State of Nevada

Department of Health and Human Services
Division of Health Care Financing and Policy

State Medicaid

Health Information Technology

Plan

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1   Executive Summary

The State of Nevada Division of Health Care Financing and Policy (DHCFP) plans to participate in the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) system incentive payment program (EHR Incentive Program) for its Medicaid eligible professionals (EPs) and eligible hospitals (EHs) (collectively Providers). The EHR Incentive Program provides an incentive payment to Nevada Medicaid Providers to adopt, implement, or upgrade (AIU) an EHR system and meet the Meaningful Use criteria. The incentive payments are part of the American Recovery and Reinvestment Act (ARRA) health care initiative to promote the use of health information technology (HIT) to improve health care outcomes and provide cost saving efficiencies in the health care system. This document provides a description of the strategic planning process that DHCFP has undertaken to participate in the EHR Incentive Program; the business and operational plan for payment of the incentives; and a HIT Roadmap presenting the direction that DHCFP plans to take to achieve the HIT vision described in this document.

As part of DHCFP's strategic planning effort, it carefully considered the current EHR usage and capacity and completed an Environmental Scan of the State of Nevada to ascertain the level of readiness of its Providers. DHCFP also considered its current data sharing partners and evaluated the level of readiness to expand its current data sharing capacity. DHCFP coordinated this strategic Medicaid planning effort with the strategic planning effort for the statewide health information exchange (Statewide HIE). This effort resulted in comprehensive knowledge of the current HIT landscape within the State of Nevada. The current HIT landscape is discussed in this document in Section 3 – Current HIT Landscape – The "As-Is" Environment.

Once DHCFP achieved a good understanding of the current HIT landscape, its planning effort focused on creating a vision of DHCFP's future HIT landscape. Within the next five years, DHCFP has specific goals to procure a replacement Medicaid Management Information System (MMIS). With that effort, DHCFP will: 1) achieve greater interoperability with its Providers; 2) improve health record sharing functionality; and 3) promote adoption of EHR technology for its Providers with the goal of achieving better health care outcomes for its beneficiaries. The effort to promote electronic exchange of health care data for the benefit of the patient will be enhanced by the improvement of access to broadband technology for the citizens of the State of Nevada. Discussion of DHCFP's future vision of HIT can be found in this document in Section 4 – Future HIT Landscape – The "To-Be" Environment.

DHCFP next defined a HIT Roadmap for achievement of its future vision. The HIT Roadmap articulates the major milestones and activities that DHCFP will achieve as it moves from its current environment to its future vision. One of DHCFP's first milestones is achieved in the submission of this State Medicaid Health Information Technology Plan (SMHP) to CMS. Additional important milestones include: 1) submitting an Implementation Advanced Planning Document (IAPD); 2) accepting Provider registrations for the EHR Incentive Program; 3) making incentive payments to Providers; and 4) sharing data with the Statewide HIE. A description of DHCFP's HIT Roadmap is found in this document in Section 5 – HIT Roadmap.

As one of the key elements to this SMHP, DHCFP has undertaken a comprehensive technical, business, and operational planning endeavor in order to be ready to make incentive payments to its Providers. This

program is known as the Nevada Provider Incentive Program (NPIP). DHCFP has carefully considered and incorporated all program integrity elements for the NPIP and will undertake rigorous administration and oversight of the NPIP, as well as continue to work hard to promote the adoption of EHR technology for its Providers. The NPIP is designed to ensure that the right payment is made to the right Provider at the right time. A description of the NPIP is found in this document in Section 6 – Nevada Provider Incentive Program Blueprint.

As part of the planning process for the NPIP functionality for Provider registration, attestation, payment, and tracking, DHCFP is considering vendor solutions being used in other states. DHCFP has received draft cost proposals from three vendors that provide electronic solutions for the program and has had demonstrations from two of the three vendors. DHCFP intends to follow the State procurement process in procuring a vendor solution. Upon completion of the procurement process, DHCFP expects that testing with CMS' National Level Repository (NLR) will begin in April 2012. It is anticipated that the Nevada Medicaid EHR Incentive Program will begin accepting registrations in June 2012 with the first incentive payments being made in July 2012. When DHCFP completes its decision making process, the analysis will be included in a future update of this document.

In regards to its promotion efforts, DHCFP has begun to implement a communication plan to inform Providers of the availability of the incentives and eligibility criteria. Provider outreach and education sessions will be performed as part of the communication approach. DHCFP's communication plan is attached hereto as Appendix K: SMHP Communication Plan.

In conclusion, DHCFP is pleased to submit this SMHP as documentation of its activities to comprehensively plan and implement its future vision as a partner to its Providers and other stakeholders in the adoption of EHR technology and the promotion of HIE.

Respectfully submitted by:

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2   Introduction and Overview

DHCFP submits this SMHP to provide CMS a description of the activities that the State expects to undertake in successfully implementing its EHR Incentive Program.

In order to submit this SMHP, DHCFP has completed a rigorous planning process designed to consider and incorporate all of the requirements for implementation of its EHR Incentive Program. These requirements include payment of the incentives for AIU and Meaningful Use of certified EHR technology for Nevada Medicaid Providers.

DHCFP carefully considered the current technology, business, and operational environment and has methodically planned the changes required to effectively administer the EHR Incentive Program. DHCFP's strategic planning process entailed coordination with the Statewide HIE planning efforts and a series of informational meetings of the essential DHCFP organizational participants and DHCFP stakeholders.

The results of DHCFP's planning process are incorporated into the following SMHP that includes all of the elements required by CMS. Specifically, this document includes a description of the following elements:

- The current and future vision for the MMIS.

- A baseline assessment of the current HIT landscape in the State of Nevada through an environmental scan.

- DHCFP's future HIT landscape.

- DHCFP's HIT Roadmap and plan.

- A description of how the SMHP was designed and developed.

- DHCFP's EHR incentive payment system and how the MMIS has been considered in developing the NPIP.

- Data sharing components of the NPIP.

- Promotion of secure data exchange in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- The process for improvements in health outcomes, clinical quality, or efficiency resulting from the adoption of certified EHR technology by Nevada Medicaid Providers.

- The method by which DHCFP will support the integration of clinical and administrative data.

- The method by which DHCFP will adopt data standards for health and data exchange and open standards for technical solutions as they become available.

- A description of the process to verify that each Provider who applies for the EHR Incentive Program meets the enrollment eligibility criteria.

- A methodology for verifying patient volume requirements are met by each Provider who applies for the EHR Incentive Program.

- A description of the monitoring and validation of registration information for each Provider who applies for the EHR Incentive Program.

- A description of how DHCFP will capture attestations from each Provider that has met the AIU or Meaningful Use criteria.

- The method by which DHCFP will monitor compliance of Providers coming into the program with different requirements depending on their participation year and a methodology for verifying this information.

- A list of specific actions planned to implement the EHR Incentive Program.

- A process to verify that no amounts higher than 100 percent of federal financial participation (FFP) will be claimed by DHCFP for reimbursement of expenditures for State payments to Providers for the EHR Incentive Program.

- A process to verify that no amounts higher than 90 percent of FFP will be claimed by DHCFP for administrative expenses in administering the EHR Incentive Program.

- A process to verify that payments made to a Provider are paid directly (or to an employer of facility to which the Provider has assigned payments) without any reduction or rebate, and that incentive payment reassignments to an entity promoting the adoption of certified EHR technology as validated by DHCFP are voluntary for the Provider involved.

- A process to verify that incentive payments received by Providers applying in Nevada are collected only from Nevada.

- A process to verify that each Provider that wishes to participate in the EHR Incentive Program supplies a valid National Provider Identifier (NPI) and a description of how the NPI will be used to coordinate with CMS.

- A process to verify that a Taxpayer Identification Number (TIN) will be provided to DHCFP for those Providers participating in the EHR Incentive Program.

- A current standard operating process for payment transactions through the financial subsystem will be used to verify that the correct funding source is used to make EHR incentive payments.

- A process to verify that: 1) Medicaid EHR Incentive Program payments are made for no more than a total of six years; 2) no Provider begins receiving payments after 2016 and incentive payments cease after 2021; and 3) an EH does not receive payments after federal Fiscal Year 2016 unless the hospital has received an incentive payment in the prior fiscal year.

- A process to verify that all hospital calculations are made consistent with the requirements.

- A process for timely and accurate payment of incentives.

- A recoupment process.

- A process to verify that Providers meet their responsibility to adopt certified EHR technology.

- A process for combating fraud and abuse.

- A process for Provider appeals.

As DHCFP continues to refine this plan and provide updates to CMS, DHCFP will continue to do operational and business planning to provide the following information:

- A description of the process to capture clinical quality data from each Provider and a description of the methodology in place to verify this information.

- The method by which DHCFP intends to address the needs of underserved and vulnerable populations. This future refinement will include information related to children, individuals with chronic conditions, Title IV-E foster care children, individuals in long term care settings, and the aged, blind, and disabled.

DHCFP plans to align the Medicaid priorities with the Statewide HIE so that its Providers are able to demonstrate Meaningful Use and are positioned to receive the maximum incentive payments and avoid future penalties. In alignment with the Statewide HIE goals, DHCFP will work toward the following priorities to support Medicaid Providers:

- Electronic eligibility and claims transactions.

- Electronic clinical laboratory orders and results delivery.

- Electronic public health reporting.

- Prescription fill status and/or medication fill history.

- Clinical summary exchange for care coordination and patient engagement.

- Quality reporting.

In addition to developing elements for the SMHP, DHCFP has also been working with the Statewide HIE and the Regional Extension Center (REC), HealthInsight, to promote the use of certified EHR technology to Providers throughout the State of Nevada.

DHCFP plans to keep CMS informed of anticipated changes to activities, scope, or objectives. DHCFP will provide annual updates and as-needed updates to CMS as its plan evolves over the next five years.

3   Current HIT Landscape – The "As-Is" Environment

This section describes the environmental assessment of the State of Nevada's Medicaid Providers and the readiness for EHR adoption and Medicaid incentive payments. This section provides the assessment documents, the tools used, the analysis applied, and the outcomes. This landscape assessment provides an understanding of the HIT and HIE issues and serves as source data for the development of the To-Be Landscape and completion of the HIT Roadmap and the IAPD.

3.1   Assessment Documents

The following sources of information were reviewed for this report:

- Nevada Health Information Technology Strategic and Operational Plan – January 31, 2011.

- Nevada Medicaid Health Information Technology Regulatory Inventory – November 15, 2010.

- Nevada Health Information Technology Regulatory and Policy Inventory – August 23, 2010.

- CMS State Medicaid Director Letter – August 17, 2010.

- Nevada Health Information Technology Statewide Assessment – August 13, 2010.

- CMS 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule – July 28, 2010.

- Nevada MMIS Takeover Request for Proposal No. 1825 – February 9, 2010.

- Nevada Medicaid Information Technology Architecture State Self-Assessment (MITA SS-A) Report v2.0 – January 2009.

- Nevada MITA Maturity Report v1.0 – December 4, 2008.

- Nevada MITA Technical Assessment v1.0 – December 4, 2008.

- Federal Regulations (Privacy and Security Review):

  o Modifications to HIPAA Privacy, Security and Enforcement Rules—45 CFR Parts 160 and 164, Modifications to the HIPAA Privacy, Security, and Enforcement Rules Under the Health Information Technology for Economic and Clinical Health Act (HITECH); Proposed Rule, July 14, 2010.

  o Modifications to HIPAA Enforcement Rule—45 C.F.R. Parts 160 and 164, HIPAA Administrative Simplification: Enforcement; Interim Final Rule, October 30, 2009.

  o Breach Notification Rule—45 C.F.R. Parts 160 and 164, Breach Notification for Unsecured Protected Health Information; Interim Final Rule, August 24, 2009.

  o HIPAA Enforcement Rule—45 C.F.R. Parts 160 and 164, HIPAA Administrative Simplification: Enforcement; Final Rule, February 16, 2006.

  o HIPAA Security Rule—45 C.F.R. Parts 160, 162, and 164, Health Insurance Reform: Security Standards; Final Rule, February 20, 2003.

- o Modifications to the HIPAA Privacy Rule—45 C.F.R. Parts 160 and 164, Standards for Privacy of Individually Identifiable Information; Final Rule, August 14, 2002.

- o HIPAA Privacy Rule--45 C.F.R. Parts 160 and 164, Standards for Privacy of Individually Identifiable Information; Final Rule, December 28, 2000.

- Nevada Revised Statutes (Privacy and Security Review):

- o Too many to note in this document. Refer to Appendix G: Nevada Health Information Technology Regulatory and Policy Inventory for a list of all HIE-relevant Nevada statutes.

- Nevada State Documents (Privacy and Security Review):
  - o Nevada Medicaid State Plan
  - o Nevada Medicaid Operations Manual
  - o Nevada Services Manual
  - o Nevada Check-up Manual
  - o Nevada Medicaid Health Information Technology Regulatory Inventory
  - o Nevada Health Information Technology Regulatory and Policy Inventory
  - o Nevada Senate Bill No. 43 (The bill makes various changes relating to electronic health records.)
  - o Division of Health Care Financing and Policy, HIPAA Security Manual Sections 100-900 and Attachments
  - o Division of Health Care Financing and Policy, HIPAA Privacy Manual Sections 100-900 and Attachments

3.1.1   Nevada Health Information Technology Statewide Assessment

Planning for HIT and HIE initiatives in Nevada falls under the umbrella of the Nevada Department of Health and Human Services (DHHS), which includes the State's Medicaid program – the Division of Health Care Financing and Policy (DHCFP) – and the Office of Health Information Technology (OHIT). DHCFP is responsible for administration of Medicaid and the Children's Health Insurance Program (CHIP)[1].

The Statewide Assessment provides a comprehensive review of the state of HIT within the Nevada health care community, including key findings. The Statewide Assessment provides the methodology for identifying stakeholders and existing HIT and HIE efforts. Rather than summarize or restate the document and to allow for complete review, the Nevada Health Information Technology Statewide Assessment is attached hereto as Appendix E.

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[1] Nevada Health Information Technology (HIT) Statewide Assessment August 13, 2010.

3.2 Medicaid Management Information System Capabilities Assessment

DHCFP's current MMIS Fiscal Agent is Magellan Medicaid Administration. The Fiscal Agent contract is undergoing a takeover at the present time. The new takeover vendor is HP Enterprise Services.

The overall MMIS is composed of a number of functional subsystems and components. The Fiscal Agent provides Pharmacy, Operations, Health Care Management, and Information Technology (IT) services.

The Pharmacy services include:

> Drug claim processing; pharmacy prior authorization; OBRA drug rebate program management; drug use review (Pro-DUR, Retro-DUR, DUR Board responsibilities); Preferred Drug List - supplemental rebate program; pharmacy and therapeutic; and Maximum Allowed Charges. The Fiscal Agent operates the pharmacy call center and manages the drug file and ePrescribing tool (SureScripts).

The Operations services include:

> The MMIS adjudication and processing of claims; Provider recruitment; enrollment and disenrollment functions; document imaging; and operation of the Provider call center.

The Health Care Management services include:

> Administration of the Pre-Admission Screening and Resident Review and long-term care admission screening requirements, as well as the prior authorization process for nursing facilities and intermediate care facilities for the mentally retarded. The Health Care Management is also responsible for Utilization Management – prior authorization of services; concurrent review; retrospective review; and certificate of need review of designated services.

The Information Technology (IT) services include:

> Technology support including design, development, and implementation; modification, documentation, training and maintenance related to the MMIS; Remedy ARS; POS Pharmacy User Interface; FirstIQ; FirstRebate; FirstTrax; FirstRX; FirstHCM; FirstRequest; FirstDARS; and associated database applications.

DHCFP provides additional IT and Information Systems (IS) support for MMIS Operations:

> The DHCFP IT Unit is responsible for the administrative oversight, deployment, operation, and maintenance of the personal computer and LAN/WAN systems for the division. This includes the development of the DHCFP PC and Network System Plan; approval of all computer hardware/software purchases, hardware/software service contracts and inventories, systems and data security; and the identification and implementation of system solutions to ensure ongoing operations of the DHCFP information system infrastructure.

> The IS Unit supports a number of information systems including MMIS, Nevada Check Up, and Health Insurance for Work Advancement. This unit consists of business process analysts that provide oversight, monitoring, data change/updates, and release control for each of the information systems and management analysts that provide project

management and oversight of the MMIS contract. The System Change Management Section is charged with controlling any changes to the MMIS system.

The current MMIS claim processing system runs on an IBM mainframe and is written in the COBOL programming language with an IBM mainframe-based data tier using IBM Customer Information Control System (CICS) for transaction processing and DB2 for relational database management. The overall MMIS is composed of a number of functional subsystems and components.

The majority of the functional subsystems reside on one of the following platforms:

- IBM Mainframe running z/OS.

- IBM RS/6000 running AIX.

- Intel-based Servers running NT Server.

DHCFP is currently working to procure: 1) a state-of-the-art MMIS; 2) a Pharmacy Benefit Management System; 3) a Medicaid Eligibility Determination System; 4) a Decision Support System and Data Warehouse solution; 5) the supporting ancillary applications; and 6) Fiscal Agent services. The procurement effort will emphasize vendor achievement and alignment of MITA principles and goals as key outcomes of the process.

Based on the MITA SS-A and Gap Analysis, there are several gaps in the current business process areas. DHCFP will consider the appropriate solution during the procurement effort.

3.3   Current Medicaid Information Technology Architecture Status

MITA is a CMS initiative designed to promote the transformation of business processes and the integration of technology across the Medicaid enterprise to improve operational efficiencies and effective administration of the Medicaid program. The purpose of the MITA framework is to provide states with a common structure to use as a foundation for assessing current practices and measuring progress in the advancement of program administration through the investment in technology.

Nevada completed a MITA SS-A in 2009. The resulting document describes the current MMIS as it aligns with the MITA framework in the "As-Is" analysis and lays the foundation for future changes that will advance the transformation of the Medicaid enterprise towards its future goals in the "To-Be" component of the assessment. The conclusions of the Nevada "As-Is" assessment rated the majority of the current business processes at a Level 1 maturity with some business processes in Level 2.

There are several business processes in the MITA SS-A that need to be leveraged in the management of the NPIP, so it is important to review and understand the "As-Is" assessment of these processes as the baseline is set for the SMHP. The following table is a summary of key findings related to processes that may overlap with processes required for the administration of incentive payments.

Table 1: Nevada MITA SS-A (2009)

Business Process	Maturity Level	Key Findings
PROVIDER MANAGEMENT		EHR Incentive Program management will require validation of Provider eligibility and management of appeals.
PM1 Enroll Provider	1	Credentialing is limited and manual.
PM3 Management of Provider Information	1	Update requests are received in writing or orally.
PM6 Manage Provider Grievance and Appeal	1	The appeal process is manual and labor intensive. Automated tool for tracking appeals does not exist.
OPERATIONS MANAGEMENT		EHR Incentive Program management will require payment of Providers.
OM13 Prepare Provider Electronic Funds Transfer (EFT) Check	2	Process is highly automated, unless a manual check is required. (This original finding is related to claims payment, based on the "As-Is" process the incentive payments would follow a manual process.) EFT is supported, but paper checks continue to be generated for a number of Providers.
PROGRAM MANAGEMENT		EHR Incentive Program payments are taxable for Providers.
PG9 Manage State Funds	1	Routinely required reports must be produced manually.
PG10 Manage F-MAP	1	Compilation of CMS 64 and MARS reports is manual and not timely.
PG11 Manage 1099's	1	NPI has caused some difficulties with identification of Providers for 1099s.

Source: FOX Systems MITA Maturity Level Document (1-2009).

This baseline will be used for the visioning of the Nevada "To-Be" Landscape for EHR Incentive Program management.

3.4 Current Electronic Health Records in Use by State Providers

As part of the data collected for the Statewide Assessment, Providers were asked which EHR was in use or planned for adoption or implementation. Data was also received from the REC on EHR systems that

are being used by the Providers they are assisting. The data results can be viewed in Appendix D, attached hereto. As shown in the data results, Nevada Providers are using a wide variety of software and systems.

3.5   Current Broadband Initiatives

Please see the Statewide Assessment attached hereto as Appendix E for details of current broadband initiatives within Nevada. In general, broadband Internet access poses challenges to Nevada's rural health care providers. The "last mile" is an issue for the State. The Broadband Task Force has begun its work to complete the mapping and assessment of gaps. There are no specific Medicaid broadband initiatives beyond the statewide initiatives.

3.6   Coordination with Medicare and Federally Funded, State Based Programs

The State of Nevada has received federal funds for broadband initiatives, as well as a Health Resources and Services Administration (HRSA) grant to promote the use of HIT. Please see the Statewide Assessment attached hereto as Appendix E for a complete listing of the grants received in Nevada.

In addition, DHCFP intends to participate with CMS to pay Providers and intends to interface with the CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System (MEIPRAS) to coordinate Provider incentive payments with Medicare.

3.7   Coordination with the Statewide Health Information Exchange

DHHS is responsible for the planning for the Nevada HIT and HIE initiatives. OHIT and DHCFP share the responsibility for HIT and HIE initiatives. Specifically, OHIT is responsible for the Statewide HIE strategic and operational planning effort and the State HIT Coordinator position is within OHIT. DHCFP has responsibility for the SMHP and participates as a member of the Governor's Health Information Technology Blue Ribbon Task Force in the planning for the Statewide HIE.

3.8   Current Public Health Initiatives

The State of Nevada has four health authorities for the public health of the State's 17 counties. There is a State level authority for 14 counties, with county level authority for the Counties of Clark and Washoe, and municipal authority for Carson City residents.

The State of Nevada currently has multiple databases for collection and transmission of health data. The full list of health databases is found in the Statewide Assessment in Appendix E, attached hereto. The immunization registry is web based with Provider ability to view, access, and update immunization records. Although data sharing is occurring throughout the State, the registry does not yet transmit data electronically to the Centers for Disease Control and Prevention (CDC). The Nevada State Health Division (NSHD) is also planning to interface with the electronic vital records system to enable the auto-population of the immunization registry with relevant birth data. Additionally, NSHD is planning to

improve the communicable disease reporting by improving the sharing of laboratory data using a standardized format.

3.9 Federally Qualified Health Centers/Rural Health Clinics

The State of Nevada has received grant funds to support the development of HIT and HIE infrastructure through HRSA. Specifically, Nevada Health Centers (NVHC) received a $1.4 million grant through HRSA (and a grant through The Lincy Foundation) to support implementation of a full EHR system. A comprehensive EHR system has been operational in NVHC clinics since May 2009. Nevada Health Centers currently have implemented NextGen Ambulatory EHR, which has been certified by the ONC for their version 5.6 SP2. NVCH are not currently on this version, but plan to upgrade by the end of this year to the certified version to be eligible for the EHR Incentive Program.

3.10 Department of Defense and Veterans Affairs

The Nevada Office of Veterans Services serves over 339,000 veterans living in the State. There are two main service offices; one in Reno and one in Las Vegas, and the Nevada Veterans Home is located in Boulder City. The EHR system in use is the Veterans Health Information System and Technology Architecture (VistA). A recent congressional directive has required the United States Department of Veterans Affairs (VA) and the Department of Defense (DoD) to share records in order to provide for the seamless care of soldiers as they transition from active duty to the VA system. Currently, in Nevada this involves links between the VA's Computerized Patient Records System and VistA systems and the Air Force Composite Health Care System and Armed Forces Health Longitudinal Technology Application systems. For this exchange, the VA and the Air Force's Mike O'Callaghan Federal Hospital have a temporary direct connection. However, a permanent "business gateway" is being developed.

3.11 Indian Health Service

Most of the Indian Health Service (IHS) clinics operate the Resource and Patient Management System (RPMS). RPMS is the national IHS EHR that is undergoing enhancements to meet Meaningful Use. The Phoenix Area Indian Health Service (PAIHS) Office in Phoenix, Arizona, oversees the delivery of health care to approximately 140,000 Native American users in the tri-state area of Arizona, Nevada and Utah. There are three urban programs, Reno, Salt Lake City, and Phoenix, within the Area; and two Tribal organizations that the PAIHS works with closely, the Inter Tribal Council of Arizona and the Inter Tribal Council of Nevada (ITCN).

ITCN is a Tribal organization serving the member reservations and colonies in Nevada. The Governing Body of ITCN consists of an executive Board, composed of Tribal Chairman from each of these Tribes. The main intent of ITCN is to serve as a large political body for the small Nevada Tribes, playing a major role in promoting health, educational, social, economic and job opportunity Programs. ITCN now manages Federal and State funded programs aimed at improving the well-being of community members throughout the State of Nevada.

Great Basin Primary Care Association (GBPCA) is the primary care association that supports and advocates on the behalf of health centers, Tribal clinics and other health care safety net providers

throughout Nevada. As Nevada's federally designated primary care association, GBPCA promotes access to affordable, comprehensive and quality health care for Nevada's underserved populations and supports and advocates on behalf of the centers, Tribal clinics and other health care safety net providers throughout the State.

The Indian Health Board of Nevada (IHBN) works with Tribal leaders, Tribal Health Care Providers, local, state, and National leaders to raise the status of Nevada's Tribal Community through advocacy, training, education, and support. The mission of the IHBN is to raise the status and resiliency of Nevada's Tribal communities through training, education, advocacy and support. The IHBN works with resources to improving access to quality health care and provide health and well being to the Tribal communities.

3.12   Current Status of Nevada Privacy and Security Regulations

A review was performed to assess the current status of Nevada's Medicaid statutes, documents, and internal policies, as well as other State statutes that may impact HIE in comparison with federal privacy and security regulations. This assessment was an important undertaking as DHHS requires that States take measures to ensure the privacy and security of patient health information.

Documents reviewed as part of the assessment included: 1) the Nevada Health Information Technology Regulatory and Policy Inventory; and 2) the Nevada Medicaid Health Information Technology Regulatory Inventory. These documents contain a thorough inventory and assessment of any and all provisions from Nevada Revised Statutes, the Nevada Medicaid State Plan, and Nevada Medicaid Manuals that may impact the creation of EHRs and the development of a HIE.

The Nevada Medicaid Health Information Technology Regulatory Inventory catalogues all Medicaid specific provisions under State statutes, the Medicaid State Plan, the Medicaid Operations and Services, and the Nevada Checkup Manuals that may impact the creation of EHRs and implementation of a HIE. The Nevada Health Information Technology Regulatory and Policy Inventory looks at State statutes more broadly and catalogues any and all provisions under Nevada Revised Statutes that could have an impact on the development of EHRs and a HIE. As part of this assessment, the Nevada Medicaid Health Information Technology Regulatory Inventory was reviewed to ensure no relevant provisions were omitted. Additionally, all statutes contained in any analysis below were reviewed and an audit of a sample of the provision citations in the Nevada Health Information Technology Regulatory and Policy Inventory was performed.

None of the Nevada statutes or Medicaid specific documents (e.g. Medicaid State Plan or Manuals) contains gaps in comparison to federal privacy and security laws. However, many of the State Manuals and statutes contain language that may need to be modified to ensure elements pertaining to an EHR are valid. Additionally, several State statutes contain stricter provisions governing the privacy and security of certain types of health information. While not in conflict with federal law, these State laws may create operational and technical burdens that reduce the efficiency of the electronic exchange of health information. Finally, some of Nevada's HIPAA privacy policies will need to be updated to include changes made under HITECH or proposed modifications to the Privacy and Security Rules of HIPAA. Each of these is discussed below.

3.12.1 Provisions with Reference to "Signatures," "Signed," "Written," "In Writing," "Facsimile Machine," and Related Requirements

A number of provisions under the Medicaid Services Manual and State statutes contain provisions that require certain documents to be "written," "in writing," or make similar references to non-electronic methods for documentation such as "handwriting." Similarly, many provisions under the Medicaid Services Manual and State statutes require certain documents to be "signed," contain a "signature," require a "physician's signature," and the like. Finally, both the Medicaid Services Manual and some State statutes require or reference the use of facsimile machines. As Providers in Nevada begin developing and exchanging EHRs, these provisions will need to be addressed to ensure appropriate accountability for electronic methods and technology. Pages 4-43 of the Nevada Medicaid Health Information Technology Regulatory Inventory and pages 50-62 and 89-96 of the Nevada Health Information Technology Regulatory and Policy Inventory contain exact language and citations to provisions containing these words or phrases.

Senate Bill No. 43 attempts to address this issue under proposed Section 12(1)(a), which states:

> Except as otherwise prohibited by federal law: (a) if a statute or regulation requires that a health care record, prescription, medical directive or other health-related document be in writing, or that such a record, prescription, directive or document be signed, an electronic health record, an electronic signature or the transmittal of health information in accordance with the provisions of sections 2 to 12, inclusive, of this act, and the regulations adopted pursuant thereto shall be deemed to comply with the requirements of the statute or regulation.

