State of Nevada

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

State Medicaid

Health Information Technology

Plan

April 12, 2017

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Revision History

SMHP Version	Nevada Action	Date Submitted	SMHP Version
1.0	Initial State Medicaid HIT Plan	April 12, 2011	Approval received on July 26, 2011
1.1	SMHP Addendum #1 for Electronic Health Record Provider Incentive Program	October 29, 2014	Approval received on January 13, 2015
1.2	SMHP Addendum #2 for Electronic Health Record Provider Incentive Program	January 14, 2016	Approval received on January 26, 2016
1.3	SMHP Addendum #3 for Electronic Record Provider Incentive Program	February 9, 2017	Approval received on March 29, 2017
2.0	Complete re-write of SMHP	April 12, 2017	

Introduction and Overview

The Nevada Department of Health and Human Services' (DHHS) Division of Health Care Financing and Policy (DHCFP) administers the Centers for Medicare & Medicaid Services (CMS) Electronic Health Record (EHR) Incentive Program (EHR Incentive Program) for its Medicaid eligible professionals (EP), eligible hospitals (EH), and Critical Access Hospitals (CAH) (collectively "Eligible Providers").

In order to participate in the EHR Incentive Program, a State Medicaid Health Information Technology Plan (SMHP) must be approved by CMS, as well as a Medicaid Health Information Technology (health IT or HIT) Implementation Advance Planning Document (I-APD) before federal funding can be accessed for program administration and incentive payments. The State's first SMHP and Medicaid HIT I-APD was approved by CMS on July 26, 2011.

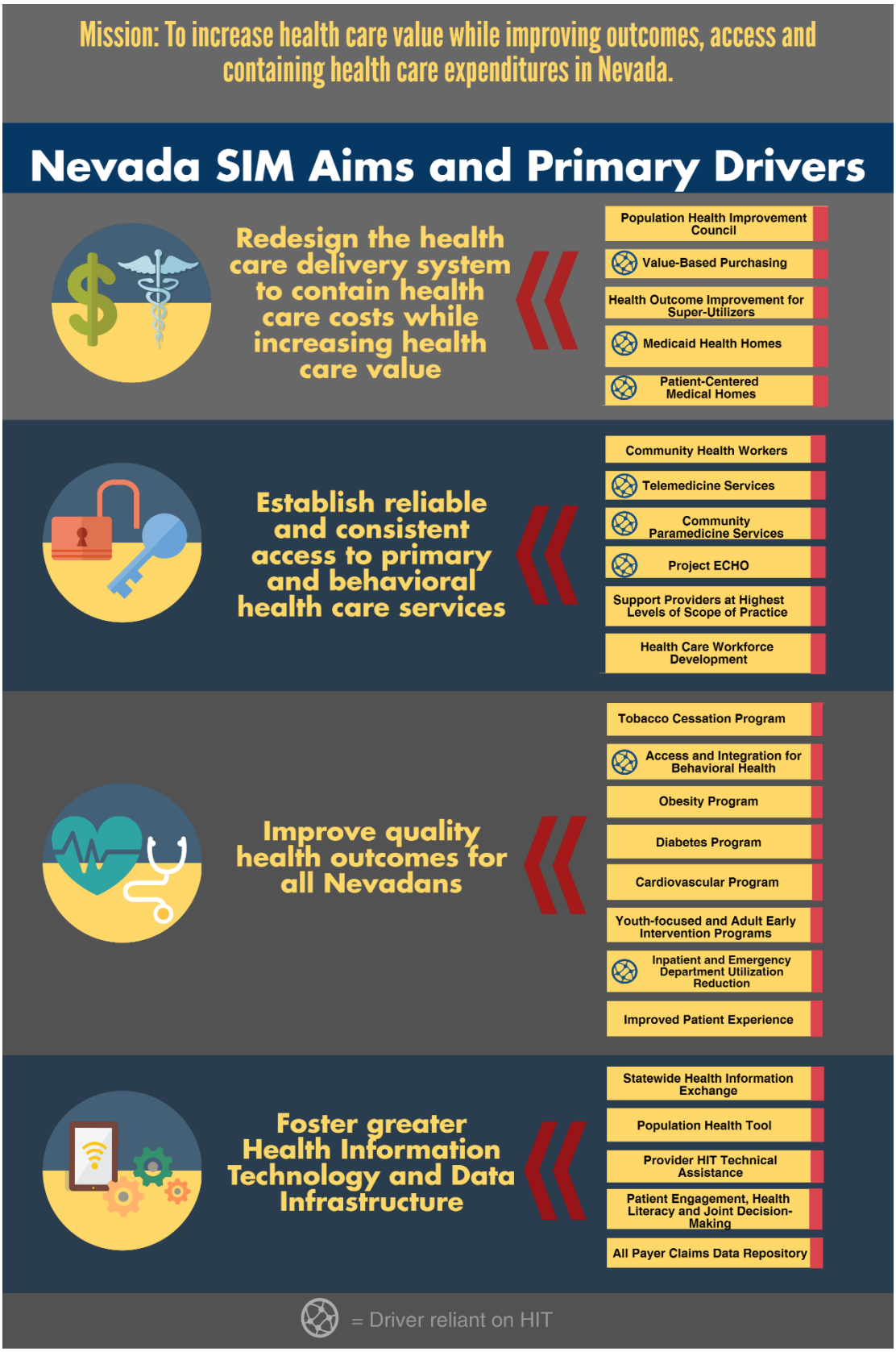
The State has achieved several goals outlined in its 2011 HIT Roadmap. Nevada has procured a replacement Medicaid Management Information System (MMIS) and is actively transitioning from its legacy systems. The State is also reaching Medicaid Information Technology Architecture (MITA) Level 2 and 3 capabilities, all to achieve greater interoperability with its providers and improve health record sharing functionality. In addition, the State has experienced vast expansion of its broadband capabilities to support use of health IT and electronic exchange statewide.

Finally, Nevada developed the requirements needed to build the operations and IT infrastructure for administering the EHR Incentive Program to successfully process registration, attestation, and payments to qualified providers, and implement a robust auditing process. While the IT infrastructure is substantially in place, the operations infrastructure continues to evolve particularly in response to the requirements in the *Modifications to Meaningful Use in 2015-2017* final rule published in October 2015.

DHCFP is committed to making meaningful and sustainable changes to its health care delivery and payment systems to improve population health and care quality while containing costs. To facilitate development of a plan to achieve this goal, Nevada received a $2 million Round Two State Innovation Model (SIM) design grant through the Center for Medicare and Medicaid Innovation (CMMI) on December 16, 2014, which supported development of a statewide, multi-payer, stakeholder informed State Health System Innovation Plan (SHSIP).

Fostering greater health IT and data infrastructure was one of four primary aims in the SHSIP, and several of the key drivers identified to address these high-level aims will leverage health IT as a core component as illustrated in *Figure 1. Nevada SIM Aims and Primary Drivers*. As effective adoption, implementation and use of health IT and infrastructure are critical to the SHSIP, DHCFP is in the process of expanding the Medicaid EHR Incentive Program for its eligible providers, and pursuing initiatives that promote the adoption of Certified EHR Technology (CEHRT) and the electronic exchange of health information.

Figure 1. Nevada SIM Aims and Primary Drivers



While statistics from the Medicaid EHR Incentive Program show that 625 EPs and 31 EHs and CAHs have received at least one incentive payment for the adoption and Meaningful Use of an EHR in Nevada, and 894 ambulatory physicians and 26 hospitals are participating in health information exchange (HIE), there is still much opportunity to increase adoption and optimization.

Stakeholders statewide repeatedly stressed the importance of ongoing technical and operational services to support health IT adoption, therefore the State is supporting the efforts of the only HIE in Nevada, EH Nevada, and the former Regional Extension Center (REC), HealthInsight, in enabling the provider community to utilize and optimize health IT in practice. Furthermore, with the publication of State Medicaid Director (SMD) Letter #16-003, the State will continue to focus on identifying and encouraging participation among all eligible providers statewide.

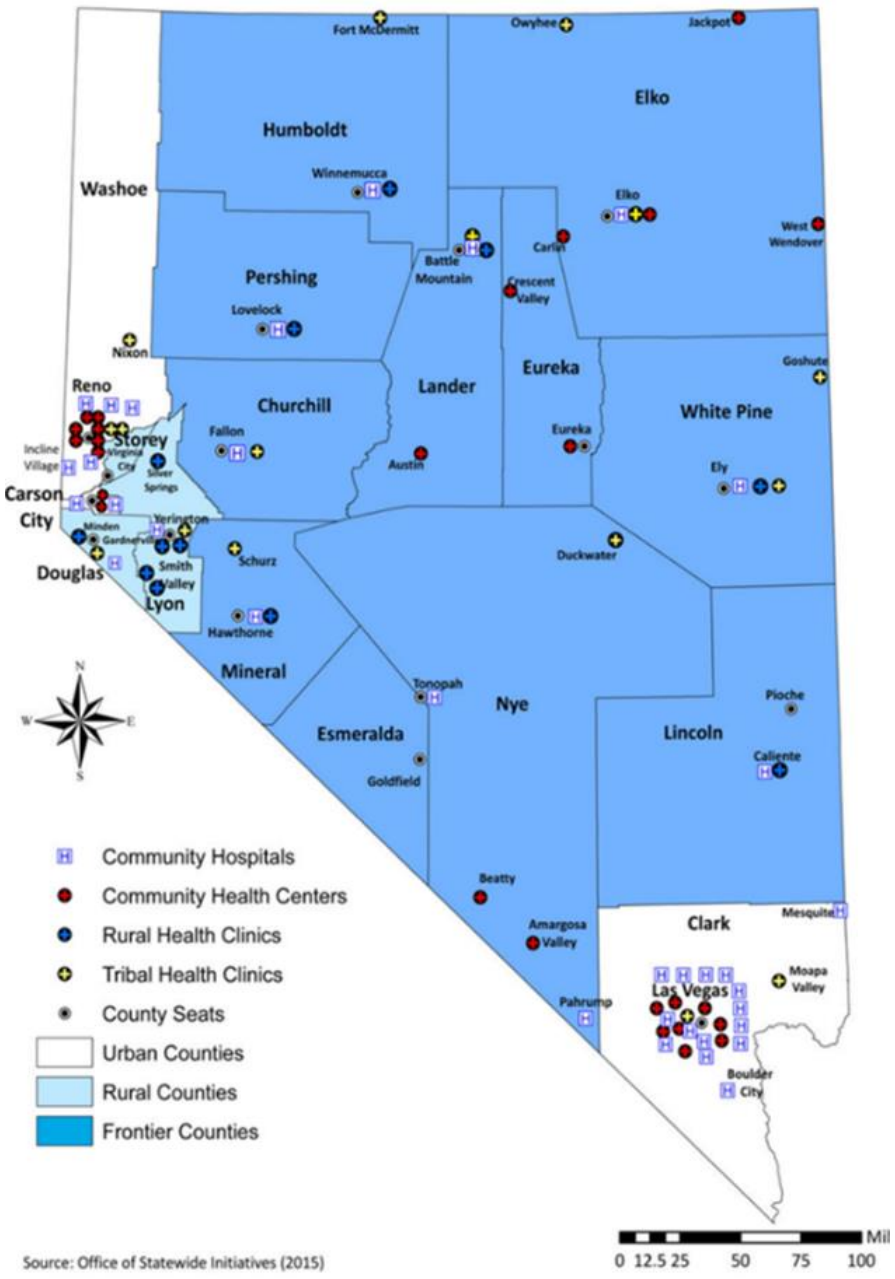
HealtHIE Nevada is an independent non-profit 501(c)(3), non-community based organization offering health information exchange services. DHHS has a seat on the HealtHIE Nevada Board of Directors and has been active in strategic direction setting leading to a set of priorities that is balanced with State goals and community provider needs, including establishing connectivity to the Nevada Division of Public and Behavioral Health (DPBH) to further streamline public health reporting and support future stages of Meaningful Use.

To further enhance care coordination and advance public health, the State is developing the infrastructure to provide access to agency related data and creating a population health data analytics tool. Through collaboration with various DHHS agencies, including the Aging and Disability Services Division (ADSD), Division of Child and Family Services (DCFS), the Division of Welfare and Supportive Services (DWSS), and DBPH, the State will first address disparate data across these Divisions, then seek to integrate all claims, utilization and clinical data. Several stakeholders noted the need for this data integration and access in order to better serve the State's Medicaid population.

The overall landscape of Nevada is unique and important to remember when assessing and planning for the future of health IT in the State. Nevada opted to expand Medicaid in January 2014, which made a substantial contribution to lower rate of uninsured Nevadans; however, Nevada has one of the strongest annual growth rates in the country, and the number of Medicaid eligible individuals is expected to rise as well. Medicaid expansion resulted in coverage for an additional 197,916 Nevadans as of October 2015. Additionally, 28,290 individuals were assessed as eligible for Medicaid/Children's Health Insurance Plan (CHIP) by the State's Insurance Marketplace.

While 88% of the population resides in its three urbanized areas, the remaining 12% live in three rural and 11 frontier areas (*Figure 2. State of Nevada Health Care Centers*).[i] Given the rural and frontier nature of the State, the locations of health care resources are of particular significance in Nevada. There are 11 counties that are designated as health professional shortage areas (HSPA)[ii], resulting in 286,000 residents living in counties that lack adequate access to health care. Among rural and frontier residents, 100% live in a behavioral health shortage area, and 51% live in primary medical and dental shortage areas.

Figure 2. State of Nevada Health Care Centers



Time and distance are not the only health care access issues the State faces. Twenty-seven percent of active physicians are retirement age 60 or older and 60% of the physician workforce is approaching retirement.[iii] In 2014, Nevada ranked 49th in the nation in the number of total active patient care physicians per 100,000 population.[iv]

The State has recognized the breadth of the activities required to achieve health care delivery transformation using HIT. Because of this, the State has identified the need for additional health IT leadership and has reinstated and filled the State HIT Coordinator position, which is housed in DHCFP, the State Medicaid Agency (SMA). The State HIT Coordinator, as well as the HIT support staff anticipated for 2017, will manage coordination of HIT efforts not only across State agencies, but with public and private stakeholders and partners as well.

As Nevada plans for its health IT future, all of these barriers and opportunities need to be kept in the forefront. DHCFP submits this SMHP Update to provide CMS a description of the activities that have occurred or are occurring in Nevada as part of the State's Health IT landscape. The update uses the CMS SMHP Checklist Companion Guide v2.0, including the following sections:

- **Section A – The State's As-Is HIT Landscape:** Describes the findings of the assessment conducted and the current state of health IT and the EHR Incentive Program in Nevada.
- **Section B – The State's To-Be Landscape:** Outlines the vision of the health IT future over the next five years and identifies achievable goals, objectives, strategies, and tactics needed to advance DHHS.
- **Section C – Activities Necessary to Administer and Oversee the EHR Incentive Program:** Outlines Nevada's implementation plan and processes to ensure that Medicaid providers in the State meet the federal and state statutory and regulatory requirements for the EHR Incentive Program payments.
- **Section D – The State's Audit Strategy:** Describes Nevada's audit controls and oversight strategy for the State's Medicaid EHR Incentive Program.
- **Section E – The State's HIT Roadmap:** Outlines the future path that depicts migration from today (As-Is) to the (To-Be) future state over the course of the next five years.

Section A. Nevada's "As-Is" Landscape

This section describes the environmental scan (e-Scan) of the State of Nevada's Medicaid providers and the readiness for EHR adoption and the expansion of HIE and HIT in Nevada. 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 future I-APDs.

A.1. Extent of EHR Adoption by Practitioners and Hospitals

SMHP Companion Guide Question A #1

EHRs in Use among Meaningful Use Participants in Nevada

The following table lists the top 20 EHR vendors in use among Medicaid and Medicare Program participants for program years 2015-2016. Two primary data sources were used to determine vendor rankings: 1) Medicaid attestation data from the Nevada EHR Incentive Payment System (NEIPS); and 2) data for Medicare attestations available from the ONC available here: https://dashboard.healthit.gov/datadashboard/documentation/ehr-products-mu-attestation-data-documentation.php. The combined data totaled 2,097 attestations for both Medicaid and Medicare for program years 2015-2016.

The top five vendors in use covered half (49.5%) of all Meaningful Use Attestations for Medicaid and Medicare Incentive Programs for 2015-2016, and included Cerner Corporation (16.8%), NextGen Healthcare (10%), eClinicalWorks (9.4%), Greenway Health (7.2%), and Epic Systems (6.1%) (*Table 1. Table A: Top EHRs in Use among Medicare and Medicaid EHR Incentive Program* Participants).

Table 1. Table A: Top EHRs in Use among Medicare and Medicaid EHR Incentive Program Participants

Table A. Top EHRs in Use Among Medicare and Medicaid EHR Incentive Program Participants			
	Vendor Name	**Count**	**%**
Rank	**Grand Total**	**2097**	**100.0%**
1	Cerner Corporation	353	16.8%
2	NextGen Healthcare	210	10.0%
3	eClinicalWorks, LLC	198	9.4%
4	Greenway Health, LLC	150	7.2%
5	Epic Systems Corporation	128	6.1%
6	athenahealth, Inc.	124	5.9%
7	GE Healthcare	102	4.9%
8	Allscripts	78	3.7%
9	McKesson	75	3.6%
10	Practice Fusion	68	3.2%
11	eMDs	64	3.1%
12	IntrinsiQ Specialty Solutions, Inc. FBO Healthtronics Information Technology Solutions Inc.	52	2.5%
13	Aprima Medical Software, Inc	31	1.5%
14	gMed, Inc.	29	1.4%
15	Medstreaming EMR, LLC	26	1.2%
16	NexTech Systems Inc.	21	1.0%
17	GEMMS	19	0.9%
18	Amazing Charts	18	0.9%
19	Connexin Software Inc	17	0.8%
20	ADP AdvancedMD	16	0.8%

Table 2. Table B: Top 10 Vendors by Provider Type/Specialty among Medicare and Medicaid Program lists the top ten vendors in use among providers that have attested to Meaningful Use in the Medicaid and Medicare Program for 2015-2016. These vendors are listed by provider type or specialty. Family/Internal/General Medicine includes Family Medicine, General Practice, Internal Medicine, Physician, and Preventative Medicine. Hospitals include acute care hospitals and dual eligible hospitals. Surgery includes all sub-specialties reported in that category including colon and rectal, neurological, orthopedic, plastic, thoracic, and transplant.

Table 2. Table B: Top 10 Vendors by Provider Type/Specialty among Medicare and Medicaid Program Participants

Table B. Top 10 Vendors By Provider Type/Specialty Among Medicare and Medicaid Program Participants			
Rank	**Vendor Name by Specialty/Provider Type**	**Count**	**%**
1	**Cerner Corporation**	**353**	**100.0%**
	Family/Internal/General Medicine	189	53.5%
	Hospital	69	19.5%
	Specialist- Podiatrist	14	4.0%
	Specialist- Psychiatry & Neurology	14	4.0%
	Student in an Organized Health Care Education/Training Program	7	2.0%
	Surgery	60	17.0%
2	**NextGen Healthcare**	**210**	**100.0%**
	Certified Nurse Midwife	1	0.5%
	Family/Internal/General Medicine	98	46.7%
	Nurse Practitioner	10	4.8%
	Phys Ass't practicing in FQHC or RHC led by a PA	9	4.3%
	Physical Medicine & Rehabilitation	1	0.5%
	Specialist	9	4.3%
	Specialist- Dentist	7	3.3%
	Specialist- Dermatology	1	0.5%
	Specialist- Obstetrics & Gynecology	1	0.5%
	Specialist- Optometrist & Ophthalmology	61	29.0%
	Specialist- Psychiatry & Neurology	4	1.9%
	Specialist- Radiology	1	0.5%
	Surgery	3	1.4%
	(blank)	4	1.9%
3	**eClinicalWorks, LLC**	**198**	**100.0%**
	Family/Internal/General Medicine	120	60.6%
	Nurse Practitioner	23	11.6%
	Physical Medicine & Rehabilitation	1	0.5%
	Specialist	4	2.0%
	Specialist- Anesthesiology	1	0.5%
	Specialist- Dermatology	4	2.0%
	Specialist- Obstetrics & Gynecology	18	9.1%
	Specialist- Otolaryngology	4	2.0%
	Specialist- Radiology	1	0.5%
	Surgery	17	8.6%
	(blank)	5	2.5%
4	**Greenway Health, LLC**	**150**	**100.0%**
	Family/Internal/General Medicine	24	16.0%

Table B. Top 10 Vendors By Provider Type/Specialty Among Medicare and Medicaid Program Participants			
Rank	**Vendor Name by Specialty/Provider Type**	**Count**	**%**
	Nurse Practitioner	2	1.3%
	Physical Medicine & Rehabilitation	1	0.7%
	Specialist	3	2.0%
	Specialist- Obstetrics & Gynecology	32	21.3%
	Specialist- Otolaryngology	6	4.0%
	Specialist- Psychiatry & Neurology	3	2.0%
	Specialist- Radiology	40	26.7%
	Student in an Organized Health Care Education/Training Program	2	1.3%
	Surgery	37	24.7%
5	**Epic Systems Corporation**	**128**	**100.0%**
	Certified Nurse Midwife	1	0.8%
	Emergency Medicine	2	1.6%
	Family/Internal/General Medicine	91	71.1%
	Hospital	4	3.1%
	Nurse Practitioner	11	8.6%
	Phys Ass't practicing in FQHC or RHC led by a PA	3	2.3%
	Physical Medicine & Rehabilitation	4	3.1%
	Specialist- Obstetrics & Gynecology	5	3.9%
	Specialist- Psychiatry & Neurology	3	2.3%
	Surgery	4	3.1%
6	**athenahealth, Inc.**	**124**	**100.0%**
	Family/Internal/General Medicine	75	60.5%
	Specialist	4	3.2%
	Specialist- Anesthesiology	1	0.8%
	Specialist- Podiatrist	2	1.6%
	Specialist- Psychiatry & Neurology	2	1.6%
	Student in an Organized Health Care Education/Training Program	4	3.2%
	Surgery	36	29.0%
7	**GE Healthcare**	**102**	**100.0%**
	Family/Internal/General Medicine	33	32.4%
	Nurse Practitioner	1	1.0%
	Physical Medicine & Rehabilitation	4	3.9%
	Specialist	1	1.0%
	Specialist- Anesthesiology	2	2.0%
	Specialist- Dermatology	27	26.5%
	Specialist- Podiatrist	1	1.0%
	Specialist- Psychiatry & Neurology	2	2.0%

Table B. Top 10 Vendors By Provider Type/Specialty Among Medicare and Medicaid Program Participants			
Rank	**Vendor Name by Specialty/Provider Type**	**Count**	**%**
	Surgery	31	30.4%
8	**Allscripts**	**78**	**100.0%**
	Family/Internal/General Medicine	41	52.6%
	Hospital	2	2.6%
	Nurse Practitioner	11	14.1%
	Specialist- Anesthesiology	3	3.8%
	Specialist- Optometrist & Ophthalmology	3	3.8%
	Surgery	17	21.8%
	(blank)	1	1.3%
9	**McKesson**	**75**	**100.0%**
	Family/Internal/General Medicine	51	68.0%
	Hospital	6	8.0%
	Specialist- Radiology	12	16.0%
	Surgery	6	8.0%
10	**Practice Fusion**	**68**	**100.0%**
	Family/Internal/General Medicine	15	22.1%
	Nurse Practitioner	3	4.4%
	Specialist	6	8.8%
	Specialist- Dentist	36	52.9%
	Specialist- Optometrist & Ophthalmology	1	1.5%
	Specialist- Podiatrist	5	7.4%
	Specialist- Psychiatry & Neurology	2	2.9%

EHR Incentive Program Overview

Implementation and Meaningful Use of CEHRT will improve access to health information for Nevada Medicaid beneficiaries and providers. Certified EHRs facilitate easier coordination of care for the many providers who may be treating Medicaid patients and provide patients with more readily accessible information needed to make important decisions about their health care.

The State of Nevada has adopted the national goals for the EHR Incentive Programs; which include:

1. Enhance care coordination and patient safety.
2. Reduce paperwork and improve efficiencies.
3. Facilitate electronic information sharing across providers, payers, and state lines.
4. Enable data sharing using state HIEs and the Sequoia Project eHealth Exchange (eHealth Exchange).

Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of health care nationwide. In accordance with provisions within the American Recovery and Reinvestment Act (ARRA), DHHS implemented the Nevada Medicaid EHR Incentive Program to

provide incentive payments to eligible EPs, EHs, and CAHs. The incentive payments directed to EPs, EHs, or CAHs are not reimbursement for services rendered by these providers but rather payments are issued to incentivize the Adoption, Implementation, or Upgrade of CEHRT and the subsequent Meaningful Use of CEHRT as defined by CMS.

DHHS elected to leverage business processes throughout the agency and, where feasible, integrate the Nevada EHR Incentive Program into the standard MITA) business processes and DHHS's day-to-day operations. Examples of these processes include EHR Incentive Program eligibility; attestation receipt and validation; and provider registration and query to the Medicare and Medicaid EHR Incentive Program Registration & Attestation (R&A) system.

According to data pulled from NEIPS in 2015 the top vendor among Medicaid EHR Incentive Program participants was eClinicalWorks (17.7%) followed by Allscripts (12%). According to data collected for 2016 attestations, NextGen Healthcare is the most widely used (35%), followed by Practice Fusion (15%). eClinicalWorks has consistently held the top rank since 2013. In 2012, Greenway was the most widely used (16.9%), however, rates have slowly declined down to 2% in 2015, with no providers reporting usage to date for 2016.

As described by the ONC, the dataset combines Meaningful Use attestations from the Medicare EHR Incentive Program and certified HIT product data from the ONC Certified Health IT Products List (CHPL). Cerner was the top EHR vendor in use in Nevada among Medicare program participants in both 2015 (18.2%) and 2016 (24%).

Summary of Nevada EHR Incentive Program Activities to Date

A summary of payments in the Nevada EHR Incentive Program to date are summarized in *Table 3. Nevada EHR Incentive Payments to Date.*

Table 3. Nevada EHR Incentive Payments to Date

EHR Incentive Payments to Date (12/31/16)	
Eligible Professionals	
Unique EP Count	625
# AIU Payments	621
AIU Payments Total	$12,856,266.00
# Meaningful Use Payments	410
Meaningful Use Payments Total	$3,405,672.00
Total EP Payments to Date	**$16,261,938.00**
Eligible Hospitals	
Unique EH/CAH Count	31
# AIU Payments	10
AIU Payments Total	$5,774,816.31
# Meaningful Use Payments	71
Meaningful Use Payments Total	$28,793,683.91
Total EH/CAH Payments to Date	**$34,568,500.22**
GRAND TOTAL (as of December 31, 2016)	**$50,830,438.22**

Source: DHCFP EHR Incentive Payments report December 31, 2016

EHRs in Use among Nevada EHR Incentive Program Participants

According to data from NEIPS (*Table 4. Medicaid Program Data 2012-2016*), in 2015 the top vendor among Medicaid EHR Incentive Program participants was eClinicalWorks (17.7%) followed by Allscripts (12%). According to collected to date for 2016 attestations, NextGen Healthcare is the most widely used (35%), followed by Practice Fusion (15%). eClinicalWorks has consistently held the top rank since 2013. In 2012, Greenway was the most widely used (16.9%), however, rates have slowly declined down to 2% in 2015, with no providers reporting usage to date for 2016.

Table 4. Medicaid Program Data 2012-2016

Medicaid Program Data 2012-2016											
2015 Rank-ing	**Vendor**	**2012**	**% of Total**	**2013**	**% of Total**	**2014**	**% of Total**	**2015**	**% of Total**	**2016**	**% of Total**
	Total	**219**		**269**		**267**		**300**		**80**	
1	eClinicalWorks LLC	28	12.8%	40	14.9 %	40	15.0%	53	17.7%	8	10.0%
2	Allscripts	10	4.6%	21	7.8%	12	4.5%	36	12.0%	4	5.0%
3	NextGen Healthcare	28	12.8%	31	11.5 %	16	6.0%	30	10.0%	28	35.0%
4	Practice Fusion	19	8.7%	17	6.3%	20	7.5%	27	9.0%	12	15.0%
5	Epic Systems Corporation	12	5.5%	11	4.1%	26	9.7%	20	6.7%		0.0%
6	Connexin Software Inc		0.0%	2	0.7%	8	3.0%	16	5.3%	1	1.3%
7	GE Healthcare	1	0.5%	25	9.3%	14	5.2%	13	4.3%	1	1.3%
8	Greenway Health LLC	37	16.9%	26	9.7%	28	10.5%	6	2.0%		0.0%
9	Aprima Medical Software Inc					7	2.6%	4	1.3%		
10	US HealthRecord Inc							4	1.3%	5	
11	AmazingCharts .com Inc	5	2.3%	9	3.3%	6	2.2%	3	1.0%	1	1.3%
12	McKesson	6	2.7%	7	2.6%	3	1.1%	3	1.0%		0.0%
13	Nth Technologies Inc		0.0%	1	0.4%	2	0.7%	3	1.0%		0.0%
14	HealthFusion	1	0.5%	1	0.4%	2	0.7%	2	0.7%		0.0%
15	Henry Schein Medical Systems	17	7.8%	11	4.1%	5	1.9%	2	0.7%		0.0%

HIT Environmental Scan (e-Scan)

In order to inform the 2016 SHSIP, a result of the SIM grant, DHCFP implemented a robust stakeholder engagement plan that included ongoing meetings, outreach events, and communications, and was further informed by an online survey. Given the focus on health care innovation to expand and support population health-based projects, use of health IT, including data capture, exchange, and analytics, was a key topic of discussion throughout the SHSIP engagement process.

Leveraging the success of SHSIP engagement initiatives, DHCFP engaged Myers and Stauffer LC to employ similar strategies to conduct the e-Scan required for the 2016 SMHP update including:

- Online survey to the provider community, including EPs and EHs.
- Coordination with partners and agencies to distribute the online survey.
- One-on-one interviews with key stakeholders identified by DHCFP, many of which participated in development of the SHSIP.
- Interviews with coordinating state agencies.

DHCFP with assistance from Myers and Stauffer developed and implemented the e-Scan between August and October 2016.

Interview Strategy and Methodology

Qualitative findings were gathered through numerous one-on-one interviews with stakeholders identified by DHCFP. The purpose of the interviews was to assess current HIT adoption in the context of specific projects at each organization; gauge stakeholder involvement in HIT activities supporting Medicaid; and identify barriers to HIT adoption and utilization.

DHCFP identified key stakeholders based on involvement with current health IT projects and relevant workgroups, partnerships, and board memberships at the Quality Improvement Organization (QIO) and former REC, HealthInsight, and HealtHIE Nevada, organizations representing segments of the provider community such as specialty associations, and other contacts identified through the interview process.

DHCFP developed a standard set of interview questions with additional questions added, as necessary, in order to address required updates from the 2011 SMHP, as well as cover any specific known initiatives or State objectives. An outreach letter was developed and approved, explaining the goal of the SMHP and included a request to participate in the interview as a critical stakeholder.

Once confirmed, interviewees received the questions in advance for ease of preparation. Interviews lasted between 45 and 60 minutes and all key DHCFP personnel were invited to attend to hear responses from stakeholders directly. Key stakeholders were engaged in further follow-up via email, when necessary.

Thirteen interviews were conducted with one organization corresponding via email only (as noted by * in *Table 5. Organizations Interviewed*). All of these organizations, with the exception of CGI Group, Inc. and the Veterans Administration, were engaged as stakeholders to develop the SHSIP.

Table 5. Organizations Interviewed

Organization	About	Contact
CGI Group, Inc.	Attestation vendor for implementation, operation, program outreach, partial audit, and support of the Medicaid EHR Incentive Program in Nevada.	Kristen Leone, Implementation Manager
HealtHIE Nevada	Private, nonprofit, community-based organization dedicated to connecting the Nevada health care community by managing an accurate real-time Health Information Exchange. The management of HealtHIE Nevada and its services are performed by HealthInsight.	Erick Maddox, HIE Director Eric Martinez, Marketing and Communications Manager
HealthInsight	Private, nonprofit, community-based organization dedicated to improving health and health care, composed of locally governed organizations in four western states: Nevada, New Mexico, Oregon, and Utah. HealthInsight also has operations in Seattle, Washington, and Glendale, California which support End-Stage Renal Disease Networks in the western United States.	Eileen Colen, Outreach Director
*** Indian Health Services (IHS)**	Combination of tribal, federal, and contract health service facilities that provide general and emergency care for eligible Native Americans.	Julieta Mendoza, DHHS Tribal Liaison
Nevada Aging and Disability Services Division (ADSD)	Represents Nevada's elders, children, and adults with disabilities or special health care needs. Developmental Services has been consolidated into this Division.	Julie Kotchevar, Deputy of Children's Services and Operations
*** Nevada Division of Child and Family Services (DCFS)**	Works in partnership with families, communities, and other government agencies to provide support and services to assist Nevada's children and families in reaching their full potential.	Jason Benshoof, IT Manager
Nevada Division of Health Care Financing and Policy (DHCFP)	Works in partnership with CMS to administer and manage the State's Medicaid, CHIP and EHR Incentive Programs.	Dave Stewart, Deputy Administrator of Health Information, Technology and Analytics Davor Milicevic, Health IT Manager
Nevada Division of Public and Behavioral Health (DPBH)	Due to the passage of Assembly Bill 488, the former Health Division and Division of Mental Health and Developmental Services merged July 1, 2013 to become the DPBH. The aim is to protect, promote, and improve both physical and behavioral health of the population.	Julia Peek, Deputy Administrator Erin Williams, IT Manager
Nevada Division of Welfare and Supportive Services (DWSS)	Works with the community and across Divisions to provide a range of public assistance benefits to all that qualify and support for children with absentee parents.	Dave Texeira, Chief IT Manager
Nevada Hospital Association	Not-for-profit, statewide trade association representing 100%of Nevada's acute care hospitals along with psychiatric, rehabilitation, and other specialty hospitals, as well as health-related agencies and organizations throughout the State.	Bill Welch, CEO
Nevada Primary Care Association (formerly Great	Federally designated primary care association for Nevada serving Section 330 Federally Qualified Health Centers.	Steve Messinger, Policy Manager

Organization	About	Contact
Basin Primary Care Association)		
Nevada Rural Hospital Partners	Alliance of 13 small and rural hospitals serving 260,000 patients.	Todd Radtke, Regional Chief Information Officer
Renown Health	Not-for-profit health system operating in Reno, Nevada	Chris Bosse, Vice President of Government Relations
State Office of Rural Health	Part of the University of Nevada, Reno School of Medicine; established by the State Legislature in 1977 to administer the delivery of health care services to rural and frontier areas in Nevada.	Gerald Ackerman, Assistant Dean, Rural Programs; Director, Office of Rural Health
Veterans Administration	Serves 339,000 veterans living in Nevada.	Miriam Escher / Sara Else, Administration

Survey Strategy and Methodology

DHCFP used the 2011 HIT Assessment survey as a guide as well as its on-site health IT, Meaningful Use, and EHR Incentive Program subject matter experts to compose the survey using the online survey tool Survey Monkey® to gather responses.

DHCFP collaborated with specific stakeholders who are known, trusted information sources to distribute and encourage participation in the online survey. Additionally, the objective to gather a representative set of responses, including those from non-registered or ineligible Medicaid providers was employed. Therefore, DHCFP leveraged existing partnerships to assist with survey distribution.

CGI, HealtHIE Nevada, HealthInsight, the Nevada State Office of Rural Health, Rural Hospital Partners, Indian Health Services (IHS), and the Nevada Primary Care Association each distributed the survey via email and newsletters. DHCFP also included a link to the survey on its EHR Incentive Program webpage to help ensure visibility among participating Medicaid providers.

A single survey was developed to solicit structured feedback from all provider groups, including EPs (both participating and non-participating providers in the EHR Incentive Program) and EHs (both participating and non-participating hospitals in the EHR Incentive Program).

The final primary survey included 39 questions. Key topics covered in the survey included:

- EHR adoption and adoption barriers.
- EHR implementation and update plans and concerns.
- Meaningful Use participation.
- HIE participation and barriers.
- High-level MITA maturity score.

Respondents were given the opportunity to participate in a 16 question follow-up survey covering MITA maturation in more detail, including:

- Management of health records.
- Prescription ordering and providing care.

- Quality control.
- Data and interoperability.

A total of 111 responses were received after removing six duplicate entries based on facility name and address. Sixty-five respondents reached the final question of the main survey. Of those of who completed the main survey, 22 opted to complete the additional survey about HIT maturity. All partial responses were used for the analysis.

Survey Demographics
The five categories of provider type outlined in the survey were:

- Medical Care – General Practice, Family Practice, Internal Medicine, Pediatrics, Physician Assistant, Nurse Practitioner, Registered Nurse.
- Medical Care – Specialist (Gastroenterology, Ear, Nose and Throat, Cardiology, Oncology, Obstetrics/Gynecology, Ophthalmology, etc.).
- Behavioral Health – Psychiatrist, Psychologist, Psychoanalyst, Social Worker.
- Dental – Dentist, Family Dentist, Dental Surgeon, and other.

The breakdown of responses by provider type is outlined i*n Table 6. Nevada Provider SMHP Survey: Provider Type Responses.*

Table 6. Nevada Provider SMHP Survey: Provider Type Responses

Provider Type Category	Percent of Responses
Medical Care - General Practice (General Practice, Family Practice, Internal Medicine, Pediatrics, Physician Assistant, Nurse Practitioner, Registered Nurse)	31.7%
Medical Care – Specialist (Gastroenterology, Ear, Nose and Throat, Cardiology, Oncology, Obstetrics/Gynecology, Ophthalmology, etc.)	24.4%
Behavioral Health – Psychiatrist, Psychologist, Psychoanalyst, Social Worker	16%
Dental – Dentist, Family Dentist, Dental Surgeon	8.5%
Other	15.9%

Thirty-two percent of respondents practiced in a primary care setting, followed by specialty care at 27 percent. Fifty-three percent were from small practices (one to five) providers and 35%were in practices with more than 21 providers. Skilled nursing and mental/behavioral health facilities, as well as IHS and dental offices, were represented in the sample.

Ninety-one percent of respondents serve Medicaid patients, with 26%indicating that more than 50 percent of their patients are enrolled in Medicaid. Fifty-five percent reported seeing patients from bordering states. California ranked as the top response followed by Arizona.

DHCFP's 2016 e-Scan survey was sent to a wide distribution list of hospitals and healthcare professionals. Approximately 990 providers enrolled in the Incentive Program and 1,550 potentially eligible providers as defined by CGI, as well as approximately 1,500 contacts in HealthInsight's database received the survey and request to participate. Thirty-three Federally Qualified Health Center (FQHCs) sites also received the survey. In order to gather feedback from the behavioral health community, the survey was sent to approximately 120 contacts on the CCBHC listserv, as

well as the Northern Nevada Behavioral Health Consortium, and the Substance Abuse Prevention and Treatment Agency contact database. Results of the e-Scan are diverse, with multiple responses from all provider types, including those that may not be participating in the Incentive Program.

Out of 89 respondents, 18% reporting having an EHR system, 20% reported using a Certified EHR (CEHRT), 30% used CEHRT with paper templates and forms, and 21% used CEHRT in a fully paperless environment for a total of 90% using some form of an EHR. Out of nine respondents without an EHR, only two reported no plans to implement an EHR, and four are planning to implement an EHR or CEHRT. Sixty-six respondents to the survey reported the EHR system in use in the practice.

Table 7. EHR Systems in Use Among e-Scan Survey Respondents illustrates the top 20 EHRs in use among those respondents.

Table 7. EHR Systems in Use Among e-Scan Survey Respondents

EHR Systems in Use Among e-Scan Survey Respondents		
Name of EHR System	**Total**	**%**
AthenaHealth	7	11%
eClinicalWorks	5	9%
Avatar	4	6%
GE Centricity	4	6%
Allscripts	3	5%
HealthFusion MediTouch	3	5%
nAbleMD	3	5%
Practice Fusion	3	5%
Valant (Behavioral Health)	3	5%
Eaglesoft Clinician (Dental)	2	3%
Foothold Awards	2	3%
Kareo	2	3%
Resource Patient and Management System (RPMS) (Indian Health Service)	2	3%
Soapware	2	3%
Advanced MD	1	1.5%
Amazing Charts	1	1.5%
axiUm (Dental)	1	1.5%
Epic	1	1.5%
eMDs	1	1.5%
gMed (Gastroenterology)	1	1.5%

Survey Limitations

- Not all providers participated in this survey despite multiple attempts to request completion; therefore, findings do not represent the entire provider population of Nevada.
- Providers who have a larger interest in Health IT, HIEs, and MU may be more willing to answer the survey as opposed to providers who do not have an interest;
- Some provider types may be overrepresented or underrepresented;

- Duplicate providers were removed based on facility and address but it is still possible that an organization could have multiple entries if they did not fill out all demographic information;
- Behavioral health organizations and locations in rural and frontier counties were specifically targeted for responses and may be over represented;
- Survey fatigue; healthcare providers have been asked to participate in numerous surveys since the original HIT Assessment, leading to no or sub-standard participation.
- Use of email distribution lists was done in collaboration with the list owners; therefore, the ability to send follow-up messages was contingent upon existing communications plans.

Assessment Documents

The following sources of information were reviewed for this SMHP update:

- Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; EHR Incentive Programs; Payment to Non-excepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital (OPPS Rule) – November 14, 2016.
- Nevada Electronic Health Record Provider Incentive Payment Program Implementation Advanced Planning Document Update – July 15, 2016.
- Nevada Broadband Taskforce Annual Report to the Governor- June 30, 2016.
- CMS State Medicaid Director Letter #16-003 – February 29, 2016.
- Nevada State Health System Innovation Plan – January 29, 2016.
- Nevada SMHP Addendum-Electronic Health Record Provider Incentive Payment Program – January 14, 2016.
- Nevada Core Medicaid Management Information System Modernization Project Implementation Advance Planning Document – December 2015.
- Nevada SMHP Addendum-Electronic Health Record Provider Incentive Payment Program – October 29, 2014.
- Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 through 2017 – October 16, 2015.
- Nevada Electronic Health Record Provider Incentive Payment Program Implementation Advanced Planning Document Update – August 13, 2014.
- State of Nevada Division of Health Care Financing and Policy MITA 3.0 State Self-Assessment (MITA SS-A); Deliverable 4.12.4 – MITA SS-A, Version 4.0 – December 2, 2013.
- Nevada Health Information Technology Strategic and Operational Plan – Updated June 7, 2013.

- Nevada State Medicaid Health Information Technology Plan – September 22, 2011.
- CMS State Medicaid Director Letter #11-004 – May 18, 2011.
- CMS State Medicaid Director Letter #10-016 – August 17, 2010.
- Nevada Health Information Technology Statewide Assessment – August 13, 2010.

A.2. Broadband Internet Access Challenges to Rural Areas

SMHP Companion Guide Question A #2

History of the Nevada Broadband Task Force

In July 2009, Governor Jim Gibbons issued an Executive Order establishing the 12-member Nevada Broadband Task Force consisting of experts and stakeholders in health care, information technology, government, insurance, business, and other industries affecting health care in Nevada. Beginning in October 2009, the task force met on a regular basis with a goal of identifying and removing barriers to broadband access and identifying opportunities for increased broadband applications and adoption in unserved or underserved areas of Nevada. Issues discussed included an operationally and financially sustainable HIE technical infrastructure that leverages current assets and investments, an effective governance structure that complies with all state and federal laws, HIE and EHR barriers, privacy and security concerns, patient consent options, meeting cooperative agreement financial match requirements, workforce needs and readiness, broadband and connectivity barriers, and the impact of the State's fragile economy on HIE financial sustainability and EHR adoption. Insufficient broadband connectivity to meet HIE and Meaningful Use requirements was also discussed. Nevada is one of the most mountainous State in the country, and the physical terrain and lack of financial resources to add statewide broadband connectivity were seen as barriers to HIE implementation.

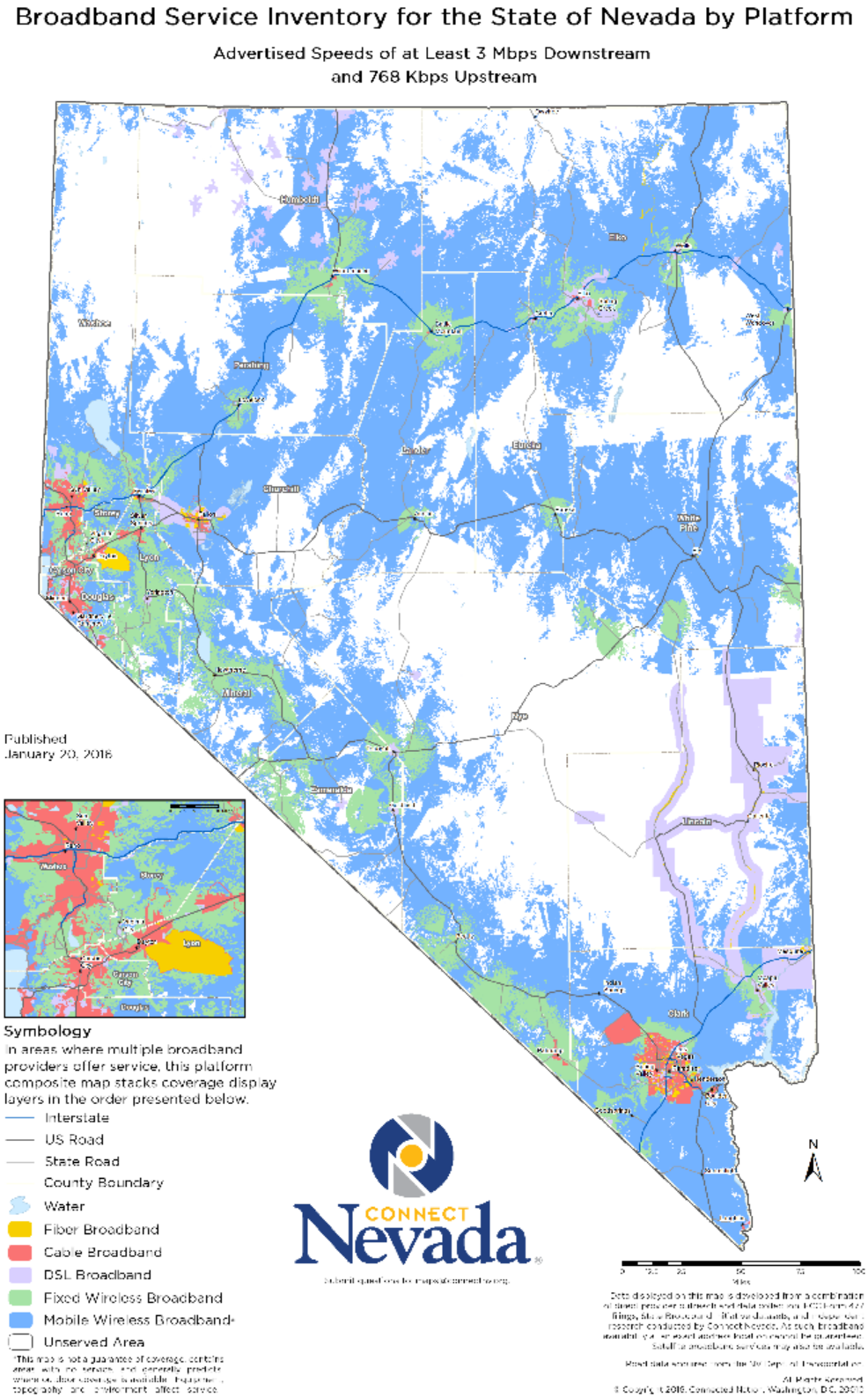
Beginning in November 2009, the Broadband Task Force coordinated efforts with the HIT Blue Ribbon Task Force regarding overlapping priorities and goals.

