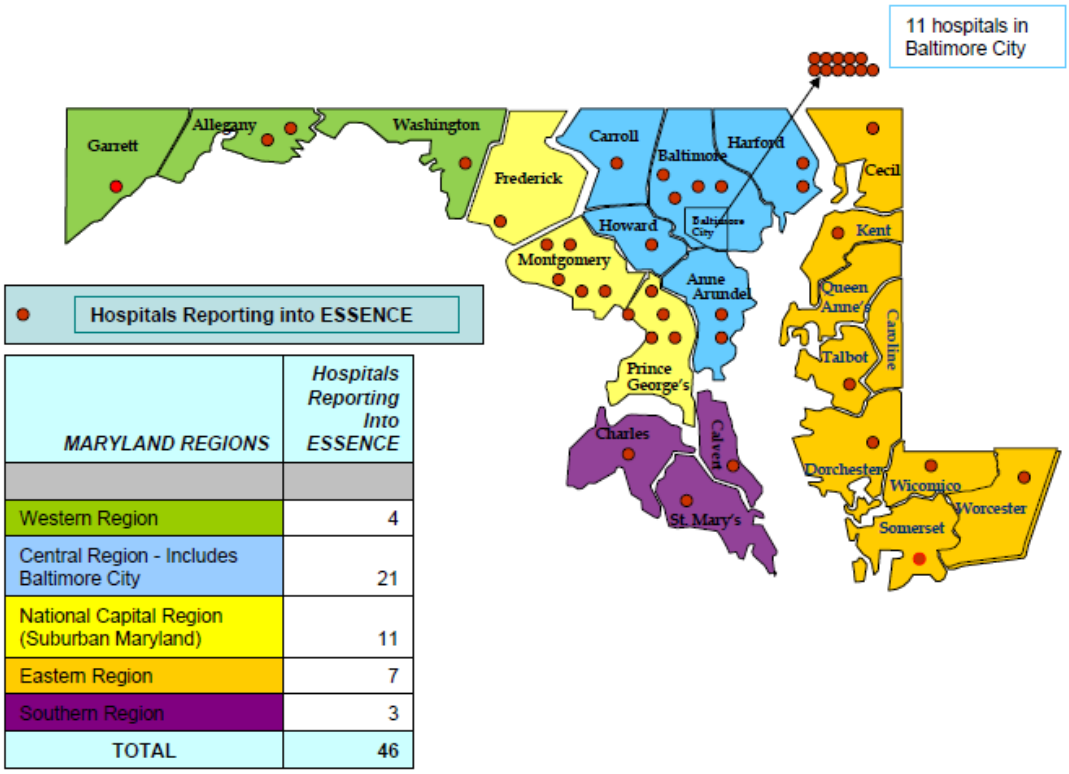


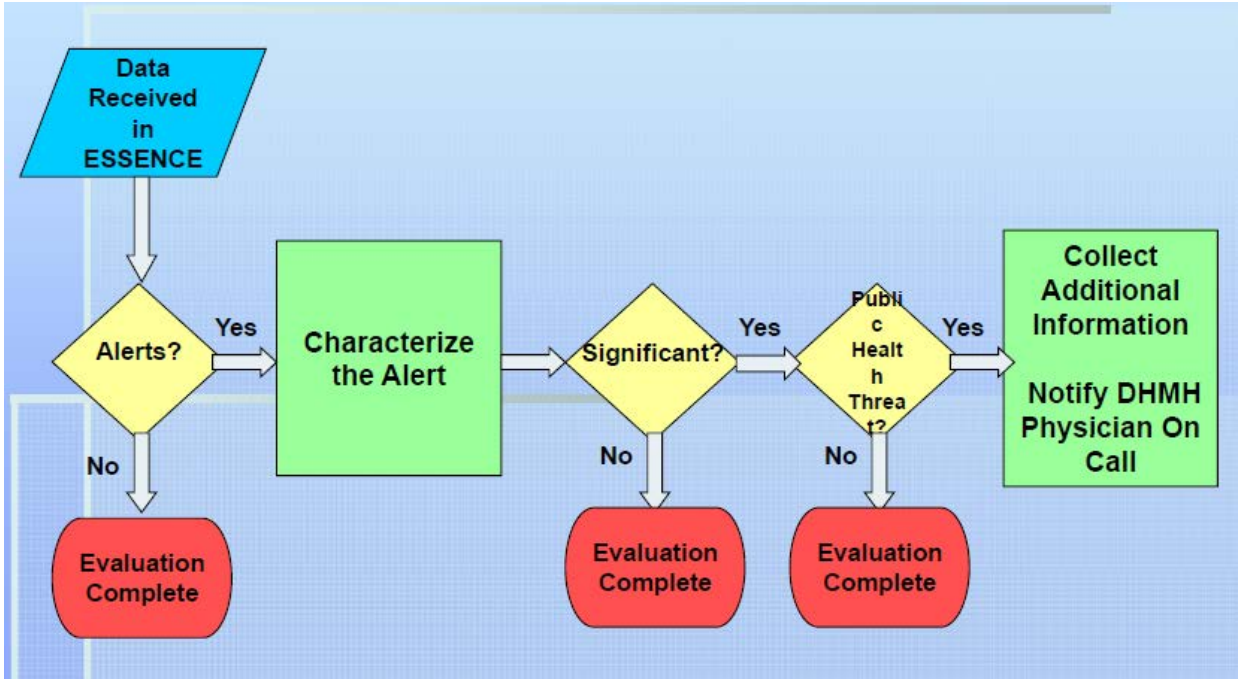
Figure A.8 – Maryland Acute Care Hospitals Reporting into ESSENCE



MARYLAND REGIONS	Hospitals Reporting Into ESSENCE
Western Region	4
Central Region - Includes Baltimore City	21
National Capital Region (Suburban Maryland)	11
Eastern Region	7
Southern Region	3
TOTAL	46

ESSENCE incorporates traditional and non-traditional health indicators from multiple data sources (emergency department chief complaints, over-the-counter medication sales, and poison control center data). ESSENCE utilizes a secure, automated process for transfer of hospital data to the system that is consistent with Federal standards for electronic disease surveillance. Data is categorized into syndromes to detect aberrations in the expected level of disease. Automated statistical algorithms are run on each syndrome and alerts are generated when the observed counts are higher than expected. ESSENCE allows for situational awareness, identification of disease clusters, early identification of cases related to outbreaks, and early indication of influenza season and assessing disease burden. The below flowchart depicts the timeline for the investigation of alters.

Figure A.9 – ESSENCE Investigation of Alerts



Technical enhancements are being done to allow for more data feeds to be incorporated into Maryland ESSENCE, such as National Capital Poison Center and Maryland Poison Center Sending. ESSENCE goals include increasing the number of reporting hospitals, incorporating additional over the counter medication sales data, incorporating school absenteeism data, and incorporating animal surveillance data.

ImmuNet

ImmuNet is Maryland's immunization registry, a confidential and secure computer database designed to collect and maintain accurate, confidential and current vaccination records. ImmuNet promotes effective and cost-efficient disease prevention and control that will improve the health of Maryland's children. In 2001, Senate Bill 626 was passed and established guidelines for creating and implementing ImmuNet. ImmuNet has proven to be extremely effective as a centralized repository for immunizations administered in the state. To date, ImmuNet contains more than 1,000,000 patient records and 12,000,000 vaccinations. In addition to tracking children in need of vaccination, ImmuNet assists in vaccine management; prints a completed school immunization certificate; consolidates immunization records; and provides offices with the capability to print reminders. Maryland has recently upgraded to a more robust version of ImmuNet, which allows for secure real-time exchange of electronic immunization records via the Internet using HL7 or other syntax formats. Thus, ImmuNet can accept non-HL7 data (ImmuNet-acceptable flat file), but we expect that with MU, all files will be standardized to HL7.

The Maryland Childhood Immunization Partnership (MCIP) has functioned as the advisory committee for ImmuNet. MCIP was established by the Maryland Chapter of the American Academy of Pediatrics and the DHMH. The partnership has worked closely with the DHMH Center for Immunization to identify the pertinent issues relevant to implementation of an immunization registry. MCIP is composed of public and private organizations, which are concerned with the issues of childhood immunization and registry development.

Public Health Systems Collaboration with Medicaid

ESSENCE, ImmuNet and Public Health have a history of collaboration with Medicaid. In addition to informing policy decisions, data from public health systems is currently being used to help develop a Maryland State Health Improvement Plan 2011-2014.[8] The Plan sets forth measurable objectives and targets in key areas of health, with a special focus on health equity. The process to develop the Plan involved meetings with many health-related agencies, including public health, to better understand current objectives, measures, and data and then to develop additional objectives and data sources. On a regular basis, Medicaid participates with the Infectious Disease and Environmental Health Administration (IDEHA) on Center for Disease Control Meaningful Use Nationwide calls for the purposes of aligning EHR Incentive Program public health objectives with Medicaid planning. Medicaid also attends internal meetings between IDEHA and CRISP over connecting public health data reporting systems with the HIE.

A.15 If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.

Although Maryland is a co-recipient of a CHIPRA Quality Demonstration Grant, the multi-state collaborative proposal does not focus on HIT. Rather, the proposal focuses on Category C: "Provider Based Models Which Improve the Delivery of Children's Health Care." All participating states are committed to improving the health and social outcomes for children with serious behavioral health needs. In regards to this grant, Maryland is interested in learning from any implementation efforts around Electronic Health Records to see how we can integrate and incorporate with our Management Information Systems (MIS) for the Care Management Entities (CME).

[8] See: hmh.maryland.gov/ship/.

Section B: Maryland's "To-Be" HIT Landscape

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

Please describe the SMA's "To Be" 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 the achievement of the SMA's long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locater Service?
3. How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?
4. Given what is known about HIE governance structures currently in place, what should be in place five 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 that will be involved, etc., please discuss HIE 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 a description of an 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 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.

B.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.

Within five years, Medicaid expects to have fully enabled an infrastructure to support a bi-directional, real-time interface with the State's Client Automated Resources Eligibility System (CARES) to improve access to the complete eligibility record, resolve data integrity issues across systems, enhance claims payment accuracy by capturing the most current eligibility information, and support inter-agency coordination to provide appropriate and cost-effective medically necessary care management services. The five year goal includes having in place the technology to support existing and new EHR initiatives, and provide enough flexibility to respond to the changing needs of EHRs. Medicaid will also be positioned to accommodate system modifications made by the statewide HIE and to access and utilize data from other state HIEs.

Health IT and the EHR Incentive Program have an enormous potential to improve care and outcomes. Medicaid has identified several key areas and related goals and outcomes. The five year journey is predictable in many ways, yet filled with challenges that cannot be fully anticipated. In its planning efforts, Medicaid has made a number of assumptions that could require plan modification at a later date. The state began its journey into implementing a statewide HIE nearly four years ago through an elaborate multi-stakeholder planning phase and the development of a number of key policy reports. In five years, Maryland expects to have in place a fully functional statewide HIE, a new MMIS system, and have completed the integration of Medicaid with the statewide HIE.