As described above, many of the provisions using "written," "signed," and/or similar language come from the Nevada Medicaid Services Manual. As written, this section of Senate Bill No. 43 applies only to provisions found in "statute" or "regulation." The Medicaid Services Manual meets the definition of a "statute" or "regulation."

3.12.2 Stricter Confidentiality Provisions

There are several Nevada Revised Statutes that create more stringent provisions regarding the privacy and security of certain health information than required by HIPAA. They include the following:

1. NRS 62E.620(9) (pertaining to the confidentiality of any evaluation and/or treatment for juvenile drug and/or alcohol dependency);

2. NRS 432B.280 (pertaining to the confidentiality of reports and records made pursuant to a child abuse/neglect case);

3. NRS 433A.360 (pertaining to the confidentiality of clinic records created in a mental health facility and requires consent to release the records, expect under limited exceptions);

4. NRS 441A.220 and NRS 441A.230 (pertaining to the confidentiality of reports and investigations of communicable diseases; requires consent to release information unless an exception is met);

5. NRS 449.720(2) (pertaining to the confidentiality of "discussions of the care of a patient, consultation with other person concerning the patient, examinations or treatments, and all communications and records concerning the patient");

6. NRS 453.720 (pertaining to the confidentiality of information generated treatment for narcotics addiction);

7. NRS 458.280 (pertaining to the confidentiality of registration and other records for patients receiving alcohol and drug abuse treatment; requires consent to release information unless an exception is met);

8. NRS 629.151, NRS 629.161 and NRS 629.171 (pertaining to the confidentiality of genetic information; requires consent to release information unless an exception is met);

9. NRS 652.190 and NRS 652.193 (establishes limitations on who may receive a report of laboratory results); and

10. NRS 639.238 (establishing limitations on who may receive a copy of a prescription).

See pages 15-45 and page 60 of the Nevada Health Information Technology Regulatory and Policy Inventory for more detail.

None of the above referenced statutes are in conflict with federal law because HIPAA permits states to have more stringent laws governing the privacy and security of patient health information and specifically states the more stringent law must be applied. However, please note that stricter state laws regarding access to and disclosure of certain records (e.g. mental health, general medical records, etc.) create technological and operational burdens to the electronic exchange of these types of information because either the information will need to be excluded (e.g. "filtered" out) or informed consent may need to be obtained.

Senate Bill No. 43 appears to contain a provision that attempts to address this concern. Section 12(1)(b) of Senate Bill No. 43 states:

> Except as otherwise prohibited by federal law: (b) If a statute or regulation requires that a health care record or information contained in a health care record be kept confidential, maintaining or transmitting that information in an electronic health record or health information exchange system in accordance with the provisions of sections 2 to 12, inclusive, of this act and the regulations adopted pursuant thereto concerning the confidentiality of records shall be deemed to comply with the requirements of the statute or regulation.

At the time of this SMHP submission, Senate Bill No. 43 is in the legislative process and is undergoing revision and amendment. Therefore, the assessment of the effect of Senate Bill No. 43 will be completed at the conclusion of the legislative session.

3.12.3 State HIPAA Privacy and Security Manuals (Policies)

The DHCFP HIPAA Privacy and Security Manuals are complete, thorough, and provide good guidance to staff required to implement the procedures. Although policies are consistent with current regulations, there are several changes proposed under the *Modifications to the HIPAA Privacy, Security, and*

Enforcement Rule Under the Health Information Technology for Economic and Clinical Health Act, Proposed Rule which may affect implementation of this plan. When the final rule is issued, the following sections of the HIPAA Privacy Manual will be reviewed:

1. Section 200 – DHCFP may want to change Section 200 referencing HITECH Section 13405(B) and make any necessary changes related to "minimum necessary" when the final rule is issued.

2. Section 300 – Address anticipated changes to patients' rights when the final rule is issued.

    o   Section 301.1C (1) addresses a recipient's right to access, inspect, and obtain a copy of protected health information. Section 13405(C) of HITECH provides individuals with a right of access to any of their protected health information maintained in an electronic format. The Proposed Rules, if adopted, would require a covered entity to make electronic protected health information available to individuals who request it "in a readable electronic form and format as agreed to by the covered entity and the individual."

    o   Section 301.1C(4) will need to be amended by January 14, 2014 to address changes made to a patient's right to an accounting of disclosures under HITECH. Currently, covered entities need to provide an accounting for disclosures made for treatment, payment, and health care operations purposes. However, HITECH Section 13405(c) will require covered entities to account for disclosures, even for these types of purposes, if the information is maintained electronically as of January 14, 2014.

    o   Section 301.1C (6) addresses patients' rights to request restrictions on the use and disclosure of their protected health information. HIPAA does not require a covered entity to accept patients' requests to restrict their protected health information. However, Section 13405(a) of HITECH requires a covered entity to comply with a requested restriction if "(1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full." It is not clear whether this provision would apply to DHCFP or not. If so, these sections of the HIPAA Privacy Manual would need to be amended.

    o   Sections 330.3(D) address the requirements of the Notice of Privacy Practices. The Proposed Rule amends HIPAA's notice of privacy practices provisions (42 CFR Section 164.520) by requiring additional statements to be added to a covered entity's Notice of Privacy Practices.

3. Sections 400.2A (4) and 400.2C (4) address limited data sets. Section 13405(B) of HITECH states that compliance with 45 CFR 164.502(b)(1) is presumed if a use, access to, or disclosure of protected health information is limited to either the minimum necessary to accomplish the intended purpose, or is a limited data set. DHCFP may want to reference HITECH and make any necessary changes related to "minimum necessary" when final rulemaking is issued.

4. Section 700 and the associated Business Associate Addendum address "Business Associate" requirements under the HIPAA Privacy and Security Rules. HITECH contains a number of provisions that create new or additional requirements for individuals or entities meeting the definition of a business associate (see Sections 13401,

13402, 13404, 13405(b) (2), 13405(c) (3) (B), 13405(d), 13406(a) and 13408). Section 13408 under HITECH contains language expanding the definition of who may be considered a "business associate" (e.g. a Health Information Exchange Organization). Changes under HITECH apply only to business associates, not covered entities. It is not clear whether DHCFP would ever be a business associate or not. If so, its Privacy and Security policies would need to be amended to address these changes.

Upon final rulemaking, DHCFP will review provisions affecting Business Associates (see Proposed Rules at sections 45 CFR 164.502(a) (5), 45 CFR 164...502(e) (1) and 45 CFR 164.504(e) (1)-(5)) and make any necessary changes to the HIPAA Privacy Manual and Business Associate Agreement.

DHCFP is considering cross referencing HIPAA Privacy Manual Section 900.3 (HIPAA Breach Procedures) with HIPAA Security Manual Section 107. "Breach" is defined under HITECH and "security incident" is defined under the HIPAA Security Rules. Although different, a specific incident may trigger both definitions and thus both processes.

DHCFP does not have any policies addressing the use and/or disclosure of protected health information for marketing and/or fundraising purposes. The HIPAA Privacy Rule addresses these requirements at 45 CFR 164.514(e)-(f). HITECH amends these provisions at Section 13406(a) and (b). The Proposed Rules also address potential changes at 45 CFR 164.508(a) (4) and 45 CFR 164.514(f). Although unlikely, if DHCFP considers marketing or fundraising using protected health information, DHCFP will develop applicable policies to safeguard that information.

DHCFP is considering creating a policy that addresses the requirements under Section 13405(d) of HITECH, entitled "Prohibition on Sale of Electronic Health Records or Protected Health Information." In general, these provisions prohibit a covered entity or Business Associate from directly or indirectly receiving remuneration in exchange for any protected health information unless an authorization is obtained or if one or the exceptions listed are met.

DHCFP does not anticipate any changes to the HIPAA Security Manual.

3.13   Conclusion

According to the findings of the Statewide Assessment, the current capability and readiness for EHRs within the Nevada health care system is fragmented. Although the Statewide Assessment did not provide a specific set of data points for the Provider community, it is likely that the Providers reflect the greater Nevada community. Therefore, the findings and conclusions of the Statewide Assessment are applicable to the current Nevada Provider community.

Nevada has enacted privacy and security statutes that are more stringent than HIPAA and has also created privacy policies and procedures. However, DHCFP has not updated its privacy and security policies to conform to the new HITECH act requirements. DHCFP has identified a series of specific recommendations and will update its privacy policies.

4   Future HIT Landscape – The "To-Be" Environment

This section aligns the current HIT landscape ("As-Is") with the vision of DHCFP for adoption, promotion, and enhancement of certified EHR technology for Medicaid Providers, and for promotion of electronic health exchange for the Medicaid agency. This section also describes the goals, objectives, and additional functionalities that are planned to promote HIT interoperability providing the greatest benefit from both clinical and administrative MMIS data. Goals of interoperability include participation in the exchange of data with the Statewide HIE and NSHD, as well as other state HIEs, state Medicaid agencies, public health agencies, and federal agencies.

4.1   Future Vision for Providers

DHCFP, the Statewide HIE, and the REC will continue to coordinate activities and communication to provide outreach, training, and education to the Provider community to enhance certified EHR adoption rates and understanding, including compliance with Meaningful Use criteria. The Statewide HIE, the REC and DHCFP are working in collaboration to create a unified message and to provide ongoing outreach and education for Providers centered on the adoption of certified EHR technology and Meaningful Use.

4.2   Future Medicaid Management Information System Capabilities

DHCFP has formally requested funding from the State of Nevada Legislature for a completely new MMIS system. This new MMIS request is based upon a five-year implementation and integration process, and is important in the migration from the current MITA Level 1 of DHCFP to MITA Level 2 and beyond.

4.3   Involvement in State Health Information Technology Environment

It is DHCFP's intent to further the adoption of certified EHR technologies and facilitate Meaningful Use for Providers within Nevada. DHCFP will coordinate with the Statewide HIE and the REC in this process.

DHCFP is focused on collaboration and participation with Statewide HIE and HIT initiatives including pursuing full integration (clinical and administration transaction support) with the Statewide HIE initiative, integration and collaboration with the NSHD, and is considering utilization of the Statewide HIE's Nationwide Health Information Network (NHIN) CONNECT-compliant NHIN Gateway as a standards-based connectivity methodology for connectivity with HIE and HIT initiatives outside Nevada.

Due to the large amount of tourism and visitors to Nevada, DHCFP sees value for selection and utilization of a standards-based connectivity methodology, such as the Statewide HIE's NHIN Gateway, to provide inter and intra State connectivity and interoperability. The Statewide HIE's NHIN Gateway provides a platform for connectivity, through the Statewide HIE, to other State agencies, other HIE

initiatives in Nevada, and connectivity to other state HIEs and agencies (outside Nevada), including Arizona, Utah, and California.

DHCFP is constructing a data warehouse with advanced analytics/components for modeling and targeting at-risk populations. By utilizing a standards-based connectivity methodology, such as the Statewide HIE's NHIN Gateway as a NHIN-based connectivity model for both clinical and administrative transactions, DHCFP can have a more real-time access to data and improved timelines for decision-making and analytics. As Providers select certified EHR technology and move towards Meaningful Use, clinical data becomes available in a real-time (or near real-time) manner. The current process of claim-based analytics and decision-making and the lag that occurs with these claim-based processes can be improved significantly with real-time or near real-time clinical and administrative queries to other State agencies, the Statewide HIE, and other state HIEs and agencies. By utilizing certified EHR technology and driving towards Meaningful Use, Providers can present the Statewide HIE, DHCFP, and NSHD with clinical and administrative data in a standardized, electronic format that can be rapidly processed and utilized for analytics. Thus, DHCFP stands to improve the abilities to coordinate care, target at-risk populations, reduce procedures and redundancies, and eliminate costs by utilizing standards-based connectivity methodologies, such as the Statewide HIE's NHIN-based connectivity, for interoperability and the migration of Providers from paper-based records to certified EHR technology.

4.4   Future Alignment with Medicaid Information Technology Architecture

DHCFP is currently in the process of procuring a new MMIS system with increased functionality and services. A key component of this procurement is to acquire a Medicaid Enterprise solution for Nevada that includes MITA Level 3 standards, such as Service Oriented Architecture (SOA) using an enterprise service bus infrastructure.

DHCFP is also in the process of implementing a data warehouse, which will be fully MITA aligned, as well as point of sales and rebate systems, which are also fully MITA aligned. Additionally, the toolsets DHCFP vendors are using for the health care management system (prior-authorization, portals, etc) are fully MITA aligned. However, the current MMIS is not able to support future or further MITA levels, and the State plans to move forward with procuring a new MMIS system and infrastructure and moving to MITA Levels 2 and beyond via this new MMIS system and infrastructure.

4.5   Future Broadband Initiatives

The Broadband Task Force has begun the mapping and assessment of gaps for connectivity in the State, as a first step toward addressing challenges of broadband Internet access for Nevada's rural health care providers, including the key issue of last mile connectivity.

The State Library and Archives received funding for public computing centers, which will also allow access for personal health records (PHRs) by consumers. The Federal Communications Commission and the United States Department of Agriculture (USDA) are both working on funding programs for rural health and Providers, thus the REC, Statewide HIE, and DHCFP are coordinating activities and looking at different ways to take advantage of these opportunities for last mile broadband for Providers. The REC,

Statewide HIE, and DHCFP are working collaboratively on coordinating with the National Broadband Resource on ways to bring last mile connectivity broadband to Nevada with an emphasis on rural health. Continuing to coordinate resources and investigate funding opportunities for Providers for last mile broadband connectivity are major initiatives that will be continued in the State.

4.6 Future Vision for Medicare and Federally-Funded, State-Based Programs

4.6.1 Medicare

CMS and other federal agencies are leading the migration to a SOA-based, MITA-compliant architecture and infrastructure, including the utilization and support of NHIN. Therefore, DHCFP will coordinate with the Statewide HIE's CONNECT-compliant NHIN Gateway for interoperable clinical and administrative transaction support with federal agencies (in addition to the State and local HIE and HIT initiatives mentioned above), including Medicare.

4.6.2 Coordination with Centers for Disease Control and Prevention

Collaboration and integration of NSHD are critical components to the roadmap for DHCFP. As Providers adopt certified EHR technology, it is vital that Providers are able to report public health incidents locally and then directly to the CDC utilizing connectivity methodologies such as NHIN. Due to the cooperative relationship between DHCFP and NSHD, DHCFP will investigate the integration of public health information into and with DHCFP systems and services, allowing for interoperable reporting and data exchange between the Statewide HIE, DHCFP, and NSHD (and, ultimately, to the CDC).

4.6.3 CMS Coordination

Quality reporting to CMS will be accomplished via the Statewide HIE (and could utilize the Statewide HIE's NHIN Gateway) and through Provider-based certified EHR technology. DHCFP will continue to coordinate with the REC, the Statewide HIE, and Providers to communicate, educate, and drive the adoption of certified EHR technology to meet Meaningful Use.

4.6.4 Health Resources and Services Administration Coordination

Nevada has received grant funds to support the development of HIT and HIE infrastructure through HRSA. NVHC received a $1.4 million grant through HRSA (and a grant through The Lincy Foundation) to support implementation of a full EHR system. A comprehensive EHR system has been operational in NVHC clinics since May 2009.

NVHC is planning to participate in the Statewide HIE, and as such, will be capable of providing both clinical and administrative data and transactions to the HIE and to DHCFP, via the Statewide HIE's NHIN Gateway and interface/coordination to and with the Statewide HIE. Additionally, DHCFP will continue to coordinate with the Statewide HIE and the REC to communicate and educate Providers, including NVHC, and coordinate resources to ensure NVHC is driving towards Meaningful Use.

Additionally, HRSA has recognized several IHS facilities as federally qualified health center (FQHC) look-alikes, to provide HRSA certified FQHC services for certain areas in Nevada. DHCFP will continue to support and communicate with these and all FQHCs to ensure the adoption of certified EHR technology and compliancy with the Meaningful Use criteria.

4.7   Future Vision for the Statewide Health Information Exchange

The State of Nevada's vision is that all of the State entities will connect to the State backbone/infrastructure to participate and collaboratively share clinical and administrative data in a standards-based format. Nevada stakeholders have been and will continue to be informed and educated about the statewide vision for Nevada, as well as their roles (i.e. correctional facilities, public health).

DHCFP is a member of the Governor's Health Information Technology Blue Ribbon Task Force, and a mandatory member of the Statewide HIE governance model. The Statewide HIE governance model has been proposed to the Nevada Legislature, and is under review.

The vision for the Statewide HIE is to continue to coordinate and work to have an interoperable HIE with integrated pieces, vendors, Providers, and participants in a statewide approach. DHCFP, the Statewide HIE, and the REC are in close coordination and full cooperation, and are working to address issues, communicate with Providers and stakeholders, and ensure information flows freely.

DHCFP is investigating the ability to interoperate with, the Statewide HIE via the Statewide HIE's CONNECT-compliant NHIN Gateway, offering clinical and administrative transactions. DHCFP continues to support and assist with education and communication to Providers about the Meaningful Use criteria as well as Provider adoption of certified EHR technology with the focus on Meaningful Use.

4.8   Future Vision for the Public Health Initiatives

DHCFP has a strong relationship with NSHD, which is the State's public health agency, and will continue to work closely with NSHD. DHCFP will work with the Statewide HIE to ensure Providers, when using certified EHR technology, can report quality metrics as well as access state level services and registries offered and/or run by NSHD. DHCFP, by connecting to the Statewide HIE and using standards-based tools such as the Statewide HIE's NHIN Gateway, will investigate integrating NSHD into any future DHCFP connectivity, potentially allowing NSHD to utilize any DHCFP standards-based tools for connectivity to the Statewide HIE. DHCFP will continue to coordinate access to NSHD services and systems for Providers and Statewide HIE members in Nevada.

4.9   Future Vision for Federally Qualified Health Centers/Rural Health Clinics

All FQHCs have expressed strong interest in participating in the Statewide HIE, including Health Access Washoe County and the NVHC, as well as the HRSA certified FQHCs. DHCFP will coordinate activities with the Statewide HIE and the REC to work towards full participation of all FQHCs in the Statewide HIE, as well as adoption and Meaningful Use of certified EHR technology by all FQHCs.

A Physician Assistant (PA) qualifies as an EP for the Medicaid EHR Incentive Program only when practicing at an FQHC/RHC that is so led by a PA. These conditions on PA eligibility apply whether the PA is qualifying because they meet Medicaid patient volume requirements or if they are qualifying because they practice predominantly in an FQHC/RHC. According to NRS 630.015, the State of Nevada defines a PA as a person who is a graduate of an academic program approved by the Board or who, by general education, practical training and experience determined to be satisfactory by the Board, is qualified to perform medical services under the supervision of a supervising physician and who has been issued a license by the Board.

The CMS Final Rule provided the authority to interpret what it means for a PA to lead an FQHC/RHC, and the State will follow that guidance and agree that a PA would be leading an FQHC/RHC under any of the following circumstances: 1) When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider); 2) When a PA is a clinical or medical director at a clinical site of practice; or 3) When a PA is an owner of an RHC. The State agrees that FQHCs and RHCs that have PAs in these leadership roles can be considered "PA-led." Furthermore, since RHCs can be practitioner owned (FQHCs cannot), the State will allow ownership to be considered "PA-led." Based on this guidance, the State will work closely with the FQHCs and RHCs to ensure that this population is represented in the Medicaid EHR Incentive Program.

4.10   Future Vision for Department of Defense and Veterans Affairs

As stated in the "As-Is," the Nevada Office of Veterans Services serves over 339,000 veterans living in the State. There are two main service offices; one in Reno and one in Las Vegas, and the Nevada Veterans Home is located in Boulder City. The EHR system in use is the VistA.

DHCFP will utilize the Statewide HIE's CONNECT-compliant NHIN Gateway to facilitate any connectivity to the DoD and the VA, including participating in the expansion of the Virtual Lifetime Electronic Record initiative. By utilizing NHIN via the Statewide HIE, DHCFP could exchange continuity of care document (CCD) clinical data summaries, as well as administrative transactions, between the Statewide HIE, the DoD, and the VA, enhancing care and decreasing costs for active duty personnel and veterans alike.

4.11   Future Vision for Indian Health Service

Nevada has several Tribal health care centers that are certified as FQHC look-alikes, and offer FQHC services, which has been allowed and certified by HRSA. Most, if not all, of the Indian Health Service in Nevada have expressed interest in participating in the Statewide HIE. Indian Health Service is implementing the RPMS EHR, and wants to interoperate with the Statewide HIE and DHCFP. By having interoperable data exchange with Indian Health Service/Tribal health care centers, both the Statewide HIE and DHCFP will benefit by real-time or near real-time reporting (including quality measures and public health), targeted analytics, care coordination, and elimination of duplicate efforts/tests/procedures.

In Nevada, Tribal clinics are reimbursed for Medicaid services as an IHS facility. Based on guidance from CMS, if Tribal clinics elect to be reimbursed as an IHS facility (or any method other than the State's FQHC reimbursement rate), they will still be considered as FQHCs for the Medicaid EHR Incentive

Program. Therefore PAs working at Tribal clinics   will be eligible for the Medicaid EHR Incentive Program as well as other practitioners at a Tribal clinic

5   HIT Roadmap

Figure 1: HIT Roadmap
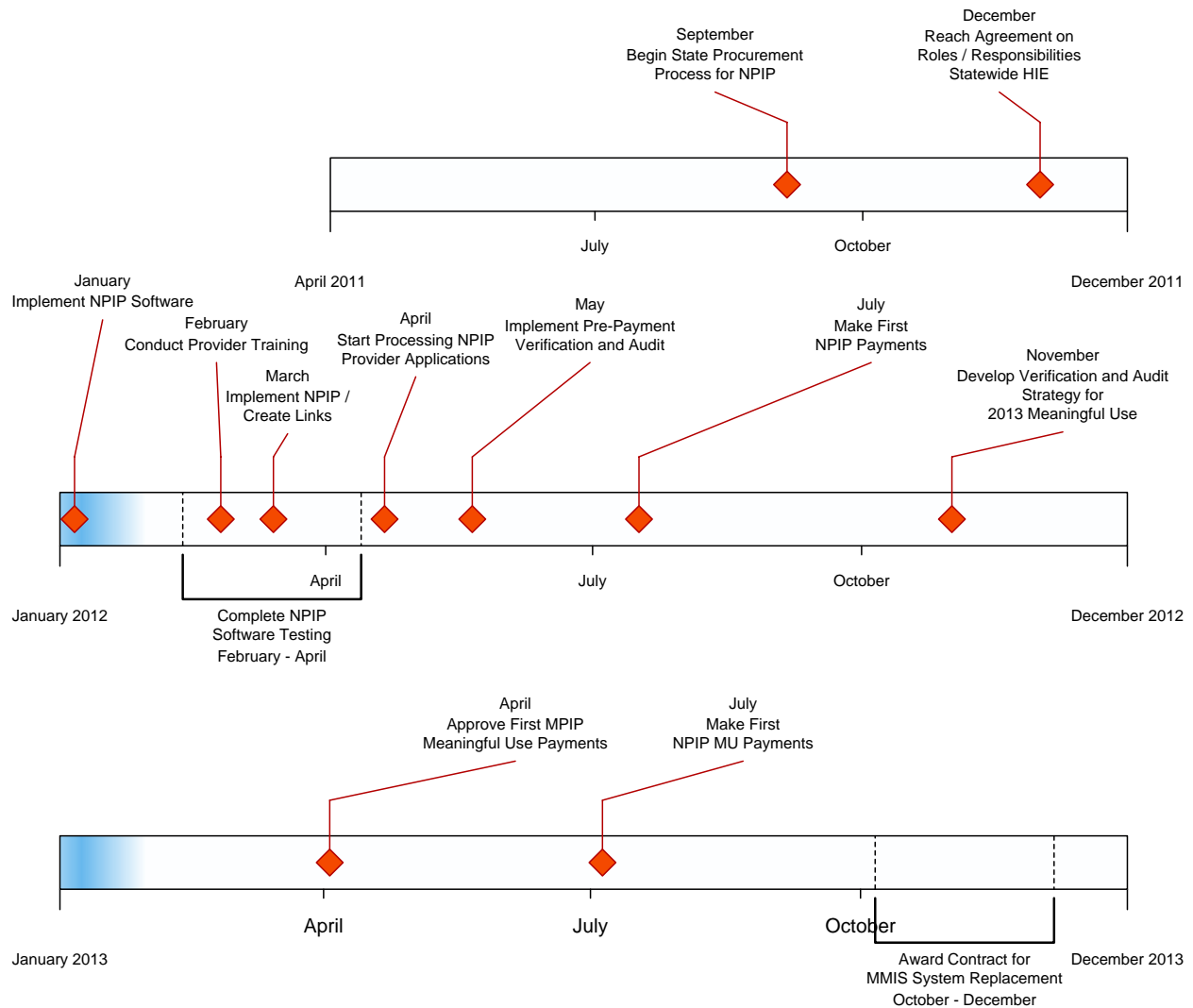
5.1   Major Activities and Milestones Moving from "As-Is" to "To-Be"

The following table shows the major activities and milestones to move DHCFP from "As-Is" to "To-Be" status. The following table illustrates the HIT Roadmap and Activities, including milestones for DHCFP. <u>Some activities occur every quarter and are shown in the activity list, but only appear as milestones in their first occurrence.</u>

Table 2: HIT Roadmap and Activities

Date	Activity (◆ = Milestone)
2011 – 2nd Quarter April/May/June	• Define roles for Medicaid Business Units in the NPIP. • Finalize program requirements for the NPIP. • Complete and submit the SMHP and IAPD documents to CMS. • Continue coordinated outreach efforts with the REC and Statewide HIE.
2011 – 3rd Quarter July/August/September	• Begin development of MMIS system replacement Request for Proposal (RFP). ◆ Begin State procurement process for software application to be used for the NPIP eligibility system. • Complete training sessions for DHCFP. • Continue coordinated outreach efforts with the REC and Statewide HIE.
2011 – 4th Quarter October/November/December	• Review CMS requirements for Meaningful Use. • Continue coordinated outreach efforts with the REC and Statewide HIE. ◆ Reach an agreement on roles and responsibilities with Statewide HIE.
2012 – 1st Quarter January/February/March	• Hire and train additional staff to be used for the NPIP. • Notify all Medicaid Providers of NPIP program changes and effective dates. • Review and revise State policy manual. ◆ Implement vendor software for the NPIP eligibility system. ◆ Complete testing of software application to be used in the NPIP. ◆ Implement NPIP software application and create links from other Medicaid websites. ◆ Conduct training sessions for Providers. • Data warehouse – plan for integration with MMIS and Statewide HIE. • Finalize an agreement on roles and responsibilities with Statewide HIE. • Continue coordinated outreach efforts with the REC and Statewide HIE.
2012 – 2nd Quarter April/May/June	• Publish NPIP manual and user guide. • Review and revise the Verification and Audit Strategy. ◆ Start accepting/approving NPIP applications for Providers (Year 1/Group 1). ◆ Implement pre-payment verifications and audits. • Conduct pre-payment verifications and post-payment audits. • Continue coordinated outreach efforts with REC in addition to Statewide HIE. • Develop requirements of the RFP for the interface to the Statewide HIE.
2012 – 3rd Quarter July/August/September	◆ Make NPIP payments (Year 1/Group 1). • Approve NPIP applications for payment (Year 1/Group 2). • Conduct pre-payment verifications and post-payment audits. • Review and revise audit selection criteria and Verification and Audit Strategy. • Continue coordinated outreach efforts with REC in addition to Statewide HIE. • Release RFP for development of the interface to the Statewide HIE.
2012 – 4th Quarter October/November/December	• Make NPIP payments (Year 1/Group 2). • Approve NPIP applications for payment (Year 1/Group 3). • Conduct pre-payment verifications and post-payment audits. • Review CMS requirements for 2013 program changes. • Develop requirements for any changes to the NPIP software application. • Review and modify the NPIP manual and user guide as needed. • Notify all Medicaid Providers of changes and effective dates. ◆ Develop Verification and Audit Strategy for year 2013 Meaningful Use and other program requirements. • Continue coordinated outreach efforts with REC in addition to Statewide HIE. • Complete development and testing of the interface to the Statewide HIE. • Implement interfaces with the Statewide HIE.