Current Broadband Internet Access in Nevada

One key issue the State continues to face is the promotion and facilitation of broadband expansion into underserved and unserved areas. While Nevada has been ranked as the "8th most connected state in the nation" by the National Telecommunications and Information Administration (NTIA) for broadband access, this statement only addresses Nevadans' "access" to broadband and does not reflect the actual adoption or utilization of the internet by consumers. Because of this, approximately seven percent of Nevada's population is underserved by broadband and three counties have zero percent access to at least 25 megabits per second (Mbps), according to BroadbandNow (http://broadbandnow.com/Nevada).

Nevada does score high in the access to broadband category because the majority of the population resides in two main urban centers, Reno/Carson City and Las Vegas. Of the State's 17 counties, 4 scored high on "access," but the remaining 13 counties remain mostly underserved or unserved (*Figure 3. Broadband Service Inventory for the State of Nevada by Platform*).

Figure 3. Broadband Service Inventory for the State of Nevada by Platform



A summary of the latest data collected by the Federal Communications Commission (FCC), NTIA and other sources shows:

- 144,000 people in Nevada are without access to a wired connection capable of 25 Mbps download speeds.
- Of the 144,000 with access, there is only one wired provider (no significant competition).
- Eight percent of the entire population, or 249,722, is without access to the current broadband standards.
- Five percent of the urban population, or 151,168, is without access.
- Sixty-five percent of the rural population, or 98,554, is without access as compared to the national average of 39 percent.

Other findings by Connect Nevada and the NTIA include:

- Construction of a robust fiber "information" highway in Nevada is particularly expensive given its geography, distances between rural communities, and the limited return on investment (ROI) realized by Internet Service Providers (ISPs) creating little incentive for ISPs to assume the high cost of construction beyond Nevada's primary urban hubs.
- The majority of Nevada's rural counties remain underserved or unserved. If the State continues to allow "market forces" to drive broadband expansion, the status quo will remain, with communities seeing little to no improvement in broadband services for their schools, local governments, public safety providers, local businesses, or residents.
- Even counties that have a high percentage of broadband adoption, there are schools and public services in these areas that lack adequate broadband service. For instance, Clark County is well connected, but the schools in Mt. Charleston and Sandy Valley still have extremely limited broadband service.

Since the conclusion of the previous Nevada Broadband Task Force in 2014, the FCC has changed the definition of "broadband," such that "high-speed Internet" service is now considered 25 Mbps upload and 3 Mbps download. Using this latest definition, 8% of Nevada residents do not have access to "fixed advanced telecommunications capability." And with respect to wireless technology, there are large areas of the State that remain unserved or marginally served by wireless coverage.

In 2015, Governor Sandoval authorized the reinstatement of the Nevada Broadband Task Force to carry on the work of the 2009 Broadband Task Force. The Task Force included representation from state agencies, private energy, data, and telecommunications sectors, and counties. The Task Force reviewed broadband policies, practices, access, and adoption; and offered recommendations in the Annual Report to the Governor[v], issued June 30, 2016. This section summarizes the annual report.

The Broadband Task Force examined policies and practices in other jurisdictions to see what worked, what did not, and what could be implemented in Nevada. Members spoke with community leaders throughout rural Nevada to better understand the real gaps and challenges in bringing broadband services to these areas. Task Force subcommittees were formed to address broadband specific issues affecting key sectors, including education, health care, broadband policy, and mapping.

The Nevada Broadband Task Force submitted its annual report to the Governor on June 30, 2016. It included nine recommendations currently under review:

1. Facilitate broadband expansion by allowing the Nevada Department of Transportation (NDOT) to install conduit and fiber systems in the state rights-of-way that support telecommunication facilities, and allow NDOT to enter into public private partnerships for cooperative fiber and conduit trades.
2. Promote "Dig Once/Joint Trenching" policies at the local levels through the creation of local model policy guidelines.
3. Establish a state broadband in education consortium and recurring funding to provide a state match to school district funds to more effectively leverage federal E-rate money, thereby creating an organized process for improving broadband connectivity to, and within E-rate eligible entities.
4. Adopt specific broadband goals for the State and create a state strategic 5-year broadband development plan for Nevada.
5. Continue the Broadband Task Force through executive order beyond June 2017, or otherwise, establish an ongoing broadband body to coordinate and collaborate on broadband adoption and deployment efforts, review and develop broadband policies, and assist in efforts to implement strategic planning goals.
6. Develop model policies and incentives for deployment of broadband in certain commercial and residential developments (e.g. create "certified" broadband or "fiber-ready" residential and/or commercial sites).
7. Assign one agency to house all Indefeasible Right of Use (IRUs) and/or Trade Agreements executed by state agencies and higher education regarding the State's broadband and fiber assets, and initiate legal review of state IRUs and/or trade agreements by counsel at least three years prior to the expiration of same.
8. Include certain broadband fiber assets on the list of critical infrastructure documents that could potentially be deemed confidential at the Governor's discretion pursuant to NRS 239C.210.
9. Establish a state funding source to provide matching funds required to enable Nevada's non-profit rural health clinics and hospitals to competitively pursue annual federal grants to help expand the use and delivery of telemedicine and distance learning.

In 2015, OSIT worked with a number of stakeholders to pursue a USDA-RUS grant for telemedicine equipment. After several meetings with stakeholders, Renown Health agreed to be the applicant and provide the matching funds. Renown developed an ambitious application, seeking the full grant sum of $500,000. The grant involved network upgrades, video equipment and telemedicine carts, which can cost from $20,000 to $50,000, for certain rural hospitals, clinics, and three of Nevada's correctional facilities. The USDA has not yet announced the 2016 grant recipients.

Federal Broadband Grants and Projects in Nevada – Update

From 2008 to 2014, the State of Nevada received a number of federal grants for broadband initiatives that included mapping, data collection, policy development, and some broadband construction projects. The following provides a summary and update on relevant broadband initiatives and federal grants.

Many of the earlier large broadband grants were funded through the ARRA, which provided a total of $7.2 billion to the NTIA and the Department of Agriculture's Rural Utilities Service (RUS) to fund projects to expand access and adoption of broadband services across the United States. NTIA utilized $4.7 billion of that funding for grants to deploy broadband infrastructure in the U.S., expand public computer center capacity, and encourage sustainable adoption of broadband service.

The State of Nevada was awarded five Broadband Technology and Opportunities Program (BTOP) state awards, one BTOP award that impacted both California and Nevada, and three BTOP awards which impacted various states at the national level (including One Economy Corporation, University Corporation for Advanced Internet Development, and the Communication Service for the Deaf). While each grant focused on slightly different areas of broadband expansion in Nevada and neighboring states, each grant influenced the outcomes in rural and frontier areas.

Additionally, DHCFP worked collaboratively on coordinating with the National Broadband Task Force to bring last mile connectivity broadband to Nevada with an emphasis on rural health.

EHR adoption has improved as a result:

- Ninety-three percent of critical access and small rural hospitals have demonstrated Meaningful Use of certified HIT.
- One hundred percent of critical access and small rural hospitals have demonstrated Meaningful Use and/or AIU of any EHR.
- Thirty-three percent of rural hospitals have adopted a basic EHR.

In all Western states, especially with Nevada's larger frontier counties and great distances between hospitals in rural areas, broadband access is critical in the use of HIT. Rural health clinics in Nevada are all associated with critical access hospitals and rural hospitals with 93% demonstration of either the adoption, implementation, or upgrade to or Meaningful Use of a Certified EHR and 100% of the same population using an EHR.

The federal broadband grants awarded in Nevada include:

California Broadband Cooperative, Inc.
Infrastructure $81,148,788

Much of the eastern Sierra region between Carson City, Nevada and Barstow, California was dependent on decades-old telephone infrastructure and had limited, insufficient broadband middle mile (segment of a telecommunications network linking a network operator's core network to the local network plant) capabilities, leaving wide swaths of the Central Valley and eastern California unserved. The California Broadband Cooperative's Digital 395 Middle Mile project built a new 553-mile, ten Gigabits per second (Gbps) middle-mile fiber network that follows U.S. Route 395 between southern and northern California. In addition to 36 municipalities, the project's proposed service area encompassed six Native American reservations and two military bases.

Connected Nation (Nevada)
Broadband Data and Development $3,993,441

Connect Nevada, established in 2009, is a subsidiary of Connected Nation, Nevada's state designee for the United States Department of Commerce's State Broadband Initiative (SBI) grant through NTIA. Connect Nevada supported the Nevada Broadband Task Force, coordinated statewide broadband activities with local broadband providers, and provided outreach to local community

technology planning teams. This effort included the development of a statewide broadband action plan for future initiatives.

Connect Nevada was originally funded for broadband planning activities and two years of data collection. In September 2010, the project was amended to extend data collection activities for an additional three years and to identify and implement best practices. The initiative received a total award of $3,993,441 and concluded in 2014.

Connect Nevada produced an inaugural map of broadband availability in spring 2010. The key goal of the map was to highlight communities and households that remain unserved or underserved by broadband service. This information was essential to estimating the broadband availability gap in the State and understanding the scope and scale of challenges in providing universal broadband service to all citizens. Since the initial map's release, Connect Nevada collected and released new data every six months, with updates in October and April annually.

A 2014 report by Connect Nevada found that an estimated 99.73% of Nevada households have broadband access via fixed or mobile broadband systems. Rural communities also saw benefits of the broadband initiative, with 95.17%of households reporting a fixed broadband service, and 99.57% of households reporting fixed or mobile broadband access. The report indicated that, at minimum, households had download speeds of 768 Kilobits per second (Kbps) or higher, and upload speeds of 200 Kbps.

Additionally, the results of Connect Nevada's 2014 Business Technology Survey revealed that more than 81% of businesses use broadband while the remaining 19% (11,000) businesses do not. Reported broadband usage among a random sampling of health care businesses increased from 70%to 77% between 2010 and 2014; however, the rate was below state average.

Nevada Hospital Association
Infrastructure $19,643,717

According to Rural Health Care and Telemedicine, prior to the passage of Assembly Bill 292, also known as the Nevada Telemedicine Act, a main barrier to the successful implementation of telemedicine in Nevada was poor broadband connectivity.

Inadequate broadband connectivity and the cost for these services continues to be a barrier to the adoption of telemedicine in the State's rural hospitals and clinics. The following information provides a summary of the broadband speeds available in the State's rural hospitals:

- Pershing General Hospital 100 Mbps.
- Humboldt General Hospital 100 Mbps.
- Battle Mountain General Hospital 40 Mbps.
- Ely (William Bee Ririe Hospital) 100 Mbps.
- Fallon (Banner) 100 Mbps Yerington ten Mbps.
- Hawthorne (Mt. Grant Hospital) 100 Mbps.
- Caliente (Grover C. Dils) 50 Mbps.
- Boulder City 100 Mbps.
- Desert View (Pahrump) 45 Mbps.

The Nevada Hospital Association (NHA) was tasked to build and operate a statewide telemedicine network to be made available to medical providers throughout the State with additional capacity for use by public safety agencies, educational institutions, tribal governments, and last-mile ISPs.

Deemed the Nevada Broadband Telemedicine Initiative (NBTI), the NHA selected The Broadband Group (TBG) to create and administer Nevada's next generation statewide telemedicine network supported by $19.6 million from the Federal Broadband Stimulus BTOP program in 2009.

TBG secured an additional $7.2 million in private matching funds. TBG created e-Care Nevada, a sub-recipient of the grant, to build a network that enables hospitals with:

- Administration and provision of the interrelated classes of telemedicine and telehealth services.
- Remote diagnostics and remote patient monitoring.
- Exchange of electronic medical records.
- Educational functions.

The award allowed the NHA and e-Care to build and operate a statewide telemedicine network to be made available to 60 medical providers throughout the State by constructing 224 new miles of fiber network while utilizing an additional 453 miles of existing fiber and 580 microwave miles to connect the rural hospitals at speeds between 100 Mbps and 1 Gbps.

Key features of the NBTI Network include:

- Potential to serve 3000 plus community anchor institutions and 6000 plus health care-related facilities.
- Planned, phased roll-out of double redundant ring, self-healing network architecture to ensure reliable continuity of service for health, public safety, and Department of Defense/Homeland Security applications.
- Robust (96-count fiber) Multi-Protocol Label Switching **(**MPLS) network components to transport Voice, Video, Data, Telemedicine, and Telemetry services over the fiber architecture improving the quality and level of services currently available.
- First ever all-fiber intrastate connection between northern (Carson/Reno) and southern urban centers (Las Vegas).
- Ultra-secure colocation/data center at Las Vegas-based Switch SuperNAP.

This next-generation broadband infrastructure supports emerging and enhanced health care services such as:

- Video-based telemedicine applications.
- Hosted health care applications, including EHR and picture archiving and communication system (PACS).
- Hosted business applications.
- Data center tools, such as storage and business continuity.
- Cloud-based services for extended access to health care practices.

Frontier Community Health Integration Program (FCHIP) Award Heal

In August 2016, four rural hospitals (Battle Mountain General Hospital in Battle Mountain, Grover C. Dils Medical Center in Caliente, Mt. Grant General Hospital in Hawthorne, and Pershing General Hospital in Lovelock) were awarded a Frontier Community Health Integration Program (FCHIP) award. These hospitals will partner with Renown Health, a not-for-profit health system in Reno, to expand provider specialty access to rural areas.

The purpose of the demonstration is to develop and test new models for the delivery of health care services in frontier areas through improving access to, and better integration of, the delivery of health care to Medicare and Medicaid beneficiaries. The primary focus is to increase access to, and improve the adequacy of, payments for acute care, extended care, and other essential health care services provided under the Medicare and Medicaid programs in frontier areas and to evaluate regulatory challenges facing frontier providers and the communities they serve.

Pyramid Lake Paiute Tribe

Department of Commerce, National Telecommunications and Information Administration
Broadband Grant
Infrastructure $7,070,006

To address low internet speeds and a general lack of access to online tools like distance learning, telemedicine, and enhanced public safety services on its reservation, the Pyramid Lake Paiute Tribe proposed a public-private partnership project to deploy a fiber-optic middle mile network across 742 square mile reservation. The project built 44 new miles of fiber in partnership with Praxis Associates that provided direct connections to local community anchor institutions at a minimum speed of ten Mbps.

Pyramid Lake Paiute Tribe Health Clinic also received a Distance Learning Telemedicine grant from the United States Department of Agriculture (USDA) to provide tele-pharmacy services to three remote tribes. The system will use the services of the tribe's IHS pharmacist and securely vend the medicines to patients hundreds of miles away.

College of Southern Nevada (ARRA HITECH HIT Education Grant, April 2010)

The U.S. Department of Health and Human Services (HHS) provided a $5.4 million grant to a consortium of 14 colleges in California, Hawaii, Arizona, and Nevada. The College of Southern Nevada is part of this consortium and provided training and education on HIT. In the second year expansion, the grant would provide an additional $5.35 million for a total allocation of $10.75 million. The grant is designed to get people trained quickly in the kind of computerized health information systems that are being installed by hospitals and medical offices across the western states.

The objective of the grant provided ONC-defined training that supports the Health Information Technology for Economic and Clinical Health Act (HITECH) implementation to a minimum of 150 student recruits each year. Training began September 30, 2010 and the first cohort graduated 2011. The college currently offers a two-year HIT associate degree and students are eligible to sit for the national registration examination leading to a credential as a Registered Health Information Technician (RHIT).

Nevada Rural Hospital Partners Foundation (Telehealth Grant, 2004)

Nevada Rural Hospital Partners (NRHP) received a grant for Digital Imaging System for Rural Nevada (DISRN) Telehealth. The DISRN program enables rural and frontier hospitals to capture digital radiographic images, implement picture archive computer systems, integrate patient information with those diagnostic images, and transmit them over an existing, secure wide area network (WAN) to a new shared, centralized image archive.

While initially focused on radiology, the system can support any type of digital diagnostic image. The program enhances access by rural physicians to virtually instant diagnostic support across great geographic distance, and is a dynamic example of how small, autonomous hospitals can share technology to reduce cost, improve quality, and increase workforce productivity. In addition, the NHA and the Nevada Rural Hospital Partners applied for ARRA grant funding to support broadband access to rural health care providers, but the funding was not awarded.

From the Health Resources and Services Administration (HRSA) civil monetary penalties (CMP) funding from 2004 – 2005, seven hospitals received equipment and software. NRHP received a second CMP grant for 2008 – 2009. Funds were used to add picture archiving and communication system (PACS)/radiology information system (RIS) capability in another NRHP member hospital, improve the RIS capability at the seven existing sites, improve electronic network capability, integrate existing teleradiology capability with distant radiologists' RIS, and provide centralized technical support for the program.

USDA Broadband Initiatives Program (BIP)
USDA supported about $2.5 million in distance learning telemedicine loans and grants for universities and community colleges, rural school districts, tribes, and medical clinics to develop broadband anchor hubs in rural communities across the State. Nearly $3 million went to Community Connect Grants to connect small towns to metropolitan areas, and $11 million in BIP funds supported infrastructure improvements. The Arizona-Nevada Tower Corporation's (ANTC) project funded, in part, by nearly $8.5 million in grant and loan funds from the USDA raised the last grant-funded tower on an extensive 34-site middle-mile network.

Rural Telephone Company
July 2010 Broadband Service Implementation
Last Mile $728,700 Loan
$1,700,300.00 Grant

This project extended Asymmetric Digital Subscriber Line2+ (ADSL2+) high speed broadband service to existing and new customers in the North Fork, Tuscarora, and Jarbidge, Nevada service areas. Rural Telephone Company estimates that approximately 700 people benefited from this project as well as over 100 businesses and ten other community institutions. This project created jobs and drove economic development in the community creating jobs for years to come. Upon conclusion, the network made services available to 272 households, 104 businesses, and 10 anchor institutions.

Nevada Department of Cultural Affairs
Public Computer Centers

This $806,000 grant, with an additional $305,000 applicant-provided match, installed more than 250 new workstations and expand the training and educational capacity at more than 30 libraries and other hubs for free computer access in 15 counties throughout the State.

The Nevada One Click Away project upgraded 34 public computer centers and created one new center. The project enhanced existing computer training programs, including computer skills training provided by librarians and volunteers, and adding accessible technology and computer classes in Spanish in the larger participating library branches. Additionally, some libraries partnered with the local Chambers of Commerce to host small business workshops focused on best practices, customer creation and retention, and marketing practices.

Arizona Nevada Tower Corporation (ANTC)
Middle Mile $2,276,650 Loan; $5,312,182 Grant

ANTC provided middle-mile broadband to enhance existing but limited fiber-optic cable and provide transport where fiber-optic cable is unavailable by using Long Term Evolution (LTE)/ Worldwide Interoperability for Microwave Access (WiMAX) ready technology. This project provided microwave radio backbone and a middle-mile system to provide significant bandwidth in 15 areas of Nevada and California. The network made services available to 12,933 households, 3,422 businesses, and 186 anchor institutions.

Reno-Sparks Indian Colony, Inc. Hungry Valley Broadband Initiative
Last Mile $400,000 Grant

Reno-Sparks Indian Colony, Inc., offered wireless broadband service speeds at a minimum of five Mbps to communities in a rural reservation in Hungry Valley. The network made services available to 162 households, one business, and four anchor institutions.

A.3. FQHC HIT/HIE HRSA Grant Funding

SMHP Companion Guide Question A #3

Federally Qualified Health Centers (FQHC)
The State of Nevada has received grant funds to support the development of HIT and HIE infrastructure through HRSA. The Nevada Health Centers (NVHC) is a private, non-profit FQHC serving Nevada's medically underserved populations with over 30 medical and dental centers, including Rural Health Clinics (RHC), and other health-related programs. NVHC received a $1.4 million grant through HRSA (and a grant through The Lincy Foundation) to support implementation of a full EHR system and has been operational in NVHC clinics since May 2009.

Nevada Primary Care Association (formerly Great Basin Primary Care Association) (NVPCA) is the federally designated Primary Care Association for the State of Nevada. NVPCA serves Section 330 funded and prospective FQHCs, tribal health centers, other primary care clinics, and community health providers located in the Reno, Sparks, Carson City, and Las Vegas metropolitan centers, as well as the frontier and rural Nevada Counties that make up 87% of its land mass. The NVPCA supports and advocates on the behalf of the special populations of Nevada including veterans; migrant and seasonal farm workers; the homeless; Native Americans; clients living in temporary housing; and clients living with HIV/AIDS. NVPCA promotes access to affordable, comprehensive, and quality health care for Nevada's underserved populations and supports and advocates on behalf of the health centers, tribal clinics, and other health care safety net providers throughout the State.

According to the HRSA data warehouse, NVPCA has received $824,445 in HRSA funds to support the collaboration and coordination of existing health centers with other safety net providers to improve and expand services, in addition to conducting surveillance analysis on emerging primary care issues, and providing operational and administrative support, fiscal development, training and technical assistance on Meaningful Use and uniform data system (UDS) reporting, which are required reporting measures for all HRSA Health Center Program grantees, and strategic planning.

Nevada currently has six FQHCs and one look-alike that provide services at 33 sites across the State. All FQHCs have adopted some form of CEHRT system, compared to that of 90 percent nationally in 2015. Three of the well-established FQHCs are connected to HealtHIE Nevada for use cases such as lab imaging and specialty referrals. All FQHCs have attested to Meaningful Use, with

the exception of new centers in Las Vegas. Because 2016 is the last year for EPs to begin participation in the Medicaid EHR Incentive Program, NVPCA will provide technical assistance to prepare the new sites for immediate Meaningful Use achievement.

Nevada has received over $366,000 HRSA Quality Improvement Awards, according to the NVPCA. FQHCs in Nevada are reporting clinical quality measures at the population level and most are trending up in one or more quality measures. For instance, Nevada had the best results in the country for FQHCs in the tobacco prevention and cessation measure via the MillionHearts program. Weight screening increased from 29%in 2012 to 69% in 2013 and up to 78%in 2015. Similar improvements were found in colorectal cancer screening.

Additionally, HRSA has recognized several IHS facilities as 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 CEHRT and compliancy with the Meaningful Use criteria.

NVPCA is in the process of getting all FQHC sites recognized as patient-centered medical homes (PCMH) by the National Committee for Quality Assurance (NCQA). Twenty-four sites across seven multi-site organizations will be PCMH-recognized (*Table 8. PCMH-Recognized Clinics*). Only two single site clinics will not be PCMH-recognized in the near future. NVHC and Community Health Alliance (CHA) received grants from HRSA Bureau of Primary Health Care in 2013 for PCMH work as a supplemental grant. HOPES, Hope Christian Health Center (HCHC), Searchlight, and FirstMed each have similar grants for FY2016 – 2017.

Table 8. PCMH-Recognized Clinics

FQHC	PCMH-Recognized Clinics				MU Achievement	EHR Adoption	EHR Certified	PCMH Renewal
Health Center	2013	2014	2015	2016				
CHA			3 (Level 2)	3 (Level 2)	2012*	2012*	Yes	2017
FirstMed					2015	2014	No	N/A
FirstPerson (Look-Alike)						2013	Yes	2017
Hope Christian					2015	2015	Yes	2017
HOPES		1 (Level 2)	1 (Level 2)	1 (Level 2)	2014	2014	Yes	2017
NVHC Level 2	1	3	3	3	2012*	2012*	Yes	2016-2018
NVHC Level 3		7	11	11				
Searchlight					N/A	2015	Yes	N/A

* 2012 is the first year for which data are available

Source: NVPC, Policy Manager

The NVPCA was awarded funding under FY 2016 Delivery System Health Information Investment (DHSII) Supplemental Funding Technical Assistance to procure and implement data aggregation software that will incorporate Medicaid claims data in order to better track clinical quality measures to support payment reform and alternative payment models (APM). The aim is to aggregate clinical and financial measures at the network level in order to allow easier participation by the FQHCs in payment reform programs like an Accountable Care Organization, for example.

All of the FQHCs in Nevada received a total DSHII award of $291,555.00 for FY 2016. Funding distribution is listed below:

- $76,856 to Community Health Alliance (Reno).
- $51,342 to FirstMed Health and Wellness Center (Las Vegas).
- $115,800 to Nevada Health Centers, Inc. (Carson City).
- $47,557 to Northern Nevada HIV Outpatient Program, Education, and Services (Reno).

Per the NVPCA, the CHA received a $66,300 award for clinical quality improvement. The award focuses on a number of areas of clinical quality including: using EHRs to report quality measures on all patients; improvements in multiple clinical quality indicators; and achieving the highest performance compared to their health center peers.

In addition, CHA will go beyond site-specific behavioral health integration to develop a new “Center for Complex Care” based in part on a Substance Abuse and Mental Health Services Administration (SAMHSA)-HRSA Center for Integrated Health Solutions (CIHS) supported model for integrated behavioral and primary care teams. Critical to the model is effective use of EHR in case reviews, day-to-day patient care, and clinical management.

The NVPCA has applied for the Accountable Health Communities (AHC) grant program through CMS. The AHC model addresses the gap between clinical care and community services. The NVPCA cited that poverty is the most influential social determinant of health. If awarded, this grant

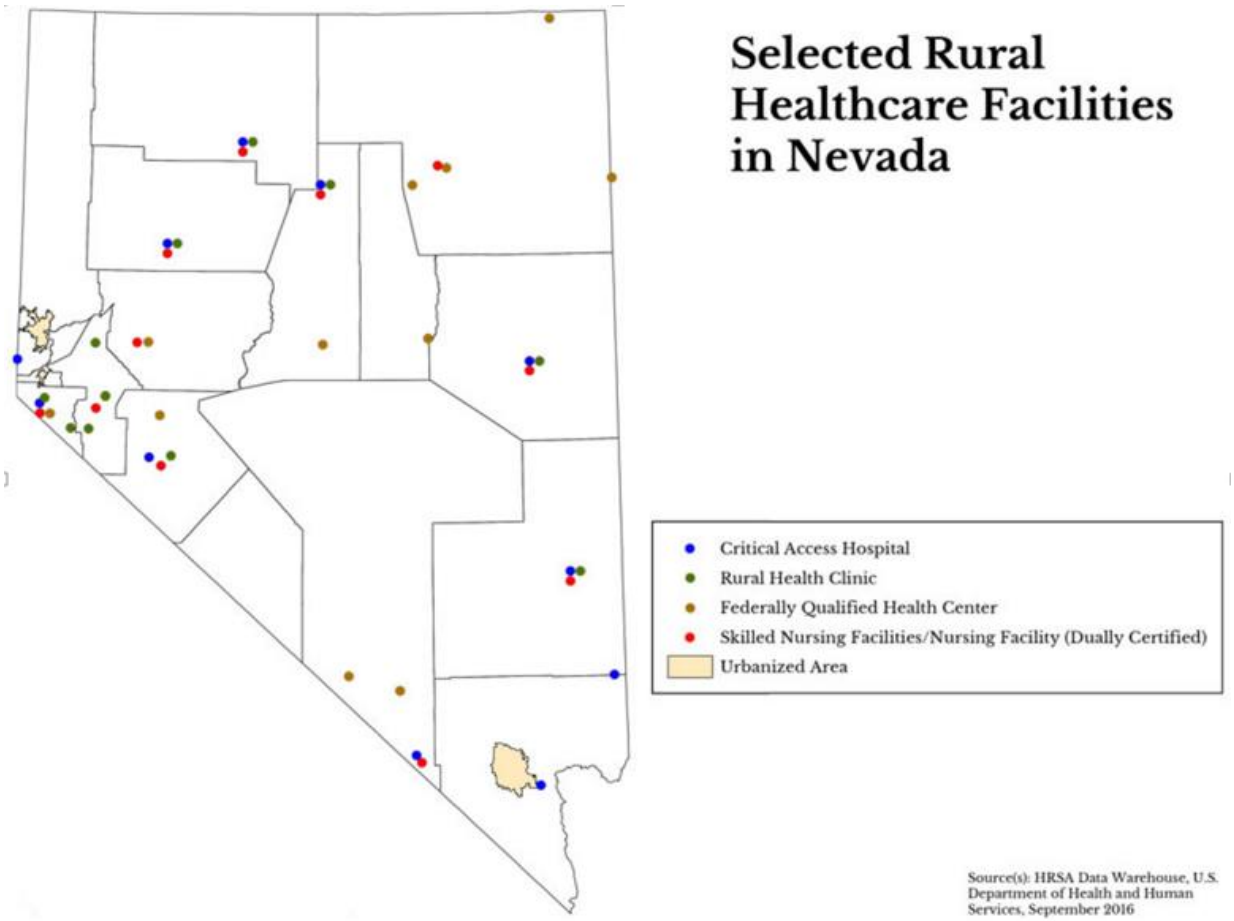
will allow FQHCs to screen for social needs in order to drive referrals to appropriate social services. Applicants are currently under review.

Rural Health Clinics and Hospitals

Within Nevada, there are two urban counties and one independent city (pop. 2,427,950), three rural counties (combined pop. 102,987), and 11 frontier counties (combined pop. 169,614). An estimated 10.7% of Nevada's population resides in rural and frontier counties spread over 86.9 percent of its land mass. Of the 37 hospitals in Nevada, 12 are identified as CAHs. There are 11 RHCs, eight of which are owned by a Nevada CAH, the remaining three by a Nevada rural sole community hospital (RSCH) (*Figure 4. Selected Rural Health Care Facilities*).

In addition to the State's few broadband issues, they have encountered other barriers to EHR adoption such as ease of use, resistance to culture change, difficulty keeping up with changes to vendor systems, and the use of different EHRs among hospitals. Nevada's rural hospitals are at 100% adoption (at least basic EHR) with five hospitals using the same EHR vendor. Additionally, all of the hospitals have established connections with the HIE either through a direct connection or a connection with public health reporting agencies.

Figure 4. Selected Rural Health Care Facilities



As a part of the Small Rural Hospital Improvement Grant Program (SHIP), Nevada utilized $134,344 for SHIP grant funding during the 2015 fiscal year. These funds supported the following activities:

- Improve rural hospitals' access to shared financial and program management expertise at NRHP.
- Support the Nevada Rural Hospital Quarterly Quality Improvement Network and rural hospitals' access to the incident management system overseen by NHRP.
- Support CAH reporting to the Medicare Beneficiary Quality Improvement Project (MBQIP) and the utilization of MBQIP data by SHIP hospitals for quality improvement.
- Support rural hospitals' access to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) vendor support and software.
- Share consortium and program coordination, consultation, facilitation, and administration at NRHP.

A.4. Veterans Administration and Indian Health Services Providers

SMHP Companion Guide Question A #4

Veterans Administration (VA)

According to the Nevada Office of Veterans Services, there are over 339,000 veterans living in the State. There are two main service offices – one in Reno and one in Las Vegas, with the Nevada Veterans Home located in Boulder City. The VA also operates four outpatient clinics, six community-based outpatient clinics, three Vet Centers, and one outreach clinic. The medical centers include Loannis A. Lougaris Veterans Administration Medical Center, part of the Sierra Nevada Health Care System located in Reno and the Southern Nevada Healthcare System in Las Vegas.

Nevada veterans reside in one of three Veterans Integrated Service Networks (VISNs) that cross state lines. The Southern Nevada Healthcare System services are available to more than 240,000 veterans in their catchment area, which includes residents of Clark, Esmeralda, Lincoln, and Nye Counties grouped together with portions of Southern California. Residents of Elko, Eureka, and White Pine Counties are grouped together with portions of several mountain states in a VISN for which no VA medical centers are located in Nevada. Residents of the remaining Counties are grouped together with portions of Northern California and are served by the Reno campus of the Loannis A. Lougaris Veterans Administration Medical Center. Approximately 120,000 veterans reside in this region, with Reno representing the largest urban area. When specialty care is not available, support is provided through a variety of means, including referrals to community hospitals and VA medical centers.

The EHR system in use is the Veterans Health Information System and Technology Architecture (VistA). A congressional directive requires the VA and the Department of Defense (DoD) to share records in order to provide for the seamless care of members of the military 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. These exchanges are established using a Joint Legacy Viewer (JLV).

The VA faces several barriers to HIE connectivity, primarily security hurdles when connecting with outside facilities. However, the VA is currently working to connect with HealtHIE Nevada. They are presently in the testing phase and working to meet security requirements.

Indian Health Programs Providers

The 19,652 tribal and Indian Health Services active users in Nevada are served by 16 Indian Health Clinics. Of these 16 clinics, there is one Urban Indian Program (Nevada Urban Indians, Inc.) and two federal clinics. Nevada's 12 tribal clinics are:

- Battle Mountain Band Human Services
- Ely Shoshone Tribal Clinic
- Fallon Tribal Health Clinic
- Ft. McDermitt Health Clinic
- Goshute Health Clinic
- Las Vegas Clinic
- Duckwater Health Clinic,
- Owyhee Community Health Center
- Pyramid Lake Tribal Health Clinic
- Reno-Sparks Tribal Health Center
- Walker River Tribal Health Clinic
- Washoe Tribal Health Clinic
- Yerington Tribal Health Clinic

The majority of these organizations operate the Resource and Patient Management System (RPMS), the national IHS EHR which is currently undergoing enhancements to meet Meaningful Use. Additionally, the Phoenix Area Indian Health Service (PAIHS) Office in Phoenix, Arizona, oversees the delivery of health care to approximately 140,000 Native Americans in the tristate area of Arizona, Nevada, and Utah.

Inter-Tribal Council of Nevada (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 a Tribal Chairperson 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 Nevada and has taken on the role of facilitating the Tribal Health Directors meetings.

A Quality Implementation Plan was recently finalized, part of which is standardization in data and reporting requirements. HealthInsight was awarded a contract with CMS in October 2016 to provide training to strengthen the capacity of Nevada's Indian Health Providers to deliver higher quality health care and address deficiencies at its hospitals. The contract is expected to last at least three years and will focus on quality improvement, sharing best practices, and meeting clinical, operational, and safety standards.

A.5. Stakeholder Engagement in HIT/HIE Activity

SMHP Companion Guide Question A #5

In order to inform the SHSIP, DHCFP formed a HIT and Data Task Force to assess the HIT requirements of the State, identify challenges, and develop solutions to existing infrastructure and related projects to enable payment and delivery system reform.

Beginning in 2015, the Task Force launched a data asset survey to public and private entities in the State that may have health information records to determine what data exists, in which format, and its level of accessibility. The goal was to understand the landscape and to create a plan to enable secure, efficient collection and availability of data sources critical to population health efforts.

Table 9. Health Information Technology and Data Task Force lists the HIT and Data Task Force members that participated in development of the SHSIP HIT priority areas and approach, which include standardization of identified data sources, implementing strategies to maximize HIT and HIE resources, development of a population health analytics tool, and supporting transformation through use of HIT.

Table 9. Health Information Technology and Data Task Force

Health Information Technology and Data Task Force	
Name	**Title and Organization**
Sarah Albers	Senior Analytic Consultant, Truven
Brett Barton	Sales Executive, HP Enterprise Services
Farron Bernhardt	Vice President of Assisted Living, Nevada HAND
Nancy Boland	County Commissioner, Esmeralda County
Paul Bowen	IT Manager III, Division of Child and Family Services
Karri Couste	DHHS
Ellen Crecelius	Deputy Director Fiscal, DHHS
Steven Decker	Executive Director, Family Support Council of Douglas County
Ron Fuschillo	Chief Information Officer, Renown
Joseph Greenway	Director, Center for Health Information Analysis - UNLV
Tim Hakamaki	Senior Director, Data Solutions, Sansio/Physio-control Data Solutions
Deborah Huber	Executive Director, HealthInsight Nevada
Peter Janson	DHHS
Julie D Kotchevar	Deputy Administrator, ADSD
Jay Kvam	Chief Biostatistician, Community Services
Cassius Lockett, Ph.D.	Director of Community Health, Southern Nevada Health District
Debbie Lofgreen	Practice Administrator, Complete Medical Consultants
Sarah McCrea, EMTP, RN	EMS Quality Improvement Coordinator, Las Vegas Fire and Rescue
Davor Milicevic	DHCFP
Martin Schiller	Executive Director, Nevada Institute of Personalized Medicine
Keith Parker	HealthInsight Nevada
Patrick Patterson	Truven
Julia Peek	DHHS

Health Information Technology and Data Task Force	
Name	**Title and Organization**
Todd Radtke	Regional Chief Information Officer, Nevada Rural Hospital Partners
Sandie Ruybalid	IT Manager, DHCFP
David Sater	IT Manager for ADSD Application Development and Support, ADSD
Dena Schmidt	Deputy Director, DHHS
David Stewart	Deputy Administrator, Information Systems, DHCFP
Troy Tuke	EMS Coordinator, Clark County Fire Department
Chris Watanabe	Regional Emergency Medical Services Authority (REMSA)
Rob Waters	Vice President of Development, Healthcare IT Connect
Andrea West	Truven
Richard Whitley	Director, DHHS
Blong Xiong	Director, Consulting, Truven
Marty Bobroske	Truven

The SHSIP also determined a need to form the Population Health Improvement Council (PHIC). The PHIC oversaw the day-to-day development and deployment of the Nevada SIM solution. The PHIC brought together State agency staff, public health experts, payers, providers, employers, consumers/advocates, and other stakeholders who have shared interests in the aims of Nevada, as outlined in the SHSIP. This body was charged with reaching a consensus on basic elements regarding outcome measure methodology, targeted improvements, and provider payment models to meet Nevada's aims. The PHIC made decisions regarding the infrastructure and IT solutions needed for providers to perform under the initial provider payment models, and determine how the State will support the adoption of the identified functionality.

Under the direction of DHCFP, the PHIC oversaw four sub-committees representing HIT, multi-payer collaborative, quality, and provider. *Table 10. Population Health Improvement Council Sub-committee Members* lists the identified HIT sub-committee members as of August 2016, and all other sub-committee members that have been selected. These sub-committees met to choose representatives for the PHIC, and DHCFP staff coordinated future meeting times.

Table 10. Population Health Improvement Council Sub-committee Members

Name	**Title and Organization**
Dena Schmidt	Division of Health and Human Services
Julia Peek	Division of Public and Behavioral Health
Joan Hall	Nevada Rural Hospital Partners
Chris Watanabe	Regional Emergency Medical Services Authority
Chuck Duarte	Community Health Alliance
Dave Stewart	Division of Health Care Financing and Policy
Steve Fisher	Divisionof Welfare and Supportive Services
Joseph Greenway	Center for Health Information Analysis - UNLV

A.6. SMA HIT/HIE Relationship with Other Entities

SMHP Companion Guide Question A #6

History of the Statewide Nevada HIE

On September 11, 2012, in accordance with Nevada's State Health Information Technology Strategic and Operational Plan (approved by the federal Department of Health and Human Services in May 2011), the Nevada Health Information Exchange (NV-HIE) was created as a non-profit corporation in Nevada. On January 13, 2013, the non-profit NV-HIE became a sub-grantee of the DHHS state HIE grant managed through the HIT Office. NV-HIE became responsible for implementing a statewide HIE governing entity, contracting with a technical solution to create an HIE, and establishing a self-supporting revenue stream.

In early 2014, the NV-HIE Board of Directors voted to cease operations, citing a reluctance to go into debt without a clear source of revenue. The federal government confirmed that Nevada met all the required grant obligations, and Nevada did not owe any federal funds back because since 2010, Nevada had successfully accomplished the grant-required milestones for building HIE infrastructure. Some major milestones included:

- Creating the mandated State HIT Coordinator position.
- Completing an approved State HIT Strategic and Operational Plan.
- Supporting the successful passage of HIE-enabling legislation (Senate Bill [SB] 43, 2011).
- Supporting the enabling of pharmacies in Nevada to conduct electronic prescribing (97 percent of pharmacies are enabled).
- Supporting HIE by medical laboratories (Nevada was ranked second highest among all grantees).

In response to ceasing operations, DHHS discussed options with partners, vendors, corporations, and non-profit entities to explore ways to expand upon this initial investment in the infrastructure for HIEs in Nevada. One such entity included HealtHIE Nevada.

HealtHIE Nevada

HealtHIE Nevada, launched July 2011, is the single remaining HIE in Nevada. HealtHIE Nevada is a private, non-profit, community-based organization dedicated to connecting the Nevada health care community by managing an accurate, real-time HIE.

The management of HealtHIE Nevada and its services are performed by HealthInsight, a recognized leader in quality improvement; transparency and public reporting; HIT programs; health care system delivery and payment reform efforts; and human factors science research and application. The core HIE technology and services are provided by OptumInsight, while Image Exchange technology and services are provided by eHealth Technologies.

In partnership with the State, HealtHIE Nevada has created a plan that includes projects both in progress and those set for immediate/near-term implementation *(Table 11. HealtHIE Nevada HIE Connection Projects)*.

Table 11. HealtHIE Nevada HIE Connection Projects

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
DHHS HIT / HIE Projects			
Initiate various County Public Health District connections to HIE	2017	Medium	By connecting various county public health districts to the HIE, the state hopes to further their goal of enhancing Nevada's HIT/HIE landscape by on-boarding/connecting systems.
DHCFP Connection to the HIE (health data from the Medicaid claim)	2018	High	Establishing an interoperable connection between HealtHIE Nevada and DHCFP, the state Medicaid agency will allow for: (1) providers treating Medicaid patients to access health data from Medicaid claims including dental, pharmacy and behavioral health data where applicable and pursuant to patient consent; and (2) will provide DHCFP with data to better measure, monitor and manage population health, drive quality and coordination of care across the full spectrum of setting.
DHCFP HIT Master Data Management	2017-2019	High	Nevada seeks to achieve a unified view of Medicaid provider and beneficiary data via a suite of data records and services that will allow DHCFP to link and synchronize Medicaid member, provider, and organization data to HIE sources. This effort will result in a single, trusted, authoritative data source.
Avatar Integration Project (DPBH and DCFS) and Avatar Implementation for Nevada Aging and Disability Services Division	2018	TBD	DCFS and DPBH currently run two instances of myAvatar. This project will allow integration of two instances of myAvatar into one. ADSD plans to replace its Harmony platform with myAvatar.
DPBH Vital Record Registry	2019	Medium	Nevada plans to connect Vital Statistics to the HIE with the goal of providing a single point of access to the statewide vital statistics. This connection would make data available to other agencies as well, including the Nevada DHCFP and the Nevada Department of Education, and school health offices.
National Outcomes Measurement System (NBOMS) or Birth Defects registry	2019	Medium	Connection of Nevada's Birth Outcomes Monitoring Program to the HIE will continue to assist in the early detection of birth defects; and to assist in ensuring the delivery of services for children identified with birth defects.
Nevada State Public Health Lab	2019	Low	The Nevada State Public Health Laboratory (NSPHL) has significant data reported that requires immediate notification of clinicians and public health partners. Implementing a connection to HealtHIE Nevada would allow a

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
			consolidated resource to transmit electronically NSPHL reports timely and efficiently.
Board of Pharmacy (PDMP)	2019	High	Nevada seeks to build a public health registry connecting the HealthHIE NV network to the Prescription Drug Monitoring Program, Nevada's solution for monitoring Schedule II-V controlled substances dispensed to residents in the State of Nevada.
Sentinel Events registry connection to HIE	2019	High	The Sentinel Event Registry (SER) Program tracks reportable sentinel events (an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum) in medical facilities which includes hospitals, surgical center for ambulatory patients, independent center for emergency medical care, and obstetric centers. Connecting this registry to the HIE will help to improve speed and efficiency in identifying events that have a need for immediate investigation and response.
DHHS Interoperability Projects	2018-2019	High	DHHS plans create a mechanism that connects desperate data sets and exchanges data across different agencies and programs.
Critical Access Hospitals Interoperability Projects (Other EHs to be identified later)			
Grover C. Dils Hospital	2017	Low	The connection of Critical Access Hospitals (CAH) to the HIE has the potential to improve health care provided in rural Nevada by connecting rural providers to faraway specialists, helping CAHs save money through electronic document exchange, and enabling patients to receive coordinated care in their own communities.
William B. Ririe Hospital	2017	Low	
Mesa View Hospital	2017	Low	
Pershing General Hospital	2017	Low	
Southern Nevada Health District (SNHD) EHR	2018	Medium	
South Lyon Medical Center	2018	Low	
Desert View	2018	Low	
Humboldt General Hospital	2018	Low	
Battle Mountain General Hospital	2018	Low	
Nye Regional Hospital	2018	Low	
Incline Village Community Hospital	2018	Low	
Boulder City Community Hospital	2018	Low	
Public Health Connection Projects (Other projects to be identified later)			
SNAMHS Laboratory System connection to HIE	2017	Medium	HealtHIE Nevada will establish a connection with the Southern Nevada Adult Mental Health System. SNAMHS collects information related to communicable diseases as part of their

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
			function to ensure the general health of the population. This information helps public health agencies prevent the spread of disease. A primary concern around disease surveillance is accurate and timely diagnosis, which often takes the form of a positive lab test result for a predefined set of monitored conditions.
WebIZ/Immunization Integration with HIE (Phase 2)	2018	High	Nevada will integrate WebIZ into the HIE, a web-based Immunization Information System (IIS) that currently contains 3.1 million records and allows access for both private and public providers with minimal hardware/software requirements.
DCFS and DPBH MyAvatar integration with HIE	2018	Medium	Integration of the state system, Avatar into the HIE will help to bring data from state agencies together improving the successful coordination of agency projects.
Statewide electronic morbidity reporting	2018	Medium	Nevada seeks to connect statewide morbidity reporting to the HIE to promote the ability address needs surrounding the leading causes of morbidity and mortality within the state.
Stroke Registry	2018	Low	Nevada will connect a stroke registry to HIE that will allow for the collection and exchange of comprehensive, continuous stroke data supports data analysis and the development of interventions to improve stroke care.
University Medical Centers			
University of Nevada – Reno	2017	Low	University systems play an important role in Nevada's health care landscape. The state plans begin onboarding of these universities to the HIE over the next twelve months.
University of Nevada – Las Vegas	2017	Low	
Touro University	2018	Low	
Roseman University	2018	Low	
EMS Connection to HIE (Other EMS agency projects to be identified later)			
Las Vegas Fire and Rescue	2019	Medium	EMS is an integral part of the health care system and actions taken by EMS providers affect outcomes, quality of care and patient satisfaction. Connection of Nevada EMS providers to the HIE will allow appropriate in the field access and the secure electronic sharing of a patient's vital medical information. This is a partial list of EMS agencies. We anticipate that this list will increase as the state continues stakeholder engagement activities with additional EMS agencies in Nevada.
Henderson Fire	2019	Medium	
North Las Vegas Fire	2019	Medium	
REMSA	2019	Medium	
Reno Fire	2019	Medium	
East Fork Fire	2019	Medium	
Southern Nevada Health District			
SNHD Vital Records	2018	Medium	DHCFP, HealthIE Nevada, and Southern Nevada Health District (SNHD) clinics will

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
SNHD Cancer Registry	2019	Medium	establish a stakeholder collaborative to create interoperable connections with public health clinics to allow for the transmittal of newborn screenings, immunization data, and other vital health information via the HIE network.
SNHD Chronic Disease Registry	2019	Medium	
SNHD Electronic health record system	2019	Medium	
SNHD Public Health Lab	2019	Low	
SNHD Birth Defect Registry	2019	Medium	
SNHD Syndromic Surveillance	2019 – 2020	Low	
SNHD Reportable Disease Surveillance	2019 – 2020	Medium	
SNHD Prescription Drug Monitoring for Opioid Surveillance	2020+	High	
Indian Health Programs (IHP)			
Indian Health Programs Interoperability Projects	2018-2019	High	Statewide IHP programs interoperability projects include connection to HIE from IHP clinical settings and connection to DPBH registries.
Value Added Service			
Care Plan Exchange	2018	Medium	DHCFP recognizes that the healthcare community is challenged to effectively and efficiently share and maintain care plans among members of a Medicaid patient's care team. In order to realize the potential of health IT and provide a more cohesive, inclusive experience for patients, DHCFP proposes deployment of a connected care plan exchange, a standards-based technology solution that allows healthcare providers, care management partners and other care team members who care for a single patient regardless of settings to exchange comprehensive care plans focus on the patient's realistic/achievable goals, optimize services, and create accountability for community-based and institutional care. This interoperable platform will also support Alternative Payment Models (APM) and include transmission of acute event and other care alerts to the care team in order to more closely coordinate care, including follow-on care and/or care transitions.
Master Provider Directory	2018	Medium	Currently, DHCFP and others in Nevada's healthcare landscape use a variety of

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
			provider directories, spread across state and non-state systems. These provider directories are often isolated from one another, limited in scope, data accuracy, and timely updates, and are costly to maintain the same information across multiple directories. As a result there is a significant need for Nevada to implement the foundation necessary to support a comprehensive provider directory using Healthcare Provider Directory (HPD) standards for both content and query in order to connect disparate provider directories existing today. The initial phase of Nevada's provider directory will be developed in an iterative fashion building upon the last version and accessible by healthcare providers, health-related state agencies, health plans serving Medicaid beneficiaries, and HealtHIE Nevada.
Master Client Index	2020+	High	Nevada DHCFP Master Client Index (MCI) will be used to ensure accuracy and availability of a person's health information, when and where it is needed to inform the best care possible. A suite of data records and services will synchronize patient, provider, and organization data from multiple sources of data into a single, trusted data source.
HIT Data Entry Portal	2018	Medium	The DHHS Data Entry Portal ("DEP") is a secure web portal giving Medicaid providers a single point of access to their patient's health information derived from a variety of HIE, HIO, state, federal data other sources. Using the DEP, providers will be able to search for and find their patient's health information via an online query mechanism using a Record Locator Service (RLS) to identify patient records that meet criteria within the search. The DEP also allows providers to access other features, functionality and data sources necessary to enhance care delivery, improve care coordination for their patients and reduce overall healthcare costs.
Telehealth	2018	Medium	Use of telehealth will offer an innovative approach to address limited access to health care services by remotely providing such services to people in communities who otherwise do not have access to care. In addition, Nevada seeks to improve healthcare quality by enhancing the use of telehealth services by establishing

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
			connections between telehealth EHRs and HealtHIE Nevada in order to give healthcare providers the ability to deliver more efficient care by having access to timely and reliable patient health data at the point of care.
Work Force Development			
Health IT Work Force	2018	Medium	Nevada will develop and deploy a multi-stakeholder strategic initiative to produce a workforce that is equipped to provide high-quality, integrated care throughout the state in order to support the state's vision for healthcare transformation. Such an initiative will begin with identification of the current workforce capacity and an assessment of education, recruitment, and training of a workforce with knowledge and skills to provide and coordinate the full continuum required to meet care delivery transformation goals.