EHR Incentive Administrative Goals and Outcomes

Medicaid will work to increase EHR adoption and ensure that as many providers who are eligible participate in the EHR Incentive Program. Medicaid will accomplish this goal by minimizing the barriers to participating and streamlining the registration process and providing registration training and assistance.

DHMH calculated this estimate based on survey responses from the Environmental Scan available in Appendix B. This report found that around 42 percent of Medicaid providers within CMS-defined eligible provider type categories may be eligible for participation in the Program given their patient volume. Among this group, 49 percent reported that they would likely participate. Using these percentages, DHMH estimated the number of providers enrolled in MMIS that met provider type criteria, estimating that around 1,300 providers would participate over the lifetime of the program. Yearly estimates are based on provider readiness, also derived from the Environmental Scan.

Table 1 - EP Registration Goals

Year	EP Registration Goal
2011	100
2012	400
2013	500
2014	600
2015 and later	1,300

Based on a 2010 HIT hospital survey conducted by MHCC, Medicaid anticipates that approximately 35 of the 46 acute care hospitals in the state plan to participate in the Medicaid EHR Incentive Program.[9] However, the MHCC estimates that 89 percent will participate in the Medicare EHR Incentive Program. The reason for the relatively low participation in the Medicaid EHR Incentive Program is that non-participating hospitals do not believe they will meet the patient volume requirements.

Table 2 - EH Registration Goals

Year	EH Registration Goal
2011	18
2012	25
2013	28
2014	35
2015 and later	35

Once a provider is registered and has completed implementation or upgrade of an EHR, the next major goal is to achieve meaningful use. Medicaid, in partnership with the REC and other health care stakeholder groups, intends to ensure that the majority of the providers achieve meaningful use in a timely manner. Medicaid, with its partners, will provide education, training and outreach activities to assist providers in achieving meaningful use. These activities will continue to ensure providers maintain meaningful use.

Table 3 - Meaningful Use Achievement Goals

Years to Meaningful Use	Meaningful Use Achievement Goal
1	50%
2	60%

[9] This estimate is derived from a survey conducted by the Maryland Health Care Commission in 2011. See: http://mhcc.maryland.gov/electronichealth/2011_Hospital_HIT_Report.pdf.

3	90%

There are several other administrative and timeline goals. These are:

- Anticipated completion of R&A testing – August 15, 2011
- EP and EH registration go-live – October - November 2011
- First EP payment – November/ December 2011
- First EH payment – December 2011

EHR Incentive Oversight Goals and Outcomes

Medicaid will provide oversight in all aspects of the EHR Incentive Program including areas in which Maryland is contracting out for support such as with eMIPP, the REC, and potentially the monitoring and oversight contractor (described in Section D). This includes, but is not limited to, administering the incentive payments, tracking meaningful use by providers, and pursuing initiatives to encourage the adoption of certified EHR technology.

The contractors selected to administer areas of the incentive program will be required to meet established performance measures. Medicaid will require the contractor to propose performance standards related to all aspects of the contractor's work, develop a disaster recovery plan, and establish a business continuity plan. Medicaid recognizes the importance of thoughtful planning around key benchmarks. The following list represents those considered to date in the strategic and operational planning for the administration of the incentive program:

Item	Description
Develop and maintain a core infrastructure	A robust web based solution
Achieve all established performance goals	Meet annual goals established by Medicaid
Conduct select program audits	Routine monthly, quarterly, and annual
Implement a comprehensive and user friendly web based portal	An easy to navigate application
Build and sustain a financial reporting interface into MMIS	Accurate and consistent data feed to MMIS
Maintain all aspects of program administration	Maintain all aspects of the operations
Establish an outreach and communication initiative	An effective program communication strategy
Implement program policies established by Medicaid	Policies governing application and payment process
Put in place a call center	A network to provide immediate user support
Implement a mechanism to manage provider disputes	An eligibility and payment mitigation process
Meet reporting and audit requirements of Medicaid	Submit timely reports and recommendations to Medicaid
Manage all aspects of a fraud and abuse program	Minimize and resolve program misuse
Calculate incentive payments	Adjudicate incentive payment requests

HIT/E Goals and Outcomes

Medicaid is an active participant in the statewide HIE efforts and is a member on the Policy Board. The Policy Board has general oversight of the statewide HIE, including the authority to evaluate and recommend to the MHCC the policies that will govern the exchange. Medicaid expects to connect with the statewide HIE as part of the implementation process of the new MMIS and to facilitate public health reporting. The vendor selected to implement the new MMIS will be required to collaborate with statewide HIE to build the interface as part of the implementation process. Medicaid has been developing the specification for the MMIS replacement system for about two years. The technology changes that Medicaid is moving toward will benefit Medicaid by improved regional health quality, reduced expense in delivering care, and improved quality in care delivery.

As more hospitals and providers interact with the HIE and adopt EHRs, and as Medicaid begins implementation of the new MMIS, this document will be updated to reflect more specific future plans. At this moment, because the HIE is nascent, the EHR program has yet to be launched, and the MMIS is still in procurement, it is unclear how these programs will align in the future. But, because of the active participation in Medicaid in these efforts, more details will be forthcoming.

B.2 *What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support the achievement of the SMA's long term goals and objectives?

Although an additional platform (eMIPP) will be acquired to implement the EHR Incentive Program (see Section 4), some MMIS changes may be required to make the program operational. Overall, MMIS will be used to store general provider enrollment, claims, and encounter information and will be the system through which EPs and Hospitals will be paid. But the new platform will be the primary system that is used for provider incentive registration, attestation, and MU storage.

Providers interested in participating in the EHR Incentive Program must use e-Medicaid to register. This registration will function as the link to the payment subsystem in MMIS. Managed Care Organization (MCO) network-only providers are not currently enrolled in MMIS, only fee-for-service (FFS) providers are currently required to complete the Medicaid enrollment process. All MCO provider information is maintained by the MCOs in which they are affiliated. MCO-based providers interested in participating in the Incentive Program will be required to enroll

with e-Medicaid so that they can be linked to the payment subsystem. More details are available in section 4.3.2.1.

To simplify interoperability between the current and future MMIS, CSC, Maryland's registration and attestation system vendor, will host EHR registration and enrollment information for Maryland's EHR Incentive Program. The secure servers will store the new registration and attestation information along with other administrative data. This information will be combined with MMIS data on eligibility and claims to accept or deny participation in the program. Gross adjustments in MMIS will be used to make payments.

CSC will utilize the Electronic Health Record Medicaid Incentive Payment Program (EHR MIPP or eMIPP), which is a web-based solution currently in use by the State of Michigan and Washington. Maryland will own the system, but not the third-party hardware, such as servers. Team CSC's eMIPP solution provides the CMS's Registration and Attestation System interfaces, Provider Registration, State work-flow/eligibility determination, and data capabilities to be the system of record for State of Maryland's EHR MIPP. The solution directly interfaces with CMS to receive and send required federal data. The system can feed payment requests to the existing MMIS or send the request to the State accounting system.

In order to achieve a quick implementation timeline, CSC will implement the eMIPP solution that is currently being implemented in the State of Michigan ("Baseline System") with very minimal changes. The few changes to the Baseline System envisioned include: changes pertaining to customization of the Portal for the State of Maryland (Logo, Department name etc.), named interfaces to the State's accounting system and provider system, modify current set of available reports to customize it for Maryland and inclusion of State specific provider payment rule/criteria into the Baseline System. These changes are minor and will not impact the functionality of the baseline system. In order to facilitate alignment between State's requirements of their eMIPP and what functionality is available in the Baseline System, CSC will demonstrate this Baseline System and leverage the existing documentation for maximum reuse. Team CSC will ensure that the walkthroughs enable the State and Team CSC to verify scope assumptions and expectations are verified. Any deviations will be collaboratively discussed with the State to manage the project cost.

Team CSC's eMIPP solution core product is web-centric and services-based for improved integration and interoperability. The scope of this project is intended to cover the functionality required to make payments for EP and EH.

B.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.)?

Using a web-based internet portal, Medicaid-enrolled providers will register for incentive payments under the EHR program within the State of Maryland. Team CSC will implement the provider intake and payment module of eMIPP to support the registration, eligibility verification, attestation processes and payment process.

The online eMIPP portal will allow EPs and EHs to register in State's EHR MIPP program to receive the yearly payment. Prior to registering at the State level, all providers must register with the Federal Registration and Attestation System (R&A) and obtain an R&A Registration ID. R&A will then notify the State about each registered provider via one of the dedicated CMS R&A interfaces. As part of the registration process the system will collect the provider's EHR "certification" information. For EPs, it will collect their Medicaid patient and total encounter volume for the stipulated reporting period to confirm their eligibility. For EHs the state will use existing cost report and discharge data submitted by the hospitals to the Heath Services Cost Review Commission (HSCRC) to confirm eligibility and calculate payments.

In the first release of eMIPP, no MU reporting will be available. Subsequent modifications to the solution will incorporate MU attestations.

B.4 Given what is known about HIE governance structures currently in place, what should be in place five years from now in order to achieve the SMA's HIT/e goals and objectives?

Most of the state's systems will need enhancements before they can support both meaningful use and HIE. Maryland's approach is to establish interoperability to the statewide HIE for all state systems, including ImmuNet, ESSENCE, and MMIS. Additional systems will be added later, details on these will be in a later version of the SMHP. All hospitals in Maryland are planned to be connected to the HIE in 2012. The HIE will strategically connect large health systems and ambulatory providers. Many ancillary data providers are already connected to the HIE and exchanging information. The HIE is also working to build interfaces with EHR vendors. DHMH and the HIE are exploring opportunities to leverage 90/10 HITECH administrative funding to increase the uptake of EHRs and connectivity to the HIE.

B.5 What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?

Maryland Medicaid's outreach strategy will leverage the current outreach strategy provided by the state-designated REC, CRISP. The REC's current outreach strategy focuses on the provider and payer side, using medical and hospital organizations. As a partner with DHMH, the REC will

add to their outreach by incorporating MCOs and Departmental communication to encourage the adoption of EHRs.

The REC brings to the table strong partnerships with MediChi, the Maryland State Medical Society, and the Hospital Association, and tested outreach strategies including webinars and fax-blasts to providers. DHMH is already in discussions with MedChi about our implementation strategy and will be working with the American Medical Association, the Pediatric Association, and the Hospital Association to provide clear and informative information on the EHR Incentive Program overall and how the State plans to implement. Further, by using a tested EHR Incentive Program vendor to provide the portal for providers to enroll in and provide attestations for the EHR Incentive Program, we will reduce the confusion associated with enrollment, as the selected vendor has already user-tested the interface technology.

Because nearly 80 percent of Medicaid enrollees participate in the State's Managed Care program, the State will work closely with MCOs in reaching out to their provider networks. The State has already begun discussions with MCO Liaisons to begin devising an outreach strategy. As of August 23, 2011, DHMH released an informational memo through the REC about the Medicaid enrollment requirements for MCO-based providers. This memo details the enrollment process and provides contact information for those providers who need additional assistance. DHMH also posted this memo on its EHR website. As the state-level enrollment process for the EHR Incentive Program becomes clearer, we will develop a step-by-step user's guide for participation. We anticipate releasing this guide in November, a few weeks ahead of state launch.

The State also plans to release a Transmittal providing an overview of and expectation for the program as well as the web address for our currently operational EHR Incentive Program homepage. Aside from this as well as the I-APD, the State will also host the user's guide and provide an email address for questions.

Additionally, each year, Maryland assesses provider adoption of EHRs. This information is used in developing strategies aimed at increasing adoption and meaningful use statewide. The state may need to explore other options to increase EHR adoption. Maryland will continue to use its annual evaluation of EHR adoption among providers as the utility for determining if a regulatory approach is required to speed EHR adoption.

B.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?

Through our early environmental scan, DHMH established a strong relationship with FQHCs. Particularly, DHMH hopes to work closely with Community Health Integrated Partnership, Inc. (CHIP) a not-for profit (501c3) Health Center Controlled Network (HCCN) under the Health

Resources and Services Administration (HRSA) whose mission it is to provide management services to federally qualified health centers (FQHC). While the overall EHR adoption rate among FQHCs is high, the rate among this group is exceptionally so.

Drawing from the experiences of HCCN and other FQHCs – who, as a group represent the highest in-provider group adoption rate percentage within the surveyed Medicaid population – will act as a model to help push adoption among other provider groups.

B.7 **How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?

See B.3 and B.5 above.

B.8 **How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?

Medicaid recognizes the significance in better understanding the needs of providers serving populations with unique needs. Getting these providers to adopt and meaningfully use EHRs is essential to improve care for children, elderly, disabled, and chronically ill consumers in the Medicaid program. As part of the environmental scan, the contractor convened four focus group discussions with providers to identify EHR adoption and support opportunities of providers treating populations with unique needs. One focus group was dedicated to Early Periodic Screening, Diagnosis, and Treatment (EPSDT) providers. The contractor's report describes its findings and includes recommendations. These recommendations will be used by Medicaid as it completes it framing activities for EHR technical assistance that is required under the ARRA incentive program. These findings will also be shared with the REC for program consideration and Medicaid outreach.

We expect enhanced coordination of care using HIT to improve outcomes for everyone for vulnerable populations will benefit more from initiatives such as medical home. In the future, certain meaningful use measures as defined by CMS are set to be core measures for the State's Patient-Centered Medical Home (PCMH) pilot project. By wrapping these measures into the incentive payments for the practices participating in PCMH, Maryland encourages their use and makes it easier for providers who participate in PCMH to also benefit from the EHR incentive payments.

B.9 If the State included a description of an 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?

Not applicable. Our CHIPRA grant is not HIT-related.

B.10 Does the SMA anticipate a need for new state legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program? Please describe.

See Section A.12.a

Section C: Maryland's Implementation Plan

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 FQHCs/RHCs meet the practices predominately requirement?
8. How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers?
9. How will the SMA verify meaningful use of certified electronic health record technology for providers' second-year participation?
10. Will the SMA be proposing any changes to the MU definition as permissible per rule-making? If so, please provide details about how the SMA assessed the issue of additional provider reporting and financial burden.
11. How will the SMA verify providers' use of certified electronic health record technology?
12. How will the SMA collect providers' MU data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term versus the longer-term?
13. How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?
14. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?
15. What IT systems changes are needed by the SMA to implement the EHR Incentive Program?

Figure C.1: Section C Questions from the CMS SMHP Template (continued)

Describe the methods OMAP employs and what activies OMAP will undertake to administer and oversee the Medicaid EHR Incentive Program:

16. What is the SMA's IT timeframe for systems modifications?

17. When does the SMA anticipate being ready to test an interface with the NLR?

18. What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe-to-mainframe interface or another means)?

19. What kind of website will the SMA host for Medicaid providers: enrollment, prog. info, etc.?

20. Does the SMA anticipate modifications to the MMIS and, if so, when does the SMA anticipate submitting an MMIS I-APD?

21. What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?

22. 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 of certified EHR technology?

23. 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?

24. What is the SMA's anticipated frequency for making the EHR Incentive payments?

25. What will be the process to assure that EHR provider payments are paid directly to the provider (or organization to which the provider has assigned payments) without any deduction or rebate?

26. 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 HHS 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?

27. 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?

28. What will be the process to assure that all hospital calculations and EP payments (including tracking EPs' 15 percent of the net average allowable costs) are made consistent with Statute and regulations?

29. 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.?

30. 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 RECs • The role, approved plans and status of the HIE cooperative agreements • State-specific readiness factors

Introduction

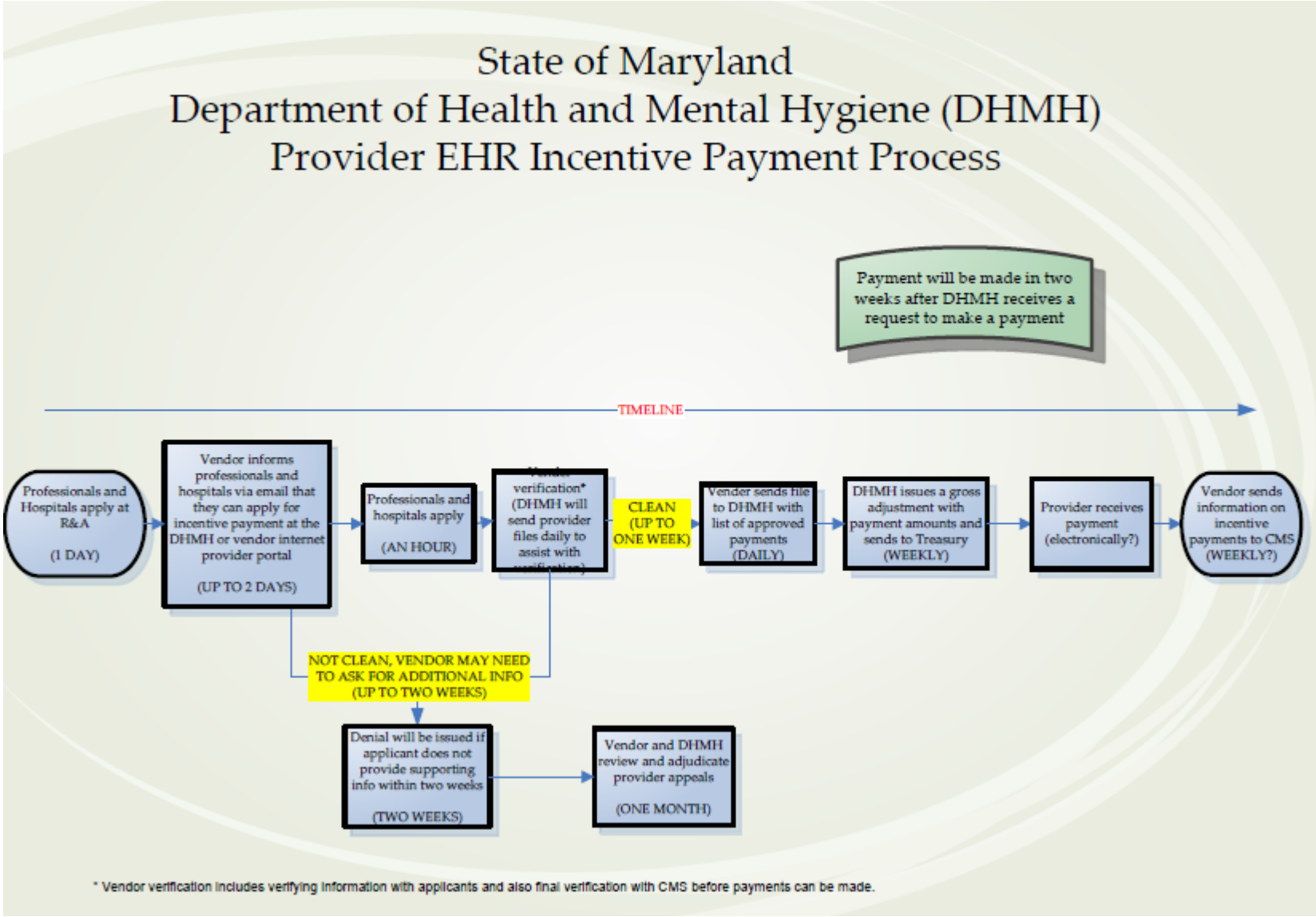
The Committee created a process flow for the Medicaid EHR incentive payment process that takes DHMH, eligible professionals, hospitals, the MMIS system, and an EHR provider through the attestation and enrollment subsystem known as the Electronic Medicaid Incentive Payment Program (eMIPP).

The timeframe for developing Maryland's eMIPP and modifying MMIS is five to six months October/November 2011. DHMH has developed the business requirements for eMIPP and modifying an existing contract for this build. Because similar eMIPP systems are already in use, Maryland can leverage current technology, modifying the "off the shelf" product to fit the State's needs. Each year additional funding for system modifications will be required for capturing and tracking new meaningful use objectives, for potential changes in R&A interfaces, for upgrades that may need to be performed for better provider experience, as well as additional monitoring, reporting, and outreach capabilities, etc.

The Department is submitting HITECH sections of the I-APD for the eMIPP implementation costs. In this section, as with the other sections, DHMH is requesting enhanced 90/10 match for all activities unless otherwise noted. Please see the I-APD for estimated amounts.

The process flow in Figure C.2 outlines DHMH's proposed process for administering and overseeing the Medicaid EHR incentive payment program. In the narrative below, DHMH 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.

Figure C.2: Maryland EHR Incentive Program Process Flow Diagram



Step 1: The Department conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29, and 30)

The Department is responsible for communicating with providers about enrolling in the Medicaid incentive program and will:

- Inform providers of the EHR Incentive Program and the requirements for participation

- Coordinate with the Regional Extension Center (REC) and the State's Health Information Exchange (HIE), Chesapeake Regional Information System for Our Patients (CRISP), and other resources to provide technical assistance and information related to EHR adoption, implementation, upgrade, and meaningful use of EHRs

- Inform providers about how to begin the enrollment process with CMS's Registration and Attestation System (R&A)

- Inform 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

- Inform providers that, to participate in the incentive program, they must be participating Medicaid providers. DHMH cannot conduct proper oversight, or reclaim overpayments, if providers are not enrolled in Medicaid. Providers not currently enrolled in Medicaid include most of our Medicaid managed care providers, physician assistants, and providers that practice in FQHCs. Requiring Medicaid enrollment will help DHMH to verify when a professional attests to practicing predominantly in a FQHC since these newly enrolled providers will now have their data collected as part of being Medicaid providers. DHMH will conduct outreach to encourage providers to sign up for Medicaid now if they are not already enrolled to try to avoid a large influx of applications to be a Medicaid provider once the EHR incentive program launches.

- Inform Physician Assistants that they are eligible for incentive payments if they are practicing in an FQHC or RHC that is so-led by a physician assistant but that they are not otherwise eligible for Medicaid. DHMH will require Physician Assistants who think they are eligible for the incentive program to apply through a special process. DHMH will outreach to FQHCs and RHCs to inform Physician Assistants about the program and how they can enroll in Medicaid and get an incentive payment. We do not believe that there are many (if any) Physician Assistants eligible for the incentive program so we will process these applications and any resulting incentive payments manually.