Date	Activity (◆ = Milestone)
2013 – 1st Quarter January/February/March	• Make NPIP payments (Year 1/Group 3). • Approve NPIP applications for payment (Year 1/Group 4). • Conduct pre-payment verifications and post-payment audits. • Review and revise State policy manual. • Finalize Verification and Audit Strategy for year 2013 Meaningful Use and other program requirements. • Update training materials on Year 2 requirements and post to the Medicaid websites. • Conduct training sessions for Providers. • Continue coordinated outreach efforts with REC in addition to Statewide HIE.
2013 – 2nd Quarter April/May/June	• Make NPIP payments (Year 1/Group 4). ◆ Approve NPIP applications for payment (Year 2/Group 1). First Meaningful Use group. • Conduct pre-payment verifications and post-payment audits. • Continue coordinated outreach efforts with REC in addition to Statewide HIE.
2013 – 3rd Quarter July/August/September	◆ Make NPIP payments (Year 2/Group 1). First Meaningful Use group. • Approve NPIP applications for payment (Year 2/Group 2). • Conduct pre-payment verifications and post-payment audits. • Continue coordinated outreach efforts with REC in addition to Statewide HIE.
2013 – 4th Quarter October/November/December	• Make NPIP payments (Year 2/Group 2). • Approve applications for payment (Year 2/Group 3). • Conduct pre-payment verifications and post-payment audits. • Review and revise audit selection criteria and Verification and Audit Strategy. • Continue coordinated outreach efforts with REC in addition to Statewide HIE. ◆ Award RFP contract for MMIS system replacement/negotiate contract.

5.2   Provider Adoption of Certified EHR Technology

The table below shows DHCFP goals for Provider adoption and Meaningful Use of certified EHR technology in Nevada:

Table 3: Goals for Provider Adoption and Meaningful Use of Certified EHR Technology

	2012	2013		2014		2015	
	Adopt Certified EHR	Adopt Certified EHR	MU of EHR	Adopt Certified EHR	MU of EHR	Adopt Certified EHR	MU of EHR
Hospitals	10	15	9	0	22	0	25
Physicians	177	104	175	81	278	61	358
Dentists	23	14	23	11	36	8	47
Nurse Practitioners	10	6	10	5	16	4	21
Certified Nurse Midwives	0	0	0	0	0	0	0
FQHC / RHC PA	1	1	1	1	2	0	2

5.3   Assumptions and Dependencies

The following assumptions and dependencies may affect the SMHP as described in this document:

Assumptions: This plan assumes that:

1. The MEIPRAS will be ready for test and implementation according to the current schedule as presented by CMS;

2. The Statewide HIE connectivity and interoperability, if selected as a primary connectivity methodology, will be available for integration and testing per the schedule listed in Table 2 – HIT Roadmap and Activities above;

3. Certification and implementation of certified EHR technology will be timely in keeping with the NPIP schedule; and

4. The NPIP Vendor Solution will be delivered on time and integrated in a timely manner.

Dependencies:

1. Testing of the NPIP Vendor Solution is dependent on the availability and functionality of the MEIPRAS being as described by CMS;

2. The Incentive Payments activities as listed in Table 2 – HIT Roadmap and Activities above are dependent on the availability and functionality of the MEIPRAS being as described by CMS; and

3. The incentive payments activities as listed in Table 2 – HIT Roadmap and Activities above are dependent on the capacity of the certified EHR vendors to meet the demands of the Provider marketplace for their product.

5.4   Participation in the State Health Information Exchange

DHCFP is working in full collaboration with the Statewide HIE and HealthInsight, the REC for Nevada and Utah, and fully plans to continue coordination of education, outreach, and training for the adoption of certified EHR technology in Nevada. The chief executive officer (CEO) of HealthInsight was a member of the HIT Task Force and serves as its Vice Chairman, providing regular updates regarding REC activities. HealthInsight staff served on Task Force Subcommittees and as subject matter experts to the Task Force, the State HIT Coordinator and Nevada Medicaid, implementing and leveraging HIE. HealthInsight plans to work with 1,500 primary care providers in Nevada and Utah by the end of 2011, and another 1,000 in 2012 to 2013. In addition to the HIT Task Force, HealthInsight is working closely with DHCFP and OHIT. The three entities have regularly scheduled meetings to ensure coordination of HIT/HIE efforts, and expect their collaboration to be an ongoing effort. HealthInsight is also coordinating and collaborating with many other HIT and HIE stakeholders in the State to assess and monitor statewide progress of EHR adoption, and its impact on providers and patients. The feedback shared with DHCFP and OHIT is valuable to their joint efforts.

DHCFP expects this collaboration and the NPIP will advance the growth of and adoption of certified EHR technology in the state.

DHCFP will coordinate with the Statewide HIE on utilizing the HIE's standards-based connectivity methodology for connectivity to other state HIEs, neighboring state HIEs and state agencies, etc. The Statewide HIE is currently evaluating a CONNECT-compliant NHIN Gateway to allow for bi-directional clinical and administrative transactions from the Statewide HIE to other states, other HIEs, etc. DHCFP will continue to collaborate with the Statewide HIE and the REC for the selection of the HIE's connectivity methodology as well as coordination of Provider communication, outreach, training, and adoption of certified EHR technology. It should also be noted that the replacement MMIS to be implemented by DHCFP includes direct connectivity to and with the Statewide HIE, including the full support of clinical and administrative transactions with and to the Statewide HIE.

5.5   Participation in the Nationwide Health Information Network

5.5.1   Alignment with MITA Mission, Goals, and Objectives

CMS expects Nevada's SMHP to be fully aligned with MITA's mission, goals, and objectives that support the Medicaid mission and goals. MITA and Medicaid's mission and goals are also aligned with federal standards including the Federal Health Architecture and the NHIN initiative. CMS expects that states will bring their business/technical capabilities in line with MITA Maturity Levels 3, 4, and 5, at which time states will agree on common data standards, jointly developed business services, and adopt NHIN standards for interoperability and data.

- MITA Maturity Level 3 [Clinical Data]: Data standards are adopted nationally. Shared repositories of data improve efficiency of access and accuracy of data used, resulting in better business process results.

- MITA Maturity Level 4 [Clinical Data]: Access to standardized clinical data through regional data exchange enhances the decision-making process. With clinical evidence, decisions can be immediate, consistent, and decisive.

- MITA Maturity Level 5 [National Interoperability/NHIN]: Data exchange on a national scale optimizes the decision-making capabilities of the state agency.

DHCFP is focused on achieving MITA Maturity Levels 3, 4, and 5 by the utilization of standards based technologies and systems, including NHIN via the Statewide HIE (and Statewide HIE NHIN Gateway) and the Federal Health Architecture (FHA).

5.5.2   Nationwide Health Information Network

NHIN comprises the conventions, standards, and shared infrastructure necessary to facilitate the secure and interoperable exchange of electronic health information, including both clinical and administrative transactions, between authorized organizations. Considerable infrastructure and standards have been defined at the national level to provide robust security, patient discovery, authentication and authorization, and auditing support. NHIN is a critical part of the national health IT agenda and FHA, including the focus on improving population health by making it possible for health information to follow the consumer, improving clinical decision making, and supporting the appropriate use of health care information beyond direct patient care.

The ONC, along with federal agencies, state agencies, and HIEs, is facilitating and encouraging the growth and connectivity to NHIN, including both NHIN Exchange and the NHIN Direct Project. As such, compliance with NHIN/FHA is an important element of the HIT Roadmap.

NHIN can facilitate the exchange of clinical and administrative data between providers, payers, patients, and other health care professionals. A list of common NHIN use cases is provided below:

- Provider to Provider: Providing the ability to locate Providers, send referrals, exchange patient medical history, and send messages for the administrative coordination of care.

- Provider to Patient: Providing the ability to send patient reminders, send patient medical history to a PHR, and to provide patient medical summaries to patients.

- Laboratory to Provider: Providing the ability to send lab results to Providers and submit reportable lab results to public health.

- Provider to Federal Agencies: Providing the ability to send quality reports, surveillance reports, and more to federal agencies.

- Provider to Pharmacy: Providing the ability to send electronic prescriptions for medications and implement drug-drug, drug-allergy, and drug-formulary checks.

- Provider to Payer: Providing the ability to check eligibility, submit claims, receive prior authorization, and submit patient information.

The NHIN initiatives include NHIN exchange, NHIN Direct, and CONNECT. NHIN Exchange and NHIN Direct are separate sets of standards and protocols used for information exchange, while CONNECT is a set of software designed to facilitate information exchange with the NHIN Exchange and NHIN Direct specifications. NHIN Exchange is meant to facilitate inter-HIE data exchange, while NHIN Direct is meant to facilitate Intra-HIE data exchange. NHIN Exchange is used for states or large Provider organizations to connect with the federal government and to communicate among HIEs.

NHIN Direct is used for Provider-to-Provider messaging and communication among smaller health care organizations. CONNECT is a federally funded, Open Source software solution for NHIN that allows for the secure and private exchange of health information. The CONNECT software, referred to as a CONNECT NHIN Gateway, is the "on ramp" to the NHIN network. However, the CONNECT software is not the only viable pathway to the NHIN network.

5.5.3   NHIN Gateways

In order to connect to the NHIN, organizations can utilize an "NHIN Gateway." A NHIN Gateway is a set of interfaces, adapters, and subsystems that facilitates connection to, and exchange with, the NHIN network. Existing NHIN Gateways can be grouped into two basic categories:

1. CONNECT-compliant gateways; and
2. Proprietary NHIN gateways.

DHCFP will utilize the Statewide HIE's NHIN Gateway for connectivity to other trading partners (states, state agencies, HIEs), to ensure coordination with the federal NHIN initiative and a standards-based

connectivity model among the Providers, stakeholders, HIEs, other state Medicaid agencies, and other networks associated with DHCFP.

5.5.4   Coordination with NHIN

The future vision for coordination with NHIN includes the utilization of the Statewide HIE's NHIN Gateway by and for DHCFP. The Statewide HIE's NHIN Gateway may be used for connection to federal agencies, including CMS; other HIE initiatives, including other state HIE initiatives; and other networks, including neighboring state Medicaid agencies and state agencies (State Departments of Health). Utilization of the Statewide HIE's NHIN Gateway will ensure DHCFP's ability to accomplish Medicaid-specific use cases (utilizing NHIN and FHA standards). DHCFP will continue the coordination of efforts with federal agencies, such as CMS, SSA, CDC, VA, and DoD.

5.5.5   Connectivity

DHCFP's vision includes the full integration of the MMIS for bi-directional exchange of clinical and administrative data with the Statewide HIE, as well as the utilization of the Statewide HIE's CONNECT NHIN Gateway in order to allow for a standards-based connectivity methodology between DHCFP / the Statewide HIE and neighboring HIEs, state agencies/departments, and federal agencies.

Specific organizations and use cases for DHCFP are listed below:

- The Statewide HIE and provider/other affiliated organizations within the HIE, including locations receiving Medicaid reimbursement;

- Other Nevada State agencies and stakeholders, such as the Nevada Public Health Laboratories/Reference Labs;

- Neighboring HIEs such as the Arizona Statewide HIE and the California Statewide HIE;

- Neighboring state agencies such as state Medicaid agencies, State Departments of Health; and

- Federal agencies such as CMS and SSA.

The use case under consideration for DHCFP, and of the Statewide HIE's NHIN Gateway, is in full alignment with the published NHIN use case of "Provider to Payer" connectivity. The Provider to Payer connectivity use case allows for near-instant eligibility verification, claim submission, prior authorization, and the exchange of patient information from Providers in regional and/or state HIEs. These capabilities give DHCFP the ability to increase the speed and efficiency of the Medicaid claims process while decreasing Medicaid fraud and abuse. Other use cases include the emerging use cases of Medicaid to public health connectivity, Medicaid to HIE clinical data exchange, Medicaid to laboratory connectivity, Medicaid to other state Medicaid agencies, Medicaid to federal agencies, and so on.

The benefits of utilizing the Statewide HIE's NHIN Gateway are:

- The ability to interact with the aforementioned trading partners (states, federal agencies, HIEs);

- The ability to leverage a standards-based platform (NHIN Exchange with an NHIN CONNECT compliant Gateway) for communication and interoperability;

- The ability to utilize NHIN for both clinical and administrative transactions with multiple trading partners; and

- A decrease in dependence on other entities to provide connectivity and interoperability with health care partners.

DHCFP will continue to seek updates and education around NHIN Direct and the impact of Provider adoption of this messaging standard.

5.5.6 Integrating the Healthcare Enterprise Statement and Standards Integration to Drive Medicaid Information Technology Architecture Compliancy

Integrating the Healthcare Enterprise (IHE) was formed by the Healthcare Information and Management Systems Society and the Radiological Society of North America. IHE is an initiative by health care professionals to improve the way health care information is shared between systems and organizations around the world for the purpose of improving the overall quality of health care to patients. The mission of IHE is to achieve interoperability of systems through the precise definition of health care tasks, the specification of standards-based communication between systems required to support those tasks, and the testing of systems to determine that they conform to the specifications. IHE promotes the coordinated use of established standards such as DICOM and HL7 to address specific clinical need in support of optimal patient care.

IHE has developed a set of profiles specifying a clear implementation path, including, but not limited to: IT infrastructure, Cardiology, Anatomic Pathology, Eye Care, Laboratory, Patient Care Coordination, Radiology, and Patient Care Devices. NHIN core services are developed based on IHE profiles, especially IT Infrastructure.

EHR systems supporting IHE profiles generally work together better, are easier to implement, and help Providers utilize information more efficiently. According to IHE.net, an IHE profile is a technical definition or standard that provides "a common language for purchasers and vendors to discuss the integration needs of healthcare sites and the integration capabilities of healthcare IT products." To ensure that EHR systems comply with IHE requirements, the IHE hosts "connectathons" to permit vendors to showcase their systems and technology.

Many EHR vendors and HIE vendors and suppliers worldwide, including foreign nations, are participating in the IHE workgroups and adopting IHE standards. As participation and adoption of IHE standards and profiles grow, so does the ability for disparate systems and infrastructures to interface, integrate, and communicate data freely.

The State of Nevada's Roadmap includes the IHE standards, as well as the NHIN (Exchange, Direct, and CONNECT) standards, and other standards-based technologies, certifications and connectivity methodologies. By considering implementation of such national and international standards, DHCFP can build a highly interoperable, standards-based infrastructure that complies with MITA and other standards.

5.5.7 Meaningful Use Provisions with Exchange Components

The table below enumerates each of the Meaningful Use provisions described in the Final Rule.

Table 4: Meaningful Use Provisions

Criteria	NHIN or Local	Relevant Standards	Comments
Core Provision			
CPOE	Local	TBD	Lower priority than other exchanges; phase 1 requirement is only for entering order into system, not to transmit them.
Adverse event clinical decision support (drug-drug/drug-allergy check).	Local	TBD	
E-prescribing	NHIN	NCPDP; HL7	
Record demographics.	Local		
Current diagnoses.	NHIN	HITSP C32	Access to clinical summaries is part of NHIN.
Maintain active medications/allergies.	Local		
Record and chart changes.	Local		
Record smoking status.	Local		
Implement one CDS rule.	Local		
Submit quality reports.	NHIN	QRDA	Base on PQRI work done to date; assume push of data for time being, no query/retrieve support required.
Provide patients a copy of their electronic health information.	NHIN or Local	Structured: HITSP C32 et.al. Unstructured: HITSP C62	Use NHIN if patient uses PHR service Provider to maintain data; messaging-based standards may apply for some exchanges.
Summary of care for each transition of care and referral (discharge summaries).	NHIN	HITSP C32 et.al.	Already supported by NHIN.

Criteria	NHIN or Local	Relevant Standards	Comments
Capability to exchange key clinical information (coordination).	NHIN	Structured: HITSP C32 et.al. Unstructured: HITSP C62	Already supported by NHIN; messaging-based standards may apply for some exchanges.
Appropriate security and privacy.	NHIN		Not technically an exchange, but the NHIN must provide the appropriate trust fabric to support the Meaningful Use provisions. Currently NHIN Exchange uses a system-level trust model, and should be reviewed to ensure that Meaningful Use requirements are accommodated.
Menu Provision			
Drug-formulary checks.	Local		
Record advance directives.	Local		
Retrieve lab results.	NHIN	HITSP C36 (HL7 v2.5.1 message-based); HITSP C37 (CDA document exchange).	Need to determine how HL7 v2 messaging can be transported over NHIN web services.
Generate lists of conditions.	Local		NHIN support for analytic queries down the road may be helpful.
Patient reminders.	Local		
Timely electronic access/ clinical summaries for each visit.	NHIN or Local	Structured: HITSP C32 et.al. Unstructured: HITSP C62	Use NHIN if patient uses PHR service Provider to maintain data; messaging-based standards may apply for some exchanges.
Patient education.	Local		
Medication reconciliation.	Local		Complete set of data for reconciliation may require exchange to receive medical history from other Providers.

Criteria	NHIN or Local	Relevant Standards	Comments
Summary of care for each transition of care and referral (discharge summaries).	NHIN	HITSP C32 et.al.	Already supported by NHIN.
Submit data to immunization registries.	NHIN	HITSP C72 (HL7 bv.2.3.1)/C78	Upgrade available based on HL7 v2.5.1.
Submit reportable lab results to public health agencies.	NHIN	CDC Implementation Guide (based on HL7 v.2.5.1)	
Provide electronic syndromic surveillance.	NHIN	GIPSE	Already implemented in CDC pilot.

6   Nevada Provider Incentive Program Blueprint

6.1   Introduction

6.1.1   Overview

This NPIP Blueprint (Blueprint) describes the high-level requirements, process flows, and technical requirements of the NPIP to interface with the MEIPRAS to enable Providers to register for Medicaid incentive payments and attest to their eligibility requirements. The Blueprint also describes the administrative processes required to support payment tracking, reporting, Provider appeals and audits. This Blueprint has liberally borrowed from efforts in other states and documentation from CMS.

As part of the planning process for the NPIP functionality for Provider registration, attestation, payment, and tracking, DHCFP is considering vendor solutions being used in other states. DHCFP has received draft cost proposals from three vendors that provide electronic solutions for the program and has had demonstrations from two of the three vendors. DHCFP intends to follow the State procurement process in procuring a vendor solution. Upon completion of the procurement process, DHCFP expects that testing with CMS' National Level Repository (NLR) will begin in April 2012. It is anticipated that the Nevada Medicaid EHR Incentive Program will begin accepting registrations in June 2012 with the first incentive payments being made in July 2012. When DHCFP completes its decision making process, the analysis will be included in a future update of this document.

6.1.2   Purpose

The focus of the DHCFP HIT strategy and plan is the adoption of certified EHR technology by Providers in Nevada. NPIP will be a public-facing software application available over the Internet where Providers supply registration and attestation data related to the Nevada Medicaid EHR Incentive Program. NPIP will be reached directly from a link on the current DHCFP web portal.

The purpose of NPIP is to capture and track Provider application, evaluate eligibility, and collect attestations in order to make timely incentive payments to qualifying Providers for the AIU and Meaningful Use of EHR technology certified by the Office of the National Coordinator for Health Information Technology (ONC). The goal of the program is to ensure the right payment is made to the right Provider at the right time.

NPIP will interface with the MEIPRAS, as well as capture and document information regarding the following:

- Current and historical eligibility information;
- Current and historical payment information;
- Appeals; and
- Audits.

Inquiry and reporting capability will be supported on all data collected in the NPIP. All NPIP transactions will be logged for monitoring, tracking, and audit purposes.

Figure 2 below depicts the high level overview of the necessary components of the NPIP. Objects highlighted green represent new business processes the State will develop/support to implement NPIP. Objects highlighted yellow represent existing business processes the State will modify/enhance to implement NPIP.

Figure 2: NPIP Solution
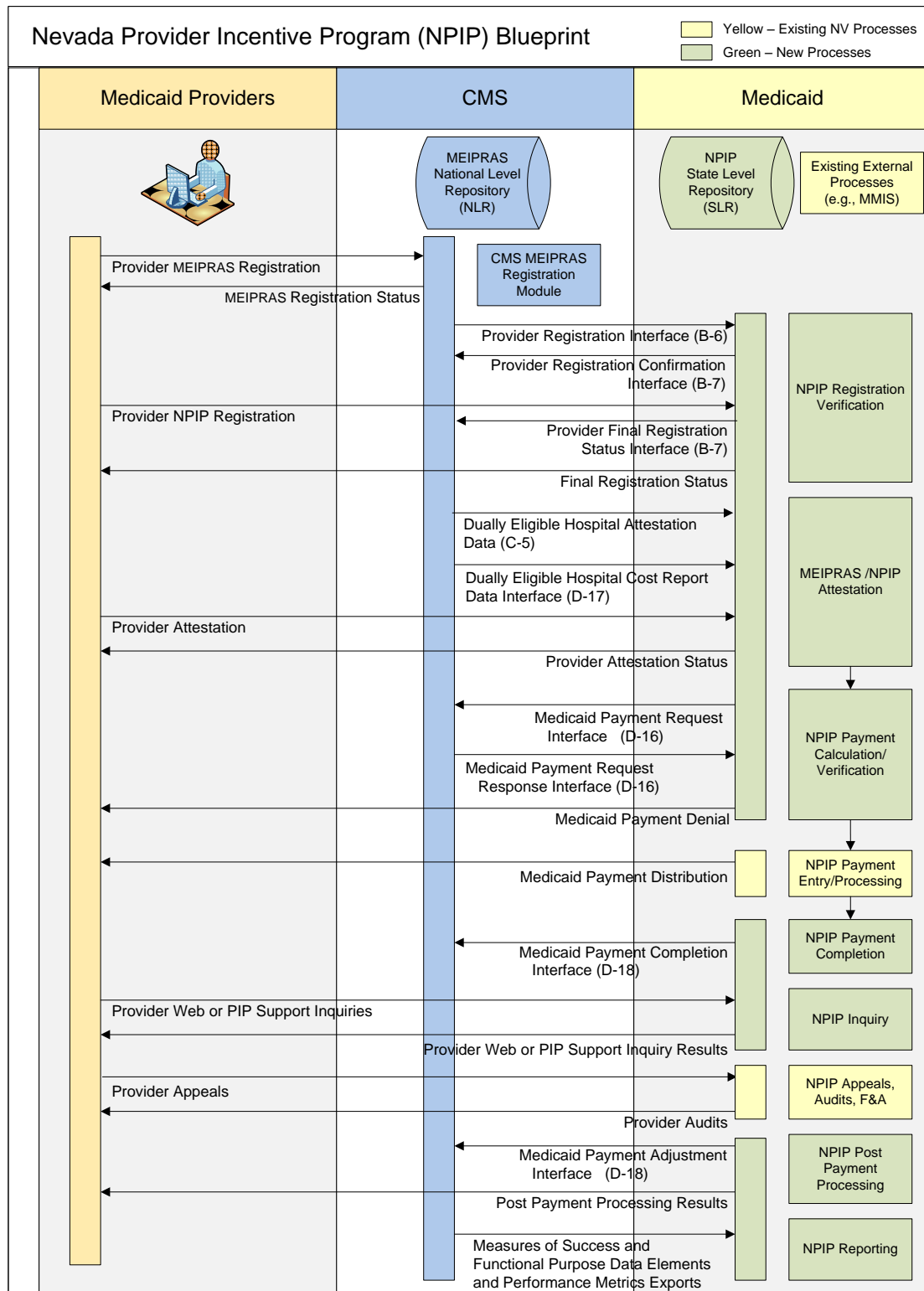
6.2   Provider Eligibility Verification

6.2.1   CMS MEIPRAS Registration Module

CMS has ownership of all processes concerning registration at the national level. A brief description is provided here. More detailed information can be found in CMS' document entitled "HITECH Interface Control Document." The most important aspect of the registration process for state Medicaid programs concerns the interface transaction sent from the MEIPRAS to the NPIP once the Provider has registered with CMS. More detail on this interface is contained in this document in Section 6.2.2.1 – Process MEIPRAS Registration Interface (B-6).

Whether Medicare or Medicaid, all Providers applying for incentives must first register with the CMS MEIPRAS. The MEIPRAS will capture basic information such as Provider type and whether the Provider is applying for Medicare, Medicaid, or both (allowed for certain hospitals). If the Provider chooses Medicaid, or both, the Provider must identify the state selected for application. The MEIPRAS will check for valid NPI, CMS Certification Number (CCN), and TIN (if on record), and for any federal level sanctions. Providers opting for Medicaid who are not included in the Social Security Administration (SSA) Death Master File will be passed through to the Medicaid State the Provider selected. If registration checks complete successfully, the new Provider information will be written to the National Level Repository (NLR) and sent in the Provider Registration Interface (B-6) to the State for validation.

MEIPRAS registration status is communicated back to the Provider.

6.2.2   NPIP Registration Verification

NPIP Provider registration is supported by the NPIP Registration Verification process. The State Level Repository (SLR) database supports the NPIP and stores Provider MEIPRAS information and the information required to administer the Medicaid EHR Incentive Program. The Provider verifies information obtained via the MEIPRAS interface and supplies additional information the State may require to determine eligibility before the attestation process. Areas of focus within the NPIP for Nevada enrollment and eligibility verification include:

- Medicaid enrollment;
- Provider type, and for professionals any hospital, FQHC or Rural Health Clinic (RHC) affiliation;
- Provider sanctions/exclusions;
- Provider licensing; and
- Provider Medicaid patient encounter volume.

DHCFP staff will conduct verifications and audits of the areas of focus stated above using the Verification and Audit Strategy detailed in Section 6.8.4. The Verification and Audit Strategy provides a methodology and data sources. The B-7 Interface will be sent back to CMS twice. The B-7 Interface will be sent back the first time as a Provider Registration Confirmation Interface (B-7) immediately after the

B-6 Interface is received, parsed, and stored. The Provider Registration Confirmation Interface (B-7) will contain an Eligibility Status of "Pending" and allow CMS to record the fact the B-6 Interface was received by DHCFP before DHCFP determines the Provider's registration status with the State. The second time the Provider's final registration status is reported back to the MEIPRAS via the Provider Final Registration Status Interface (B-7). At this time, the B-7 transaction will contain an Eligibility Status of "Accepted" or "Rejected" notifying CMS of the Provider's registration status with the NPIP. NPIP final registration status is also communicated back to the Provider.

Figure 3 below depicts the overview of the necessary components of the enrollment verification. The processes themselves are described in more detail following the diagram.

Figure 3: NPIP Registration Verification
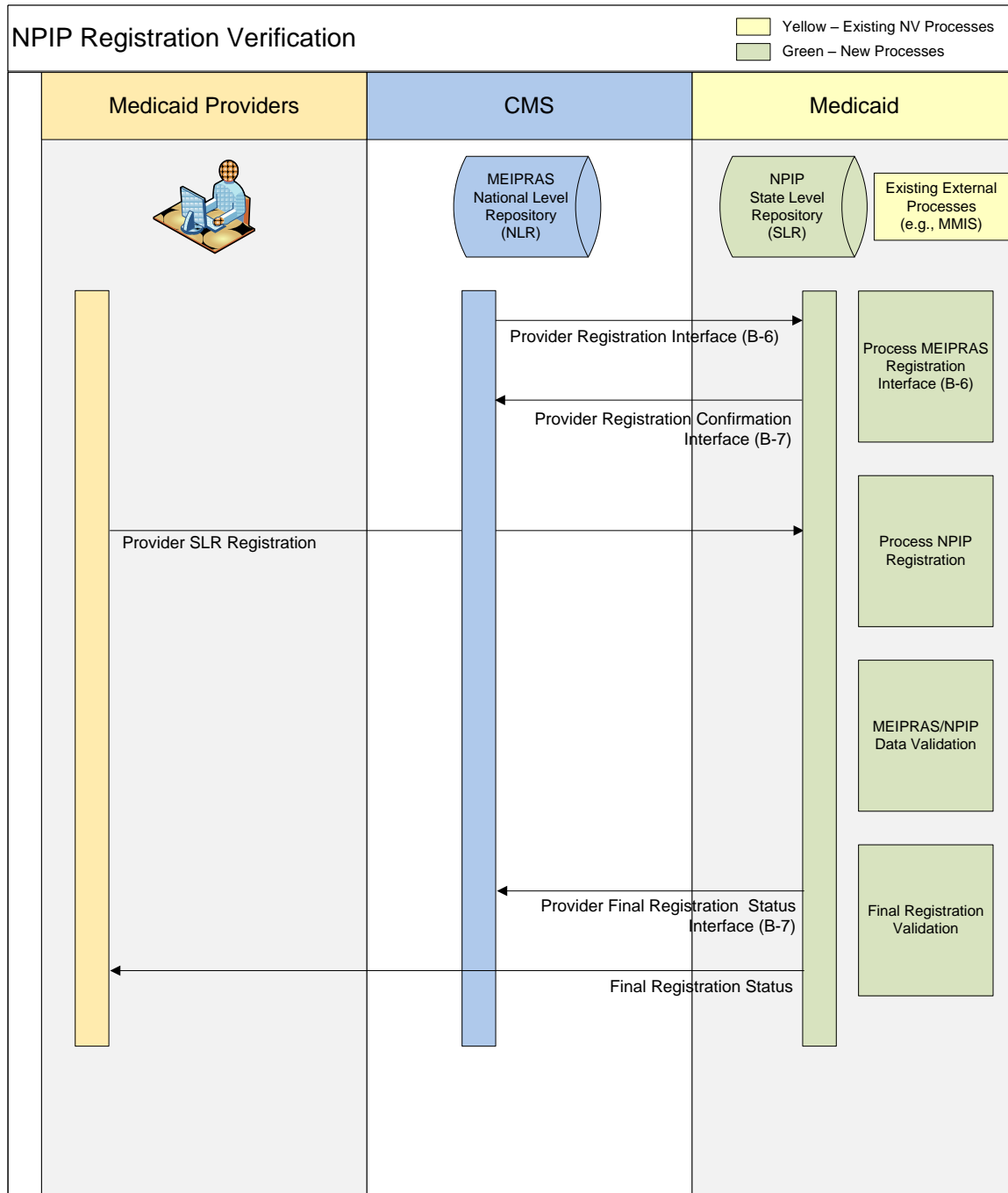
6.2.2.1 Process MEIPRAS Registration Interface (B-6)

The MEIPRAS Registration Interface process will accept and parse the B-6 Interface. The purpose of the B-6 Interface is to inform Nevada of new, updated, and inactivated Medicaid registrations. The MEIPRAS will send Nevada batch feeds of new Providers that sign up for the Medicaid EHR Incentive Program and selected or switched to Medicaid. Also included in the data are any updates/changes to the

Provider entries and any registration inactivation events. A detailed description of this interface can be found in CMS' document entitled "HITECH Interface Control Document."