With the closure of NV-HIE and subsequent regulatory changes, the State's role in HIE evolved from establishing and governing a statewide health information system, to establishing a regulation for HIEs. DHHS is in the final stages of enacting the revisions to the Nevada Administrative Code (NAC) Chapter 439, giving the DHHS regulatory authority over HIEs operating in the State.

Regional Extension Center (REC)

HealthInsight served as the REC in Nevada and Utah supporting CAHs, rural hospitals, and primary care providers (PCPs) as they strived to meet Meaningful Use requirements. In Nevada, the REC allowed HealthInsight to improve Nevada's interoperability and create an HIE, HealtHIE Nevada, after the closing of the statewide HIE in 2014. Throughout Nevada and Utah, HealthInsight has supported more than 1,463 PCPs and 30 CAHs and rural hospitals in achieving the following:

- 100% of PCPs launched an EHR.
  - 798 Nevada providers.
  - 1,169 Utah providers.
- 95% of PCPs have met Meaningful Use requirements for the first 90-day reporting period for Stage 1.
  - 535 Nevada providers.
  - 852 Utah providers.
- 100% of the CAHs and rural hospitals launched an EHR.
- 100% of CAHs and rural hospitals have met Meaningful Use requirements for the first 90-day reporting period for Stage 1.

While funding for REC services ended in June 2015, DHCFP is now working with HealthInsight to provide REC-like technical assistance to Medicaid EPs. This proposed work will be outlined in a forthcoming I-APD.

Commercial Health Plans and Medicaid Managed Care Organizations in Nevada and Connections to HIE

In 2011, about 84% of Medicaid beneficiaries were enrolled in some form of Managed Care Organization (MCO) through the Nevada Mandatory Health Maintenance Program.

Nevada contracts with two for profit health plans, Amerigroup Community Care and Health Plan of Nevada, to provide services to Medicaid beneficiaries, and selects plans that will be delivered through these organizations via a competitive bidding process. To provide care for any high need beneficiaries not served by the Mandatory Health Maintenance Program, such as those in rural areas, Nevada received federal approval for a section 1115 demonstration entitled the Nevada Comprehensive Care Waiver (NCCW). Individuals eligible for NCCW receive benefits in a fee-for-service (FFS) model.

In accordance with legislation SB514, the State has an opportunity to evaluate alternative Medicaid delivery models, and must conduct an impact analysis of managed care program implementation for the waiver population. An analysis was completed September 2016.

The State aims to design managed care delivery solutions that integrate medical, behavioral health, and social needs to promote patient-centered care. Currently, MCOs report CAHPS, HEDIS and other performance data. The State is in the process of procuring new MCOs to be effective July 2017. Selected plans and the State will jointly determine the set of quality scores eligible for performance incentives at the beginning of the contract period, including participation in HIE.

The following are commercial health plan and MCO member lives in HealtHIE Nevada:

- Amerigroup (MCO): 190,455 Medicaid member lives

- United Healthcare (MCO): 273,136 Medicaid member lives
- United Healthcare (Non-Medicaid): 426,864 commercial member lives

In accordance to the HealtHIE Nevada Fee Schedule in Table 8, the commercial health plan pays its "fair share" at approximately $1.76M per year into the HIE while the MCOs collectively pay $1.16M for Medicaid lives. HealtHIE Nevada continuously pursues additional commercial health plans to participate in the HIE network.

A.7. Health Information Exchange Governance Structure

SMHP Companion Guide Question A #7

HealtHIE Nevada is governed by a board of directors ("the Board") made up of senior leaders from the founding organizations (http://healthienevada.org/about/board-of-directors/):

- Catholic Healthcare West
- Healthcare Partners
- Nevada Orthopedic and Spine Center
- Renown Health
- Southwest Medical Associates, Inc.
- Sunrise Health System
- The Valley Health System
- University Medical Center of Southern Nevada

In order to represent interests of all stakeholders, the Board has also added community stakeholders from Steinberg Diagnostics, Medical Imaging, and NRHP. HealthInsight's (Nevada) Executive Director is an ex officio, non-voting member of the board.

A representative from DHHS also serves as a full voting member of the Board of Directors with rights and privileges for oversight as outlined in the organization's bylaws. As an active stakeholder in the governance structure of HealtHIE Nevada, DHHS participates regularly in planning meetings to determine HIE participation rules and develop the strategic plan for the deployment of HIE across the state. (*Table 12. HealtHIE Nevada Board of Directors*)

Table 12. HealtHIE Nevada Board of Directors

Name	Title	Organization	Board Allocation
Chris Bosse	VP Government Relations	Renown Health	Health System
Jon Bilstein	CEO	Nevada Orthopedic and Spine Center	Provider
Brian G. Brannman	CEO	University Medical Center Las Vegas	Education
Joan Summers Hall	President	Nevada Rural Hospital Partners/Liability Cooperative of Nevada	Community Stakeholder
Deborah Huber	Executive Director	HealthInsight	HIE
Jeffrey Murawsky	CMO	Sunrise Hospital and Medical Center of Las Vegas	Provider
Robert Schaich	SVP/CIO	United Healthcare of Nevada/Southwest Medical Associates	Payer

Name	Title	Organization	Board Allocation
Dena Schmidt	Deputy Director of Programs	Department of Health and Human Services/Division of Health Care Financing and Policy	State/Payer
Mason Van Houweling	CEO	University Medical Center of Southern Nevada	Education
Mark Winkler	Founding Partner	Steinberg Diagnostic Medical Imaging Centers	Community Stakeholder

HealtHIE Nevada's values and guiding principles include:

- Patient-centered care
- Involving patients and providers
- Achieving financial sustainability
- Protecting information integrity
- Evolving to meet community needs
- Earning the trust of all stakeholders

Table 13. HealtHIE Nevada Fee Structure below outlines the HealtHIE Nevada fee structure for healthcare service providers as well as payers, including Nevada MCOs. Fees paid by commercial health plans in Nevada will be identified as the "fair share" amount in support of health information exchange capabilities and sustainability in Nevada.

Table 13. HealtHIE Nevada Fee Structure

Fee Structure As of 8/1/13	
Provider fee based on size of practice –Per month per provider	
0-24 providers	$50
25-99 providers	$42
100+ providers	$38
Ancillary Services – Per month	
Laboratories	$300
Imaging Centers	$300
Long Term Acute Care	$250
Skilled Nursing Facilities	$300
Home Health/Infusion Agencies	$200
Dialysis Centers	$300
Hospice	$100
Payers, Health Plans, Employers – Per member per month	
Member	$.21
Acute Care Hospitals – Annual fee based on prior year's average daily census (ADC) as reported to the State of Nevada	
250+ ADC	$100,000
150-249	$85,000
75-149	$50,000
0-74	$5,000

Source: HealtHIE Nevada

A.8. The MMIS Role in the Current HIT/HIE Environment

SMHP Companion Guide Question A #8

Medicaid Management Information System (MMIS) HIT/HIE Environment
The top priority area identified as part of the state's MITA SS-A was modernization of the State's MMIS system. The project commenced early 2014 with MMIS supporting services implementation and certification anticipated by June 2018. DHCFP's prior MMIS Fiscal Agent (FA) was Magellan Medicaid Administration. The FA contract was re-procured and the new vendor is Hewlett Packard (HP) Enterprise Services (HPES), contracted to perform core MMIS modernization project services. In the proposed response, HPES conducted a gap analysis to crosswalk the HP Healthcare Platform to the State's requirements. The necessary configurations and customizations to the base interChange solution will be made in accordance with CMS MITA business functional areas. Additionally, Nevada will procure a separate Independent Verification and Validation (IV&V) vendor for the MMIS modernization activities.

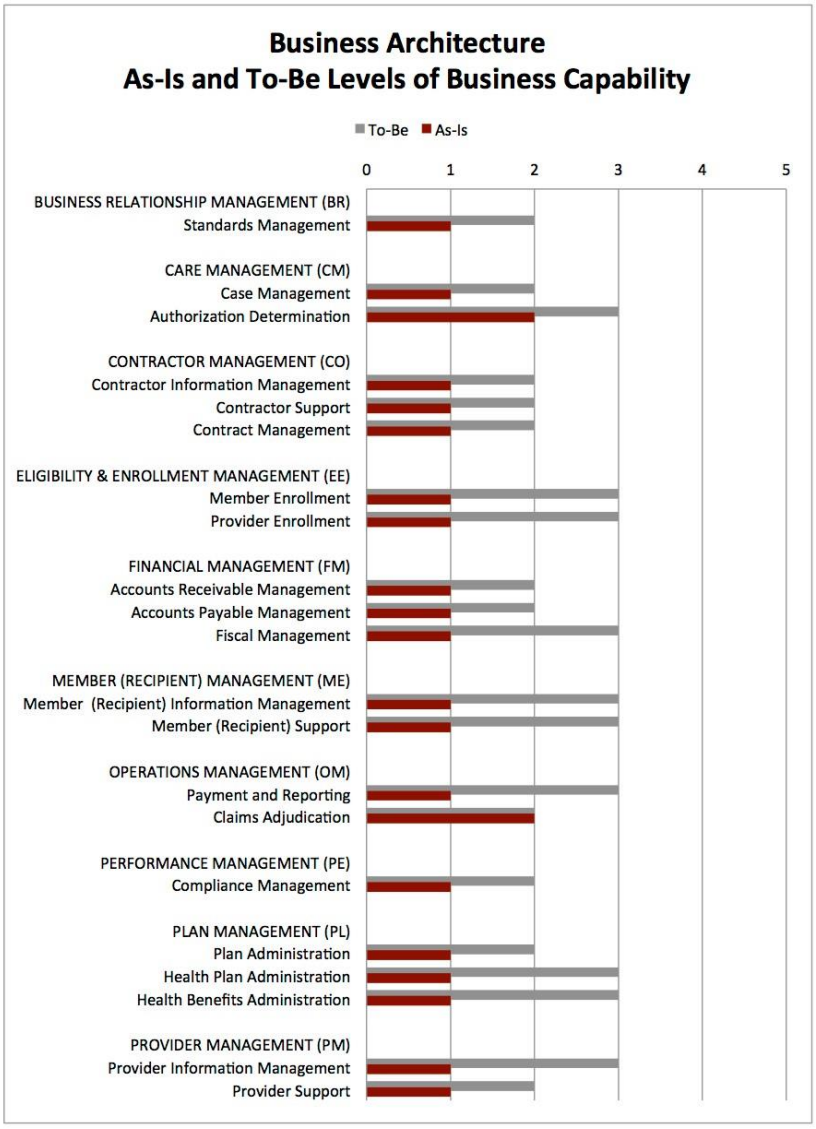
Currently, the core MMIS claims processing system is all that remains for the State to transition from the legacy First Health MMIS. The following components and peripherals were modernized as a result of the FA transition and part of compliance with state and federal initiatives:

- Pharmacy Benefit Management (PBM) system
- Data warehouse
- Drug rebate
- Third party liability
- Health care provider portal
- Online Document Retrieval and Archive System (ODRAS)
- Pre-Admission Screening and Resident Review (PASSR) tool
- Transformed Medicaid Statistical Information System (TMSIS) Decision Support System (DSS) and Truven's J-SURS

Medicaid Information Technology Architecture (MITA)
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 an updated MITA SS-A in 2013 based on MITA Framework 3.0 released by CMS in April 2010. 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 (*Figure 5. Business Architecture*). 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. The To-Be Future Vision results indicated that most business processes will reach Levels 2 and 3 capabilities.

Figure 5. Business Architecture



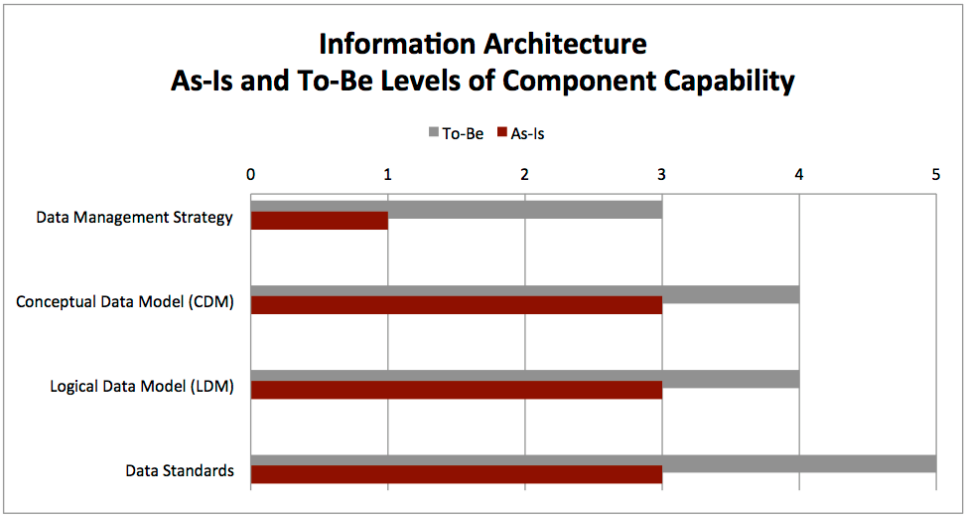
The Information Architecture Framework describes information strategy, architecture, and data. It is divided into four areas:

- Data Management Strategy — provides a structure for sharing Medicaid information both internally and externally.
- Conceptual Data Model (CDM) — provides a depiction of major business information objects and their relationships with each other. It also provides a basis for the Logical Data Model.
- Logical Data Model (LDM) — provides a more detailed accounting of Medicaid enterprise information. It is based upon the CDM.
- Data Standards — emphasizes standards to ensure data interoperability.

Based on the To-Be themes identified and development of the subsequent Roadmap, findings indicate the Nevada's Medicaid Enterprise will be able to advance its maturity greatly in the following areas (*Figure 6. Information Architecture*):

- Data management governance model.
- Common data architecture among the business areas.
- Enterprise-wide support of the CDM.
- Development of the LDM.

Figure 6. Information Architecture

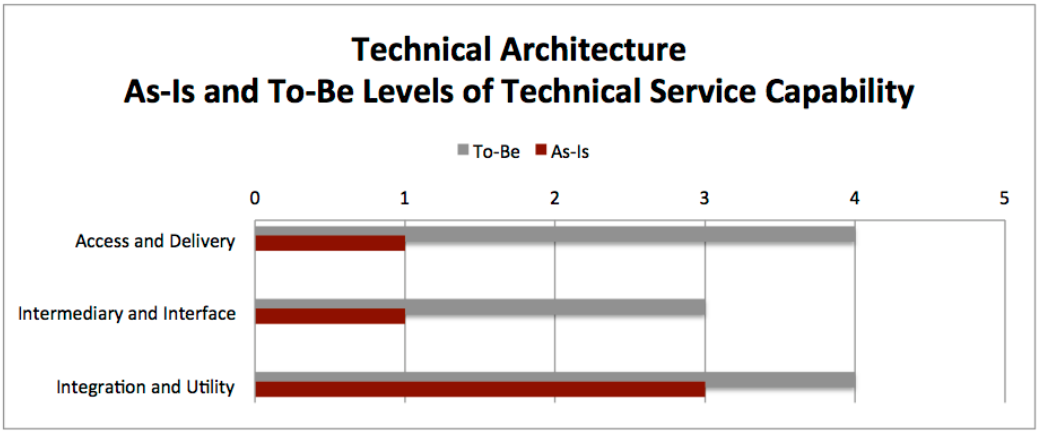


The Technical Architecture Framework is a collection of three Technical Service Areas (TSA) – similar to business areas in the Business Architecture model – and 15 associated Technical Service Classifications (TSC) — similar to business processes in the Business Architecture model. The three TSAs include (*Figure 7. Technical Architecture*):

- Access and Delivery — Covers design, Section 508 compliance, language support, business intelligence, and forms and reports services. It also covers performance measures, and security and privacy mechanisms.
- Intermediary and Interface — Covers process orchestration, Enterprise Service Bus (ESB), middleware/intermediate services, and workflow and relationship management functionality.
- Integration and Utility — Covers programming stacks, database access layer services, scalability, logging and configuration management, versioning, and decision management/rules engines used by claims processing systems.

Based on the To-Be themes identified and development of the subsequent Roadmap, findings indicate the Nevada's Medicaid Enterprise will be able to augment its existing business intelligence capabilities to advance even further by providing these services to other systems. In addition, with the procurement of new technology to support the Medicaid Enterprise, the State will be able to capitalize on a Service-Oriented Architecture, which would increase the Enterprise's Information Architecture capabilities.

Figure 7. Technical Architecture



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 Nationwide Health Information Network (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 conclusive.
- 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 state's only HIE (and HIE NHIN Gateway) and the Federal Health Architecture (FHA).

Enterprise Data Warehouse with Business Intelligence

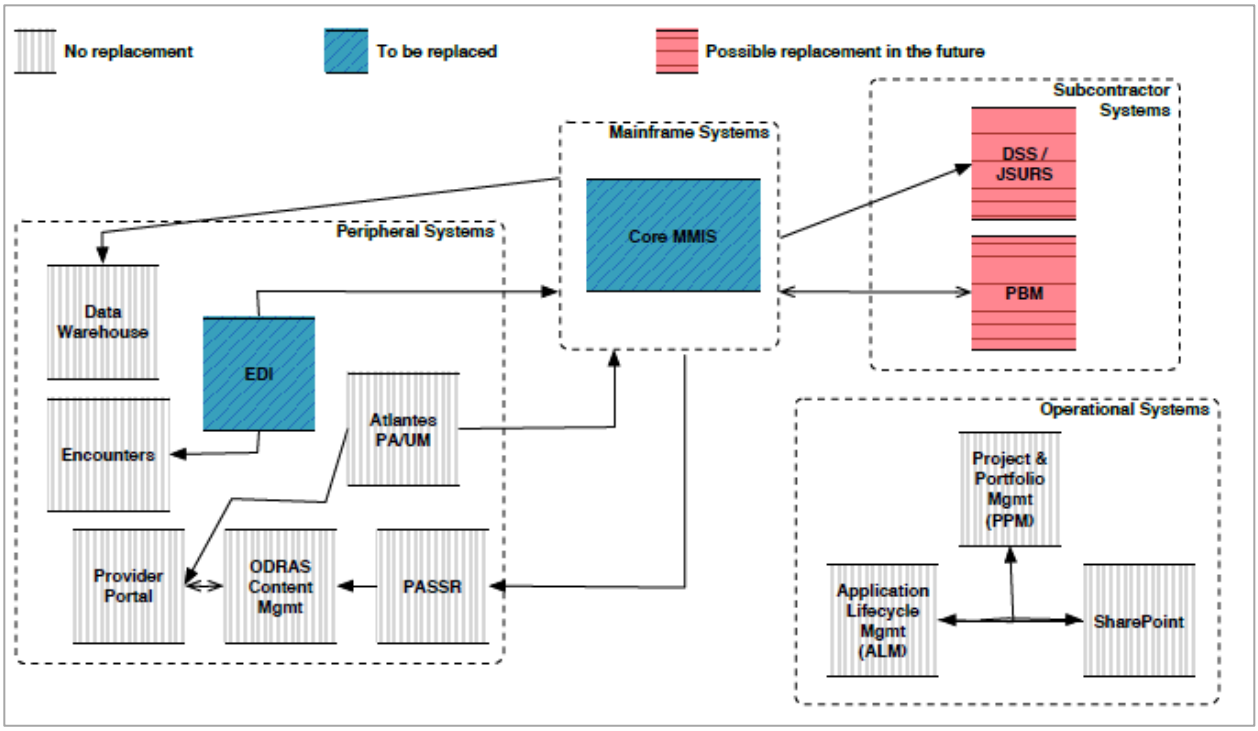
HPES has previously implemented a data warehouse built on an enterprise capable architecture. This solution will replace the existing legacy data model based data warehouse with an interChange base model that will continue to provide accessible, accurate, timely business intelligence for DHCFP decision-making.

The MITA business process of Manage Incentive Payment will continue to be a shared responsibility between DHCFP and HPES. DHCFP will perform the business steps to calculate the payments for the EHR and Primary Care Incentive Payment (PCIP) Program, then send a communication to HPES to issue those payments. HPES will enter the data into the MMIS timely and accurately.

Figure 8. Core MMIS Modernization Project displays a high-level view of the scope of the Core MMIS Modernization under the HPES amendment. The scope of work for this alternative includes

the replacement of Nevada's core claims processor and Electronic Data Interchange (EDI) peripheral system. The core claims processing system includes claims, reference, provider, member, third party liability, managed care, and financial. In an effort to advance MITA maturity, simplify the MMIS technology architecture and reduce operating costs, the EDI solution will also be replaced with the HPES shared service EDI solution.

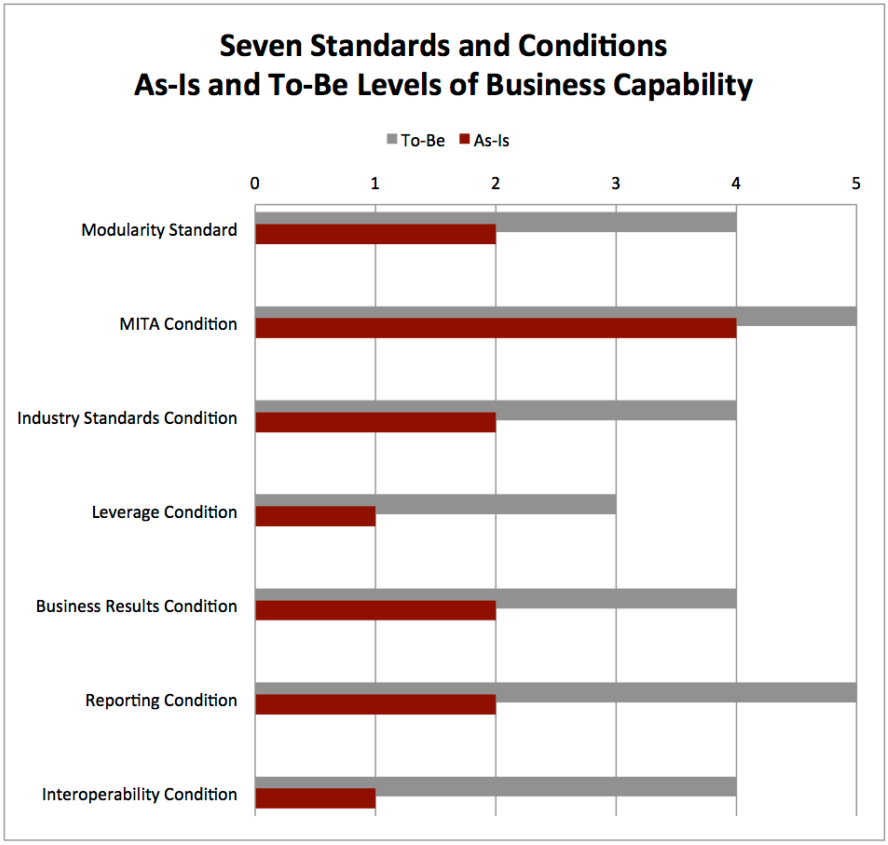
Figure 8. Core MMIS Modernization Project



MITA Maturity Levels and the Seven Conditions and Standards Alignment

DHCFP is committed to complying with the "Seven Standards and Conditions "pursuant to 42 Code of Federal Regulations (CFR) 433 Subpart C. As guided from the findings from the 2013 SS-A, the State sought to make advancements to its Medicaid Enterprise by adopting a service-oriented architecture, moving towards electronic transactions when conducting business, and implementing web services (*Figure 9. MITA Seven Standards and Conditions: Levels of Business Capability*).

Figure 9. MITA Seven Standards and Conditions: Levels of Business Capability



The proposed interChange Health care Platform provides the foundation enabling DHCFP to mature the Medicaid enterprise alongside CMS "Seven Standards and Conditions" and MITA 3.0 principles. DHCFP has considered the conditions and standards in the evaluation of alternatives and selection of the HPES interChange solution.

1- Modularity Condition

The Modularity Standard sets a vision of a modular, flexible approach to systems architecture—service-oriented architecture (SOA), exposed application programming interfaces (APIs), and business rules engine—for streamlined submission of business rules to a Nevada DHHS designated repository. The MMIS employs a multi-tier architecture that places an emphasis on reuse and flexibility.

2- Interoperability Condition

The interoperability condition sets the vision of how the MMIS engages with the broader health care ecosystem in a defined and service-oriented manner; enabling interactions with the required data services: HIE EHR Personal Health Records (PHR), and Health Insurance Exchange (HIX). The key architectural standard in place is the use of interfaces based on open standards. The HPES solution utilizes an ESB for integration with peripheral systems (PBM, Enterprise Document Management System (EDMS), DSS/Data Warehouse (DW), etc.) as well as external systems. The ESB supports service directory and orchestration, message and transaction management as well as tracking and auditing. The proposed architecture allows the decoupling of tightly coupled point-to-point interfaces between peripheral systems within the MMIS environment.

3- MITA Condition

The Nevada MITA 3.0 State Self-Assessment (SS-A) dated December 2, 2013 contains findings duplicated across several business functional areas that result in a maturity rating of Level 1. The HPES interChange solution allows Nevada to align with and advance to maturity Level 3. The following are examples of how the HPES interChange solution is aligns to progressing MITA Maturity:

- Online MITA Business Process Step Documentation mapped to MITA 3.0.
- Integrated workflow and service framework across the DHCFP enterprise.

4- Industry Standards Condition

The HPES EDGE process framework makes sure that industry standards are incorporated throughout the MMIS modernization process, including but not limited to:

- Supporting Health Insurance Portability and Accountability Act (HIPAA) standard transactions and HIPAA code sets for transaction processing.
- Enforcing HIPAA security and privacy standards across the MMIS.
- Incorporating Affordable Care Act (ACA) Section 1104 and Section 1561 transaction standards and operating rules.
- User interfaces/web portals meeting the guidelines of the Americans with Disabilities Act (ADA) and Section 508 of the Rehabilitation Act of 1973.
- Supporting Health Level Seven International (HL7) and Nationwide Health Information Network (NwHIN) standards in the larger healthcare ecosystem.

5- Leverage Condition

The HPES interChange base MMIS has delivered a CMS-certified system that was approved based on its capability to extend its reach to other states; thus, Nevada and other states do not need to pay for “ground-up” development but can take advantage of the tens of thousands of hours in development and testing spent proving the operational effectiveness of this base system. HPES understands the importance of its approach to MITA and the eventual evolution of multistate solutions as a way to reduce overall cost and improve the ability to share health care information.

6- Business Results Condition

Two highlights of the interChange solution to highlight concerning the business results condition:

- Quality of the member’s health care experience with the program.
- The ability to provide accurate and timely data to report and analyze results of the program.

7- Reporting Condition

HPES already has in place a variety of solutions that will help DHCFP measure the effectiveness of its services including the following:

- Truven Advantage suite for analytical reporting.
- Truven J-SURS for utilization review.
- Enterprise Data Warehouse on the Vertica platform for ad-hoc reporting on all Medicaid MMIS enterprise data.

A.9. State Activities Underway to Facilitate HIT/HIE Adoption

SMHP Companion Guide Question A #9

Current Contracted Services

The SMA has contracted for the following services to support the adoption of the HIT/HIE activities comprising the operation and administration of the EHR Incentive Program (*Table 14. Current State Activities to Facilitate HIE/EHR Adoption – Contracted Services*).

Table 14. Current State Activities to Facilitate HIE/EHR Adoption – Contracted Services

Current State Activities to Facilitate HIE/EHR Adoption – Contracted			
Activity	**Description**	**Contractor**	**I-APD Status**
Attestation system vendor	Application hosting, technical support, payment processing, interface operations, defect resolution, provider support and outreach efforts, and audit support	CGI	Approved contract
Provider technical assistance	Continuation of REC-like services related to health IT	HealthInsight	Approved contract
Consulting professional services	Environmental scan, SMHP update, and I=APD-U as needed	Myers and Stauffer	Approved contract

Future Planned Contracted Services

The activities identified in the table below represent activities to be included in the Federal Fiscal Years (FFY) 2017 – 2018 and/or 2018 – 2019. DHHS will submit a new HITECH/HIE I-APD to CMS for review and approval (*Table 15. Future Planned State Activities to Facilitate HIE/EHR Adoption*).

Table 15. Future Planned State Activities to Facilitate HIE/EHR Adoption

Future Planned State Activities to Facilitate HIE/EHR Adoption – Contracted			
Activity	**Description**	**Contractor**	**IAPD Status**
Operations and Implementation Promotion, Outreach, and Support	Application hosting of NEIPS, technical support, payment processing and interface operations, defect resolution, audit support. Identify potentially eligible Medicaid providers and outreach support for the program in order to meet the CMS EHR Provider Incentive Payment Program requirements and regulations. Call center for provider support. Co-developing and presenting webinars, and launching targeted outreach campaigns.	CGI	Approved FFY2017-18
Provider Training and Outreach	Continuation of REC-like services.	HealthInsight	Approved FFY2017-18
HIE Connectivity and Interface Development	Connect NV State Public Health Registries to HIE to allow Medicaid providers to meet Meaningful Use PH reporting requirements.	HealtHIE Nevada	Approved FFY2017-18

A.10. SMA's Relationship to the State HIT Coordinator

SMHP Companion Guide Question A #10

Nevada has identified the need for additional HIT leadership to support the State's HIT initiatives and Medicaid administration purposes. The State has reinstated the HIT Coordinator position, which has officially been filled as of December 2016. Previously, the State's HIT Project Manager led coordination efforts of HIT initiatives statewide, as well as management of the EHR Incentive Program.

The HIT Coordinator will oversee the day-to-day development and deployment of the Nevada SHSIP and serve the Medicaid enterprise. The position is housed in the Medicaid agency with responsibility for managing coordination across the relevant state agencies. While the HIT Coordinator position is vital to leading HIT initiatives as outlined in the SHSIP, Nevada also anticipated the need for support staff and resources to support the deployment of these projects in areas including, but not limited to:

- Data analytics.
- Medicaid EHR incentive payment program support.
- Public health.
- Social determinant data studies.
- Strategy and planning (including sustainability).
- Provider/patient engagement.

The State established an HIT Unit to provide HIT project management, HIT data analytics, statistical analysis, and Medicaid caseload projections. The Unit will serve as the source of HIT communication, oversight, and data management.

Nevada will use enhanced Medicaid funding (90%federal match/10% state match) to support the Medicaid share of these needs and use other state funds and work with private payers or other funding sources to finance the remaining share of these costs.

A.11. SMA Activities to Influence EHR Incentive Program and Use of Data

SMHP Companion Guide Question A #11

Access Nevada
Access Nevada is DWSS' public facing web application that provides clients with the opportunity to submit an electronic application for Medicaid, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Implemented in 2010, the State plans to modernize the system to the latest available technology and communication platforms.

No Wrong Door
The No Wrong Door project is envisioned to embrace the "no wrong door" approach to serving the DHHS clientele through an integrated overarching case management system to guide a citizen in the State to all of the possible DHHS programs that they are eligible for electronically.

The No Wrong Door portal will allow a client to create an account, enter demographic and other required data and be known to all DHHS Divisions for purposes of applying for benefits, self-reporting changes such as change of address, track their case(s) through the process, and access correspondence.

Coordination with Medicare and Federally Funded, State-Based Programs
Nevada was awarded by a SIM grant by CMMI, a SAMHSA planning grant for Certified Community Behavioral Health Clinics (CCBHC), a Children's Behavioral Health System of Care grant, in addition to an Office of the National Coordinator (ONC) HIE grant. In order to meet the goals of these grant programs, it is imperative that HIT be an integral part of planning and implementation. The need for interoperability is critically important in order to transform the State's delivery system, implement payment reform and integrate physical health and behavioral health.

Nevada Division of Child and Family Services (DCFS)
Nevada DCFS continues to work to enhance Unified Nevada Information Technology for Youth (UNITY), an integrated system supporting DCFS. Recent projects completed or launched include:

- ***Central Registry Interface*** –The project was requested by DPBH. The project is a web service based interface between DPBH's provider systems to UNITY that facilitates background checks using UNITY's Central Registry. The project went into production on December 1, 2015.
- ***Sex Trafficking Indicator*** – This project was requested by Washoe County Department of Social Services (WCDSS). A sex trafficking indicator was added to the Person Directory and Person Detail pages. The previous sex trafficking tracking characteristic was not person (child) specific and was limited in its applicability. This new feature will improve the tracking of this information and connect it to the person's record. This project went into production on May 3, 2016.
- ***Advanced Foster Care (AFC)/ Specialized Foster Care*** – This project was requested by Nevada's Decision Making Group (DMG) and the Nevada legislature. This project will provide functionality to track advanced foster care, or the placement of children in specialized foster homes when the child exhibits a need for special care for physical, mental or emotional issues. This project first phase deployment took place in December 2016. Other phases are estimated to be completed by 2017.

A.12. State Laws or Regulations Impacting the EHR Incentive Program

SMHP Companion Guide Question A #12

Nevada Administrative Code (NAC) Chapter 439
DHHS is presently in the final stages of enacting revisions to chapter 439 of the NAC. Sections 439.581 through 439.595 of the NRS provide for an HIE across Nevada. The establishment of an HIE system for the electronic movement, storage, analysis, and exchange of electronic health records, health-related information, and related data began in Nevada before these statutes were enacted in 2011.

Under a previously existing law, the director of DHHS was required to establish a statewide health information exchange and a governing entity for the system. SB 48, was amended in the 78th Legislative Session, eliminate the requirement that the director regulate the HIE and requires instead that the director regulate HIEs operating in the State. The goals of the regulation are to:

- Establish an oversight process that will protect the public interest on matters pertaining to health information exchange.
- Ensure that organizations involved in HIE are adhering to nationally recognized standards and requirements.
- Allow Nevada providers and hospitals to access pertinent patient health information to improve health outcomes.
- Promote exchange of health information.
- Ensure patients have the appropriate privacy and security protections in place.

In January 2016, a proposed change was made to Chapter 439 of NAC, prescribing the requirements for a HIE. A revised version of that regulation was proposed in June 2016. The purpose of these changes is to establish an oversight process, promote the exchange of health information, ensure HIE organizations are adhering to national standards, allow Nevada providers and hospitals to access patient health information to improve health outcomes, and ensure patients have the appropriate privacy and security protections in place. The regulation requires an HIE to meet the following criteria in order to operate or apply for certification within the state:

- Comply with federal and state privacy and security laws and regulations.
- Facilitate sharing of health information across public and private sectors.
- Support public health initiatives.
- Comply with Meaningful Use according to the HITECH Act.
- Use enterprise master client index and master provider directory.
- Provide interoperable infrastructure for exchange of information.
- Prove operational and financial sustainability.
- Meet standards for routine electronic auditing.

Chapter 439 of NAC requires that an application for certification of a health information exchange, including proof that the exchange meets the requirements listed above, it is operationally and financially stable, standards are in place for routing auditing, and a renewal is required every three years.

Additionally, the regulation prescribes that any patient who is authorized under state law to opt out of electronic disclosure of health information, owns any health information concerning him or her that is disclosed, retrieved, or maintained using a health information exchange. It also prescribes that Medicaid recipients cannot opt out of participation in the exchange per NRS 439.538. At the start of the 2017 legislative session, early discussions began about changing the regulations so that all patient electronic health information would be included in the health information exchange requiring a patient to “opt out” of participation. Currently, with the exception of Medicaid recipients, all patients must advise their health care professional that they give permission for their health information to be included in the HIE.

The regulation also requires an authorized user to obtain the informed written and voluntary consent of a patient before retrieving health information from the exchange and prescribed procedures for providing and revoking consent. All authorized users can access records of any patient without

consent in an emergency, pursuant to 45. CFR 164.312. Consents obtained prior to the adoption of the regulation will be grandfathered in.

Provisional certification requirements for HIEs operating on the date of the regulations are described. HIEs currently operating are certified until a date its application is approved under these provisions and one year after the effective date of this regulation.

Additionally, the new regulation authorizes and provides guidelines for appeal hearing, prescribes who may use the HIE, when and how routine audits and risk assessments must be performed, and how breaches and patient confidentiality must be handled. HIEs currently operating prior to the regulation are certified until their application is approved or denied by the director or one year after the effective date of this regulation. Renewal of certification is required every three years.

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 the State to 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 (NRS), the Nevada Medicaid State Plan, and Nevada Medicaid Manuals that may impact the creation of EHRs and the development of an 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 (Nevada's CHIP) Manuals that may impact the creation of EHRs and implementation of an HIE. The Nevada Health Information Technology Regulatory and Policy Inventory looks at State statutes more broadly and catalogues any and all provisions under NRA that could have an impact on the development of EHRs and an 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.

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 HIT 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.

SB 48 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 SB 48 applies only to provisions found in statute or regulation. The Medicaid Services Manual meets the definition of a statute or regulation.

Stricter Confidentiality Provisions

There are several NRS 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). NRS 432B.280 is hereby amended to read as follows:

   1. Except as otherwise provided in NRS 239.0115, 432B.165, 432B.175 and 439.538 and except as otherwise authorized or required pursuant to NRS 432B.290, ***information maintained by an agency which provides child welfare services, including, without limitation,*** reports ***and investigations*** made pursuant to this chapter, **[**as well as all records concerning these reports and investigations thereof, are**]** ***is*** confidential.

   2. Any person, law enforcement agency or public agency, institution or facility who willfully releases **[**data**]** or **[**information concerning**]** ***disseminates*** such **[**reports and investigations,**]** ***information,*** except:

      (a) Pursuant to a criminal prosecution relating to the abuse or neglect of a child;

      (b) As otherwise authorized pursuant to NRS 432B.165 and 432B.175;

      (c) As otherwise authorized or required pursuant to NRS 432B.290;

      (d) As otherwise authorized or required pursuant to NRS 439.538; or

(e) As otherwise required pursuant to NRS 432B.513, is guilty of a gross misdemeanor.

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. NAC 449.0118 (pertaining to Nevada Health Division's authority to suspend the license of a hospital that does not comply with Chapter 449 medical facility laws or related regulations). NAC 449.0118 was amended in 2012.

6. 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).

7. NRS 450b.238 (pertaining to required record keeping by hospitals to keep medical records regarding trauma treatment).

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

9. NRS 458.055 (pertaining to requirement for Division to adopt regulations that govern the confidentiality of substance abuse treatment records).

10. NAC 458.163 (pertaining to individuals operating alcohol and drug abuse programs ensuring program compliance with Part 2. In the event of conflict between federal regulations and state laws, the more restrictive law applies. Client must provide separate and explicit consent to the disclosure of identifying information, including the client's HIV status. Confidential information will only be disclosed in accordance with Part 2).

11. 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). NRS 458.280 was amended in 2015 to read as follows: Amended in 2015 as follows:

1. Except as otherwise provided in subsection 2, NRS 439.538, 442.300 to 442.330, inclusive, and 449.705 and chapter 629 of NRS, the registration and other records of a treatment facility ***and treatment provider*** are confidential and must not be disclosed to any person not connected with the treatment facility ***or treatment provider*** without the consent of the patient.

2. The provisions of subsection 1 do not restrict the use of a patient's records for the purpose of research into the causes and treatment of alcoholism if such information is:

(a) Not published in a way that discloses the patient's name or other identifying information; or

(b) Disclosed pursuant to NRS 439.538.

12. 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). NRS 629.161 was amended to read as follows:

    1. It is unlawful to retain genetic information that identifies a person, without first obtaining the informed consent of the person or the person's legal guardian pursuant to NRS 629.181, unless retention of the genetic information is:

        (a) Authorized or required pursuant to NRS 439.538;

        (b) Necessary to conduct a criminal investigation, an investigation concerning the death of a person or a criminal or juvenile proceeding;

        (c) Authorized pursuant to an order of a court of competent jurisdiction; or

        (d) Necessary for a medical facility to maintain a medical record of the person.

    2. A person who has authorized another person to retain his or her genetic information may request that person to destroy the genetic information. If so requested, the person who retains that genetic information shall destroy the information, unless retention of that information is:

        (a) Authorized or required pursuant to NRS 439.538;

        (b) Necessary to conduct a criminal investigation, an investigation concerning the death of a person or a criminal or juvenile proceeding;

        (c) Authorized by an order of a court of competent jurisdiction;

        (d) Necessary for a medical facility to maintain a medical record of the person; or

        (e) Authorized or required by state or federal law or regulation.

    3. Except as otherwise provided in subsection 4 or by federal law or regulation, a person who obtains the genetic information of a person for use in a study shall destroy that information upon:

        (a) The completion of the study; or

        (b) The withdrawal of the person from the study.

    4. A person whose genetic information is used in a study may authorize the person who conducts the study to retain that genetic information after the study is completed or upon his or her withdrawal from the study. **Sec. 5.** This act becomes effective on July 1, 2015.

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

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

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.

SB 48 appears to contain a provision that addresses this concern. Section 12(1)(b) of SB 48 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.*

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:

Section 200 – DHCFP may want to change Section 200 referencing HITECH Section 13405(B) and make any necessary changes related.

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

    a) Section 300.1C(1) addresses a recipient's right to access, inspect, and obtain a copy of protected health information (PHI). Section 13405(C) of HITECH provides individuals with a right of access to any of their PHI maintained in an electronic format. The Proposed Rules, if adopted, would require a covered entity to make electronic PHI available to individuals who request it in a readable electronic form and format as agreed to by the covered entity and the individual.

    b) Section 300.1C(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.

    c) Section 300.1C(6) addresses patients' rights to request restrictions on the use and disclosure of their PHI. HIPAA does not require a covered entity to accept patients' requests to restrict their PHI. 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 PHI 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.

d) Sections 300.3(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.

2. 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 PHI 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.

Section 700 and the associated Business Associate Addendum address Business Associatell 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 associatell (e.g. a HIE 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 incidentll 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 PHI 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 PHI, 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 EHR 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 PHI 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.

A.13. HIT/HIE Activities Crossing State Borders

SMHP Companion Guide Question A #13

Medicaid Providers
Currently providers from bordering states can be enrolled as Nevada Medicaid providers and Nevada Medicaid receives data from these out-of-state providers. This exchange of information allows Nevada providers who are relying on patients from one of Nevada's border state's Medicaid programs to meet volumes for EHR Incentive Program eligibility. To date, 31 Nevada Medicaid providers have attested using out of state encounters for multiple years of the program.

Additionally, the surrounding states will have access to Nevada Medicaid eligibility and patient volume information to verify corresponding data for providers relying on Nevada information for their EHR Incentive Programs. Since HealtHIE Nevada is beginning to cross state lines, the SMA will have an increasing opportunity to foster interstate HIE to better serve Nevada Medicaid beneficiaries that cross state lines.

Patient-Centered Data Home Pilot
HealtHIE Nevada launched a pilot of the patient-centered data home (PCDH) concept alongside the Utah Health Information Network (UHIN). UHIN launched a PCDH pilot with the Arizona Health-e Connection (AzHeC) and the Quality Health Network (QHN) in western Colorado in June of 2016.

The pilot tests a method of exchanging admission, discharge and transfer (ADT) alerts between HealtHIE Nevada and UHIN that will notify providers of a triggering event that occurs outside of the patient's state, and will confirm the availability and location of clinical data. This would enable providers to initiate a query to access real-time information across state lines. The goal is to ensure health information is available to providers in regardless of where the patient may live or present for care. The PCDH concept will impact Medicaid patients living in the rural eastern parts of Nevada who frequently seek care in southern Utah and Salt Lake City.

National Electronic Interstate Compact Enterprise (NEICE)
The Interstate Compact on the Placement of Children (ICPC) was established in 1960 to provide a uniform level framework for the placement of children across state lines in foster care and adoptive homes. Frequently, children waiting to be placed with an adoption family, relative or foster parent in another state spend more time waiting for this to occur when compared to placements within the same state because of the outdated, administratively burdensome processes. Nevada adopted ICPC in 1985 and approximately 1500 children move in and out of Nevada through the ICPC process each year.

The National Electronic Interstate Compact Enterprise (NEICE) was launched in August 2014 and Nevada was one of six states selected to participate in the 17-month pilot project. Participating states report reduced administrative costs and staff time required to process cases, and more effective use of case workers' time. Nationwide, placement time has decreased 30%for interstate foster care placements and, on average, states using the electronic case processing system have been able to reduce the time it takes to identify a family for a child and prepare necessary paperwork from 24 to 13 business days.

Nevada was selected to present project successes at the Association of Administrators of the Interstate Compact on the Placement of Children (AAICPC) meeting in June 2015. At the time, the State had built an interface that was user-friendly with ease of connection in approximately 450 hours of team effort.

Nevada built a data interface between NEICE and its child welfare information system, UNITY, further reducing the time and effort required to prepare ICPC forms and "consume" ICPC responses from partner states. Additionally, court orders from family courts in Clark County were easily made available for review and incorporation into required placement documentation.