In order to communicate this information to providers, DHMH is developing a communications strategy that draws heavily from the groundwork already laid by the REC which includes: identifying events, communication channels, materials, content, and audiences. The Department has already and will continue to release Information Provider Transmittals

describing Maryland's EHR Incentive Program including program requirements, provider types eligible, the R&A, program oversight, and the application and attestation process. The Department releases these transmittals through a fax list maintained by the REC and provided by MedChi, Maryland's medical association. These transmittals are also posted on Maryland's EHR Incentive Program website. To reach hospitals, the Department is working with an acute care hospital contact list maintained by the Maryland Health Care Commission for surveying these hospitals. The Department is also reaching out to hospitals to refine the contact list in preparation for hospital incentive payment calculations and any other necessary correspondences. In addition to the Provider Transmittal, DHMH will develop and issue information on the Remittance Advice banner messages to address such topics as:

- Continue to update information available on DHMH's website, link to REC website for more provider outreach information with links back to DHMH's website
- Inform providers where HIT information is located on the web and what type of information is provided there, including DHMH's, the Regional Extension Center's, the Maryland Health Care Commission's, and CMS's websites.
- Getting ready for the Medicaid incentive payment – describing the R&A and how to register, getting an NPI, requirements to be a Medicaid-enrolled provider, registering with DHMH's provider portal.
- Inform providers how to begin the application process with Maryland Medicaid once they have successfully registered at the R&A as well as the importance of providing an email address at the R&A for communication purposes.
- Develop a provider manual that will help hospitals and professionals to understand and apply for incentive payments.

Additionally, this information will also be described in a fax-blast to provider organizations, and possibly an email blast, depending on the availability of provider emails. The Department will also consider leveraging social media.

As part of the communications process and strategy, DHMH will continue to meet with provider groups, particularly the Managed Care Organization Liaison Meeting, The Maryland State Medical Society (MedChi), the Local Health Officers Round Table, Maryland Medicaid Advisory Committee (MMAC) the Maryland Chapter of the American Academy of Pediatrics, and the Hospital Association of Maryland. DHMH expects these meetings to occur on a quarterly or near-monthly frequency, with more frequent meetings as needed.

As stated above, DHMH will rely heavily on CRISP, Maryland's Regional Extension Center (REC), for outreach and provider assistance. Because the REC has extensive knowledge about outreaching to providers interested in adopting EHRs, DHMH is collaborating with the REC to

perform Medicaid provider outreach and education activities. Coordinated activities include the communication of eligibility requirements, as well as registration and participation instructions. For example, the REC continues to hold a series of webinars to educate providers about the EHR Incentive Program in which DHMH and the REC discussed the EHR Incentive Program and how to access the technical support of the REC. In addition to educational outreach, DHMH expects to conduct training sessions, possibly administering them jointly with the REC. At this point, DHMH is still developing the training schedule and has not finalized training frequency or forum.

The Department, in coordination with the REC, is developing an interactive web-based FAQ page (similar to the one available at the CMS level). This FAQ will be hosted by the REC, but linked from the Department's EHR Incentive Program web page. The Department will also host fact sheets and user guides.

DHMH expects its communication strategy to evolve with the program. The current strategy is expected to be complete in late fall 2011, shortly before launch.

There is a great deal of interest in the EHR Incentive Program and DHMH has already fielded numerous questions from providers, consumer advocates, other state agencies, and other stakeholders. While DHMH usually receives questions via our direct emails to EHR experts within DHMH, many "early adopters" or interested providers have received their information from the REC because they have been actively engaging providers. Although DHMH meets with the REC to discuss questions as they arise, DHMH believes that a communications plan with consistent messages and multiple venues for information distribution will help to raise provider awareness, understanding, participation, and eventually help to retain providers in the incentive program and have them become meaningful users.

To ensure that all educational materials are accurate and communicate a uniform message, DHMH will develop and/or approve two types of provider education and outreach materials in coordination with the other bureaus and offices in DHMH, the Maryland Health Care Commission, the REC, CMS, and ONC, and others:

1. Materials that explain the Medicaid EHR Incentive Program; and
2. Educational and technical assistance materials on implementation, upgrade, and meaningful use of EHRs.

The Department plans to engage its partners to help distribute outreach materials. These partners include: Managed Care Organizations, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Nursing staff, the REC, DentaQuest (Maryland's Oral Health contractor), CRISP, and others. Materials will include Maryland EHR Incentive Program-specific information and information provided by CMS, the REC, and ONC.

In terms of materials related to EHR adoption, DHMH will work with its partners, particularly the REC, and CMS to gather existing materials and tools (such as the eligibility tool under

development by CMS) that describe model practices and provide background and provide technical assistance on adoption, implementation, upgrade, and meaningful use of EHRs. Maryland will also be requesting funds as part of the I-APD to work with the REC on outreach and provider engagement and is already engaging providers through webcasts and by answering questions from providers on the Medicaid EHR incentive program. DHMH will leverage an existing agreement between MHCC and the REC, which is all described in more detail in the I-APD.

In addition to the written materials and partner entities described above, providers will be able to obtain information about the program via DHMH's EHR-specific webpage, the REC's webpage, and the MHCC's webpage. All websites reference the others and provide unique information for providers. For example, DHMH's webpage provides planning information about the EHR Incentive Program from both the State and Federal perspective,[10] including links to syndicated content from CMS, while the REC provides information on Management Service Organization entities to help providers choose and implement certified EHRs, and the MHCC provides a robust EHR system comparison tool so that providers can easily identify the appropriate EHR systems for them. The Department hopes that these linkages with other HIT-related websites, combined with the listing of the webpage on all communications with providers about the EHR incentive program (including informational transmittals, webinars, fax blasts, and emails) will promote traffic to the website.

DHMH is exploring options including an Administrative Service Organization (ASO) or use of our current provider enrollment and relations hotlines to ensure that provider needs are met through help center support. The Department's provider relations help center is open Monday through Friday 8 AM to 5PM. While we explore the most appropriate method for provider support, the Department is working closely with the Regional Extension Center (REC) to provide support as well. By using the REC, the Department can collect data on the amount of effort required to maintain the help line. Thus far, the REC has fielded many technical questions about the program; and, when questions relate to provider enrollment, they forward this information to the Department. Regardless of whether we use the current provider relations call center or an ASO, we anticipate implementing a similar referral system; and, as has been the case thus far, we plan to provide feedback to any provider seeking assistance within 3 business days. Like the REC, the ASO help center or provider relations help center will have systems in place to track calls. Systems will be modified to capture and report information about the EHR Incentive Program-related calls, e.g., reason code and provider type. To help administer the incentive program, DHMH will gather information about providers that inquire about the program, e.g., to gain a sense of how many providers will be applying when the program goes live. DHMH will also host "how-to" guides for providers registering and attesting through eMIPP. The Department plans to decide whether we will procure a dedicated help center or continue to use the REC and the provider relations help center shortly after the launch of the incentive program in November.

[10] See: http://www.dhmh.state.md.us/mma/ehr/index.html

In the case of materials for Medicaid recipients, DHMH will coordinate with CMS and ONC as part of their efforts to educate recipients. The Department will also coordinate with the State's HIE implementing organization, CRISP. The Department has a seat on the HIE's Policy Board, and will use this position to work closely with the HIE to develop a communications strategy for providers, patients, and payers on the value of HIE and to address privacy and security concerns. The Department will also continue to engage the members of the MMAC to review and provide feedback on the materials as they relate to consumers.

Although over 80 percent of Medicaid participants enroll with an MCO through the HealthChoice program, DHMH is not planning to establish fiscal arrangements with the PH-MCOs (response to question 27). However, DHMH is continuing to think of ways to leverage MCOs to support the EHR Incentive Program. Further, as mentioned in section B.5, DHMH has issued instructions for MCO-based provider enrollment and posted it to its website. As the state-level enrollment process for the EHR Incentive Program becomes clearer, we will develop a step-by-step user's guide for participation. We anticipate releasing this guide in November, a few weeks ahead of state launch.

There are numerous organizations within Maryland that are available to serve as state-designated adoption entities including the REC and Community Health Integrated Partnership, Inc. (CHIP), a not-for profit (501c3) Health Center Controlled Network (HCCN) under the Health Resources and Services Administration (HRSA) to provide management services to federally qualified health centers (FQHC). With CHIP's help, these FQHCs maintain a robust and integrated EHR system. DHMH will continue to explore these options going forward in response to provider needs.

Step 2: Providers will enroll in the Registration and Attestation System (R&A) (Response to Questions #1, 16, 17, 30)

Before the provider can apply to participate in the program, the provider must enroll in the Federal 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 Medicaid EHR Incentive Programs or between Medicaid and Medicare (applies only to eligible professionals, hospitals can receive both Medicaid and Medicare incentive payments). The Department is contracting with CSC to implement the eMIPP system that will serve as the interface between the R&A and Maryland's MMIS and will serve as the registration and attestation portal for Medicaid providers applying to Maryland's Medicaid EHR Incentive Program. eMIPP was designed as part of a multi-state collective which will allow participating states to achieve cost-savings and share lessons learned.

The State of Michigan and the State of Washington are already utilizing this technology to administer their EHR Incentive Programs. The Department is planning to test the interface in the second CMS group test (group 4) in September 2011. The Department's EHR Incentive

Program will not begin until testing with the R&A is complete, eMIPP testing is complete, and Maryland has been approved by CMS to "Go Live."

The Department's understanding is that the R&A will collect from providers the 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)
- Record Number: A unique identifier for each record on the interface file
- Program Option: EP's choice of program to use for incentives. Valid values include Medicare or Medicaid. For hospitals, a selection of Dually Eligible will be available
- State: The selected State for Medicaid participation
- Provider Type: Differentiates types of providers as listed in HITECH legislation
- Confirmation number: Unique number created by the R&A and used by the State if desired to confirm the provider's identity for registration
- Providers will indicate whether they wish to assign their incentive payment (and, if so, to whom they wish to assign their incentive payments) in the R&A
- Email address of applicant

The R&A will also interface with other sources of provider information including the Medicare Exclusions Database and the ONC's Certified Health IT Product List (CHPL), which will help to identify providers who are ineligible due to exclusions or sanctions and to verify certified EHR technology.

Step 3: The R&A will provide information to DHMH through eMIPP interfaces about providers who have applied for the incentive program (Response to Questions #14, 18, 20, 29)

The provider applicant will begin the application process by entering information at the CMS R&A and then the R&A will send the provider information to the State in a daily batch file. Once the file of Maryland applicants is received by the R&A, it will be loaded into eMIPP. eMIPP will edit to determine if the applicant is enrolled in Maryland Medicaid program through an interface with the State's Medicaid Management Information System (MMIS).

It is our preference to communicate electronically with applying providers. DHMH will email the provider to inform them that they may visit the State's EHR Registration System provided by eMIPP to begin registration at the State level. Providers must be registered with the State's MMIS system before they can proceed with registration with eMIPP.

If a provider is not enrolled with Medicaid, they will be directed to visit DHMH's eMedicaid portal to register as a provider. A provider that does not see Fee for Service (FFS) patients, but only participates in Medicaid as a Managed Care Organization (MCO) network provider, will be informed that although they must register with DHMH as a Medicaid provider, they are still only an MCO network provider and will not be required to see FFS. Eighty percent (80%) of Medicaid clients are in MCOs, while around 70 percent of providers participating in Maryland Medicaid may only be enrolled in the HealthChoice (managed care) program. This means that a significant number of providers who may participate in the program will likely come from the MCO-only provider pool and would have to use the eMedicaid registration process before registering to participate in the EHR Incentive Program with the State. To date, the current process of enrolling providers through eMedicaid and directing providers who need additional assistance to provider relations has succeeded in getting MCO-based providers ready to enroll in the Medicaid EHR Incentive Program.

Given the large number of providers that need to enroll in Medicaid to receive a payment, we will use resources identified in the IAPD to help enroll providers in Medicaid, e.g., any changes to the eMedicaid process, following up on Medicaid provider application requirements like licensure and credentialing. Also, we will help Physician Assistants to enroll if they are eligible for incentive payments.

To help inform providers of the additional registration steps, Medicaid MCO Liaisons will outreach to providers. Such a group is already in existence, and they are aware of the EHR Incentive Program.

The eMIPP system will be used to process most of the stages of the provider application process including:

- Interface to the R&A
- Verify components of application
- Help to determine eligibility
- Accept applicant attestations
- Determine payment amounts and send message to MMIS to make payment (including confirmation)[11]
- Accept confirmation of applications and digital signature
- Accept meaningful use attestations

eMIPP's provider interface gathers complete information at application in a manner that reduces burden for the applicant. An eMIPP user guide and hover bubbles within the application will provide additional instructions regarding the information that the provider applicant is being asked to provide or confirm.

[11] The payment determination will be electronically routed to MMIS for gross adjustment payments to the provider's designated Tax Identification Number (TIN).

eMIPP is an application that is being added to the existing MMIS Enterprise architecture. This application provides for a user-interface web portal. This new web portal will interface with DHMH's MMIS system to validate provider information received from the R&A. Additionally, once a provider incentive application is approved for payment, the payment will be generated through the current MMIS financial system. This will allow DHMH to leverage current financial transactions, including payment via check or EFT, remittance advice notifying the provider of payment, and 1099 processing. An additional benefit of eMIPP is its portability: with Maryland engaged in MMIS upgrades, a portable system will allow for a smooth transition between the existing and future MMIS.

In addition to the provider interface, eMIPP will have interfaces that Department staff will use to review and process provider applications and attestations. For example, Department users will be able to access an actionable task list from the state registration workflow and receive time-based alerts generated by the system and other data driven threshold reminders. The event management framework driving the user interface also facilitates timely user action, through escalation and reminders, and can initiate new business processes and execute a business action automatically.

Step 4: eMIPP runs edits on info from R&A to determine which providers to contact for the application process (Response to Questions #1, 15, 16, 29)

Not all applications referred by the R&A will meet DHMH's requirements. eMIPP's initial edit is based on an active provider batch file sent from MMIS to eMIPP. This file contains all active, non-sanctioned, provider-type eligible professionals and hospitals. Those providers that do not meet program requirements will be pended for review by authorized State personnel. The pending process allows the State to notify a provider that additional steps are required before registration can occur at the State. Some may be denied, and some applicants may be referred back to the R&A to correct previously submitted information. For example, providers must be enrolled as Medicaid providers without disqualifying sanctions or exclusions in order to qualify for the incentive program. Providers who are not enrolled will need to enroll with Medicaid prior to using eMIPP. Information on DHMH's website will instruct 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 will not be able to access eMIPP and again will be directed to DHMH for assistance.

Initially, the REC will help DHMH provide technical support and field additional programmatic questions. This will allow run-on time for the potential RFP process to procure help center services. The ASO contractor that DHMH is considering for help-line services will provide technical support and general information about the Program. The ASO will have contact information for the Office of Planning staff if provider questions are beyond a technical or general scope.

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

If the enrolled provider has a valid logon ID and provider type, eMIPP will perform 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 a R&A record. If a match is found, the provider has been verified and will begin the application process, but if no match is found then the provider will be notified that there is not a match with a record from the R&A and that the provider should contact DHMH.

If a provider does not pass the eMIPP edits, then the record will be suspended in eMIPP and DHMH will:

- Refer providers back to the R&A for errors on data provided at the R&A (e.g., incorrect Payee Tax-ID)
- Refer non-participating Medicaid providers to Provider Enrollment for assistance with program enrollment
- Resolve discrepancies between the provider type entered at the R&A and the provider type stored in the MMIS, i.e., non-EHR provider type in MMIS
- Suspend and refer applicants sent from the R&A with exclusions for investigation by the Program Integrity Unit at DHMH

If edits are passed, then the provider proceeds to Step 5. If edits are not passed DHMH will contact the provider explaining the reason for the suspension (e.g., provider not enrolled, etc.). The Department will work with those whose applications have been suspended to make every effort to resolve inconsistencies and errors before denying the application.

If the provider passes the eMIPP edits and checks in Step 4, applicants will be able to return to the eMIPP portal to attest no earlier than 24 hours from initial interface with eMIPP. This will allow systems to verify all initial information.

Step 5: Providers submit application and attestation form in eMIPP and eMIPP concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28, and 30)

Providers may obtain information about the application process via the DHMH website, the REC, and eventually the ASO contractor. As part of the eMIPP vendor services, DHMH will have access to an accompanying guide for the eMIPP system to walk applicants through the application and attestation process. The development and release of this document will be

incorporated into the development timeline to be released before the State registration and attestation program goes live.

eMIPP has the capability to suspend and deny applications based on system logic. The Department is in the process of determining at which points in the process applications will be suspended or denied.

eMIPP will capture the information submitted during the application and attestation process. The system will apply real-time edits to verify that values entered are valid and that required fields are completed. The eMIPP web-based form will allow providers to save the partially completed application, exit the system, and return later to complete the form. If a record is suspended in eMIPP, the provider will be instructed to contact designated members of DHMH or the eMIPP help team (depending on the type of question) for assistance in order to resume the application process. The following steps outline the information that providers will need to enter to apply and attest.

1. Provider is asked to first enter identifying information, including their R&A Registration ID number. Once this has been entered, the provider encounters a screen with data obtained from R&A. The provider must confirm information obtained from the R&A including the National Provider Identifier, CMS Certification Number (for hospitals), legal name, business name, address, phone number, personal tax ID, payee tax ID, R&A confirmation number, and email address.

2. If information is not confirmed, the eMIPP record will be suspended as incomplete and the applicant will be directed to the R&A to fix the information; otherwise, the provider will proceed to next steps. Once the data is corrected at the R&A, if appropriate the provider will be able to reenter eMIPP to resume the application process within two days.

3. Applicant will indicate type of individual provider or type of hospital: physician, dentist, midwife, nurse practitioner, physician assistants practicing in FQHCs/RHCs "so led" by an FQHC/RHC, and pediatrician (to determine required volume threshold) for eligible professionals. Physician Assistants are not currently eligible for Medicaid providers and DHMH will develop a way to enroll them to make payments that was described earlier.

4. Providers are asked if they are a "hospital-based provider." A "hospital-based provider" is an eligible provider (EP) who furnishes 90% or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital. Only Medicaid EPs practicing predominantly in an FQHC or RHC are not subject to the hospital-based exclusion. If the threshold is not reached, then the applicant is directed to proceed to the next question.

5. Applicants will complete the application and attestation information in eMIPP.

6. Applicant is asked if s/he "practices predominantly" in an FQHC or RHC. An EP "practices predominantly" at an FQHC or RHC when the clinical locations for over 50 percent of his or her total patient encounters over a period of 6 months occurs at an FQHC or RHC. If the applicant responds, "Yes" then the applicant will complete the patient volume table including, numerator (consisting of Medicaid and "needy individuals") and denominator. A "needy individual" is anyone who meets any of the following criteria: (1) they are receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP); (2) they are furnished uncompensated care by the provider; or (3) they are furnished services at either no cost or reduced cost based on a sliding fee scale determined by an individual's ability to pay.

   If provider applicant does not practice predominantly in an FQHC or did not meet the 30 percent patient volume requirement based on FQHC entry, provider will complete a separate patient volume table including, numerator (paid Medicaid encounters only), and denominator). The system checks will calculate patient volumes (including if a provider practices in an FQHC and/or other locations) and pends applications for DHMH review and approval.

   All applications will be "pended" in eMIPP in order for a designated staff member to double-check all eligibility requirements and then allow payments. In most cases, this will just be a "sign off" process, since patient volume has already been checked through a manual MMIS query. Some eligible providers/hospitals may be in the pending status longer than others due to difficulties associated with their attestation. For instance, the State anticipates that out-of-state provider patient volume verification, group patient volumes, and very large MCO-based patient volumes whose 90 day period is less than 6 months old, will require additional time by State staff to verify eligibility. To help mitigate this process, the State will accept patient volume verification by either email, fax, or mail.

PATIENT VOLUME INFORMATION

7. Applicants are asked to select how s/he will calculate their patient volume. Maryland will allow providers to count Fee-for-Service patients and Managed Care patient encounters towards their patient volume. While any provider can choose any continuous 90-day representative period in the previous calendar year, Maryland, because of encounter data lag for managed care encounters, will go back to the most-recent and complete data to verify whether an EPs patient volume is within the patient volume requirement. Further, applicants can choose between calculating their patient volume through either a group methodology or using their own individual volume. Physicians, dentists, certified nurse midwives, nurse practitioners, and physician assistants must meet a 30 percent patient volume, further clarified below. Pediatricians must be a 20 percent patient volume (in exchange for 2/3 the amount in incentives). Pediatricians carry a specialty code of 016 in MMIS. While a practicing pediatrician is not aware of this designation, when they enrolled with Maryland Medicaid, they submitted

proof of their specialty, including documentation of three years experience, completion of a fellowship or submit proof that they are certified by the American Board of Pediatrics, in order to be enrolled as a pediatrician. When entering numerator volume, the applicant must report Medicaid in-state volume as well as out-of-state Medicaid volume. DHMH will be able to validate in-state patient volume using Maryland MMIS claim volume data. Although DHMH will need to manually look up patient volume in MMIS for Year 1, in Year 2, supporting documentation may be uploaded by the provider. Applicants will be instructed that the encounters discussed below must meet the CMS definition of encounter in the final rule in order to be included as part of the patient volume calculation.

- According to the Final Rule, EPs not practicing predominantly in an FQHC or RHC cannot include CHIP patients in their Medicaid patient volume calculations. DHMH has a Children's Health Insurance Program (CHIP) Medicaid Expansion program. Children enrolled in this program receive Medicaid services and DHMH receives enhanced match for providing this coverage. DHMH has discussed a formula for removing encounters from these patients from patient volume calculations for EPs not practicing predominantly in an FQHC or RHC. Because providers cannot identify CHIP beneficiaries, DHMH has calculated the proportion of encounters reimbursed by CMS at the enhanced CHIP rate, which is described in Appendix E. DHMH will use this proportion to make sure that EPs not practicing predominantly in an FQHC or RHC do not qualify using these encounters. EPs who do practice predominantly in an FQHC or RHC calculate patient volume using a "needy individual" criteria, which is described in Step 6 above.

<u>Individual Volume</u>: For an individual applying as an eligible professional (not using group) the calculation will be based on any representative, continuous 90-day period in the preceding calendar year and will be calculated as follows:

- {[Total (Medicaid managed care) encounters in a 90 day period] + [Unduplicated (Medicaid) fee for service encounters in the same 90-day period]/[Total patient encounters] + [All unduplicated encounters in that same 90-day period]} * 100.

  If EP practices predominately in a FQHC then their patient volume is based on "needy individuals." To calculate patient volume using the "needy individual" criteria, please use the definition provided in Step 6 above follow the formula below.

  {[Total ("needy individual") patients encounters in any representative continuous 90-day period in the preceding calendar year] + [Unduplicated ("needy individual") encounters in the same 90-day period]/[Total patients in that same 90-day period,]} * 100

Group volume: Maryland will allow clinics and group practices to use the practice or clinic Medicaid patient volume (or needy individual patient volume, insofar as it applies) and apply it to all EPs in their practice under three conditions: (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (e.g., it would not be appropriate for EPs who only see Medicare, commercial, or self-pay patients); (2) there is an auditable data source to support the clinic's patient volume determination; and (3) so long as the practice and EPs decide to use one methodology in each year (i.e., clinics or groups could not have one EP choose to count his or her clinic or group patient volume for his or her individual patient volume, while the others use the group- or clinic-level data). For an individual applying as an eligible professional using the Group calculation method, the calculation would be the same as the calculations for individuals, but instead doing the calculation for the individual, you would use the group-level data.

- EP will be asked to enter Group NPI (for verification purposes) that comprises the encounter volume they are entering and all members of the group will need to use the same patient volume methodology. If the group is an FQHC then it will include needy individuals in the total Medicaid encounter volume.

- Applicants will be able to submit documentation to validate patient volume as part of the application process by either email, fax, or mail. DHMH will use MMIS claims and encounter data to verify patient volumes for fee-for-service and managed care but there are many providers who do not have claims or encounter data history and DHMH will review these providers to make sure patient volume requirements are met. Acceptable documentation includes information from provider billing systems and information submitted as part of Federal grant requirements to the Health Resources and Services Administration by FQHCs.

- The Department will calculate patient volume and payments for all Acute Care Hospitals (including critical access hospitals) using information submitted by applying hospitals and the Health Services Cost Review Commission (HSCRC) Hospital Inpatient Discharge Data and the Disclosure of Hospital Financial and Statistical Information. Acute care hospitals' patient volume is based off of the previous fiscal year and excludes CHIP discharges. The Medicaid patient volume methodology is shown below and includes only inpatient and emergency room discharges (Places of Service 21 and 23):

  Medicaid Discharges/ Total discharges = % Medicaid Patient Volume (to qualify must be 10 percent; no threshold for Children's Hospitals)

- Medicaid patient volume calculations are for 90 day periods and all service locations, self-selected by the provider. Again, provider patient volumes are based on the previous calendar year, while hospitals' are based off of the previous fiscal year.

8. Description and attestation of Adoption, Implementation, or Upgrade phases – applicants must select one phase, then respond to questions to verify that they have, indeed, reached that phase.

   - Maryland defines the phases as:

     1. Adopt: acquiring, purchasing or securing access to certified EHR technology;
     2. Implement: installing or commencing utilization of certified EHR technology capable of meeting meaningful use requirements; or
     3. Upgrade: expanding the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology

   - In the first year, an upload feature for supporting documentation is not available, but will be available in year 2. In Year 1, providers will be able to email, fax or mail supporting documentation. The Department will save this information and add it to the provider's or hospital's EHR incentive file. For auditing purposes, DHMH will continue to follow CMS guidance on acceptable documentation to demonstrate AIU but will accept receipts, lease agreements, formal and/or legal documents, vendor contracts, canceled checks, user or license agreements. All EPs will be required to attest to adopt, implement, or upgrade in the first program year one.

   - All questions will emphasize that the EHR software purchased with incentive payments must be Federally-certified, as designated by a CMS Certification Number. Providers and hospitals will input their CMS Certification Number during attestation and DHMH will establish and maintain an interface with CHPL to verify applicant information on their software systems through eMIPP.

   - Responses to these questions will be used to direct technical assistance (TA), e.g., reports will be generated and recommendations for TA sent to the REC

9. Only hospitals that are dually eligible for Medicare and Medicaid will be able to attest to meaningful use in payment year 1 and the first year of the program. Hospitals that meet meaningful use criteria under Medicare will be deemed meaningful users under Medicaid. Maryland's R&A, eMIPP, through an interface with the Federal R&A will receive a weekly Medicare Hospital Attestation Reporting Data (C-5) file that will confirm hospital dual eligibility attestation. The State will verify hospital Medicaid eligibility and send the required response file to CMS before payment.

10. Applicant must complete remaining attestations including:

- Confirmation of voluntarily assigning payment to the entity indicated on the info from the R&A (payee TIN) or as established by financial arrangements in MMIS. According to the Final Rule, an eligible professional may reassign their payments to an employer or entity with which the eligible professional has a valid contractual arrangement allowing the entity to bill for the professional's services. The Department safeguards that such reassignment occurs by matching the NPI number of the EP enrolled at the R&A with all other viable payee IDs, including social security numbers. These relationships are established within MMIS through the legacy Medical Assistance number and will be uploaded to eMIPPs nightly via batch file transfer and overwrite. This means that all current NPI-to-payee relationships will be stored and then recreated in eMIPP nightly to allow providers registering for the EHR Incentive Program to choose the most up-to-date payee information on file with the State.

- Confirmation that foregoing information is true, accurate, and complete. The application will reinforce that the applicant is technically the professional or hospital, not the preparer, and the applicant will be held responsible for inaccurate or false information and overpayments.

11. eMIPP will present the entire application to the applicant for final confirmation. At this point, the system will allow changes. If changes are made, then eMIPP will perform edits based on the changes and process the application accordingly. If the application is error free, then a prompt appears for the applicant to FINISH and to indicate that no further changes will be permitted. Applicants will need to contact DHMH if they wish to make additional changes after the application has been submitted. The application and attestation form will require both the applicant and preparer (if different) to digitally sign the form and the preparer will need to disclose relationship with provider. The Department will require hospital applicants to attest that the applicant understands the program and is authorized to attest to the information.

Step 6: DHMH reviews pended provider application and attestation and determines eligibility or addresses reasons for suspension (Response to Questions 22 and 28)

The eMIPP system will have a series of system features to help applicants submit a complete and accurate application. These tools will supply definitions and guidance on the application questions and warnings will flash for incomplete submissions and responses that will terminate the application process. The eMIPP vendor will modify existing user guides based on Maryland's system to provide additional instructions.

Once the provider has completed the application and attestation, eMIPP provides a state-level approval attestation module that will allow certain DHMH staff members access to provider attestation information. Based on the level of security clearance afforded to individuals at the State, a provider's application can be reviewed for accuracy, given clearance for payment (resulting in an information exchange with the R&A), or suspended. Further discussion is

needed as to the scenarios that can occur, who will address (states versus CMS), and the potential impact on the information exchanged with the R&A. eMIPP will address most of the edits and checks as part of the system logic, so DHMH will initially review patient volume estimates and the pended applications and attestations.

The Department anticipates reviewing EP applications based on information provided in the applications that have been flagged for review and 100 percent of the hospital applications prior to making a payment. The Department will review all applications through an MMIS query to verify patient volume requirements. For those providers whose patient volumes are close to the participation threshold, their file will be flag for future post-payment audits. Further, because eMIPP maintains a directory of provider information, DHMH will periodically review this information to assure data integrity.

The system will allow DHMH to sort by, and/or generate reports on, provider type, adoption, implementation, upgrade, or meaningful use, patient volume, and other information fields submitted in eMIPP so that DHMH can prioritize reviews. The Department will review the application and attestation form for any information that has caused the application to suspend and follow up with the applicant as necessary. eMIPP is designed to be interactive, so that Department staff can update eMIPP with their determinations after reviewing the application and enter notes.

Before going live, DHMH will develop a review process/workflow that identifies staffing and follows recent guidance provided by CMS on auditing elements (pre versus post), and how approval will be communicated to providers. The auditing requirements will be specified as part of the agreement between the Office of Health Care Quality (OHCQ) (and potentially an ASO vendor in future years) which will perform these functions. DHMH will work with OHCQ on the audit strategy to finalize how and when applications are reviewed. DHMH will rely on guidance provided by CMS through the forthcoming monitoring guide and the auditing Community of Practice. The Department will follow up with providers when they require clarification, but eMIPP has been designed to reduce the need for this manual intervention, since it will allow DHMH to assure that all fields are completed with acceptable values before the application/attestation form is finalized.

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

Step 7: DHMH denies provider's application (Response to Questions #1, 20, 22)

Once the review is complete, DHMH will send email correspondence to providers who do not appear to be eligible for the Medicaid EHR Incentive Program indicating a "preliminary finding" of not eligible. This message will describe the reason why the provider does not seem eligible and will then request additional information. Providers will have up to 30 days to respond to this preliminary finding. If a provider does not respond to this letter or is otherwise determined

not eligible, then DHMH will send a final determination letter and information about the appeal process. The Department will also inform CMS of the denial and provide a reason code for each denial.

The Department's goal is to review applications, any additional information, and make a decision about the applicant's eligibility within six weeks of receiving an application. However, the process of working with providers on suspended applications may take longer than six weeks. And, as the number or participating providers grows, DHMH may need to re-assess staffing needs to reduce the lag-time for providers to receive timely appeals response. Providers have the option to appeal a "not eligible" determination.

The Department will handle such appeals the same way that DHMH currently addresses provider appeals on other matters as defined in COMAR 10.01.03.

Overview of Appeals Process

According to COMAR 10.01.03, an individual may request an appeal hearing by giving a clear statement, in writing, to any financial agent of the Division of Reimbursements of the Department of Health and Mental Hygiene that he/she desires an opportunity to present for review their grievance. This statement must be made within 30 days following the conclusion of the action or inaction which is the subject of the appeal. This statement shall be forwarded immediately to the Chief of Reimbursements. When the Division receives a request for a hearing, it shall assist the appellant in submitting and processing the request. DHMH will follow the pre-trial hearing and hearing procedures outline in COMAR 10.01.03, and, in the event the provider or hospital appeals the administrative law judge's decision, they may appeal to the Board of Review as provided by law in Health-General Article, §2-207, Annotated Code of Maryland.

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

eMIPP will display the entire completed application confirmed at the R&A. The system will display instructions for printing the summary information along with a "Contact Us" button that allows an email to be sent to DHMH for inquiries, and information about how to track the status of the application. The system will also generate correspondence to the provider indicating that the application is complete and pending final review with the R&A, the provider will be notified of the payment status.

Step 9: eMIPP interfaces list of providers who pass edits to 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 editing. The Department's proposed approach assumes that when the state informs the R&A that a payment is ready to be made and the R&A has approved

payment, the R&A will "lock" the record so that the provider cannot switch programs or States until after the provider receives the payment from the State that is identified in the R&A as being ready to make a payment. The Department will submit required information from interface D-16.

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

DHMH will send correspondence 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 will include information about the estimated timing of the payments, meaningful use requirements in future years, how to apply for future payments, information on oversight mechanisms that will be used, the tax implications of the incentive payment, and the web address where other EHR information will be sent.

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

DHMH will issue a remittance advice and make the incentive payment using a gross adjustment. A unique gross adjustment reason code will be generated and payments will be processed with the weekly Medicaid Financial Cycle. The payment method (paper, electronic funds transfer (EFT)) will be driven by the information used for claims payment on the provider enrollment file. A remittance advice will provide information on the incentive payment that has been made. Upon completion of the payment cycle, the MMIS will return payment data to eMIPP for financial management. eMIPP will generate a payment transaction including pay information to the R&A on a monthly payment file. The provider applicant/payee (to whom the payment is assigned) combination must be valid in the MMIS in order to make payment. MCO providers will receive incentive payments like fee-for-service providers to reduce complexity.

The Department will establish a schedule for making payments.

- For eligible professionals, payments are spaced out over six payment years (not necessarily consecutive years). EPs will receive $21,250 for the first year of participation, followed by an annual payment of $8,500 for each subsequent year of participation. Pediatricians will receive a different payment schedule: pediatricians that have at least 20% Medicaid patient volume will receive $14,167 for the first year of participation followed by payments of $5,667 for subsequent years of participation. Payments will be made over six years and the amount may be reduced by other sources of funding for EHR investment. eMIPP will request information on other sources of funding as part of the application process.

- For eligible hospitals, payments will be made over four years: 50 percent in the first year, 30 percent in the second year, and 10 percent in the third and fourth years.

Payments are again based on the calculations described in the CMS regulations and will be made over four years.

Using the eMIPP system in combination with establishing processes for reviewing suspended applications and attestations and generating reports/worklists showing the status of a given application, will allow DHMH to make timely provider incentive payments. In the best case scenario (no missing, incomplete, or inaccurate information) DHMH anticipates making payments to EPs within 10-12 days of their application completion date and within three weeks of the application completion date for hospitals. This time frame is in Figure C.2.

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

As described in the above steps, the eMIPP system contains numerous checks and edits that will help DHMH to conduct payment oversight at the point of application and attestation. Section D describes DHMH's proposed post-payment oversight activities in detail, but, in short, DHMH will focus on three areas: provider eligibility, reviewing attestations, and payment reviews.

DHMH will identify areas of risk in the eligibility determination and payment processes to design studies and reviews that will mitigate the risk of making an improper payment. For example, our auditing partner will conduct quarterly and annual random sampling studies to audit information submitted in attestation forms and from other areas, e.g., meaningful use information, patient volume, FQHC predominantly practice attestations, and assignment of payments. DHMH understands the programmatic risks of improper payments and will develop 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)

DHMH is aware that having the incentive payments may motivate providers to begin the adoption process but the incentive payments alone will not be sufficient for successful adoption, implementation, and meaningful use. Using the same communications strategy as described in Step 1, DHMH will collaborate with the REC, HealthChoice MCOs, DentaQuest, and vendors who provide technical assistance and other resources to educate providers about the incentive program and also to provide technical assistance and information on EHR adoption, implementation, upgrade, and meaningful use of EHRs.

In addition to reviewing providers who return for additional payments, DHMH 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 DHMH and will be included as a program evaluation metric in Section E.

This is a new program and new administrative process for DHMH. As the program evolves and DHMH begins to understand how providers will fare with adoption and meaningful use, DHMH's strategies will also evolve to continue to help providers to achieve meaningful use. This may include the addition of dedicated staff, or an increase in contractor scope for technical assistance and auditing.

As reflected in the I-APD, DHMH anticipates using seven current staff (at 0.15 FTE) to help with public health reporting, outreach, administration, and attestations. DHMH also anticipates contracting for additional public health attestation assistance, perhaps one ASO for auditing, and an additional ASO for help-line support if program participation volume requires it.

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

The Department is not proposing any changes to the proposed meaningful use rule criteria at this time. Using the same communications strategy as described above in Step 1, DHMH will collaborate with the HealthChoice MCOs, DentaQuest, and the RECs to the extent possible to educate providers about the meaningful use requirements in their second payment year and also to provide technical assistance about meaningful use of EHRs in year 2. The Department also anticipates that there will be provider education materials available through the CMS and ONC communications and outreach activities. As the program evolves and DHMH is able to assess a provider's ability to meet the meaningful use requirements, DHMH's strategies will also evolve to continue to help providers to achieve meaningful use.

Step 15: Meaningful use payment request or renewal (Response to Questions #9, 12, 13, 30)

DHMH will accept hospitals deemed as meaningful users by CMS in their second payment year. The Department is also planning to update eMIPP, create new eligibility screens, and establish a review process during which it will validate the continued eligibility of each participating providers and that meaningful use requirements are met. The renewal process will incorporate oversight reviews of continuing provider eligibility (e.g., patient volume); check against new information in the R&A, meaningful use criteria, and a review to ensure that provider information such as practice sites has not changed.

During the lifetime of the incentive program, DHMH anticipates that eMIPP will be sufficient to collect and store the information needed to process eligibility and make payments.

Our vendor will provide secure, off-site storage during the lifetime of the program. The Department's decision to host information off-site will benefit us greatly in the future, as we prepare for the new MMIS system in the coming years.

As eMIPP and the State's MMIS develop, DHMH looks forward to leveraging the ongoing success of the statewide HIE. The statewide HIE will enable critical information to be shared

among providers of different organizations and different regions in real-time; support the use of evidence-based medicine; contribute to public health initiatives in bio-surveillance and disease tracking; and prepare for emergency preparedness efforts that will positively impact health care outcomes by providing greater access to secure and accurate health information. The architecture of the statewide HIE is a distributed model where data remains at the source and the statewide HIE acts as the conduit for the secure transmission of this data from one provider or organization to another.

Efforts to connect providers to the statewide HIE have centered on hospitals, since they are considered large suppliers of data, and will then proceed to connect ambulatory care practices. The Montgomery County hospitals were the first to begin connecting to the statewide HIE; most of these hospitals as well as Quest Diagnostics, LabCorp, RadNet, and American Radiology are connected to the exchange. The statewide HIE anticipates connecting ambulatory care providers beginning in 2011 and expects to have all hospitals connected within two years.

In the future, certain meaningful use measures as defined by CMS are set to be core measures for the State's Patient-Centered Medical Home (PCMH) pilot project. By wrapping these measures into the incentive payments for the practices participating in PCMH, Maryland encourages their use and makes it easier for providers who participate in PCMH to also benefit from the EHR incentive payments.

Section D: Maryland's Audit Strategy

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

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

1. Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.
2. How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?
3. Describe the actions the SMA will take when fraud and abuse is detected.
4. Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.
5. Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed? (i.e. probe sampling; random sampling)
6. What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight 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 ovesrsight be allocated?

Section D: Maryland's Audit Strategy

Introduction

Oversight and auditing efforts will focus on data elements associated with provider eligibility and meaningful use, and on payment reviews. Below are examples of criteria from each area:

Provider Eligibility

- Is enrolled and participating Medicaid provider
- Meets final rule provider definition
- Meets hospital-based provider definition
- Meets Medicaid patient volume thresholds
- Adheres to DHMH's Medicaid patient volume methodology
- Practicing predominantly in Federally Qualified Health Centers and Rural Health Clinics meet relevant patient volume thresholds and rules

Meaningful Use, Adoption, Implementation, and Upgrade

- Meets requirements for adoption, implementation or upgrade in participation year one
- Meets criteria for the appropriate stage of meaningful use
- Acquires, implements, upgrades to, and meaningfully uses a certified EHR system

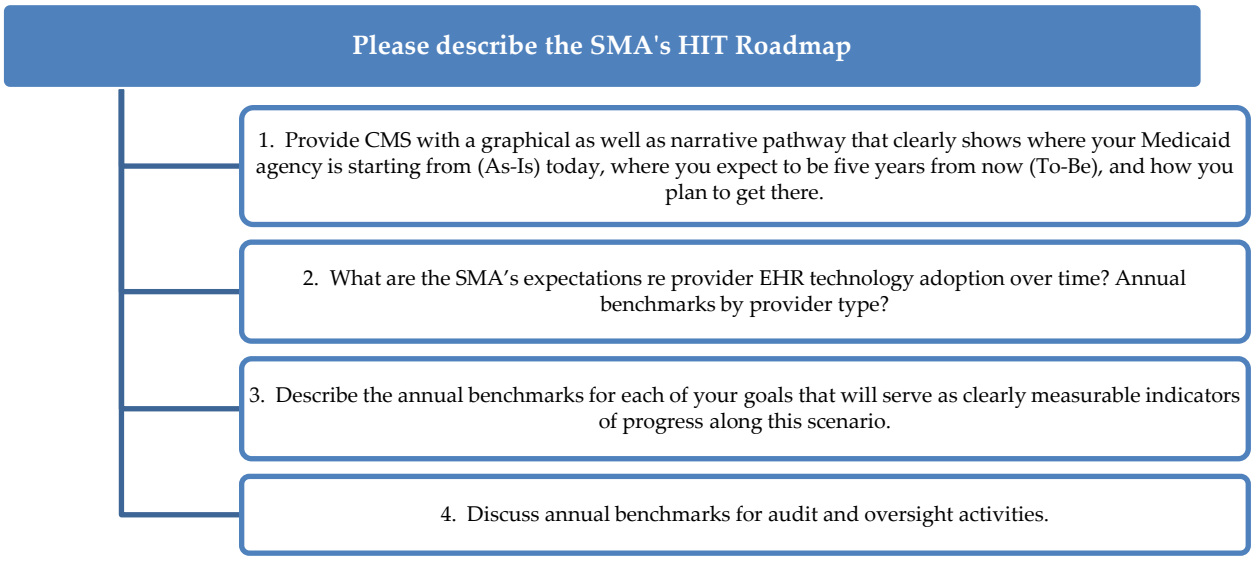
Payment

- Has not received duplicative payments
- Returns overpayments in a timely manner
- Has received payment both as part of a group and as an individual provider
- Has received payment from out-of-state

NOTE: The balance of this section has been removed. DHMH will engage in a series of pre- and post-payment reviews of eligibility and payment information in order to ensure program integrity. All participants in the Medicaid EHR Incentive Program are asked to draw from auditable data sources when reporting information and to keep this information for five years.

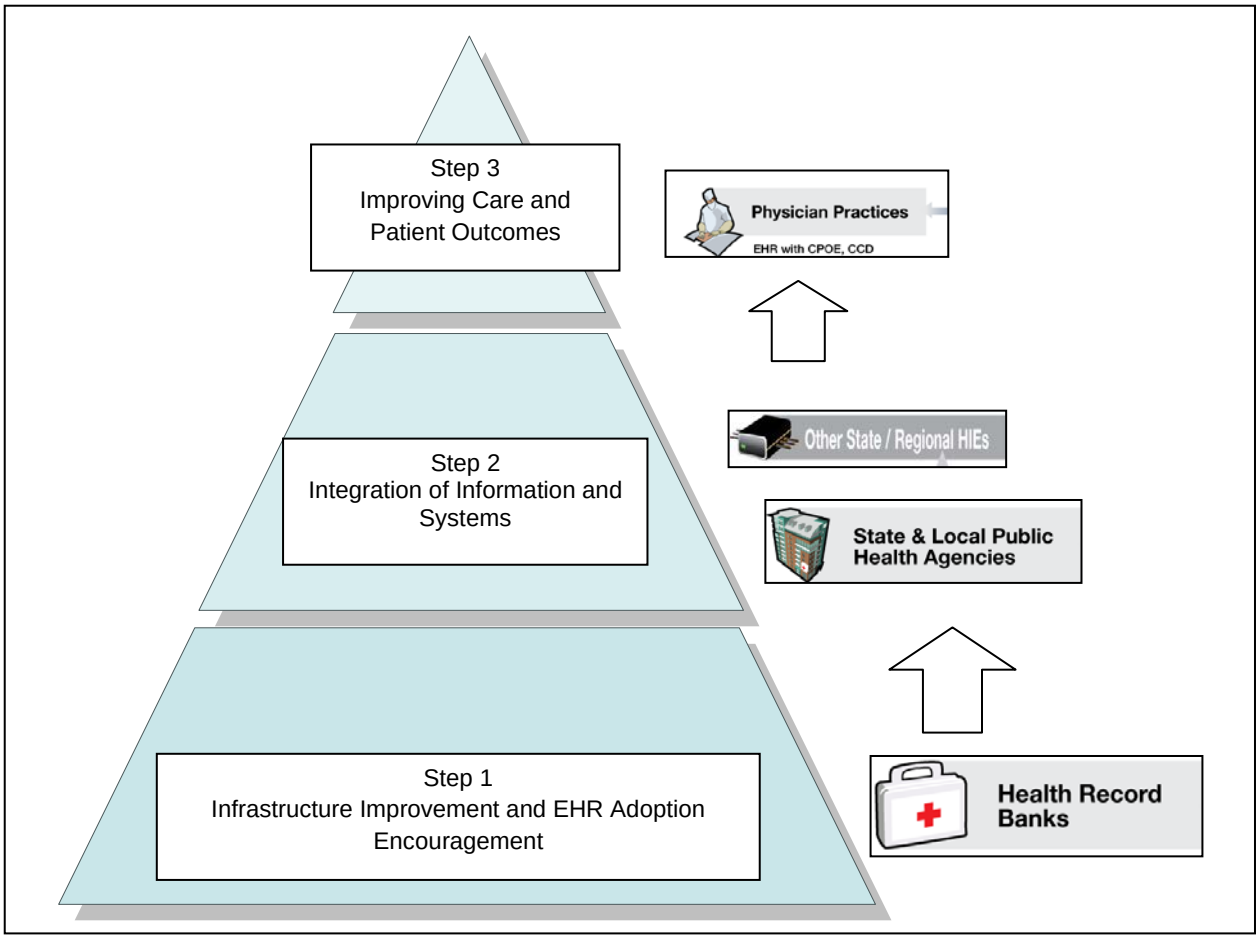
Section E: Maryland's HIT Roadmap

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



E.1 Provide CMS with a graphical as well as narrative pathway that clearly shows where your Medicaid agency is starting from today, where you expect to be five years from now, and how you plan to get there.

Figure E.2: Maryland HIT Pathway



DHMH's Roadmap is meant to describe the overall journey to achieving the To Be vision and EHR Incentive payments – with the appropriate milestones for achievement.

Where Medicaid is starting from today

Medicaid currently uses a legacy system for benefit administration and claims processing. The current system has been in place since 1992. This system is a direct descendant of the original MMIS applications based upon the Federal Blue Book specification and technical architecture of the 1970s. Over the years, Medicaid has become increasingly complex, with service changes, eligibility changes, and new regulations. The rate of change in Medicaid is among the greatest of any major program serving the public, whether government or privately operated. New

program needs are difficult to address with the existing system. Labor-intensive workarounds are used to address these changes in the short-term, but do not represent a long-term solution.

Medicaid in five years

In five years, Medicaid will have replaced its existing system with a product that supports off the shelf solutions, a call center, document management, customer support management, and connectivity to the statewide HIE. The MMIS system of the future will support Service Oriented Architecture infrastructure that integrates improved data sharing; automates claims and eligibility processing, allowing the development of waiver, long term care and state run program eligibility solutions to directly address the inefficient eligibility determination process and eliminate silo systems; and improve care and customer management. Medicaid expects to use the MITA 2.0 framework as the basis of the new MMIS infrastructure and plans to use the MITA transition planning process as a basis for future MMIS improvements, along with adopting best practices in information technology investments.

Pathway

In order to move from the current legacy MMIS system, relatively low EHR adoption among Medicaid providers, and a developing HIE, to a fully enabled infrastructure supporting bi-directional, real-time interfaces within the State's Client Automated Resources Eligibility System connected to the HIE and EHRs, Medicaid will make take the following steps. These steps are depicted in Figure E.2 above.

<u>Step 1: Infrastructure Improvement and EHR adoption encouragement</u>

MMIS Upgrade: Medicaid issued an RFP to identify a vendor to replace the existing MMIS legacy system in May 2010. Responses to the RFP were due in August and Medicaid is on target to make an award during in late 2011. The new Medicaid system will include imaging and workflow management and a robust business rules engine to aid in creating and managing flexible benefit plans.

HIE Collaboration and Connectivity: Medicaid is an active participant in the statewide HIE efforts and is a member on the Policy Board. The Policy Board has general oversight of the statewide HIE, including the authority to evaluate and recommend to the MHCC the policies that will govern the exchange. Medicaid expects to connect with the statewide HIE as part of the implementation process of the new MMIS. The vendor selected to implement the new MMIS will be required to collaborate with statewide HIE to build the interface as part of the implementation process.

Encouraging the Adoption of EHRs: Through participation in the Medicaid EHR Incentive Program, Medicaid will begin the process of encouraging EHR adoption among providers. As providers begin to adopt certified EHRs, Medicaid will use the developing HIE to leverage data sharing and submission by encouraging providers to connect. To strengthen the connection between the HIE and Medicaid, Medicaid will partner with the REC -- which is also the state-designated HIE -- to aid in outreach activities and to facilitate HIE connectivity as the infrastructure advances.

Step 2: Integration of Information and Systems

Clinical Quality Measures: In Year 2 of the EHR Incentive Program, Medicaid will begin to receive clinical quality measures. This information will be integrated into the new MMIS and used by Medicaid to better understand the Medicaid population and to facilitate decision making.

HIE Cross-Border Interfacing: Medicaid will also work closely with the HIE as connections are established between border states in order to facilitate patient-level data access for providers across borders in a secure and safe manner.

Step 3: Improving Care and Patient Outcomes

Data gathered by EHRs and facilitated by the HIE will aid Medicaid in making decisions that improve patient care and outcomes.

E.2 What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type?

Implementing the EHR Incentive Program is a major undertaking, systems have to be designed, built and tested; Medicaid staff and the provider community have to be informed and educated; new policies, procedures and audit plans have to be developed, tested and implemented. Section B.1 covers the EHR incentive administrative goals and outcomes including benchmarks for adoption, by provider type, on an annual basis.

As we described in Section B, hospital and professional adoption rates match up closely with national adoption trends. Therefore, Maryland will tie its EHR adoption goals to the national adoption goals. See Figure E.3 below for these rates. We will track and make updates to this timeline in future releases of the SMHP.

Figure E.3 – Maryland's EHR Adoption Rate Goals

Year	National EHR Adoption Targets (ONC)	Maryland Medicaid Physician Adoption Rate	Maryland Hospital Adoption Rate
Baseline (year)	Less than 20%	Approximately 19% (2009)	55% (2010)
2011	20%	20%	60%
2012	40%	40%	65%
2013	60%	60%	70%
2014	80%	80%	80%

E.3 Describe the annual benchmarks for each of your goals that will serve as clearly measurable indicators of progress along this scenario?

DHMH has annual goals for EHR adoption that are aligned with national goals. The Medicaid EHR incentive program will help providers adopt EHRs and DHMH will leverage the services available through the REC to promote EHR adoption and meaningful use. We will use information collected through eMIPP and as part of the reporting requirements to CMS (number of EPs adopting, meaningful use, etc) to track our progress and make program corrections if necessary.

We also have operational and program requirements related to developing a provider manual and other program materials and monitoring our vendors for the eMIPP application and registration and the ASO contract for monitoring. DHMH will closely monitor our contracts and develop performance requirements, benchmarks, and goals to make sure contractors are helping to make our EHR incentive program as effective as possible.

E.4 Discuss annual benchmarks for audit oversight activities

Program oversight is broken into three categories for the EHR Incentive Program. The first is provider eligibility verification, which includes the random eligibility verification audits. The timeline for eligibility verification depends on program launch and auditing implementation.

The second program oversight category is meaningful use verification. This process will begin once the meaningful use collection and tracking system is ready and providers start to apply for their second participation year. The specific details associated with meaningful use audits will depend on the registration system and input from our auditors.

Program Integrity is the third program oversight category and includes several related goals. Program integrity will provide an independent review of incentive activities and monitoring for fraud and abuse. As with any new program, general program integrity may naturally lag behind implementation. One outstanding factor is the sampling rate for program integrity. The goal is finalize the sampling rate once clearer participation levels are available and no later than 18 months after registration go live.

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Glossary of Terms and Acronyms

The matrix below provides a glossary of terms and acronyms that are frequently used in discussions about DHMH of Health and Mental Hygiene's HIT initiative.

Term	Acronym	Definition
Technology		
Health Information Technology	HIT	• Allows comprehensive management of medical information and its secure exchange between health care consumers and providers • 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
Electronic Medical Record	EMR	• The legal record created in hospitals and ambulatory environments that is the source of data for an electronic health record (EHR) • A record of clinical services for patient encounters in a single provider organization; does not include encounter information from other provider organizations • 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 • Owned by the provider organization • May allow patient access to some results information through a portal, but is not interactive
Electronic Health Record	EHR	• A subset of information from multiple provider organizations where a patient has had encounters • 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 • Connected by a Health Information Exchange (HIE) • 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 • Owned by patient • Provides interactive patient access and ability for the patient to append information

Glossary of Terms and Acronyms

Term	Acronym	Definition
Personal Health Record	PHR	• Electronic, cumulative record of health-related information for an individual in a private, secure and confidential manner • Drawn from multiple sources • Created, gathered, and managed by the individual • Integrity of the data and control of access are the responsibility of the individual
Health Information Exchange	HIE	• The sharing of clinical and administrative data across the boundaries of health care institutions and providers • The mobilization of healthcare information electronically across organizations within a region, community or hospital system • Provides capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged • Goal is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable patient-centered care
Chesapeake Regional Information System for Our Patients	CRISP	• A statewide health information exchange funded under the Office of the National Coordinator for HIT's Statewide HIE Collaborative Agreement program that will connect regional HIE's and integrated health systems
Medicare and Medicaid EHR Incentive Program Registration and Attestation System	R&A	• A repository that will be available to states to help avoid duplication of payments to providers participating in the EHR Incentive Program • Information the repository is proposed to store includes provider registration information, meaningful use attestations and incentive payment information