Figure 4: Process MEIPRAS Registration Interface (B-6)
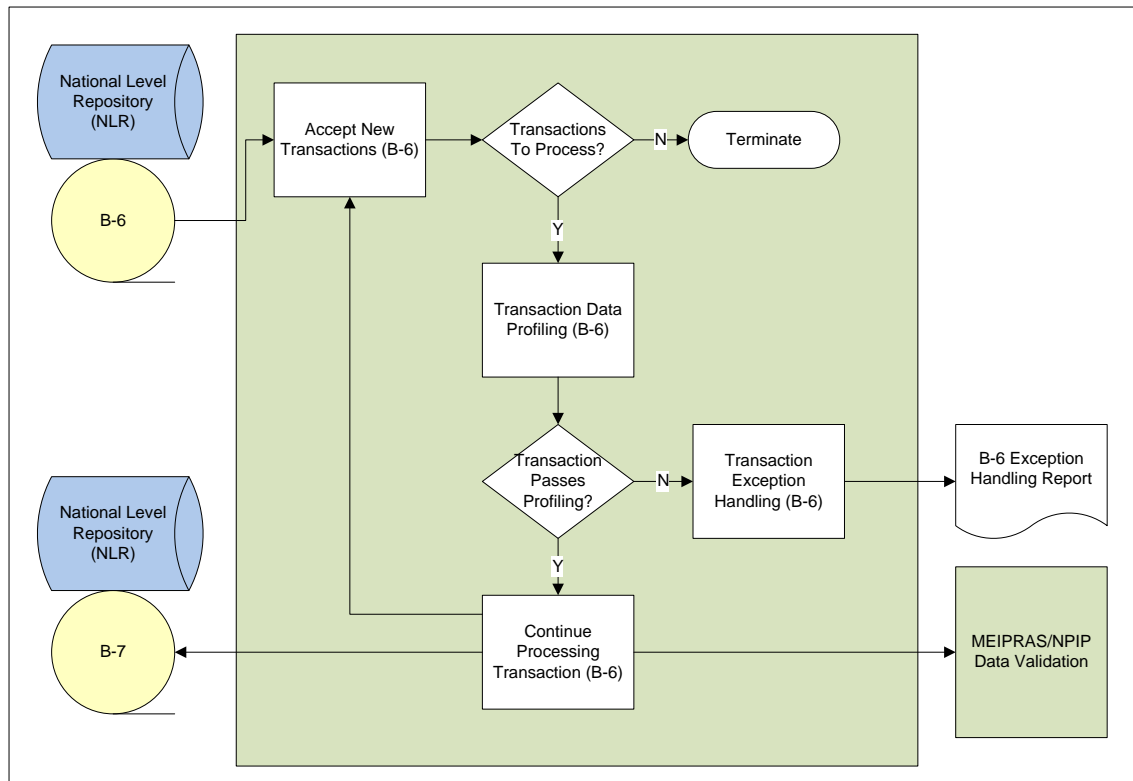
This process will perform the following actions:

- Accept new transactions;

- Perform Data Profiling, based on CMS Interface requirements, for:
    - Record Content: Header/Trailer Schema and Record Schema;
    - Data Element: Data Type, Length/Size, and Code Constraints;

- Perform Exception Handling on B-6 transactions not passing Data Profiling quality controls;

- For accepted data, create the Provider Registration Confirmation Interface (B-7) with an Eligibility Status of "Pending"; and

- Allow processing to continue for accepted data.

Processes to manage transactions that do not pass Exception Handling are not described because the HITECH Interface Control Document states that CMS does not expect any exceptions from the B-6 Interface. In any case, the process will have to account for any B-6 transactions that cannot be parsed successfully. Nevada will create a report of B-6 transactions that cannot be parsed and work directly with CMS to resolve any issues.

If the transaction passes Data Profiling processing, the process named "MEIPRAS/NPIP Data Validation" (described later in this section) is executed.

6.2.2.2 Process NPIP Registration

The NPIP Registration process allows a Provider to establish a NPIP User Account and associate EPs to group practices or clinics. EPs have the option to use the overall Medicaid/Needy Individual patient volume for the clinic or group practice where they render medical services rather than their individual patient volume. All EPs associated with a given clinic/group practice will use one set of patient volume criteria, the criteria established for the clinic/group practice as a whole.

EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);

2. There is an auditable data source to support the clinic's patient volume determination; and

3. The practice and EPs decide to use one methodology in each year – in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data. The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

The NPIP Registration process will accept registration requests from Nevada Medicaid Providers. All Provider-specific information required to validate eligibility is collected. This data listed below is described in more detail in the process named "Final Registration Validation."

- NPI

- Data required to ensure current licensing

- Data required to ensure exclusion from sanctions by the State

- Provider Type

- Patient Volume

- EP specific registration data

Figure 5: Process NPIP Registration
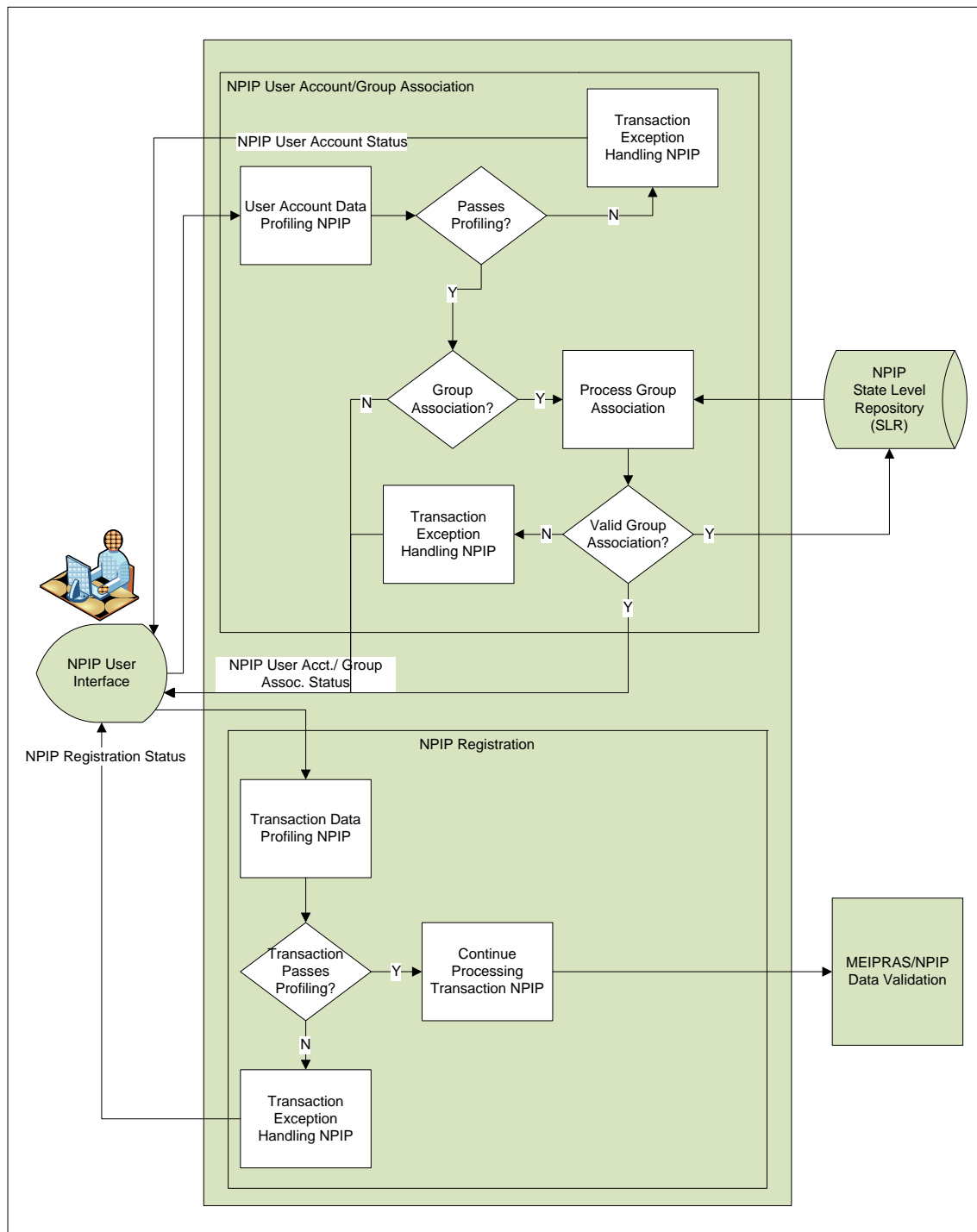
The User Account process will perform the following actions:

- Ensure the new user is uniquely identified;

- Ensure contact information, such as email address, is captured; and

- Ensure a pre-defined User Role is assigned. This is important to determine if the user is authorized to perform specific tasks in the NPIP. For example, associating Providers to group or updating Provider NPIP data.

The Group Association process will perform the following actions:

- Ensure the user's NPIP Role allows this capability;

- Validates the Group ID (the unique identifier Nevada uses to identify a specific practice) and that Providers are in the Group (clinic or group practice); and

- Identifies all Providers, via NPI, associated with a particular Group. Providers associated to a Group will be using the patient volume calculated for the Group.

The NPIP Registration process will perform the following actions:

- Accept new transactions;

- Perform Data Profiling for:

    o   Record Content: Header/Trailer Schema and Record Schema;

    o   Data Element: Data Type, Length/Size, and Code Constraints;

- Perform Exception Handling on transactions not passing Data Profiling quality controls; and

- Allow processing to continue with the process "MEIPRAS/NPIP Data Validation" for accepted data.

6.2.2.3 MEIPRAS/NPIP Data Validation

The MEIPRAS/NPIP Data Validation process supports the requirements that Provider data in the B-6 Interface be verified by the Provider. Process execution logic depends on different scenarios.

Figure 6 below depicts the overview of the necessary components of MEIPRAS/NPIP Data Validation. The processes themselves are described in more detail following the diagram.

Figure 6: MEIPRAS/NPIP Data Validation
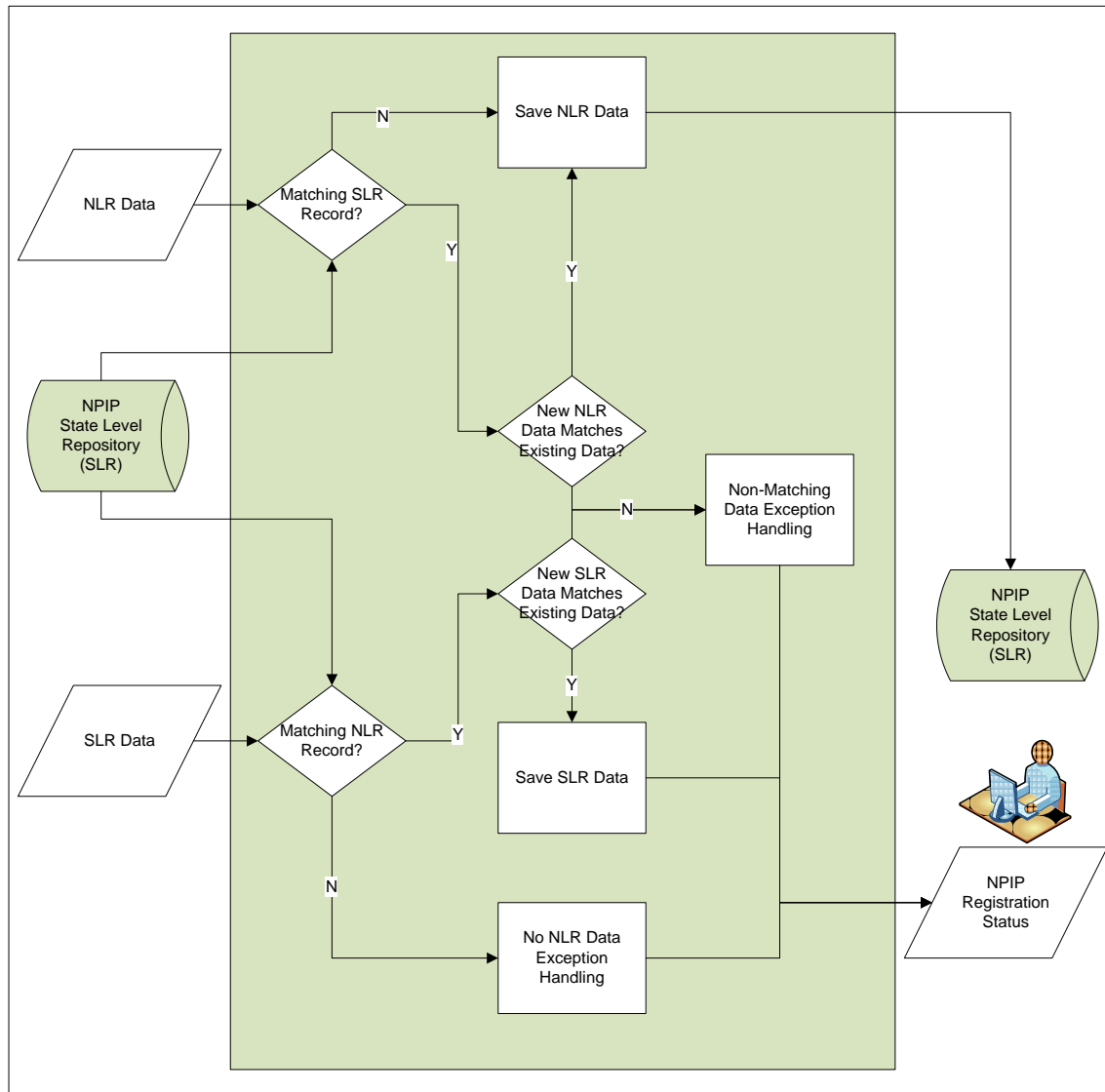
The NPIP will prohibit Providers from registering before the B-6 Interface is processed by the State.

- <u>NPI from a B-6 Interface being processed does not match an NPIP Provider Registration transaction</u>: The B-6 Interface is stored in the SLR awaiting NPIP Provider Registration using the same NPI.

- <u>NPI from a B-6 Interface being processed does match an NPIP Provider Registration transaction</u>: In this case the Provider may have made a change to existing MEIPRAS registration data. The data from the B-6 Interface is matched against the data input by the Provider during NPIP Provider Registration. If all data matches, the process named "Final Registration Validation" (described later in this section) is executed. If data does not match, the Provider is informed via the NPIP Registration Status communication channel. The Provider must make changes in the MEIPRAS or the NPIP to make all data match.

- NPI from an NPIP Registration transaction being processed does not match a B-6 Interface: The Provider is not allowed to register with the NPIP. The Provider is informed via the NPIP Registration Status communication channel.

- NPI from an NPIP Registration transaction being processed does match a B-6 Interface: The Provider views and confirms the MEIPRAS registration data received via the data B-6 Interface. If all data matches, the process named "Final Registration Validation" (described later in this section) is executed. If data does not match, the Provider is informed via the NPIP Registration Status communication channel. The Provider must make changes in the MEIPRAS. The Provider is not allowed to register with the NPIP.

All new transactions, MEIPRAS or NPIP, are inserted in the SLR with data elements identifying the chronology, via date/time stamps, of record insertion. Existing data is not updated. This is done to maintain a complete auditable history of data changes.

6.2.2.4 Final Registration Validation

The Provider will validate all MEIPRAS and NPIP Registration data and attest to its accuracy. Additionally, the State may access electronically stored data from sources other than the NPIP data input by the Provider to ensure data accuracy during the registration process.

Figure 7 below depicts the overview of the necessary components of the Final Registration Validation. The processes themselves are described in more detail following the diagram.

Figure 7: Final Registration Validation
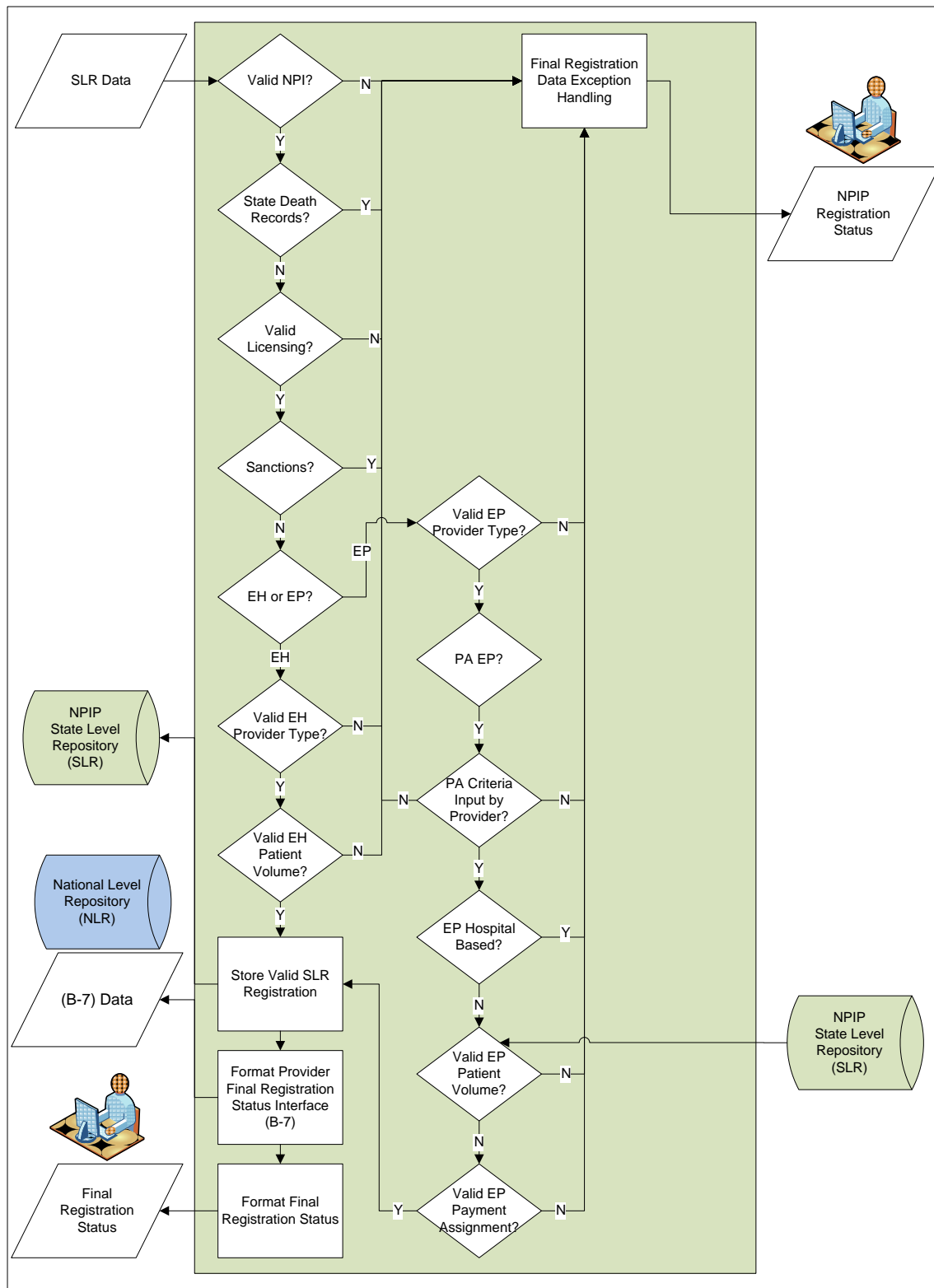
Final Registration Validation will include the following:

- NPI is valid;

- Verifying the Provider is not listed in Nevada Death Records;

- Providers have current licenses issued by the state in which they are located;

- Provider is not sanctioned by the State;

- Provider Type is included in the application and is a valid code. This is described in more detail below in Section 6.2.2.5 – Specific Requirements for Eligible Professionals and Eligible Hospitals, and is separated by EP and EH requirements; and

- Provider Volume meets program requirements. This is described in more detail below and separated by EP and EH requirements in Section 6.2.2.5 – Specific Requirements for Eligible Professionals and Eligible Hospitals of this document.

For purposes of calculating EP eligible patient volume, a Medicaid encounter is defined as services rendered to an individual on any one day where:

- Medicaid (or a Medicaid demonstration project approved under Section 1115 of the Social Security Act) paid for part or all of the service; or

- Medicaid (or a Medicaid demonstration project approved under Section 1115 of the Social Security Act) paid all or part of the individual's premiums, co-payments, and cost sharing.

For the purpose of this program, Medicaid is defined as any program administered by the State authorized under Title XIX of the Social Security Act. This includes both fee-for-service and managed care. It does not include any other program or programs authorized under Title XXI for the Social Security Act, including CHIP. To assist in accurately calculating EP and EH patient volumes, DHCFP and State Medicaid Providers are able to distinguish between Medicaid and CHIP recipients.

6.2.2.5 Specific Requirements for Eligible Professionals and Eligible Hospitals

EPs and EHs must meet different eligibility criteria for final validation.

Medicaid EH criteria include the following:

Provider Type

- Acute Care Hospital:
  - The average length of patient stay is 25 days or fewer; and
  - The CCN (previously known as the Medicare Provider number) has the last four digits in the series 0001 – 0879.

- Critical Access Hospital (CAH):
  - The average length of patient stay is 25 days or fewer; and
  - The CCN has the last four digits in the series 1300 – 1399.

- Children's Hospital:

  o The hospital is separately certified as a children's hospital - either freestanding or a hospital within hospital; and

  o The CCN has the last four digits in the series 3300 – 3399.

DHCFP will utilize the applicable statistics from the most recently filed Medicare Cost Reports to validate average length of stay and patient volumes.

Patient Volume

Acute Care and Critical Access Hospitals must meet a 10 percent patient volume over a 90-day period in the most recent fiscal year prior to the year of reporting to qualify for the program. Children's hospitals have no patient volume requirements. Patient volume can be aggregated from multiple locations or states.

The same 90 day period must be used in both the numerator and denominator of the equation. DHCFP plans to request providers assess patient volume with the period beginning with the first day of the month. However, if providers believe that they would have met patient volume using an alternate date DHCFP will allow an appeal. .

- (Total Medicaid patient encounters / total patient encounters) x 100 = n%.

Medicaid EP criteria include the following:

Provider Type and Provider Specialty

Provider Type is defined by CMS and specific to the B-6 Interface. Provider Specialty will be validated using standard X12 Electronic Data Interchange Provider Taxonomy Codes.

- The Provider is one of the following:

  o A physician;

  o A dentist;

  o A certified nurse-midwife;

  o A nurse practitioner; or

  o A PA practicing in a FQHC or RHC, which is so led by a PA.

PA Criteria

- A PA practicing predominately in a FQHC or RHC providing care to "Needy Individuals":

  o Practicing Predominantly - A PA for whom the clinical location accounts for over 50 percent of his or her total patient encounters over a period of six months in the most recent calendar year occurs at a FQHC or RHC;

  o Needy Individual - A patient that meets one of the following criteria:

    ▪ Receives medical assistance from Medicaid;

- ▪ Receives medical assistance from CHIP;

- ▪ Receives uncompensated care by the Provider; or

- ▪ Receives services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay.

<u>Provider is Not Hospital Based</u>

- • Not Hospital Based - A Provider who furnishes 90 percent or less of his or her covered professional services in the calendar year preceding the payment year in a hospital setting. A setting is considered a hospital setting if it is identified by the codes used in the HIPAA standard transactions that identifies the site of service as an inpatient hospital (POS code 21) or emergency room (POS code 23).

    DHCFP will follow CMS guidance when auditing this program requirement.

    Data elements to capture for each EP:

    - o Place of Service (POS); and

    - o Encounter/Service volume.

<u>Patient Volume</u>

To offer flexibility and support for both the Medicaid fee-for-service and managed care model, DHCFP has opted to make both EP patient volume calculations listed in the CMS Final Rule available. DHCFP will allow patient volume to be aggregated from multiple locations or states. DHCFP will require the Provider to confirm that the same 90-day period is used in both the numerator and denominator of the equation. DHCFP plans to request the period to begin with the first day of the month. However, if providers believe that they would have met patient volume using an alternate date DHCFP will allow an appeal. DHCFP also states that providers have a deadline of 60 days after the end of the calendar year for EPs and end of the federal fiscal year for EHs to attest to the previous year's volume.

The first option is that EPs must have a minimum of 30 percent of all patient encounters attributable to Medicaid during a 90-day period in the most recent calendar year prior to the year of reporting, with the exception of pediatricians who must only reach a 20 percent patient volume. Pediatricians with 20 to 29 percent patient volume will receive two-thirds of the yearly Medicaid EHR incentive payment. For more details, please refer to this document in Section 6.4.1.1 – Eligible Professional Payment Calculation.

- • If the EP is not practicing predominantly in a FQHC or RHC: (Total Medicaid Encounters / Total Encounters) x 100 = n%.

- • If the EP is practicing predominantly in a FQHC or RHC: ((Medically Needy Patient Encounters + Medicaid Encounters) / Total Patient Encounters) x 100 = n%.

The second option is that EPs must have a minimum of 30 percent of the total Medicaid patients assigned to the EP's panel in a continuous 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period, plus unduplicated Medicaid encounters in the same 90-day period. Pediatricians must only reach a 20 percent patient volume.

- ((Total Medicaid Panel Members Seen + Total Unduplicated Medicaid Encounters) / (Total Assigned Panel Members Seen + Total All Payer Encounters)) x 100 = n%.

Medicaid EHR Incentive Payment Assignment

When registering for the Medicaid EHR Incentive Program in NPIP, Providers may assign their incentive payments to their employer or other entity if the employer or other entity has a valid contractual arrangement allowing the entity to bill and receive payment for the Provider's professional services. They may also assign payments to entities promoting the adoption of certified EHR technology, as designated by the State and meeting the following requirements:

- The State has established a method to designate entities promoting the adoption of certified EHR technology that comports with the federal definition in §495.302.

- The State publishes and makes available to all EPs a voluntary mechanism for designating annual payments and includes information about the verification mechanism the State will use to ensure that the assignment is voluntary and that no more than 5 percent of the annual payment is retained by the entity for costs not related to certified EHR technology.

Such assignment of payments must be entirely voluntary for the Provider.

If the Provider meets all registration and eligibility validation checks, the Provider Final Registration Status Interface (B-7) is formatted and sent to the MEIPRAS informing CMS that the Provider qualifies for a Medicaid EHR incentive payment.

If the Provider does not meet all registration and eligibility validation checks, the Provider Final Registration Status Interface (B-7) transaction is formatted and sent to the MEIPRAS, informing CMS of the reason the Provider does not qualify for the Medicaid EHR Incentive Program using standard reject reason codes defined by CMS.

The Provider is informed about Final Registration Status via the Final Registration Status communication channel.

6.3   MEIPRAS/NPIP Attestation

The next step in applying for the Medicaid EHR Incentive Program is for the Provider to access the NPIP to answer a variety of questions attesting to the Provider's AIU and/or Meaningful Use of certified EHR technology. NPIP Attestation may occur immediately after registration or it may occur at a later date.

DHCFP will verify this information, along with the remaining attestation data below, before issuing the MEIPRAS payment request. This will be done after the Provider completes and saves attestation data.