Nevada reported a notable improvement in the quality of data contained in the required forms, which eliminated any unnecessary back and forth. By the end of the pilot, Nevada reported that NEICE-enabled private adoptions between Nevada and another pilot state took only one hour to complete.

Ten states, including the original pilot sites, are utilizing NEICE and 21 are planning to join. States that join before June 2018 will receive technical assistance from the technology vendor.

The "Modernizing the Interstate Placement of Children in Foster Care Act" was introduced in the U.S. House of Representatives in February, 2016, which would have allocated $5 million for grants to states to develop processes to develop a centralized electronic system for the exchange of data and documents to expedite the placement process.

A.14. Current Interoperability of State Immunization/Public Health

SMHP Companion Guide Question A #14

Electronic Public Health Reporting

Effective July 1, 2013, the Nevada public health authorities, Nevada State Health Division, and the Division of Mental Health and Developmental Services, merged into DPBH, with an aim to create efficiencies and improve the Division's ability to develop and launch necessary services.

Prior to the close of NV-HIE in early 2014, several information services were in development to enable electronic public health reporting including immunizations, syndromic surveillance, and notifiable lab results to support achievement of Meaningful Use.

DHCFP, DCFS, and DPBH are dedicated to working with Medicaid providers to maximize efforts related to Meaningful Use. Reporting to specialized public health registries is a public health objective for Modified Stage 2 Meaningful Use in addition to expanding services available to providers through HealtHIE Nevada.

Current public health reporting for DPBH is manual in nature. While 56% of respondents of the 2016 e-Scan reported that the practice is fully utilizing an EHR for patient data tracking, only 24% reported that they routinely submit data to public health registries electronically, with most data being transmitted by fax or email. Given the current landscape, DPBH is unable to accept new provider electronic connections to DPBH for reporting due to limited technical resources. Instead, providers are placed on the waiting list and no progress is being made currently.

Electronic health information systems can reshape the practice of public health including public health surveillance, disease analysis, investigation and control, decision making, quality assurance, and education. Unlike incentives in the clinical care system, limited funding is available to public health departments to develop the necessary information infrastructure and workforce capacity to capitalize on EHRs, Meaningful Use and collection of Quality Reporting Data Architecture (QRDA) I and QRDA III data.

It is imperative that this process become electronic in order to utilize Medicaid providers' EHRs and to limit the amount of time that their staff takes to manually complete forms and fax them to DPBH. Based on this, DPBH has established a set of HIT and HIE related objectives to guide the EHR

Incentive Program toward the overarching goal to improve the quality and coordination of care by connecting providers to patient information at the point of service through Meaningful Use of EHRs.

DPBH has prioritized efforts related electronic laboratory and provider reporting through HealtHIE Nevada. HealtHIE Nevada is the only operating HIE in the state allowing all providers to have one connection to the HIE and for the HIE to have only one connection to public health departments making for streamlined communication, better disease surveillance of Medicaid recipients, better data accuracy, and an easy transition of care.

These efforts streamline provider reporting and allow for greater and more complete and timely reporting as specified primarily in NAC Chapters 441 A, Electronic Laboratory Reporting (ELR) of communicable disease and syndromic surveillance (https://www.leg.state.nv.us/NAC/NAC-441A.html), and NAC 457 cancer(http://www.leg.state.nv.us/nac/nac-457.html) requiring providers to report to public health departments. All providers currently reporting communicable diseases to ELR are Medicaid providers.

Immunization Registry

Nevada's Immunization Information System (IIS), WebIZ, is a web-based IIS that allows access for both private and public providers with minimal hardware/software requirements. Nevada's WebIZ currently contains over 3.1 million records, including over 890,000 for patients aged 0 through 17 years. As of August 2016, there are over 1,300 public and private organizations, including physicians, health districts, community health nurses and school districts that have access to view, create and update immunization records.

The architecture of WebIZ supports direct EHR interfaces to support real time submission of required HL7 messaging. These interfaces eliminate the need for HIE, however, connection via HIE can also enable access to an enterprise master patient index and master provider directory. These projects are currently in development pending future funding. The goal is to provide a single point of access to the statewide IIS and vital statistics that's available to other agencies as well, including the Nevada DHCFP and the Nevada Department of Education, and school health offices.

Syndromic Surveillance

As of 2013, one of the four health districts in Nevada report receiving data on syndromic surveillance results on a voluntary basis by hospitals. Only 3% of providers reported sending results for syndromic surveillance. There are no reporting requirements statewide, nor are there any plans to establish such requirements. Hospitals and urgent care facilities submit chief "complaint" data into EpiCenter. The state is in the process of adding more facilities that can submit complaint data. The information is pulled real-time. With the exception of Southern Nevada Health District (SNHD), the districts can access the system and obtain surveillance data.

HealtHIE Nevada developed the capability to connect participating hospitals to DPBH's syndromic surveillance system called BioSense 2.0. This not only allows the hospital to meet Meaningful Use requirements, but also streamlines the connection and reporting process for DPBH by allowing a single connection for multiple facilities.

As of 2014, the state reported that 35 providers were reporting through Biosense, half directly and half through the HIE. The State continues to encourage the ten urgent care centers to report as well.

Electronic Laboratory Reporting and Cancer Registry

Current participation levels in the Nevada Central Cancer Registry (NCCR) and ELR are very low and the process is heavily manual. As a result, EPs are not able to fully meet the Meaningful Use requirements without using the Public Health Reporting Alternate Exclusion. DBPH has partnered

with HealtHIE Nevada to provide connectivity services for the Nevada Central Cancer Registry and Electronic Laboratory Report – Communicable Diseases, which will better coordinate efforts to meet the needs of Modified Stage 2 Meaningful Use for Medicaid providers in Nevada.

HealtHIE Nevada's services will prove to be valuable in the areas of data tracking, sharing, analysis, and reporting on DPBH state programs. This also will allow for timelier reporting and will limit issues related to human error by limiting the number of times the information is entered into a data system. Reporting of cancer and communicable disease is required by NRS and it applies to all Medicaid providers in the state.

Nevada Central Cancer Registry

Cancer reporting from ambulatory providers to state cancer registries is a public health objective for Modified Stage 2 Meaningful Use. Population-based cancer surveillance is critical for cancer control activities aimed at reducing cancer morbidity and mortality, the second leading cause of death in the United States. The NCCR is mandated to collect complete and timely cancer diagnostic, treatment, and outcome data from hospitals, medical laboratories, facilities that provide screening, diagnostic or therapeutic services, and physicians.

The NCCR uses Registry Plus, a suite of publicly available free software programs for collecting and processing cancer registry data. Registry Plus will allow for electronic reporting from providers, laboratories, and HIE services. Specifically, the Physician Reporting module of Registry Plus includes functions to import HL7 Clinical Document Architecture (CDA) documents (manually, from a specific folder; through the DOS Command Line Interface; or via the Public Health Information Network Messaging System (PHINMS), parse out codes and text from specific sections of the HL7 CDA document, and map or translate HL7 CDA data elements to North American Association of Central Cancer Registries (NAACCR) data items and coding conventions to automatically generate a NAACCR abstract. Default values can also be set for standard, required NAACCR data items for which no information is found in the CDA document.

It is estimated that a majority of providers currently reporting to the NCCR are Medicaid providers. This connection will allow for better coordination of care as non-eligible providers submit transition of care reports to Medicaid eligible providers for care of newly eligible Medicaid recipients. The proposed connection will allow Medicaid providers to connect to the HIE and submit data to DBPH and meet the requirements of Meaningful Use.

Electronic Laboratory Reporting (ELR)

Nevada utilizes the National Electronic Disease Surveillance System (NEDSS) Base System (NBS), an information system developed by the Centers for Disease Control and Prevention (CDC) to help reporting jurisdictions manage reportable disease data and send notifiable diseases data to the CDC using Public Health Information Network (PHIN) standards. All hospitals, health care providers, and laboratories are required to report all communicable disease cases, including those nationally-notifiable conditions, to DPBH. The State plans to leverage the fact that all hospitals that are connected to the HIE are participating in the Medicaid EHR Incentive Program, therefore using an existing system to report this data will streamline efforts and increase efficiency as there will be no duplication of efforts and the State will exercise prudent spending practices.

Both of these connections will further support state law that mandates all providers submit data to the public health department. In addition, this effort promotes and benefits the Nevada Medicaid providers in their efforts to meet other Meaningful Use objectives and measures, specifically objective 5 of Modified Stage 2 Meaningful Use which states that providers which transition patients care to another setting of care need to provide a summary of care record in efforts to meet the

continuity of care requirements. The State anticipates that provider onboarding to the NCCR and ELR will be completed by September 2017.

DHCFP was received funding approval for FFY 2016-2017 for these projects.

The project objectives are as follows:

- A single standardized method allows efficient and accurate transmission of cancer and communicable disease information while reducing the burden on Medicaid providers and EHR system-specific or registry-specific implementations.
- Automated electronic reporting to reduce labor and duplication of effort for health care providers and public health registries, and increase the security, completeness, timeliness, and accuracy of cancer surveillance data.
- HealtHIE Nevada will utilize the technology solution vendor's project management resources to enable the proposed physician practices and community health centers to achieve greater efficiency by streamlining day-to-day operations.

Other Potential Use for the HIE for Public Health Reporting

The Nevada State Public Health Laboratory (NSPHL) has significant data reported that requires immediate clinician/public health partner notification. Nevada does not currently have the financial resources or manpower to develop electronic interfaces with all clients statewide to assure rapid reporting of important test results. Implementing a connection to HealtHIE Nevada would allow a consolidated resource to transmit electronically NSPHL reports timely and efficiently.

DPBH is also requesting to onboard one new registry to HealtHIE Nevada, the Nevada Birth Outcome Monitoring System (NBOMS), also known as the State's birth defects registry. Currently, NBOMS tracks and reviews data trends which provides useful insights for birth defects. However, the current NBOMS system is too manual and time consuming and an HIE connection would expedite the process.

SNHD wishes to connect to HealtHIE Nevada allowing for automated electronic reporting which is expected to reduce labor for ambulatory health care and increase the security, completeness, timeliness, and accuracy of reportable disease, syndromic surveillance, cancer, and trauma data.

- ***Electronic Lab Reporting for Reportable Conditions*** **-** All hospitals, healthcare providers, and laboratories are required to report all communicable disease cases and SNHD receives all reports except from small providers. SNHD connection to the HIE will enable smaller providers to transmit this information electronically through the HIE.
- ***Syndromic Surveillance*** **-** SNHD is partnering with DPBH in hosting a new Syndromic Surveillance system, Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE). Connection to the HIE will enable the State to capture additional syndromic data to feed to ESSENCE.
- ***Public Health Registry Reporting*** **-** Connection to the HIE will enable capture of specific case data to state public health registries more completely and in a more timely manner.
- ***Pharmacy Reporting*** **-** SNHD is in the process of creating an SNHD pharmacy to provide medications to SNHD clients. Prescriptions filled through the SNHD pharmacy can be reported into the HIE through the proposed connection.

- ***Chronic Disease Management -*** Access to data obtained from the HIE will enable Nevada to describe the burden of chronic diseases such as diabetes, hypertension, obesity, etc. It will also help the State to identify and monitor population trends, risk factors, intervention opportunities, and evaluate programs.

SNHD Office of Disease Surveillance (ODS) has additional needs to connect to the HIE. With the additional connections, SNHD ODS and health care providers will have access to treatment and continuity of care data which will become more labor-efficient, timely, and accurate.

- ***Communicable Disease Treatment Monitoring -*** Connection to the HIE will reduce labor and increase efficiency by allowing ODS investigators and health care providers to obtain communicable disease and surveillance activity information through the HIE.
- ***Continuity of Care -*** Connection to the HIE will reduce labor and increase efficiency by allowing SNHD providers and ODS investigators to often obtain continuity of care information of HIV patients through the HIE.
- ***Meaningful Use Case Reporting -*** Connection to the HIE will reduce labor and increase efficiency by allowing ODS investigators to obtain electronic case reporting information through the HIE.

A.15. HIT Related Grant Awards to the State

SMHP Companion Guide Question A #15

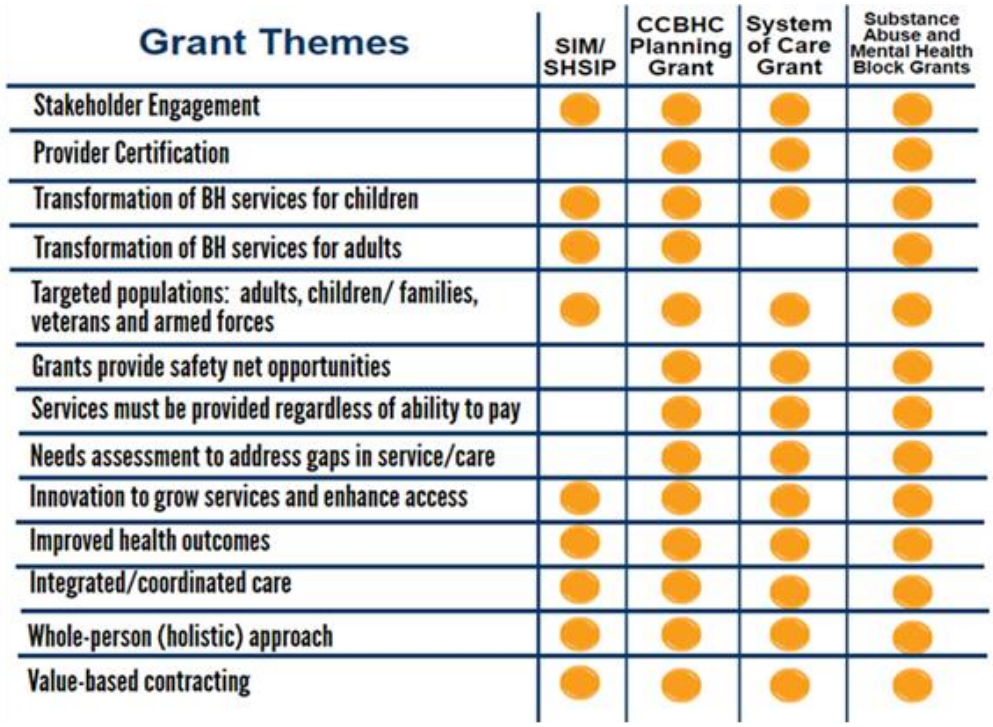
Nevada has focused its efforts on innovation within behavioral health through cross-system collaboration, payment reform, integration of behavioral health and primary health care, and implementation of high-quality service delivery systems to meet the Triple Aim of health care. The SIM project focused on whole health, integrated care across a multi-payer system. In 2015, DCFS was the recipient of the Children's Behavioral Health System of Care grant, to support efforts to develop a comprehensive behavioral health service delivery model focused on improving outcomes through care coordination and the implementation evidence-based practices.

In 2016, Nevada was also awarded intensive technical assistance on the integration of Primary and Mental Health through the Medicaid Innovation Accelerator Program (PMH-IAP) and continues to focus on the use of quality measures to establish benchmarks and provide monitoring and evaluation of outcomes within integrated care settings. The CCBHC planning grant, awarded to eight states including Nevada, provided the optimal opportunity to align multiple activities, both past and present, to drive the innovation and expansion of behavioral health services under the demonstration program.

Ensuring availability and accessibility is one of the foundational tenets of the CCBHC demonstration program in Nevada. Through a collaborative partnership with DWSS, individuals seeking services through a CCBHC will have access to same day eligibility for SNAP, TANF, Women, Infants, and Children (WIC) program, and Medicaid. During the planning grant period, DHCFP expanded access and availability of services under the CCBHC demonstration program through the addition on services not currently covered by the Medicaid State Plan. DCFS, though grant alignment efforts, is working with CCBHCs to provide necessary trainings and technical assistance to support the expansion of children's behavioral health services and evidence-based practices. In an effort to fulfill the obligation of CCBHCs to provide services to individuals regardless of ability, for those individuals

who are identified as having no payer source and found ineligible for Medicaid, assistance to enroll in health insurance will be provided while services rendered will be covered, in part, by leveraging the Community Mental Health Services (MHBG) and Substance Abuse Prevention and Treatment (SABG) Block Grants (*Figure 10. CCBHC Grant Themes*).

Figure 10. CCBHC Grant Themes



Grant Themes	SIM/ SHSIP	CCBHC Planning Grant	System of Care Grant	Substance Abuse and Mental Health Block Grants
Stakeholder Engagement	●	●	●	●
Provider Certification		●	●	●
Transformation of BH services for children	●	●	●	●
Transformation of BH services for adults	●	●		●
Targeted populations: adults, children/ families, veterans and armed forces	●	●	●	●
Grants provide safety net opportunities		●	●	●
Services must be provided regardless of ability to pay		●	●	●
Needs assessment to address gaps in service/care		●	●	●
Innovation to grow services and enhance access	●	●	●	●
Improved health outcomes	●	●	●	●
Integrated/coordinated care	●	●	●	●
Whole-person (holistic) approach	●	●	●	●
Value-based contracting	●	●	●	●

Source: CCBHC Executive Committee Presentation, April 4, 2016

State of Nevada Commission on Behavior Health, System of Care Implementation Grant

In 2015, the *Mental Health America* report ranked Nevada 49th in the nation for access to mental health services and poor outcomes for those receiving services. This access and quality of care issue is particularly concerning given that over 30% of adolescents in Nevada self-reported significant levels of anxiety or depression. In 2009, almost one-quarter of Nevada's public middle school students seriously thought about suicide, 30% had used alcohol or illegal drugs, and 13%had attempted suicide. For Nevada's younger children, nearly 20% of elementary school children have behavioral health care needs.

The Nevada System of Care implementation grant builds upon previous successes in the state and aims to infuse and expand the System of Care philosophy throughout children's behavioral health policies and services across the State of Nevada.

Under this implementation grant, DCFS will also expand children's behavioral health services to include mobile crisis, the First Episode Psychosis program (Enliven), wraparound, diagnostic and evaluation services, utilization management and care coordination. Additionally, DCFS will develop and/or coordinate the enhancement of youth-guided and family-driven supportive services such as peer support and respite programs.

These activities are summarized into four broad goals. These goals serve as the organizing framework from which activities are planned, implemented and evaluated. The goals are:

- ***Goal One -*** Generate support among families and youth, providers, and decision policy makers at state and local levels, to support expansion of the SOC approach, transitioning the Division of Child and Family Services, Children's Mental Health from a direct care provider to an agency that primarily provides planning, provider enrollment, utilization management through an assessment center, technical assistance and training, continuous quality improvement.
- ***Goal Two -*** Maximize public and private funding at the state and local levels to provide a SOC with accountability, efficiency and effective statewide funding sources.
- ***Goal Three -*** Implement workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared to provide effective services and support consistent with the SOC approach.
- ***Goal Four -*** Establish an ongoing locus of management and accountability for SOC to ensure accountable, reliable, responsible, evidence and data-based decision making to improve child and family outcomes and to provide transparency at all levels.

Nevada State Innovation Model Grant

To facilitate the development of a plan to achieve a future state of meaningful and sustainable changes to its health care deliver and payment systems, Nevada received a $2 million Round Two SIM design grant through the Center for Medicare and Medicaid Innovation (CMMI) on December 16, 2014, with the 1-year grant period beginning on February 1, 2015. Nevada's award supported the development of a statewide, multi-payer, stakeholder-informed State Health System Innovation Plan (SHSIP).

Nevada executed an extensive stakeholder engagement process that will continue in various forms through the implementation and evaluation of the SHSIP. Through this process, the Nevada DHCFP formed and received input from workgroups, Task Forces, the Nevada SIM Core Team, an Executive Committee and a Multi-Payer Collaborative (MPC). Broader stakeholder engagement was accomplished through a series of kickoff meetings, community meetings held throughout the state, and stakeholder update meetings.

Nevada submitted the SHSIP for the SIM Model Cooperative Agreement on December 28, 2015, and received confirmation that the plan met CMMI criteria and standards on February 19, 2016.

Health IT was one of the four aims of the SHSIP. The key business HIT needs identified include:

- Developing the infrastructure to provide access to demographic and health-related data in disparate location, in various formats, and bring that data together.
- Utilizing the disparate data to present information in a useful way to providers, payers and patients for purposes of improving health.
- Creating a population health analytics tool to measure population health and population health improvement.
- Promoting the increased availability and exchange of PHI through an HIE.
- Providing technical and business support to providers adopting, implementing and using HIT in a meaningful way.

The SHSIP outlined a phased-approach of short and long term strategies to move from the current HIT environment to the envisioned future environment. As a part of this plan, a short term strategy

to leverage QRDA was devised, specifically, the HL7 QRDA III standard structure for reporting aggregate quality data for electronic Clinical Quality Measures (eCQMs).

The long-term strategy was created in five parts:

- Expanding the HIE.
- Maximizing the use of existing data and registries.
- Creating an All Payer Claims Data Repository (SPCDR).
- Introducing a population health analytics tool.
- Creating a role-based portal for providers, patients, the public and administrative purposes.

Certified Community Behavioral Health Clinics Grant (CCBHC)
Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 supports states in establishing Certified Community Behavioral Health Clinics (CCBHC) through the creation and evaluation of a CCBHC 223 Demonstration Program. In October 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration with CMS, awarded planning grants to 24 states. Nevada received a planning grant in the amount of $933,067.00.

The goal of the CCBHC Demonstration Program is to support improvement of behavioral health outcomes through the integration of primary health care with behavioral health care, and increased access to high quality, coordinated care for Medicaid and CHIP beneficiaries.

The objective of the CCBHC Demonstration Program is to improve the availability of, access to, and participation in assisted outpatient mental health treatment, in addition to demonstrating the potential to expand available behavioral health services without increasing net federal spending. The Nevada SHSIP will support efforts to ensure these goals are met. Ensuring availability and accessibility is one of the foundational tenets of the CCBHC demonstration program in Nevada. Through a collaborative partnership with DWSS, individuals seeking services through a CCBHC will have access to same day eligibility for SNAP, TANF, WIC program, and Medicaid. During the planning grant period, DHCFP expanded access and availability of services under the CCBHC demonstration program through the addition on services not currently covered by the Medicaid State Plan.

CCBHC planning milestones include:

- ***RFA Process Complete -*** Four CCBHCs were selected for participation based on requirements established by CMS. Two of the CCBHC selected are located in urban areas, and two serving frontier counties:
  - Vitality Unlimited, Elko, Nevada (Frontier- Elko County)
  - New Frontier, Fallon, Nevada (Frontier- Churchill County)
  - Bridge Counseling, Las Vegas, Nevada (Urban- Clark County)
  - WestCare, Henderson, Nevada (Urban- Clark County)
- **Convened Steering and Executive Committees** - Included representation from Nevada's Behavioral Health Planning and Advisory Council, which identified five of the top behavioral health priorities to be addressed in 2016-2018.
- **Aligned Grants -** System of Care and MH/SA Block Grants.

- **Planning Community Based Needs Assessments** - Selected CCBHCs participated in focus groups with key community partners, providers, and consumers/families.
- Planning Stakeholder and Consumer Public Workshop.
- Developing Services, EBPs, and CCBHC Delivery Model.
- Developing two-step Certification Process.

On October 31, 2016, the conclusion of the planning grant period, Nevada submitted an application to participate in the two-year Demonstration Program Notice of award was received in December 2016.

Key impact goals for the state's participation in the program include:

- Expanding targeted case management (TCM) to individuals with substance use disorder to address social determinants of health.
- Reducing wait times for outpatient services.
- Reducing behavioral health related visits to the Emergency Department (ED).
- Increasing follow-up after hospitalization.
- Decreasing 30-day re-admission rates following behavioral health impatient discharge.
- Improving family and consumer ratings on participation in mental health statistical measure.

Participating CCBHCs will be eligible for quality based bonus payment based on performance. MMIS and administrative claims data will be maintained and compiled by DHCFP to measure state-led measures, while EHR data will be obtained to review clinic-led measures. In order to minimize the reporting burden on individual CCBHC sites, Nevada will utilize current technology solutions being used by the facility for billing, EHR, and case management or referral.

Systems vary, but project staff completed several steps to ensure that data collection can occur immediately upon the demonstration application being awarded. The first step was to assess the CCBHC's ability to collect and report on the required performance measures. Following that, staff met with each CCBHC to develop custom data reporting solutions and understand the technical assistance needs and other gaps among participants. In addition, providers are eligible for quality bonus payments based on performance.

Clarity was selected as an additional data collection tool which will allow data to be gathered related to referrals to formal and informal supports and services throughout a CCBHC catchment area for case management. Reports will be generated to provide CCBHCs with relevant data related to the utilization of community supports and services. Clarity is a networked, computerized record keeping system and is a requirement for all programs and agencies providing services to low-income households and homeless individuals.

Medicaid Accelerator Program (IAP) Physical and Mental Health Integration

This IAP program priority area, announced in December 2015, targeted support was made available to up to 10 Medicaid agencies interested in expanding or improving mental and physical health integration efforts. Responses were due January 2016, of which Nevada was one of four states selected to receive technical assistance.

Two quality metrics were selected to address as part of the project based on the following criteria:

- Applicable to diverse populations (general Medicaid enrollees, adults with serious mental illness, etc.).
- Applicable to diverse state IAP PMH initiatives.
- Alignment with existing Medicaid measurement efforts.
- Preference for National Quality Forum (NQF) endorsement.
- Measurement of domains that can be improved by the IAP PMH states' initiatives to integrate physical and mental health.

The first measure addresses follow-up after hospitalization for mental illness, which reduces the likelihood of readmission. The second measure addresses follow-up after emergency department visits for mental illness, which may indicate a general access to care issue and is associated with higher rates of readmission.

These measures are required quality measures in the CCBHC demonstration. In addition, these issues were commonly cited among stakeholders as among top priority areas the State should address.

Office of the National Coordinator Community Interoperability and Health Information Exchange Cooperative Agreement Program

DHHS was among 10 awardees of the ONC's grant to support HIE and care coordination in September 2015. The aim of the grant was to support care providers who weren't able to receive incentive payments under the EHR Incentive Programs. By doing so, electronic exchange of health information would expand further to support Nevada's broader health care continuum, integrating behavioral health and physical health care. Long periods for admission and transfer once patients entered the ED is the problem DHHS chose to address with this grant. Additionally, many patients in the mental health system frequently visited the ER, typically inappropriately.

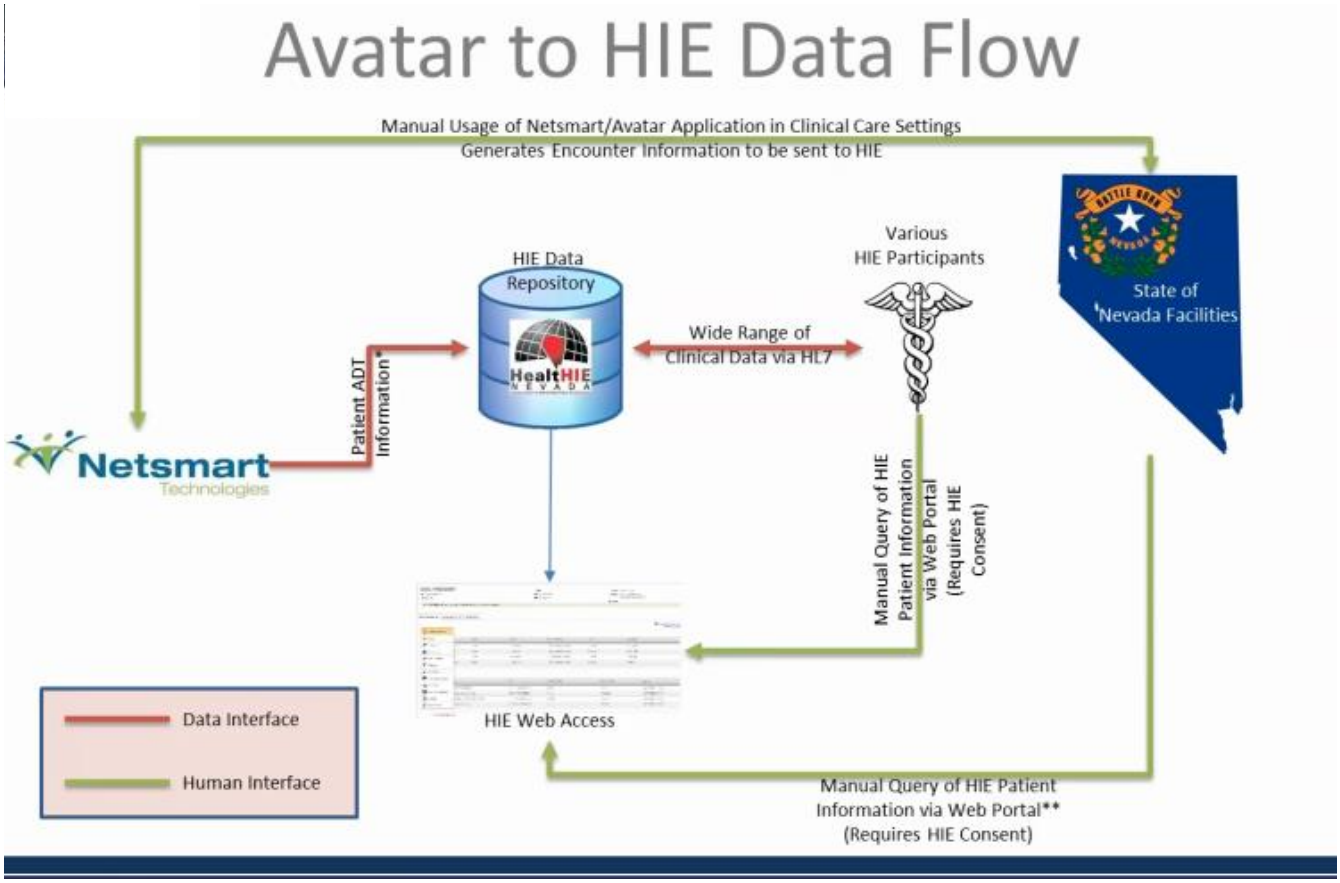
The process to share information between the facilities was inefficient, primarily by phone or fax. This grant sought to enable easy access to the ER record and other available patient records, as well as initiate alerts to mental health providers of a patient's ER visit by connecting Nevada's DPBH to HealtHIE Nevada. This connection would enable a window into the behavioral health history of a patient and allow access to the patient's medical history by the mental health system ultimately enabling better-informed clinical decision-making.

DPBH worked with EHR developer NetSmart Technologies to leverage the available tool, CareConnect, ensuring that the resulting system would also meet Stage 2 Meaningful Use requirements and support all federal and state policies, including standards for health information exchange. NetSmart worked to get the state's system, myAvatar, connected to CareConnect in order to submit data to HealtHIE Nevada. Mental health providers have been given tutorials on the HIE and data retrieval and more training will potentially be delivered when DPBH is ready to onboard for data sharing with participating ERs.

There are 11 demographic elements that the state will submit to HealtHIE Nevada as a result of the grant. Statute 42 CFR Part 2, limiting the exchange of substance use information, creates many challenges. The 11 demographic elements included did not include data related to the patient's chief complaint, so this was not an issue for this grant; however, 42 CFR Part 2 will continue to be a challenge as other mental health facilities are on-boarded in the future. (*Figure 11. NetSmart to HealtHIE Nevada Data Flow*)

Connection to HealtHIE Nevada was established in August 2016 while the grant period concluded in September 2016. Final reports were submitted October 31, 2016 and are under evaluation.

Figure 11. NetSmart to HealtHIE Nevada Data Flow



Source: DPBH Presentation to the ONC, May 28, 2016

Section B. The State's "To-Be" HIT Landscapes

Overview

Nevada's "To-Be" HIT landscape describes the vision for making significant and sustainable changes to its health care delivery and improvement through the adoption and Meaningful Use of HIT by the state's healthcare providers in alignment with the Triple Aim of improved population health, better care and greater value health care spending.

This section describes the goals, objectives, and additional functionalities that are planned to promote HIT/HIE interoperability as described in the accompanying IAPD-U to be submitted on March 2017.

B.1. SMA Five Year HIT/HIE Goals

SMHP Companion Guide Question B #1

In its January 2016 State Innovation Model (SIM) Plan, Nevada identified four overarching aims to increase health care value while improving outcomes, access and containing health care expenditures in the state.

These Nevada aims are:

1. Redesigned system to contain costs and increase value
2. Reliable and consistent access to primary and behavioral health care
3. Improve health outcomes and quality ratings
4. Greater health information technology and data infrastructure adoption

Aligned to these aims, DHCFP identified key HIT/HIE goals to be achieved within the next five-years These goals represent a 3-prong approach to establishing the Nevada Health IT Continuum: (1) maximize the quality and efficiency of the healthcare services our beneficiaries receive, (2) improve their health outcomes, and (3) reduce the cost of healthcare in Nevada.

Nevada Health Information Technology Continuum for Transformative Healthcare

HIT/HIE GOAL 1

Substantially Increase Nevada Medicaid Provider Adoption and Use of Electronic Health Records and Health Information Exchange: Within the next 5 years, DHCFP will increase the total percentage of all Medicaid EPs and non-EPs who have adopted EHRs to 100% and those who use interoperable HIE to 80% .

HIT/HIE Goal 1 Objectives and Strategies

Promote and drive awareness for Medicaid provider adoption and use of EHR and Health Information Exchange.

- Implement REC-like services and leverage existing provider outreach and educational services, specifically, technical assistance provided by HealthInsight and CGI, and expand activities to include behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies,

laboratories, correctional health providers emergency medical service providers, public health providers and other Medicaid providers.

- Create HIT/HIE toolkit, including a communication plan to promote and drive awareness of EHR and HIE to EPs and other Medicaid providers listed above.

Establish mechanisms incentivizing Medicaid providers to on-board to Nevada's statewide Health Information Exchange.

- Provide HIE technical assistance and on-boarding services to assist Medicaid providers seeking to create interoperable connections and achieve Meaningful Use with certified EHR systems.
- Create a technical assistance and on-boarding services plan first targeting FQHCs, RHCs, and those providers servicing unique and vulnerable populations of Medicaid beneficiaries.
- Develop an Intermediary Program to incentivize EPs to establish interoperable HIE connections among their practices and with other Medicaid providers across the State.

Create a measurement framework and report HIT/HIE activity and progress

- Strengthen Nevada's public-private collaboration of key health care stakeholders, including the Nevada Health IT Leadership Council to enhance oversight and governance of HIT/HIE activities across the state.
- Create a project plan and timeline of achievable milestones to support provider awareness, adoption, and use of EHR and HIE, including built-in accountability to the Nevada Health IT Leadership Council to ensure sustained, forward progress.
- Develop a tactical plan to expand Nevada's current HIT/HIE landscape that is aligned to the progress against the ONC's "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0"[vi]

Projected/Actual Number of EPs Attesting for AIU through 2016

As of August 2015, Nevada estimated that 1,860 unique providers meet volume requirements for the Medicaid EHR Incentive Program and of those, approximately 1,000 unique providers will attest at least once in the program as an update to the FFY 2017-18 HIT APD approved by CMS in September 2016. All EHs in Nevada have participated at least once in the Incentive Program and DHCFP anticipates that all EHs will receive three years of payments, or 100% of their calculated payment. Please note the SFY 2015 numbers in the table below include all attestations to date from the inception of the program.

Table 16. Nevada Medicaid EHR Goals for Eligible Professionals below outlines Nevada EHR Incentive Program goals as originally outlined in the "Stage 1 Final Rule, Table 35". The Nevada EHR Incentive Program started in 2012, so the federal estimates for providers that will receive incentive payments per program year have been revised appropriately. Pediatrician payments have been estimated at 10%. In addition, all estimates are based on the anticipated number of registration by the end of 2017.

Nevada Medicaid EHR Goals for Eligible Professionals EHR Adoption, Meaningful Use Program Metrics Program Years 2015-2020
Overview

Nevada Medicaid EHR Goals for Eligible Professionals EHR Adoption, Meaningful Use Program Metrics Program Years 2015-2020					
NV Number of Physicians, PAs, NPs, Dentists	**NV Number of Pediatricians**	**Number of Physicians Who Meet the Volume Requirements**	**Number of Pediatricians Who Meet the Volume Requirements**	**NV Number of Physicians Registered as of 12/31/16**	**NV Number of Physicians Anticipated to Register as of 9/30/17**
6,201	307	1,860	154	993	2,000
Program Year 2015 Actuals					
Federal Estimate of Percentage Who Will Receive Payments for PY 2015	**Number of NV EPs who Received Payments at $21,250 Level**	**Number of NV Pediatricians who Received Payments at $14,167 Level**	**Number of NV EPs who Received Payments at $8,500 Level**	**Number of NV Pediatricians who Received Payments at the $5,667 Level**	**NV Payments for PY 2015**
36%	129	6	147	8	$4,121,088
Program Year 2016 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2016	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2016**
40.5%	400	33	347	30	$12,087,021
Program Year 2017 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2017	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2017**
45.3%	0	0	815	91	$7,443,197
Program Year 2018 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2018	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2018**
30.7%	0	0	553	61	$5,046,187
Program Year 2019 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2019	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2019**
21.9%	0	0	394	44	$3,598,348
Program Year 2020 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2020	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2020**
15.1%	0	0	272	30	$2,482,010

Table 17. Nevada Medicaid EHR Goals for Eligible Hospitals outlines the Nevada EHR Incentive Program goals for Eligible Hospitals.

Table 16. Nevada Medicaid EHR Goals for Eligible Professionals

Nevada Medicaid EHR Goals for Eligible Professionals EHR Adoption, Meaningful Use Program Metrics Program Years 2015-2020					
Overview					
NV Number of Physicians, PAs, NPs, Dentists	**NV Number of Pediatricians**	**Number of Physicians Who Meet the Volume Requirements**	**Number of Pediatricians Who Meet the Volume Requirements**	**NV Number of Physicians Registered as of 12/31/16**	**NV Number of Physicians Anticipated to Register as of 9/30/17**
6,201	307	1,860	154	993	2,000
Program Year 2015 Actuals					
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36%	129	6	147	8	$4,121,088
Program Year 2016 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2016	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2016**
40.5%	400	33	347	30	$12,087,021
Program Year 2017 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2017	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2017**
45.3%	0	0	815	91	$7,443,197
Program Year 2018 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2018	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2018**
30.7%	0	0	553	61	$5,046,187
Program Year 2019 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2019	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2019**
21.9%	0	0	394	44	$3,598,348
Program Year 2020 Estimates					
Federal Estimate of Percentage Who Will Receive Payments for PY 2020	**Number of NV EPs to Receive Payments at $21,250 Level**	**Number of NV Pediatricians to Receive Payments at $14,167 Level**	**Number of NV EPs to Receive Payments at $8,500 Level**	**Number of NV Pediatricians to Receive Payments at the $5,667 Level**	**Estimated NV Payments for PY 2020**

Nevada Medicaid EHR Goals for Eligible Professionals EHR Adoption, Meaningful Use Program Metrics Program Years 2015-2020					
15.1%	0	0	272	30	$2,482,010

Table 17. Nevada Medicaid EHR Goals for Eligible Hospitals

Nevada Medicaid EHR Goals for Eligible Hospitals EHR Adoption, Meaningful Use Program Metrics PY 2015 - 2020						
DESCRIPTION	**PY 2015**	**PY 2016 Estimates**	**PY 2017 Estimates**	**PY 2018 Estimates**	**PY 2019 Estimates**	**PY 2020 Estimates**
EH Registered in NEIPS	31	31	31	31	**All Nevada eligible hospitals will be paid by 2019**	
EH Receive AIU payment (EHs can skip AIU)	10	4	0	0		
Registered EH Received AIU payment	32.2%	12.9%	0%	0%		
EH Receive Meaningful Use Stage 1 Payment (*all payments starting in 2016 will be Stage 2*)	31	0	0	0		
Successful EH Received Meaningful Use Stage 1 Payment	100%	0%	0%	0%		
EH Receive Meaningful Use Stage 2 Payment (*all payments starting in 2018 will be Stage 3*)	13	27	31	0		
Successful EH Received Stage 2 Payment	41.9%	87%	100%	0		
EH Receive Meaningful Use Stage 3 Payment	0	0	0	4		
Successful EH Received Meaningful Use Stage 3 Payment (*all payments starting in 2018 will be Stage 3*)	0%	0%	0%	100%		

Medicaid Managed Care Organizations Data Tracking

In 2011, approximately 84% of Medicaid beneficiaries were enrolled in some form of MCO through the Nevada Mandatory Health Maintenance Program. Nevada contracts with two for-profit health plans, Amerigroup Community Care and Health Plan of Nevada, to provide services to Medicaid beneficiaries, and selects plans that will be delivered through these organizations via a competitive bidding process.

To provide care for any high need beneficiaries not served by the Mandatory Health Maintenance Program such as those in rural areas, Nevada received federal approval for a section 1115 demonstration called the Nevada Comprehensive Care Waiver (NCCW).

In accordance with legislation SB514, the state has an opportunity to evaluate alternative Medicaid delivery models, and must conduct an impact analysis of managed care program implementation for the waiver population. Analysis was completed September 2016 and DHCFP will use the early part of 2017 to review the analysis and consider public comments collected for analysis.

The state aims to design managed care delivery solutions that integrate medical, behavioral health, and social needs to promote patient centered care. Currently, MCOs report Consumer Assessment of Healthcare Providers & Systems (CAHPS), Healthcare Effectiveness Data and Information Set (HEDIS) and other performance data.

Nevada also has a pay-for-performance program in which it provides monetary incentive payments, not to exceed one million dollars annually, to plans that report quality scores at or above the national HEDIS 90th percentile in a single year and/or a 10% improvement from one year to the next.

As of July 1, 2017, DHCFP will have two additional MCOs and one dental plan to service Nevada Medicaid beneficiaries. These selected are required to join HealtHIE Nevada. All of the MCO plans will collaborate with the State to jointly determine the set of quality scores eligible for performance incentives at the beginning of the contract period.

HIT/HIE GOAL 2

Significantly Enhance Nevada's HIT/HIE Landscape by On-boarding/Connecting Systems and Advancing the HIE Architecture to Enable Interoperability among Medicaid Providers and to Support the State's Integrated Health Care Goals.

Increase by at least 70% the current electronic, secure data sharing of patient health information between EPs and other Medicaid healthcare providers, including behavioral health providers, substance abuse treatment providers, long-term care providers, community-based providers and other Medicaid providers to support beneficiary care coordination.

HIT/HIE Goal 2 Objectives and Strategies:

Expand upon the statewide interoperable health IT infrastructure to give Nevada Medicaid providers access to patient health information and demonstrate Meaningful Use.

- Enhance the state's HIT infrastructure by adding key HIE architecture components, which will become the basis for a set of key value-propositions encouraging Medicaid providers to adopt and use health information technologies to demonstrate Meaningful Use.
- Facilitate various public health connections to the HIE including the Nevada State Public Health Laboratory (NSPHL), the Nevada Birth Outcome Monitoring System (NBOMS), SNHD, the SNHD Office of Disease Surveillance (ODS); county public health districts, and onboard a HIT program manager to manage the projects along with connecting behavioral health providers to the HIE.

- Identify and document specific HIT/HIE use cases to support Nevada's recently awarded Certified Community Behavioral Health Clinics (CCBHC) demonstration initiative and other grant awards to measurably improve care coordination in physical health and behavioral health treatment.
- Provide HIE technical assistance and on-boarding services to Medicaid providers adopting value-add services such as encounter alerting and care plan exchange.

Utilize new data exchange mechanisms to monitor anticipated outcomes resulting from widespread provider adoption and use of an interoperable HIE.

- Enable robust technology solutions to support care planning, management and information sharing among providers and community-based social support service agencies.
- Ensure better care coordination resulting in improved health outcomes of Medicaid beneficiaries and other Nevada residents with behavioral health conditions by advancing integrated health care between physical and behavioral health.
- Reduce gaps in care during transitions across care settings through improved coordination for individuals with behavioral health (mental health and substance use disorder) conditions.
- Leverage HIE connection with the Nevada Prescription Drug Monitoring Program (PDMP) and Medication History service allowing prescribers, dispensers or other registered users to query for and access information to prevent adverse drug events and significantly reduce opioid abuse.[vii]
- Improve health care and related services for children and youth in foster care, as well as other vulnerable populations.
- Leverage advanced HIE architect components to support Medicaid providers participating in Alternative Payment Models (APM).

Create a measurement framework and report HIT/HIE activity and progress.

- Issue milestone status in quarterly reports to Nevada Health IT Leadership Council and measure Nevada's progress against the ONC's "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0." through widespread exchange and use of health information.[viii]

HIT/HIE GOAL 3

Implement health information technology presenting a unified view of health data from across Medicaid and the HIE network to help achieve the Department's vision of enhancing care coordination, improving quality, and reducing related health costs. Within the next five years, DHCFP will implement and utilize a Master Data Management (MDM) solution to strengthen Nevada's capabilities in data analytics and reporting.

HIT/HIE Goal 3 Objectives and Strategies:

Using a Phased Approach for Design, Development and Implementation of an MDM to Facilitate Effective Population Health Management

- **Phase 1:** Implement Enterprise Data Governance (EDG), initial data analytics capabilities with self-service reporting dashboards.
- **Phase 2:** Establish connections with HIE and implement products and services for integration and transformation of clinical and claims data, including robust business intelligence (BI) architecture and predictive analytics capabilities with advanced reporting dashboards and business process engineering redesign.
- **Phase 3:** Deploy public-facing dashboards and complete implementation of advanced BI platform and tools within the MDM.

Employ a system implementation approach that is modular, flexible and scalable to maximize the ability to evolve and take advantage of the best approaches to technology and health care delivery. Create Measurement Framework and Report HIT/HIE Activity and Progress.

- Create a project plan and time line of achievable milestones to ensure successful implementation of all phases of the Department's MDM.
- Define measurement framework and accountable reporting structure to ensure forward progress is maintained and project milestones are met.

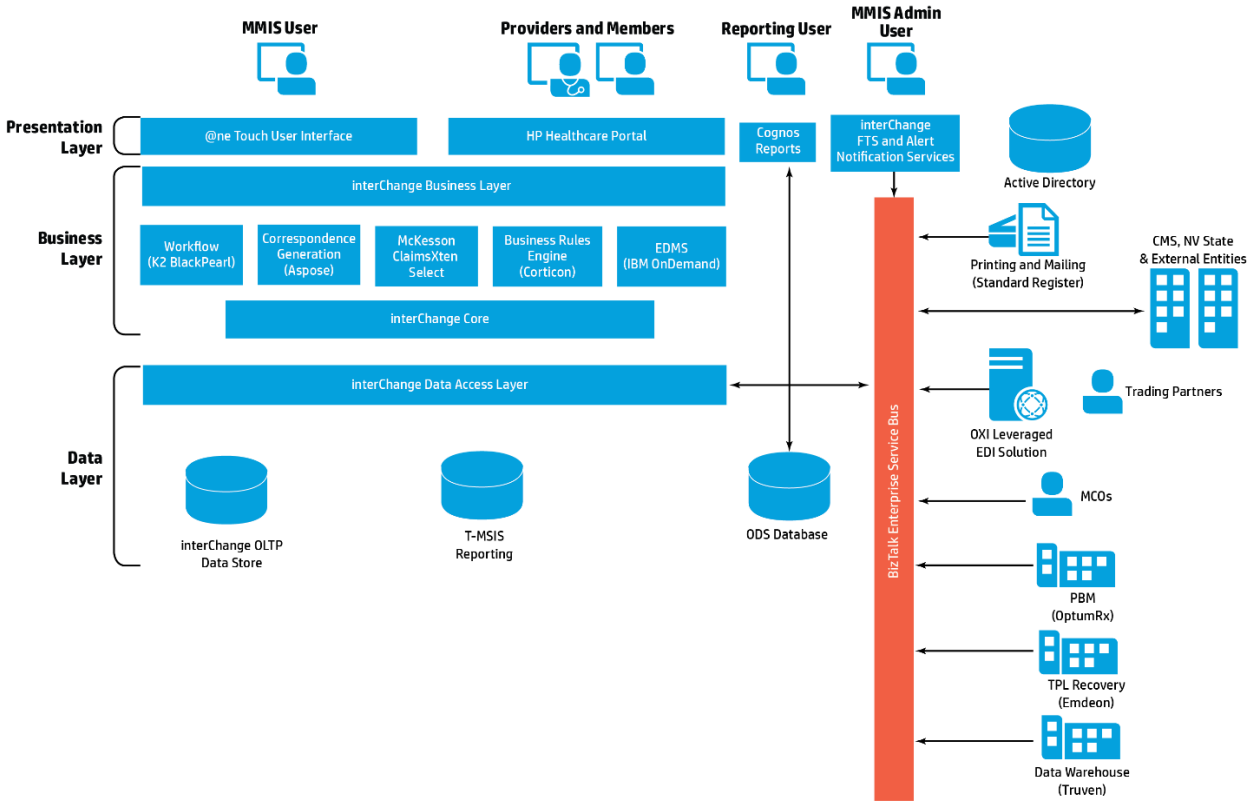
B.2. Future of DHHS IT System Architecture

SMHP Companion Guide Question B #2

SMA System Next Generation 2020

Figure 12. SMA System Next Generation 20 depicts Nevada SMA IT system architecture which will support the state's long-term goals and objectives, including an enterprise service bus, a master client index, record locator services, and internet portals.

Figure 12. SMA System Next Generation 20



Plans to Leverage the State Level Repository (SLR) for Purposes beyond the EHR Incentive Program

According to the EHR Incentive Program Manager, the original RFP for the SLR (NEIPS) ensures that DHCFP will have access to all of the data housed in the SLR once the program ends. The SLR can be used for any file exchanging and the infrastructure of the portal can be repurposed to collect other types of data via file transfer and upload. DHCFP received a quarterly extract from CGI, the SLR vendor; however, there is no plan in place that outlines where this data will be permanently housed or for which purposes this data will be used.

Medicaid Provider Interfaces with SMA IT System
With the modernization of the MMIS planned for 2017, providers will have a portal to make updates to their accounts, view claims, check eligibility, and communicate directly with Medicaid.

State and Local Program Interfaces with SMA IT System
The following programs interface with the Nevada DHHS MMIS IT system many of which are part of the Medicaid eligibility determination process for both acute and long term care members. Nevada agencies administer the following programs which interface with the SMA IT system:

- SNAP
- TANF
- Behavioral Health
- WIC
- MyAvatar
- Rural CHN
- Vital Records
- OPHIE/Epidemiology
- Women's Health Connection
- Immunizations Registry
- Colorectal Program
- Ryan White / HIV
- Newborn Hearing Program
- Pharmacy NNAMHS/SNAMHS
- Nevada Trauma Registry
- HCQC, EMS, EHS, Child Care

DHHS is dedicated to the Medicaid beneficiaries in the State as well as any other individual that interfaces with Medicaid services. Although there are numerous projects that have either secured funding, commenced their planning phase, or started initial implementation phases, there is a lot of potential for future integration with Medicaid systems, through existing or in development HIE connections.

Nevada Division of Child and Family Services – Central Registry Interface
The project was requested by the sister agency, DPBH. The project created a web service based interface between DPBH's provider system to the Unified Nevada Information Technology for Youth (UNITY) system that will facilitate background checks using UNITY's Central Registry. Project went live in production on December 1, 2015.

Center for Health Information Analysis
The Center for Health Information Analysis for Nevada (CHIA), a research center at the University of Nevada – Las Vegas, is a current resource for DHHS' various divisions. CHIA could be queried for baseline data purposes and reporting and is already contracted by DHCFP to collect certain billing record fields from all hospital inpatient, outpatient, and ambulatory surgical centers.

Access Nevada

Modernization of Access Nevada, DWSS' public facing web application that provides clients with the opportunity to submit an electronic application for Medicaid, will not only streamline operations at DWSS by adding electronic communication and tracking, but will enable clients with self-reporting options including reporting changes in areas such as income and contact information and reapplication for benefits. The MMIS Modernization project includes updates to the existing interfaces with Eligibility and Enrollment with implementation set to begin in mid-2017.

Planned Data-Related Projects and HIE Connections

While there are numerous HIT/HIE activities that are already in some phase of implementation, there are many other opportunities for Nevada to expand the state's HIT interoperability. *Table 18. Planned HealtHIE Nevada HIE Connection Projects* lists the projects currently in discussion or planning phases either directly with DHCFP or with related DHHS divisions that serve the Medicaid population.

Table 18. Planned HealtHIE Nevada HIE Connection Projects

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
DHHS HIT / HIE Projects			
Initiate various County Public Health District connections to HIE	2017	Medium	By connecting various county public health districts to the HIE, the state hopes to further their goal of enhancing Nevada's HIT/HIE landscape by on-boarding/connecting systems.
DHCFP Connection to the HIE (health data from the Medicaid claim)	2018	High	Establishing an interoperable connection between HealtHIE Nevada and DHCFP, the state Medicaid agency will allow for: (1) providers treating Medicaid patients to access health data from Medicaid claims including dental, pharmacy and behavioral health data where applicable and pursuant to patient consent; and (2) will provide DHCFP with data to better measure, monitor and manage population health, drive quality and coordination of care across the full spectrum of setting.
DHCFP HIT Master Data Management	2017-2019	High	Nevada seeks to achieve a unified view of Medicaid provider and beneficiary data via a suite of data records and services that will allow DHCFP to link and synchronize Medicaid member, provider, and organization data to HIE sources. This effort will result in a single, trusted, authoritative data source.
Avatar Integration Project (DPBH and DCFS) and Avatar Implementation for Nevada Aging and Disability Services Division	2018	TBD	DCFS and DPBH currently run two instances of myAvatar. This project will allow integration of two instances of myAvatar into one. ADSD plans to replace its Harmony platform with myAvatar.
DPBH Vital Record Registry	2019	Medium	Nevada plans to connect Vital Statistics to the HIE with the goal of providing a single

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
			point of access to the statewide vital statistics. This connection would make data available to other agencies as well, including the Nevada DHCFP and the Nevada Department of Education, and school health offices.
National Outcomes Measurement System (NBOMS) or Birth Defects registry	2019	Medium	Connection of Nevada's Birth Outcomes Monitoring Program to the HIE will continue to assist in the early detection of birth defects; and to assist in ensuring the delivery of services for children identified with birth defects.
Nevada State Public Health Lab	2019	Low	The Nevada State Public Health Laboratory (NSPHL) has significant data reported that requires immediate notification of clinicians and public health partners. Implementing a connection to HealtHIE Nevada would allow a consolidated resource to transmit electronically NSPHL reports timely and efficiently.
Board of Pharmacy (PDMP)	2019	High	Nevada seeks to build a public health registry connecting the HealthHIE NV network to the Prescription Drug Monitoring Program, Nevada's solution for monitoring Schedule II-V controlled substances dispensed to residents in the State of Nevada.
Sentinel Events registry connection to HIE	2019	High	The Sentinel Event Registry (SER) Program tracks reportable sentinel events (an event included in Appendix A of "Serious Reportable Events in Healthcare--2011 Update: A Consensus Report," published by the National Quality Forum) in medical facilities which includes hospitals, surgical center for ambulatory patients, independent center for emergency medical care, and obstetric centers. Connecting this registry to the HIE will help to improve speed and efficiency in identifying events that have a need for immediate investigation and response.
DHHS Interoperability Projects	2018-2019	High	DHHS plans create a mechanism that connects desperate data sets and exchanges data across different agencies and programs.
Critical Access Hospitals Interoperability Projects (Other EHs to be identified later)			
Grover C. Dils Hospital	2017	Low	The connection of Critical Access Hospitals (CAH) to the HIE has the potential to improve health care provided in rural Nevada by connecting rural
William B. Ririe Hospital	2017	Low	
Mesa View Hospital	2017	Low	
Pershing General Hospital	2017	Low	

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
Southern Nevada Health District (SNHD) EHR	2018	Medium	providers to faraway specialists, helping CAHs save money through electronic document exchange, and enabling patients to receive coordinated care in their own communities.
South Lyon Medical Center	2018	Low	
Desert View	2018	Low	
Humboldt General Hospital	2018	Low	
Battle Mountain General Hospital	2018	Low	
Nye Regional Hospital	2018	Low	
Incline Village Community Hospital	2018	Low	
Boulder City Community Hospital	2018	Low	
Public Health Connection Projects (Other projects to be identified later)			
SNAMHS Laboratory System connection to HIE	2017	Medium	HealtHIE Nevada will establish a connection with the Southern Nevada Adult Mental Health System. SNAMHS collects information related to communicable diseases as part of their function to ensure the general health of the population. This information helps public health agencies prevent the spread of disease. A primary concern around disease surveillance is accurate and timely diagnosis, which often takes the form of a positive lab test result for a predefined set of monitored conditions.
WebIZ/Immunization Integration with HIE (Phase 2)	2018	High	Nevada will integrate WebIZ into the HIE, a web-based Immunization Information System (IIS) that currently contains 3.1 million records and allows access for both private and public providers with minimal hardware/software requirements.
DCFS and DPBH MyAvatar integration with HIE	2018	Medium	Integration of the state system, Avatar into the HIE will help to bring data from state agencies together improving the successful coordination of agency projects.
Statewide electronic morbidity reporting	2018	Medium	Nevada seeks to connect statewide morbidity reporting to the HIE to promote the ability address needs surrounding the leading causes of morbidity and mortality within the state.
Stroke Registry	2018	Low	Nevada will connect a stroke registry to HIE that will allow for the collection and exchange of comprehensive, continuous stroke data supports data analysis and the development of interventions to improve stroke care.
University Medical Centers			
University of Nevada – Reno	2017	Low	University systems play an important role in Nevada's health care landscape. The

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
University of Nevada – Las Vegas	2017	Low	state plans begin onboarding of these universities to the HIE over the next twelve months.
Touro University	2018	Low	
Roseman University	2018	Low	
EMS Connection to HIE (Other EMS agency projects to be identified later)			
Las Vegas Fire and Rescue	2019	Medium	EMS is an integral part of the health care system and actions taken by EMS providers affect outcomes, quality of care and patient satisfaction. Connection of Nevada EMS providers to the HIE will allow appropriate in the field access and the secure electronic sharing of a patient's vital medical information. This is a partial list of EMS agencies. We anticipate that this list will increase as the state continues stakeholder engagement activities with additional EMS agencies in Nevada.
Henderson Fire	2019	Medium	
North Las Vegas Fire	2019	Medium	
REMSA	2019	Medium	
Reno Fire	2019	Medium	
East Fork Fire	2019	Medium	
Southern Nevada Health District			
SNHD Vital Records	2018	Medium	DHCFP, HealthIE Nevada, and Southern Nevada Health District (SNHD) clinics will establish a stakeholder collaborative to create interoperable connections with public health clinics to allow for the transmittal of newborn screenings, immunization data, and other vital health information via the HIE network.
SNHD Cancer Registry	2019	Medium	
SNHD Chronic Disease Registry	2019	Medium	
SNHD Electronic health record system	2019	Medium	
SNHD Public Health Lab	2019	Low	
SNHD Birth Defect Registry	2019	Medium	
SNHD Syndromic Surveillance	2019 – 2020	Low	
SNHD Reportable Disease Surveillance	2019 – 2020	Medium	
SNHD Prescription Drug Monitoring for Opioid Surveillance	2020+	High	
Indian Health Programs (IHP)			
Indian Health Programs Interoperability Projects	2018-2019	High	Statewide IHP programs interoperability projects include connection to HIE from IHP clinical settings and connection to DPBH registries.
Value Added Service			
Care Plan Exchange	2018	Medium	DHCFP recognizes that the healthcare community is challenged to effectively and efficiently share and maintain care plans among members of a Medicaid patient's

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
			care team. In order to realize the potential of health IT and provide a more cohesive, inclusive experience for patients, DHCFP proposes deployment of a connected care plan exchange, a standards-based technology solution that allows healthcare providers, care management partners and other care team members who care for a single patient regardless of settings to exchange comprehensive care plans focus on the patient's realistic/achievable goals, optimize services, and create accountability for community-based and institutional care. This interoperable platform will also support Alternative Payment Models (APM) and include transmission of acute event and other care alerts to the care team in order to more closely coordinate care, including follow-on care and/or care transitions.
Master Provider Directory	2018	Medium	Currently, DHCFP and others in Nevada's healthcare landscape use a variety of provider directories, spread across state and non-state systems. These provider directories are often isolated from one another, limited in scope, data accuracy, and timely updates, and are costly to maintain the same information across multiple directories. As a result there is a significant need for Nevada to implement the foundation necessary to support a comprehensive provider directory using Healthcare Provider Directory (HPD) standards for both content and query in order to connect disparate provider directories existing today. The initial phase of Nevada's provider directory will be developed in an iterative fashion building upon the last version and accessible by healthcare providers, health-related state agencies, health plans serving Medicaid beneficiaries, and HealtHIE Nevada.
Master Client Index	2020+	High	Nevada DHCFP Master Client Index (MCI) will be used to ensure accuracy and availability of a person's health information, when and where it is needed to inform the best care possible. A suite of data records and services will synchronize patient, provider, and organization data from multiple sources of data into a single, trusted data source.
HIT Data Entry Portal	2018	Medium	The DHHS Data Entry Portal ("DEP") is a secure web portal giving Medicaid

Project	Planned Year of Completion	Anticipated Level of Effort	Brief Description
			providers a single point of access to their patient's health information derived from a variety of HIE, HIO, state, federal data other sources. Using the DEP, providers will be able to search for and find their patient's health information via an online query mechanism using a Record Locator Service (RLS) to identify patient records that meet criteria within the search. The DEP also allows providers to access other features, functionality and data sources necessary to enhance care delivery, improve care coordination for their patients and reduce overall healthcare costs.
Telehealth	2018	Medium	Use of telehealth will offer an innovative approach to address limited access to health care services by remotely providing such services to people in communities who otherwise do not have access to care. In addition, Nevada seeks to improve healthcare quality by enhancing the use of telehealth services by establishing connections between telehealth EHRs and HealtHIE Nevada in order to give healthcare providers the ability to deliver more efficient care by having access to timely and reliable patient health data at the point of care.
Work Force Development			
Health IT Work Force	2018	Medium	Nevada will develop and deploy a multi-stakeholder strategic initiative to produce a workforce that is equipped to provide high-quality, integrated care throughout the state in order to support the state's vision for healthcare transformation. Such an initiative will begin with identification of the current workforce capacity and an assessment of education, recruitment, and training of a workforce with knowledge and skills to provide and coordinate the full continuum required to meet care delivery transformation goals.

Future Planned Initiatives Creating Connections to the Nevada HIE

The following is a prioritized list of DHHS planned HIT/HIE initiatives establishing essential functionality and interoperable connections to further support EPs in achieving Meaningful Use:

Critical Access Hospitals / Rural Hospitals

Over the next two years, HealtHIE Nevada plans on connecting at least 11 additional CAH or rural hospitals to the HIE. With the addition of REC-like services to be provided by HealthInsight, additional CAHs and rural hospitals will be on-boarded to the HIE in subsequent years.

Nevada Universities
Because university systems play an important role in Nevada's health care landscape, HealtHIE Nevada will be working with University of Nevada - Reno (UNR) and University of Nevada - Las Vegas (UNLV) in the next 12 months to establish connections. Once UNR and UNLV are complete for HIE connectivity including standard ADT, laboratory, and radiology results, work will begin on Touro University and Roseman University connections.

Fire and Rescue
As part of the longer-term roadmap, numerous fire and rescue organizations will be connected to the HIE. At present, six organizations have been identified for connection. As it is not a current functionality of the HIE, updates are in development to enable fire and rescue connections.

No Wrong Door
Through this connection, DHHS will be able to track individuals and families to provide a holistic assistance plan based on their life circumstances. With this connection, DHHS will have the additional ability to make referrals to other divisions for services and track outcomes and client participation in these programs.

The No Wrong Door portal also allows DHHS to access all of the different applications that are required to conduct business through one screen via tabs, increasing productivity.

The No Wrong Door portal is scalable so that other agencies and departments, such as the Department of Education and the Department of Employment, Rehabilitation and Training, can be added to further enhance the experience of the Nevada citizen when accessing services provided by the State. Funded through a 90% federal match/10% state match, the project is anticipated to kick off July 2017.

Master Client Index
Because DHHS has no easy way to track individual clients accessing services across Divisions, the Master Client Index (MCI) would track unique clients in each of the programs within the Department of Health and Human Services (DHHS).

The Enterprise Master Client Index is a database that maintains a unique identifier for every participant in DHHS Enterprise programs. The MCI is meant to create a cross-index of all DHHS databases; it does not replace unique identifiers used by each Division or create an ID to be utilized by all users. By ensuring that a client is logically represented only once and with the same set of demographic and registration data, the MCI allows for improved access to client data and increased coordination of services across the DHHS Divisions.

MCI goals include:

- Facilitating interfaces between human service programs by providing a common unique client identifier (MCI Number).
- Facilitating the coordination of services for clients between DHHS Divisions permitting agencies to share common client demographic information and allowing all programs to share access to changes in this information.
- Providing the ability to identify and track the status of specific programs and cases in which each client is involved.
- Providing an accurate, unduplicated count of clients across programs.

Development and launch of the MCI is part of the state's five year goals. Funded through a 90%federal match/10% state match, the project is set to commence July 2017. The anticipated benefits include the ability to utilize data and query tools to identify and target specific populations for additional services in order to increase positive health outcomes and decrease levels of anxiety or depression.

Nevada Event Notification Alerts for Family and Child Services

An event notification system (ENS) is an automated alerting service that provides timely notifications to subscribing providers and health plans when patients are discharged from a hospital or emergency department. Hospitals serve as the primary data source by submission of admit, discharge, transfer (ADT) messages to the ENS system. The system will rely on the existing infrastructure and data capture from hospitals by HealtHIE Nevada. This system will also rely on the State's forthcoming master client index and participation by Medicaid providers serving children in foster care. The state, HealtHIE NV, participating providers, and participating hospitals will work collaboratively to ensure accuracy and completeness of data and to gather lessons learned and successes of this particular use case to inform expansion efforts of the ENS to other divisions.

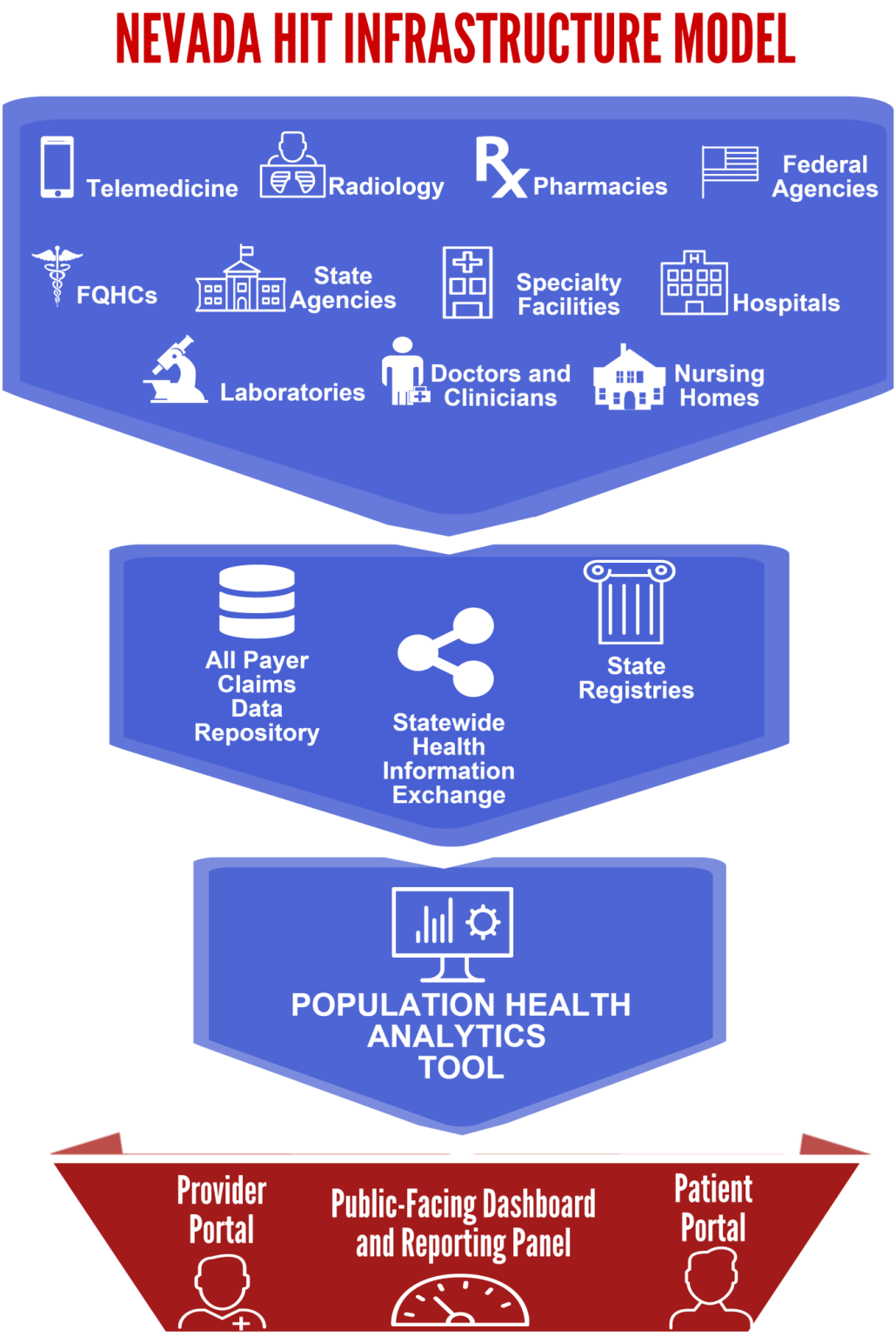
Nevada Birth Outcome Monitoring System

DPBH is also requesting to onboard one new registry to HealtHIE Nevada in year 3 of the project roadmap, the Nevada Birth Outcome Monitoring System (NBOMS), also known as the state's birth defects registry. Currently, NBOMS tracks and reviews data trends which provides useful insights for birth defects. However, the current NBOMS system is too manual and time consuming and an HIE connection would expedite the process. This registry could also be used by EPs attesting to Modified Stage 2 or Stage 3 Meaningful Use in the EHR Incentive Program.

Proposed Nevada HIT Infrastructure Model

Figure 13. Proposed Nevada HIT Infrastructure Model depicts the overall proposed Nevada HIT Infrastructure Model.This includes aggregation and analysis of data for population health management purposes and the collection and exchange of health data by providers, patients and caregivers using HealtHIE Nevada and other interoperable systems and applications..

Figure 13. Proposed Nevada HIT Infrastructure Model



Public Health Initiatives

Electronic health information systems can reshape the practice of public health including public health surveillance, disease analysis, investigation and control, decision making, quality assurance, and education. Unlike incentives in the clinical care system, limited funding is available to public health departments to develop the necessary information infrastructure to capitalize on EHRs, Meaningful Use and collection of quality data.

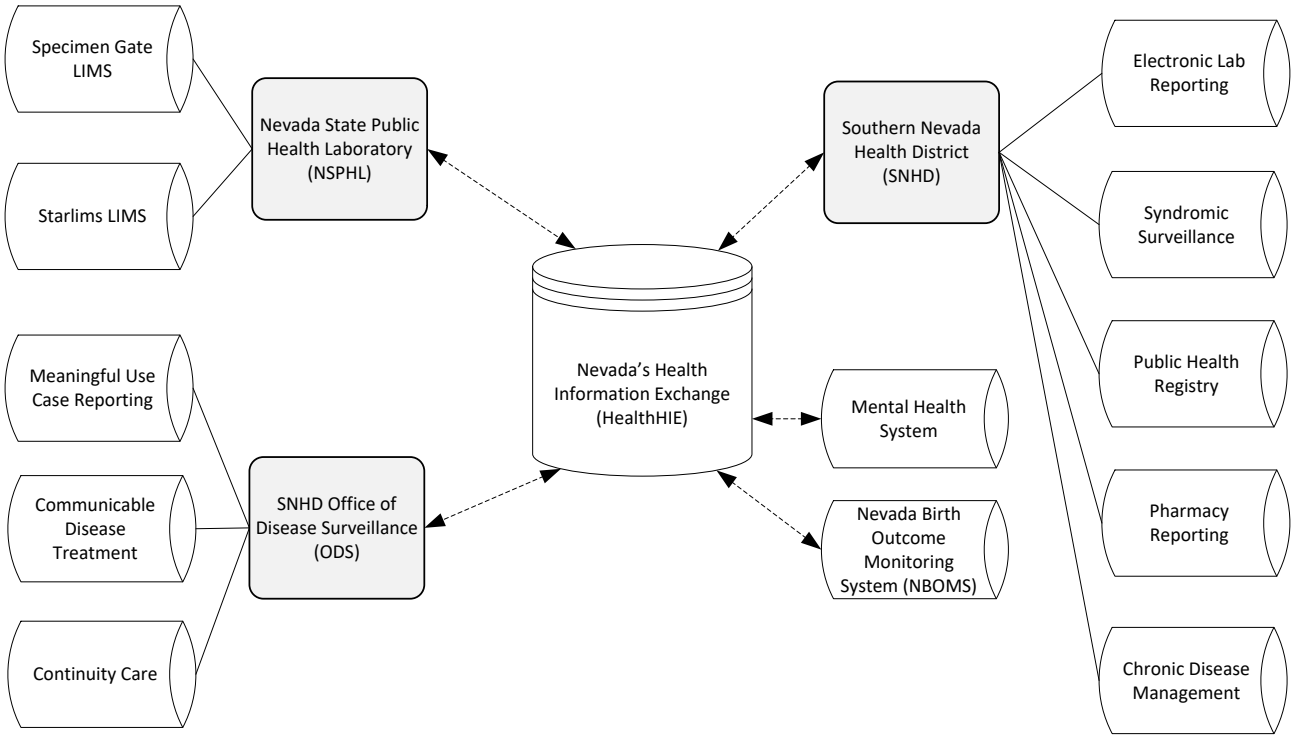
DPBH does not have the resources to establish a provider connection to public health registries as required by state law and Modified Stage 2 Meaningful Use.. In order for DHCFP to further support the adoption of EHRs and to promote Meaningful Use, the connection of public health registries to the HIE is necessary. DPBH, in conjunction with DHCFP has prioritized efforts related to electronic laboratory and provider reporting through HealtHIE Nevada and anticipate working with DHCFP to submit an HIE IAPD, Appendix D funding request.

Public Health – HIT Strategy

DPBH will leverage the services and functionality of the HIE, HealtHIE Nevada, to promote HIT across the provider community. This includes working with HealtHIE Nevada to educate providers about the HIE and their capacity to assist providers in meeting Modified Stage 2 MU. Also, DHCFP will work with HealthInsight to explore how they will support the EHR Incentive Program in areas such as aggregated reporting of clinical quality measures.

This strategy includes public health connections to the HIE including the Nevada State Public Health Laboratory (NSPHL), the Nevada Birth Outcome Monitoring System (NBOMS), Southern Nevada Health District (SNHD), and the SNHD Office of Disease Surveillance (ODS). This strategy additionally includes the provision of a Health IT Program Manager to manage the projects along with connecting mental health providers to the HIE. (*Figure 14. Nevada's "TO-BE" Public Health HIT/HIE Environment)*

Figure 14. Nevada's "TO-BE" Public Health HIT/HIE Environment



Nevada expects to submit an Implementation Advance Planning Document for FFY17/18 to support the following PH registry connections to HealtHIE Nevada:

- The Nevada State Public Health Laboratory (NSPHL)
- Nevada Birth Outcome Monitoring System (NBOMS), also known as the state's birth defects registry.

Immunization Registry

More than 1,300 public and private organization, including physician, health districts, community health nurses, and school districts have access to view, create, and update immunization records, DBPH is looking to provide a single point of access to the statewide Immunization Information System (IIS), including access to DHCFP. DBPH has begun planning these projects and awaits future funding. DHCFP and DBPH are working with HealtHIE Nevada to implement a bidirectional interface in year 2 of the HIE roadmap.

Public Health Connections to HIE

Nevada State Public Health Laboratory Connection to HIE

The NSPHL has significant data reported that requires immediate clinician/public health partner notification. The State of Nevada does not currently have the financial resources or manpower to develop electronic interfaces with all clients statewide to assure rapid reporting of important test results. Implementing a connection to HealtHIE NV would provide a consolidated resource to electronically transmit NSPHL reports timely and efficiently. Connecting NSPHL to the HIE may involve the following tasks:

- **Acquire NSPHL IT Professional** - Acquire an NSPHL IT professional at the NSPHL to participate in the development, implementation, validation and protocol design for the HIE system connection and utilization.
- **Connect NSPHL Specimen Gate LIMS to HIE** - Develop and implement an HIE connection for the NSPHL Specimen Gate LIMS.
- **Connect NSPHL Starlims LIMS to HIE** - Develop and implement and HIE connection for the NSPHL Starlims LIMS.
- **Maintain Staff** - Maintain staff to monitor HIE connectivity daily to assure operational system oversight at the NSPHL.

Southern Nevada Health District (SNHD) Connection to HIE

SNHD wishes to connect to HealtHIE Nevada. This will allow for automated electronic reporting which is expected to reduce labor for ambulatory healthcare, and increase the security, completeness, timeliness, and accuracy of reportable disease, syndromic surveillance, cancer, and trauma data. An SNHD pharmacy reporting connection to the HealtHIE NV would also be included. Anticipated electronic reporting is expected to include:

- **Electronic Lab Reporting for Reportable Conditions** - All hospitals, health care providers, and laboratories are required to report all communicable disease cases.SNHD receives all reports except from small providers. SNHD's connection to HealtHIE NV will enable smaller providers to transmit this information electronically through the HIE.
- **Syndromic Surveillance** - SNHD is partnering with Nevada DPBH in hosting a new syndromic surveillance system (Essence). Connection to HealtHIE NV will enable SNHD to capture additional syndromic data to feed to Essence.

- **Public Health Registry Reporting** - Connection to HealtHIE NV will enable SNHD to capture specific case data to state public health registries more completely and in a more timely fashion.
- **Pharmacy Reporting** - SNHD is in the process of creating an SNHD pharmacy to provide medications to SNHD clients. Prescriptions filled through the SNHD pharmacy can be reported into the HIE through the proposed connection.
- **Chronic Disease Management** - Access to data obtained from the HIE will enable SNHD to describe the burden of chronic diseases such as diabetes, hypertension, obesity, etc. It will also help SNHD identify and monitor population trends, risk factors, intervention opportunities, and evaluate programs.

Southern Nevada Health District Office of Disease Surveillance Connection to HIE

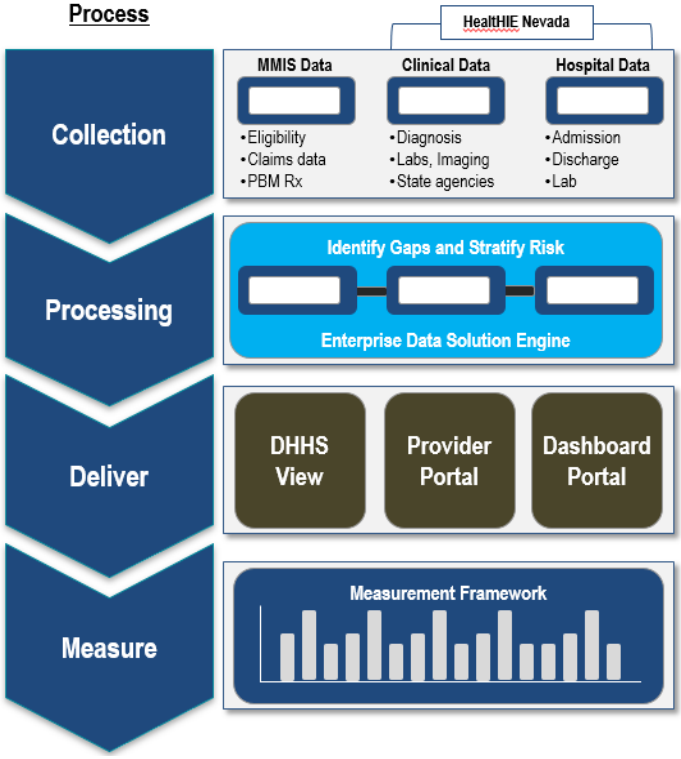
SNHD ODS has additional needs to connect to the HIE. With the additional connections SNHD ODS and healthcare providers will have access to treatment and continuity of care data which will become more labor-efficient, timely, and accurate. ODS-specific connection needs include:

- **Communicable Disease Treatment Monitoring** - Connection to the HIE will reduce labor and increase efficiency by allowing ODS investigators and health care providers to obtain communicable disease and surveillance activity information through the HIE.
- **Continuity of Care** - Connection to the HIE will reduce labor and increase efficiency by allowing SNHD providers and ODS investigators to often obtain continuity of care information of HIV patients through the HIE.
- **Meaningful Use Case Reporting** - Connection to the HIE will reduce labor and increase efficiency by allowing ODS investigators to obtain electronic case reporting information through the HIE.

Nevada DHCFP Master Data Management Solution

Figure 15. DHCFP Master Data Management Solution depicts the overall proposed DHCFP Master Data Management Solution. With the ability to measure, monitor, and manage population health, drive quality and coordination across the full spectrum of care, MDM will give Nevada health departments, state agencies, and other healthcare stakeholder organizations the information and insights necessary to support various multi-faceted health improvement initiatives at many levels.

Figure 15. DHCFP Master Data Management Solution



By applying a patient-centric, data-driven model – the MDM will provide insight to managed care trends and Medicaid beneficiary health status. The following are high-level components of the MDM model:

- Access Data
- Identify Gaps
- Stratify Risks
- Engage Patients
- Measure Outcomes
- Improve Quality

The MDM will include the implementation of data governance activities, the aggregation, integration and transformation of claims and clinical data, and the use of data analytics, business intelligence tools and various dashboards of actionable information. The MDM will aid providers and policy makers to make informed decisions and choices with regards to the care of the sickest and most expensive high-rick Medicaid members– navigating them to improved care coordination, adherence programs, and proper utilization of services.

B.3. How Medicaid Providers Interface with the SMA Related to the EHR Incentive Program

SMHP Companion Guide Question B #3

Medicaid Provider Interface with the EHR Management System
Providers have consistently communicated that in order to achieve improved outcomes and decrease cost, they must have access to current, complete, and actionable patient data. Furthermore, if providers will be reimbursed based on the outcomes of the populations they treat, technical applications need to exist to permit the provider to know how well they are progressing toward those value-based reimbursement targets.

Stakeholders have advised that they are not inclined to visit a different website or portal for every payer. Development and deployment of a centralized provider portal that reflects the provider's performance at an aggregate level, as well as by payer, is planned. Furthermore, the portal will assist the provider in identifying gaps in care and actionable steps to resolve those gaps. To ensure this tool includes the ability to measure outcomes, connectivity to a robust HIE is required.

Plans to Leverage the State Level Repository
At this time, there are no plans to leverage the State Level Repository.

Medicaid Providers Accessing Nevada EHR Incentive Program System (NEIPS)
There are more than 993 Medicaid providers registered in the Nevada EHR Incentive Program System (NEIPS), with a projection of 1,500 by the end of program year 2016, the last year for providers to begin participation in the Medicaid EHR Incentive Program. They are from the following Medicaid specialties:

- MD/DO
- Nurse Practitioner
- Certified Nurse Mid-Wife
- Dentist
- Physician Assistant

Local and State Programs Interfacing with SLR (NEIPS)
There are no local or state programs interfacing with the NEIPS other than the Medicaid EHR Incentive Program.

B.4. HIE Governance Planning and SMA HIT/HIE Goals and Objectives

SMHP Companion Guide Question B #4

Health Information Exchange in Nevada
DHHS is in the final stages of enacting the revisions to the Nevada Administrative Code (NAC), giving the DHHS regulatory authority over HIE systems operating in the state. Given that broad exchange and capture is critical to achievement of future stages of Meaningful Use, this is a priority area for DHHS.

HIE legislation was proposed January 9, 2016, and revised in June after seeking public comment through stakeholder engagement at open workshop meetings. Stakeholders that participated in development workshops represent various constituencies and included Nevada Rural Health Partners, HealthInsight, Renown Health, Nevada Hospital Association, Nevada Chiro Association, Dignity Health, HealtHIE Nevada, Banner Churchill Medical Center, Amerigroup, and the Nevada Division of Insurance.

The current proposed legislation sets forth key requirements for health information exchanges that operate in the State, one of which is to be capable of Meaningful Use pursuant to the criteria prescribed in the Health Information Technology for Economic and Clinical Health Act of 2009. Other key goals of such requirements are to ensure that private HIEs operating in the State 1) follow applicable laws; 2) facilitate sharing of information across public and private sectors; 3) support public and population health initiatives through collaboration with government agencies and other organizations; 4) provide secure, interoperable infrastructure that is accessible to all eligible health care providers; and 5) ensure a high threshold of availability.

Responses to such regulatory requirements by stakeholders has been positive, citing the potential for increased participation in the HIE through clarification on consent and reduction of risk associated with data pull. Revised regulations have not yet been promulgated.

As of September 2013, only seven states, including Nevada, had an opt-in policy for HIE. Nevada believes that the receipt and understanding of an educational document is a key component in guiding a meaningful decision process and developing patient trust. However, disadvantages noted by the provider community include upfront burden and longer time required for aggregation and pull of patient data.

It is important to note the State has enabled automatic opt-in for Medicaid beneficiaries improving access to data to drive future population health initiatives in partnership with the state.

Nevada is adding information to the Medicaid application that will advise beneficiaries of opt-in status as well as how beneficiaries can manage their consent choice if their status changes.

HealtHIE Nevada is certified as an eHealth Exchange participating in the Sequoia Project. Through eHealth Exchange, HealtHIE Nevada has successfully exchanged certificates and established connectivity with the Veterans Administration and a go-live date is anticipated by the end of January 2017. Upon completion, the process will begin to establish connectivity with the Department of Defense.

HealtHIE Nevada has also begun testing connectivity with Dignity Health, which has locations in Nevada, California, and Arizona, and the go live date is anticipated by end December 2016.

In 2017, the following eHealth Exchange connections will be initiated:

- Mayo Clinic
- Cleveland Clinic
- Arizona HIE
- Idaho HIE
- Oregon HIE (Jefferson & OCHIN)
- DaVita Dialysis

- Social Security Administration

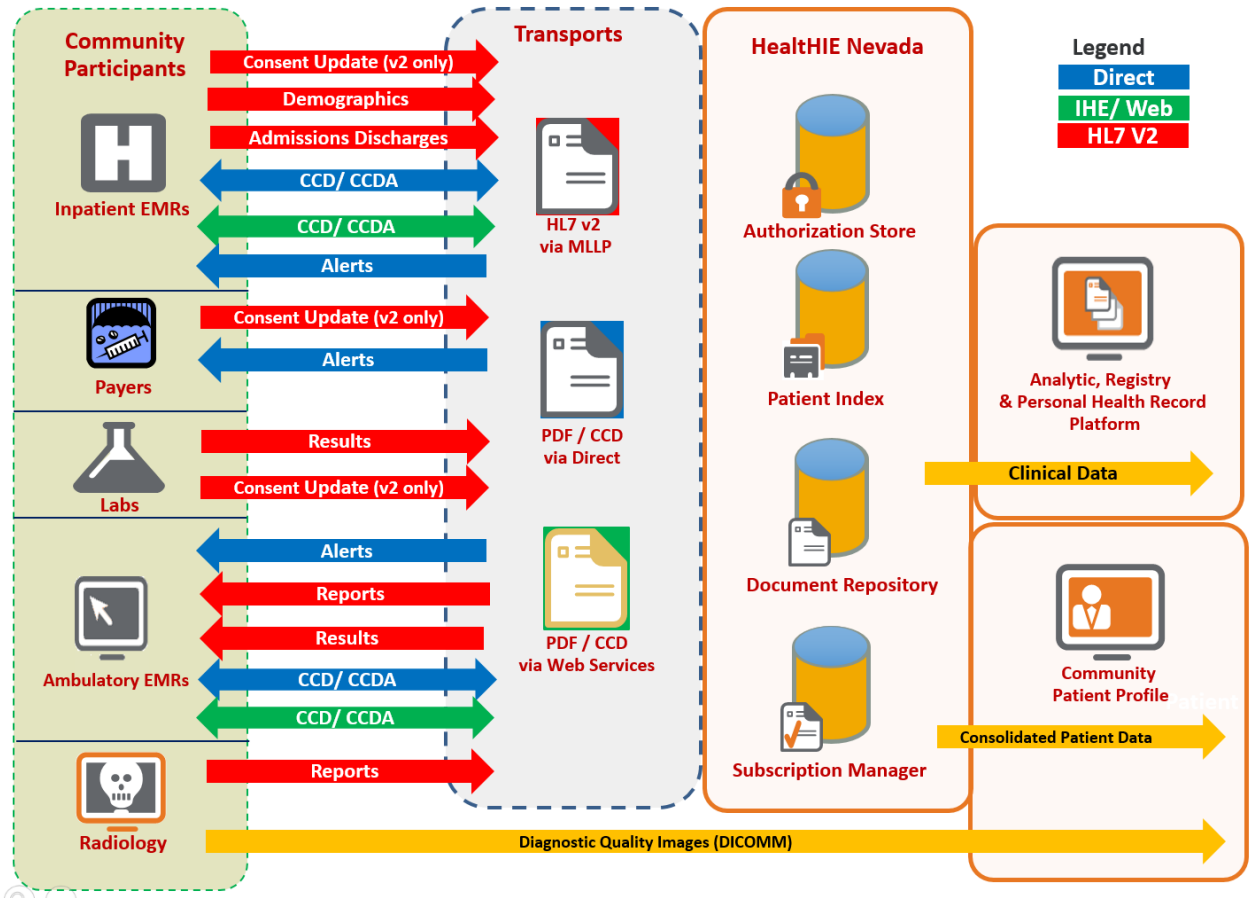
Finally, as HealtHIE Nevada's strategic direction is set by its Board of Directors, a key priority in 2017 and beyond is to increase the integration and availability of Physician Orders for Life Sustaining Treatment (POLST) and Advanced Directives from key sources into the HIE. Such will support providers in delivering care to the state's rapidly aging population.

HIE Participation Onboarding and Health

As a result of the initial state-sponsored HIE, all of the state's urban health care settings are connected to HealtHIE Nevada, and most rural centers are in the process (*Figure 16. "TO-BE" HIE Infrastructure Model)*. About 20% of the state's licensed physicians are participating. As of September 2016, 894 ambulatory physicians, 2 EMS agencies, 26 hospital facilities, three payer organizations covering 694,172 lives, 5 non-hospital based diagnostic imaging centers, four non-hospital based diagnostic laboratory centers, and 17 LTAC, SNF, home health and hospice agencies were participating.

In terms of the number of individuals' records within HealtHIE Nevada, there are 2,310,346 unique patients represented in the HIE as of November 1, 2015. However, this number consists of Nevadans as well as citizens from other states who received care by a provider contributing to the Nevada HIE. Similarly, Nevadans who received care outside of the state are unlikely to have their records represented in HealtHIE Nevada.

Figure 16. "TO-BE" HIE Infrastructure Model



The current HIE infrastructure provides for the direct exchange of PHI from provider to provider. However, the query-based exchange function that a provider would use when trying to pull all PHI available on a patient requires patient consent; a key barrier reported among stakeholders. The current model is an opt-in model for exchanging PHI. Consent options available under the Nevada HIE consist of three options:

- Patient agrees for all providers to have access to all of the patient's PHI via the HIE.
- Access to PHI is permitted but only in emergency situations.
- Patient refuses to permit sharing of any PHI.

Patients refusing to share their PHI still have their PHI loaded into the HIE if the provider participates; however, sharing of that information is not permitted.

Of the more than 2.3 million unique individuals whose PHI is represented in the HIE, approximately 500,000 have consent records. Of these 500,000 consent records, 93% are unrestricted sharing, 3 percent are emergency sharing only, and 4% do not permit any sharing. Medicaid and CHIP patient consent is automatic. With these variables considered, a relatively small percentage of Nevadans have some portion of their PHI information available in the HIE, and an even smaller percentage of Nevadans have complete records in HealtHIE Nevada.

Recently, the consent process has been revised to provide more information to patients and guidance, which promises increased rates of consent for PHI sharing via the HIE. However, if a patient opts out from sharing certain types of PHI in their record (i.e., sensitive PHI: genetic testing, behavioral health services, AIDS/HIV or STDs), the patient is fully opted out. There is currently no capability to suppress only the sensitive PHI from the record.

As illustrated in the stakeholder engagement process, a primary barrier to HIE adoption is the cost of connection. The State intends to use the enhanced federal funding to connect Medicaid providers for the purposes of the MU Program. While this covers a large share of the provider community, alternate funding (i.e., an assessment on claims, or voluntary payer contributions to a shared system) will be required to help connect the non-Medicaid MU providers. These onboarding initiatives will adhere to CMS requirements found in the guidance at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/federal-financial-participation-for-hit-and-hie.html.

As past HIE onboarding shows, the reality is that providers must actually use the HIE. The information that is accessible through the HIE will serve as a key tool to permit providers to achieve improved outcomes and better population health. Many stakeholders reported that payer participation is critical to promoting further adoption. In doing so, reimbursement incentives may be tied to outcomes and population health, which is expected to improve provider contribution and use of the HIE.

However as HealtHIE Nevada's first emergency department participant has proven, consent can successfully be built into the registration process in order to enable the hospital's providers to integrate electronic exchange into their clinical workflow and realize immediate benefits in patient care. As a result, providers have seen immediate results in clinical care. For example, providers caring for a patient have been given immediate access to diagnostic test and laboratory results, physician notes, consultation reports, and discharge summaries, in addition to the names of providers involved in patient care from another facility. Such impact in clinical practice will be important to share with the community going forward, especially in response to SMD Letter #16-003, which will allow non-eligible providers to participate in health information exchange.

HIE Governance Structure

Due to the discontinuation of services by the state-run HIE, NV-HIE in 2014, the HIE governance structure is maintained by HealtHIE Nevada which services as a public-private non-profit organization.

The management of HealtHIE Nevada and its services are performed by HealthInsight, a recognized leader in quality improvement, transparency and public reporting, health information technology programs, healthcare system delivery and payment reform efforts, and human factors science research and application.

With the closure of NV-HIE and subsequent regulatory changes, the state's role in HIE evolved from establishing and governing a statewide health information system, to establishing a regulation for health information exchanges. DHHS is in the final stages of enacting the revisions to the Nevada Administrative Code (NAC) Chapter 439, giving the DHHS regulatory authority over HIEs operating in the state.

The regulation requires an HIE to meet and verify compliance with the following criteria in order to operate or apply for certification within the state:

- Comply with federal and state privacy and security laws and regulations.
- Facilitate sharing of health information across public and private sectors.
- Support public health initiatives.
- Comply with Meaningful Use according to the HITECH Act.
- Use enterprise master client index and master provider directory.
- Provide interoperable infrastructure for exchange of information.
- Prove operational and financial sustainability.
- Meet standards for routine electronic auditing.