The MEIPRAS may send Medicare hospital attestation data to Nevada for dually eligible hospitals via the Dually Eligible Hospital Attestation Data Interface (C-5). NPIP will evaluate the C-5 Interface Transaction attestation data to determine if the hospital has been approved for Medicare payment. If the hospital is eligible for Medicare payment then the hospital will be deemed eligible for Medicaid payment and will not have to perform the NPIP Attestation process, specific to the Meaningful Use criteria contained in the C-5 Interface Transaction. CMS still requires the State send the Medicaid Payment

Request Response Interface (D-16) transaction prior to issuing payment. Dually eligible hospitals will still have to meet the Medicaid patient volume requirements.

The MEIPRAS may also send hospital Cost Report data to Nevada for dually eligible hospitals via the Dually Eligible Hospital Cost Report Data Interface (D-17). The Medicare Cost Report may be useful as an aid in computing the Medicaid EHR incentive payments.

Figure 8 below depicts the overview of the necessary components of attestation. The processes themselves are described in more detail following the diagram.

Figure 8: MEIPRAS/NPIP Attestation
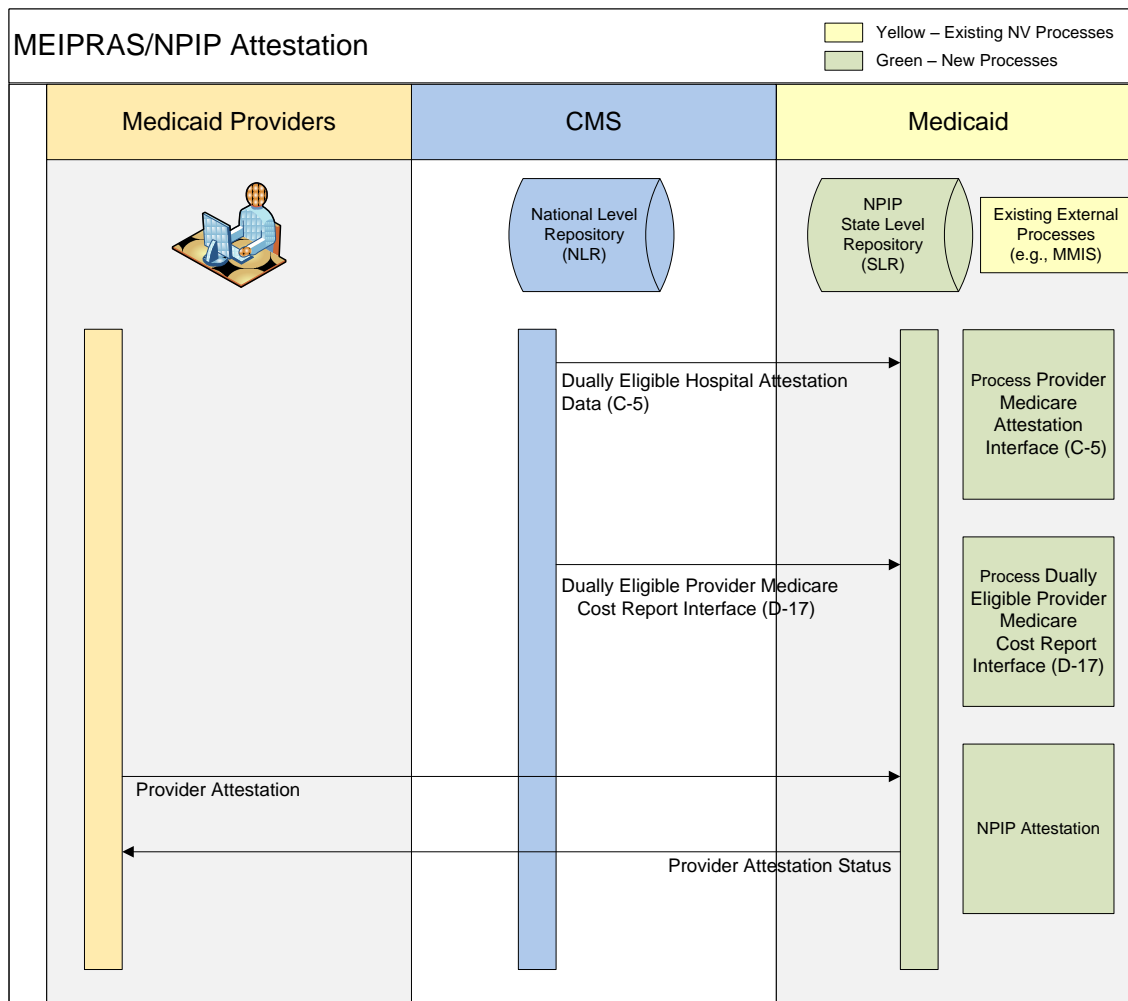
6.3.1 Process Dually Eligible Hospital Attestation Data Interface (C-5)

This process will accept and parse the C-5 Interface from the MEIPRAS. The purpose of the C-5 Interface is to inform Nevada of Medicare attestation data (Meaningful Use) for dually eligible hospitals. A detailed description of this interface can be found in the document entitled "HITECH Interface Control Document."

Figure 9: Process Dually Eligible Hospital Attestation Data Interface (C-5)
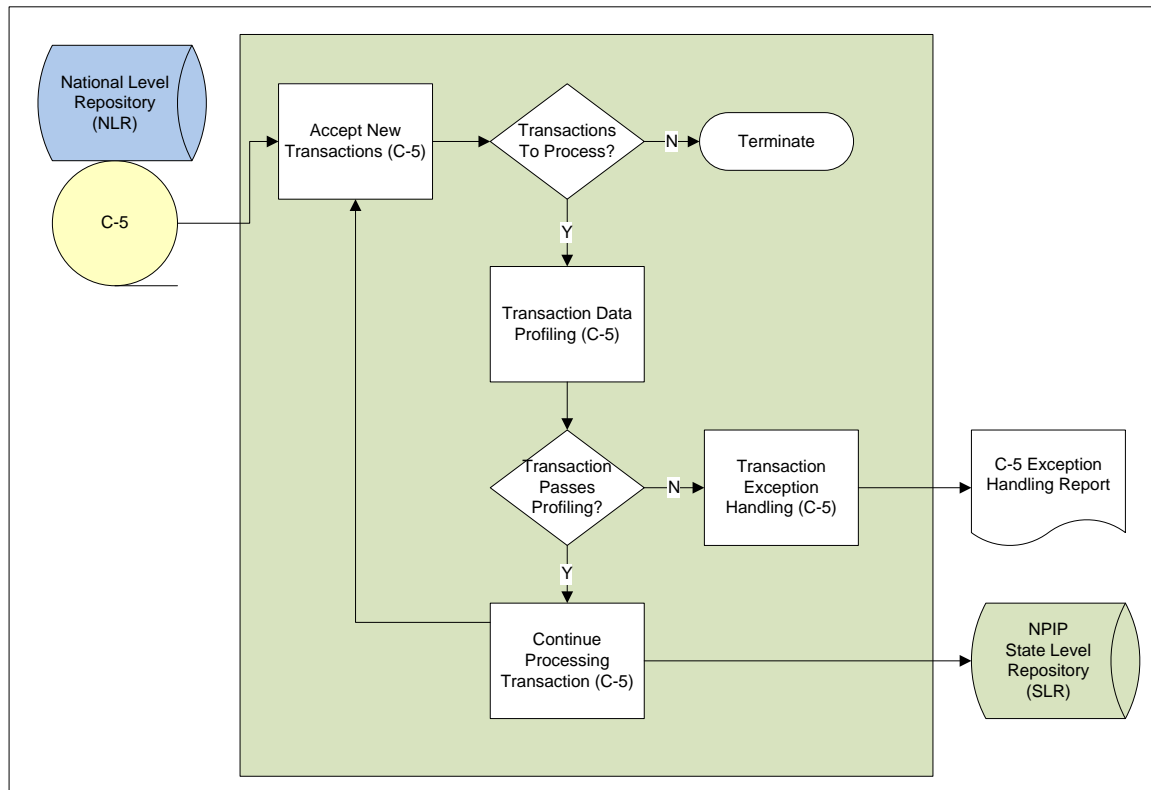
This process will perform the following actions:

- Accept new transactions;
- Perform Data Profiling, based on CMS Interface requirements, for:
  - Record Content: Header/Trailer Schema and Record Schema;
  - Data Element: Data Type, Length/Size, and Code Constraints; and
- Perform Exception Handling on C-5 transactions not passing Data Profiling quality controls.

Processes to manage transactions that do not pass Exception Handling are not described because the HITECH Interface Control Document states that CMS does not expect any exceptions. In any case, the process will have to account for any C-5 transactions that cannot be parsed successfully. Nevada will create a report of C-5 transactions that cannot be parsed and work directly with CMS to resolve issues.

If the transaction passes Data Profiling processing, the data will be stored in the SLR.

6.3.2 Process Dually Eligible Hospital Cost Report Data Interface (D-17)

This process will accept and parse the D-17 Interface from the MEIPRAS. The purpose of the D-17 Interface is to send hospital Cost Report data to the State for dually eligible hospitals. The Medicare Cost

Report may be useful as an aid in computing the Medicaid EHR incentive payments. A detailed description of this interface can be found in the document entitled "HITECH Interface Control Document."

Figure 10: Process Dually Eligible Hospital Cost Report Data Interface (D-17)
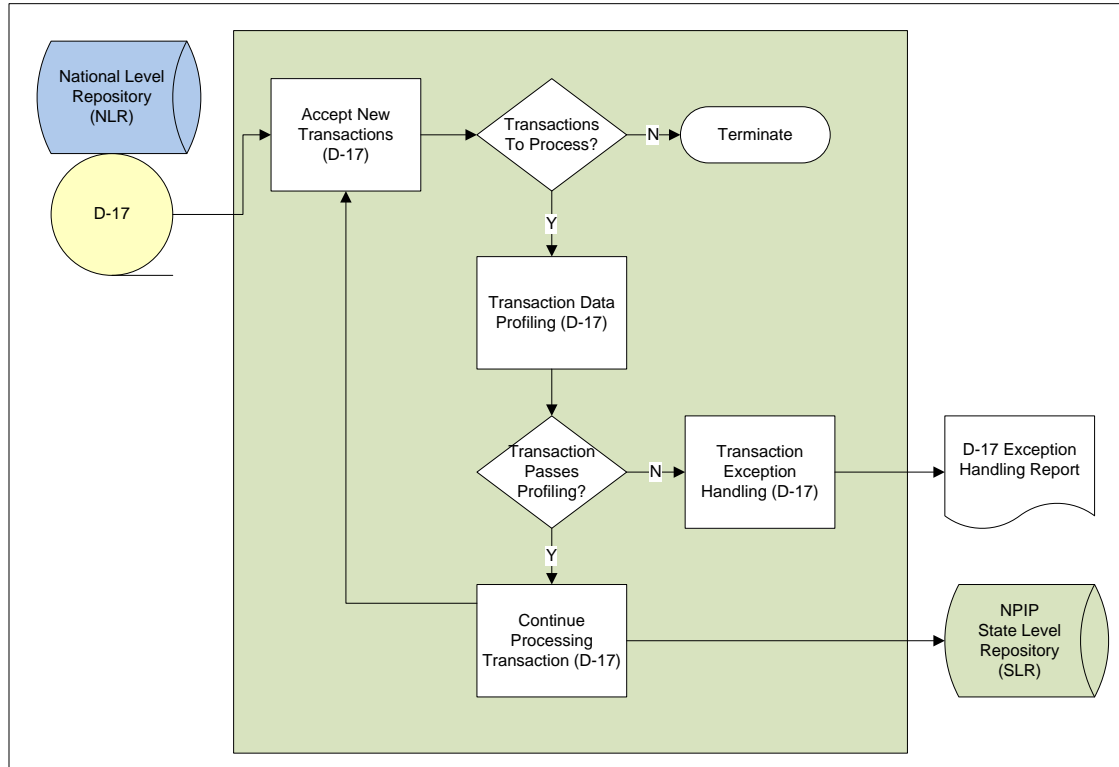
This process will perform the following actions:

- Accept new transactions;
- Perform Data Profiling, based on CMS Interface requirements, for:
  - Record Content: Header/Trailer Schema and Record Schema;
  - Data Element: Data Type, Length/Size, and Code Constraints; and
- Perform Exception Handling on D-17 transactions not passing Data Profiling quality controls.

Processes to manage transactions that do not pass Exception Handling are not described because the HITECH Interface Control Document states that CMS does not expect any exceptions. In any case, the process will have to account for any D-17 transactions that cannot be parsed successfully. DHCFP will create a report of D-17 transactions that cannot be parsed and work directly with CMS to resolve issues.

If the transaction passes Data Profiling processing, the data will be stored in the SLR.

6.3.3   NPIP Attestation

The Provider will access NPIP to answer a variety of questions attesting to the Provider's AIU and/or Meaningful Use of certified EHR technology. If the C-5 transaction was received from the MEIPRAS for a dually eligible hospital the EH will not have to go through the NPIP Attestation process. Patient volume will still have to be validated. After the Provider completes and saves attestation data, DHCFP will verify the information. This will be done before issuing the payment request to the MEIPRAS via the Medicaid Payment Request Interface (D-16).

Figure 11 below depicts the overview of the necessary components of Attestation. The processes themselves are described in more detail following the diagram.

Figure 11: NPIP Attestation
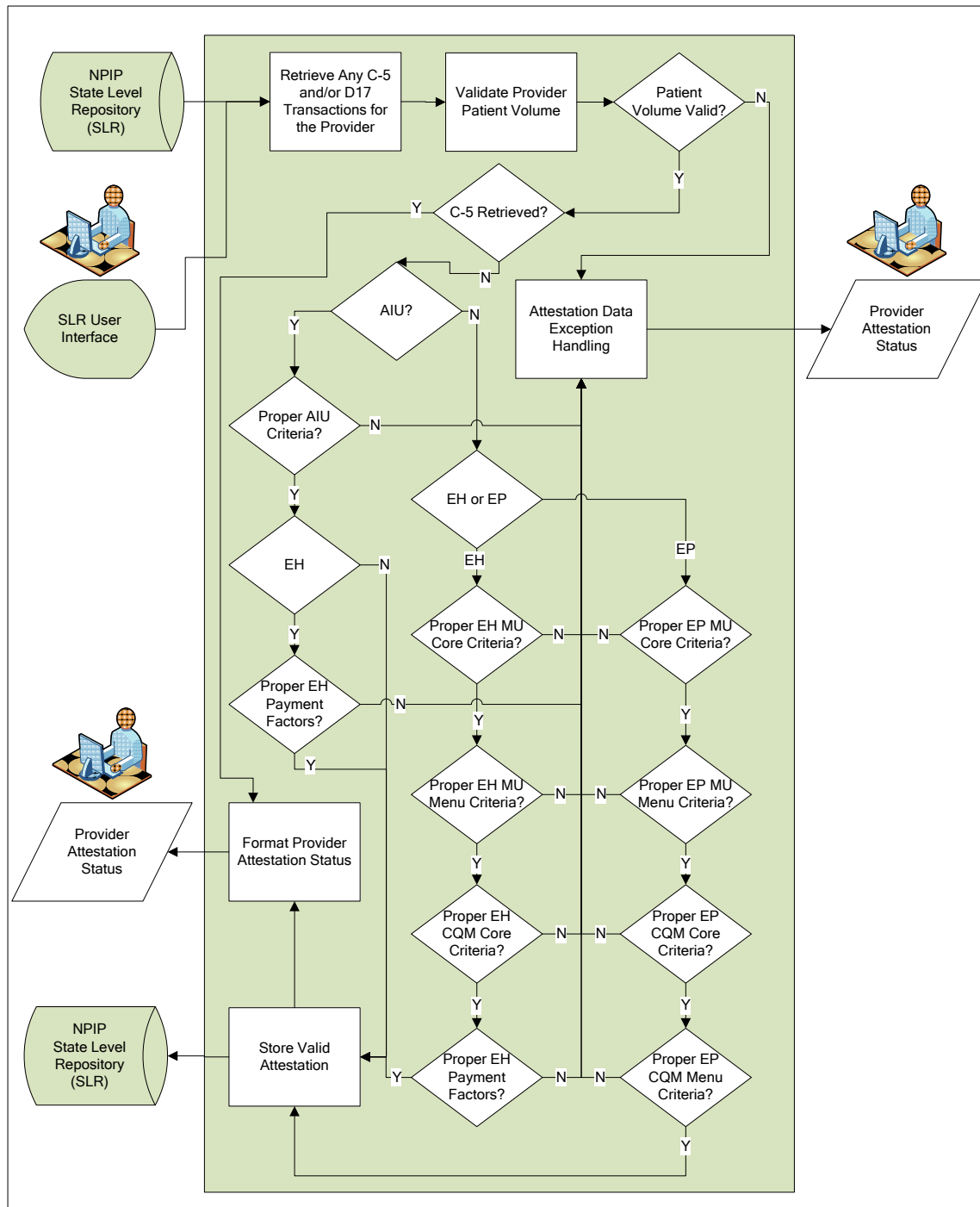
6.3.3.1 Dually Eligible Hospital Data Retrieval

The first step in NPIP Attestation will retrieve any existing Dually Eligible Hospital Attestation Data Interface (C-5) transaction and any Dually Eligible Hospital Cost Report Data Interface (D-17) transaction that may be stored in the SLR for this Provider. If any data are found the EH

will receive the Attestation Status without repeating the Attestation process. Patient volume will still be validated.

6.3.3.2 Patient Volume Validation

Patient Volume data, collected during registration, will be validated to ensure it was collected within one year of the attestation data being collected. If provider volume data was collected within one year of attestation data the patient volume data will be considered valid. If not, the provider will have to confirm or update the patient volume data.

6.3.3.3 Adoption, Implementation, or Upgrade

Along with the attestation information described above, the Provider also may attest, at a minimum, in the first year to AIU of certified EHR technology. CMS publishes a list of codes identifying every ONC-certified EHR system. The Provider must enter the proper code, known as the CMS EHR Certification ID, to identify the complete EHR system or combination of modular systems. The code must match one of the codes in the list of ONC-certified EHR systems.

Adoption is defined as evidence that demonstrates the Provider acquired, purchased or secured access to certified EHR technology. This evidence would serve to differentiate between activities that may not result in installation (such as researching EHRs or interviewing EHR vendors).

Implementation is defined as the Provider installed or commenced utilization of certified EHR technology. Implementation activities include: 1) staff training in the certified EHR technology; 2) data entry of patients' demographic and administrative data into the EHR; or 3) establishing data exchange agreements and relationships between the Provider's certified EHR technology and other Providers, such as laboratories, pharmacies, or HIEs.

Upgrade is defined as the Provider moving from non-certified to certified EHR technology.

The Provider supplies the following attestation and documentation information to qualify for the AIU incentive payment: DHCFP will accept documentation information in non-electronic forms for the AIU incentive payments. Providers may submit the documentation either scanned, faxed or mailed.

- Criteria:
  - Adoption, implementation, or upgrade;
  - A brief textual description of how the Provider meets the criteria for adoption, implementation, or upgrade of certified EHR technology; and
  - Attachment of external documents supporting adoption, implementation, or upgrade of certified EHR technology – at a minimum Providers must supply a purchase order, signed contract, or other document that provides proof that a certified EHR was/will be purchased.
- Certified EHR technology:

  CMS publishes a list of codes identifying every ONC-certified EHR system. The Provider must enter the code to identify the EHR technology being attested to. The code entered must match a

code, known as the CMS EHR Certification ID, in the list of ONC-certified EHR systems. Validation will be performed in a pre-payment automated mode.

6.3.3.4 Meaningful Use

In the first year of the Medicaid EHR Incentive Program all Medicaid Providers have to attest to AIU rather than Meaningful Use. In the second and subsequent years, DHCFP will verify Meaningful Use of a certified EHR technology through attestation in NPIP. In the second and subsequent years, Providers will be required to confirm that all registration and eligibility information is correct.

For EPs, there are a total of 25 Meaningful Use objectives: 15 core objectives and 10 menu set objectives. A total of 20 of the objectives must be completed to qualify for an incentive payment; 15 required core objectives; and the remaining 5 objectives may be chosen from the list of 10 menu set objectives.

For EHs, there are a total of 24 Meaningful Use objectives: 14 core objectives and 10 menu set objectives. A total of 19 of the objectives must be completed to qualify for an incentive payment; 14 required core objectives; and the remaining 5 objectives may be chosen from the list of 10 menu set objectives.

Subject to 42 CFR Part 495.332, the State may propose a revised definition of Meaningful Use of certified EHR technology, subject to CMS prior approval, but only with respect to the following objectives:

1. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.

2. Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.

3. Capability to provide electronic submission of reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice; and

4. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission in accordance with applicable law and practice.

To simplify processes and encourage EHR adoption, DHCFP is not proposing to add any menu set objectives to the required core set for a Provider to meet Meaningful Use.

Some Meaningful Use objectives are not applicable to every Provider's clinical practice, eliminating any eligible patients or actions for the measure denominator. In these cases, the EP will be excluded from having to meet that measure. Examples of exclusions include dentists that do not perform immunizations and chiropractors that do not e-prescribe.

Additionally, Providers will have to submit clinical quality measures (CQMs). EPs will have options on the CQMs reported. EHs are required to report all 15 CQMs. These requirements are described in more detail later in this section, under the headings "Eligible Professional Clinical Quality Measures" and "Eligible Hospital Clinical Quality Measures."

Stage 1 Meaningful Use Core Criteria

All Meaningful Use core objectives must be met, unless an exception applies. However, the objectives listed below do not allow exceptions:

1. Core Objective: Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines.

   Measure: More than 30 percent of unique patients with at least one medication in their medication list seen by the EP or admitted to the EH or CAH inpatient or emergency department (POS 21 *Inpatient hospital* or 23 *Emergency room – hospital*) have at least one medication order entered using CPOE.

2. Core Objective: Implement drug/drug and drug/allergy interaction checks.

   Measure: The EP/EH/CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.

3. Core Objective: Maintain an up-to-date problem list of current and active diagnoses.

   Measure: More than 80 percent of all unique patients seen by the EP or admitted to the EH or CAH inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.

4. Core Objective: Maintain active medication list.

   Measure: More than 80 percent of all unique patients seen by the EP or admitted to the EH or CAH inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

5. Core Objective: Maintain active medication allergy list.

   Measure: More than 80 percent of all unique patients seen by the EP or admitted to the EH or CAH inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

6. Core Objective: Record and chart changes in vital signs, including: height, weight, blood pressure, calculation and display of body mass index (BMI), and plot and display growth charts for children 2-10 years (including BMI).

   Measure: For more than 50 percent of all unique patients age two and over seen by the EP or admitted to EH or CAH inpatient or emergency department (POS 21 or 23), height, weight, and blood pressure are recorded as structured data.

7. Core Objective: Record smoking status for patients 13 years-old or older.

   Measure: More than 50 percent of all unique patients 13 years-old or older seen by the EP or admitted to the EH or CAH inpatient or emergency department (POS 21 or 23) have smoking status recorded.

8. Core Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.

Measure: More than 50 percent of all patients of the EP or the inpatient or emergency departments of the EH or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within three business days.

9. Core Objective: Capability to exchange key clinical information (such as problem list, medication list, medication allergies, and diagnostic test results) among Providers of care and patient authorized entities electronically.

   Measure: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information. There are no exceptions to this requirement.

10. Core Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

    Measure: Conduct or review a security risk analysis, as required under the HIPAA Security Rule, and implement security updates as necessary and correct identified security deficiencies as part of its risk management process. There are no exceptions to this requirement.

11. Core Objective — EP only: Generate and transmit permissible prescriptions electronically (eRx).

    Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

12. Core Objective — EP only: Record demographics, including: preferred language, gender, race, ethnicity, and date of birth.

    Measure: More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.

13. Core Objective — EP only: Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance that rule.

    Measure: There are no allowable exclusions for this objective.

14. Core Objective — EP only: Report ambulatory CQMs to CMS or states.

    Measure: For 2011, provide aggregate numerator, denominator, and exclusions through attestation. For 2012, electronically submit CQMs.

15. Core Objective — EP only: Provide clinical summaries for patients for each office visit.

    Measure: Clinical summaries provided to patients for more than 50 percent of all office visits within three business days.

16. Core Objective — Hospital/CAH only: Record demographics, including: preferred language, gender, race, ethnicity, date of birth, and date and preliminary cause of death in the event of mortality in the EH or CAH.

    Measure: More than 50 percent of all unique patients admitted to the EH or CAH inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.

17. Core Objective — Hospital/CAH only: Implement one clinical decision support rule related to a high priority hospital condition, along with the ability to track compliance with that rule.

Measure: There are no exclusions for this objective and its associated measure.

18. Core Objective — Hospital/CAH only: Report hospital CQMs to CMS or states.

    Measure: For 2011, provide aggregate numerator, denominator, and exclusions through attestation. For 2012, electronically submit CQMs.

19. Core Objective — Hospital/CAH only: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.

    Measure: More than 50 percent of all patients who are discharged from an EH or CAH inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

Stage 1 Meaningful Use Menu Set Criteria

Five of ten menu objectives must be met, unless exceptions apply. One of the five objectives chosen must be a population health-related objective, which are the first three objectives listed below.

1. Menu Objective: Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.

    Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, EH, or CAH submits such information have the capacity to receive the information electronically).

2. Menu Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

    Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, EH, or CAH submits such information have the capacity to receive the information electronically).

3. Menu Objective — Hospital/CAH only: Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.

    Measure: Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies, and follow-up submission if the test is successful (unless none of the public health agencies to which EH or CAH submits such information have the capacity to receive the information electronically).

4. Menu Objective: Implement drug formulary checks.

    Measure: The EP/EH/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.

5. Menu Objective: Incorporate clinical lab-test results into certified EHR technology as structured data.

    Measure: More than 40 percent of all clinical lab tests results ordered by the EP or by an authorized Provider of the EH or CAH for patients admitted to its inpatient or emergency

department (POS 21 or 23) during the EHR reporting period, whose results are either in a positive/negative or numerical format, are incorporated in certified EHR technology as structured data. The percentage is based on labs ordered for patients whose records are maintained using certified EHR technology.

6. Menu Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

   Measure: Generate at least one report listing patients of the EP, EH, or CAH with a specific condition. Specific conditions are those conditions listed in the active patient problem list.

7. Menu Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate.

   Measure: More than ten percent of all unique patients seen by the EP or admitted to the EH or CAH inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources.

8. Menu Objective: The EP, EH, or CAH that receives a patient from another setting of care or Provider of care or believes an encounter is relevant should perform medication reconciliation.

   Measure: The EP, EH, or CAH that performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the EH or CAH inpatient or emergency department (POS 21 or 23).

9. Menu Objective: The EP, EH, or CAH that transitions its patient to another setting of care or Provider of care or refers their patient to another Provider of care should provide summary of care record for each transition of care or referral.

   Measure: The EP, EH, or CAH that transitions or refers its patient to another setting of care or Provider of care, provides a summary of care record for more than 50 percent of transitions of care and referrals.

10. Menu Objective — EP only: Send reminders to patients per patient preference for preventive/follow-up care.

    Measure: More than 20 percent of all unique patients 65 years or older or five years old or younger were sent an appropriate reminder during the EHR reporting period.

11. Menu Objective — EP only: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP.

    Measure: More than ten percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.

12. Menu Objective — Hospital/CAH only: Record advance directives for patients 65 years old or older.

    Measure: More than 50 percent of all unique patients 65 years old or older admitted to the EH or CAH inpatient department (POS 21) have an indication of an advance directive status recorded.

Eligible Professional Clinical Quality Measures

EPs must report from the table of 44 CQMs that includes three Core, three Alternate Core, and 38 additional CQMs.

- Core CQMs: EPs must report on three required core CQMs.

- Alternate Core CQMs: If the denominator of one or more of the required core measures is zero, then EPs are required to report results for up to three alternate core measures.

- Additional CQMs: EPs must also select three CQMs from a set of 38 additional CQMs (excluding the core/alternate core measures). It is acceptable to have a zero denominator provided the EP does not have an applicable population.

In sum, EPs must report on six total measures: three required core measures (substituting alternate core measures where necessary) and three additional measures. A maximum of nine measures would be reported if the EP needed to attest to the three required core, the three alternate core measures, and the three additional measures. Reporting will require a numeric value for each numerator, denominator, and exclusion required by a given CQM, if applicable.

The EP Core CQMs (alternative core measures marked with *) are provided in the table below:

Table 5: Eligible Professional Core and Alternate Core Clinical Quality Measures

NQF #	PQRI #	Developer	Description
0421	128	CMS/QIP [1]	Patients more than 18 years old whose BMI[2] was calculated within six months, and who have a documented follow-up plan if BMI falls outside parameters.
0013	n/a	AMA-PCPI[3]	Patients more than 18 years old who have a diagnosis of hypertension seen in at least two office visits, with blood pressure recorded.
0028	n/a	AMA-PCPI	Patients more than 18 years old who were seen at least twice and asked at least once about tobacco use in 24 months, and who received cessation intervention if they are users.
0038	n/a	NCQA[4]	* Two-year-old children who received DTaP[5], polio, MMR[6], flu, hepatitis B, chicken pox, PCV[7], hepatitis A and rotavirus vaccines by their second birthday.
0041	110	AMA-PCPI	* Patients more than 50 years old who received a flu vaccine (September to February).
0024	n/a	NCQA	* Patients from 2 to 17 years old who visited a primary care provider (PCP) or ob-gyn physician, had evidence of BMI percentile documentation, and received counseling for nutrition and physical activity.