A representative from DHHS serves as a full voting member of the Board of Directors with whatever right and privileges for oversight as outlined in the organization's by-laws. As an active stakeholder in the governance structure of HealtHIE Nevada, DHHS participates regularly in planning meetings to determine HIE participation rules and develop the strategic plan for the deployment of HIE across the state. In addition, the state's HIT Project Manager has begun participating regularly in tactical meetings with HealthInsight, HealtHIE Nevada, and OptumInsight, the health information exchange technology solution. The goal is to work collaboratively to ensure the state's short and long term goals are supported by HealtHIE Nevada's operational plan, and short and long term priorities.

Current HIT/HIE Initiatives Supporting SMA Program Management, Population Health Management and Potential Funding Requirements

As Identified in the State Health System Innovation Plan (SHSIP), key stakeholders in Nevada identified a proposed HIT infrastructure which incorporates the HIE, the broad health care community, public registries, an all payers claims database, and a population health database and analytics tool, looking forward to a public-facing tool.

SMA HIT/HIE Goals and Objectives

The Nevada Medicaid EHR Incentive Program has laid the foundation for secure, electronic clinical data exchange by increasing the number of Medicaid providers adopting and using EHRs throughout

the State. Wherever possible the Nevada SMA will build upon existing system architecture to achieve SMA HIT/HIE goals and objectives listed in Section B1.

Health Information Exchange: HealtHIE Nevada Goals and Objectives
The following are the 2016-2017 goals and measures identified by HealtHIE Nevada's board of directors:

HealtHIE Nevada GOAL 1
Increase the number of unique patients with consent on file:
1) Achieve a total 60% of patients in the patient index with consent form on file by June 30, 2017.
2) Electronically Integrate Nevada Medicaid Eligibility information into the consent data in the HIE.

HealtHIE Nevada GOAL 1 Measure
1) Percentage of consent forms on file compared to total Patient Index.
2) Patient data and "Yes" consent value reflected for Nevada Medicaid lives.

HealtHIE Nevada GOAL 2
Achieve and maintain financial sustainability of the HIE by:
1) Establishing a reserve fund equal to the budgeted FY2016-17 increase in net assets ($107,397) by June 30, 2017. The actual value will be adjusted +/- by board approval of new projects.

HealtHIE Nevada GOAL 2 Measure
Change in Net Assets

HealtHIE Nevada GOAL 3
Achieve and/or maintain HIE market penetration rates indicated for each of the following settings by June 30, 2017:
1) Hospitals – 97% data participation based upon statewide hospital average daily census.
2) Physicians- 75% increase of licensed physician participation.

HealtHIE Nevada GOAL 3 Measure
1) Annual average daily census total from participating acute care hospitals providing data to HIE / Total annual average daily census of all Nevada acute care facilities.
2) Baseline participation on July 1, 2016 – 884.

HealtHIE Nevada GOAL 4
Increase the utilization of the HIE:
1) Increase patient access queries by 50% from baseline.
2) Increase HL7 and direct secure messaging results delivery 50% from baseline.

HealtHIE Nevada GOAL 4 Measure
Measured on a quarterly basis:
1) Total # of queries / Total # of baseline queries (13,127) + 50% (6564).
2) Total # of Direct and HL7 Messages sent from HIE / Total # of baseline HL7 Messages sent from HIE (527,169) + 50% (263,585).

HealtHIE Nevada GOAL 5
Complete Security Risk Assessments (SRAs) for 50% of the HIE small (1-24) physician office participants by June 30, 2017.

HealtHIE Nevada GOAL 5 Measure
Total number of SRAs completed / total number of small physician offices with participation agreements.

HealthHIE Nevada GOAL 6
In partnership with a participating hospital and academic center, define the criteria for a study of HealthHIE Nevada's impact on imaging utilization in the Nevada market by June 30, 2017.

HealthHIE Nevada GOAL 6 Measure
Documented and established criteria for study.

B.5. Provider EHR Adoption and Meaningful Use Advancement Strategies of the SMA

SMHP Companion Guide Question B #5

Nevada's 12 Month Strategy to Encourage Provider Adoption of Certified EHRs and Health Information Exchange
HealthInsight serviced as the Nevada REC, and assisted practices with a number of activities related to the adoption, implementation and Meaningful Use of EHRs. The success of the REC program nationwide, and particularly in Nevada, demonstrated a great need for technical assistance for EPs, EHs, and CAHs (Eligible Providers) regarding the adoption and use of Certified Electronic Health Record Technology (CEHRT), workflow redesign, Meaningful Use, and attestation to Meaningful Use.

The REC grant services ended in Nevada in June 2015, HealthInsight continued to take provider questions if received via phone or email; however, the aid is minimal and cannot fully cover the assistance needed.

The availability of these types of services has been important in attaining the State's progress toward EHR adoption, implementation and Meaningful U. Stakeholders around the State have expressed that continuation of certain aspects of the REC functions are still necessary to increase Medicaid provider adoption and use of EHRs, Modified Stage 2 and Stage 3 MU, and HIEs throughout Nevada.

Since such services are no longer available to Nevada Medicaid providers, DHCFP will leverage the former REC services menu, stakeholder engagement findings, and technical assistance needs identified by SHSIP HIT and Data Task Force held throughout 2015 to define and implement an outreach and education strategy targeting Medicaid provider adoption and use of EHRs and HIE, further establishing a robust HIT infrastructure throughout the state.

Use of Education and Outreach Strategies to Encourage Movement to Meaningful Use
The Modified Stage 2 final rule changes outlines large changes to the definition of Meaningful Use and requires Eligible Providers to change their focus from numerous, basic objectives and measures around data collection to the exchange of health information, care coordination, and patient engagement. For many Eligible Providers having recently attested to Adopt, Implement, or Upgrade (AIU) or Meaningful Use for the first time, the leap to Modified Stage 2 in program year 2016 is quite large.

With additional funding starting in 2017 due to the HIT/HIE IAPD, Appendix D, additional and more frequent, targeted education and outreach to Eligible Providers can be planned and executed. The last year for a provider to first attest in the Medicaid EHR Incentive Program in 2016; however, that does not mean that providers won't be attesting to Meaningful Use for the first time after 2017 in order to avoid Medicare penalties or to adhere to new MACRA guidelines starting in 2019. These Medicaid-enrolled providers will required ongoing education on the Meaning Use requirements.

Opportunities for education and outreach activities include:

- Meetings with Professional Associations
  - Education on Meaningful Use and HIE can be shared with the professional association member base which includes Eligible and non-Eligible Providers.
- Workshops and Webinars
  - Workshops are a great tool for educating a large number of providers at one time while giving them direct access to subject matter experts.
  - Due to the large amount of distance between hospitals and clinics in the rural and frontier counties of Nevada, webinars can be used to enhance workshops and can be made available on the DHCFP and HealthInsight websites for provider use at any time.
  - Topics for workshops and webinars could include:
    - Modified Stage 2 Meaningful Use
    - Stage 3 Meaningful Use
    - Quality Data Collection
    - 2015 Edition CEHRT requirements
    - Public Health Reporting Requirements

Recruitment of Non-Eligible Professionals
As the need for HIE grows in Nevada and across its state borders, DHCFP will work with HealtHIE Nevada and other organizations advance in its interoperability capabilities and volume expansion. DHCFP will also explore opportunities provided by SMD Letter #16-003 that will allow non-eligible providers to participate in health information exchange.

B.6. SMA Encouragement of FQHC EHR Adoption

SMHP Companion Guide Question B #6

FQHCs and RHCs Connections to HealtHIE Nevada
Nevada has a total of six FQHCs at 33 sites across the state, in addition to one FQHC look-alike and all have adopted a certified EHR. There are 11 RHCs in the state and eight of those are owned by a Nevada CAH. All of the 12 CAHs in the state are participating in the EHR Incentive Program. With extended funding through an HIT/HIE IAPD, Appendix D, all providers that have participated in the EHR Incentive Program will be offered technical assistance and education/outreach opportunities.

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

Five of the six FQHCs and the FQHC look-alike are currently participating in HealtHIE Nevada resulting in a high adoption rate. Unfortunately, only three of the CAHs that own RHCs are participating in HIE. Many CAHs and rural hospitals and their RHCs by extension, find the costs prohibitive and want to see a larger ROI.

There is a large opportunity for DHCFP, through a 90% federal match/10% state match, to work with HealtHIE Nevada and the CAH/rural hospital community to onboard more hospitals. Since most of the RHCs in the state are owned and/or connected to a CAH or rural hospital, onboarding these organizations will greatly improve the quality of data in the HIE.

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 (*Table 19. EHR Incentive Program Attestations by Provider Type)*.

Table 19. EHR Incentive Program Attestations by Provider Type

	Nevada FQHC Providers										MU status in 2015
	2011		2012		2013		2014		2015		
Health Center	EP	Mid-Level	EP	Mid-Level	EP	Mid-Level	EP	Mid-Level	EP	Mid-Level	
CHA	6.29	5.08	5.92	7.98	3.8	12	4.08	11.15	6.7	12	all eligible providers at all sites are participating
FirstMed					0.95	1.04	1.82	1.5	1.75	2.25	some eligible providers at some sites are participating
Hope Christian									0.41	0	all eligible providers at all sites are participating
HOPES							0.42	2.49	0.92	4.63	all eligible providers at all sites are participating
Nevada Health Centers	20.16	10.32	20.99	12.07	19	13.9	23.37	17.62	21.22	17.9	all eligible providers at all sites are participating

	Nevada FQHC Providers										MU status in 2015
	2011		2012		2013		2014		2015		
Searchlight									0.16	0.06	our eligible providers are not yet participating
	26.45	15.4	26.91	20.05	23.75	26.94	29.69	32.76	31.16	36.84	**Total**
			1.74%	30.19%	-11.74%	34.36%	25.01%	21.60%	4.95%	12.45%	Annual Growth
									17.81%	139.22%	2011-2015 Growth

Notes: All that qualified attested in 2015. FirstMed reports some, but not all EPs in the program, but Searchlight reports none at this time. Some of Nevada Health Centers' rural clinics are run by mid-level provider that would qualify, but no way to know how many. (Mid-Level includes PA/APRNs).

FQHCs and RHCs Connections to SMA's IT Systems

At this time, the FQHCs and RHCs do not have any planned connections to the SMA's IT systems.

Telehealth Access

In 2011, the Nevada Legislature defined telemedicine and established its practice. The promotion of telehealth continued with the passage of AB292 during the 2015 legislative session. AB292 defined telehealth as, "A mode of delivering health services using information and audiovisual communication technology, not including standard telephone, facsimile or electronic mail, to enable diagnosis, consultation, treatment, care management and provision of information to patients from providers of health care at other locations."

As a result of AB292, Chapter 629 of NRS requires prior authorization and payment of service to be covered to the same extent as though services are provided in person or by other means. AB292 further defines the definition of telehealth and requires private insurance and Medicaid to pay for telehealth services. The law further states that providers that are not within the same network can be used to provide telehealth services.

Largely championed by the University of Nevada School of Medicine, telehealth services have expanded to include behavioral health for online counseling and therapy, ophthalmology, radiology and many other subspecialties. There are approximately 83 telemedicine sites in the State currently able to participate in direct consultations.

The growing use of telemedicine and telehealth is essential to transforming Nevada's health care delivery system. In order to expand and align telemedicine and telehealth programs, the State plans to:

- Develop a Task Force for telemedicine services, ensuring that a needs assessment is conducted to determine the breadth of telemedicine and the number of additional presentation sites required to effectively improve access has been recommended.
- Establish a number of additional telemedicine presentation sites to increase access of care.

B.7. SMA Needs Assessment and Technical Assistance for Medicaid Providers

SMHP Companion Guide Question B #7

Eligible Professional Technical Assistance

As illustrated in the stakeholder engagement process, a key function required to advance HIT adoption statewide is ongoing technical assistance with integrating EHR functionality within practice software and routing business operations. DHCFP, HealtHIE Nevada, and HealthInsight 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. DHCFP has a fully executed agreement for FFY17/18 to support HealthInsight through continuation of REC-like services. The aim is to offer support from EHR onboarding to full HIE integration. Services include but are not limited to:

- Initial readiness assessments
- Work flow analysis
- Selection tools
- Referrals to mentor clinics
- Contract negotiation tools
- Project management and implementation
- Privacy and security best practices
- HIE assistance
- Consultation on getting to Meaningful Use

Expanding HIE Adoption to Behavioral Health, Long-Term Care and All Other Medicaid Providers

DHCFP is focused on activities to significantly expand HIE adoption and use by establishing connections between EPs and other Medicaid providers, including behavioral health providers, substance abuse treatment providers, long-term providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and community-based Medicaid providers in order to aid EPs demonstrate Meaningful Use. As outlined in Section B1 of this SMHP, Nevada will enhance its HIT infrastructure by adding HIE architecture components, including but not limited to provider directories, care plan exchange, encounter alerting, and connections with public health systems including the Nevada Prescription Drug Monitoring Program.

Challenges for EPs, Behavioral Health, Long-Term to Overcome and Lessons Learned to Adopt CEHRT

Barriers to CEHRT adoption still exist for most provider types nearly seven years after the introduction of the EHR Incentive Programs nationwide. Nevada's Medicaid EHR Incentive Program opened in 2012 and, even though Nevada has predicted that there are approximately 1,000 eligible Medicaid providers in the state, only 600 have participated in at least one program year. Part of the reason for the 60% participation level is that there are barriers to adoption and full use of an EHR still exist.

As part of the e-Scan conducted in the fall of 2016 for this SMHP update, a survey was disseminated to all providers that have participated in the Incentive Program in addition to eligible providers who may not have participated as well as non-eligible providers. Those participating in the survey were asked about barriers to EHR adoption and concerns that they have with CEHRT. *Figure 17. EHR Adoption Barriers* and *Figure 18. EHR Usage Concerns* illustrate the responses to these two questions:

Figure 17. EHR Adoption Barriers

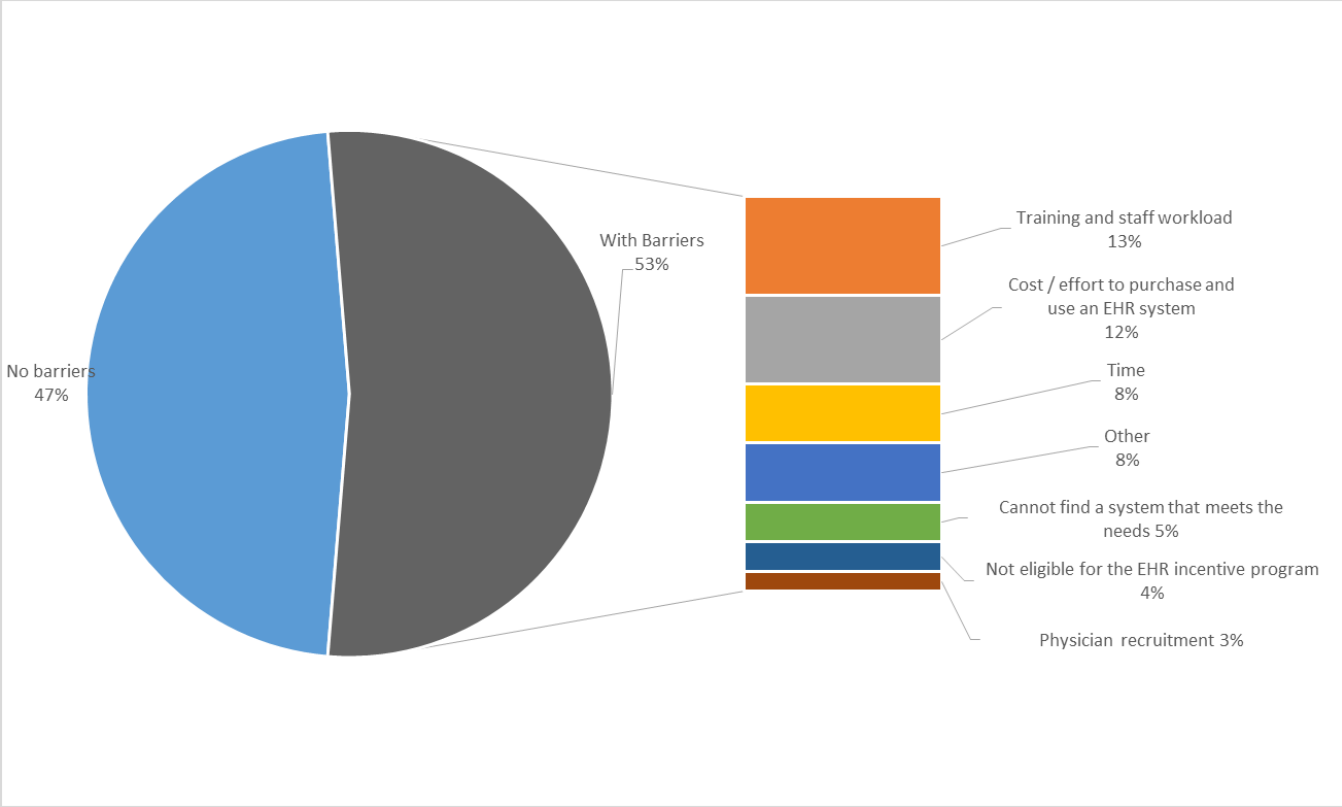
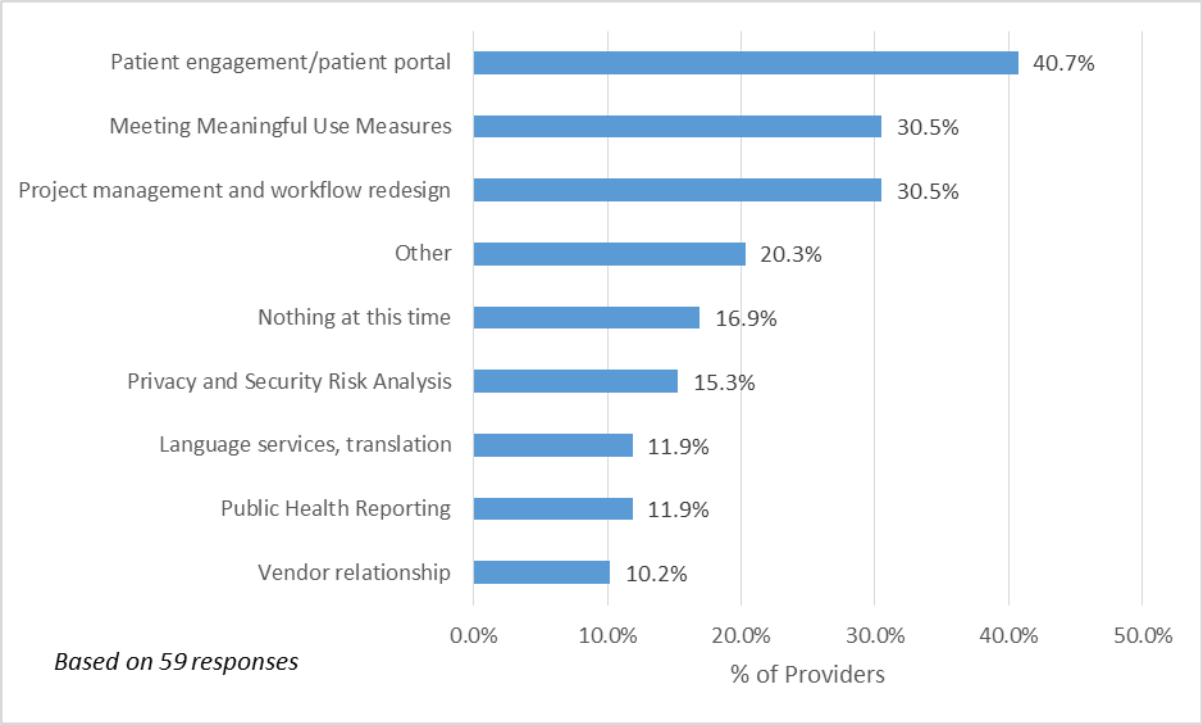


Figure 17. EHR Adoption Barriers that the general barriers to full EHR adoption are similar to those seen at the beginning of the REC program in 2011. Overall, the adjustment to using an EHR including training of staff, staff turnover, workflow design and redesign and the time to accomplish all of these things are the largest barriers among the providers that responded to the survey.

Figure 18. EHR Usage Concerns



Changes to Meaningful Use and CEHRT edition requirements in 2014 added the requirement of a patient portal which caused a lot of delays and concern for providers participating in the EHR Incentive Program. As seen in the chart above, the 2016 survey highlighted the concern around patient engagement and patient portals along with meeting the updated Meaningful Use objective and measures for Modified Stage 2. In addition, much like *Figure 18. EHR Usage Concerns* above, workflow redesign is a large concern around the proper and continued use of CEHRT.

Providers that have successfully adopted an EHR and are Stage 2 Meaningful Users also encounter barriers with fully using their EHRs. These providers may work in a network with a low rate of EHR adoption causing issues with health information exchange or care coordination, which may cause them to miss an EHR incentive payment, incur penalties, and not provide a high level of care to their patients.

Behavioral health providers, in addition to the aforementioned barriers, need to navigate stricter data sharing guidelines, such as those in 42 CFR Part 2 and a smaller selection of EHRs that will meet their practice and patient needs while being certified for the Incentive Program. While many behavioral and mental health care providers could successfully attest to AIU or Stage 1 Meaningful Use, the progressive stages are proving to be much more difficult.

Long Term, Post-Acute Care (LTPAC) facilities, although a very important part of the health care continuum, are typically low adopters of HIT, in particular certified EHRs. According to HealthIT.gov, (https://www.healthit.gov/policy-researchers-implementers/long-term-post-acute-care) LTPAC providers are not eligible for the EHR Incentive Programs; however, LTPACs will play a large role in Modified Stage 2 and Stage 3 because the coordination of care and health information exchange components will require acute care and ambulatory care providers to exchange standardized clinical data with LTPACs.

B.8. SMA Management of Populations with Unique Needs

SMHP Companion Guide Question B #8

Serving Populations with Unique Needs
The following HIT/HIE projects are in development or are being considered for development to service Nevada Medicaid populations with specific and unique needs:

Project ECHO
The goal of Project ECHO Nevada is to meet the needs of primary care providers by offering an alternative to costly travel and long waits for patients who need specialty care. Rural and under-served areas benefit from specialty care becoming available locally, and without the cost and time of accessing specialists directly. Project ECHO Nevada will be available to any community and provider desiring to participate through the Nevada System of Higher Education (NSHE) telecommunications system upgrade to support up to 100 Gbps in September 2015.

Project ECHO is an innovative, successful project through the University of Nevada – School of Medicine (UNSOM). This initiative brings together PCPs to review individual cases with specialists on patients with like conditions. This gives providers additional support to treat complex patients based on recommendations from specialists well-versed in the latest evidence-based treatment. This effort also offers a unique learning opportunity. Currently, Project ECHO specialists moderate conferences with a group of providers monthly. During these conferences, providers discuss patient symptoms and treatment history while specialists make recommendations for future treatment planning. This learning environment allows all providers to learn about treatment recommendations for current patients as well as prepare for patient conditions they may come in contact with in the future.

Project ECHO increases the reach of the specialist in a constructive, effective manner. This program is not simply a provider-to-specialist consultation that only affects the care of one patient. This program has the potential to affect the care for all patients being treated by the PCPs participating in the conferences.

To promote expanded access to specialists, an assessment will be completed identifying the current reach of Project ECHO, identifying gaps (e.g., geography or by specialty) and setting goals for program expansion.

Status and future plans include:

- Conduct an assessment identifying the current reach of Project ECHO. By ***Q3 2017***, an assessment will be completed identifying the current reach of Project ECHO, what percentage of providers have access to additional specialist support, gaps and goals.
- Ensure that PCPs have access to specialists to support treatment decisions. By ***Q4 2019***, the number of PCPs who have access to specialists will be increased from baseline (as determined through the assessment) by 15%.

Future plans to further address rural challenges regarding HIT included the Nevada SHIP Program, proposed fiscal year beginning June 1, 2016 (FY 2016), will utilize $117,000 in pooled SHIP-grant funding from 13 SHIP-eligible hospitals in Nevada for network-oriented activities to:

- Improve rural hospitals' access to shared quality improvement (QI) program management and HIT expertise at NRHP.

- Support rural hospitals' access to the incident management system overseen by NRHP.
- Support the Nevada Rural Hospital Quarterly (QI) Network, including network members' participation in quarterly network meetings and the annual Western Region Flex Conference.
- Support CAH reporting to the Medicare Beneficiary Quality Improvement Project (MBQIP) and the utilization of MBQIP data by SHIP hospitals for quality improvement.
- Support rural hospitals' access to HCAHPS software and technical assistance.
- Shared consortium and program coordination, consultation, facilitation, and administration at NRHP.

During the project period, proposed activities will extend best practices and technical assistance that have been developed by the Nevada SHSIP Program in collaboration between the Nevada State Office of Rural Health and Nevada Rural Hospital Partners.

B.9. Grant Leverage of the EHR Incentive Program

SMHP Companion Guide Question B #9

Nevada State Innovation Model Grant
Two of the key business HIT needs identified in the State Health System Innovation Plan as a result of the SIM grant include:

- Promoting the increased availability and exchange of PHI through an HIE.
- Providing technical and business support to providers adopting, implementing and using HIT in a meaningful way

Promoting the increased availability and exchange of health data through HealtHIE Nevada will promote the greater use and further adoption of EHRs by not only eligible providers, but will expand the sharing of data to non-eligible providers. Having the ability to share data with a wider network of providers will aid eligible providers with the Health Information Exchange, Medication Reconciliation, and Public Health Reporting Meaningful Use objectives and measures.

Certified Community Behavioral Health Center Grant
The objective of the CCBHC Demonstration Program is to improve the availability of, access to, and participation in assisted outpatient mental health treatment, in addition to demonstrating the potential to expand available behavioral health services without increasing net federal spending. The aforementioned Nevada State Health System Innovation Plan (SHSIP) will support efforts to ensure these goals are met.

Once CCBHCs are integrated into the HIT landscape of Nevada, the sharing of behavioral health data with a potentially wider net of providers, the use of EHRs will result in a larger ROI. Even though many behavioral health providers do not participate in the EHR Incentive Program, the greater use of EHRs will support the overall HIT / HIE goals of Nevada.

ONC Community Interoperability and Health Information Exchange Cooperative Agreement Grant
The Nevada Division of Public and Behavioral Health was among 10 awardees of the ONC's grant to support health information exchange and care coordination in September 2015. The aim of the

grant was to support care providers who weren't able to receive incentive payments under the EHR Incentive Programs. By doing so, electronic exchange of health information would expand further to support Nevada's broader health care continuum, integrating behavioral health and physical health care.

DPBH worked with EHR developer NetSmart Technologies to leverage the available tool, CareConnect, ensuring that the resulting system would also meet Modified Stage 2 Meaningful Use requirements and supports all federal and state policies, including standards for health information exchange.

Because this grant required DPBH to focus on providers not eligible for the Medicaid EHR Incentive Program, the outcomes didn't directly aid mental and behavioral health care providers attest to Meaningful Use; however, having mental health data flow into the HIE would ultimately help eligible providers reach Meaningful Use objectives such as Health Information Exchange and Public Health Reporting.

B.10. SMA Need for New or Changed State Laws

SMHP Companion Guide Question B #10

Nevada is considering transitioning from an opt-in state to an opt-out state and will seek support for this policy change in the upcoming 2018 Nevada Legislative session. As part of this anticipated transition, key DHCFP health IT leadership and staffers will initiate a multi-stakeholder collaborative to address the technology and policy requirements for data segmentation to enable sensitive electronic health information to flow among authorized users while adhering to privacy protection requirements for various data types. The group will leverage the Data Segmentation for Privacy (DS4P) Initiative findings and proven test cases/pilots in utilizing standards and implementing privacy policies for sharing sensitive health information across organizational boundaries.

B.11. SMA Need for Issue Management and Other Institution Involvement for Five Year Goal Realization

SMHP Companion Guide Question B #11

Over the next five years, DHCFP will advance new payment in care delivery models through the leveraged use of health information technology and the interoperable connections established with a wide variety of care provider types. In order to achieve this goal DHCFP will address the need for and development of data use agreements and other data sharing instruments associated with the flow of information between the SMA and the following organization types, including but limited to:

- Emergency Medical Services
- Medical colleges and universities
- School health clinics
- MCOs and commercial health plans
- Telehealth providers
- Community mental health and substance use disorder treatment provider organizations

- Social service organizations
- Public health districts and clinics
- Consumer-facing personal health records and patient portal systems

In the near term, DHCFP will work with HealtHIE Nevada and others to devise a long-term sustainability strategy to provide on-going maintenance of these connection types. Finally, in collaboration with healthcare stakeholders throughout Nevada DHCFP will identify and provide recommendations regarding strategies to utilize the vendors to drive the adoption, utilization, and meaningful use of both EHR and HIE.

Section C. Activities Necessary to Administer and Oversee the EHR Incentive Program

Program Overview

This section includes a description of the business processes the DHCFP employs to ensure that eligible professionals (EPs and EHs) including CAHs, (collectively Eligible Providers) have met federal and state statutory requirements to receive incentive payments in the Nevada Medicaid EHR Incentive Program (Incentive Program). DHCFP plans to continue using their standard MITA business processes where feasible, and integrate the Nevada EHR Incentive Program into day-to-day operations in partnership with CGI Group, Inc. (CGI) where appropriate. Examples of state-specific business processes that have been developed include:

- Provider registration.
- Provider eligibility determination and verification.
- Medicaid patient volume verification.
- Provider attestation verification Adopt, Implement or Upgrade AIU and Meaningful Use.
- Query to the Medicare and Medicaid EHR Incentive Program Registration & Attestation System (CMS R&A).

The EHR Incentive Program Manager (Program Manager) is responsible for developing operational policies and procedures for the EHR Incentive Program, researching regulatory questions as they arise, and completing additional activities to plan, coordinate and update the SMHP and IAPD and oversight of the pre- and post-payment activities. The EHR Incentive Program Manager is responsible for overall coordination of program, oversight, and supervision of CGI for pre-payment activities

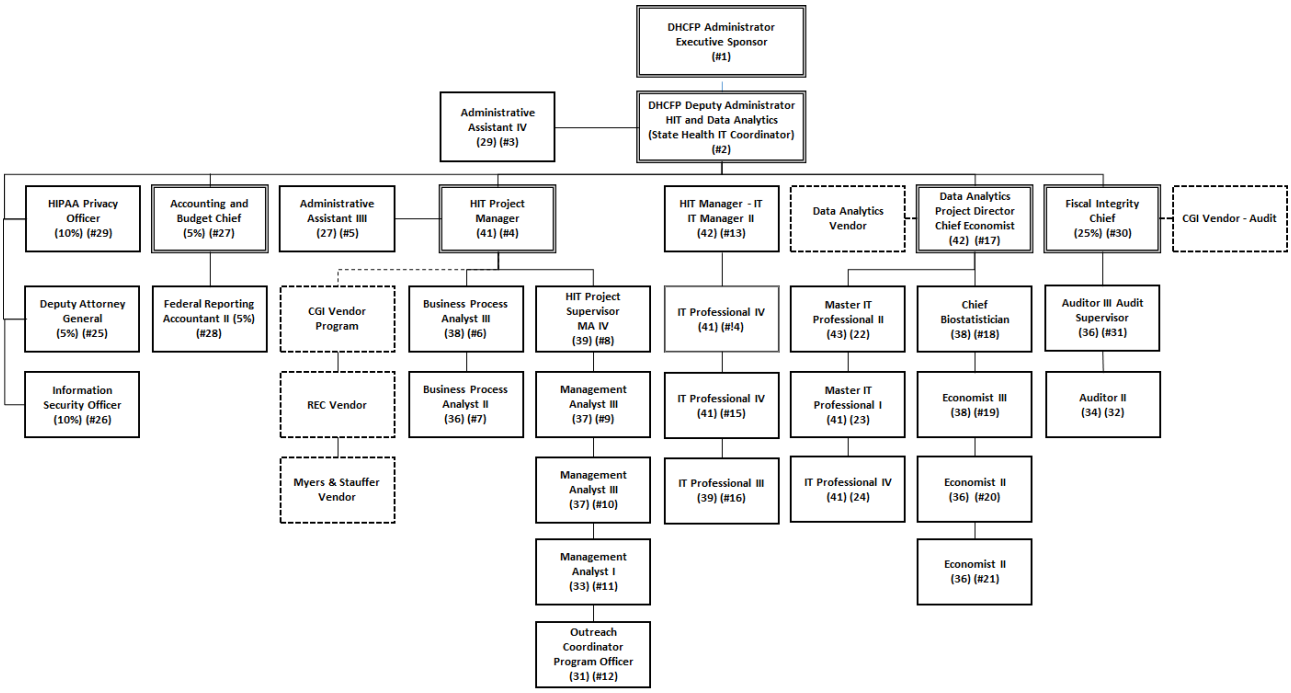
In addition, CGI supports the review and approval of requests received from the NEIPS, monthly payment processing and required EHR Incentive payment reporting. In their role as program administrator, DHCFP and the EHR Incentive Program Manager also coordinates provider outreach with CGI, which provides technical services to EPs, EHs, and CAHs enrolling in the Incentive Program.

DHCFP leverages existing Medicaid business processes to manage the program including provider enrollment, provider payment process, provider audits, and state and federal reporting.

Program Organization

DHCFP has oversight of the EHR Incentive Program administration. The Incentive Program is facilitated by a web-based application, CGI Medicaid Incentive 360® (MI360) that has an interface to the CMS R&A and the Nevada MMIS. CGI provides integrated services with NEIPS including a help desk, provider outreach and education, and management of the pre-payment verification for all EH attestations. (*Figure 19. State Personnel Organizational Chart)*

Figure 19. State Personnel Organizational Chart



C.1. SMA Verification of Provider Sanction, License, Qualification Status

SMHP Companion Guide Question C #1

C.1. Provider Eligibility Determination

EP/EH/CAH Registration

EPs, EHs, and CAHs are required to register at the national level in the CMS EHR Incentive Program Registration and Attestation System (CMS R&A) prior to registering at the Nevada state level. In order to register, all Eligible Providers are required to have a National Provider Identifier (NPI) and an active National Plan & Provider Enumeration System (NPPES) web user account.

Specifically, EHs and CAHs must also have a current Provider Enrollment, Chain and Ownership System (PECOS) enrollment record. At registration, the CMS R&A will verify that providers are not subject to federal exclusion, including checking against the Death Master File and Office of the Inspector General Federal database, as well as ensuring the provider is not federally sanctioned. Eligible Providers will receive a registration status from the CMS R&A, including unsuccessful registrations with reasons for the unsuccessful registration.

The Nevada EHR Incentive Payment System (NEIPS) is the tool for Nevada Eligible Providers to use for registering for and attesting to the Medicaid EHR Incentive Program each eligible program

year. To be eligible for the Nevada Incentive Program, Eligible Providers must be enrolled in the MMIS as a traditional Medicaid provider and meet certain Medicaid patient volume requirements. Areas of focus within the NEIPS 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
- Provider Medicaid patient encounter volume

Eligible Providers can access NEIPS through the Nevada Division of Health Care Financing and Policy Provider Portal with an active User ID once they have received confirmation of their registration at the national level with the CMS R&A. (*Figure 20. EP Registration and Attestation Processes/Figure 21. EP and EH/CAH Registration and Attestation Processes)*

Figure 20. EP Registration and Attestation Processes

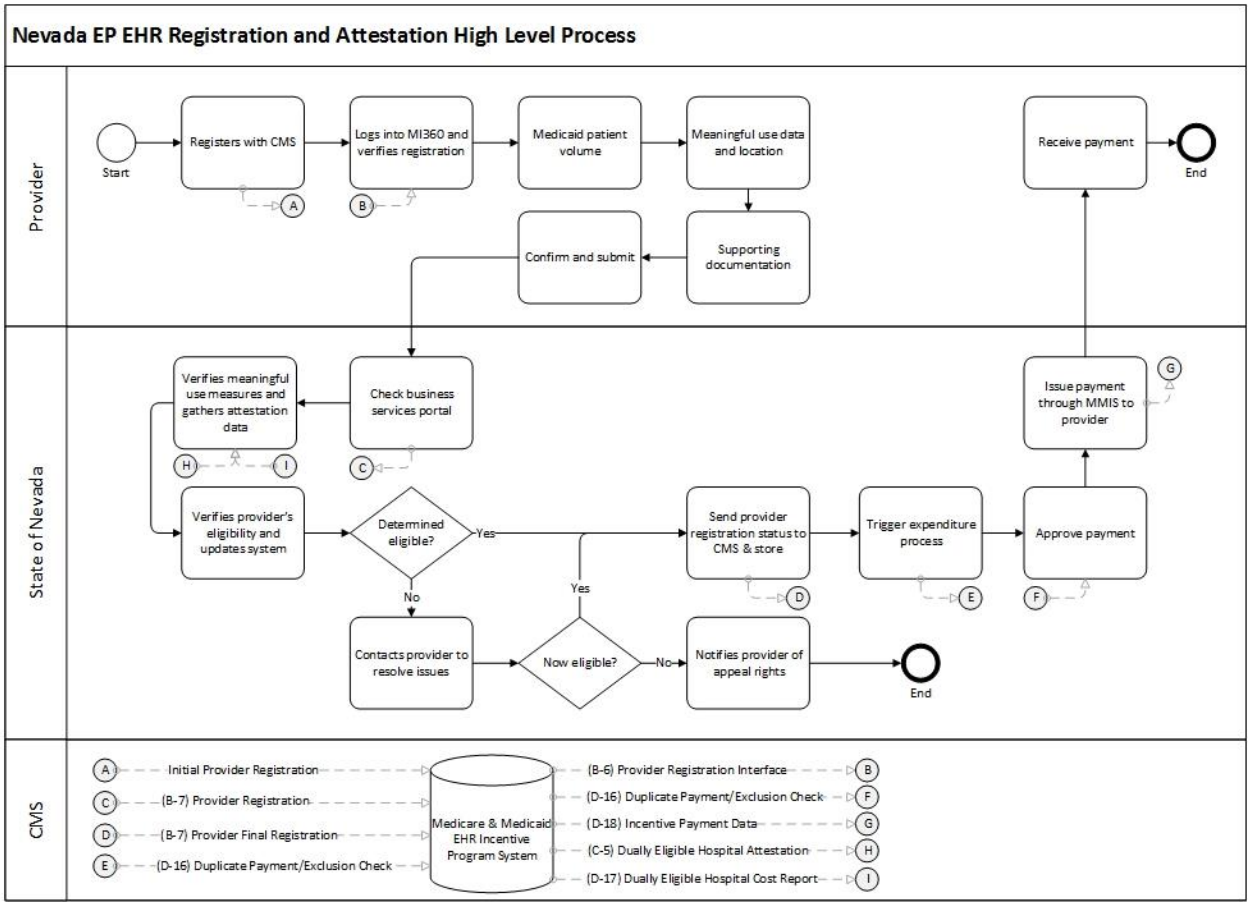
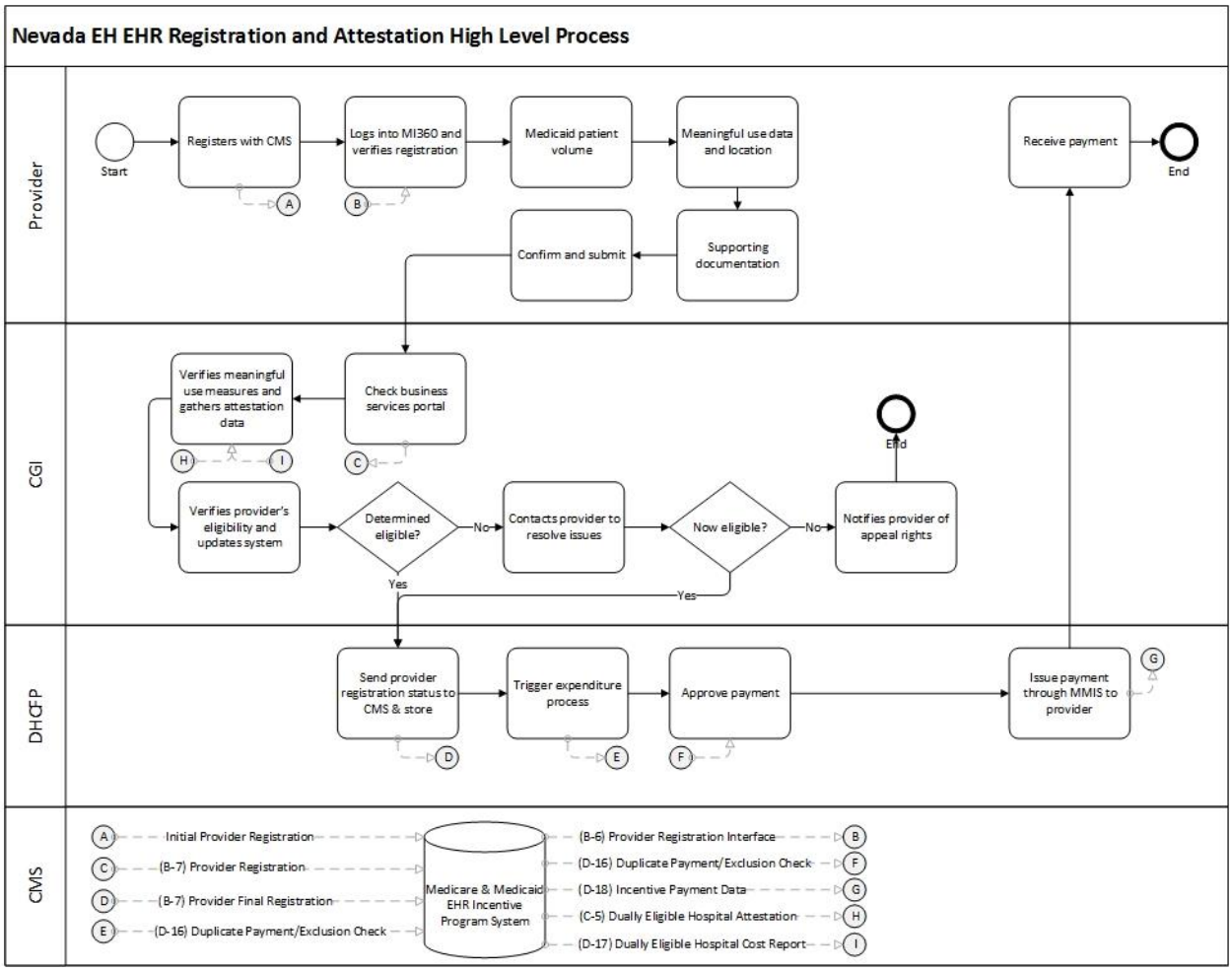


Figure 21. EP and EH/CAH Registration and Attestation Processes



EP/EH/CAH Eligibility Determination

DHCFP verifies that all EPs, EHs, and CAHs are credentialed, not sanctioned, and are one of the types of eligible providers allowed in the Medicaid EHR Incentive Program. In addition, through the verification process, DHCFP will verify that EPs are not hospital-based and will verify whether an EP is practicing predominantly at a Rural Health Center (RHC) or Federally-Qualified Health Center (FQHC), when applicable.

Eligible Professionals include:

- Physicians (primarily doctors of medicine [MD] and doctors of osteopathy[DO])
- Nurse Practitioners (NP)
- Certified nurse-midwives (CNM)
- Dentists (DDS)
- Physician assistants (PA) who furnish services in a FQHC or RHC that is so led by a PA
- Eligible Hospitals include 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:
  - The hospital is separately certified as a children's hospital - either freestanding or a hospital within hospital; and
  - The CCN has the last four digits in the series 3300 – 3399

C.2. SMA Verification of Provider "Hospital-Based" Status

SMHP Companion Guide Question C #2

Definitions

Not Hospital-Based

A provider who furnishes less than 90% of his/her covered professional services in the calendar year preceding the payment year in a hospital setting is considered not hospital-based. 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 ED (POS code 23).

In addition, if a provider does perform more than 90% of his/her covered professional services in the calendar year preceding the payment year in a hospital setting, the provider may be eligible if the Certified EHR is used is owned or self-funded by the provider.

DHCFP will follow CMS guidance when auditing this program requirement. Data elements to capture for each EP include place of service (POS) and encounter/service volume.

Physician Assistant "So Led" Criteria

Physician assistants are eligible for the Nevada Incentive Program when practicing in a FQHC or a RHC that is so led by a PA. DHCFP will consider a FQHC or RHC so led by a PA if:

- The PA is the primary provider in the clinic (e.g., when there is a part-time physician and a full-time PA); or
- The PA is a clinical or medical director at a clinical site of practice; or
- The PA is an owner of a FQHC or RHC.

C.3. SMA Verification of Provider Attestation

SMHP Companion Guide Question C #3

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 Verification and Audit Strategy includes three components:

1. DHCFP will avoid improper payments by assuring payments only go to providers eligible for the program. Audits and reviews are conducted in a manner that focuses audit efforts on those providers that present the highest risk for inappropriate payment. The DHCFP audit strategy employs a pre-payment review of all provider attestations to determine, with reasonable assurance, provider eligibility for incentive payment. Verifications conducted during pre-payment review include but not limited to reasonableness tests utilizing claims or cost report data.
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.

DHCFP will conduct its pre-payment and post-payment audits using desk and on-site audits. All providers are given reminders in correspondence through the verification and attestation process of the possibility for audit, as well as the requirement that all records supporting the numbers in the attestation must be retained for six years. Two auditors are always involved in the approval and final review processes.

2014 Certified EHR Technology Flexibility Rule

On September 4, 2014, CMS published the 2014 Edition CEHRT Flexibility Rule due to the delays in the availability of 2014 Edition CEHRT upgrade/updates for Eligible Providers with existing 2011 Edition CEHRTs. In October 2014, DHCFP submitted and subsequently received approval for their SMHP Addendum for updates necessary to the EHR Incentive Program for program year 2014.

Updates to NEIPS included prompts Eligible Providers to answer whether or not they will be taking advantage of the 2014 CEHRT Flexibility Rule. If Eligible Providers answered “no,” they were required to attest to program year 2014 program requirements. The following options were giving to this group of Eligible Providers:

- **2014 Edition CEHRT** – Eligible Providers using 2014 Edition CEHRT had the following options based on whether they were scheduled to attest to Stage 1 or Stage 2 Meaningful Use in 2014:
  - Scheduled for Stage 1 in 2014
    - 2014 Stage 1 Meaningful Use Objectives and Measures
  - Scheduled for Stage 2 in 2014
    - 2014 Stage 1 Meaningful Use Objectives and Measures; or
    - Stage 2 Objectives and Measures

If Eligible Providers answered “yes,” Eligible Providers chose between one of two attestation options:

- **2011 Edition CEHRT** – Eligible Providers were only provided the option to attest to the 2013 Stage 1 Meaningful Use Objectives and Measures; regardless of whether they were scheduled for Stage 1 or Stage 2; or
- **Combination 2011 and 2014 Edition CEHRT** – Eligible Providers had the following options based on whether they were scheduled to attest to Stage 1 or Stage 2 Meaningful Use in 2014:
  - Scheduled for Stage 1 in 2014
    - 2013 Stage 1 Meaningful Use Objectives and Measures; or
    - 2014 Stage 1 Meaningful Use Objectives and Measures
  - Scheduled for Stage 2 in 2014
    - 2013 Stage 1 Meaningful Use Objectives and Measures; or
    - 2014 Stage 1 Meaningful Use Objectives and Measures; or
    - Stage 2 Objectives and Measures

A few system constraints were implemented in NEIPS to help enforce the rule and prevent data and attestation inconsistencies:

- Eligible Providers electing to exercise the benefits of the 2014 CEHRT Flexibility Rule will be required to expressly attest that they qualify for the exception by selecting their 2014 attestation method and entering a qualification explanation;
- Eligible Providers will be required to fully attest to the set of Meaningful Use Objectives and Measures based on the stage and year selected. They are not provided the option or ability to attest to 2013 Stage 1 Meaningful Use Objectives and 2014 Stage 1 Meaningful Use Objectives; and
- Dually-eligible hospitals' Meaningful Use status will be determined by the CMS R&A C-5 transaction. The NEIPS will not prompt or allow dually-eligible hospitals to enter any MU attestation information.