The EP Additional CQMs are provided in the table below:

EPs must choose three from the 38 among the clinical areas of: diabetes, heart conditions, women's health, cancer, asthma, or miscellaneous. The Provider is informed about attestation status via the Provider Attestation Status communication channel.

Table 6: Eligible Professional Additional Clinical Quality Measures

NQF #	PQRI #	Developer	Description
1	NQF 0059	PQRI 1	Title: Diabetes: Hemoglobin A1c Poor Control Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.
2	NQF 0064	PQRI 2	Title: Diabetes: Low Density Lipoprotein (LDL) Management and Control Description: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL).
3	NQF 0061	PQRI 3	Title: Diabetes: Blood Pressure Management Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.
4	NQF 0081	PQRI 5	Title: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.
5	NQF 0070	PQRI 7	Title: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.
6	NQF 0043	PQRI 111	Title: Pneumonia Vaccination Status for Older Adults Description: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
7	NQF 0031	PQRI 112	Title: Breast Cancer Screening Description: Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.
8	NQF 0034	PQRI 113	Title: Colorectal Cancer Screening Description: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
9	NQF 0067	PQRI 6	Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD

NQF #	PQRI #	Developer	Description
			Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
10	NQF 0083	PQRI 8	Title: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
11	NQF 0105	PQRI 9	Title: Anti-depressant medication management: (a) Effective Acute Phase Treatment,(b)Effective Continuation Phase Treatment Description: The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
12	NQF 0086	PQRI 12	Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation Description: Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.
13	NQF 0088	PQRI 18	Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.
14	NQF 0089	PQRI 19	Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
15	NQF 0047	PQRI 53	Title: Asthma Pharmacologic Therapy Description: Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
16	NQF 0001	PQRI 64	Title: Asthma Assessment Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and

NQF #	PQRI #	Developer	Description
			nocturnal asthma symptoms.
17	NQF 0002	PQRI 66	Title: Appropriate Testing for Children with Pharyngitis Description: Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
18	NQF 0387	PQRI 71	Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.
19	NQF 0385	PQRI 72	Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.
20	NQF 0389	PQRI 102	Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.
21	NQF 0027	PQRI 115	Title: Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies Description: Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.
22	NQF 0055	PQRI 117	Title: Diabetes: Eye Exam Description: Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.
23	NQF 0062	PQRI 119	Title: Diabetes: Urine Screening Description: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.

NQF #	PQRI #	Developer	Description
24	NQF 0056	PQRI 163	Title: Diabetes: Foot Exam Description: The percentage of patients aged 18 - 75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).
25	NQF 0074	PQRI 197	Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
26	NQF 0084	PQRI 200	Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation Description: Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.
27	NQF 0073	PQRI 201	Title: Ischemic Vascular Disease (IVD): Blood Pressure Management Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).
28	NQF 0068	PQRI 204	Title: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.
29	NQF 0004		Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement Description: The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
30	NQF 0012		Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal

NQF #	PQRI #	Developer	Description
			care visit.
31	NQF 0014		Title: Prenatal Care: Anti-D Immune Globulin Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
32	NQF 0018		Title: Controlling High Blood Pressure Description: The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year
33	NQF 0032		Title: Cervical Cancer Screening Description: Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer
34	NQF 0033		Title: Chlamydia Screening for Women Description: Percentage of women 15- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
35	NQF 0036		Title: Use of Appropriate Medications for Asthma Description: Percentage of patients 5 - 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).
36	NQF 0052		Title: Low Back Pain: Use of Imaging Studies Description: Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.
37	NQF 0075		Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dL.
38	NQF 0575		Title: Diabetes: Hemoglobin A1c Control (<8.0%) Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.

Eligible Hospital Clinical Quality Measures

EHs must report all 15 CQMs listed in the table below:

Table 7: Eligible Hospital Clinical Quality Measures

NQF #	Developer	Description
0495	CMS/OFMQ	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.
0497	CMS/OFMQ	Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status.
0435	The Joint Commission	Ischemic stroke patients prescribed antithrombotictherapy at hospital discharge.
0436	The Joint Commission	Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.
0437	The Joint Commission	Acute ischemic stroke patients who arrive at this hospital within two hours of time last known well and for whom IV t-PA was initiated at this hospital within three hours of time last known well.
0438	The Joint Commission	Ischemic stroke patients administered antithrombotic therapy by the end of hospital day two.
0439	The Joint Commission	Ischemic stroke patients with LDL ! 100 mg/dL, or LDL not measured, or, who were on a lipidlowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.
0440	The Joint Commission	Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.
0441	The Joint Commission	Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.

NQF #	Developer	Description
0371	The Joint Commission	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.
0372	The Joint Commission	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).
0373	The Joint Commission	This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) ! 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.
0374	The Joint Commission	This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.
0375	The Joint Commission	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health, home hospice or discharged/transferred to court/law enforcement on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.
0376	The Joint Commission	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.

6.3.3.5 Proper EH Payment Factors

Providers need to supply several factors that go into the EH Medicaid EHR incentive payment calculation. These factors are based on the hospital fiscal year that ends during the federal fiscal year prior to the hospital fiscal year that serves as the first payment year and are listed below:

- Medicaid Discharges (Most Recent three Years);

- Medicaid Acute Inpatient Bed Days;

- Medicaid Managed Care Acute Inpatient Bed Days;

- Total Acute Inpatient Bed Days;

- Total Hospital Charges; and

- Total Hospital Uncompensated Charges (Less Bad Debt).

If any of this data are available from an MEIPRAS Dually Eligible Hospital Cost Report Data Interface (D-17) transaction previously stored in the SLR, the Provider will be able to view it and attest it is correct. Otherwise, the Provider will have to supply and attest to the data.

The Provider is informed about attestation status via the Provider Attestation Status communication channel.

6.4   NPIP Payment Calculation/Verification

The payment process involves a number of important activities:

- Verifying the Provider qualifies for a payment based on all the attestation information;

- Parsing the Dually Eligible Hospital Cost Report Data Interface (D-17) that is used as part of the hospital payment calculation;

- Calculating the payment;

- Verifying with CMS, via the MEIPRAS, the Provider should not be denied payment; and

- Tracking the payment and verifying that the right payment was made to the right Provider at the right time.

6.4.1   Payment Calculation

Payments are calculated differently for professionals, managed care providers, and hospitals. There are also some cost report data elements passed to the State from the MEIPRAS via the Dually Eligible Hospital Cost Report Data Interface (D-17) that are used as part of the hospital payment calculation.

6.4.1.1 Eligible Professional Payment Calculation

As of January 2011, CMS revised the EP Payment Calculation methodology. CMS has decided to use a fixed amount each year for the 85 percent of the net average allowable cost considered for the Medicaid EHR incentive payment and the 15 percent cost responsibility of the EP. EPs will no longer have to enter or attest to their cost data or money they receive from other funding sources related to EHR implementation and use. The State will no longer have to verify/audit the EP cost figures. The NPIP will determine the fixed EP Medicaid EHR incentive payment, based on the EP's year of participation, from the table below. The table includes payment for AIU.

Table 8: Medicaid Eligible Professional AIU and MU Payment Matrix

Year	Medicaid EP Adoption Year					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Note: The total for pediatricians who meet the 20 percent patient volume but fall short of the 30 percent patient volume is $14,167 in the first year and $5,667 in subsequent years. This adds up to a maximum Medicaid EHR incentive payment of $42,500 over a six-year period.

6.4.1.2 Eligible Hospital Payment Calculation

Based on hospital data entered during registration, the NPIP will calculate the total EH Medicaid EHR incentive payment amount and DHCFP will verify the accuracy of the calculation through auditable data sources. The total amount is the sum over four years of (a) the base amount of $2,000,000 plus (b) the discharge related amount defined as $200 for the 1,150 through the 23,000 discharge for the first payment. Transition factors are applied to years one through four in the following amounts; Year 1 = 100%, Year 2 = 75%, Year 3 = 50%, and Year 4 = 25%.

For the first payment year, data on hospital discharges from the hospital fiscal year that ends during the federal fiscal year prior to the hospital fiscal year that serves as the first payment year will be used as the basis for determining the discharge-related amount. To determine the discharge-related amount for the three subsequent payment years that are included in determining the total EH Medicaid EHR incentive payment amount, the number of discharges will be based on the average annual growth rate for the hospital over the most recent three years of available data. Note: If a hospital's average annual rate of growth is negative over the three-year period, the rate should be applied as such.

Auditable data sources will be used to calculate the total EH Medicaid EHR incentive payment amounts. Auditable data sources include: 1) Provider's Medicare/Medicaid cost reports; 2) payment and utilization information from MMIS (or other automated claims processing systems or information retrieval systems); 3) hospital financial statements and accounting records; and 4) hospital reports from the University of Nevada Las Vegas Center for Health Information Analysis.

The "Medicaid Share," which is applied against the total EH Medicaid EHR incentive payment amount, is essentially the percentage of a hospital's acute inpatient non-charity care days that are attributable to Medicaid inpatients.

The numerator of the Medicaid Share is the sum of:

- The estimated number of Medicaid acute inpatient-bed-days; and
- The estimated number of Medicaid managed care acute inpatient-bed-days.

The denominator of the Medicaid Share is the product of:

- The estimated total number of acute inpatient-bed-days for the eligible hospital during that period; and
- The estimated total amount of the EH's charges during that period, not including any charges that are attributable to charity care divided by the estimated total amount of the hospital's charges during that period.

The estimated total charges and charity care charges amounts used in the formula must represent acute inpatient hospital services only and exclude any professional charges associated with the acute inpatient stay. Note: The removal of charges attributable to charity care in the formula, in effect, increases the Medicaid Share resulting in higher incentive payments for hospitals that provide a greater proportion of charity care.

States have options in setting a payment schedule, but no annual payment can exceed 50 percent of the total calculated hospital Medicaid EHR incentive payment and payments cannot exceed 90 percent of this total over two consecutive years. Therefore, the full amount of the total incentive payment cannot be made to a hospital in fewer than three payment years beginning in 2011, and the full amount could be spread out over a maximum of six payment years by the State.

Section 1905(t)(5)(D) requires that a hospital cannot receive payments after 2016 unless the hospital received a payment for the previous year. Prior to 2016, Medicaid EHR incentive payments to EHs can be made on a non-consecutive annual basis. Hospitals receiving a Medicaid EHR incentive payment must receive payments on a consecutive annual basis after the year 2016.

Due to the high cost of hospital software and, further, to encourage the early adoption of certified EHR technology in hospitals, DHCFP plans to pay the total EH Medicaid EHR incentive payment amount over the minimum three year period and at the maximum allowable percentages in each year which the EH qualifies for payment: Year 1 = 50%, Year 2 = 40%, Year 3 = 10%.

Calculation of the total EH Medicaid EHR incentive payment amount is a one-time calculation based on the following steps:

1. Calculate the average annual growth rate over three years using the Medicare/Medicaid Cost Reports prior to the most current Cost Report.
2. Calculate the total discharges. Only discharges between and including 1,150 and 23,000 per CCN will be allowable discharges.

3. Calculate each of the next four years' total discharges by multiplying the previous year's discharges times the average computed growth rate.

4. Calculate the total EH Medicaid EHR incentive payment amount for each year by multiplying (total eligible discharges times $200) plus the $2,000,000 base.

5. Apply the appropriate transition factor to each year's total EH Medicaid EHR incentive payment amount. (Year 1 = 100%, Year 2 = 75%, Year 3 = 50%, Year 4 = 25%).

6. Calculate the total EH Medicaid EHR incentive payment amount by adding the total of each year with the transition factor applied.

    a. Calculation of the Medicaid Share percentage:

        1) Total Medicaid days includes both the total Medicaid Days and total Medicaid HMO days from the Medicare/Medicaid Cost Report.

        2) Calculate the non-charity percentage. Subtract uncompensated care from total hospital charges Divide the result by the total hospital charges.

        3) Calculate the non-charity days by multiplying the non-charity percentage times the total hospital days.

        4) Calculate the Medicaid Share percentage by dividing the Medicaid days by the non-charity days.

7. Apply the Medicaid Share percentage to the total EH Medicaid EHR incentive payment amount. (See Medicaid Share calculation above). This is the hospital's Medicaid Total EHR incentive payment amount.

6.4.1.3 Managed Care Payment Calculation

The calculation of Managed Care capitation rates is not required as DHCFP will pay Providers through the Medicaid Fee-for-Service (FFS) program and not through a Provider's Managed Care contract. The Nevada hospital payment calculations are found in Appendix I.

6.4.2 CMS Verification

Before payment can be distributed, a final CMS verification will be performed to validate that the Provider can receive payment. The validation is done via the Medicaid Payment Request Response Interface (D-16) to the MEIPRAS. The MEIPRAS will return a batch interface transaction via the Medicaid Payment Request Response Interface (D-16) authorizing the payment or denying it with a Denial Reason, such as a duplicate payment.

6.5 NPIP Payment Entry/Processing

CMS has not provided the detailed level of requirements for this capability as they have for other EHR Incentive Program capability. CMS expects existing State MMIS processes can be used, with minimal modifications, to take advantage of existing reconciliation, accounting, tracking, and reporting capability supporting Provider reimbursement.

Part of the Medicaid EHR Incentive Program requires that the State:

- Make and distribute payments;

- Make a payment within 45 days of receiving the Medicaid Payment Request Response Interface (D-16) payment authorization transaction;

- Ensure duplicate payments are not made;

- Distinguish Medicaid EHR incentive payments from any other payments made to the Provider;

- Have a process in place to assure that Medicaid EHR incentive payments are made without reduction or rebate and have been paid directly to an EP or to an employer, a facility, or an eligible third-party entity to which the Medicaid EP has assigned payments;

- Have processes in place to ensure that only appropriate funding sources are used to make Medicaid EHR incentive payments and that a methodology for verifying such information is available; and

- Satisfy the CMS defined periodic reporting requirements specific to the Medicaid EHR Incentive Program.

This process must be able to do the following:

- Accept input data from the NPIP Payment Calculation/Verification process. This can be done through an automated data feed or via direct data entry;

- Satisfy the CMS requirements listed above; and

- Notify the NPIP that payment was made, allowing the NPIP to create the batch interface transaction (Medicaid Payment Completion Interface (D-18)) notifying the MEIPRAS that payment is complete.

DHCFP plans to process the Medicaid EHR incentive payments through a financial transaction similar to the current claims payment process with a program-specific transaction code to clearly distinguish the category of payment. DHCFP will use its existing MMIS application to issue and track Medicaid EHR incentive payments. The MMIS will accept from the NPIP an inbound file of Medicaid EHR incentive payments to issue and distribute to Providers. The Medicaid EHR incentive payment status will be tracked through MMIS using existing processes and functionality. The MMIS will produce an outbound Medicaid EHR incentive payment file that can be used by the NPIP for payment confirmation and creation of historical payment logs.

6.6   NPIP Payment Completion

As stated above, the NPIP will send a Medicaid Payment Completion Interface transaction (D-18) to the MEIPRAS when the payment is distributed to the Provider. This requirement will be satisfied using the MMIS outbound payment file described above.

6.7   NPIP Inquiry

Inquiry processes allow Providers to track the progress of their incentive payments. Inquiry processes may also be used by NPIP Support Representatives to answer Providers' questions or offer guidance to Providers to correct information that is hindering the Provider's ability to get paid.

6.8   NPIP Appeals, Audits, and Fraud and Abuse

DHCFP will support the Medicaid EHR Incentive Program with oversight provided for appeals, audits, as well as fraud and abuse detection and prevention. This support will use processes and resources external to the NPIP. Specifically, DHCFP will coordinate oversight activities with leadership from the MMIS/IT Unit IS Projects Office (IS Projects Office) and the Audit Unit. Pre-payment verification will be completed by the IS Projects Office, and all pre-payment and post-payment audits will be conducted by the Audit Unit.

DHCFP will maintain "Historical Log" information in the NPIP to document the initiation, progress, and results of each appeal, audit, and fraud and abuse case. This documentation will simplify reporting and assist in answering Provider questions.

CMS requires each state to decide the criteria for pre-payment, payment, and post-payment audits and the method for payment recovery. The DHCFP oversight program is outlined below and includes the Verification and Audit Strategy and the fraud and abuse and appeals requirements.

6.8.1   Oversight

Oversight activities will be coordinated between the IS Projects Office and the Audit Unit. Specifically, the IS Projects Office staff will conduct the pre-payment reviews and verifications and the Audit Unit will conduct the pre-payment and post-payment audits. Reporting and monitoring functions will be performed by the IS Projects Office staff. Close coordination between these DHCFP units ensures that Medicaid funds are used appropriately and in compliance with federal and State regulations. Existing audit experience will enable DHCFP to perform effective audits of the Medicaid EHR Incentive Program. Referrals will be made to the Medicaid Fraud Control Unit (MFCU) through the Surveillance and Utilization Review Unit in accordance with current procedures in the event that staff believe there is any fraud or abuse occurring in this program.

The level of oversight and monitoring includes the tracking and verification of the activities necessary for a Medicaid Provider to receive an incentive payment for each payment year. As part of the oversight program, the Verification and Audit Strategy provides the specifics of the pre-payment and post-payment verifications and audits. In addition to the Verification and Audit Strategy, oversight activities include the collection and reporting of data on Provider AIU in the first year and Meaningful Use in subsequent years.

The Verification and Audit Strategy includes three components:

1. DHCFP will avoid improper payments by assuring payments only go to Providers eligible for the program.

2. DHCFP will ensure Meaningful Use through a combination of monitoring/validation and audit before payments are disbursed and selective audits after payments are disbursed.

3. DHCFP will prevent/identify suspected fraud and abuse through data analysis and Provider audits.

As the first line of financial oversight of Providers, DHCFP plans pre-payment verifications that will be completed through the registration and attestation solution and MEIPRAS interface. Application and attestation oversight and verification will ensure that each Provider meets eligibility criteria upon enrollment and re-enrollment. Verifications will assess patient volume, as well as the non-hospital based requirement. As the second line of financial oversight, DHCFP will perform pre-payment audits of Providers meeting certain criteria as well as random audits. Each Provider could be targeted for pre-payment audit. The third line of financial oversight will occur through the post-payment audit process. The full set of verifications and audits, including the auditable data sources, is defined in this document in Section 6.8.4 – Verification and Audit Strategy.

DHCFP used the CMS assumptions and formulas published in the Federal Register on July 28, 2010 to estimate the incentive payments to the EPs and EHs. The assumptions were provided as part of the preamble discussion to the Final Rule for EHR Incentive Programs for Medicare and Medicaid. The assumptions used are found on pages 44558 through 44560. The final rules are found in 42 CFR Parts 412,413, 422 and 495. The formulas are found in 42 CFR Part 495.

Based on the calculations DHCFP estimates the following total Medicaid EHR incentive payments:

Table 9: Estimate of Medicaid EHR Incentive Payments

Eligible professionals	HIGH Estimate = $78,228,948 LOW Estimate = $41,402,169
Eligible hospitals	$38,223,039

When calculating the payments being made each year under the program, the "High Scenario" and "Low Scenario" were calculated as detailed in Table 34 of the Final Rule was used for 2011 and it was assumed that all applicants in the group would receive the Year One payments. DHCFP determined that the low scenario was applicable and based its further estimates using these figures. In addition to using the low estimates, DHCFP assumes that: 1) the 2011 class of applicants applying in 2012 would qualify for their Year Two payments; and 2) the incremental percentage of new applicants would receive their Year One payments. The model continues through 2016 with each new group of applicants receiving their Year One payments and earlier classes of applicants receiving later year payments. Beginning in 2017, the group of applicants that first received their Year One payments in 2011 has now received all six years of payments, and therefore drop out of the calculation. The 2012 class drops out of the 2018 calculations and the 2013 class is excluded from the 2019 projections. For full calculations of the EP and EH estimates, see Appendices I and J, attached hereto.

DHCFP will use MMIS to make the incentive payments to Providers. A detailed description of the payment methodology is included in this document in Section 6.4 – NPIP Payment Calculation/Verification.

DHCFP plans to claim federal reimbursement in accordance with all applicable federal laws, regulations, and policy guidance. More specifically, DHCFP has a current standard operating process in place to ensure that its expenditures for administration of the Medicaid EHR Incentive Program will not be claimed at amounts higher than 90 percent of the cost of such administration. DHCFP will establish a separate reporting category to identify all direct costs related to the Medicaid EHR Incentive Program. DHCFP will allocate indirect costs related to the Medicaid EHR Incentive Program by applying allocation methodologies that will be approved in its revised Cost Allocation Plan. Administrative costs will be reconciled at the end of each quarter to ensure no administrative expenditures are charged as both direct and indirect costs.

Administrative expenditures related to the Medicaid EHR Incentive Program erroneously claimed at an amount higher than 90 percent will be discovered during the preparation of the quarterly CMS-64 report and corrected.

DHCFP also has a process in place to ensure that it does not claim amounts higher than 100 percent of the cost of such payments to Providers. This control process will be supported by reports based on data extracted from the MMIS and NPIP.

DHCFP plans to use the automated functions in NPIP and the MEIPRAS to assure that no duplicate Medicaid EHR incentive payments are paid by more than one state or between the Medicaid and Medicare programs. The NPIP automated processes and manual stops will also ensure that the incentive payments are made accurately, without reduction or rebate and will be made directly to a Provider or to an eligible third-party entity to which the Provider has assigned payments.

DHCFP plans to use a comprehensive attestation document that will ensure DHCFP and CMS that the Provider meets the requirements for a Provider. DHCFP will review the Provider attestations as identified in this document in Section 6.3.3 – NPIP Attestation. Additionally, DHCFP plans to include statements on the attestation that the Provider attests to having completed the forms correctly and is subject to an audit. Moreover, DHCFP plans to require the following:

- The Provider's signature (electronic signature is acceptable);

- A statement that: ''This is to certify that the foregoing information is true, accurate, and complete.'';

- A statement that: "I understand that Medicaid EHR incentive payments submitted under this Provider number will be from federal funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.";

- The above statements to appear directly above the Provider's signature or, if they are printed on the reverse of the form, a reference to the statements must appear immediately preceding the Provider's signature;

- Provider attestation is resubmitted upon a change in the Provider's representative; and

- Provider attestation is updated as needed.

Most importantly, DHCFP will use its current recoupment process to recover overpayments and will take further administrative action, if necessary, regarding any improper payments. DHCFP recognizes the need to repay to CMS all FFP received by Providers regardless of whether DHCFP has received

recoupment. DHCFP will implement a process for tracking overpayments using the NPIP and the MMIS reporting capabilities.

DHCFP is encouraging each of its Providers to adopt certified EHR technology and is working to implement the Communication Plan. Additionally, DHCFP is working with its vendor, REC, and Statewide HIT Coordinator to develop a coordinated approach to Provider outreach and education. The Communication Plan is attached hereto as Appendix K.

DHCFP anticipates that Providers will be able to access the NPIP call center to address Provider questions regarding the incentive program. Additionally, the Communication Plan will take advantage of the robust existing Provider communication infrastructure and will incorporate the timeline and rollout of incentive payments.

The appeal processes will proceed in accordance with State regulations. This process is fully described in this document in Section 6.8.2 – Administrative Redetermination and Appeal Plan.

DHCFP will continue to review and revise its Verification and Audit Strategy as risks emerge. This approach allows for flexibility and amendment to the Verification and Audit Strategy. DHCFP will perform an annual/semi-annual Medicaid EHR Incentive Program Risk Assessment and will make adjustments based on the results.

Once the NPIP is fully operational, DHCFP plans to implement a process to collect CQM. DHCFP will also take into account the effect this data collection will have on the ongoing Medicaid program.

DHCFP has determined that it will make Medicaid EHR incentive payments from the MMIS on a weekly basis. DHCFP will make the payments to the Provider, the employer, or a facility assigned the payments without any reduction or rebate.

6.8.2   Administrative Redetermination and Appeal Plan

This section of the SMHP describes the DHCFP appeals process regarding the Provider incentive program appeal rights. This section specifies the valid reasons for appeal and the types of Providers that can apply. Through HITECH Act Regulation 42 CFR: Part 495 Subpart D § 495.370, CMS defined the following process requirements for a Medicaid Provider receiving EHR incentive payments.

DHCFP will provide an appeals procedure that allows Providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as:

- Provider eligibility determinations;
- Demonstration of adopting, implementing, and upgrading, and Meaningful Use eligibility for incentives;
- Incentive payments; and
- Incentive payment amounts.

DHCFP process ensures the following:

- The Provider (whether an individual or an entity) has an opportunity to challenge the State's determination under this Part by submitting documents or data or both to support the Provider's claim; and

- The process employs methods for conducting an appeal through the Fiscal Agent and/or a fair hearing consistent with the State's Administrative Procedure law(s).

Specifically, Medicaid Providers can appeal if they believe that they have been denied an incentive payment or have received an incorrect payment amount because of incorrect determinations of eligibility, including but not limited to the following DHCFP decisions:

- Measuring patient volume;

- Demonstrating Meaningful Use; and

- Efforts to adopt, implement or upgrade to certified EHR technology.

DHCFP has determined that its Providers will be able to submit additional information through an informal process prior to a formal appeal. This process will begin with initial access through the NPIP. This will be an informal data correction and resolution method and the Provider will be afforded the opportunity to make changes to their NPIP information. If this method results in a denial decision, DHCFP will provide a written notification of the denial action by email to the Provider. The Provider may challenge the DHCFP action at that time by filing an appeal. Appeals will go through the Fiscal Agent and will be processed as defined in the Medicaid Operations Manual. The Provider will receive a notice of decision, and, if denied, the requested action relating to the Medicaid EHR Incentive Program, the Provider may file a fair hearing request in accordance with the Medicaid Service Manual Chapter 3100.

DHCFP will update its appeals process after the program begins and lessons are learned from the number and type of appeals being filed and processed.

6.8.3   Fraud and Abuse

Through HITECH Act Regulation 42 CFR: Part 495 Subpart D § 495.368, CMS defined the following fraud and abuse prevention process requirements for a Medicaid Provider receiving EHR incentive payments.

The State must comply with federal requirements to:

- Ensure the qualifications of the Providers who request Medicaid EHR incentive payments;

- Detect improper payments; and

- Refer cases of suspected fraud to the MFCU.

The State will take corrective action in the case of improper EHR payment incentives to Medicaid Providers and will repay to CMS all FFP received by Providers identified as an overpayment regardless of recoupment from such Providers. DHCFP believes that Section 6506 of the Patient Protection and Affordable Care Act (PPACA) provides DHCFP with 365 days from discovery of the overpayment to

repay. DHCFP will follow the current federal requirements as stated in 42 CFR Part 456.23 and State recoupment procedures as outlined in the Medicaid Services Manual Sections as stated below:

3302.2 ADMINISTRATIVE ACTION

Administrative Action is an action taken by the DHCFP which includes but is not limited to: the recovery of improper payments; issuance of educational letters; issuance of warning letters; issuance of recoupment/recovery letters; special claims reviews or onsite audits; requests for provider corrective action plans; requests for provider self audits; referral to appropriate civil agencies (licensing bodies); referral to the MFCU; denial of provider applications; suspension and termination of provider status; and other actions as stated in policy 3303.3A. See the Social Security Act Sections: 1128, 1128A, 1128B, and 1903.

3303.3A COVERAGE AND LIMITATIONS

1. Administrative Actions. The DHCFP is authorized to take Administrative Actions to ensure compliance with program policies, state statutes and federal laws and regulations.

2. In response to the discovery of fraud, abuse or improper payments in the Medicaid and Nevada Check Up programs. The DHCFP may initiate more than one Administrative Action at one time, if warranted. (e.g. issuance of a recoupment/recovery letter and request a corrective action plan) The types of Administrative Actions that may be taken by the DHCFP are as follows:

> c. Issuance of recoupment/recovery letters. The DHCFP may issue a recoupment/recovery letter to a provider if the results of an investigation indicate the provider was improperly paid for one or more services. A recoupment/recovery letter may also be sent after a provider fails to submit sufficient and appropriate documentation within the timeframes requested in a warning letter. Recoupment/recovery letters will be sent by certified mail, with a return receipt requested. The letter will notify the provider of the nature of the improper payment, the amount to be recovered and the method of repayment. The provider Fair Hearing process is available to dispute recoupment/recovery letters unless the recoupment/recovery letter was the result of the provider's failure to provide sufficient and necessary information to establish medical necessity and to fully disclose the basis for the type, extent and level of services provided within the timeframes indicated in the letter that requested such information; or the provider's failure to provide sufficient and appropriate documentation within specified timeframes for the mandated federal PERM reviews.

DHCFP will comply with all federal laws and regulations designed to prevent fraud, waste, and abuse.

6.8.4   Verification and Audit Strategy

DHCFP plans to implement a Verification and Audit Strategy that includes pre-payment verifications, pre-payment audits and post-payment audits. During the first 90 days, DHCFP will be evaluating the level of participation and creating an inventory of the types of EPs who apply for the incentives, as well as the number of hospitals. The initial list of registrations will be evaluated and considered as DHCFP initiates the pre-payment verifications, audits and post-payment audits upon the program's first payment. DHCFP will also seek information from other States regarding their evaluation of the initial implementation and will evaluate and set the benchmarks for audits during first year of participation.

The DHCFP Verification and Audit Strategy for the Medicaid EHR Incentive Program is designed to be timely and balance risk with available resources. The strategy is also designed to provide assurance that the right incentive payments will be made to the right Provider before initiating the Medicaid EHR incentive payment. The plan provides monitoring for the following:

- Provider eligibility: DHCFP will verify that Providers are credentialed, not sanctioned, and not hospital-based, and are one of the types of Providers eligible for the Medicaid EHR Incentive Program.

  NPIP will verify the application and will pass or suspend the application. Some sanctions from other states will pass the validations such as expired licenses from other states. The application contains an attestation covering the eligibility criteria including the hospital-based physician criteria. Pre-payment audit queues will be used for additional validations.

- Patient volume: DHCFP will verify the attestation data, including use of proxy data (such as claims), where appropriate, to identify risk.

- Compare EPs Medicaid patient volume supplied during attestation to the previous year's Medicaid patient volume. If the attested patient volume is outside a 30 percent variance of the previous year's Medicaid patient volume, the Provider will be queued for audit. AIU attestation patient volume is based on a 90-day period, so the comparison will be made to the MMIS data from the same period of the previous year.

- Certified EHR technology: DHCFP will collect the certified EHR technology code as part of Provider attestation for AIU, and NPIP will verify that the code is on the ONC's list of certified EHR technology prior to issuing an incentive payment to that Provider.

Verification workflow will start after the Provider completes registration and attestation. DHCFP will have up to 45 days to distribute payment. This 45-day period starts after payment authorization is confirmed through the Medicaid Payment Request Response Interface (D-16). If a Provider is not selected for pre-payment verification or audit by one of the criteria below, eligibility will be automated and based on the attestation data.

DHCFP plans to verify all of the following during pre-payment verifications:

- Review of AIU attestation documentation;

- For dually certified hospitals, the Medicaid patient volume percentage and the results of the Medicare audits when available;

- The federal sanctions list/database from the Office of Inspector General; and

- The State of Nevada sanction list/database.

DHCFP plans to conduct random and targeted pre-payment audits, as well as random and targeted post-payment audits. DHCFP will use a random sampling automated tool to generate a list of up to five percent of all Providers for both pre and post-payment audits. DHCFP will conduct its pre-payment and post-payment audits using desk and onsite audits.

For pre-payment targeted audits, DHCFP will select the following:

- Providers with significant variance (30 percent) in volume to the prior year;

- Providers with patient volume that is within plus or minus 2.5 percent of the minimum;

- Providers who are the subject of an unrelated program integrity review opened as the result of data mining or complaint about Medicaid billing practices;

- Providers with a sudden drop or spike in Medicaid claims volume after receipt of incentive funds;

- All Medicaid-only hospitals;

- Pediatricians who claim eligibility for the program and are below 30% volume;

- All Medicaid Providers, based on NPI, with Medicaid EHR incentive payments over $300,000; and

- EPs who attest to predominantly practicing in FQHCs/RHCs and review the "needy patient" volume calculations.

For post-payment targeted audits, DHCFP will select the following:

- Validation of AIU attestation documentation;

- Patient volume where Medicaid patients include both in-state and out-of-state patient volume;

- Providers who report a significantly higher patient volume for the 90 day period for attestation compared to historical claims data for the previous year;

- Providers included in group patient volume calculations;

- Providers requesting assignment to payee TIN for an organization to which they have not been previously associated;

- Providers who have had any Medicare or Medicaid sanctions in the past 12 months; and

As the program is implemented, post-payment audits will focus on areas of risk identified from pre-payment verification and previous audit findings.

The information required for audits may go beyond the data stored in the SLR. Other auditable data sources may include:

- Provider enrollment files maintained by DHCFP;

- Provider EHR system data associated with Meaningful Use criteria;

- State licensing and accreditation boards;

- Provider Medicaid cost reports;

- Provider, encounter, and claims data and reimbursement information stored in the MMIS;

- Provider financial statements, accounting records, and patient information; and

- Statewide HIE.

DHCFP acknowledges that the Verification and Audit Strategy outlined above will be evaluated on a semi-annual basis and the plan will be revised to reflect the level of risk encountered based on lessons learned as the incentive payment program proceeds.

DHCFP will develop a detailed audit protocol beyond the Verification and Audit Strategy to address the entire audit process and will include:

- Steps to validate needy patient volume, this validation may include claims data analysis an possible onsite verification of Provider's patient accounts;

- Steps to verify AIU, which could include a checklist and possible onsite review of a Provider's EHR system; including obtaining documentation beyond that submitted during registration, for example additional proof of purchase, vendor agreements, etc.

The benchmarks for the Verification and Audit Strategy will be established after the detailed audit protocols are completed and at the conclusion of the first 90 days of the program. During the first 90 days, DHCFP will be evaluating the level of participation and creating an inventory of the types of EPs who apply for the incentives, as well as the number of hospitals. The initial list of registrations will be evaluated and considered as DHCFP initiates the pre-payment verifications, audits and post-payment audits. DHCFP will also seek information from other States regarding their evaluation of the initial implementation and will evaluate and set the benchmarks for the first year of participation after this 90 day period has concluded. Verification and audit findings and conclusions will be reported to DHCFP leadership on a regular basis.

The following table is a "checklist" of items to verify or audit for those Providers identified based on the audit criteria above.

Table 10: Checklist of Items to Verify or Audit

Requirement	Pre/Post Payment	Automated State Level Repository System /Manual Process
Eligibility		
Collect and verify basic information to assure Provider enrollment eligibility upon enrollment or reenrollment to the Medicaid EHR Incentive Program.	Pre-Pay	NPIP
Collect and verify basic information to assure patient volume in the numerator.	Pre-Pay	NPIP Manual - MMIS Reporting Extract

Requirement	Pre/Post Payment	Automated State Level Repository System /Manual Process
Collect and verify basic information to assure that EPs are not hospital-based, including the determination that substantially all health care services are not furnished in a hospital setting, either inpatient or outpatient.	Pre-Pay	NPIP Manual - MMIS Reporting Extract
Collect and verify basic information to assure that PA EPs are practicing predominantly in a FQHC or RHC and are so led by the PA.	Pre-Pay	NPIP Manual - MMIS Reporting Extract
Assure that Medicaid Providers who wish to participate in the EHR incentive payment program has or will have an NPI and will choose only one program from which to receive the incentive payment using the NPI, a TIN, and CMS' national Provider election database.	Pre-Pay	NPIP
Based on Provider type, assure that the Provider meets all requirements to be eligible to participate in the Medicaid EHR Incentive Program as a Medicaid Provider. "All requirements" means all requirements that can be verified using external data sources available to DHCFP.	Pre-Pay	NPIP Manual - MMIS Reporting Extract
To eliminate long term care hospitals, ensure that a hospital eligible for incentive payments has demonstrated an average length of stay of 25 days or less.	Pre-Pay	NPIP Manual - MEIPRAS download of the Cost Report data. Computing this for a given hospital requires total patient days and total Medicaid days for the period.
Ensure all eligibility information is verified at least on an annual basis. Provider eligibility info is only going to be verified when the Provider requests a Medicaid EHR incentive payment via the NPIP.		NPIP
Adopt/Implement/Upgrade		
Verify the Provider has met the certified EHR requirements, through use of the certified EHR code and attached vendor contracts/purchase order. Manual verification is required to ensure the document attached is the type of document attested to. This is for the Providers identified for audit.	Pre-Pay	NPIP
Meaningful Use		

Requirement	Pre/Post Payment	Automated State Level Repository System /Manual Process
Based on Provider type, assure the Meaningful Use Core requirements have been attested to and are accurate.	Pre-Pay	NPIP Manual - MMIS Reporting Extract
Based on Provider type, assure the proper number of Meaningful Use Menu Item requirements have been attested to and are accurate.	Pre-Pay	NPIP Manual - MMIS Reporting Extract
Capture and verify clinical quality data from each Provider. This is part of Meaningful Use and does not impact the first year. DHCFP is putting processes in place to audit clinical quality data as CMS finalizes Meaningful Use regulations.	Pre-Pay	Automated – NPIP Manual - MMIS Reporting Extract And/or other external sources
Payment Calculation/Verification		
Based on Provider type, assure the first year payment is accurately calculated.	Pre-Pay	NPIP
Based on Provider type, assure the payment for years two through six are accurately calculated.	Pre-Pay	NPIP
Assure a Provider does not receive incentive payments for more than six years.	Pre-Pay	NPIP
Assure a Provider does not receive duplicate payments for any given year.	Pre-Pay	Automated – MEIPRAS/NPIP
Ensure that each Provider that collects a Medicaid EHR incentive payment has collected a payment from only one state, even if the Provider is licensed to practice in multiple states.	Pre-Pay	Automated – MEIPRAS/NPIP
Assure payments are not made for any year starting after the year of 2015 unless the Provider has been provided payment for a previous year within the active program period.	Pre-Pay	NPIP
Payment		
Assure that Medicaid EHR incentive payments are made without reduction or rebate have been paid directly to a Provider or to an employer, a facility, or an eligible third-party entity to which the Medicaid Provider has assigned payments.	Pre-Pay	NPIP

Requirement	Pre/Post Payment	Automated State Level Repository System /Manual Process
Ensure that any existing fiscal relationships with Providers to disburse the incentive payments through Medicaid managed care plans does not result in payments that exceed 105 percent of the capitation rate, in order to comply with the Medicaid managed care incentive payment rules at §438.6(v)(5)(iii). This will not be relevant since Nevada also has a Fee-For-Service Agreement will all its MCO providers.	Pre-Pay	NPIP/MMIS Manual - MMIS Reporting Extract
Ensure that only appropriate funding sources are used to make Medicaid EHR incentive payments. DHCFP plans to apportion money from the proper account, via existing DHCFP accounting processes, before the money is disbursed.	Pre-Pay	Manual or through MMIS accounting processes.
Post-Payment		
Post-payment audits	Post-Pay	Manual - using the following auditable data sources: NPIP Provider enrollment files maintained by DHCFP. State licensing and accreditation boards. OIG exclusion list. Program Integrity state exclusion list. Provider Medicare and Medicaid cost reports. Provider encounter and claims data, and reimbursement information stored in the MMIS. Provider financial statements, patient data, and accounting records. Statewide HIE information may be used as an auditable data source as the statewide HIE is implemented.

6.9 NPIP Post-Payment Processing

Whenever a Provider's Medicaid EHR incentive payment is adjusted, the State will notify CMS via a Medicaid Payment Adjustment Interface (D-18) transaction, the same transaction used to notify CMS a

Medicaid EHR incentive payment was made. This transaction will accept negative amounts. A positive value identifies payment to be made. A negative value identifies payment to recoup. The transaction will be sent the day after the Provider's Medicaid EHR incentive payment is adjusted.

6.10   NPIP Reporting

6.10.1 NPIP Reporting

Information submitted to CMS will include the following information:

- Reports on Provider AIU of certified EHR technology activities and payments (Year 1);

- Aggregated, de-identified Meaningful Use data (Year 2 and beyond);

- Aggregated data on AIU, Meaningful Use, CQMs, and payments for unique needs (e.g. children) (Year 2 and beyond);

- Volume statistics on type, practice locations, and Providers who qualified for Medicaid EHR incentive payments (Year 1 and beyond); and

- Audit payment history from the MEIPRAS and NPIP (which must be reconciled).

DHCFP plans to implement a NPIP that incorporates reporting capabilities for the Medicaid EHR Incentive Program. The initial reporting capability of the NPIP for internal DHCFP may use includes but is not limited to:

- Incomplete registration applications;

- MEIPRAS applications waiting on NPIP registration;

- Active registration applications with CMS;

- Active registration applications attached to a group;

- Attestation applications currently pending;

- Active registrations not meeting eligibility threshold;

- Applications pending payment; and

- Completed application payments.

Using the above referenced NPIP, DHCFP is planning to submit the following regular annual reports to CMS:

- Provider AIU activities and payments;

- Number, type, and practice locations of Providers who qualified on the basis of AIU;

- Aggregated data tables representing Provider AIU;

- Aggregated and de-identified Meaningful Use of certified EHR technology and payments. (This table is not anticipated in the first annual report because Providers are only required to demonstrate AIU.);

- Number, type, and practice locations of Providers who qualified on the basis of demonstrating Meaningful Use. (This table is not anticipated in the first annual report because Providers are only required to demonstrate AIU.);

- Aggregated data tables representing the Providers' Meaningful Use and CQM data. (This table is not anticipated in the first annual report because Providers are only required to demonstrate AIU.); and

- Description and quantitative data on how the DHCFP Medicaid EHR Incentive Program addressed individuals with unique needs, such as children. (This information is not anticipated in the first annual report because this information may not be collected during the first year of the program.)

Additional financial oversight reports DHCFP may use internally include:

Table 11: Additional Financial Oversight Reports

Report	Frequency
Reports showing payments pending to eligible professional or eligible hospital.	Weekly and Monthly
Reports showing payments made to eligible professional or eligible hospital.	Weekly and Monthly
Payment reconciliation reports to track payment by NPI/Provider ID from NPIP to MMIS to NPIP to MEIPRAS. Medicaid EHR incentive payment calculation by provider. Dollars input in to the MMIS system by provider. Payments made by MMIS to provider. Payments reported to the NPIP by provider. Payments reported to the MEIPRAS by Provider.	Weekly and Monthly.
Reports tracking the status of all applications in the redetermination or appeals processes.	Weekly and Monthly
CMS Report with number of providers by type and location using AIU	Monthly
Aggregated Tables for AIU	Monthly
CMS Report with number of providers by type and location using Meaningful Use	Monthly
Aggregated Tables for Meaningful Use	Monthly
Quantitative data on how the Medicaid EHR Incentive Program addressed individual with unique needs, such as children.	Monthly

DHCFP will create additional reports as necessary to administer, manage, and monitor NPIP. CMS is creating Measures of Success and Functional Purpose Data Elements and Performance Metrics Exports from the MEIPRAS for states to use for reporting. CMS expects these files will be in a simple CSV format.

6.10.2 CMS Required Financial Reporting

CMS required financial reporting will be supported by existing Medicaid processes external to NPIP.

Under the Recovery Act, States have the option to participate in the Medicaid EHR Incentive Program. The Recovery Act provides 100 percent FFP to states for Medicaid EHR incentive payments to eligible Medicaid Providers to adopt, implement, upgrade, and meaningfully use certified EHR technology, and 90 percent FFP for state administrative expenses related to the program.

States may receive 90 percent FFP for reasonable administrative expenditures incurred in planning and implementing the program, subject to CMS prior approval. (Note, as required by § 495.358, all costs are subject to cost allocation rules in 45 CFR Part 95.)

States will be responsible for estimating the expenditures for the Medicaid EHR Incentive Program on the state's quarterly budget estimate reports via Form CMS-37. These reports are used as the basis for Medicaid quarterly grant awards that would be advanced to the state for the Medicaid EHR Incentive Program. These forms are submitted electronically to CMS via the Medicaid and State CHIP Budget and Expenditure System (MBES/CBES). On Form CMS-37, states should include any projections of administration related expenditures for the implementation costs. On Form CMS-64, a state submits on a quarterly basis actual expenses incurred, which is used to reconcile the Medicaid funding advanced to states for the quarter made on the basis of the Form CMS-37.

To assist states in properly reporting expenditures using the MBES/CBES, the CMS-37 and CMS-64 reports include a new category for reporting the 90 percent FFP match for State administrative expenses associated with the Medicaid EHR Incentive Program. The new category will be called "Health Information Technology Administration." This reporting category is located on the 64.10 base page, lines 24A and 24B, for Administration. Implementation expenditures are included on lines 24C and 24D.

6.10.3 Additional CMS Required Reporting

Section 495.352 reporting requirements mandate each state submit a quarterly progress report documenting specific implementation and oversight activities performed. The report will include progress in implementing the State's approved Medicaid HIT plan. In addition to submission of the quarterly report to CMS, DHCFP will use this information for multiple reporting purposes and will capture the following data for compliance, monitoring and program use. DHCFP plans to collect and report on the following:

- Number of appeals and fair hearings;
- Number of decisions upheld;
- Number of providers registering as adopters;
- Number of providers registering as implementers;
- Number of providers registering as "upgraders";
- Number of audits;
- Number of registrations processed;

- Number of registrations;

- Dollar amount of payments;

- Length of time to process payments;

- Number of payments made by provider type;

- Amount of payments made by provider type;

- Number of registrations rejected; and

- Call center statistics.

Appendix A: Acronyms

Acronym	Stands For:
AIU	adopt, implement, or upgrade
ARRA	American Recovery and Reinvestment Act
BMI	body mass index
CAH	Critical Access Hospital
CCD	continuity of care document
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid
CCN	CMS Certification Number
CHIP	Children's Health Insurance Program
CICS	Customer Information Control System
CMS	Centers for Medicare and Medicaid Services
CPOE	computerized physician order entry
CQM	Clinical Quality Measures
DHCFP	State of Nevada Division of Health Care Financing and Policy
DHHS	Nevada Department of Health and Human Services
DoD	Department of Defense
EFT	electronic funds transfer
EH	eligible hospital
EHR	electronic health records
EMR	electronic medical records
EP	eligible professional
FFP	federal financial participation
FHA	Federal Health Architecture
FQHC	federally qualified health center
GBPCA	Great Basin Primary Care Association
HIE	health information exchange

Acronym	Stands For:
HIPAA	Health Information Portability and Accessibility Act of 1996
HIT	health information technology
HITECH	Health Information Technology for Economic and Clinical Health
HRSA	Health Resources and Services Administration
IAPD	Implementation Advanced Planning Document
IHBN	Indian Health Board of Nevada
IHE	Integrating the Healthcare Enterprise
ITCN	Inter Tribal Council of Nevada
MBES/CBES	Medicaid and State CHIP Budget and Expenditure System
MEIPRAS	Medicare and Medicaid EHR Incentive Program Registration and Attestation System
MFCU	Medicaid Fraud Control Unit
MITA	Medicaid Information Technology Architecture
MITA SS-A	Medicaid Information Technology Architecture State Self-Assessment
MMIS	Medicaid Management Information System
NHIN	Nationwide Health Information Network
NLR	National Level Repository
NPI	National Provider Identifier
NPIP	Nevada Provider Incentive Program
NVHC	Nevada Health Centers
NSHD	Nevada State Health Division
OHIT	State of Nevada Office of Health Information Technology
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PAIHS	Phoenix Area Indian Health Service
PHR	personal health record
POS	Place of Service
REC	Regional Extension Center
RFP	Request for Proposal

Acronym	Stands For:
RHC	Rural Health Clinic
RPMS	Resource and Patient Management System
RSNA	Radiology Society of North America
SLR	State Level Repository
SMHP	State Medicaid Health Information Technology Plan
SOA	Service Oriented Architecture
SSA	Social Security Administration
TANF	Temporary Assistance for Needy Families
TIN	Taxpayer Identification Number
USDA	United States Department of Agriculture
VA	Veterans Affairs
VistA	Veterans Health Information System and Technology Architecture

Appendix B: Glossary

Term	Definition
American Recovery and Reinvestment Act (ARRA)	An economic stimulus package enacted by the 111th Congress in February 2009, commonly referred to as the Stimulus or The Recovery Act.
authentication	Authentication is a method or methods employed to prove that the person or entity accessing information has the proper authorization. Generally used to protect confidential information and network or application access.
authorization	Authorization is a system established to grant access to information. Authorization also establishes the level of access an individual or entity has to a data set and includes a management component—an individual or individuals must be designated to authorize access and manage access once access is approved.
broadband	A medium that can carry multiple signals, or channels of information, at the same time without interference. Broadband Internet connections enable high-resolution videoconferencing and other applications that require rapid, synchronous exchange of data.
Children's Health Insurance Program (CHIP)	CHIP program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.
computerized physician order entry (CPOE)	Computer-based systems that automate and standardize the clinical ordering process in order to eliminate illegible, incomplete, and confusing orders. CPOE systems typically require physicians to enter information into predefined fields by typing or making selections from on-screen menus. CPOE systems often incorporate, or integrate with, decision support systems.
CONNECT	CONNECT is an open source software solution that supports health information exchange – both locally and at the national level. CONNECT uses Nationwide Health Information Network standards and governance to make sure that health information exchanges are compatible with other exchanges being set up throughout the country.
continuity of care document	An electronic document exchange standard for sharing patient summary information, including the most commonly needed pertinent information about current and past health status in a form that can be shared by all computer applications, such as web browsers and EMR/EHR software systems.

Term	Definition
Critical Access Hospital (CAH)	A hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures.
Customer Control System (CCS)	Customer Control System (CCS) is a transaction server that runs primarily on IBM mainframe systems under z/OS and z/VSE. CICS is a transaction manager designed for rapid, high-volume online processing.
data warehouse	A large database that stores information like a data repository but goes a step further, allowing users to access data to perform research-oriented analysis.
Decision Support System (DSS)	A computer-based information system that supports business or organizational decision-making activities intended to help decision makers compile useful information from a combination of raw data, documents, personal knowledge, or business models to identify and solve problems and make decisions.
e-prescribing	Practice in which drug prescriptions are entered into an automated data entry system (handheld, PC, or other), rather than handwriting them on paper. The prescriptions can then be printed for the patient or sent to a pharmacy via the Internet or other electronic means.
electronic data interchange	Electronic data interchange is the structured transmission of data between organizations by electronic means. It is used to transfer electronic documents or business data from one computer system to another computer system, i.e. from one trading partner to another trading partner without human intervention.
electronic health record (EHR)	An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.
electronic medical record (EMR)	An electronic record of health-related information for an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Term	Definition
enterprise service bus	An enterprise service bus (ESB) is a software architecture construct which provides fundamental services for complex architectures via an event-driven and standards-based messaging engine (the bus). Developers typically implement an ESB using technologies found in a category of middleware infrastructure products, usually based on recognized standards. An ESB generally provides an abstraction layer on top of an implementation of an enterprise messaging system, which allows integration architects to exploit the value of messaging without writing code. Unlike the more classical enterprise application integration (EAI) approach of a monolithic stack in a hub and spoke architecture, an enterprise service bus builds on base functions broken up into their constituent parts, with distributed deployment where needed, working in harmony as necessary.
Federal Health Architecture (FHA)	A collaborative body composed of several federal departments and agencies, including the Department of Health and Human Services, the Department of Homeland Security, the Department of Veterans Affairs, the Environmental Protection Agency, the United States Department of Agriculture, the Department of Defense, and the Department of Energy. FHA provides a framework for linking health business processes to technology solutions and standards, and for demonstrating how these solutions achieve improved health performance outcomes.
Federally Qualified Health Center (FQHC)	A health center that receives cost-based reimbursement for Medicare and Medicaid patients as a mechanism to increase primary care services to high risk populations in underserved areas.
formulary	A list of medications (both generic and brand names) that are covered by a specific health insurance plan or pharmacy benefit manager, used to encourage utilization of more cost-effective drugs. Hospitals sometimes use formularies of their own, for the same reason.
health information exchange (HIE)	The electronic movement of health-related information among organizations according to nationally recognized standards.
Health Information Technology Blue Ribbon Task Force	In September 2009, Nevada Governor Jim Gibbons issued an Executive Order establishing the HIT Blue Ribbon Task Force and appointed a diverse group of 20 key stakeholders and industry leaders, including representatives from Nevada Medicaid, Nevada's REC, health systems and providers, public health, insurance, payers, the university system, and consumers. The mission of the Task Force is to provide oversight and guidance to Department of Health and Human Services/Office of Health Information Technology regarding HIT and HIE activities and initiatives, and to provide input to DHHS for developing the Statewide HIE infrastructure.

Term	Definition
health information technology (HIT)	The 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.
Health Information Technology for Economic and Clinical Health Act (HITECH)	On February 17, 2009, President Obama signed into law the Health Information Technology and Clinical Health Act (HITECH) as part of the American Recovery and Reinvestment Act. HITECH codifies and funds the Office of the National Coordinator for Health Information Technology and provides for the infusion of $19 billion over a four-year period, in grants and loans, for infrastructure and incentive payments under Medicare and Medicaid for providers who adopt and use health information technology. It also expands security and privacy provisions and penalties to HIPAA Business Associates of covered entities.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	A federal law intended to improve the portability of health insurance and simplify health care administration. HIPAA sets standards for electronic transmission of claims-related information and for ensuring the security and privacy of all individually identifiable health information.
Indian Health Service	A part of the U.S. Public Health Service within the US Department of Health and Human Services, the Indian Health Service is responsible for providing federal health services to American Indians and Alaska Natives.
Integrating the Healthcare Enterprise (IHE)	Integrating the Healthcare Enterprise (IHE) was formed by the Healthcare Information and Management Systems Society and the Radiological Society of North America. IHE is an initiative by health care professionals to improve the way health care information is shared between systems and organizations around the world for the purpose of improving the overall quality of health care to patients. The mission of IHE is to achieve interoperability of systems through the precise definition of health care tasks, the specification of standards-based communication between systems required to support those tasks, and the testing of systems to determine that they conform to the specifications.
interoperability	HIMSS' definition of interoperability is "ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities."

Term	Definition
Lincy Foundation, The	The Lincy Foundation was formed by Mr. Kirk Kerkorian in 1989 in response to the devastating earthquake in Spitak, Armenia. The substantial contributions from the newly formed Lincy Foundation provided housing to thousands of displaced individuals and families and reconstruction of roads and other key infrastructure. During the 20 years since its founding, The Lincy Foundation has provided financial gifts to humanitarian efforts of numerous U.S. charities while continuing to provide support to Armenia. Funding of The Lincy Foundation is provided solely by Kerkorian's company, Tracinda Corporation.
Medicaid Information Technology Architecture (MITA)	A federal, business-driven initiative that affects the Medicaid enterprise in all states by improving Medicaid program administration, via the establishment of national guidelines for processes and technologies. MITA is a common business and technology vision for state Medicaid organizations that supports the unique needs of each state.
Medicaid Management Information System (MMIS)	The MMIS is one of the primary repositories of provider information. MMIS capabilities will be leveraged to fulfill a range of functions, including the provision of data necessary to enable payment administration by the state's fiscal intermediary.
Medicaid and State CHIP Budget and Expenditure System (MBES/CBES)	This is the reporting system to CMS that documents actual expenditures that CMS will pay to States for the Medicaid program expenditures. The Form 64 is a statement of expenditures and reconciles the monetary advance made to the state on the basis of the Form 37. When using the MBES/CBES states can electronically submit their Form 64 and do not have to submit a hard copy.
Medicare and Medicaid EHR Incentive Program Registration and Attestation System (MEIPRAS)	This web system supports the Medicare and Medicaid EHR Incentive Programs. Those wanting to take part in the program will use this system to register and participate in the program.
Nationwide Health Information Network (NHIN)	The federal government's program to implement a national interoperable system for sharing electronic medical records or EMRs (a.k.a. electronic health records or EHR). NHIN describes the technologies, standards, laws, policies, programs and practices that enable health information to be shared among health decision makers, including consumers and patients, to promote improvements in health and healthcare. The development of a vision for the NHIN began more than a decade ago with publication of an Institute of Medicine report, "The Computer-Based Patient Record".

Term	Definition
NHIN Gateway	A NHIN Gateway is a set of interfaces, adapters, and subsystems that facilitates connection to, and exchange with, the NHIN network.
National Level Repository (NLR)	The NLR is the federal database that stores Medicaid and Medicare EHR Incentive Program data. This database supports MEIPRAS.
Nevada Provider Incentive Program (NPIP)	This web system supports the Nevada Medicaid EHR Incentive Program. Those wanting to take part in the program will use this system to register and participate in the program.
Office of the National Coordinator for Health Information Technology (ONC)	ONC provides leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care and the ability of consumers to manage their care and safety.
personal health record (PHR)	An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.
Pharmacy Benefit Management	A third party administrator of prescription drug programs primarily responsible for processing and paying prescription drug claims. They also are responsible for developing and maintaining the formulary, contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers.
portal	A website that offers a range of resources, such as email, chat boards, search engines, and content.
Provider	A provider is an individual or group of individuals who directly (primary care physicians, psychiatrists, nurses, surgeons, etc) or indirectly (laboratories, radiology clinics, etc) provide health care to patients. In the case of this SMHP and the EHR Incentive Program, Provider refers to both eligible professionals (EPs) and eligible hospitals (EHs).
public health	Public health is the art and science of safeguarding and improving community health through organized community effort involving prevention of disease, control of communicable disease, application of sanitary measures, health education, and monitoring of environmental hazards.
Regional Extension Center (REC)	An organization that has received funding under the Health Information Technology for Economic and Clinical Health Act to assist health care providers with the selection and implementation of EHR technology.

Term	Definition
Resource and Patient Management System (RPMS)	Resource and Patient Management System (RPMS) is a decentralized automated information system of over 60 integrated software applications. Many RPMS applications can function in a standalone environment if necessary or appropriate. The system is designed to operate on micro- and mini-computers located in Indian Health Service or tribal healthcare facilities. RPMS software modules fall into three major categories: 1) practice management applications that perform patient registration, scheduling, billing, referrals, and linkage functions; 2) clinical applications that support various healthcare programs within IHS; and 3) infrastructure applications.
Rural Health Clinic (RHC)	A clinic certified to receive special Medicare and Medicaid reimbursement, intended to increase primary care services for Medicaid and Medicare patients in rural communities.
stakeholder	A stakeholder is any organization or individual that has a stake in the exchange of health information, including health care providers, health plans, health care clearinghouses, regulatory agencies, associations, consumers, and technology vendors.
State Level Repository (SLR)	The SLR is the database supporting the NPIP administration. The SLR will capture state-collected data elements as part of the intake. The SLR will contain basic data elements that have been transferred from the NLR (e.g., National Provider Identifier (NPI); CMS Certification Number (CCN) for an EH; EP type; affiliation, etc.). The SLR will capture other relevant information from the EP/EH (e.g., email address; EP affiliation with a managed care organization) to establish eligibility for the EHR incentive program, including patient volume and attestation information.
University of Nevada Las Vegas Center for Health Information Analysis (CHIA)	CHIA serves the community by making specific Nevada health care related data available to both the private and public sectors. It is a research center at the University of Nevada Las Vegas under the Vice President of Research and Graduate Studies. It works in conjunction with the Division of Health Care Financing and Policy of the Department of Health and Human Services for the State of Nevada. Its goal is to provide meaningful data to help research organizations in developing utilization patterns, health status and related issues.
vendor	A vendor is an organization that provides services and supplies to other organizations. In the context of health information exchange, the term usually refers to technology vendors who provide hardware or software, such as EHRs, e-prescribing technology, or security software.
Veterans Health Information System and Technology Architecture (VistA)	An enterprise-wide information system – a collection of about 100 integrated software modules – built around an EHR, used throughout the United States Department of Veterans Affairs medical system, known as the Veterans Health Administration.

Appendix C: Responses to CMS State Medicaid HIT Plan Questions

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

| **The State's "As-Is" HIT Landscape:** This information should be a result of the environmental scan and assessment conducted with the CMS HIT P-APD funding; or was available to the SMA through other means (e.g. was part of the ONC HIE cooperative agreement planning and assessment activities or other HIT/E assessments.) | 1. What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State's providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of provider? Does the SMA have data on EHR adoption by types of provider (e.g. children's hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)?

RESPONSE: The Nevada EHR adoption data gathering was completed in August 2010 and is an assessment of overall statewide use and is not specific to Medicaid provider types. The data results show that almost 46% of the providers surveyed have an EHR system and another 32% plan to implement a system within five years. The data is provided for urban and rural providers, and was stratified by type of EHR. Current State data indicates that there are 49 active Acute Care Hospitals, 25 of which are likely to meet Medicaid volume threshold requirements (based on FY 2009 data). As of November 2010, the State also reports as enrolled Medicaid providers 5,139 Physicians, 708 Dentists and Dental Surgeons, 318 Certified Nurse Practitioners, 300 Pediatricians, 7 Certified Nurse Midwives, and 366 Physician's Assistants (PA), although only 36 PA's are anticipated to meet the eligibility requirements.

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

RESPONSE: The State of Nevada established a Broadband Task Force in July 2009. The Task Force is currently identifying the issues of broadband access, as well as providing oversight of American Recovery and Reinvestment Act (ARRA) funding for broadband mapping and data management.   Providers in Nevada's rural counties are often underserved by broadband. Nevada is the most mountainous state and the physical terrain may require alternate connectivity solutions. Lack of financial resources to add statewide broadband connectivity may impede HIE implementation.

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.

RESPONSE: Nevada Health Centers have received a $1.4 million HRSA grant to support the development of HIT and HIE infrastructure. Additionally, the health centers also received a grant through the Lincy Foundation to support implementation of a full EHR system. A comprehensive EHR system has been operational in NVHC clinics since May 2009.

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

RESPONSE: The Nevada Office of Veterans Services has two main service offices, one in Reno and one in Las Vegas, as well as the Nevada Veterans Home located in Boulder City. The EHR system in place for the Nevada VA services is the Veterans Health Information System and Technology Architecture (VistA). A recent congressional directive has |

required the Veterans Administration and Department of Defense to share records in order to provide for the seamless care of soldiers as they transition from active duty to the Veterans Administration (VA) system. Currently in Nevada, this involves links between the VA's Computerized Patient Records System (CPRS) and VistA systems and the Air Force Composite Health Care System (CHCS) and Armed Forces Health Longitudinal Technology Application (AHLTA) systems. For this exchange, the VA and the Air Force's Mike O'Callaghan Federal Hospital have a direct connection temporarily. However, a "business gateway" is being developed.

Most of the Indian Health Services clinics operate the Resource and Patient Management System (RPMS). RPMS is the national IHS EHR system that is undergoing enhancements to meet Meaningful Use. Additionally, IHS is planning to provide health care services in Nevada through "look alike FQHC" facilities with providers who will be eligible for EHR incentive payments. One of the issues for IHS facilities will involve broadband connectivity.

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

   RESPONSE: Nevada has a network of stakeholders engaged in HIT/HIE. The Governor's HIT Blue Ribbon Task Force includes a diverse group of 20 key stakeholders and industry leaders, including representatives from Nevada Medicaid, Nevada's REC, health systems and providers, public health, insurance, payers, the university system, and consumers. The mission of the Task Force is to provide oversight and guidance to the Nevada DHHS regarding HIT and HIE activities and to provide input to DHHS for developing the Statewide HIE infrastructure. These stakeholders actively participate in all planning activities and are currently planning for the governance structure of the Statewide HIE

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?

   RESPONSE: DHCFP does not have any existing HIT/HIE relationships at this time.

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?

   RESPONSE: The proposed governance structure of the Statewide HIE is currently being developed to include the State designated entity. The Statewide HIE governance model has been proposed to the Nevada Legislature, and is under review. DHCFP participates in the Governor's HIT Blue Ribbon Task Force.

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.

   RESPONSE: DHCFP is currently transitioning MMIS functions from Magellan Medicaid Administration to Hewlett Packard. This is a takeover of current functions for the next five-year period. Magellan Medicaid Administration currently provides MMIS services for DHCFP through a contract scheduled to terminate on September 29, 2012. During this time, DHCFP will be working to procure a replacement MITA-aligned MMIS.

9. What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible

providers to implement EHR systems and achieve meaningful use?

RESPONSE: Nevada has submitted a final Statewide Health Information Exchange Strategic and Operational Plan. Additionally, the Governor's HIT Blue Ribbon Task Force meets regularly to discuss requirements for the governance and operation of a Statewide HIE. Nevada's REC HealthInsight has signed up over 400 primary care providers. DHCFP and the Statewide HIE are planning to provide a unified message for promotion of certified EHR technology to all Nevada providers.

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.

RESPONSE: Planning for HIT and HIE initiatives in Nevada falls under the umbrella of DHHS, which includes the OHIT and DHCFP (the State Medicaid Agency). DHCFP is responsible for developing the SMHP. OHIT is responsible for administering the ARRA HITECH State HIE Cooperative Agreement, through ONC. HealthInsight participates in regularly scheduled meetings with the State HIT Coordinator and DHCFP.

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?

RESPONSE: DHCFP is currently planning for an MMIS procurement that will likely influence the direction of the EHR incentive program over the next five years. DHCFP has not made any decisions yet regarding the functionality that may be incorporated into the MMIS. DHCFP will explore the ability to leverage existing data sources and participation in the Statewide HIE.

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.

RESPONSE: Nevada has submitted a proposed set of legislative changes (SB 43) for the 2011 Legislative session. DHCFP has privacy and security regulations and policies and procedures that are more stringent than federal HIPAA. In the event the legislation is updated, DHCFP will update its privacy and security policies in light of the new requirements under HITECH And HIPAA.

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.

RESPONSE: The current Statewide Assessment does not address HIT/HIE activities that cross Nevada's borders. The State Medicaid records currently shows a total of 1,703 Physician providers, 48 Dentistry providers, 87 Certified Nurse Practitioner providers, 19 Certified Nurse Midwives, and 81 PAs enrolled as out-of-state Medicaid providers in Nevada.

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

RESPONSE: There is no current interoperability of the State public health immunization registry and public health surveillance reporting databases.

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.

RESPONSE: *Nevada has not received a CHIPRA HIT related grant. Nevada received a data warehouse Medicaid Transformation Grant; however, the State did not execute the grant and returned the funding.*

* May be deferred.

** The first part of this question may be deferred but States do need to include a description of their HIE(s)' geographic reach and current level of participation. |

SECTION B: The State's "To-BE" Landscape

| The State'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.

RESPONSE: *DHCFP is participating with the REC and Statewide HIE initiatives, and will continue to coordinate with both to further ensure the education of providers on Meaningful Use, as well as the adoption of certified EHR technology in Nevada.*

2. * What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Services Bus? Master Patient Index? Record Locater Service?

RESPONSE: *DHCFP has a goal of procuring a new MMIS system to include both clinical and administrative data, as well as a full interface to the Statewide HIE for clinical and administrative data feeds, as well as other (surrounding) state HIEs and state agencies for data. DHCFP is building a comprehensive data warehouse, and will utilize these data feeds to provide real-time, or near real-time, analytics via the data warehouse to increase Medicaid efficiencies and decrease costs.*

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.)?

RESPONSE: *DHCFP is investigating a vendor solution/application for the integrated Nevada Provider Incentive Program.*

4. Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA's HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.

RESPONSE: *DHCFP is fully participating with the REC and Statewide HIE initiatives, and will continue to coordinate with both to ensure the education of providers on Meaningful Use as well as the adoption of certified EHR technology in Nevada.* |

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

   RESPONSE: DHCFP, the Statewide HIE, and the REC will continue to coordinate activities and communication to provide outreach, training, and education to the Provider community to enhance certified EHR adoption rates and understanding and full compliancy of Meaningful Use. All three agencies are working in collaboration to hire a marketing firm to create a unified message and to provide ongoing outreach and education for providers, centered on the adoption of certified EHR technology and Meaningful Use.

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?

   RESPONSE: All FQHCs have expressed strong interest in participating in the Statewide HIE, including Health Access Washoe County and the NVHC, as well as the HRSA certified FQHCs. DHCFP will coordinate activities with the Statewide HIE and the REC to work towards full participation of all FQHCs in the Statewide HIE as well as adoption and Meaningful Use of certified EHR technology by all FQHCs.

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

   RESPONSE: DHCFP is continuing to coordinate efforts with the Statewide HIE and the REC to provide marketing, education, training, and outreach to providers in Nevada on Meaningful Use and the adoption 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?

   RESPONSE: DHCFP, in coordination with the Statewide HIE and the REC, are targeting specialty and unique needs populations and providers to ensure education and the adoption of certified EHR technology, as well as participation in the REC and the Statewide HIE. The Statewide HIE, the REC, and DHCFP are working in collaboration to hire a marketing firm to create a unified message and to provide ongoing outreach and education for providers, centered on the adoption of certified EHR technology and Meaningful Use.

9. If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.?

   RESPONSE: The State Library and Archives received funding for public computing centers, which will provide Internet to consumers to access personal health records. The Federal Communication Commission and USDA are both working on funding programs for rural health and providers, thus the Statewide HIE, DHCFP, and the REC are coordinating activities and looking at different ways to take advantage of these opportunities for last mile broadband for providers. The REC, Statewide HIE and DHCFP are working collaboratively on coordinating with the National Broadband Resource and ways to bring last mile connectivity broadband to Nevada with an emphasis on rural health. Continuing to coordinate resources and investigate funding opportunities for providers for last mile broadband connectivity are major initiatives that will be continued in the State.

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

| | Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.

RESPONSE: In cooperation with the State HIT Coordinator, DHCFP is participating fully in efforts to ensure that any and all new legislation (or changes to existing legislation) required will be comprehensive and include not only DHCFP but also the Statewide HIE and other HIT initiatives.

Please include other issues that the SMA believes need to be addressed, institutions that will need to be present and interoperability arrangements that will need to exist in the next five years to achieve its goals.

* This question may be deferred if the timing of the submission of the SMHP does not accord with when the long-term vision for the Medicaid IT system is decided. It would be helpful though to note if plans are known to include any of the listed functionalities/business processes.

** May be deferred. |
|---|---|

SECTION C: Activities Necessary to Administer and Oversee the EHR Incentive Payment Program

| **The State's Implementation Plan:** Provide a description of the processes the SMA will employ to ensure that eligible professional and eligible hospital have met Federal and State statutory and regulatory requirements for the EHR Incentive Payments. | 1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

RESPONSE: DHCFP will conduct a manual review of all applications against the OIG list.

2. How will the SMA verify whether EPs are hospital-based or not?

RESPONSE: DHCFP will rely on the attestations from the NPIP for the initial determination and will conduct targeted audits on a certain percentage of all providers.

3. How will the SMA verify the overall content of provider attestations?

RESPONSE: DHCFP will rely on the attestations from the NPIP for the initial determination and will conduct targeted audits on a certain percentage of all providers.

4. How will the SMA communicate to its providers regarding their eligibility, payments, etc?

RESPONSE: The initial communication strategy consists of engaging providers through multiple parallel communication methods. Initial strategy includes use of current DHCFP existing communication channels, expansion of the web and online capabilities and face-to-face outreach and education sessions.

5. What methodology will the SMA use to calculate patient volume?

RESPONSE: DHCFP will allow EPs to use either CMS methodology from 42 CFR Part 495 to calculate patient volume for EPs. DHCFP will use the EH patient volume calculation methodology from 42 CFR Part 495. |
|---|---|

6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?

RESPONSE: DHCFP will use the MMIS claims data and cost reports to verify patient volume.

7. How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement?

RESPONSE: DHCFP will verify FQHC/RHC EPs volume using MMIS claims data and cost reports.

6. How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers?

RESPONSE: DHCFP will require that providers upload documentation into the NPIP with the attestations. This documentation will include invoices, purchase orders, contracts or other proof of purchase.

7. How will the SMA verify Meaningful Use of certified electronic health record technology for providers' second participation years?

RESPONSE: DHCFP plans to accept attestations of Meaningful Use and subsequently conduct targeted and random audits to verify Meaningful Use.

8. Will the SMA be proposing any changes to the MU definition as permissible per rule-making? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden.

RESPONSE: DHCFP does not plan any changes to the federal definition of Meaningful Use.

9. How will the SMA verify providers' use of certified electronic health record technology?

RESPONSE: DHCFP plans to accept attestations regarding the use of certified EHR technology that includes entry of the CMS EHR Certification ID. Subsequently, DHCFP will conduct targeted and random audits using the ONC and CMS lists of certified EHR technology.

10. How will the SMA collect providers' Meaningful Use data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term and a different approach for the longer-term?

RESPONSE: DHCFP will collect Meaningful Use data using the NPIP. At this point, DHCFP does not envision using different approaches for the short-term versus long-term.

11. * How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?

RESPONSE: DHCFP has not assessed how this data collection and analysis aligns with collection of other clinical quality measures data. This information will be provided in subsequent versions of the SMHP.

12. What IT, fiscal and communication systems will be used to implement the EHR Incentive

Program?

RESPONSE: DHCFP plans to use the current MMIS system and current communications channels for implementation of the EHR Incentive Program. Additionally, DHCFP is assessing the need to acquire a vendor solution to support processes not currently supported by existing capability.

13. What IT systems changes are needed by the SMA to implement the EHR Incentive Program?

RESPONSE: DHCFP plans to implement the EHR Incentive Program using the payment processes currently in place. Minor business process changes are anticipated. Additionally, DHCFP is assessing the need to acquire a vendor solution to support processes not currently supported by existing capability.

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

RESPONSE: Upon completion of the procurement process, DHCFP expects that testing with CMS' National Level Repository (NLR) will begin in April 2012. It is anticipated that the Nevada Medicaid EHR Incentive Program will begin accepting registrations in June 2012 with the first incentive payments being made in July 2012. When DHCFP completes its decision making process, the analysis will be included in a future update of this document.

15. When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)?

RESPONSE: DHCFP understands that testing with the NLR should begin two months prior to the anticipated launch date of the program. When DHCFP completes its decision making process, the analysis will be included in a future update of this document.

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

RESPONSE: A provider website portal will be in place.

17. What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc?

RESPONSE: DHCFP is assessing the need to acquire a vendor solution that will include this functionality.

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

RESPONSE: MMIS modifications related to the EHR Incentive Program will be submitted with the HIT I-APD as a separate section of that I-APD.

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

RESPONSE: DHCFP is assessing the need to acquire a vendor solution that will include these services.

20. What will the SMA establish as a provider appeal process relative to: a) the incentive

payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and Meaningful Use certified EHR technology?

RESPONSE: DHCFP has determined that its Providers will be able to submit additional information through an informal process prior to a formal appeal. This process will begin with initial access through the NPIP. This will be an informal data correction and resolution method and the Provider will be afforded the opportunity to make changes to their NPIP information. If this method results in a denial decision, DHCFP will provide a written notification of the denial action by email to the Provider. The Provider may challenge the DHCFP action at that time by filing an appeal. From there, the appeals process will follow the current process in place.

21. What will be the process to assure that all Federal funding, both for the 100 percent incentive payments, as well as the 90 percent HIT Administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS FFP?

    RESPONSE: DHCFP has a current standard operating procedure for accounting. This process will be adopted to assure that the Medicaid EHR incentive payments, as well as the 90% match, are properly accounted for.

22. What is the SMA's anticipated frequency for making the EHR incentive payments (e.g. monthly, semi-monthly, etc.)?

    RESPONSE: DHCFP plans to distribute the EHR incentive payments as weekly batch processing through the MMIS.

22. What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate?

    RESPONSE: DHCFP will follow its payment process currently in place for claims payments for the EHR incentive payments. This process does not have any opportunity for rebate or deduction.

23. What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such a payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption?

    RESPONSE: DHCFP has not designated an entity promoting the adoption of certified EHR technology. Therefore, no response is required.

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

    RESPONSE: DHCFP does not directly contract or enroll managed care providers. All Nevada Medicaid providers enroll through the DHCFP Fee-for-Service (FFS) program. Therefore, the calculation of Managed Care capitation rates is not required.

25. What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs' 15% of the net average allowable costs of certified EHR

technology) are made consistent with the Statute and regulation?

RESPONSE: This is no longer required and is not applicable as per the Medicare and Medicaid Extenders Act of 2010.

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

RESPONSE: DHCFP is assessing the need to acquire a vendor solution to support processes not currently supported by existing capability. The role existing SMA contractors will play will be more clear once a solution is selected.

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

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

RESPONSE:

Assumptions: This plan assumes that:

1. *The MEIPRAS will be ready for test and implementation according to the current schedule as presented by CMS;*

2. *The Statewide HIE connectivity and interoperability, if selected as a primary connectivity methodology, will be available for integration and testing per the schedule listed in Table 2 – HIT Roadmap and Activities above;*

3. *Certification and implementation of certified EHR technology will be timely in keeping with the NPIP schedule; and*

4. *The NPIP Vendor Solution will be delivered on time and integrated in a timely manner.*

Dependencies:

1. *Testing of the NPIP Vendor Solution is dependent on the availability and functionality of the MEIPRAS being as described by CMS;*

2. *The Incentive Payments activities as listed in Table 2 – HIT Roadmap and Activities above are dependent on the availability and functionality of the MEIPRAS being as described by CMS; and*

3. *The incentive payments activities as listed in Table 2 – HIT Roadmap and Activities above are dependent on the capacity of the certified EHR technology vendors to meet the demands of the Provider marketplace for their product.*

* May be deferred.

SECTION D: The State's Audit Strategy	
The State's Audit Strategy: Provide a description of the audit, controls and oversight strategy for the State's EHR Incentive Payment Program.	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.

RESPONSE: DHCFP is currently assessing the need for additional audit staff that may include contractors. DHCFP has designed the following verification and audit methods:

- *Provider eligibility: DHCFP will verify that providers are credentialed, not sanctioned, and not hospital-based, and are one of the types of Providers eligible for the Medicaid EHR Incentive Program.*
  - o *NPIP will verify the application and will pass or suspend the application. Some sanctions from other states will pass the validations such as expired licenses from other states. The application contains an attestation covering the eligibility criteria including the hospital - based physician criteria. Pre-Payment verifications and audit queues will be used for additional validations.*

- *Patient volume: DHCFP will verify or audit the attestation data, including use of proxy data (such as claims), where appropriate, to identify risk.*
  - o *Compare EPs Medicaid patient volume supplied during attestation to the previous year's Medicaid patient volume. If the attested patient volume is outside a 30% variance of the previous year's Medicaid patient volume the Provider will be queued for audit. A/I/U attestation patient volume is based on a 90 day period, so the comparison will be made to the MMIS data from the same period of the previous year.*

- *Certified EHR technology: DHCFP will collect the certified EHR technology code as part of Provider attestation for AIU, and NPIP will verify that the code is on the ONC's list of certified EHR technology prior to issuing an incentive payment to that Provider.*

DHCFP plans to verify all of the following during pre payment verifications:

- *Review of AIU attestation documentation;*

- *For dually certified hospitals, Medicaid will verify the Medicaid percentage and review the results of the Medicare audits when available;*

- *The federal sanctions list/database from the Office of Inspector General; and*

- *The State of Nevada sanction list/database.*

DHCFP plans to conduct random and targeted pre-payment audits, as well as random and targeted post-payment audits. DHCFP will use a random sampling automated tool to generate a list of up to five percent of all Providers for both pre and post-payment audits.

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DHCFP will conduct its pre-payment and post-payment audits using desk and onsite audits.

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?

    RESPONSE: DHCFP will track the overpayments through NPIP and MMIS reporting capabilities.

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

    RESPONSE: DHCFP will follow its current standard operating procedure and refer all fraud and abuse to the MFCU.

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.

    RESPONSE: DHCFP plans to consider all existing data sources to verify Meaningful Use.

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)

    RESPONSE: Please see the response to Section D – Question 1.

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)?

    RESPONSE: DHCFP plans to incorporate existing program integrity and program audit standard operating procedures.

7. Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?

    RESPONSE: DHCFP has Medicaid EHR Incentive Program staff within the MMIS/IT Unit reporting directly to the Medicaid Administrator and an Audit Unit reporting directly to the Medicaid Administrator. These units have responsibility for pre-payment verification, pre-payment audits and post-payment audits as well as monitoring and reporting functions.

* The sampling methodology part of this question may be deferred until the State has formulated a methodology based upon the size of their EHR incentive payment recipient universe.

** May be deferred.

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SECTION E: The State's HIT Roadmap

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The State's HIT Roadmap: Annual

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1. * Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be),

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Measurable Targets Tied to Goals	and how it plans to get there. *RESPONSE: The narrative and graphical pathways are shown in at the beginning of the Roadmap section. The graphic and narrative tables clearly show the prominent activities by quarter, highlighting significant milestones along the way.* 2. What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type? *RESPONSE: The EP and EH EHR adoption over time are highlighted in the Roadmap section. This table highlights the State expectations for adoption over time. The Eligible Professionals category is broken down by provider type by year.* 3. Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario. *RESPONSE: The EP and EH EHR adoption goals over time are highlighted in the Roadmap section.* 4. Discuss annual benchmarks for audit and oversight activities. *RESPONSE: DHCFP plans to implement a Verification and Audit Strategy that includes pre-payment verifications, pre-payment audits and post-payment audits. During the first 90 days, DHCFP will be evaluating the level of participation and creating an inventory of the types of EPs who apply for the incentives, as well as the number of hospitals. The initial list of registrations will be evaluated and considered as DHCFP initiates the pre-payment verifications, audits and post-payment audits upon the program's first payment. DHCFP will also seek information from other States regarding their evaluation of the initial implementation and will evaluate and set the benchmarks for audits during the first year of participation.* CMS is looking for a strategic plan and the tactical steps that SMAs will be taking or will take successfully implement the EHR Incentive Program and its related HIT/E goals and objectives. We are specifically interested in those activities SMAs will be taking to make the incentive payments to its providers, and the steps they will use to monitor provider eligibility including Meaningful Use. We also are interested in the steps SMAs plan to take to support provider adoption of certified EHR technologies. We would like to see the SMA's plan for how to leverage existing infrastructure and/or build new infrastructure to foster HIE between Medicaid's trading partners within the State, with other States in the area where Medicaid clients also receive care, and with any Federal providers and/or partners. * Where the State is deferring some of its longer-term planning and benchmark development for HIT/E in order to focus on the immediate implementation needs around the EHR Incentive Program, please clearly note which areas are still under development in the SMA's HIT Roadmap and will be deferred.

Appendix D: Current Electronic Health Records in Use by State Providers

Results from the online survey portion of the Nevada Health Information Technology Statewide Assessment, finalized on August 13, 2010:

When asked to indicate the EHR(s) and version(s) being used in a Provider's organization, the following is a list of the top EHR systems identified along with a separate list from those who indicated an interest in registering for the Medicaid EHR Incentive Program.

All Responses	Yes, Medicaid Incentives
NextGen	NextGen
Allscripts (Homecare, Pro EHR, Touchworks)	Office Mate
eClinical Works	eClinical Works
Amazing Charts	Amazing Charts
AVATAR	Allscripts (Homecare, Pro EHR)
Dentrix	
Medinotes e	
Office Mate	

Data received from the REC on EHR systems that are being used by the Providers they are assisting, current as of March 2, 2011:

NV Sites	Providers	EHR	Pct of sites	Pct of docs
23	59	eClinicalWorks	28.75%	24.28%
9	46	Allscripts	11.25%	18.93%
9	11	SOAPware	11.25%	4.53%
7	10	Amazing Charts EHR	8.75%	4.12%
7	16	e-MDs Solution Series EMR	8.75%	6.58%
7	16	"Other"	8.75%	6.58%
4	13	Greenway Prime Suite	5.00%	5.35%
3	6	Alteer	3.75%	2.47%
2	45	NextGen EHR	2.50%	18.52%
2	3	Sage	2.50%	1.23%
1	1	Chartlogic	1.25%	0.41%
1	1	InTuun	1.25%	0.41%
1	1	Medisoft Clinical EMR	1.25%	0.41%
1	12	Micro MD	1.25%	4.94%
1	1	Practice Partner	1.25%	0.41%
1	1	Quest 360 EHR	1.25%	0.41%
1	1	SynaMed	1.25%	0.41%
80	**243**	**Total sites & providers**		

Appendix E: Nevada HIT Statewide Assessment

This document is included as an electronic PDF file on the CD enclosure and the URL for this document is listed below:

https://dhcfp.nv.gov/EHRI/Nevada_HIT_Statewide_Assessment.pdf

Appendix F: Nevada HIT Strategic and Operational Plan

This document is included as an electronic PDF file on the CD enclosure and the URL for this document is listed below:

http://dhhs.nv.gov/PDFs/HIT/NV_StaeHITPlan_AppendixG.pdf

Appendix G: Nevada HIT Regulatory and Policy Inventory

This document is included as an electronic PDF file on the CD enclosure and the URL for this document is listed below:

http://dhhs.nv.gov/HOLD/HIT/Meetings/2010/2010-08-23_NVHITRegInventory.pdf

Appendix H: Nevada Medicaid HIT Regulatory Inventory

This document is included as an electronic PDF file on the CD enclosure and the URL for this document is listed below:

http://dhhs.nv.gov/PDFs/HIT/NV_Medicaid_HITRegInventory_Nov2010.pdf

Appendix I: Estimated EP Incentive Payments

This document is included as an electronic PDF file on the CD enclosure.

Appendix J: Estimated EH Incentive Payments

This document is included as an electronic PDF file on the CD enclosure.

Appendix K: SMHP Communication Plan

This document is included as an electronic PDF file on the CD enclosure.