C.4. SMA Communication with Providers Regarding Eligibility, Payment, Etc.

SMHP Companion Guide Question C #4

Please see *Appendix E* for the Electronic Health Record Incentive Program Communications Plan.

C.5. SMA Methodology for Patient Volume Calculation

SMHP Companion Guide Question C #5

Participation in the Medicaid EHR Incentive Program requires eligible providers meet a patient volume target established by CMS. The table below lists the required patient volume thresholds by provider type *(Table 20. Patient Volume Threshold Criteria)*.

Table 20. Patient Volume Threshold Criteria

Patient Volume Threshold Criteria	
Provider Type	**Minimum 90-day Medicaid Patient Volume Threshold**
Eligible Professionals	
Physicians (MD or DO)	30%
Pediatricians	30% or optional 20% for reduced payment
Dentists	30%
Certified Nurse Midwives	30%
Nurse Practitioners	30%
Physician Assistants practicing in an FQHC/RHC led by a PA	30%
Note: All Medicaid EPs practicing predominantly in a FQHC or RHC may use needy individual patient volume in their encounter calculation	
Eligible Hospitals	
Children's Hospitals (CCN 3300-3399)	0%
Acute Care Hospitals (incl CAHs; CCN 0001-0879; 1300-1399)	10%

Eligible Professionals

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 in addition to requiring the Provider to attest to the fact that the same 90-day period must be, and is, used in both the numerator and denominator of the equation.

EPs in the first year of the program may attest for Adopt, Implement, or Upgrade (AIU) or Meaningful Use. Many EPs choose to attest to Meaningful Use in the first year of the Medicaid EHR Incentive Program avoid Medicare payment adjustments. NEIPS allows EPs attesting for the first time in the Incentive Program to attest to Meaningful Use, if necessary.

EPs must have a minimum of 30%patient encounters attributable to Medicaid members during a 90-day period in the most recent calendar year prior to the year of reporting or in the 12 months preceding the date of attestation. The Nevada Incentive Program currently does not allow EPs to include Children's Health Insurance Program (CHIP) encounters in the Medicaid patient volume EP calculation. Because CHIP encounters are not allowed, pediatricians in the Nevada Incentive Program may qualify at a lower, 20% patient volume. Pediatricians with 20-29% patient volume will receive two-thirds of the yearly incentive payment.

DHCFP does allow EPs to use out-of-state Medicaid encounters in the patient volume calculation. Although Nevada cannot calculate the number of EPs that use Nevada encounters in other state's patient volume calculations, Nevada has had 31 EPs use out-of-state encounters in their attestations to date.

DHCFP amended Provider Enrollment options to include a category for participating in the EHR Incentive Program only. This allows EPs that are participating in a Group attestation to receive incentive payments even if they do not see Medicaid patients during the eligibility period.

EPs that practice predominantly in a FQHC or a RHC are allowed to include Needy Individual encounters in their calculation for 30% patient volume. CHIP encounters may be included in the Needy Individual patient volume for these EPs.

Qualifying Patient Encounters/Calculations

For the purpose of the Nevada Incentive Program, a qualifying Medicaid encounter for an EP is services rendered to an individual currently enrolled in Medicaid in a 24-hour period regardless of amount paid or not paid by Medicaid. This includes encounters for dually eligible members (eligible for both Medicaid and Medicare).

NEIPS will require EPs to enter a numerator and denominator to calculate patient volume along with a start and end date for the calculation. NEIPS requires a start date to begin on the 1st of a month; however, if an EP or EH needs to begin a continuous 90-day period on a date other than the 1st, EPs and EHs can contact the CGI call center for assistance.

Qualifying patient encounters must fall within a continuous 90-day period within the prior calendar year to the attestation or in the 12 months preceding the date of attestation.

- ***Patient Encounter Calculation -*** EPs ***divide*** the total Medicaid patient encounters in any representative, continuous 90-day period within the prior calendar year or in the 12 months preceding the date of attestation ***by*** the total patient encounters in the same 90-day period.

For EPs that practice predominantly in a FQHC or RHC, Needy Individuals are persons meeting any of the following criteria: 1) Medicaid or CHIP paid for all or part of the service or paid all or part of the Medicaid member's premiums, co-payments, and cost shared, 2) the services were furnished at no cost, or 3) the services were paid for at a reduced cost based on a sliding fee scale determined by the member's ability to pay.

- ***Patient Encounter Calculation w/Needy Individuals***: EPs working in a FQHC or RHC divide the total needy individual patient encounters in any representative, continuous 90-day period within the prior calendar year or in the 12 months preceding the date of attestation ***by*** the total patient encounters in the same 90-day period.

Out-of-State Patient Encounters

DHCFP understands that Medicaid members from another state will see Nevada Medicaid Providers, so the Nevada Incentive Program does allow Eligible Providers to include encounters for out-of-state Medicaid members. Out-of-state encounters will need to be verified separately since they cannot be verified through Nevada MMIS.

Group Determination

Clinics, group practices, and other group arrangements may choose to submit an attestation using a group volume calculation as outlined in the Final Rule. EPs attesting to group patient volume in order to reach the 30 percent encounter volume must adhere to the following:

- An attestation must include all EPs in the group; if an EP elects to attest individually, the clinic or practice cannot attest as a group and each EP must submit an individual attestation;
- All EPs in the group must use the same calculation methodology in each program year;
- The group must use the entire clinic or practice's patient volume and not limit it in any way; non-eligible providers encounters must be included;
- If an EP works at more than one group, each group may only include those encounters from the EP that are associated with their group; and,

- An EP can only register and receive one incentive payment per program year regardless of the number of groups that use the EPs encounters in the group patient encounter calculation.

Eligible Hospitals

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.

EH Patient Volume Calculation

Eligible hospitals' patient volume calculations are derived from any representative, continuous, 90-day period within either:

- The hospital's fiscal year ending during the prior federal fiscal year to the program year; or
- The last 12 months preceding the provider's attestation date.

Note: The hospital's patient volume period requirements are different from the hospital's Meaningful Use reporting period requirements.

Calculating the necessary patient volume for eligible hospitals includes:

- Medicaid Encounters - POS 21 (inpatient) discharges plus the Medicaid POS 23 (emergency department) discharges;
- Divide the Medicaid discharges by the total POS 21 (inpatient) and (POS 23) emergency department discharges; and
- Multiply the number in # 2 by 100; this is the hospital's Medicaid patient volume percentage. If the amount is greater than or equal to 10 percent, the hospital is eligible.

Note: Children's hospitals do not have a patient volume requirement.

For the purposes of the Nevada Incentive Program, a qualifying Medicaid discharge for an EH is services in which Medicaid (including out-of-state Medicaid and Medicaid-managed care programs) paid for part or all of the services (including premiums, co-payments, and/or cost sharing), encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter, encounters provided to Medicaid members for which no payments were received, or medical services provided to Medicaid members that were not covered under Nevada's Medicaid program.

NEIPS will require EHs to enter a numerator and denominator to calculate patient volume and DHCFP will utilize the applicable statistics from the most recently filed Medicare cost reports to validate average length of stay and patient volumes.

C.6. SMA Verification of Eligible Professionals and Eligible Hospitals Patient Volumes

SMHP Companion Guide Question C #6

Eligible Professionals

As the first line of financial oversight of EPs, DHCFP plans pre-payment verifications. Application and attestation oversight and verification will ensure that 100% of providers meets eligibility criteria upon enrollment and re-enrollment.

Pre-payment control elements reviewed by DHCFP include but are not limited to the following:

- Eligible provider type.
- Provider qualified to practice in State/Current Medicaid provider.
- Federal or State sanctions or exclusions.
- Physician Assistant LED FQHC/RHC.
- EP is not hospital-based.
- EP practicing predominately in an FQHC or RHC.
- CEHRT.
- Multiple locations.
- Group attestation.
- 30 percent needy patient volume.
- Pediatricians with volume less than 30%.
- For dually-certified hospitals, the Medicaid patient volume percentage and the results of the Medicare audits when available.
- All Medicaid Providers, based on NPI, with Medicaid EHR incentive payments over $300,000.

Providers must supply a robust set of documentation to verify qualification for AIU and Meaningful Use attestation. Document Checklists are sent to providers to help ensure all of the required documentation is uploaded into NEIPS to complete the review. Providers can contact the EHR Help Desk for assistance.

The provider supplies the following attestation and documentation information to qualify for the AIU incentive payment:

- Patient Volume – provider-supplied Excel file
- Certified EHR technology – in addition to the automatic check against the ONC CHPL, the provider supplies the following:

  Copy of screen print showing EHR software and version with practice name.

  EHR invoice from the vendor of most recent upgrade.

EHR vendor contract or lease agreement, or Freeware validation letter in lieu of invoice and contract.

- Pediatricians- copy of Pediatrician certification from the American Board of Pediatrics (ABP) or from American Osteopathic Board of Pediatrics (AOBP)
- FQHC, RHC, and IHP are also required to submit:

  List of all Providers with titles, date of employment, and locations.

  A copy of each provider's employment contract.

  PA-led facility letter (if necessary).
- Groups - a list of all Group Providers with titles, date of employment, and locations (if more than one).

The provider must resubmit the information listed above, and also supplies the following additional attestation and documentation information to qualify for the Meaningful Use incentive payment:

- Meaningful Use Dashboard Report illustrating the 90 day attestation including a 1-page summary of Core and Menu Measures results.
- Explanation for each exclusion declared.
- Test results of Public Health Data transmission or exclusion letter from the registry confirming declaration of intent to transmit.
- Security risk analysis report, signed and dated.

Verification of CEHRT against CHPL (Done Automatically via NEIPs)

In order to satisfy audit requirements for patient volume, DHCFP reviews patient volume files in detail to ensure understanding of how the numerator and denominator have been calculated for the period, and verifies the numerators against MMIS and prior year data. 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. 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.

Attesting providers are required to upload or securely email an Excel or PDF report that includes the following items for all patient encounters, including those from uninsured patients, for the 90-day reporting period:

- Patient Name (or ID).
- Date of Visit.
- Location (if more than one).
- Provider Name.
- Insurance Payer.

Attesting providers that cannot generate the report electronically are offered other options.

DHCFP will rely on existing data to reduce provider burden and maintain integrity and efficacy of oversight processes. For instance, DHCFP plans to use provider data in MMIS to verify provider eligibility. However, many data sources are under construction, and when they become operational the existing data will be used as a proxy data for Meaningful Use verification. Meaningful Use data

from Public Health (Public Health Objectives) is received by Fiscal Integrity team monthly and any attestations to this data are verified according to the Audit Strategy. In lieu of verification by proxy, high risk providers must upload measures data for measures within 2% of the measure threshold.

Eligible Hospitals

As the first line of financial oversight of EHs, DHCFP plans pre-payment verifications to be conducted by CGI.

Before CGI begins a review of an EH attestation, receipt of cost reports is confirmed along with the verification. Once confirmed, the CGI Program Specialist will conduct the pre-payment review. The review of the cost report may include the following points:

- Growth rate calculation.
- Medicaid share calculation.
- Total inpatient days.
- Medicaid inpatient days.

In addition to the required cost reports, one or more of the following documents are required to qualify for an AIU “Adopt” or “Upgrade” payment:

- Signed contract listing the hospital and the vendor.
- Signed purchase order listing the hospital and the vendor.
- Invoice listing the hospital and the vendor.
- Memorandum of Understanding listing the hospital and the vendor
- Email from Certified EHR vendor listing the hospital and the vendor.

In addition to the above required documents, EHs must submit one of the following for a successful “Implementation” attestation:

- Maintenance contract.
- User License Agreement.
- Installation Contract.
- System Logs.
- Evidence of cost, contract, or third-party verification of Certified EHR technology graining with dates as far back as the purchase.

For all subsequent EH attestations for Meaningful Use (year 2+), no additional documentation will be required. The meaningful use attestation data received from CMS via the C5 transaction will be used. For all Medicaid-only EHs where meaningful use data is not received from CMS via the C5 transaction, CGI will perform a review on the following:

- Meaningful Use Summary Report review including MU objectives and CQMs.
- Certified EHR technology CHPL ID.
- Meaningful Use exclusions.

C.7. SMA Verification of EP "Practices Predominantly" Requirement for FQHCs/RHCs

SMHP Companion Guide Question C #7

For the Nevada Incentive Program, "practicing predominantly" is defined as an eligible provider type for whom over 50 percent of his or her total patient encounters over a period of six months in the most recent calendar year occur at a FQHC or RHC.

The process for verifying FQHC or RHC patient encounters is also described in C6. SMA Verification of Eligible Professionals and Eligible Hospitals Patient Volumes.

C.8. SMA Verification of Adopt, Implement, Upgrade of CEHRT

SMHP Companion Guide Question C #8

Starting in 2012, EPs in the state of Nevada were able to attest to adopting, implementing, or upgrading (AIU) to a Certified EHR. Certified EHRs are identified through the Office of the National Coordinator (ONC) Certified HIT Product List (CHPL) and obtain a Certification ID to identify the complete EHR system or combination of modular systems. Certification IDs will be verified in NEIPS once entered by the EP, EH, or CAH. AIU is defined as:

- **Adoption**: acquisition, purchase, or secured access to certified EHR technology. This definition does not include activities that may not result in installation (such as researching EHRs or interviewing EHR vendors)
- **Implementation**: installed or commenced utilization of certified EHR technology, e.g. staff training in the certified EHR technology, data entry of patients' demographic and administrative data into the EHR, establishing data exchange agreements and relationships between the Provider's certified EHR technology and other Providers, such as laboratories, pharmacies, or HIEs
- **Upgrade**: moving from non-certified EHR to certified EHR technology

AIU Attestation Requirements
The Provider supplies the following attestation and documentation information to qualify for the AIU incentive payment:

- Patient Volume:
  - An Excel file must be submitted that includes the list of all patient encounters, sorted by insurance payer, for the 90-day Patient Volume Reporting Period. The file also includes patients without insurance. Insurance payers included in the Medicaid numerator must also be specified.
  - The five (5) required fields in the Excel file are:
    - Patient ID
    - Date of visit
    - Location (if more than one)
    - Provider

- Insurance payer

- Certified EHR technology:
  - CMS publishes a list product codes identifying every ONC-certified Product List (CHPL), which is also available from the EHR vendor. The provider must enter the CHPL product number to identify the EHR technology being attested to, and Copy of screen print showing EHR software and version with practice name, and EHR invoice from the vendor of most recent upgrade, and EHR vendor contract or lease agreement, or Freeware validation letter in lieu of invoice and contract.
- Pediatricians are also required to submit a copy of pediatrician certification from the American Board of Pediatrics (ABP) or from American Osteopathic Board of Pediatrics (AOBP).
- FQHC, RHC, and IHP are also required to submit:
  - List of all providers with titles, date of employment, and locations, and
  - A copy of each provider's employment contract.
  - PA-led facility letter;
- Groups are also required to submit a list of all group providers with titles, date of employment, and locations (if more than one).

C.9. SMA Verification of CEHRT for Second Year Meaningful Use

SMHP Companion Guide Question C #9

At the opening of the Nevada Incentive Program in 2012, Eligible Providers could only attest to AIU with 2013 being the first year for Meaningful Use attestations. Due to some changes to the program and updates to NEIPS, Eligible Providers may chose in their first year to attest to either AIU or Meaningful Use.

In the first year of Meaningful Use participation, Eligible Providers must demonstrate Meaningful Use for a 90-day EHR reporting period which much occur during the same calendar year. In subsequent years, Eligible Providers will demonstrate Meaningful Use for a full year EHR reporting period. In program years 2011-2014 of the EHR Incentive Programs, EHs and CAHs were required to have an EHR reporting period that matched the federal fiscal year; however, with changes in the Modifications to Meaningful Use in 2015 through 2017 final rule published in December 2015, EHs and CAHs will have an EHR reporting period within the calendar year.

In September 2014, CMS published the 2014 Edition Certified Electronic Health Record Technology (CEHRT) Flexibility Rule which allowed Eligible Providers attesting to Meaningful Use to use a 90-day EHR reporting period regardless of which year in the program or to which stage of Meaningful Use the Eligible Provider is attesting for program year 2014 only.

The *Modifications to Meaningful Use in 2015 through 2017* final rule was published in October 2015 which allowed Eligible Providers to have a 90-day EHR reporting period in the calendar year for the 2015 program year only. Due to the transition for EHs and CAHs to a calendar year schedule, they were allowed to choose a 90-day reporting period from October 1, 2014 to December 31, 2015.

The Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record (EHR) Incentive Programs; Payment to Non-excepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital final rule published in November 2016 allows EPs, EHs, and CAHs to use a 90-day reporting period in the calendar year for program years 2016 and 2017.

Meaningful Use Attestation Requirements

The Provider must resubmit the information listed in Section C.8.1 and also supplies the following additional attestation and documentation information to qualify for the Meaningful Use incentive payment:

- Meaningful Use Dashboard Report illustrating the 90-day attestation including a 1-page summary of Core and Menu Measures results;
- Explanation for each exclusion declared;
- Test results of public health data transmission or exclusion letter from the registry confirming declaration of intent to transmit; and
- Security risk analysis report, signed a dated.

Modifications to Meaningful Use in 2015-2017 SMHP Addendum

On October 16, 2015, CMS published the Medicare and Medicaid Programs; Electronic Health Record (EHR) Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 through 2017 (Modified Stage 2) in the Federal Register. This Final Rule revises the regulatory requirements for achieving Meaningful Use in the Medicare and Medicaid EHR Incentive Programs for Program Years 2015 through 2017. This Final Rule also establishes the baseline requirements for Stage 3 Meaningful Use that becomes optional in Program Year 2017 and compulsory for all program participants in Program Year 2018 and beyond.

In January 2016, DHCFP submitted and subsequently received approval for their SMHP Addendum for updates necessary to the EHR Incentive Program for program year 2015 through 2017.

Attestation System and Infrastructure Changes

Reporting Period

All program year 2015 attestations will require a 90-day EHR reporting period regardless of stage or prior attestations. For EHs and CAHs, the continuous 90-day period must occur entirely between October 1, 2014 and December 31, 2015. EPs are required to attest using a 90-day EHR reporting period for Program Year 2015 falling within the calendar year 2015, regardless of stage or prior attestations.

Certified EHR Technology Edition

All program year 2015 attestations require a 2014 Edition Certified EHR Technology. The NEIPS will continue to use the ONC CHPL to ensure that the provider attests with a valid 2014 Edition CEHRT.

In program years 2016 and 2017, participating providers have the option to use a 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of the two. The NEIPS CEHRT verification module will be modified to recognize the 2015 Edition CEHRT numbers after the ONC publishes the numbering mechanism that will be used.

Changes to Meaningful Use Attestation Schedule

Table 21. Stage of Meaningful Use Criterial by First Year below outlines the new attestation schedule based on the Modified Stage 2 final rule.

Table 21. Stage of Meaningful Use Criterial by First Year

First Year Demonstrating Meaningful Use	Stage of Meaningful Use				
	2015	2016	2017	2018	2019 and Future Years
2011	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2012	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2013	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2014	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2015	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2016	N/A	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2017	N/A	N/A	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2018	N/A	N/A	N/A	Stage 3	Stage 3
2019 & Future Years	N/A	N/A	N/A	N/A	Stage 3

Changes to Meaningful Use Objectives and Measures

DHCFP completed a broad analysis of the Modified Stage 2 final rule and the following table outline the changes to Meaningful Use that DHCFP has incorporated starting with the 2015 program year for EPs, EHs and CAHs, respectively. (*Table 22. Eligible Professionals Modifications to Meaningful Use/Table 23. Eligible Hospitals Modifications to Meaningful Use*)

Table 22. Eligible Professionals Modifications to Meaningful Use

Eligible Professionals (EP) – 2015-2017 Modifications to Meaningful Use (MU)		
Change	**Explanation**	**Effective Program Year**
Remove the differentiation between Meaningful Use Core and Menu objectives	Starting in 2015, all Meaningful Use objectives will be required and will be considered "Core" objectives.	2015 2016 2017
Stage 1 specifications for EPs in 2015; lower thresholds and exclusions	EPs scheduled to demonstrate Stage 1 Meaningful Use in 2015 will be required to report to the Stage 2 Meaningful Use objectives for all consolidated objectives. EPs will report on Stage 1 Meaningful Use specifications for objectives that have a lower threshold in Stage 1 Meaningful Use than Stage 2 Meaningful Use. Exclusions for objectives that do not have an equivalent Stage 2 Meaningful Use objective are available. If an EP is scheduled to demonstrate Stage 1 Meaningful Use in 2015 but can attest to the Stage 2 Meaningful Use threshold on an objective, he/she may choose to do so.	2015
Modified Stage 2 Meaningful Use objectives in 2016 and 2017	All EPs will attest to the modified, consolidated Stage 2 Meaningful Use objectives in 2016 and 2017, regardless of stage in 2015, including Adopt, Implement or Upgrade (AIU).	2016 2017
Meaningful Use required measures for 2015-2017	The 10 modified Meaningful Use measures for EPs in 2015-2017 include: 1. Protect Patient Health Information 2. Clinical Decision Support 3. Computerized Physician Order Entry (CPOE) 4. Electronic Prescribing 5. Health Information Exchange 6. Patient Specific Health Education 7. Medication Reconciliation 8. Patient Electronic Access a. Measure 2 – remove 5% threshold for 2015 and 2016 and require that at least one (1) patient (or authorized representative) seen by the EP views, downloads, or transmits their health information to a third party. b. Measure 2 – in 2017, the threshold returns to 5% of all unique patients (or authorized representative) seen by the EP views, downloads, or transmits their health information to a third party. 9. Secure Electronic Messaging a. In 2015, the capability for patients to send a secure electronic message with the EP is fully enabled in the CEHRT.	2015 2016 2017

Eligible Professionals (EP) – 2015-2017 Modifications to Meaningful Use (MU)		
Change	**Explanation**	**Effective Program Year**
	b. In 2016, at least one patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of the CEHRT. c. In 2017, at least 5% of unique patients seen by the EP sent a secure message using the electronic messaging function of the CEHRT. 10. Public Health Reporting	
Discontinued Meaningful Use measures 2015-Forward	The Meaningful Use measures discontinued starting in program year 2015 and moving forward through the program include: 1. Record Demographics 2. Record Vital Signs 3. Record Smoking Status 4. Clinical Summaries 5. Structured Lab Results 6. Patient Lists 7. Patient Reminders 8. Summary of Care a. Measure 1 – Any method b. Measure 3 – Test 9. Electronic Notes 10. Imaging Results 11. Family Health History	2015 2016 2017

Table 23. Eligible Hospitals Modifications to Meaningful Use

Eligible Hospitals (EH) and Critical Access Hospitals (CAH) – 2015-2017 Modifications to Meaningful Use (MU)		
Change	**Explanation**	**Effective Program Year**
Remove the differentiation between Meaningful Use Core and Menu objectives	Starting in 2015, all Meaningful Use objectives will be required and will be considered "Core" objectives.	2015 2016 2017
Stage 1 specifications for EPs in 2015; lower thresholds and exclusions	EHs scheduled to demonstrate Stage 1 Meaningful Use in 2015 will be required to report to the Stage 2 Meaningful Use objectives for all consolidated objectives. EPs will report on Stage 1 Meaningful Use specifications for objectives that have a lower threshold in Stage 1 MU than Stage 2 Meaningful Use. Exclusions for objectives that do not have an equivalent Stage 2 Meaningful Use objective are available. If an EH is scheduled to demonstrate Stage 1 Meaningful Use in 2015 but can attest to the Stage 2 Meaningful Use threshold on an objective, the EH may choose to do so.	2015
Modified Stage 2 Meaningful Use objectives in 2016 and 2017	All EHs will attest to the modified, consolidated Stage 2 Meaningful Use objectives in 2016 and 2017, regardless of stage in 2015, including Adopt, Implement or Upgrade (AIU).	2016 2017
Meaningful Use required measures for 2015-2017	The nine modified Meaningful Use measures for EHs in 2015-2017 include: 1. Protect Patient Health Information 2. Clinical Decision Support 3. Computerized Physician Order Entry (CPOE) 4. Electronic Prescribing 5. Health Information Exchange 6. Patient Specific Health Education 7. Medication Reconciliation 8. Patient Electronic Access a. Measure 2 – remove 5% threshold for 2015 and 2016 and require that at least one (1) patient (or authorized representative) discharged from the EH's inpatient (POS21) or emergency department (POS23) views, downloads, or transmits their health information to a third party. b. Measure 2 – in 2017, the threshold returns to 5% of all unique patients (or authorized representative) discharged from the EH's inpatient (POS21) or emergency department (POS23) views, downloads, or transmits their health information to a third party. 9. Public Health Reporting	2015 2016 2017
Discontinued Meaningful Use measures 2015-Forward	The Meaningful Use measures discontinued starting in program year 2015 and moving forward through the program include: 1. Record Vital Signs 2. Record Smoking Status 3. Structured Lab Results 4. Patient Lists 5. Summary of Care a. Measure 1 – Any method	2015 2016 2017

Eligible Hospitals (EH) and Critical Access Hospitals (CAH) – 2015-2017 Modifications to Meaningful Use (MU)		
Change	**Explanation**	**Effective Program Year**
	b. Measure 3 – Test 6. Electronic Notes 7. Imaging Results 8. Family Health History 9. eMAR 10. Structured Labs to Ambulatory Providers 11. Advanced Directives	

Documentation Requirement Changes

Based on the evaluation of the regulatory changed defined in the Modified Stage 2 final rule, DHCFP concluded that the existing documentation requirements sufficiently corroborate the provider attestation for the respective measures. *Table 24. Supplemental Documentation Requirements* presents the supplemental documentation requirements for each objective based on Eligible Provider type.

Table 24. Supplemental Documentation Requirements

Modified Stage 2 Objective	EP Doc Req'd?	EH Doc Req'd?
Objective 1: Protect Electronic Health Information	Y	Y
Objective 2: Clinical Decision Support	Y	Y
Objective 3: CPOE	N	N
Objective 4: Electronic Prescribing	N	N
Objective 5: Health Information Exchange	Y	Y
Objective 6: Patient Specific Education	N	N
Objective 7: Medication Reconciliation	N	N
Objective 8: Patient Electronic Access (VDT)	N	N
Objective 9: Secure Messaging	N	N/A
Objective 10: Public Health	Y	Y

Additional documentation may be requested for all Meaningful Use Objectives and Measures during post-payment audit. DHCFP will not impose any documentation requirement for Eligible Providers to validate their "intent" when exercising the alternate exclusion based on "they did not plan to attest to a Menu Objective."

Additional Changes in Program Years 2016 and 2017
On November 14, 2016, CMS published the Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record Incentive Programs; Payment to Non-excepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital in the Federal Register. The CMS EHR Incentive Program website contains a concise outline of the changes for 2016 and 2017.

An overview of the OPPS final rule changes for the EHR Incentive Programs is available.

Changes to specific MU objectives for EPs are outlined in Table 23 and for EHs in Table 24 above. Additional changes include:

EHR Reporting Period

- For all returning participants, the EHR reporting period will be a minimum of any continuous 90-day period between January 1, 2016 and December 31, 2016 for program year 2016. The EHR reporting period will be a minimum of any continuous 90-day period between January 1, 2017 and December 31, 2017 for program year 2017.
    - All returning providers that have successfully attested to MU at least once will attest to a 90-day reporting period for CQMs in program year 2016 and a 365-day reporting period for CQMs for program year 2017.
- For EPs, EH, and CAHs that have not successfully demonstrated Meaningful Use in a prior year, the EHR reporting period is any continuous 90-day period between January 1 and December 31, 2016.
    - For all EPs, EH, and CAHs that choose to report CQMs by attestation in 2016, the reporting period will be 90-days
    - No new attestations for EPs, EHs, CAHs that have not successfully attested to either AIU or MU prior to program year 2017 will be allowed to attest. Program Year 2016 is the last year for providers to participate in the Medicaid EHR Incentive Program.

EH and CAH Payment in the Prior Year
EHs and CAHs will not be allowed to attest in program year 2017 or in subsequent program years if a payment was not received in 2016.

Stage 3 Meaningful Use
Beginning in 2017, NEIPS will allow EPs, EHs and CAHs to choose to attest to Stage 3 Objectives and Measures, if ready to attest to Stage 3 with a 2015 Edition CEHRT. NEIPS will verify the ONC CHPL ID when the provider begins and attestation.

In 2018, all EPs, EHs and CAHs will be required to attest to Stage 3 Objectives and Measures only. Any changes made to the Stage 3 guidelines between the update of this SMHP and the beginning of the 2018 program year will be reflected in future addendums or updates.

Stage 3 Objectives for EPs include:

- Protect Patient Health Information

- Electronic Prescribing (eRx)
- Clinical Decision Support
- Computerized Provider Order Entry (CPOE)
- Patient Electronic Access to Health Information
- Coordination of Care through Patient Engagement
- Health Information Exchange
- Public Health and Clinical Data Registry Reporting

Stage 3 Objectives for EHs and CAHs include:

- Protect Patient Health Information
- Electronic Prescribing (eRx)
- Patient Electronic Access to Health Information
- Coordination of Care through Patient Engagement
- Health Information Exchange
- Public Health and Clinical Data Registry Reporting

Privacy Regulatory Changes
On an ongoing basis DHHS ensures the state's HIT efforts, including the EHR Incentive Program, are aligned and fostering stakeholder compliance with appropriate state and federal privacy and security provisions and industry standards.

Early in 2013 final omnibus amendments to the Privacy, Security, Breach Notification and Enforcement Rules of the Health Information Portability and Accountability Act (HIPAA) were issued, as directed by the HITECH Act of 2009. DHHS is working to assess its internal operations to ensure full compliance.

Recent Changes in State Laws and Regulations
At this time, no state laws or regulations have been identified that will impact the continued operation of the Incentive Program, and no new laws are currently anticipated as a result.

C.10. SMA Proposal of Permissible Changes for Meaningful Use

SMHP Companion Guide Question C #10

Permissible Changes to the Meaningful Use Definition
DHCFP does not alter the definition of Meaningful Use objectives/measures as allowed in the Final Rule.

Program Year "Tail End" Period
Typically, a "tail end" period for the Nevada Medicaid EHR Incentive Program is 90 days past the end of the calendar year. For example, with a December 31 deadline and 90-day "tail end period", providers would have until March 31 to submit attestations. In previous program years, DHCFP has been granted extensions as needed.

Specifically for program year 2016, DHCFP was granted a longer tail end period to accommodate any new EPs and EHs. All program year 2016 attestations will have a September 30, 2017, deadline. The extended tail end period was approved by CMS on March 17, 2017, via email. Those providers actively engaged with DHCFP will be allowed to complete their attestations past September 30, 2017.

C.11. SMA Verification of Providers' Use of CEHRT

SMHP Companion Guide Question C#11

The process for verifying a provider's use of CEHRT is outlined, in detail, in Section C.8.

C.12. SMA Collection of Meaningful Use and ECQM Data

SMHP Companion Guide Question C #12

CGI Group, Inc. was chosen as the attestation vendor for implementation, operation, program outreach, partial audit and support of the Medicaid EHR Incentive Program in Nevada. With the most recent IAPD-U) for the EHR Incentive Program, the contract between DHCFP and CGI has been extended through June of 2019.

Recent estimates indicate that 1,500 providers meet the Medicaid patient volume requirement and 1,000 will apply and receive payments. The extension of the contract will not only allow CGI to continue the work as the Attestation Vendor, but will supplement activities that will encourage provider participation prior to the program year 2016 cutoff. These activities may include webinars, targeted outreach, and identifying potentially eligible Medicaid providers.

State Level Registry

CGI implemented the SLR for Nevada, the Nevada EHR Incentive Payment System (NEIPS) in August 2012. NEIPS is the Nevada-configured version of the CGI Medicaid Incentive 360® (MI360) product. Having the capability to record Meaningful Use objectives and measures, in addition to Clinical Quality Measures (CQM), NEIPS consists of the following primary components:

- **Provider Portal** – Web-based application used by providers to pre prepare and submit Medicaid EHR Incentive Program attestations;
- **Business Services Portal** - Web-based application used by the state Medicaid agencies, and/or their agents, to administer the Medicaid EHR Incentive Program including pre-payment reviews, data reporting, metric dashboards and reporting (Meaningful Use and CQM), payment approval processing, appeal management and access control;
- **Hosting Services** - NEIPS is operated as a hosted, Software as a Service offering for the participating states. Each state's NEIPS implementation has a dedicated partition with a separate instance of the configured software application as well as segregated data storage;
- **Business Services Center** - The NEIPS EHR Incentive Program Support provides business operation support for the provider community as well as the client state Medicaid department. The NEIPS Specialists support the participating provider through live phone as well as email support. The Program Specialists are extensively trained on the overall

Program rules and regulations, as well as the unique regulation implementations defined by each state. Questions for program specialists regarding NEIPS can be directed to NV_Support@NVEHRSupport.com; and

- **Integration Services** - NEIPS provides multi-level integration with external stakeholder information systems, including state Medicaid MMIS, Office of National Coordinator of Healthcare Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS).Integration is supported through Single-Sign-On (SSO), web-services as well as secured batch file exchange protocols.

Short Term vs. Long Term Data Collection Approaches
DHCFP's plan and execution for the EHR Incentive Program does not include more than 1 approach.

C.13. Data Collection Alignment with Other CQM Data

SMHP Companion Guide Question C #13

DHHS was not a CHIPRA, HIT-related grant recipient. In addition, Nevada received a data warehouse Medicaid Transformation Grant; however, the State did not execute the grant and returned the funding.

Currently, CQM collection is available with NEIPS and collected annually as providers attest to Meaningful Use.

DHCFP recognizes the need to have a plan for the existing CQM data captured in the SLR along with other sources of quality data and plans to utilize this data for analytic efforts. In addition, QRDA III data is available in the HIE and, as outlined in the SHSIP, the data will be used for population health efforts.

C.14. IT, Fiscal and Communication Systems That Will Support Implementation of the EHR Implementation Program

SMHP Companion Guide Question C #14

IT Systems
The IT Systems for the EHR Incentive Program are outlines in Section C.12.1. State Level Registry

Fiscal Systems
DHCFP plans to use the current MMIS system and current communications channels for implementation of the EHR Incentive Program. The State's Integrated Financial System is being used to issue incentive payments. Incentive payments, once approved and released in NEIPS, are included in weekly provider run files through MMIS. The payment file is uploaded into Advantage Financial for approval of the journal vouchers allowing funds to be transferred into the liability account for payments from the State's account.

Communication Systems
DHCFP has a toll-free phone number dedicated to the EHR Incentive Program along with a number for CGI's call center for any technical support with the MI360 State Level Registry (SLR), Nevada's registration and attestation system for the EHR Incentive Program. CGI also has the capability to

send out fax blasts to providers as needed to communicate deadlines, program announcements and reminders. Communicating by fax still proves to be an effective method for communication with Nevada providers.

Finally, DHCFP has an email inbox dedicated to the EHR Incentive Program and health IT (NevadaHIT@dhcfp.nv.gov) in addition to the EHR Incentive Program Support email (NV_Support@NVEHRSupport.com) managed and monitored by CGI.

C.15. SMA IT System Changes Needed to Implement the EHR Incentive Program

SMHP Companion Guide Question C #15

No new system changes are required for the continued management of the EHR Incentive Program. Required system changes due to changes in the Meaningful Use stage definitions is discussed in Section C.16 SMA Timeframe for Systems Modifications.

C.16. SMA Timeframe for Systems Modifications

SMHP Companion Guide Question C #16

The initial configuration of the CGI Medicaid Incentive 360® (MI360) solution for Nevada in 2012 has been updated continually to support the program regulatory evolution. Major modifications were made to support the initial two stages of Meaningful Use and the Modifications of the rule in late 2015 and modifications will continue to address Meaningful Use stage and program changes.

C.17. Interface Testing with CMS National Level Repository

SMHP Companion Guide Question C #17

At the opening of the Medicaid EHR Incentive Program in 2012, Nevada EHR Incentive Program System (NEIPS) product was ready to transmit data to CMS and allow CMS to transmit data to NEIPS, according to established schedules.

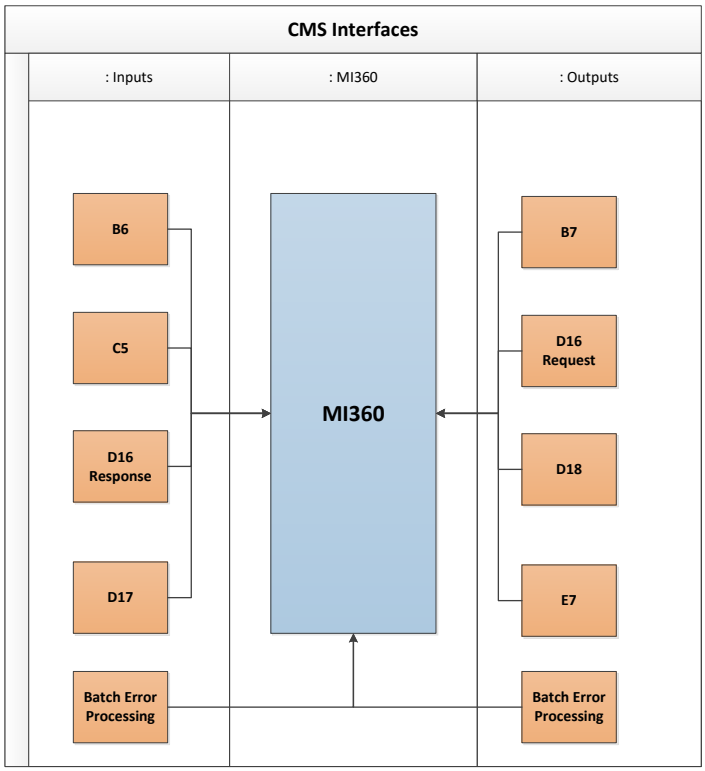
C.18. SMA Acceptance of Medicaid Provider NRL Registration Data

SMHP Companion Guide Question C #18

CMS Interfaces

The Nevada EHR Incentive Program System (NEIPS) transmits data to CMS and CMS transmits data to NEIPS, according to established schedules. *Figure 22. CMS Interfaces* summarizes the CMS interfaces.

Figure 22. CMS Interfaces



CMS has identified the following six batch interface services to facilitate the required data exchanges with CMS NLR system for NLR ID verification, duplicate payment check and for program cost reporting:

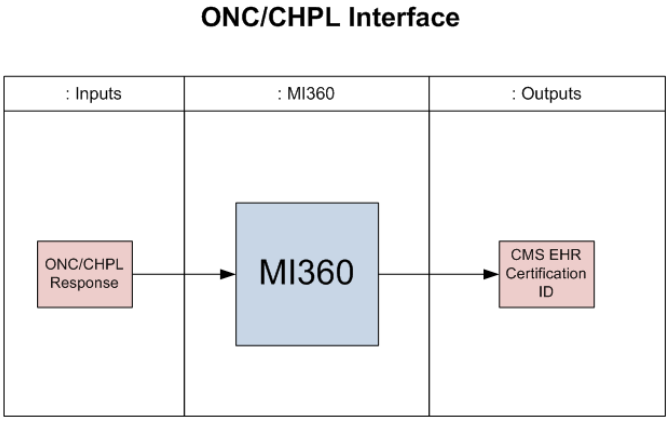
- B6 – Provider Registration Interface: the date that the provider was last added or updated in the CMS EHR Incentive.
- C5 – Dually Eligible Hospital Attestation.
- D16 Request/Response – Duplicate Payment/Exclusion Check: a confirmation that the batch transaction was received.
- D17 – Dually Eligible Hospital Cost Report.
- B7 – Provider Registration: this transaction can be resent as either an eligible or an ineligible B7. If the status is Not Eligible, a reject reason will be required.
- D18 – Incentive Payment Data: this transaction can only be resent if the attestation application has a status that indicates payment has been made by the State, and only if SLR gets no response from CMS.
- E7 – States/NLR Audit Data: the E7 batch transmission is sent any time there is a change in the status of an Audit being performed on the provider.

These interfaces have been tested with CMS and are readily available for any state implementation, including Nevada. In addition, the E7 – States/NLR Audit Data interface provides auditability of payment information, data changes, and user updates to support the required federal and state audits.

ONC Interface

NEIPS interfaces with the ONC Certified HIT Product List (CHPL) to verify an Eligible Provider-entered EHR Certification ID by sending a Certification ID to CHPL. CHPL will return a Yes/No to indicate whether or not the Certification ID is a current, valid Certification ID. (*Figure 23. ONC/Certified HIT Product List Interface*)

Figure 23. ONC/Certified HIT Product List Interface



State Interfaces

The Nevada MMIS and the two MCOs provide input into the NEIPS solution. Examples include, but are not limited to:

- MMIS Interfaces
  - Provider Demographics
  - Provider Group
  - Payment Error
  - Payment Confirmation
  - Payment Request
- EP Encounters: Interfaces are currently established with Nevada MCOs Amerigroup and United Healthcare (Health Plan of Nevada). State interfaces will be established with two additional MCOs, Silver Summit (Centene) and Aetna by July 1, 2017.
- EH Claims: An interface with Truven Health Analytics is used to transmit Eligible Hospital claims data.

C.19. SMA Website Development for Medicaid Provider Engagement

SMHP Companion Guide Question C #19

The EHR Incentive Program – dedicated DHCFP website is described in detail in Appendix E, Electronic Health Records Incentive Program Communication Plan.

C.20. SMA Anticipation of Modifications to MMIS

SMHP Companion Guide Question C #20)

The top priority area identified as part of the State's 2013 MITA SS-A was modernization of the State's MMIS system. The project commenced early 2014 with MMIS supporting services implementation and certification anticipated by June 2018 due to the submission and subsequent approval of the DHCFP Core Medicaid Management Information System Modernization Project, Implementation Advance Planning Document dated December 2015.

A more detailed description of the project is outlined in Section A.8 Medicaid Management Information System HIT/HIE Environment.

C.21. SMA Provision of a Help Desk

SMHP Companion Guide Question C #21

Attestation system vendor, CGI is responsible for performing provider enrollment, customer service, help desk support and maintenance of the State Level Registry (SLR), the Nevada EHR Incentive Payment System (NEIPS).

Additional resources for providers are outlined in Appendix E, Electronic Health Records Incentive Program Communication Plan.

C.22. SMA Provision for Provider Appeal Regarding Eligibility, Payment, AIU

SMHP Companion Guide Question C #22

The Nevada EHR Incentive Program Support is operated by CGI Business Service Center (BSC) Representatives who will process first and second level appeals in the NEIPS system.

A first level appeal is considered the provider's first appeal of a specified eligibility decision in the system. The NEIPS Support Manager will assign a NEIPS Support Representative to work the first level appeal.

The second level appeal is considered the appeal of a previously denied eligibility appeal by the provider (an escalated appeal within the NEIPS Support Process). The NEIPS Support Manager will assign these appeals to a NEIPS Support Representative – the Representative assigned to the first level appeal cannot be assigned to the second level appeal. Upon denial of the second level appeal, the Notice of Denial document will be emailed to the provider by the NEIPS Support Representative.

Policy questions, clarification, any program eligibility questions the NEIPS Support Representative may have or need in regards to the processing of the appeal will be directed to the NEIPS Support Manager. If further clarification is required, the NEIPS Support Manager will then follow the established DHCFP Point of Contact Process established for the EHR Incentive Program.

NEIPS Support questions regarding the DHCFP / DHHS process for handling denied appeals, issuing the Notice of Denial, handling additional appeals following two (2) denials, hearing packet assembly and delivery, Notice of Denial templates, etc. will be directed to DHCFP Point of Contact

by the NEIPS Support Manager. The DHCFP Point of Contact will address policies and procedures to be established.

C.23. SMA Accounting for Separation of HITECH and FFS Funds

SMHP Companion Guide Question C #23

DHCFP consistently meets all of the CMS reporting requirements for the EHR Incentive Program through the various reporting tools. DHCFP submits program participation data to CMS including:

- 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 Provider's Meaningful Use and CQM data.

CMS Required Financial Reporting

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

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% 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% 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.

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 registrations rejected
- Call center statistics

C.24. SMA Anticipated Frequency of EHR Incentive Payments

SMHP Companion Guide Question C #24

Payments for EPs in the Medicaid EHR Incentive Program are set payments based on the first year. The Nevada EHR Incentive Program started accepting AIU attestations in 2012. EPs are eligible to receive up to six payments for a maximum total of $63,750.00. The Nevada Incentive Program does allow EPs to skip attestation years if necessary with the understanding that a maximum of six payments will be made before the end of the program in 2021.

Incentive payments are typically made on a weekly basis and within 45 days of the attestation passing the pre-payment verification process. If an attestation is placed on hold for any reason during the pre-payment verification, the payment time line will be delayed.

Table 25. Medicaid EHR Incentive Payments by Calendar Year below illustrates the maximum Medicaid EHR incentive payments an EP can receive by year and the total incentive payments possible if an EP qualifies each year.

Table 25. Medicaid EHR Incentive Payments by Calendar Year

Year	Medicaid EPs Who Began Participation In					
	2011	2012	2013	2014	2015	2016
2011	$21,250.00					
2012	$8,500.00	$21,250.00				
2013	$8,500.00	$8,500.00	$21,250.00			
2014	$8,500.00	$8,500.00	$8,500.00	$21,250.00		
2015	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$21,250.00	
2016	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00	$21,250.00
2017		$8,500.00	$8,500.00	$8,500.00	$8,500.00	$8,500.00
2018			$8,500.00	$8,500.00	$8,500.00	$8,500.00
2019				$8,500.00	$8,500.00	$8,500.00
2020					$8,500.00	$8,500.00
2021						$8,500.00
Total	**$63,750.00**	**$63,750.00**	**$63,750.00**	**$63,750.00**	**$63,750.00**	**$63,750.00**

Source: CMS Medicaid Electronic Health Record Incentive Payments for Eligible Professionals, Updated May 2013

Please note, the total for pediatricians who meet the 20% patient volume but fall short of the 30% patient volume is $14,167.00 in the first year and $5,667.00 in subsequent years for a maximum Medicaid EHR Incentive Program payment of $42,500.00 over a six-year period.

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.

Coordination with Medicare to Verify Payment and Avoid Duplicate Payments

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 CMS R&A. The CMS R&A 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.

Eligible Hospitals Payment Calculation

The Nevada Incentive Program pays the aggregate EH incentive payment amount over a period of three years, with no more than one payment per program year for those EHs that successfully attest to AIU and Meaningful Use.

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 pays 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%. Based on hospital data entered during registration, NEIPS will calculate the total EH Medicaid EHR incentive payment amount and DHCFP will verify the accuracy of the calculation through auditable data sources. The hospital must enter (1) four consecutive years of discharge data, (2) acute Medicaid Days for one year, (3) acute Medicaid HMO days for one year, (4) acute Total Days for one year, (5) Hospital Charges for one year, and (6) Charity Care Charges for one year into the State's system. The aggregate EH payment amount is calculated based on an Overall EHR Amount times a Medicaid Share.

Overall EHR Amount

The Overall EHR 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 1,150th through the 23,000th discharge for the first payment then a pro-rated amount of 75% percent in year 2, 50% in year 3, and 25% in year 4. For years 2-4, the rate of growth is assumed to be the previous three years' average. If a hospital's rate of growth is negative over the three year period, it will be applied as such.

Medicaid Share

The "Medicaid Share," which is applied against the Overall EHR Amount, is essentially the percentage of a hospital's 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 inpatient-bed-days; and
- The estimated number of Medicaid managed care inpatient-bed-days.

The denominator of the Medicaid Share is the product of:

- The estimated total number of inpatient-bed-days for the EH 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 inpatient hospital services only and exclude any professional charges associated with the inpatient stay.

Note that 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.

Data Sources

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.

Detailed EH Calculation

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

1. Obtain EH inpatient discharge data based on the hospital fiscal year that ends during the federal fiscal year (FFY) prior to the first payment year (base year) and the three hospital fiscal years prior to the base year.

    - Year 1 data reflects inpatient discharges over a 12-month period ending in the Federal Fiscal Year before the hospital's fiscal year that serves as the first payment year;
    - Inpatient discharge data should be based upon total discharges regardless of any source of payment; and
    - Labor & Delivery days may be included in Medicaid Inpatient Days FFS when reported in a separate Medicare Cost Report line item if the days are included as part of the hospital's acute level of care.

      EXAMPLE:
      Year 1 discharges = 2,000
      Year 2 discharges = 1,957
      Year 3 discharges = 1,909
      Year 4 discharges = 1,878

2. Using the discharge data from base year (from #1), calculate the annual growth rates for Years 2 through 4:

    - Year 2 = discharges in base year / discharges in Year 2
    - Year 3 = discharges in Year 2 / discharges in Year 3
    - Year 4 = discharges in Year 3 / discharges in Year 4

      EXAMPLE:
      Year 2 = 2,000 / 1,957 = 1.022 = .022 annual growth rate
      Year 3 = 1,957 / 1,909 = 1.025 = .025 annual growth rate
      Year 4 = 1,909 / 1,878 = 1.017 = .017 annual growth rate

3. Using the growth rates from Years 2 through 4 (from #2), calculate the average annual growth rate factor. This factor will be applied in #4 even if it is negative.

    - (Growth rate Year 2 + growth rate Year 3 + growth rate Year 4) / 3

      EXAMPLE:
      .022 + .025 + .017 = .064 growth rates of Years 2 - 4
      .0639 / 3 = .0212 average annual growth rate factor

4. Using the discharges from base year (from #1) and average annual growth rate factor (from #3), calculate the average annual growth rate for Years 2 through 4

    - Year 2 = (number of discharges in Year 1 * average annual growth rate factor) + number of discharges in Year 1

- Year 3 = (Year 2 calculated amount * average annual growth rate factor) + Year 2 calculated amount)
- Year 4 = (Year 3 calculated amount X average annual growth rate factor) + Year 3 calculated amount)

EXAMPLE:
Year 2 = (2,000 * .0212) + 2,000 = 2,042.42
Year 3 = (2,042.42 * .0212) + 2,042.42 = 2,085.73
Year 4 = (2,085.73 * .0212) + 2,085.73 = 2,129.96

5. Using the discharges for the base year (from #1) and the average annual growth rates for Years 2 through 4 (from #4), calculate the discharge related amount for Years 1 through 4. An additional $200 is paid for discharges between 1,150 and 23,000.

- Base year = if number of discharges is between 1,150 and 23,000, use this formula: (base year number of discharges – 1,149) * 200; otherwise, use number of discharges for the base year only
- Year 2 = if number of discharges is between 1,150 and 23,000, use this formula: Year 2 average annual growth rate – 1,149) * 200; otherwise, use Year 2 average annual growth rate only
- Year 3 = if number of discharges is between 1,150 and 23,000, use this formula: (Year 3 average annual growth rate – 1,149) * 200; otherwise, use Year 3 average annual growth rate only
- Year 4 = if number of discharges is between 1,150 and 23,000, use this formula: (Year 4 average annual growth rate – 1,149) * 200; otherwise, use Year 4 average annual growth rate only

EXAMPLE:
Year 1 = (2,000 - 1,149) * 200 = 170,200
Year 2 = (2,042 - 1,149) * 200 = 178,683
Year 3 = (2,086 - 1,149) * 200 = 187,346
Year 4 = (2,130 - 1,149) * 200 = 196,193

6. Using the discharge related amount for Years 1 through 4 (from #5), calculate the initial amount with transition factor for Years 1 through 4

- Year 1 = ($2,000,000 + Year 1 discharge related amount) * 1
- Year 2 = ($2,000,000 + Year 2 discharge related amount) * .75
- Year 3 = ($2,000,000 + Year 3 discharge related amount) * .50
- Year 4 = ($2,000,000 + Year 4 discharge related amount) * .25

EXAMPLE:
Year 1 = ($2,000,000 + $170,200) * 1 = $2,170,200
Year 2 = ($2,000,000 + $178,800) * .75 = $1,634,012
Year 3 = ($2,000,000 + $187,600) * .50 = $1,093,673
Year 4 = ($2,000,000 + $196,400) * .25 = $549,048

7. Using the initial amount with transition factor for Years 1 through 4 (from #6), calculate the overall EHR amount

   - (Year 1 Initial Amount With Transition Factor + Year 2 Initial Amount With Transition Factor + Year 3 Initial Amount With Transition Factor + Year 4 Initial Amount With Transition Factor)

     EXAMPLE:
     ($2,170,200 + $1,634,012 + $1,093,673 + $549,048) = $5,446,933

8. Obtain one year of hospital-submitted inpatient bed-days data from the same time period used to obtain the discharge data (i.e., the base year) to calculate the Medicaid share numerator.

   - Numerator = for a 12-month period, the number of Medicaid inpatient bed days + the number of Medicaid managed care inpatient bed days (not including CHIP)
   - In the absence of data for individuals enrolled in a managed care organization, pre-paid inpatient health plan, or pre-paid ambulatory health plan, the amount is deemed to be 0
   - Data may not include inpatient-bed-days attributable to individuals with respect to whom payment may be made under Medicare Part A, or inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C
   - Nursery (excluding neonatal intensive care unit, i.e., NICU), observation, psychosis (if in distinct part unit), rehabilitation (if in distinct part unit), skilled nursing, swing bed, and hospice are not included in inpatient bed-day or discharge counts in calculating hospital incentives.

     EXAMPLE:
     Base year Medicaid inpatient bed-days = 7,000

9. Calculate the Medicaid share denominator

   - Denominator = total number of inpatient-bed-days for the hospital during the same 12-month period as the numerator * [(the total amount of the hospital's charges during the same period - any charges that are attributable to charity care) / the total amount of the hospital's charges during the same period];
   - In the absence of data for [(the total amount of the hospital's charges during the 12-month period - any charges that are attributable to charity care) / the total amount of the hospital's charges during the period], the amount is deemed to be 1;
   - The estimated total charges and charity care charges amounts must preclude any professional charges associated with the stay.
   - Nursery (excluding neonatal intensive care unit, i.e., NICU), observation, psychosis (if in distinct part unit), rehabilitation (if in distinct part unit), skilled

nursing, swing bed, and hospice are not included in inpatient bed-day or discharge counts in calculating hospital incentives.

- For Hospital Charges and Hospital Cost data used in the Medicaid Share calculation, nursery (including NICU), observation, psychosis, rehabilitation, skilled nursing, swing bed, and hospice are included in the hospital charges or hospital cost counts because they reflect the total amount of the eligible hospital's charges.
- Charity care charges are an initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria for care delivered for the entire facility as defined in the CMS Hospital Medicare Cost Report. EHs may use their most recently filed Medicare Cost Report to document charity care charges. This report must reflect the same reporting period used to determine the Medicaid EHR incentive program payment.
- 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.

  EXAMPLE:
  Year 1 total bed days = 21,000
  Charity care = $1,300,000
  Total charges = $10,000,000
  Total charges excluding charity care = $10,000,000 - $1,300,000 = $8,700,000
  21,000 * ($8,700,000 / $10,000,000) = 18,270

10. Using the Medicaid share numerator (from #8) and the Medicaid share denominator (from #9), calculate the Medicaid share:
    - Medicaid share = Medicaid share numerator / Medicaid share denominator

      EXAMPLE:
      7,000 / 18,270 = 38.31%

11. Using the overall EHR amount (from #7) and the Medicaid share (from #10), calculate the aggregate EHR amount:
    - Aggregate EHR amount = overall EHR amount * Medicaid share

      EXAMPLE:
      $5,446,933 * 38.31% = $2,086,947.51

C.25. SMA Verification of Payment to Provider without Deduction or Rebate

(SMHP Companion Guide Question C #25

When registering for the Medicaid EHR Incentive Program, Eligible Professionals 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 EP'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.

C.26. SMA Verification Payments to Entities Supporting Adoption of CEHRT

SMHP Companion Guide Question C #26

The CMS Companion Guide Checklist v2.0 does not require Section C26 for an SMHP update. See Section C25 for the State's current process on verifying payments to entities supporting the adoption of CEHRT.

C.27. SMA Process of Fiscal Arrangements for Payment Disbursement

SMHP Companion Guide Question C #27

The CMS Companion Guide Checklist v2.0 does not require this section for an SMHP update. According to the State's response in the 2011 Nevada SMHP, DHCFP does not directly contract or enroll managed care providers, therefore, the calculation of Managed Care capitation rates is not required.

C.28. SMA Verification of Calculation and Payment Incentives are Consistent with Statue and Regulation

(SMHP Companion Guide Question C #28

As outlined in the comments in Appendix C of the 2011 Nevada SMHP (Section C, Question 25), this is no longer required and is not applicable as per the Medicare and Medicaid Extenders Act of 2010.

C.29. Role of SMA Contractors in Implementing the EHR Incentive Program

SMHP Companion Guide Question C #29

Outreach to and communication with Eligible Providers is critical to participation in and success of the Nevada EHR Incentive Program. The EHR Incentive Program Manager, in partnership with CGI, is responsible for outreach to Eligible Providers communicating prior, during, and after each program

year. The Program Manager provides oversight of all outreach activities performed by DHCFP and CGI including topics on Nevada EHR Incentive Payment System (NEIPS), eligibility requirements as well as education on Meaningful Use using various communication tools. In addition, HealthInsight served as the Regional Extension Center (REC) for Nevada and Utah and, although they no longer provide REC-like services to Medicaid Eligible Providers, they do assist any previous REC participant with program, regulation, and policy questions.

Additionally, CGI's Business Service Center (BSC) Agents will conduct a call campaign for all providers (EPs and EHs) that have participated previously and have not yet started a 2016 attestation or have started one and are currently "In Progress." All calls and follow-up will be tracked and logged in the Contact Log in NEIPS. BSC Agents will reach out to providers no less than three times over the course of three weeks and, when contact is made, BSC Agents will offer assistance with the attestation process.

In addition to the call campaign, a mass mailing template will be created by CGI and approved by DHCFP for EHs that will inform about program year deadlines, the inability to skip program years, and the CMS attestation grace period end date with a reminder that all dually-eligible hospitals must attest at the federal level prior to the state level.

C.30. Description of SMA Assumptions, Path, Training and Planning Dependencies

SMHP Companion Guide Question C #30

The EHR Incentive Program was implemented in 2012 and there are no current changes. The State's plan continues to include the following assumptions as well as dependencies:

- Assumptions:
    - CMS will update, implement, and test the CMS Registration and Attestation system as necessary, and
    - The NEIPS system will be updated, implemented, and tested as necessary.
- Dependencies:
    - Timely updates to NEIPS is dependent on the availability of updated standards as described by CMS, and
    - Vendor updates to CEHRT for the 2015 Edition standards.

Section D. The State's Audit Strategy

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 NEIPS. DHCFP will coordinate oversight activities with the Audit Unit. Pre-payment verification and post-payment audits are conducted by the Audit Unit.

DHCFP sent an updated 2014 Audit Strategy document to CMS on February 11, 2015 as a separate stand-alone document. At the date of this SMHP update, DHCFP is working on an updated Audit Strategy to be submitted to CMS in early 2017.

D.1. SMA Methods to Avoid Improper Payments

(SMHP Companion Guide Question D #1

Upon attestation completion (Confirm and Submit), Provider enrollment is set to "Payment Pending". At that time, the following processes occur:

1. Pre-payment Review

   All pre-payment review and will be asked to provide additional information to support their attestation volumes and documentation proving they have adopted, implemented or upgraded (AIU) to certified EHR technology.

   DHCFP may request the following:
   - Payer-mix report and/or;
   - Detailed report showing all encounters and/or;
   - Any additional documents as deemed necessary by the reviewer including, but not limited to signed contracts, invoices, or purchase agreements to validate AIU attestation.

   Once the provider has successfully passed through the pre-payment review, State level checks (Provider and Payee Checks) are performed.

2. Provider Check

   The provider is checked to determine if any state exclusions/sanctions have been applied since the attestation. If any exclusions and/or sanctions exist, the provider is set to "Not Eligible" and the process is stopped.

3. Payee Check

   The payee is checked to determine if any state exclusions/sanctions have been applied since the attestation. If any exclusions and/or sanctions exist, provider is set back to "In Progress" and sent an email stating they need to select a new payee either with CMS or in NEIPS (if another matching enrollment for the NPI/TIN combination is active) prior to receiving payment.

4. Payment Approval Queue

The State reviews providers who have successfully been passed through the above processes and approves them for payment. The provider and payee are evaluated against State Sanction/Exclusion data again to ensure no changes have occurred while sitting in the payment queue.

5. Federal Payment Check

A request for payment review is sent to CMS. CMS will deny request if:

- Provider is federally sanctioned;
- Provider is participating in the Medicare program and is not a dually eligible hospital;
- An Eligible Provider (EP) has been paid for the same program year by another state; and/or;
- Provider's registration record is NOT "Active" with CMS.

If the provider enters the CMS site to review their registration, their registration resets to "In Progress". The State cannot pay a provider whose status is "In Progress" within the CMS system. The provider must remember to confirm all changes before they exit the CMS portal – even if no changes are made.

6. State Payment Request

Payment request is sent to the State's MMIS system where it passes through validation edits. If the payee is valid, the payment request is processed based on the State defined payment cycle. Upon confirmation of the request acceptance from the MMIS payment system, the provider is set to "Paid" status and payment confirmation is sent to CMS (D18).

7. Payment Disbursement

The State issues payment only after all of the above checks and reviews have been passed. The Provider should expect their incentive payment within 45 days following the completion of above reviews and checks.

D.2. SMA Methods Employed to Identify Fraud and Abuse

SMHP Companion Guide Question D #2

DHCFP will be submitting an updated Audit Strategy to CMS in early 2017. The question referring to methods employed to identify fraud and abuse will be addressed in the update.

D.3. SMA Tracking of Overpayments

SMHP Companion Guide Question D #3

DHCFP will be submitting an updated Audit Strategy to CMS in early 2017. The question referring to methods employed to track overpayments to providers will be addressed in the update.

D.4. SMA Process for Managing Detection of Fraud and Abuse

SMHP Companion Guide Question D #4

In the event the auditor suspects fraud or abuse associated with the EHR program or with provider claims billings during the course of a review or audit, DHCFP will follow the current federal requirements as stated in 42 CFR Part 456.23, as well as procedures established by the State. Under existing procedures, the DHCFP Surveillance, Utilization and Review (SUR) Unit, will be notified of the details in writing. The DHCFP SUR Unit performs an initial review, and if it is determined there is a possible fraud or abuse, the SUR unit refers the case to the Medicaid Fraud Control Unit (MFCU) in Nevada's Attorney General's Office.

D.5. SMA Intent Regarding Leveraging Existing Data Sources for Verification of Meaningful Use

SMHP Companion Guide Question D #5

DHCFP will be submitting an updated Audit Strategy to CMS in early 2017. The question referring to DHCFP's intent regarding leveraging existing data sources for verification of Meaningful Use will be addressed in the update.

D.6. SMA Use of Sampling as Part of Its Audit Strategy

SMHP Companion Guide Question D #6

DHCFP will be submitting an updated Audit Strategy to CMS in early 2017. The question referring to the use of sampling as part of DHCFP's audit strategy will be addressed in the update.

D.7. SMA Methods to Relieve Provider Burden and Maintain Integrity and Efficacy of the Oversight Process

SMHP Companion Guide Question D #7

DHCFP will be submitting an updated Audit Strategy to CMS in early 2017. The question referring to methods to relieve provider burden and maintain integrity and efficacy of the oversight process will be addressed in the update.

D.8. Program Integrity Operations Locations

SMHP Companion Guide Question D #8

DHCFP will be submitting an updated Audit Strategy to CMS in early 2017. The question referring to program integrity operations locations will be addressed in the update.

Section E. The State's HIT Roadmap

E.1. SMA Graphical/Narrative Pathway from "As-Is" to "To-Be"

SMHP Companion Guide Question E #1

"As-Is" and "To-Be" Pathway

Over the next five years, as *Figure 24. Nevada's AS-IS to To-Be Pathway, 2017-2021* and *Figure 25. Nevada's Health IT Development History and Planned Initiatives* depicts, the Nevada Medicaid agency is anticipating that nearly 100% of all EPs and non-EPs (as applicable) will be using an EHR with nearly 80 percent of them accessing interoperable HIE. At this degree of HIT deployment, the agency will focus on three areas:

1. Almost 100 percent adoption and use of EHR by EPs and other Medicaid providers
2. Building a robust HIT/HIE infrastructure in Nevada with interoperable system connections (pharmacies, clinical laboratories, public health providers), as well as vital HIE architecture components such as provider directories, care plan exchange, event alerting, public health registries, and more.
3. Implementing an Master Data Management (MDM) Solution comprised of a comprehensive data governance program, enterprise data warehouse, decision support services, and business intelligence tools with capabilities to integrate and transform clinical data from the HIE network and claims data to present providers and policy makers with information and insights to improve Medicaid and other state programs, delivery of health care-related services, beneficiary health outcomes, and reduce health care costs.

Figure 24. Nevada's AS-IS to To-Be Pathway, 2017-2021

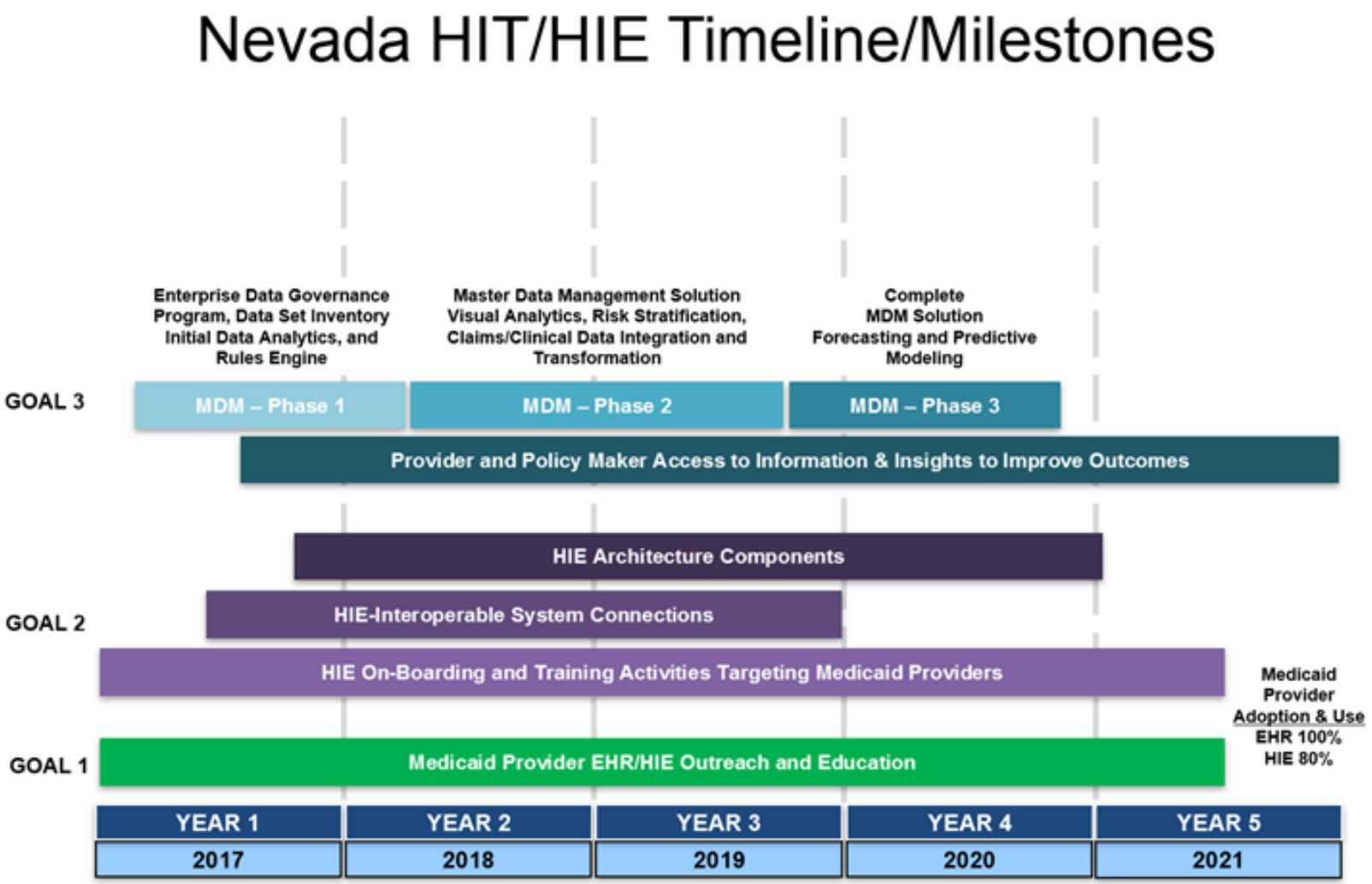
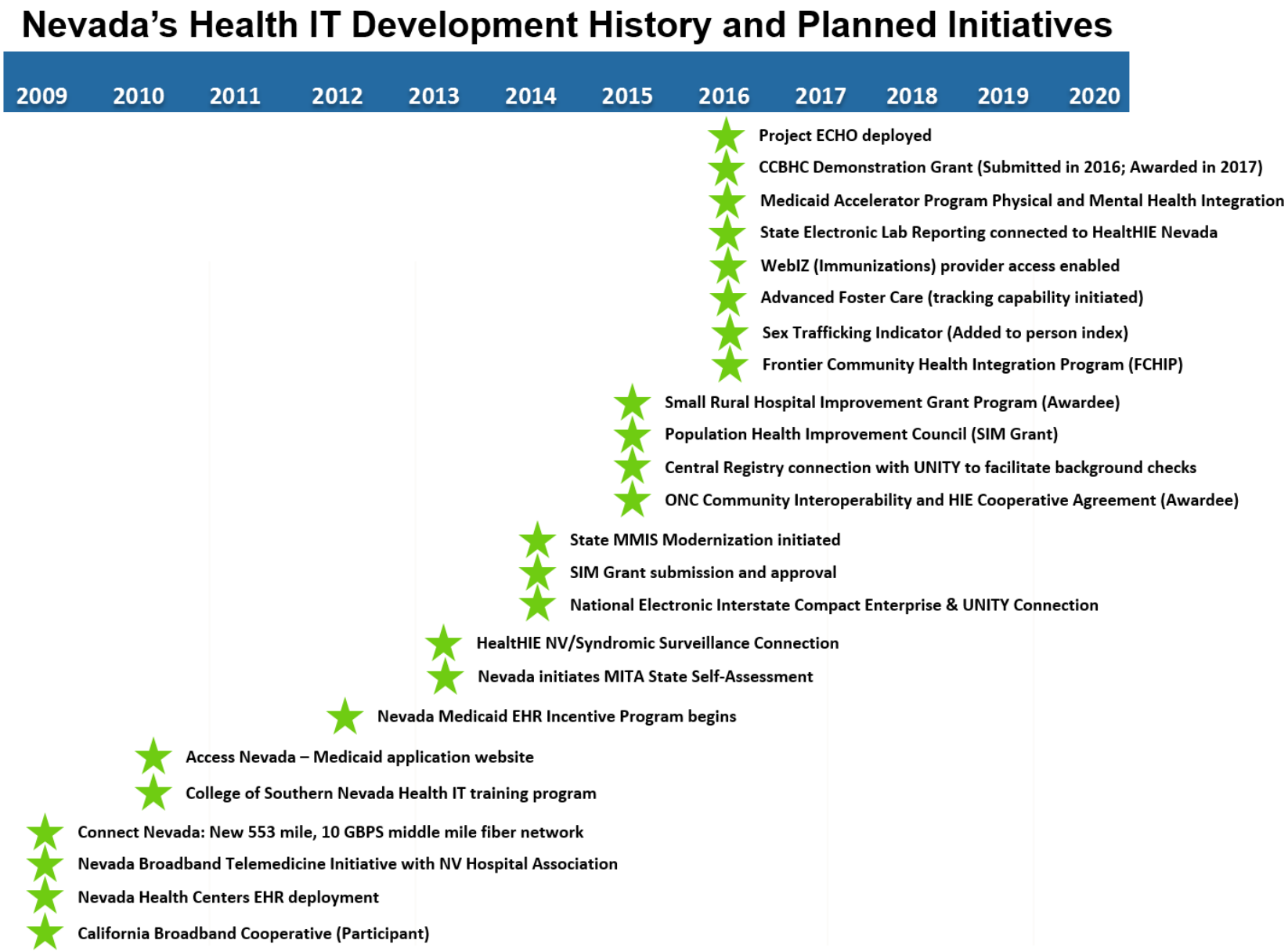
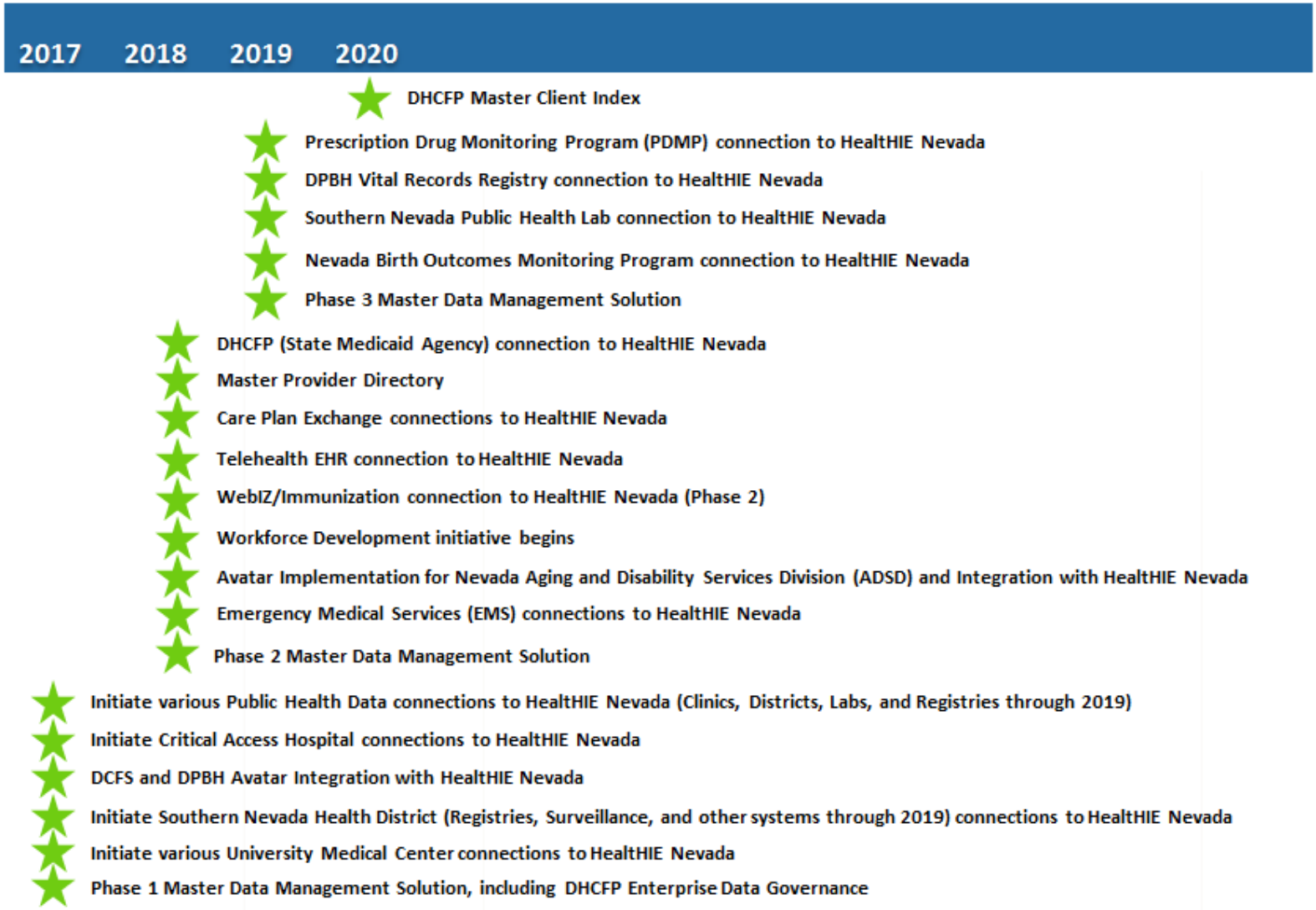


Figure 25. Nevada's Health IT Development History and Planned Initiatives



Nevada's Health IT Development History and Planned Initiatives



E.2. SMA Expectations Regarding Provider EHR Technology Adoption over Time and Annual Benchmarks

SMHP Companion Guide Question E #2

SMA Expectation of Provider EHR Adoption

Benchmarks for SMA Goals in Registration and Participation in the EHR Incentive Program
In addition to its long-term goals for the EHR Incentive Program, DHCFP is committed to encouraging EHR and HIE adoption for eligible providers and other Medicaid providers, including but not limited to behavioral health, long term care, and community-based workers over the next five years *(Table 26. EHR Meaningful Use Rate Goals,* 2017-2021).

Note: As of December 31, 2016, Nevada had 625 unique EPs attest to AIU and 31 unique EHs attested to the EHR Incentive Program. Because 2016 is the last year for providers to start participation in the EHR Incentive Program, the number of unique providers will reach its maximum at the end of the 2016 program year, with a CMS-approved tail end date of September 30, 2017. Nevada is anticipating a total of 1,000 unique providers in the EHR Incentive Program.

Note: As of Q4 2016, Nevada had 410 unique EPs who have received Meaningful Use payments and the potential target is 1,000. Below is the percent toward the goal of 1,000 that Nevada has targeted.

Table 26. EHR Meaningful Use Rate Goals, 2017-2021

	2017	2018	2019	2020	2021
EP	75.5%	90%	100%	100%	100%

E.3. Benchmarks for SMA Goals

SMHP Companion Guide Question E #3

Table 27. 2017- 2021 Nevada HIT Goals, Strategies and Milestones summarizes Nevada's HIT goals, strategies and milestones for 2017 – 2021.

Table 27. 2017- 2021 Nevada HIT Goals, Strategies and Milestones

GOAL	STRATEGY	SHORT-TERM OBJECTIVES	LONG-TERM OBJECTIVES
1. Substantially increase Nevada Medicaid provider adoption and use of Electronic Health Records and Health Information Exchange.	• Promote and drive awareness of EHR and HIE to increase Medicaid provider adoption and use of EHR and HIE for EPs to demonstrate Meaningful Use. • Establish mechanisms incentivizing Medicaid Providers to on-board to HIE and utilize interoperable components. • Create measurement framework and report HIT/HIE activities and progress to Nevada Health IT Leadership Council.	• Promotion/Outreach and Support: DHCFP will pursue initiatives to encourage the adoption of certified EHR technology to promote health care quality and exchange of health care information by both and between EPs and other Medicaid providers. • DHCFP proposes to collaborate with HealthInsight to provide assistance to both EPs and other Medicaid providers for outreach, education and on-boarding support to the Nevada HIE.	• Widespread use of EHR and HIE among providers throughout Nevada resulting in opportunities for improved care coordination, patient safety, health outcomes, and financial aspects supporting health care.
2. Significantly enhance Nevada's HIT/HIE landscape by on-boarding/connecting interoperable systems and advancing the HIE architecture to enable interoperability among Medicaid providers and to support integrated health care.	• Implement a statewide interoperable health IT infrastructure to give Medicaid providers access to real-time clinical data establishing a learning health system in Nevada. • Enhance the state's HIT infrastructure by adding key HIE architecture components becomes basis for value-proposition encouraging Medicaid providers to adopt and use health information technologies to demonstrate Meaningful Use. • Develop connections with key interoperable systems and add HIE architecture to support an Interoperable Learning Health System in Nevada. • Create measurement framework and report HIT/HIE activities and	Interoperability Efforts: DHCFP proposes to collaborate with HealthInsight and various state agencies to: 1. Expand both the volume of participating Medicaid providers and volume of patient health records by establishing additional provider system connections to the HIE, including: • Pharmacies (national and local). • Clinical Laboratories for both lab orders and results. • Nevada Public Health Providers. 2. Enhance the statewide interoperable infrastructure with several HIE components that most directly supports EPs in coordinating care with other Medicaid providers in order to demonstrate Meaningful Use. Such	• EPs will have the health IT tools and services necessary to improve coordination of care across providers and transitions of care in Meaningful Use modified Stage 2 and Stage 3. • Nevada's Medicaid provider community, including non-EPs such as behavioral health providers, long-term care providers, substance abuse specialists, and others will have access to robust interoperable HIE and related technology components to better treat, coordinate care, and manage costs of their patients. • Development of Nevada's HIT Landscape will be aligned to the goals of "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0," published by the Department of Health and Human Services, Office of

GOAL	STRATEGY	SHORT-TERM OBJECTIVES	LONG-TERM OBJECTIVES
	progress to Nevada Health IT Leadership Council.	interoperable and HIE architecture components include: • **Provider Directories:** Develop and implement advanced provider directories with dynamic, bi-directional connections to Nevada Public Health, behavioral healthcare providers, long-term care providers, substance abuse providers. • **Secure Electronic Messaging:** Expand services to EPs and non-EPs who exchange health data with them. • **Care Plan Exchange:** Create a robust, standards-based technology solution that allows Medicaid providers, care management partners and others who care for a single patient regardless of settings, to exchange comprehensive care plans focused on the patient's goals, to optimize services, and create accountability for community-based and institutional care. • **Encounter Alerting:** Establish an Event Notification Service (ENS) to transmit real-time communications to EPs and other Medicaid providers regarding admission, discharge, or transfer of Medicaid patients, including structured data regarding treatment plans, medication history, drug allergies, or other secure content that aids in the coordination of patient care,	the National Coordinator (ONC) for Health Information Technology.

GOAL	STRATEGY	SHORT-TERM OBJECTIVES	LONG-TERM OBJECTIVES
		including coordination of social services as appropriate. **Public Health Systems:** Develop interoperable connections between Nevada public health laboratories and registries, including the state Prescription Drug Monitoring Program (PDMP) to enable improved public health reporting, allow for exchange of public health data in accordance with state and Federal law, and provide all Nevada prescribers and dispensers access to medication history data for the purposes of preventing adverse drug events and prescribing drug monitoring.	
3. Establish a comprehensive Master Data Management (MDM) to effectively manage Nevada care trends, improve the State's Medicaid beneficiary health outcomes and reduce health care costs.	• Implement an Enterprise Data Governance Program approach to define accountability for managing claims and clinical data and support the delivery of the right information, to the right person, at the right time. • Lay the foundation to: - Facilitate data-driven decisions and enhances the foundation front-end through the integration of claims and clinical data (from HealtHIE Nevada HIE and other identified sources). - Dimensionally model the database architecture and build business rules library with consistent data definitions. - Initiate efforts to generate both patient care information and	At this time DHCFP proposes to transform its current systems for data storage and analytics capabilities into a mature information infrastructure built in three phases. DHCFP proposes to collaborate with the following contractors for DDI of Enterprise Data Solution - Phase 1: • Enterprise Data Governance and Data Analytics Advisory Services. • Phase 1 Decision Support Services. • Development of a Request for Proposal for Phase 2 and 3 of the Master Data Management. • Development of an IAPD-U to fund DHCFP Master Data Management – Phases 2 and 3.	• A data governance program will be broadly established, supporting alignment of Medicaid information demand with value delivery to other state agencies. • Initiation of MDM Phase 1 will give Nevada health departments, state agencies and other healthcare stakeholder organizations who are connected via HIE, with the information and insights necessary to support various multi-faceted health improvement initiatives at many levels.

GOAL	STRATEGY	SHORT-TERM OBJECTIVES	LONG-TERM OBJECTIVES
	provider performance measures for overall quality improvement. • Create measurement framework and report HIT/HIE activities and progress to Nevada Health IT Leadership Council.		

E.4. Benchmarks for Audit and Oversight Activities

SMHP Companion Guide Question E #4

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

- Number of reviews conducted by DHCFP. EHR incentive payment reviews will be incorporated into other reviews.
- 100 percent of overpayment recouped within one year for categories described in Section D.
- Number of technical assistance referrals made and resolved.
- Special studies and findings such as patient volume reviews.

These findings will be reported in the CMS audit database.

Appendix A. Nevada SMHP Addendum – February 9, 2017

This SMHP Addendum addresses the Modifications to Meaningful Use 2015 through 2017 specific regulations as well as the regulation set forth in the OPPS Final Rule.

Appendix B. Nevada SMHP Addendum – January 14, 2016

This SMHP Addendum addresses the Modifications to Meaningful Use 2015 through 2017 and specific regulations related to Modified Stage 2 Meaningful Use Final Rule.

Appendix C. Nevada SMHP Addendum – October 29, 2014

This SMHP Addendum addressed recent final rule at 79 FR 52910 which grants flexibility to eligible providers who are unable to fully implement 2014 Edition certified electronic health record technology (CEHRT) for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability.

Appendix D. SLR Screen Designs

The SLR screen designs were submitted in response to CMS recent final rule, the 2015-2017 Modifications and Stage 3 Final Rule published on October 16, 2015, the Outpatient Prospective Payment System (OPPS) rule published on November 14, 2016, and the MACRA/MIPS Final Rule issued on October 14, 2016. CMS approved the Nevada SLR screen designs on March 27, 2017.

Appendix E. Electronic Health Records Incentive Program Communication Plan

Appendix F. Acronym List

ACRONYM	DESCRIPTION
AAICPC	Association of Administrators of the Interstate Compact on the Placement of Children
ABP	American Board of Pediatrics
ACA	Affordable Care Act
ADA	Americans with Disabilities Act
ADC	Average Daily Census
ADSD	Aging and Disability Services Division
ADSL	Asymmetric Digital Subscriber Line
ADT	Admission, Discharge and Transfer
AFC	Advanced Foster Care
AHC	Accountable Health Communities
AIU	Adopt, Implement or Upgrade
ANTC	Arizona-Nevada Tower Corporations
AOBP	American Osteopathic Board of Pediatrics
API	Application Programming Interface
APM	Alternative Payment Model
ARRA	American Recovery and Reinvestment Act
AzHeC	Arizona Health-e Connection
BIP	Broadband Initiatives Program
BPHC	Bureau of Primary Health Care
BTOP	Broadband Technology and Opportunity
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBES	CHIP Budget and Expenditure System
CCBHC	Certified Community Behavioral Health Clinic
CDA	Clinical Document Architecture
CDC	Centers for Disease Control and Prevention
CDM	Conceptual Data Model
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHA	Community Health Alliance
CHIA	Center for Health Information Analysis for Nevada
CHIP	Children's Health Insurance Plan
CIHS	Center for Integrated Health Solutions
CMMI	Centers for Medicare and Medicaid Innovation

ACRONYM	DESCRIPTION
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality Measure
CY	Clinical Year
DCFS	Division of Child and Family Services
DDS	Dentist
DHCFP	Division of Health Care Financing and Policy
DHHS	Department of Health and Human Services
DHSII	Delivery System Health Information Investment
DISRN	Digital Imaging System for Rural Nevada
DMG	Decision Making Group
DO	Doctor of Osteopathic Medicine
DoD	Department of Defense
DPBH	Nevada Division of Public and Behavioral Health
DSS	Decision Support System
DW	Data Warehouse
DWSS	Nevada Division of Welfare and Supportive Services
eCQMs	electronic Clinical Quality Measures
ED	Emergency Department
EDI	Electronic Data Interchange
EDMS	Enterprise Document Management System
EH	Eligible Hospital
EHR	Electronic Health Record
ELR	Electronic Laboratory Reporting
EMS	Emergency Management Services
EP	Eligible Professional
eRx	Electronic Prescribing
ESB	Enterprise Service Bus
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics
FA	Fiscal Agent
FCC	Federal Communications Commission
FCHIP	Frontier Community Health Integration Program
FFP	Federal Financial Participation
FFS	Fee-for-Service

ACRONYM	DESCRIPTION
FFY	Federal Fiscal Year
FHA	Federal Health Architecture
FQHC	Federally Qualified Health Center
Gbps	Gigabits per second
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCHC	Hope Christian Health Center
Health IT	Health Information Technology
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HIX	Health Insurance Exchange
HL7	Health Level Seven International
HP	Hewlett Packard
HPES	Hewlett Packard Enterprise Services
HRSA	Health Resources and Services Administration
HSPA	Health Professional Shortage Area
IAP	Innovation Accelerator Program
I-APD	Implementation Advance Planning Document
IAPD-U	Implementation Advance Planning Document Update
ICPC	Interstate Compact on the Placement of Children
IHP	Indian Health Program
IHS	Indian Health Services
IIS	Immunization Information System
IRU	Indefeasible Right of Use
IS	Information System
ISP	Internet Service Provider
IT	Information Technology
ITCN	Inter-Tribal Council of Nevada
IV&V	Independent Verification and Validation
JLV	Joint Legacy Viewer
Kbps	Kilobits per second
LDM	Logical Data Model
LIMS	Laboratory Information Management System

ACRONYM	DESCRIPTION
LTE	Long Term Evolution
LTPAC	Long Term, Post-Acute Care
MACRA	Medicare Access and CHIP Reauthorization Act
MBES	Medicaid and Budget and Expenditure System
Mbps	Megabit per second
MBQIP	Medicare Beneficiary Quality Improvement Project
MCI	Master Client Index
MCO	Managed Care Organization
MD	Doctor of Medicine
MDM	Master Data Management solution
MEIPRAS	Medicare and Medicaid EHR Incentive Program Registration and Attestation System
MFCU	Medicaid Fraud Control Unit
MHBG	Community Mental Health Services
MITA	Medicaid Information Technology Architecture
MITA SS-A	Medicaid Information Technology Architecture State Self-Assessment
MMIS	Medicaid Management Information System
MPC	Multi-Payer Collaborative
MPLS	Multi-Protocol Label Switching
MU	Meaningful Use
NAACCR	North American Association of Central Cancer Registries
NAC	Nevada Administrative Code
NBOMS	Nevada Birth Outcome Monitoring System
NBS	NEDSS Base System
NBTI	Nevada Broadband Telemedicine Initiative
NCCR	Nevada Central Cancer Registry
NCCW	Nevada Comprehensive Care Waiver
NCQA	National Committee for Quality Assurance
NDOT	Nevada Department of Transportation
NEDSS	National Electronic Disease Surveillance System
NEICE	National Electronic Interstate Compact Enterprise
NEIPS	Nevada EHR Incentive Payment System
NHA	Nevada Hospital Association
NHIN	Nationwide Health Information Network
NICU	Neonatal Intensive Care Unit
NP	Nurse Practitioner
NPI	National Provider Identifier

ACRONYM	DESCRIPTION
NPIP	Nevada Provider Incentive Program
NPPES	National Plan & Provider Enumeration System
NQF	National Quality Forum
NRHP	Nevada Rural Hospital Partners
NRS	Nevada Revised Statue
NSHE	Nevada System of Higher Education
NSPHL	Nevada State Public Health Laboratory
NTIA	National Telecommunications and Information Administration
NVHC	Nevada Health Center
NV-HIE	Nevada Health Information Exchange
NVPCA	Nevada Primary Care Association
NwHIN	Nationwide Health Information Network
ODRAS	Online Document Retrieval and Archive System
ODS	Office of Disease Surveillance
OHIT	Office of Health Information Technology
ONC	Office of the National Coordinator
OPPS Rule	Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; EHR Incentive Programs; Payment to Non-excepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing (VBP) Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital
PA	Physician Assistant
PACS	Picture Archiving and Communication System
PAIHS	Phoenix Area Indian Health Service
PAMA	Protecting Access to Medicare Act
PASSR	Pre Admission Screening and Resident Review
PBM	Pharmacy Benefit Management
PCDH	Patient-Centered Data Home
PCIP	Primary Care Incentive Payment
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PECOS	Provider Enrollment, Chain and Ownership System
PHI	Protected Health Information
PHIC	Population Health Improvement Council

ACRONYM	DESCRIPTION
PHIN	Public Health Information Network
PHINMS	Public Health Information Network Messaging System
PHR	Personal Health Record
PMH-IAP	Primary and Mental Health through the Medicaid Innovation Accelerator Program
POLST	Physician Orders for Life Sustaining Treatment
POS	Place of Service
PPACA	Patient Protection and Affordable Care Act
PY	Payment Year
QHN	Quality Health Network
QI	Quality Improvement
QIO	Quality Improvement Organization
QRDA	Quality Reporting Document Architecture
R&A	Registration and Attestation
REC	Regional Extension Center
REMSA	Regional Emergency Medical Services Authority
RFP	Request for Proposal
RHC	Rural Health Clinic
RHIT	Registered Health Information Technician
RIS	Radiology Information System
ROI	Return on Investment
RPMS	Resource and Patient Management System
RSCH	Rural Sole Community Hospital
RUS	Rural Utilities Service
SABG	Substance Abuse Prevention and Treatment Block Grants
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBI	State Broadband Initiative
SHIP	Small Rural Hospital Improvement Grant Program
SHSIP	State Health System Innovation Plan
SIM	State Innovation Model
SLR	State Level Repository
SMA	State Medicaid Agency
SMD	State Medicaid Director
SMHP	State Medicaid Health Information Technology Plan
SNAP	Supplemental Nutrition Assistance Program
SNHD	Southern Nevada Health District

ACRONYM	DESCRIPTION
SOA	Service Oriented Architecture
SOC	System of Care
SSO	Single-Sign-On
STD	Sexually Transmitted Disease
SUR	Surveillance, Utilization and Review
TANF	Temporary Assistance for Needy Families
TBG	The Broadband Group
TCM	Targeted Case Management
TIN	Tax Identification Number
TMSIS	Transformed Medicaid Statistical Information System
TSA	Technical Service Area
TSC	Technical Service Classification
UDS	Uniform Data System
UHIN	Utah Health Information Network
UNITY	Unified Nevada Information Technology for Youth
UNSOM	University of Nevada – School of Medicine
USDA	United States Department of Agriculture
VA	Veterans Administration
VBP	Value-Based Purchasing
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information System and Technology Architecture
WAN	Wide Area Network
WCDSS	Washoe County Department of Social Services
WIC	Women, Infants, and Children
WiMAX	Worldwide Interoperability for Microwave Access

Endnotes

[i] Urbanized Area Carson City, Nev., Urbanized Area Las Vegas–Henderson, Nev., Urbanized Area Reno, Nev.--CA Urbanized Area, https://www.census.gov/prod/cen2010/cph-2-30.pdf(accessed December 8, 2015).

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[iv] https://www.aamc.org/download/447202/data/nevadaprofile.pdf (accessed December 8, 2015).

[v] Nevada Broadband Taskforce Annual Report to the Governor. Available at: http://osit.nv.gov/uploadedFiles/ositnvgov/Content/Meetings/Broadband/2016/2016%20Broadband%20Task%20Force%20Report%20to%20the%20Governor%206-30-2016%20[FINAL].pdf (accessed December 2016)

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[vii]http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Programs/ClinicalSAPTA/State%20of%20Nevada%20Plan%20to%20Reduce%20Prescription%20Drug%20Abuse.pdf

[viii] https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf