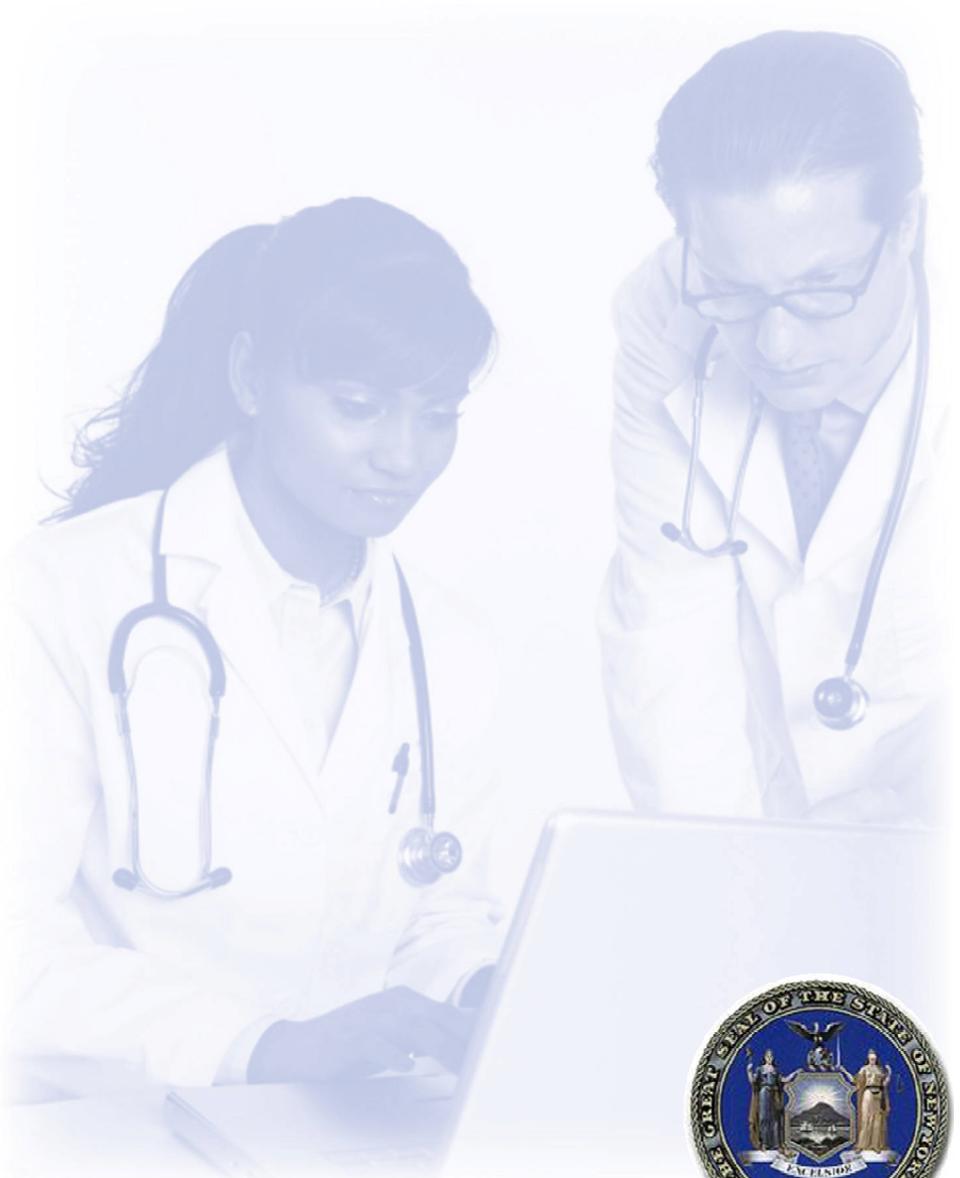




# NEW YORK STATE MEDICAID Health Information Technology Plan (NY-SMHP)



**June 20, 2011**

This document represents the outcome of extensive effort on the part of the New York State Office of Health Insurance Programs and collaboration with the New York State Office of the Medicaid Inspector General, New York State Office of Health Information Technology Transformation, New York eHealth Collaborative, and many other stakeholder organizations. The plan authors wish to acknowledge the extensive contributions of time, expertise, and content on the part of these organizations.

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# BACKGROUND

## 1. Introduction

In order for NY Medicaid to provide its members with healthcare that meets 21<sup>st</sup> century standards of quality, reliability, and cost-effectiveness, it is important that Medicaid providers move from the paper-based systems of yesterday to interconnected electronic health information technology (HIT) systems, especially the replacement of paper patient files with electronic health records (EHR). Widespread adoption of HIT in NY Medicaid and throughout the State will facilitate coordination between providers, improve the quality of care patients receive, increase patient safety (for example, by enabling point-of-service detection of harmful interactions between prescription medications), and support more efficient allocation of limited healthcare resources. Used to its fullest, HIT can empower healthcare professionals and patients to work together to achieve better healthcare outcomes at a lower cost, ensuring the long-term sustainability and effectiveness of the Medicaid system.

Recognizing the importance of HIT, in 2009 the U.S. Congress included provisions in the American Recovery and Reinvestment Act (the "Recovery Act") allocating approximately \$19B to provide incentives for adoption of HIT among Medicaid and Medicare providers.

The New York State Medicaid Health Information Technology Plan (NY-SMHP) has been developed in accordance with all Section 4201 Medicaid provisions of the Recovery Act. It provides the Centers for Medicare and Medicaid Services (CMS) with detailed descriptions of NY Medicaid's plans to implement the health information technology/health information exchange (HIT/E) provisions of the Recovery Act across the NY Medicaid program.

This NY-SMHP will focus on the development of patient centered HIT/E capabilities across the NY Medicaid program, including the design, development, and implementation of administrative mechanisms and information systems to encourage the adoption and meaningful use of certified electronic health record (EHR) technology.

The New York Office of Health Information Technology Transformation (OHITT), in collaboration with the New York eHealth Collaborative (NYeC), is developing the State's overall HIT Strategic Plan to support both the public and private healthcare sectors.

This NY-SMHP will detail NY Medicaid's plans to develop Medicaid Health Information Exchange (MHIE) capabilities within the Medicaid program, while OHITT continues to serve as the coordinating agency for HIT/E initiatives statewide, focusing on the development of the statewide HIT/E infrastructure.

## 2. Statement of Direction for NY Medicaid Health Information Exchange Initiatives

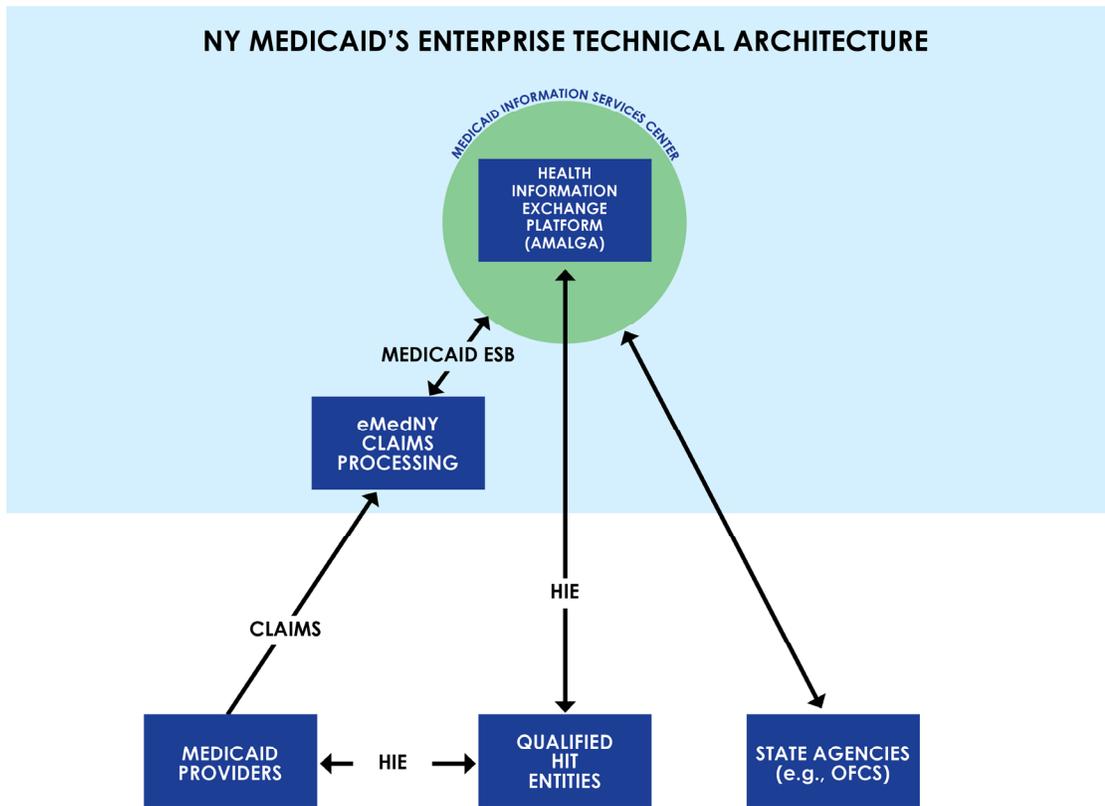
The NY Medicaid program is in a unique position among the state's community of healthcare payors. While one of the primary functions of the program is issuance of payments to healthcare providers, it also plays a significant role in shaping public healthcare policy. It is with this unique position within the healthcare industry in mind that the NY Medicaid program will: 1) define its role in the health information exchange (HIE) arena, 2) implement the Medicaid EHR Incentive Program, and 3) support adoption of meaningful use as defined by the CMS.

### **NY Medicaid's Health Information Exchange Activities**

With respect to MHIE activities, the NY Medicaid program will assume a more traditional insurance payor role. Working with Medicaid providers and other duly authorized organizations, MHIE activities will focus on the delivery of information that will add value to the clinical experience of the Medicaid insured population.

Specifically, the Department of Health, Office of Health Insurance Programs (OHIP), which has program and policy responsibility for NY Medicaid, has pursued a number of activities to implement the Medicaid Program Technical Architecture. OHIP has established the MHIE offering information (initially claims information) in a secure and robust manner. The Medicaid Information Services Center ("the Center") will serve as the information integration hub for all program information, as illustrated in Exhibit 1 below. Eventually, healthcare information from other human services organizations will be incorporated into the Center. The technical architecture of the Center will substantially conform to Nationwide Health Information Network (NHIN) standards.

All MHIE activities will be circumscribed by the program's involvement with the Medicaid insured population.



**Exhibit 1** NY Medicaid's Enterprise Technical Architecture

### **NY Medicaid's Role in the Public Healthcare Policy Agenda**

As a public healthcare insurer, the NY Medicaid program plays a significant role in the shaping of healthcare delivery systems. As a healthcare claims payor, NY Medicaid is also in a unique position to utilize claims data to help shape public healthcare policy. The program will continue its involvement in a wide array of public healthcare policy forums. Topics including intergovernmental relations for both program and financial issues will continue to serve as key elements of the program's relationship with the Federal government.

NY Medicaid will continue its active role in shaping legislative initiatives and working with a wide constituency in the healthcare industry. The program will also continue working with other NYS agencies on program and policy issues, as well as operational support.

### **3. NY Medicaid's Reform Agenda and Program Quality Improvement Initiatives**

#### **Medicaid Redesign**

NY Medicaid spends more than \$53 billion annually to provide health care to more than 4.7 million people in need. Recognizing that the State's current fiscal constraints

necessitate specific budget reductions for Medicaid spending, and that NY Medicaid's payment system often creates financial disincentives for the delivery of high-value, cost-effective, quality health care, Governor Cuomo has launched an initiative to effect a fundamental restructuring of the NY Medicaid program that achieves measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure.

More information on the Governor's Medicaid redesign initiative can be found online at [http://www.health.ny.gov/health\\_care/medicaid/redesign/](http://www.health.ny.gov/health_care/medicaid/redesign/).

### **Prior Reform and Quality Improvement Efforts**

Even prior to the creation of the Medicaid Redesign Team, NY Medicaid has played an important role in shaping healthcare delivery systems and public healthcare policy through a broad reform agenda and range of quality improvement initiatives. These improvements include both policy and operational areas.

NY Medicaid's health reform agenda has included rationalizing reimbursement; expanding coverage and access to care; pursuing improvements in quality and outcomes; improving care for enrollees with complex medical needs; making advancements in long-term care; assuring program integrity; and strengthening information technology systems. New York has made significant strides in achieving these reform objectives. It has broadened coverage, making it more accessible; increased investment in ambulatory care to reduce preventable inpatient hospital stays; and strengthened the commitment to quality through primary care standards, retrospective review of services, and selective contracting.

Public policy and operational quality improvement initiatives include:

- **Reimbursement and Rate Reform** – NY Medicaid has taken the initial steps in developing “Pay for Performance” initiatives for its Medicaid Managed Care Program, which covers 3.2 million people. These initiatives link compensation to the quality of outcomes, standardized quality measures, or the extent to which specific goals are achieved. The state has also reformed Medicaid rates to encourage care in the right setting, as well as to buy value and high quality, cost-effective care.
- **Establishment of Medical Homes** – State legislation incentivizing the creation and use of Patient-Centered Medical Homes was recently implemented, employing National Committee for Quality Assurance (NCQA) accreditation standards.
- **e-Prescribing Incentive Program** – An e-Prescribing Incentive Program using the National Council for Prescription Drug Programs (NCPDP) and Medicare Part D standards was implemented in May 2010. This program is designed to

promote e-prescribing and to reduce the incidence of adverse drug effects.

- **Medicaid Medication History Exchange Pilot and EHRs** – The use of EHRs has been promoted through the Medicaid Medication History Exchange pilot project. Approximately 180 days of patient prescriptions can now be shared electronically between Medicaid and selected healthcare providers and their patients.

#### 4. Planning Process Summary

A series of structured activities was completed to develop this NY-SMHP, including:

##### **Provider Outreach**

Outreach activities included the construction, distribution, compilation, and analysis of provider survey instruments; development and distribution of educational materials to promote the use of HIT and EHRs; provider focus groups; and analysis of focus group data. This analysis included review of the distribution of providers servicing Medicaid, Medicare, and other populations, as well as issues associated with policy and procedure development.

##### **“As-Is” Landscape Description**

Section A, the “As-Is” Landscape Description, was developed via analysis of provider outreach and focus group data; review of the Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A); definition of the field of eligible providers; and definition and analysis of barriers to acceptance of HIT by Medicaid beneficiaries. The process also included an assessment of the current program and IT environments; assessment of the interrelationships between Medicaid, Medicare, and other populations as they relate to the adoption of HIT and EHRs; and identification of policy issues and areas where additional guidance from CMS is required.

##### **“To-Be” Landscape Description**

Section B, the “To Be” Landscape Description, was developed via key stakeholder and senior management interviews, as well as the analysis of As-Is Landscape data to identify short- and long-term goals and recommendations to ensure cost-effective strategies.

##### **Implementation Plan**

Section C, the State’s Implementation Plan, was developed via the analysis of requirements set forth in the Section 4201 Medicaid provisions of the Recovery Act and by NY Medicaid senior administrators. This strategy defines a proposed approach to

provider eligibility determination, as well as the issuance and tracking of incentive payments.

### **Medicaid EHR Incentive Program Audit Strategy**

Section D, the State's Audit Strategy, was developed via the analysis of requirements set forth in the Section 4201 Medicaid provisions of the Recovery Act and through discussion with OHIP and Office of the Medicaid Inspector General (OMIG) staff. The audit processes described in this section are designed to ensure the integrity of program financial operations as well as validate provider eligibility and compliance with all program guidelines.

### **HIT Roadmap**

Section E, the State's HIT Roadmap, was developed via analysis of the As-Is and To-Be Landscape Descriptions, including short- and long-term goals and recommendations, to ensure cost-effective strategies; and EHR Incentive Payment Administration, Oversight, and Audit Strategies. The roadmap includes measurable benchmarks, milestones, tasks, and timelines to guide project progress.



## SECTION A

# THE STATE'S "AS-IS" HIT LANDSCAPE

This section presents the results of the environmental scan and assessment, completed with Center for Medicare and Medicaid Services (CMS) Health Information Technology (HIT) Planning Advance Planning Document (P-APD) funding.

## 1. Current extent of EHR adoption by practitioners and hospitals

*What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State's providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of provider? Does the SMA have data on EHR adoption by types of provider (e.g., children's hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)? Source: CMS SMHP Template Question A.1*

In order to evaluate the current extent of EHR adoption, the Office of Health Insurance Programs (OHIP) conducted web-based surveys of eligible professionals (including physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in federally qualified health centers or rural health clinics led by a physician assistant) and hospitals in July–August 2010. The surveys were designed to assess the level of EHR adoption among providers, to establish a baseline of meaningful use (and awareness of meaningful use criteria) among those that have already adopted EHR, and to evaluate respondents' plans for moving toward meaningful use over the next five years. The surveys asked specific questions regarding providers' use of EHR systems as it pertains to the meaningful use criteria.

A total of 1,060 practitioners completed the eligible professional survey, including the following (note that these selections were not mutually exclusive, and some respondents did not select any professional credentials):

Credentials	Respondents
M.D.	669
Dentist	194
Nurse Practitioner	95
D.O.	43
Physician Assistant	37
Other professional credentials	34
Certified Nurse Midwife	23

**Table A-1** Professional credentials reported by respondents to EP survey

The eligible hospital survey was completed by 97 hospitals. The majority of respondents were acute care hospitals, with a mix of demographics including:

- 59 large hospitals (200 or more beds) and 38 small hospitals, a 61%/38% split; and
- 69 urban hospitals (according to the definition of “urban” set forth in the New York Public Health Law) and 28 rural hospitals, a 71%/29% split.

A comprehensive analysis of survey results is currently underway, and upon completion of this analysis a full survey report will be submitted under separate cover. For a summary of the survey methodology, including a complete list of survey questions, see Appendix III (“Survey of Eligible Professionals/Hospitals”).

## 2. Broadband access challenges to HIT/E in rural areas

*To what extent does broadband internet access pose a challenge to HIT/E in the State’s rural areas? Did the State receive any broadband grants? Source: CMS SMHP Template Question A.2*

NY Medicaid recognizes that broadband internet access has an impact on successful adoption of EHR technology. In 2009, the Office of the New York State Chief Information Officer and Office for Technology (CIO/OFT) released the results of an effort on the part of the NYS Council for Universal Broadband to map the estimated availability of wired broadband internet access throughout the State. The results of this study suggest that while broadband internet access is unlikely to be a barrier to HIT/E activities in most areas, New York—like most states—will have broadband access challenges in certain locations.

Considering that the challenges to adoption of HIT/E in rural areas caused by lack of availability of broadband internet access are universal to all healthcare participants and providers, NY Medicaid defers to OHITT for coordination of statewide activities in this area. To the extent needed and requested by OHITT, NY Medicaid will participate in statewide activities initiated by OHITT and will provide data to support these activities.

- **General Initiatives for HIT/HIE:** For more information on the CIO/OFT broadband access study and statewide activities underway to overcome broadband access challenges in rural areas, see Appendix II (“General Initiatives for HIT/HIE”), Subsections 1 and 2.

### 3. Existing HRSA funding for HIT/EHR

*Does the State have Federally Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe. Source: CMS SMHP Template Question A.3*

NY Medicaid recognizes that the advent of Federally Qualified Health Center (FQHC) networks has had an impact on the successful adoption of EHR technology. According to the Community Health Care Association of New York State (CHCANYS), which counts fifty-six FQHCs among its more than 400 member community health centers, FQHCs and related facilities (such as FQHC “look-alikes”) are well ahead of the overall trend in adopting EHRs: 60% of CHCANYS member facilities are currently operating EHRs, and another 16% have implementations in progress. Over the past two years, HRSA has provided grants to four organizations in the State in support of HIT activities in FQHCs.

Considering that the role of FQHCs in leading the adoption of HIT and HIE in the broader healthcare environment is not limited to Medicaid participants and providers, NY Medicaid defers to OHITT for coordination of statewide activities in this area. To the extent needed and requested by OHITT, NY Medicaid will participate in statewide activities initiated by OHITT and will provide data to support these activities.

- **General Initiatives for HIT/HIE:** For more information on federal funding for FQHCs and the broader role FQHCs play in statewide HIE and EHR adoption, see Appendix II (“General Initiatives for HIT/HIE”), Subsection 3.

### 4. EHRs in VA/IHS clinical facilities

*Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe. Source: CMS SMHP Template Question A.4*

NY Medicaid recognizes that federally funded clinical facilities such as Veterans Administration (VA) and Indian Health Service (IHS) facilities have an impact on successful adoption of EHR technology. Both the VA and IHS have existing EHR adoption programs for their facilities:

- The Veterans Health Administration of the Department of Veterans Affairs operates twelve medical centers, forty-eight Community-Based Outpatient Clinics (CBOCs), and sixteen Vet Centers throughout the State. The VA operates a custom EHR, the Computerized Patient Record Service (CPRS),

as part of the overall Veterans Health Information Systems and Technology Architecture (VistA).

- The IHS has provided a clinical information system to four tribal outpatient clinics in New York: Oneida Indian Nation Health Program in Oneida, St Regis Mohawk Health Services in Akwesasne, and Seneca Nation of Indians in Allegany and Cattaraugus Counties. The system, called RPMS (Resource and Patient Management System), is based on the VA's VistA infrastructure. Work is currently underway to update RPMS to meet certification criteria established by the Office of the National Coordinator for HIT (ONC), and IHS plans to submit RPMS for certification in late 2010 or early 2011. Two other tribes, the Tonawanda and Tuscarora, use EMR contract managers for their EHRs.

During the stakeholder outreach process, letters were sent to tribal health administrators for all New York State tribes soliciting their input as stakeholders. The tribes indicated that they would be interested in collaborating with the State in the future as additional clinical data becomes available. As the program progresses, NY Medicaid will work with the National Indian Health Board, the Regional Extension Center (REC) for all tribes and Alaska natives nationwide, to coordinate message and programs.

Considering that the need to learn from and build upon HIE and EHR programs already in place in federal health systems is universal to all healthcare participants and providers throughout the State, NY Medicaid defers to OHITT for coordination of statewide activities in this area. To the extent needed and requested by OHITT, NY Medicaid will participate in statewide activities initiated by OHITT and will provide data to support these activities.

- **General Initiatives for HIT/HIE:** For more information on the HIE and EHR capabilities of VA and IHS facilities, and the coordination of HIT/E strategy with these programs, see Appendix II ("General Initiatives for HIT/HIE"), Subsection 4.

## 5. Existing HIT/E relationships and activities

*What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized? Source: CMS SMHP Template Question A.5*

New York State has a unique mix of governmental and non-governmental organizations charged with HIT/E policy development tasks that will have an impact on successful adoption of EHR technology throughout the state. Recognizing that

Medicaid participants and providers compose a major constituency for these stakeholder organizations, NY Medicaid seeks to participate in their policy development activities to provide assistance and represent the interests of Medicaid members and providers.

To the extent appropriate, NY Medicaid will participate in policy development activities initiated by governmental and non-governmental HIT/E stakeholders and will provide data to support these activities.

- **General Initiatives for HIT/HIE:** For more information on existing HIT/E stakeholder organizations beyond NY Medicaid and the activities they have underway, see Appendix II ("General Initiatives for HIT/HIE"), Subsection 5.

## 6. SMA relationships

*Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc.) of these activities? Source: CMS SMHP Template Question A.6*

NY Medicaid relies on a number of entities outside the Department to fulfill its mission to provide effective, cost-efficient healthcare to New Yorkers in need. These relationships are supported by data-sharing agreements that supply the entities with the information they need to provide data analysis and policy guidance. The costs for implementing and maintaining these data-sharing systems are allocated 100% to NY Medicaid. Some examples of such data sharing agreements are:

- Local Medicaid services such as eligibility and long-term care management are conducted by the 58 local departments of social services (LDSS), consisting of county departments of social services in 57 counties and the New York City Human Resources Administration/Department of Social Services (HRA/DSS). In support of these responsibilities, each LDSS has a data-sharing agreement with NY Medicaid that grants them direct access to the Center.
- APS Healthcare and Thomson Reuters manage the State's Medicaid clinical best practice utilization review program. Under this program, NY Medicaid claims data is analyzed to identify patterns of service outside of evidence-based care guidelines and opportunities for improving patient safety and quality of care.
- Under State law, the State University of New York (SUNY) is charged with the responsibility for establishing NY Medicaid utilization thresholds. To facilitate the development, analysis, and updates to these thresholds, research and

clinical experts at the university's Stony Brook campus are granted direct access to the Center. This data sharing is governed by a formal memorandum of understanding (MOU) between the Department and SUNY.

- SUNY is also responsible for retrospective drug utilization review (RetroDUR) for NY Medicaid prescription claims. Under a formal data-sharing agreement, SUNY accesses Medicaid pharmacy claims data to generate case reviews of selected Medicaid patients for safety and appropriateness of therapy, and alerts prescribers and pharmacists to potential drug therapy problems due to therapeutic duplication, drug-to-disease contraindications, drug-to-drug interactions, incorrect drug dosage or duration of drug treatment, drug allergy reactions, and/or clinical abuse/misuse.

NY Medicaid is also involved in preliminary HIE activities in support of clinical quality improvement programs and medical studies. For example:

- Encounter data for 36,457 NY Medicaid patients who visited urban public hospitals between 2001 and 2006 were shared with New York University for use in a study that tested the use of regression analysis to case-find Medicaid patients at high-risk for hospitalization in the next 12 months and to identify intervention-amenable characteristics to reduce hospitalization risk. The study, "Medicaid Patients at High Risk for Frequent Hospital Admission: Real-time Identification and Remedial Risks," was published in the *Journal of Urban Health* in 2009.
- A study currently underway at the Dana-Farber/Harvard Cancer Center is using NY Medicaid enrollment and claims histories linked to other data sources (including hospital discharge abstracts and tumor registry data) to evaluate the quality of care delivered to indigent patients with cancer. Ultimately, the goal of the study is to inform design of sustainable systems architecture for ongoing surveillance of the quality of cancer care.
- Under the terms of a formal MOU between the Department and the NYS Office of Mental Health (OMH), weekly downloads of Medicaid medication claims history data are provided to OMH in support of a four-year initiative to improve the quality and efficiency of psychotropic prescribing practices in New York State. This project is based on the adaptation of a successful OMH program (the Psychiatric Services and Clinical Knowledge Enhancement System, or PSYCKES) to the Medicaid population. Initially developed for use in state psychiatric facilities, where it supported significant improvement in medication practices, PSYCKES provides web-

based tools that allow users to navigate through state-, region-, county-, agency-, program-, and recipient-level reports to review quality indicators, identify consumers whose treatment could benefit from review, and obtain medication and service utilization information to support quality improvement and clinical decision-making.

## 7. Health information exchanges

*Specifically, if there are health information exchange organizations in the State, what is their governance structure, and is the SMA involved? How extensive is their geographic reach and scope of participation? Source: CMS SMHP Template Question A.7*

Health information exchange in New York State is the responsibility of the State's twelve Regional Health Information Organizations (RHIOs), supported by nine Community Health Information Technology Adoption Collaboratives (CHITAs) whose mission is to facilitate the adoption of interoperable EHRs and to provide support services. Healthcare providers throughout the state are also directly involved in HIE activities such as electronic prescribing. The success of meaningful HIE in the State is critical to the clinical care improvements that are expected from the widespread adoption of EHR technology.

Recognizing that the need for reliability, security, and interoperability in HIE is universal to all healthcare participants and providers, NY Medicaid defers to OHITT for coordination of statewide activities in this area. To the extent needed and requested by OHITT, NY Medicaid will participate in statewide activities initiated by OHITT and will provide data to support these activities.

- **General Initiatives for HIT/HIE:** For more information on the HIE organizations active throughout the State, and their governance structure, see Appendix II ("General Initiatives for HIT/HIE"), Subsection 6.

## 8. Role of MMIS in HIT/E environment; coordination between HIT Plan and MITA transition plans

*Please describe the role of the MMIS in the SMA's current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and, if so, briefly describe how. Source: CMS SMHP Template Question A.8*

The State's Medicaid Management Information System (MMIS), eMedNY, provides HIE services directly to providers through a number of interface paradigms, including

interactive voice response systems, Simple Object Access Protocol (SOAP) web services, and a provider web portal. The services provided by the MMIS include:

- Prescription Formulary
- Eligibility Verification
- Medication History

### **Prescription Formulary**

The complete up-to-date Medicaid prescription formulary is available on the eMedNY website. Interested parties may download the complete formulary list, or may search for drugs by any field in the formulary data, including National Drug Code (NDC) number, drug type, cost, and description. Access to the formulary data does not require an eMedNY provider account.

### **Eligibility Verification**

The Medicaid Eligibility Verification System (MEVS) was initially implemented in 1985. It allows providers to verify eligibility for Medicaid services in real time. Inquiries are submitted using the Health Insurance Portability and Accountability Act (HIPAA) X12 270 Eligibility Benefit Inquiry format, and responses are provided in the HIPAA X12 271 Eligibility Benefit Response format.

### **Medication History**

Through the use of the Medication History service, healthcare providers can obtain a medication history on Medicaid participants in real time. Providers submit medication requests via SOAP web services in either the National Council for Prescription Drug Programs (NCPDP) Version 10.6 Medical History Request format or the Health Information Technology Standards Panel (HITSP) T23 Patient Demographics Query (PDQ) MEDS History Request format. Responses, available in either the NCPDP Script 10.6 or HL7 Continuity of Care Document (CCD) format, include information on prescription claims paid by Medicaid over the last 180 days.

A complete discussion of the technical details of using the Medication History service is available on the eMedNY website at [http://www.emedny.org/hipaa/emedny\\_transactions/Technical/eMedNY\\_Real-Time\\_SOAP\\_Users\\_Guide.pdf](http://www.emedny.org/hipaa/emedny_transactions/Technical/eMedNY_Real-Time_SOAP_Users_Guide.pdf).

### **MITA Transition Plan Coordination**

In 2009, OHIP conducted an extensive MITA State Self-Assessment (SS-A) to determine the current maturity level ("As Is") of Medicaid business operations and to establish a "To Be" vision for the evolution of the State Medicaid program's MITA maturity level over time. Recognizing that business processes form the core activities of the Medicaid program, and in keeping with the guiding principle that MITA "represents a business-driven enterprise transformation," the SS-A draws primarily on the Business

Architecture (BA) component of the MITA Framework. The SS-A sets forth specific objectives for reaching a higher maturity level in each business process identified in the MITA framework; the actual steps needed to achieve these objectives are developed as part of the transition planning process and are documented in the MITA Transition and Implementation Plan (TIP).

The State's MITA TIP identifies two procurement initiatives underway within the State Medicaid program that will significantly advance the maturity level of many business processes while supporting the goals of the State's HIT plan:

- The **Replacement Medicaid Management Information System (R-MMIS)** will implement a service oriented architecture (SOA) employing reusable components and services consistent with MITA interoperability standards (as they become available). This architecture supports HIE goals such as the exposure of MMIS services within the broader State infrastructure. Additionally, the R-MMIS will support HIE through the adoption of data representation and interchange standards, such as HIPAA 5010, DCPDP D.0 Electronic Data Interchange, and International Classification of Diseases (ICD)-10. A Request for Proposals (RFP) for the R-MMIS has been published by the Department, with proposals due by October 29, 2010.
- The **Medicaid Information Services Center**, an expansion of the data storage and access capabilities currently provided by the Medicaid Data Warehouse (MDW), will also employ MITA-standard data models and interchange formats (to the extent they are available) to provide service consumers with a consistent representation of health information from disparate sources.

## 9. Activities currently underway to facilitate HIE/EHR adoption

*What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use? Source: CMS SMHP Template Question A.9*

### Stakeholder Outreach Program

Between February and June 2010, OHIP conducted a series of stakeholder outreach meetings with State agencies and stakeholder organizations to educate them on the current status of the Medicaid EHR Incentive Program and to solicit input on EHR adoption incentives, the current state of stakeholder adoption, and the need for future educational outreach. Prior to each meeting, the agency or organization was provided with background information regarding the incentive program, which

was reinforced by an overview of the program provided by OHIP at the start of the meeting. The overview meetings, most of which were also attended by a representative of OHITT, served both as a briefing for stakeholder organizations and an opportunity for those organizations to ask clarifying questions regarding the program. Stakeholder organizations were then offered the opportunity to hold a follow-up meeting to provide formal feedback. Appendix V ("Stakeholder Outreach") shows the formal feedback provided to the Department of Health as a result of these outreach meetings.

The following forty stakeholder organizations were included in the stakeholder outreach program:

- Adirondack Regional Community Health Information Exchange (ARCHIE)
- American Academy of Pediatrics (AAP)
- Brooklyn Health Information Exchange (BHIX)
- Community Health Care Association of New York State (CHCANYS)
- Empire Justice
- Family Planning Advocates (FPA)
- Fidelis Care NY
- Greater New York Hospital Association (GNYHA)
- Health Advancement Collaborative of Central New York (HAC-CNY)
- Healthcare Association of NYS (HANYS)
- Healthcare Information Xchange of New York (HIXNY)
- HEALTHeLINK
- Home Care Association of New York State (HCA)
- Hospice and Palliative Care Association of New York State (HPCANYS)
- Indian Health Service
- Interboro RHIO
- Legal Aid Society
- Long Island Patient Information Exchange (LIPIX)
- Medicaid Matters
- Medical Society of the State of New York (MSSNY)
- New York Chapter of the American College of Physicians (NYACP)
- New York Clinical Information Exchange (NYCLIX)
- New York eHealth Collaborative (NYeC)
- New York State Academy of Family Physicians (NYSAFP)
- New York State Association of Healthcare Providers (NYSHCP)
- New York State Association of Licensed Midwives (NYSALM)
- New York State Coalition of Prepaid Health Services Plans (PHSP Coalition)
- New York State Dental Association (NYSDA)

- New York State Health Facilities Association (NYSHFA)
- New York State Society of Physician Assistants (NYSSPA)
- Nurse Practitioner Association New York State (NPA)
- NY Health Foundation (NYSHealth)
- NYS Association of Homes and Services for the Aging (NYAHS)
- Primary Care Information Project (PCIP)
- State University of New York (SUNY)
- Suffolk County Health Services
- Taconic Health Information Network and Community (THINC)
- United Hospital Fund (UHF)
- United Jewish Appeal Federation of NY (UJAFEDNY)
- Urban Health Plan (UHP)
- Visiting Nurse Services of NY (VNSNY)

Additionally, outreach meetings were conducted with the following nine state agencies:

- DOH Office of Long Term Care (OLTC)
- DOH Office of Health Information Technology Transformation (OHITT)
- DOH Office of Public Health (OPH)
- DOH Office of Health Systems Management (OHSM)
- Office for People With Developmental Disabilities (OPWDD)
- Office of Alcoholism and Substance Abuse Services (OASAS)
- Office of Children and Family Services (OCFS)
- Office of Mental Health (OMH)
- Office of Temporary and Disability Assistance (OTDA)

### **Provider Outreach**

The Department of Health collaborated with the New York chapter of the American College of Physicians (NYACP) and New York's two RECs—NYeC REC and the New York City Regional Electronic Adoption Center for Health (NYC REACH)—to conduct provider outreach in seven cities throughout the State in the spring of 2010:

- Brooklyn (New York City)
- Melville (Long Island)
- Buffalo
- Syracuse
- Binghamton
- Albany
- Tarrytown (Westchester County)

Each “New York EHR Meaningful Use Summit” featured presentations from State and regional agencies, including OHITT (the State’s HIT coordinator), presenting on meaningful use criteria; OHIP (the SMA) presenting on the State’s e-Prescribing incentive program; and presentations by the REC and local RHIO on resources supporting EHR adoption. Additionally, EHR vendors were invited to conduct product demonstrations to give providers the opportunity to see EHR systems in action.

Following up on the success of the spring 2010 series, a second series of EHR Summits was conducted in September 2010 in the following cities:

- Buffalo (Western NY)
- Rochester (Finger Lakes North)
- Syracuse (Central New York)
- Troy (Capital District)
- Johnson City (Southern Tier)
- Tarrytown (Hudson Valley)
- Melville (Long Island)

The fall series, a collaboration of OHIP, NYeC REC, CMS, and local RHIOs, was designed to educate providers on the details of both the Medicare and Medicaid EHR Incentive Programs. Separate sessions were conducted within each summit to provide information and assistance to new EHR adopters (focusing on the value proposition of adopting EHR technology and local resources to assist with adoption), as well as more experienced EHR users (focusing on the details of the meaningful use objectives and resources available to help advance their practice toward meaningful use).

### **e-Prescribing Incentive Program**

To encourage the use of electronic prescribing (e-prescribing), OHIP instituted a program on May 1, 2010, to provide financial incentives to providers that issue prescriptions electronically and pharmacies that accept e-prescriptions. Under this program, eligible providers (including physicians, dentists, nurse practitioners, podiatrists, optometrists, and licensed midwives) receive incentive payments of \$0.80 per dispensed Medicaid ambulatory e-prescription (including refills), and retail pharmacies receive incentive payments of \$0.20 per dispensed e-prescription. To be eligible for the incentive payments, the prescriptions must be transmitted via “encrypted, interoperable computer-to-computer electronic data interchange in machine-readable (non-facsimile) format, compliant with Medicare Part D standards.” By leveraging existing standards such as Medicare Part D and the NCPDP, and by excluding computer-to-facsimile transmissions, the State expects that this incentive payment program will promote the general adoption of interoperable EHR systems. A copy of the guidance issued by NY Medicaid on the e-prescribing incentive program can be viewed in Appendix VII (“Medicaid Update on e-Prescribing Incentive”). For

more information on the development of the e-prescribing incentive program, please see the case study prepared by the Agency for Healthcare Research and Quality (AHRQ), included in Appendix VIII ("AHRQ Case Study on e-Prescribing Incentive Program").

According to information provided by Surescripts, a national e-prescribing intermediary, e-prescribing has made significant strides in physician penetration in NYS. New e-prescriptions increased from 264,426 in 2006 to 3,389,978 in 2008, representing an increase of 1182% over two years.<sup>1</sup>

### **Patient-Centered Medical Home Initiatives**

NY Medicaid has chosen to adopt medical home standards that are consistent with those of the National Committee for Quality Assurance's (NCQA) Physician Practice Connections® - Patient-Centered Medical Home Program (PPC-PCMH™). The PPC-PCMH™ is a model of care that seeks to strengthen the physician-patient relationship and quality of care (especially at transitions in care) by promoting improved access, coordinated care, and enhanced patient/family engagement.

The NCQA has designed a recognition program to certify (based on objective measures) the degree to which a primary care practice meets the operational principles of a patient-centered medical home. The NCQA program features three tiers of medical home recognition. Achievement of a given tier is dependent on a point-scoring system whereby points are awarded if the practice has achieved competency in a given business/practice management process. The levels are described below:

- Level 1 functions as the basic tier and can be achieved without deploying an EHR.
- Level 2 requires some electronic functions.
- Level 3 requires a fully functional EHR.

NY Medicaid has engaged the not-for-profit healthcare consulting organization IPRO to provide assistance with the transition to PCMH for practices that are not eligible or cannot afford the services of RECs. Participating practices should have at least 30% of their active patients in Medicaid (fee-for service or managed care), Child Health Plus, or Family Health Plus insurance, or be uninsured, and must commit to applying to NCQA for PCMH recognition within 6–12 months of joining the project. The objectives of the project are as follows:

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<sup>1</sup> Additional information published by Surescripts on e-prescribing in New York State can be obtained online at <http://www.surescripts.com/about-e-prescribing/progress-reports/state.aspx?state=ny>.

- Recruit and assist eligible ambulatory care practices to achieve National Committee for Quality Assurance (NCQA) medical home recognition
- Promote a preferred set of monitored clinical conditions, such as asthma and diabetes, that must be part of the medical home recognition process, and assist practices in quality improvement in those conditions
- Promote and facilitate both short- and long-term adoption and meaningful use of EHRs

Through the project, IPRO will provide ongoing, personalized consultation to participating practices, free of charge, in the following areas:

- Readiness assessment
- Team building and team meeting facilitation
- Workflow mapping and support
- Assistance with development of written protocols for office processes
- Operational evaluation and support
- Clinical condition selection
- Assistance in performance monitoring
- EHR-focused practice transformation and decision support use

Effective July 1, 2010, NY Medicaid began a program to provide incentive payments for primary care services provided to Medicaid beneficiaries by office-based physician and registered nurse practitioner practices, FQHCs, and Diagnostic and Treatment Centers (D&TCs) recognized by NY Medicaid and the NCQA as operating a PCMH. Consistent with NCQA recognition levels, there are three levels of incentive payments for fee-for-service providers, as illustrated in Table A-2, below:

Setting	Level I	Level II	Level III
Article 28 clinics	\$5.50	\$11.25	\$16.75
Office-based practitioners	\$7.00	\$14.25	\$21.25

**Table A-2** Medicaid PCMH incentive payment amounts

NY Medicaid issued guidance on the PCMH incentive program in two issues of the “Medicaid Update” newsletter, which can be viewed in Appendix IX (“Medicaid Update on PCMH Incentive”).

NY Medicaid seeks to promote the adoption of Patient-Centered Medical Homes, and it is anticipated that organizations establishing themselves as Patient-Centered Medical Homes will be well positioned to achieve the meaningful use objectives set forth for the Medicaid EHR Incentive Program.

## **Hudson Headwaters Health Network**

As one of the initiatives funded under Healthcare Efficiency and Affordability Law for New Yorkers (HEAL NY) Phase 10, Hudson Headwaters represents another program developed jointly by NY Medicaid and OHITT. With \$7M in funding, the Adirondack Medical Home Multipayor Demonstration Program seeks to establish a demonstration PCMH in the upper northeastern region of the State serving recipients of public medical assistance (both fee-for-service and managed care), as well as enrollees and subscribers of commercial (or employer-sponsored self-funded) health insurance plans, health maintenance organizations, and managed care plans.

In this endeavor, the Adirondack Health Institute Care Improvement Initiative will work in tandem with the Adirondack PCMH Pilot to improve and enhance the provision of healthcare services in the region. The Project will leverage the progress and infrastructure of the PCMH Pilot. PCMH providers will apply population-based, evidence-based, and patient-centered approaches for diabetes care using EHRs and care managements tools made available under the Project to facilitate, or further integrate, practice improvements to increase the effectiveness of clinical interventions, with the ultimate goal of improving quality of care (especially at transitions in care).

## **Telemedicine**

Telemedicine systems are interactive audio and video telecommunication systems that allow real-time interactive consultation services to take place between a physician at one physical location and a patient at a different location. Since 2006, Medicaid has reimbursed practitioners for clinical consultations performed via telemedicine in the emergency room and inpatient hospital settings. In order to be eligible for reimbursement, the consultation must be in a medical specialty not available at the patient's location (the "spoke site"), and the consultation with the specialist (at the "hub site") must be conducted via a fully interactive, secure two-way audio and video telecommunication system that also supports review of diagnostic tests integral to the consultation. Effective February 1, 2010, reimbursement for telemedicine services was extended to services rendered in hospital ambulatory settings.

Recognizing a significant deficiency in the diagnosis and treatment of stroke caused by the lack of access to neurologist/stroke specialists in rural communities, NY Medicaid collaborated with the Office of Health Systems Management (OHSM) and the Office of Rural Health (ORH) to develop a Telemedicine Stroke Program modeled after a successful program in Georgia called REACH (Remote Evaluation of Acute Ischemic Stroke). Through this program, telemedicine consultations are provided from four hub hospitals: Basset Hospital in Cooperstown; Millard Fillmore Gates Circle Hospital in Buffalo; Strong Memorial Hospital at the University of Rochester; and Upstate

University Hospital in Syracuse. Specialists at these hub hospitals are able to remotely examine patients in rural emergency rooms and inpatient hospitals from any broadband-connected laptop/computer, using a HIPAA-compliant web-based system; this system allows them to review computed tomography (CT) scans in real time and make recommendations regarding treatment, including the administration of tissue plasminogen activator (tPA).

### **Statewide activities**

In addition to the NY Medicaid programs listed above, additional initiatives currently underway throughout the state to encourage HIE and EHR adoption will have an impact on the success of the Medicaid EHR Incentive Program. Recognizing that the scope of these statewide initiatives is not limited to Medicaid members and providers, NY Medicaid defers to OHITT for the coordination of strategy and effort under the “all payor” model. To the extent needed and requested by OHITT, NY Medicaid will participate in statewide activities initiated by OHITT and will provide data to support these activities.

NYeC, OHITT, and OHIP are separately funded and claimed entities. NYeC and OHITT are funded through ONC and State grants, while OHIP is funded through Medicaid. On joint activities, each organization expends and claims its own funding sources. There is no commingling of expenditures or claims.

- **General Initiatives for HIT/HIE:** For more information on statewide activities currently underway to encourage HIE and EHR adoption, see Appendix II (“General Initiatives for HIT/HIE”), Subsection 7.

## **10. Relationship of State HIT Coordinator to SMA**

*Explain the SMA’s relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program. Source: CMS SMHP Template Question A.10*

NY Medicaid has engaged with OHITT and NYeC in a concerted process designed to coordinate NY Medicaid and statewide HIT plans, align programs to common goals, and reduce duplication of effort.

Currently, OHITT (in collaboration with NYeC) is developing the State’s overall HIT Strategic Plan to support both the public and private healthcare sectors. While OHIP develops programs to foster the adoption of EHRs and HIE among Medicaid providers (as illustrated by this SMHP), OHITT continues to serve as the coordinating agency for

HIT/E initiatives statewide, focusing on the development of the statewide HIT/E infrastructure under an “all payor” model.

As part of the activities involved in developing New York’s SMHP, NY Medicaid conducted several plan integration meetings with OHITT and NYeC. These meetings identified the touch points between the NY-SMHP and NYeC/OHITT’s strategic and operational plans for statewide HIT/HIE and identified areas where resources could be leveraged in the future. Independent of these meetings, OHITT was invited to collaborate in all of the stakeholder meetings to provide their perspective and to inform stakeholders of OHITT plan activities. In addition, OHITT representatives to the Medicaid EHR Incentive Program Project Office were involved in all project status meetings. The information shared across these meetings provided the baseline to develop approaches for NY Medicaid and OHITT HIT/E plans that best meet the needs of NYS residents.

## **11. Activities currently underway likely to influence Medicaid EHR Incentive Program**

*What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years?  
Source: CMS SMHP Template Question A.11*

NY Medicaid has undertaken several initiatives to promote and improve EHR activities among their Medicaid providers. These initiatives include the following:

### **Reimbursement and Rate Reform**

NY Medicaid has taken the initial steps in developing Pay-for-Performance initiatives which link compensation to the quality of outcomes, standardized quality measures, or the extent to which specific goals are achieved.

Currently, NY Medicaid pay-for-performance initiatives are focused on the managed care system, which covers 3.2 million Medicaid members in the State. Health plans are rated annually under the Quality Assurance Reporting Requirements (QARR), a set of measures adopted from the NCQA’s Healthcare Effectiveness Data and Information Set (HEDIS)—with State-specific quality measures added to address public health issues of particular importance in New York—as well as patient satisfaction measures from the annual national consumer satisfaction survey called Consumer Assessment of Healthcare Providers and Systems (CAHPS). Each plan receives a score from 0–150, consisting of ten points for meeting or exceeding a benchmark value (representing the 75<sup>th</sup> percentile score two years prior to the reporting year) in each of ten QARR clinical quality measures, and up to ten additional points based on the rating it achieved relative to the statewide average on each of five QARR patient satisfaction measures from the most recent survey. Medicaid managed care plans

achieving high scores qualify for financial incentives of up to 3% of the plan premium, and higher preference in auto-assignment of enrollees.

With more widespread adoption and meaningful use of EHR technology, NY Medicaid will have the capability to collect clinical quality data from providers participating on a fee-for-service basis. By leveraging this information to measure and compare quality of care, pay-for-performance initiatives can be developed at the individual provider level.

### **Establishment of Medical Homes**

State legislation is in place to provide incentives for the creation and use of PCMHs employing NCQA accreditation standards. The NCQA PPC-PCMH™ is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family engagement. Effective July 1, 2010, NY Medicaid began to provide incentives to office-based physician and registered nurse practitioner practices, FQHCs, and D&TCs recognized by NY Medicaid and the NCQA as operating a PCMH™.

### **e-Prescribing Incentive Program**

An e-prescribing incentive program using the NCPDP and Medicare Part D standards is in progress. Effective May 1, 2010, NY Medicaid began to provide incentives to encourage electronic prescribing (e-prescribing). As described in the New York State fiscal year 2009-2010 Health Budget, eligible Medicaid prescribers receive an incentive payment of \$0.80 per dispensed ambulatory Medicaid e-prescription, and eligible retail pharmacies receive \$0.20 per dispensed Medicaid e-prescription. The long-term goals of the program are to reduce medication errors, encourage pharmaceutical practices that produce better patient outcomes, and yield savings.

Authorization for the e-prescribing incentive program was granted by State law, and neither that law nor any policies adopted by the State to implement this program require that other payments or incentives be considered in determining whether the a provider is eligible for the incentive. Overall, NY Medicaid sees no conflict in a provider receiving both the e-prescribing incentive and the Medicaid EHR incentive for the same period.

### **Medicaid Medication History Exchange Pilot and EHRs**

In 2007, NY Medicaid and the New York City Department of Health and Mental Hygiene (NYCDOHMH) launched a pilot program to enable the exchange of medication history and formulary information between the Medicaid program and participants in the Primary Care Information Project in New York City. The pilot system allowed Medicaid providers to use the web-based Medication History Pilot Interface

(MHPI)—provided by vendor eClinicalWorks—to submit an NCPDP SCRIPT 8.1 medication history request. The response to this request would contain a history of the 50 most recent medications prescribed, filled, and claimed under Medicaid for the patient in question.

In 2008, the pilot program was successfully concluded and the Medication History service was extended to Medicaid providers throughout the state. The service now uses a direct-access model to provide medication history claims information for the previous 180 days in NCPDP SCRIPT or HL7 CCD format; the first provider participating in the production service is New York Presbyterian Hospital.

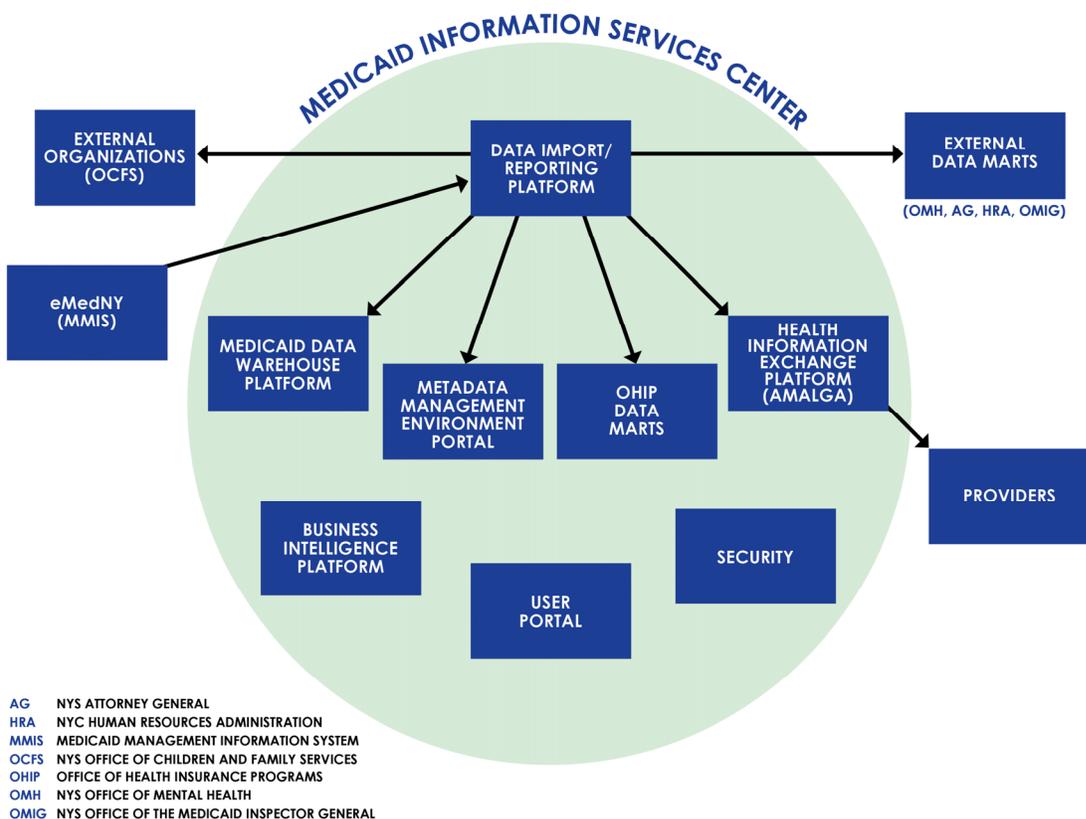
### **Medicaid Information Services Center**

NY Medicaid recognizes that emerging national standards for healthcare information accessibility and interoperability reflect increasing expectations for the management of program data and the use of that data to improve the delivery of healthcare services and to detect fraud and abuse. Meeting these expectations will require that the most sophisticated technology tools available be leveraged to assist in monitoring the quality and appropriateness of care, controlling expenditures, finding new ways to deliver care while containing costs, sharing and exchanging data with other agencies, and providing access to selected information for providers, beneficiaries, policy-makers, and other stakeholders.

NY Medicaid has concluded that, although pending updates to the MDW will play a critical role in providing timely and efficient access to the data already being collected, the current data sources do not contain all the information necessary to support new State and federal policies and initiatives. Successful use of HIT and HIE as a means of shaping a healthcare system that is efficient, effective, and accessible will require the collection and meaningful integration of information from many disparate sources in formats including structured data, unstructured text, and images.

In response to this need, NY Medicaid is in the process of expanding the data integration services currently provided by the MDW into a Medicaid Information Service Center ("the Center"). In addition to data from the MDW, the Center will gather information from other agencies such as the OCFS. The Center will serve as NY Medicaid's HIE platform, utilizing Microsoft's Amalga software package, which offers the ability to capture, consolidate, store, access, and quickly present data from multiple environments in meaningful ways.

Exhibit A-1, below, shows the architecture of the proposed Center.



**Exhibit A-1** NY Medicaid Information Services Center Architecture

The technical architecture of the proposed Center substantially conforms to Nationwide Health Information Network (NHIN) standards.

### Medicaid Management Information System Replacement

NY Medicaid recently released an RFP to procure an R-MMIS and successor fiscal agent. The primary objective is to implement a federally-certifiable R-MMIS that provides:

- All functionality currently supported by eMedNY, New York State's federally certified MMIS
- Enhanced functionality for provider servicing and pharmacy benefit management, as well as dental claims and prior approval processing
- Support for the HIPAA version 5010 and NCPDP D.0 Electronic Data Interchange (EDI) standards
- Support for the ICD-10 Coding System
- A commercial-off-the-shelf (COTS) Financial Management System (FMS) solution

- An enterprise technical and application architecture sufficiently flexible to support system enhancements that meet the changing needs of New York State's Medicaid program, based on the CMS MITA standards

### **Provider Outreach**

Following up on the success of the spring and fall 2010 "New York EHR Meaningful Use Summit" seminar series in raising awareness among eligible providers about the Medicaid EHR Incentive Program, meaningful use criteria, and local resources available to help with EHR and HIE adoption, NY Medicaid plans to continue extending and expanding the provider outreach program. The outreach campaign will leverage both traditional and emerging channels of communication and engagement with the provider community to encourage participation in the Medicaid EHR Incentive Program and adoption/meaningful use of EHR technology in general. Plans for the next phase of the provider outreach program are still under development, but the program is expected to include some or all of the following elements:

- Informational publications
- Webinars
- In-person presentations
- Engagement of new media and social networking

Provider outreach efforts will leverage existing educational resources, including materials made available by CMS and the efforts of RECs, customized to the specific details of participating in the Medicaid EHR Incentive Program in New York State. For example, provider outreach materials will emphasize the fact that the Medicaid EHR Incentive Program, in contrast to the Medicare program, allows providers to qualify in the first year by demonstrating only adopt/implement/upgrade activities (not requiring meaningful use until the second participation year), and does not require that plan participation years be contiguous.

## **12. Recent changes to state laws/regulations**

*Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe. Source: CMS SMHP Template Question A.12*

### **Health Care Improvement Act**

Part C of Chapter 58 of the Laws of 2009 (known as the "Health Care Improvement Act"), enacted on April 7, 2009, established several programs designed to "ensure that New Yorkers have access to a high-performing health system and that New York Medicaid buys quality, cost-effective care by ... investing in health information technology". These programs, described previously in this document, are:

- Patient-Centered Medical Home incentive program, described previously: §25 (beginning on page 58 of the legislation)
- Adirondack Medical Home multipayor demonstration program, described previously: §26-a (beginning on page 59 of the legislation)
- e-Prescribing Incentive Program, described previously: §49 (beginning on page 70 of the legislation)

### **Authority of the Commissioner of Health**

Part A of Chapter 58 of the Laws of 2010, enacted on July 2, 2010, invests the Commissioner of Health with the authority to make such rules and regulations as are necessary for the implementation of the Medicaid EHR Incentive Program and the statewide HIE network, as well as the authority to place requirements on organizations covered by 42 U.S.C. 17938 or any other organizations that exchange data through the network. These provisions are contained in §11 of the legislation.

### **e-Prescribing of Controlled Substances**

Chapter 178 of the Laws of 2010, enacted on July 15, 2010, amends the Public Health Law of New York to allow controlled substances to be prescribed electronically, to the extent that such electronic prescribing is authorized by federal regulations. It also allows the pharmacist who fills an electronic prescription for a controlled substance to endorse the prescription using an electronic signature.

### **Regulations of the Commissioner, NYS Department of Education**

NYS Pharmacy: Laws, Rules & Regulations: Part 63, effective August 20, 2009, facilitates e-prescribing by allowing pharmacies to accept and store e-scripts electronically. The provisions are contained in §63.6 Regulation and Operation of New York Establishments.

## **13. Activities across state borders**

*Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing healthcare services by Medicaid beneficiaries? Please describe. Source: CMS SMHP Template Question A.13*

As part of the broader statewide HIT/E infrastructure, activities that cross state borders will fall under the responsibility of OHITT. As can be seen from the data provided below, NY Medicaid claims data suggests that only a very small proportion of beneficiaries cross state lines in order to access Medicaid healthcare services. The following table shows the dollar value of claims paid in 2009 according to the location of service.

Type of Claim	Location	Total Claim Value	Proportion of Total Value
Medical	Within NYS	\$1,647,980,065	97.00%
	Outside NYS	\$38,850,345	3.00%
Institutional	Within NYS	\$40,912,068,818	99.50%
	Outside NYS	\$206,841,431	0.5%

**Table A-3** Medicaid claims paid in 2009 by type and location

In addition to the question of Medicaid beneficiaries crossing state lines to access services, there is the possibility that some providers will engage in cross-state activities with regard to Medicaid EHR Incentive Program enrollment and support. Providers are likely to cross into New York from any of the five bordering states (Vermont, Massachusetts, Connecticut, New Jersey, and Pennsylvania). Since administrative costs for supporting each provider are identified with the state in which the provider registers for incentive payments, there is a possibility that the State could incur administrative costs for supporting providers but be unable to recoup those costs through the 90% federal financial participation (FFP) if the providers ultimately register in another state. However, three factors suggest that the cost impact will be minimal:

- First, the cost of many of the provider support activities currently under consideration, such as webinars, online publications, and social media efforts, are constant or vary only slightly with respect to the number of providers who utilize them.
- Second, the activities with significant cost for each provider supported, such as in-person presentations and call center support, will be specific to the State's implementation of the Medicaid EHR Incentive Program, so their benefit to a provider registering in another state would be limited.
- Third, any minor costs resulting from cross-border use of support resources are likely to be offset by similar activities caused by other providers who leverage support resources in other states but ultimately register for the program in New York.

For these reasons, NY Medicaid does not believe there is a need to develop a costly and highly sophisticated cost allocation system to recover the minor costs incurred as a result of supporting providers who ultimately register in another state.

NY Medicaid recognizes that additional cross-border HIT/E activities currently underway, or planned for the near future, may have an impact on the successful adoption of EHR technology. Recognizing that the scope of these cross-border activities is not limited to Medicaid members and providers, NY Medicaid defers to

OHITT for the coordination of strategy and effort under the “all payor” model. To the extent needed and requested by OHITT, NY Medicaid will participate in statewide activities initiated by OHITT and will provide data to support these activities.

- **General Initiatives for HIT/HIE:** For more information on current and future cross-border HIT/E activities, see Appendix II (“General Initiatives for HIT/HIE”), Subsection 8.

## 14. Interoperability of immunization and public health databases

*What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)? Source: CMS SMHP Template Question A.14*

NY Medicaid is currently engaged in planning activities regarding interoperability of Medicaid data sources with child health information, such as immunization and newborn genetic screening data, through the CHI<sup>2</sup> project (see Appendix II, “General Initiatives for HIT/HIE”, and Appendix XII, “CHI<sup>2</sup> Project Documents,” for more information on this project). At this time, NY Medicaid data sources are not interoperable with immunization or public health surveillance databases. Subsequent updates to this SMHP will provide information on activities to improve interoperability.

Recognizing that the need for interoperability among immunization and public health surveillance databases is universal to all healthcare participants and providers, NY Medicaid defers to OHITT for coordination of statewide activities in this area. To the extent needed and requested by OHITT, NY Medicaid will participate in statewide activities initiated by OHITT and will provide data to support these activities.

- **General Initiatives for HIT/HIE:** For more information on the current status of interoperability among immunization and public health surveillance databases, see Appendix II (“General Initiatives for HIT/HIE”), Subsection 9, and Appendix XII (“CHI<sup>2</sup> Project Documents”).

## 15. HIT-related grants already awarded

*If the State was awarded a HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description. Source: CMS SMHP Template Question A.15*

NY Medicaid has not been awarded any HIT-related grants. To the extent that such grants have been received by other entities within the state, coordination of activities funded by the grants will be addressed in the statewide HIT plan developed by OHITT.

## **SECTION B**

# **THE STATE'S "TO-BE" HIT LANDSCAPE**

This section presents a description of specific HIT/E goals and objectives to be achieved in the next five years, including MITA/Enterprise architecture improvements and governance structures necessary to achieve stated goals and objectives.

## 1. HIT/E goals and objectives

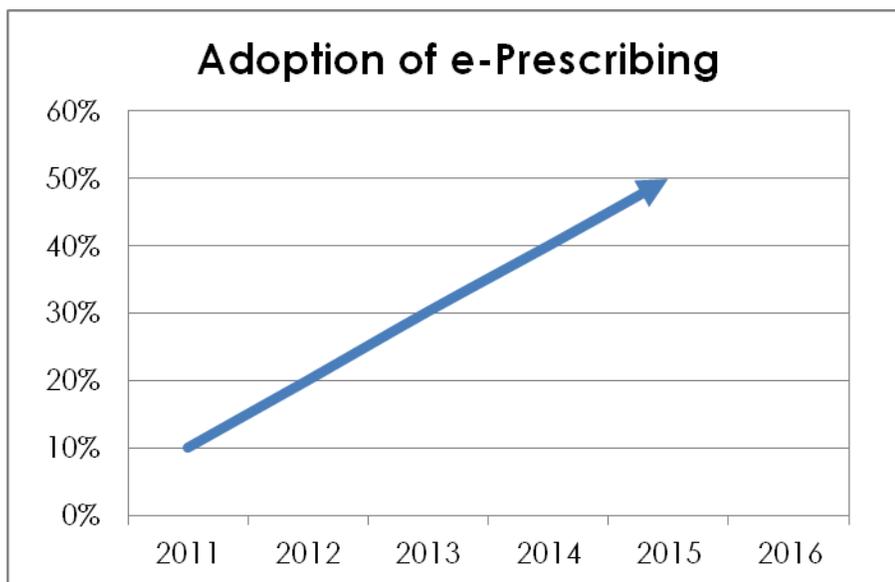
*Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc. Source: CMS SMHP Template Question B.1*

The Center for Health Workforce Studies (CHWS) at the University at Albany (part of the State University of New York) reports annually on the results of an ongoing survey of physicians in New York State. Questionnaires for this survey are distributed to all physicians as part of the required biennial re-registration of their licenses with the State Education Department; each year, the CHWS releases results from the previous two-year period (so as to represent the complete set of physicians in each report). In the survey, physicians are asked to estimate the percentage of their patients whose primary source of payment is Medicare, Medicaid, self-pay, or other. According to a 2006 analysis of survey response data by the CHWS, 11.25% of the approximately 80,000 licensed physicians in New York State serve a sufficient number of Medicaid clients to be eligible for the Medicaid EHR Incentive Program. The survey data was not analyzed by other aspects of eligibility for the Medicaid EHR Incentive Program, such as care setting (i.e., whether physicians were hospital-based), nor did it include other eligible professionals such as nurse practitioners or eligible physician assistants.

Considering the uncertainty over how many eligible providers will choose to participate, and the potential overlap between the provider groups eligible for the Medicaid and Medicare incentive programs, it is difficult to develop informed estimates as to the number of providers who will ultimately register for the program. As a result, NY Medicaid has chosen to focus on the transition of Medicaid EHR Incentive Program participants from the adoption of EHR technology to the achievement of Stage 1 meaningful use as a measurable objective for the program. We believe that a reasonable goal is for 10–20% of eligible professionals and hospitals that enroll in the Medicaid EHR Incentive Program by December 31, 2011 to reach Stage 1 meaningful use goals by December 31, 2012, increasing to 20–30% by December 31, 2013.

One component of HIT/E that is expected to see significant near-term increases in adoption is electronic prescribing, thanks to the Medicaid program implemented in May 2010 that provides financial incentives to eligible providers who issue prescriptions electronically, as well as to pharmacies that accept e-prescriptions. Goals for this program are based on the average percentage of Medicaid prescription claims submitted with prescription origin code 3 (signifying an e-prescription) relative to the total number of Medicaid prescription claims over the course of the 12-month period beginning May 1 each year (the anniversary of the program's inception) and ending

April 30 of the following year. NY Medicaid has set the goal of reaching an average of 10% e-prescriptions for the period ending April 30, 2011, 20% for the period ending April 30, 2012, and 30% for the period ending April 30, 2013.



**Exhibit B-1** Annual goals for e-prescribing

Early indications suggest good progress toward the first annual goal: e-prescribing is already up from 5.51% of the overall Medicaid prescription volume in January 2010 to 8.75% in June 2010. Going forward, e-prescribing across the Medicaid program will be tracked on a monthly basis by analyzing claims in the MMIS; statistics on individual providers' e-prescribing rates will also be available, since every claim will include the prescriber's National Provider Identifier (NPI). Since the prescription origin code is now required on all Medicaid pharmacy claims (claims without the code are automatically rejected) the accuracy of these statistics will be very high.

The Medicaid Medication History service, currently part of eMedNY and scheduled for re-implementation as part of the Medicaid Information Services Center by late 2011, supports point-of-care decision support for e-prescribing (especially in the detection of drug-drug interactions). Medication history obtained through this service has particular value when accessed through an HIE intermediary that can combine this information with other sources of medication history (from pharmacies, pharmacy benefit managers, and others), as well as other clinical data in a clinical document structure to enhance clinical decision support capabilities, such as drug-drug interaction checking. This use case was initially included as part of HEAL 5 grant funding, and participating organizations include the Brooklyn Health Information Exchange - BHIX, the Greater Rochester RHIO, THINC RHIO, the Western New York

Clinical Information Exchange, Southern Tier Health Link, the Health Information Exchange of New York, and the Bronx RHIO.

As detailed in the State's MITA Transition and Implementation Plan, NY Medicaid has set a goal to move all processes to at least MITA maturity level 3 within five years, with some processes moving to higher maturity levels based on the availability of national standards for interoperability.

As other HIT/E initiatives develop, NY Medicaid will use participation statistics to further refine existing goals and establish new metrics. For example, the Medicaid Medication History service will provide highly accurate provider usage data due to the use of Public Key Infrastructure (PKI) security and the requirement that providers supply a valid NPI when accessing the service. Combined with the fact that accessing the service is a component of the "perform medication reconciliation" meaningful use objective, we expect that early participation statistics will be useful in developing an additional metric for success of the Medicaid EHR Incentive Program.

NY Medicaid anticipates that the further development of goals and objectives for the adoption of EHR technology and the success of HIE initiatives will be significantly informed by the outcome of the eligible professional/hospital survey (currently underway), as well as the stakeholder outreach and communications campaigns planned for the fall of 2010. Future updates to this SMHP will include more refined goals and objectives based on these activities and preliminary figures regarding the level of participation in the Medicaid EHR Incentive Program.

## **2. NY Medicaid's IT system architecture**

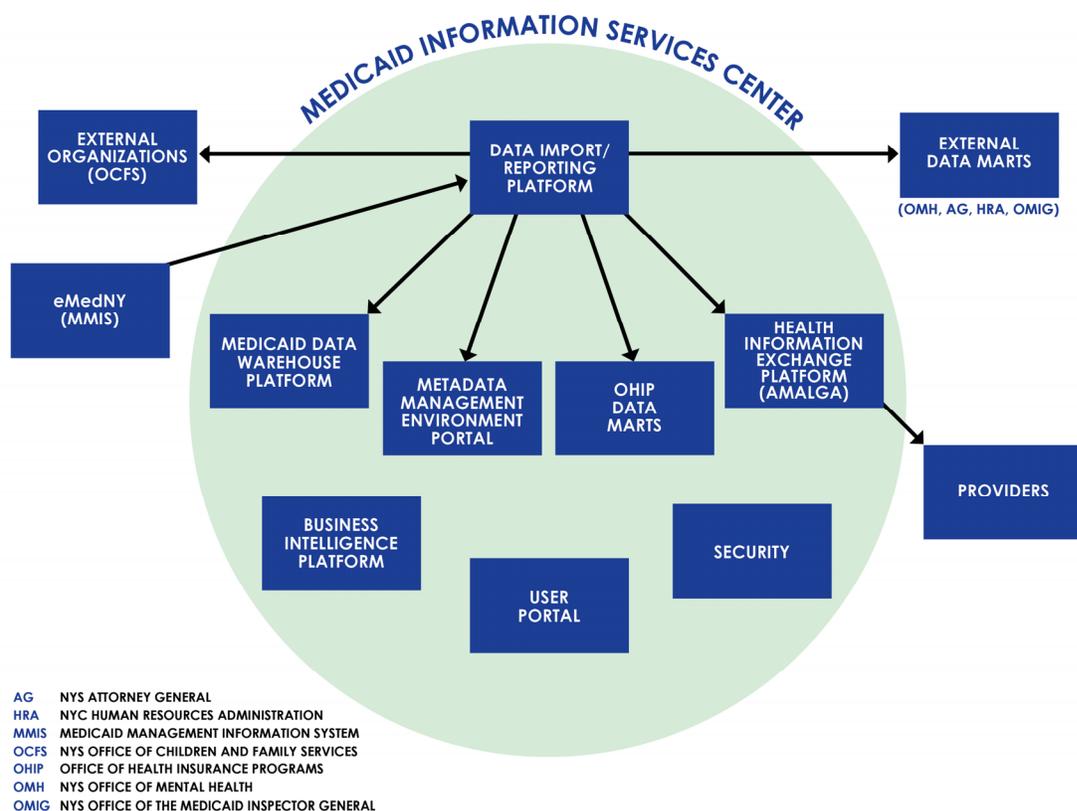
*What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locator Service? Source: CMS SMHP Template Question B.2*

NY Medicaid is currently engaged in efforts to completely replace the two main outward-facing components of the IT system architecture: the MMIS and the MDW. In support of the MITA architecture, the plan is to transition these systems to a service-oriented architecture, allowing for a standards-based enterprise service bus (ESB) that will be available to Medicaid providers. Development of services supporting statewide HIE, such as Master Patient Index and/or Record Locator Service, will be coordinated by OHITT; NY Medicaid will participate in these activities to the extent that Medicaid data is required to implement the services.

### **NY Medicaid Information Services Center**

It is anticipated that the Center, the successor to the MDW, will be operational by the summer of 2011. NY Medicaid will rely on the Center as the point of central

technical services for the Medicaid provider/client population HIE functionality. This project represents a complete redesign of the data warehouse as a new array of services for Medicaid providers and partners, including HIE, business intelligence (BI), and data transformation and publishing, published on the Medicaid ESB. In addition to access via the ESB, the Center will feature a user portal that allows users to build innovative queries and execute reports directly, without requiring custom application development. Exhibit B-2, below, shows the proposed architecture of the Center.



**Exhibit B-2** NY Medicaid Information Services Center Architecture

The Center project will initially focus on re-implementing the existing Medicaid data services within the current MDW and the Medicaid ESB; for example, the Medication History service currently linked directly to the MMIS claims system will be moved to the Center by late 2011. NY Medicaid will implement a patient-centered application to render information on Medicaid insured using Microsoft Amalga, a commercial off-the-shelf (COTS) application. In later implementation phases the Center will expand to include other Medicaid claims data, such as visit history and diagnoses, and will serve as the repository for clinical quality reporting data received from participants in the Medicaid EHR Incentive Program. The Center will conform to NHIN standards and will

be the primary means for rendering HL7 Continuity of Care Documents (CCD) for the exchange of healthcare information with external organizations.

### **MMIS Updates**

In the shorter term, a major (117,000-hour) project is currently underway to bring the current MMIS into compliance with HIPAA 5010 transaction sets by January 1, 2012. A testing environment for 5010 transactions will be available for provider testing beginning in the summer of 2011. Additionally, the MMIS is being updated in accordance with the migration to the ICD-10 code set. As of October 2013, the MMIS will be ready to accept claims in both the ICD-9 code set (for service rendered before October 1, 2013) and ICD-10 (for service rendered on October 1, 2013 or later).

### **All-Payor Database**

Among the proposals from the Governor's Medicaid Redesign Team incorporated into the fiscal year 2011-2012 budget was a proposal suggesting the implementation of a centralized database to aggregate claims information (and potentially clinical data) for all medical encounters in the State, including those paid by Medicaid, Medicare and other insurance providers, as well as self-pay encounters. In the context of current and proposed efforts to aggregate clinical and claims data in New York, a centralized All-Payor Database would provide economies of scale and improvements in data integrity and access control, building on the work already done in this area through the development of the Medicaid Medication History Project. The All-Payers Database would add value to both the statewide health information exchange (HIE) infrastructure and individual providers' Electronic Health Records (EHR) systems. Finally, an All-Payers Database would have the potential to assist both practitioners and healthcare institutions in achieving meaningful use of EHR technology as it could provide a potential repository for clinical quality metrics, immunization data, syndromic surveillance data, and laboratory data, thus allowing the provider community to take full advantage of financial incentives offered by the federal government.

## **3. Provider interface with the EHR Incentive Program**

*How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)? Source: CMS SMHP Template Question B.3*

As with all other Medicaid provider activities in NYS, the primary vehicle for interface between Medicaid providers and NY Medicaid regarding the Medicaid EHR Incentive Program will be eMedNY. To extend the functionality of eMedNY for administering the program, a new component called the eMedNY Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) is being developed and

added to the eMedNY website. This new component will enable state-level application by program participants; collection of eligibility, meaningful use data, and cost data; and coordination of incentive payments. The eMedNY Medicaid EHR Incentive Program Administrative Support Service will leverage existing data sources and contractor arrangements to streamline the implementation of the program and reduce the burden on eligible professionals and institutions for participating in the program. This new eMedNY service will be developed under the terms of an amendment to the contract with the incumbent MMIS contractor.

Provider interaction with the eMedNY Medicaid EHR Incentive Program Administrative Support Service begins with registration for the Medicaid EHR Incentive Program through the CMS National Level Repository (NLR). NY Medicaid will receive a daily transmission from the NLR containing data on the providers who have registered since the last transmission. NY Medicaid will then notify those providers (via e-mail for providers whose e-mail addresses are on file, and via postal mail for all others) that they can visit the eMedNY website to begin the application process.

The eMedNY Medicaid EHR Incentive Program Administrative Support Service application process will consist of a browser-based form interface allowing the provider to confirm demographic data pre-populated from the existing MMIS system and supply the required attestations (such as patient volume, certification status of the provider's EHR technology, costs incurred to adopt/implement/upgrade or meaningfully use the EHR system, and funding received by the provider as contributions to the EHR system). Although providers will not be required to submit supporting documentation (such as receipts) for qualified expenses and vendor contracts, they will be directed to retain documentation to support all attestations against the possibility of post-payment audit. The browser-based interface will allow the eMedNY Medicaid EHR Incentive Program Administrative Support Service to automatically calculate derived values from provider input; for example, in order to verify that the provider meets the applicable minimum Medicaid patient volume for eligibility in the Medicaid EHR Incentive Program, the provider will be asked to supply the specific values for all numerator and denominator inputs for the chosen patient volume calculation method (such as the number of Medicaid patient encounters and the total number of patient encounters during the chosen patient volume reporting period). The eMedNY Medicaid EHR Incentive Program Administrative Support Service will then calculate the actual Medicaid patient volume by applying the chosen calculation. It is the goal and intent of NY Medicaid that the eMedNY Medicaid EHR Incentive Program Administrative Support Service will be capable of leveraging existing data sources, custom program logic, and manual application review to validate provider eligibility prior to issuing incentive payments, to the extent that mechanisms to make conclusive assessments on each eligibility criterion are available.

In subsequent years of participation in the Medicaid EHR Incentive Program, providers will return to the eMedNY Medicaid EHR Incentive Program Administrative Support Service (via the eMedNY provider website) annually to reapply and report on their progress toward meaningful use of EHR technology, and to request additional Medicaid EHR Incentive Program payments. The eMedNY Medicaid EHR Incentive Program Administrative Support Service will allow the provider to confirm and update existing information (such as demographic and patient volume data) and supply additional information relevant to the provider's current program participation year (including meaningful use criteria and clinical quality data which will be passed to the Center).

For more information on eMedNY Medicaid EHR Incentive Program Administrative Support Service functionality, please see Section C ("The State's Implementation Plan").

#### 4. HIE governance

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

In its role as the statewide coordinator of health IT programs and policies, OHITT will continue over the next five years to create and advance the necessary governance structure and policies to ensure that health IT services can be implemented in a coordinated and secure manner. In its stewardship of the proposed statewide HIE network, OHITT will need to address issues of privacy, security, and interoperability among systems operated by the various qualified HIT entities and integrated healthcare delivery networks. Recently enacted state legislation invests the Commissioner of Health with the authority to place requirements on organizations that exchange healthcare data through the statewide HIE network; these requirements will need to be developed by OHITT in concert with NY Medicaid and NYeC under the statewide collaboration process. As these requirements are developed, NY Medicaid will implement the necessary processes.

In particular, the current Medicaid requirements for entities acting on behalf of a provider need to be amended to include a definition and requirements for HIE intermediaries such as qualified HIT entities. These intermediaries will support the Medicaid program's goals and objectives by facilitating provider access to clinical and administrative data and by assisting with analysis and effective use of that data.

In so doing, these intermediaries will play a role similar to the “service bureaus” currently empowered to perform administrative activities such as billing on providers’ behalf. For this reason, it is conceivable that the governance of these HIE intermediaries will be modeled on governance policies already in place for existing billing service organizations.

Considering the fact that gathering and transmitting personal health information electronically are critical components of meaningful use, it can be anticipated that issues surrounding privacy and security of patient information will need to be resolved to ensure the success of the Medicaid EHR Incentive Program. Privacy and security issues generally fall into two categories:

1. Appropriate handling and storage of protected health information (PHI)
2. Proper de-identification of data so it no longer qualifies as PHI

NY Medicaid has already expended considerable effort in resolving the first category of issues when it implemented the Medicaid Medication History service (currently in production and scheduled for migration to the Medicaid Information Services Center in mid-2011). Medication history records are PHI and have additional complications related to restrictions on the sharing of substance abuse treatment information. The consent and access policies developed for the Medication History service will be leveraged in addressing any privacy and security issues that arise related to the sharing of PHI in meeting meaningful use objectives, such as: e-prescribing; clinical decision support; exchange of key clinical information among providers of care; medication reconciliation; and transmission of summary of care records at transitions in care. It is anticipated that the ONC certification process for EHR systems and modules will ensure that PHI is properly secured within providers’ own systems.

With respect to the use of health information in meaningful use reporting and submission of clinical quality measures, the eMedNY attestation/submission interface will be designed to only accept properly de-identified information. This information will include, at most, aggregated numerator and denominator counts for specified activities (such as e-prescribing and computerized physician order entry). The attestation/submission interface will not provide the means for submitting any personally identifiable information.

Other HIE governance issues that remain to be resolved include:

- Federal regulation of interstate HIE, including transactional security and the resolution of conflicts between state requirements on credentialing of HIE organizations and patient consent for participating in HIE activities

- Business continuity and disaster recovery: how the overall HIE infrastructure is protected against the possibility that HIE participants may experience technological issues or business failure
- Compliance with forthcoming federal rules (per the notice of proposed rulemaking published in the Federal Register on July 14, 2010) extending HIPAA privacy and security requirements to other entities such as subcontractors of business associates

## 5. Supporting and promoting EHR adoption

*What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology? Source: CMS SMHP Template Question B.5*

Over the next twelve months, NY Medicaid will engage in a comprehensive provider outreach program to educate eligible professionals around the state about EHR technologies, the benefits of participation in HIE activities, and the Medicaid EHR Incentive Program in particular. To this end, NY Medicaid plans to amend their current agreement with CSC to provide adoption support through the current eMedNY website and helpdesk, as well as to provide technical assistance as required. In addition, the provider outreach program will build on the success of the "New York EHR Meaningful Use Summit" series, extending the scope of participation by embracing multiple methods of communication, including:

- A dedicated section of the Department website (<http://www.health.state.ny.us>) with a general overview of the Medicaid EHR Incentive Program and links to detailed information on the CMS website
- Press releases describing important developments and changes in the Medicaid EHR Incentive Program, state and regional HIE activities, and the HIT environment in general
- Informational materials on the Medicaid EHR Incentive Program (such as brochures or flyers) based on CMS-provided templates, customized with State-specific information
- Attendance and participation in conferences and public events organized by professional organizations, advocacy groups, and other HIT/E stakeholders
- A real-time interactive webinar (also viewable on demand) to provide information and updates on the Medicaid EHR Incentive Program to interested parties and answer their questions

- In-person seminars with representatives of state and local agencies and organizations involved in EHR implementation, HIE, and the Medicaid EHR Incentive Program, some focusing on adoption of EHR technologies and others designed for existing users of EHR who want information on moving toward meaningful use
- Multi-platform social media outreach to engage early technology adopters among health professionals, quickly disseminate information about emerging EHR technology and HIE opportunities, and empower the community of EHR adopters to support each other along the path to meaningful use

The e-prescribing incentive program instituted on May 1, 2010 will also have the effect of encouraging adoption of certified EHR technology. Under this program, eligible providers (including physicians, dentists, nurse practitioners, podiatrists, optometrists, and licensed midwives) receive incentive payments of \$0.80 per dispensed Medicaid ambulatory e-prescription (including refills), and retail pharmacies receive incentive payments of \$0.20 per dispensed e-prescription. To be eligible for the incentive payments, the prescriptions must be transmitted via “encrypted, interoperable computer-to-computer electronic data interchange in machine-readable (non-facsimile) format, compliant with Medicare Part D standards.” By leveraging existing standards such as Medicare Part D and the NCPDP, and by excluding computer-to-facsimile transmissions, the State expects that this incentive payment program will promote the general adoption of interoperable EHR systems. A copy of the guidance issued by NY Medicaid on the e-prescribing incentive program can be viewed in Appendix VII (“Medicaid Update on e-Prescribing Incentive”).

NY Medicaid is working with the State’s two RECs to coordinate efforts to encourage the adoption and meaningful use of EHR technology. NY Medicaid’s intent is to supplement the efforts of the RECs by focusing on providing support and assistance to the Medicaid providers that are excluded from REC services. For more information on the activities being undertaken by the RECs, see Appendix II (“General Initiatives for HIT/HIE”).

Future updates to this SMHP will include more details on specific activities, goals, and achievements in provider outreach and encouragement of EHR technology adoption.

## 6. FQHC and HRSA HIT EHR funding

*If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption? Source: CMS SMHP Template Question B.6*

New York's fifty-nine Federally Qualified Health Centers (also known as Community Health Centers or CHCs) play a significant role in caring for Medicaid patients throughout the State. As some of the earliest adopters of the Patient Centered Medical Home model of care delivery, they are an important part of encouraging widespread adoption of EHR technology. The Community Health Care Association of New York State (CHCANYS), the advocacy group for CHCs in New York, reports that more than half of the 445 community health locations in the State currently have EHR systems, and another 20% have EHR implementations in progress. As part of the Stakeholder Outreach initiative, NY Medicaid met with CHCANYS to discuss the role of FQHCs in EHR adoption and the specific concerns of FQHCs relative to the Medicaid EHR Incentive Program. For a summary of the results of that meeting, see Appendix V ("Stakeholder Outreach").

Coordination of funding for FQHCs from external sources, such as HRSA, is outside the scope of NY Medicaid activities. To the extent that activities are currently underway to leverage federal funding to FQHCs for encouraging EHR adoption, they will be documented in the statewide HIT plan published by OHITT.

## 7. Technical assistance to providers

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

Technical assistance for the Medicaid EHR Incentive Program in New York will be provided by NY Medicaid's authorized fiscal agent through amendments to the existing contract for eMedNY provider technical support. The eMedNY call center, which currently handles more than one million provider support calls every year, will be augmented to provide support for adoption, implementation, and upgrade of EHR technology by eligible Medicaid providers and hospitals, as well as meaningful use activities. Augmentation of the existing provider support infrastructure will be accomplished by adding resources (phone lines, support staff, etc.) dedicated to supporting the Medicaid EHR Incentive Program. The fiscal agent will maintain strict separation of costs between MMIS support resources and those dedicated to support of the Medicaid EHR Incentive Program. By so doing, the former can be allocated

100% to ongoing MMIS operations and the latter can be allocated 100% to the Medicaid EHR Incentive program for 90% FFP.

By leveraging the existing provider support channels, NY Medicaid will enable providers to seek assistance in a familiar environment, thus reducing the burden on providers for adopting EHR technology and achieving meaningful use. Beyond the current contract term, technical support will continue to be a component of the NY Medicaid fiscal agent contract.

## 8. Populations with unique needs

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

NY Medicaid has identified populations with unique needs pertaining to coordination of care and health information exchange and is continuously engaged in the process of identifying the needs of those populations and developing programs to meet those needs. Some examples of such populations are:

- Children in the care of the Office of Children and Family Services (OCFS) through foster care and the juvenile justice system
- Adults with serious mental illness and children with serious emotional disturbances
- New Yorkers with developmental disabilities
- New Yorkers suffering from substance abuse and behavioral health issues

One particular need shared by many of these populations is related to the fact that they experience a greater-than-average number of transitions in care. The initiatives already underway by NY Medicaid to improve care outcomes at transitions of care—such as the Medication History Service, e-Prescribing Incentive, and Patient-Centered Medical Home Incentive—are, therefore, expected to benefit these populations in even greater numbers than the general patient population.

NY Medicaid is already experiencing success in addressing the particular need for improvements in the prescribing of psychotropic drugs to individuals diagnosed with a serious mental illness. Over the past decade, a number of studies have documented quality issues, including under- and overdosing of medications, inadequate duration of medication trials, frequent changes in medication regimens, medication adherence issues, off-label use of psychotropic medications in children, and the use of polypharmacy. Psychotropic polypharmacy is a particular concern due to potential side effects, such as weight gain, diabetes, and metabolic syndrome, as well as increased risks of drug-drug interactions. To address these clinical quality issues, NY

Medicaid and OMH are engaged in a four-year initiative to improve the quality and efficiency of psychotropic prescribing practices through the adaptation of a successful OMH program, the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), to the Medicaid population. Initially developed for use in state psychiatric facilities, where it supported significant improvement in medication practices, PSYCKES provides web-based tools that allow users to navigate through state-, region-, county-, agency-, program-, and recipient-level reports to review quality indicators, identify consumers whose treatment could benefit from review, and obtain medication and service utilization information to support quality improvement and clinical decision-making.

In the future, the improvements in quality of care for individuals with serious mental illness that have been achieved through the sharing of healthcare information between NY Medicaid and OMH will be extended to reach additional populations with special needs. Over the next year, NY Medicaid will work with OCFS to develop a use case for data sharing in support of clinical improvements in care for children in the juvenile justice system, with the goal of implementing this use case by late 2011. Additional public health initiatives are planned to begin in late 2011 for a projected implementation in 2012.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is in the process of assembling a multi-state collaborative to create an open source electronic health record to integrate behavioral health with primary care for individuals with mental and substance abuse disorders. A multi-state advance planning document (APD) for this initiative is currently being developed. NY Medicaid is supporting the APD development activities being led within the State by the Office of Alcoholism and Substance Abuse Services (OASAS).

Beyond reaching out to specific populations already identified as having unique needs, NY Medicaid is pursuing infrastructure improvements that will make it easier to respond to emergent needs. In particular, the architecture for the new Center is based on flexible web services, which can quickly be adapted and combined to deliver targeted, actionable information wherever the need presents itself.

## 9. Use of HIT-related grants

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

NY Medicaid has not been awarded any HIT-related grants. To the extent that such grants have been received by other entities within the state, the use of these grants for encouraging the adoption of HIE and EHR technologies will be addressed in the statewide HIT plan developed by OHITT.

With the variety of initiatives currently underway to facilitate the transformation of healthcare in New York State to meaningfully use HIT and HIE—including the previously mentioned HEAL NY grant program, PCMH demonstration program, and Medicaid e-prescribing and PCMH incentives—there is clearly a need to align objectives and leverage collected data and developed policies across the various initiatives. However, NY Medicaid's role in the overall alignment of HIT/E initiatives is generally limited to the Medicaid-eligible population, and in the specific case of the Medicaid EHR Incentive Program, to the universe of eligible professionals and hospitals. As such, for authorized parties, NY Medicaid will make information available through the MDW component of the Center. Through publicly-available updates to this SMHP, NY Medicaid will also report on the impact of the Medicaid EHR Incentive Program on EHR adoption, as well as clinical and cost outcomes.

## 10. Legislative issues

*Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe. Source: CMS SMHP Template Question B.10*

Significant work has been done in 2009 and 2010 to reconcile State legislation to the realities of modern healthcare. For a description of recent legislation affecting e-prescribing and the authority of the Commissioner of Health to regulate HIE, see Section A of this SMHP.

### Remaining State legislative issues

Certain provisions in State law governing prescriptions present a particular barrier to the widespread adoption of electronic prescribing in New York. Specifically, in its current form, the State education law specifies that prescriptions must contain a

“dispense as written” (DAW) section having specific physical properties such as font size and physical measurement (an obvious barrier to the adoption of electronic prescribing), and contains no allowance for prescriptions to be validated by electronic signature. Legislation to update these provisions of State law has been proposed; pending the enactment of this legislation, many pharmacies will not accept electronic prescriptions (seriously hindering the ability of eligible professionals and hospitals to meet the e-prescribing meaningful use objective of the Medicaid EHR Incentive Program).

To support accurate reporting of electronic prescribing as a proportion of each provider’s overall prescription volume, NY Medicaid is currently involved in discussions with the New York State Board of Pharmacy to mandate the use of the provider’s NPI as the prescriber identifier on all prescriptions. Future updates to this SMHP will comment on the progress of this initiative.

### **Federal restrictions on HIE**

One federal legislative issue that remains to be resolved has to do with the incorporation of health records from substance abuse treatment facilities in HIE activities. Federal confidentiality law and regulations (codified as 42 U.S.C. §290dd-2 and 42 CFR Part 2) place special restrictions on the disclosure of health information resulting from substance abuse treatment programs, including substance abuse-related diagnoses, prescriptions pertaining to the treatment of substance abuse conditions, and even the fact that an individual participated in a substance abuse treatment program. Individuals may consent to the disclosure of such information to HIE organizations, but 42 CFR Part 2 requires that such consent must include (among other information) the identity of both the program or person authorized to make the disclosure and the individual(s) or organization(s) authorized to receive the information, as well as the duration and specific purpose of the disclosure. This means that a blanket consent to disclose patient information to all members of an HIE organization without specifically enumerating them, or one that grants consent to disclose information to future members of the HIE organization, is not compliant with 42 CFR Part 2 and may not be used to authorize disclosure of substance abuse treatment information. Substance abuse treatment programs may share patient information with HIE organizations for the purpose of providing services to the program (such as holding and storing patient data, receiving and reviewing requests for disclosures to third parties, and facilitating the electronic exchange of patient information) without specific patient consent if they have a Qualified Service Organization Agreement (QSOA) with the HIE organization, but disclosure of this information to a third party by the HIE organization still requires specific consent in the manner dictated by 42 CFR Part 2. Consequently, HIE services that require aggregation of healthcare information,

such as comprehensive medication history services, may neither include information regarding substance abuse treatment nor indicate that protected information has been omitted (as this would constitute affirmative verification that the individual had received substance abuse treatment), unless consent has been granted by the individual for disclosure to the specific individual seeking access to the information. Although NY Medicaid does not propose a specific solution to this problem, this obstacle to the implementation of certain HIE services must be addressed in order to ensure that the services can be implemented in a manner consistent with federal laws and regulations, while retaining their reliability and effectiveness.

#### **Federal regulations regarding generic substitution of e-prescriptions**

In addition to the barrier to widespread adoption of e-prescribing imposed by State education laws requiring physical “dispense as written” provisions (as described above), federal regulations regarding generic substitution are also hampering the adoption of e-prescribing. Specifically, although federal Medicaid law was amended in 2007 to allow an electronic alternative to the handwritten “brand medically necessary” statement, the Secretary of Health and Human Services has not formally adopted a suitable electronic alternative. Until such time as an electronic alternative for the “brand medically necessary” statement is in place, this regulation will serve as a significant barrier to the adoption of e-prescribing in New York.



## SECTION C

# THE STATE'S IMPLEMENTATION PLAN

This section provides a description of processes NY Medicaid will employ to ensure that eligible medical professionals and hospitals have met all Federal and State statutory and regulatory requirements governing electronic health record incentive payments.

## The eMedNY Medicaid EHR Incentive Program Administrative Support Service

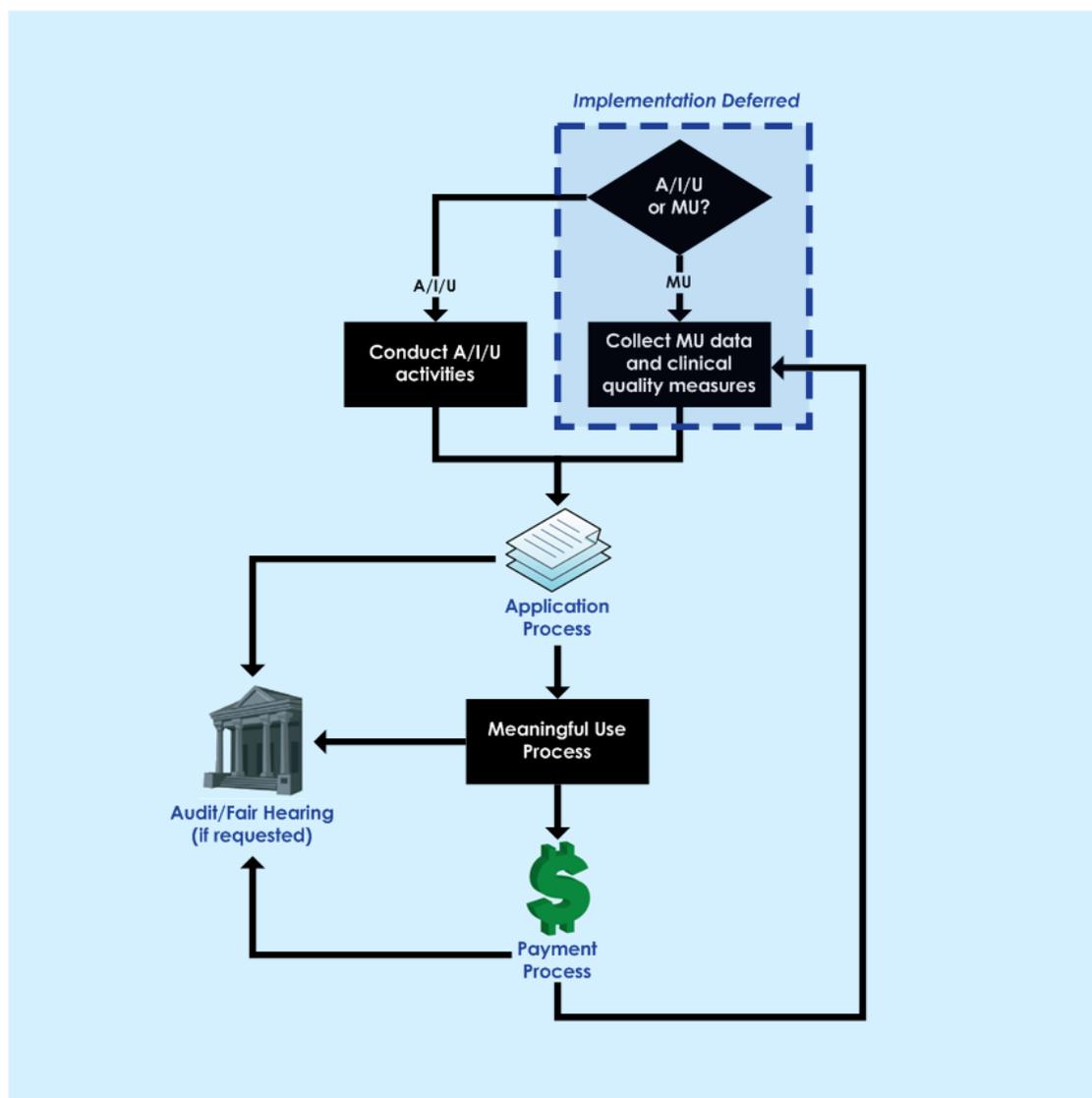
The primary administration vehicle for the Medicaid EHR Incentive Program will be the eMedNY Medicaid EHR Incentive Program Administrative Support Service (MEIPASS). This application, currently under development through the joint efforts of NYSTEC and Computer Sciences Corporation (CSC), is a new module within eMedNY that will be responsible for program application, eligibility activities, collection of meaningful use data, and coordination of incentive payments. The eMedNY Medicaid EHR Incentive Program Administrative Support Service will leverage existing data sources (such as the state MMIS) and contractor arrangements (such as the existing contract with CSC to provide claims payment services) to streamline the implementation of the program and reduce the burden on the eligible provider for participating in the program.

In the first year of New York's Medicaid EHR Incentive Program, eMedNY MEIPASS will be capable of supporting all activities that are relevant to providers' first program participation year, including:

- registration;
- general program eligibility;
- attestation to adoption, implementation, and upgrade activities; and
- incentive program payments.

In future program years, eMedNY MEIPASS functionality will expand to cover activities relevant to providers' second and subsequent years of program participation including attestation to meaningful use and submission of clinical quality measures. Future versions of this NY-SMHP will describe the details of this functionality including screenshots of the meaningful use attestation interface.

More information on the eMedNY Medicaid EHR Incentive Program Administrative Support Service is provided throughout this section of the SMHP.



**Exhibit C-1** Overview of eMedNY Medicaid EHR Incentive Program Administrative Support Service Workflows

## Verification of provider eligibility

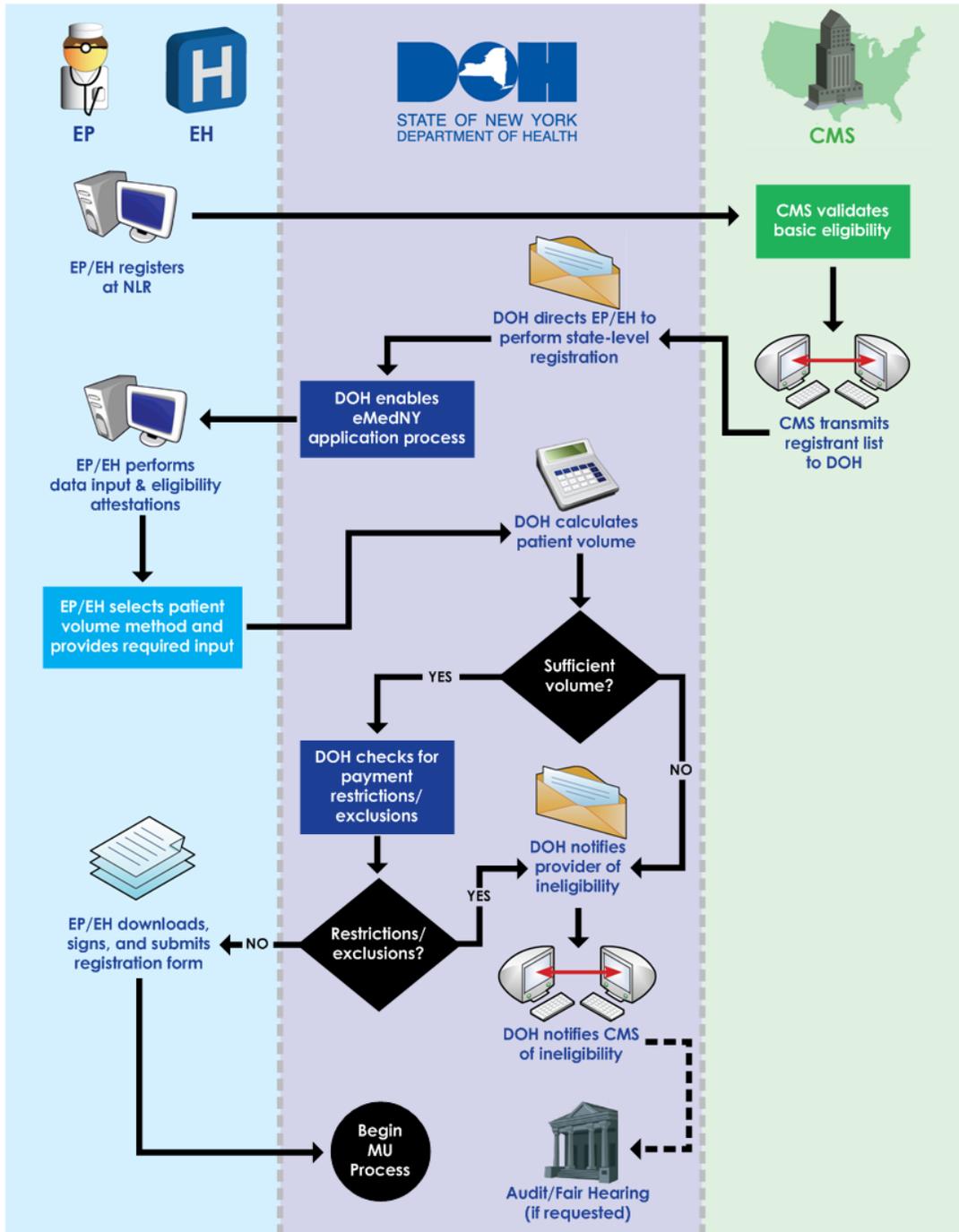
Eligible professionals and hospitals will begin the process of applying for the Medicaid EHR Incentive Program by visiting the website of the CMS National Level Repository (NLR) and logging in with the required information, such as National Provider Identifier (NPI) and CMS Certification Number (CCN). (Providers who visit the eMedNY website to apply before registering with the NLR will be directed to visit the NLR and register there to unlock the eMedNY application interface.) The NLR website will collect basic information on the applicant, such as name, e-mail address, business address, telephone number, and the desired incentive program (Medicare or Medicaid, and state if applicable). CMS will then transmit to NY Medicaid a list of applicants who selected the Medicaid EHR Incentive Program in New York, along with

the registration data collected on these applicants. Upon receiving this application information from the NLR, NY Medicaid will generate a notification to be sent via e-mail or postal mail to each registrant. This notification will inform the registrant that NY Medicaid has received the registration data from the NLR and inviting the registrant to log in to eMedNY in order to perform the required State-level registration and eligibility attestation using the eMedNY Medicaid EHR Incentive Program Administrative Support Service. Verification of provider eligibility will be automated to the extent possible given the currently available data sources.

NY Medicaid currently requires the use of physical signatures to initially verify the authenticity of provider applications, and to establish a basis for the subsequent use of electronic signatures. For example, a provider who wishes to submit transactions (such as Medicaid claims) electronically must first submit a physically signed, notarized form requesting an Electronic/Paper Transmitter Identification Number (ETIN). This form certifies that the provider agrees to the terms of electronic submission, including the stipulation that the physical signature will apply to all subsequent transactions submitted electronically. It is the intent of NY Medicaid to use a similar process for the Medicaid EHR Incentive Program requiring providers to supply a physical signature once and allowing them to certify subsequent attestations using an electronic signature.

At the time they complete the application process in their first program participation year, providers will be presented with an electronically-generated form showing the contents of their attestations as to program eligibility and Medicaid patient volume, and listing the terms by which they will be allowed to certify future attestations using an electronic signature. Each provider must print and sign this form and return it by postal mail to NY Medicaid; once this form has been received and processed by NY Medicaid, the provider will be allowed to continue with the Meaningful Use workflow and all further attestations will be certified using the provider's electronic signature. This process is mandatory; other than the initial application form that authorizes the electronic signature, no further physical signatures will be accepted. During the final design and implementation of the eMedNY Medicaid EHR Incentive Program Administrative Support Service in the third quarter of 2011, NY Medicaid will evaluate the possibility of leveraging the existing ETIN process for establishing electronic signature authority, which would further streamline the process for those providers who already submit Medicaid claims electronically by removing the need for the physical signature form during initial registration for the Medicaid EHR Incentive Program.

Exhibit C-2 shows an overview of the eMedNY Medicaid EHR Incentive Program Administrative Support Service application process.



**Exhibit C-2** eMedNY Medicaid EHR Incentive Program Administrative Support Service Application Workflow

## 1. Verification of provider licensing and sanction status

*How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers? Source: CMS SMHP Template Question C.1*

The eMedNY Medicaid EHR Incentive Program Administrative Support Service application process is initiated from within the provider web interface to the state MMIS, eMedNY. Only active New York Medicaid providers who have completed the first phase of NLR registration, and for whom the NLR has generated a transaction to the state, will be presented with the opportunity to launch the eMedNY Medicaid EHR Incentive Program Administrative Support Service application process. This ensures that checks on basic eligibility, such as having an NPI and being an eligible provider type, are done even before the eMedNY Medicaid EHR Incentive Program Administrative Support Service application process begins.

EHR Incentive Payments will be processed by the State's fiscal agent (CSC) through the existing workflow established for Medicaid claims payments, which already includes pre-payment checks of the Medicaid provider file to ensure recipients are properly licensed and not subject to sanctions or payment restrictions. License status and provider sanctions are monitored on an ongoing basis, integrating real-time license status updates from the State Department of Education and periodic notifications of sanctions and exclusions from OMIG and the Office of the Inspector General (OIG), to ensure that provider eligibility status is kept up to date.

In 2009, a Program Integrity Review conducted by the CMS Medicaid Integrity Group (MIG) identified some issues related to NY Medicaid's enrollment process with regards to criminal conviction information. In response to the MIG's initial findings, NY Medicaid amended the enrollment application for Medicaid fee-for-service providers to require that the disclosure of sanctions, criminal convictions, and licensing/certification issues on behalf of the applicant as well as "any partners, directors, officers, agents, or managing employees of the named provider completing this form." After the MIG released its final report on December 20, 2010, NY Medicaid further amended the enrollment application to require that applicants "attach a list names and addresses of any partners, directors, officers, agents or managing employees" that were the subject of these disclosures. These steps resolved the issues brought forward by the MIG's Program Integrity Review to ensure that only appropriate providers are receiving federal funds.

## 2. Verification of provider's "hospital-based" status

*How will the SMA verify whether EPs are hospital-based or not? Source: CMS SMHP Template Question C.2*

According to the criteria established by CMS through the federal rule-making process for the Medicaid EHR Incentive Program, EPs are considered to furnish "substantially all" of their Medicaid-covered services in a hospital setting, and thus are ineligible for participation in the Medicaid EHR Incentive Program (unless they practice predominantly in an FQHC or RHC), if at least 90% of covered professional services are rendered in a hospital setting. The "hospital setting" is explicitly defined as consisting of locations represented by the CMS Place of Service (POS) codes 21 (Inpatient Hospital) and 23 (Emergency Room, Hospital).

During eMedNY Medicaid EHR Incentive Program Administrative Support Service processing for eligible professionals, the applicant will be required to attest that he/she is not hospital-based according to this definition. Available data on NY Medicaid fee-for-service claims and managed care encounters will be leveraged to determine the percentage of Medicaid claims during the previous year that were submitted with the two hospital-based POS codes, as compared to the total number of Medicaid claims submitted by the provider over the same period. If at least 90% of the claims submitted during the previous year were within these two POS codes (and the provider does not qualify separately through the "practices predominantly" criteria), the eMedNY Medicaid EHR Incentive Program Administrative Support Service would automatically reject the registration pending an issue resolution process initiated by the provider.

## 3. Verification of overall content of provider attestations

*How will the SMA verify the overall content of provider attestations? Source: CMS SMHP Template Question C.3*

The eligible hospital/provider is primarily responsible for the content of self-attestations. NY Medicaid anticipates utilizing CMS-developed templates for back-up that document certain aspects (e.g., methodology for determining Medicaid/medicaid patient volume thresholds); other aspects of provider attestations, such as use of certified EHR technology, would be verified against CMS or ONC files.

The table below shows a summary of the methods NY Medicaid plans to use to validate the overall content of each provider attestation.

Validation	Pre-Payment		Post-Payment	
	Automatic	Manual	Automatic	Manual
Eligible provider type	✓			✓
Provider is not sanctioned or excluded from receiving Medicaid payments	✓			✓
Provider is actively enrolled in NY Medicaid	✓			✓
Provider is not hospital-based	✓			✓
Provider practices predominately at an FQHC or RHC		✓		✓
Provider demonstrates sufficient Medicaid patient volume		✓		✓
Provider demonstrates adoption, implementation, or upgrade of certified EHR technology				✓
At least 50% of provider's patient encounters occur at a location with certified EHR technology				✓
Payment is assigned to an appropriate recipient under 42 CFR § 495.10(f)(1)				✓
Inputs to hospital incentive calculation	✓			✓

**Table C-1** Summary of validation methods for provider attestations

For the items that NY Medicaid plans to validate automatically, the following data sources will be used:

- The NY Medicaid provider file will be used to validate eligible provider type, sanctions/exclusions, and active enrollment in NY Medicaid, as described in section 1 above.

- NY Medicaid claims and managed care encounter data will be used to validate that EPs are not hospital-based, as described in section 2 above.
- The Institutional Cost Report submitted annually to the State by hospitals will be used to validate the inputs to the hospital incentive payment calculation as described below in the section titled “EHR Incentive Payment Processing” and in Appendix VI (“Hospital Incentive Payment Calculation”).

Manual pre-payment validation of the indicated EP attestations will be conducted by randomly selecting a subset of Medicaid EHR Incentive Program applications for verification by program support staff. Applications that are selected for verification will be held in a pending status after the provider completes all required attestations and before payment is issued; program staff will verify the provider attestations against fee-for-service claims history and managed care encounter data, requesting additional documentation from the provider as needed, and either approve the application if the information substantiates the provider's attestations or reject the application (subject to an issue resolution process initiated by the provider) if the attestations cannot be substantiated. Given the smaller number of hospitals eligible to participate in the Medicaid EHR Incentive Program and the larger value of each hospital incentive payment, NY Medicaid will directly verify that the attested values for all hospital incentive applications match the values submitted in the appropriate hospital cost report and will not allow hospitals to attest to different values than those previously certified in the cost report.

Other mechanisms of validating overall provider attestation will be expanded upon as the process develops. At the beginning of the program, NY Medicaid will:

- Investigate the availability of suitable data on participation in Medicaid, Child Health Plus, Family Health Plus, supplemental nutrition assistance, and federally-subsidized school breakfast/lunch programs in the areas served by a FQHC or RHC for use in estimating the proportion of needy individuals in the area, in order to compare that estimate to the proportion of needy individuals claimed by providers at that facility as a test of reasonableness.
- Direct eligible providers to retain documentation to support all attestations for no less than six years after each payment year against the possibility of post-payment audit.
- Determine the feasibility of leveraging existing Medicaid claims data to conduct a test of reasonableness for providers' attestation that they meet the meaningful use criteria for electronic prescriptions
- Investigate the possibility of working with private e-prescribing intermediaries such as Surescripts to obtain records of e-prescribing activity that could be used during post-payment audit to validate providers'

attestations, at least as far as validating the numerator, and ensure the use of certified EHR technology through the use of a verification service once it is made available by ONC.

#### 4. Communication with providers

*How will the SMA communicate to its providers regarding their eligibility, payments, etc? Source: CMS SMHP Template Question C.4*

The three primary methods of ongoing communications with eligible professionals/hospitals enrolled in the Medicaid EHR Incentive Program will be through the eMedNY web interface, e-mail, and postal mail. Providers will be required to supply an e-mail address during the process of registering with the NLR, and this e-mail address will be supplied to NY Medicaid as part of the electronic transfer of registration data; NY Medicaid will then use this e-mail address to communicate non-confidential information to providers. If a provider's e-mail address is not available at the beginning of the state application process, NY Medicaid will send initial correspondence via postal mail requesting the provider's e-mail address. All subsequent communications will then be made via e-mail. Providers will also be able to use a secure messaging interface on the website to view information such as eligibility status updates and incentive payment notifications. Official notice of decisions regarding provider applications will be sent in writing.

Additionally, key information about program status will be conveyed by the state of the eMedNY user interface itself. For example, a provider who has not yet enrolled in the program will see a user interface element (such as a button or hyperlink) directing them to enroll at the NLR website; once the NLR enrollment is complete and the relevant information has been transmitted to the eMedNY Medicaid EHR Incentive Program Administrative Support Service, the system will notify the provider that his/her status has changed by replacing this user interface element with one that allows him/her to launch the eMedNY Medicaid EHR Incentive Program Administrative Support Service to begin the state-level eligibility verification process.

#### 5. Methodology for calculating patient volume

*What methodology will the SMA use to calculate patient volume? Source: CMS SMHP Template Question C.5*

The methodology for calculating patient volume to determine providers' eligibility was established through the federal rule-making process. According to the published rule, eligibility (with respect to patient volume) for any given year is determined by selecting a representative continuous 90-day period during the previous year and

calculating a proportion of patient encounters where the numerator is the number of Medicaid patient encounters and the denominator is all patient encounters for the same period. In order for an eligible professional to receive incentive payments, this proportion must be greater than 30%, with the exception of pediatricians (who qualify for incentives at a reduced rate if their Medicaid patient volume is between 20% and 30%) and EPs practicing predominantly in an FQHC or RHC (who may substitute “needy individuals” as defined in §495.302 for “Medicaid patients” when demonstrating the 30% proportion). Acute care hospitals need a minimum patient volume of 10% Medicaid to be eligible for incentive payments.

NY Medicaid will also allow providers to qualify for the Medicaid EHR Incentive Program using the alternative patient volume methodology set forth in the final rule. Under this alternative, providers may count Medicaid patients current on the provider's patient panel during the 90-day reporting period (including any Medicaid managed care panel, medical or health home program panel, or similar provider structure with capitation and/or case assignment), plus all other Medicaid encounters for that EP during the reporting period, in the numerator, so long as they also count the total number of patients assigned through these panels in the denominator. Providers may not double-count patients on panels who have also had an encounter during the 90-day reporting period. Consistent with the final rule, NY Medicaid will accept, as a proxy for assessing what patients are “current” on a provider's panel for the reporting period, any patients on the panel who had an encounter during the calendar year previous to the 90-day reporting period.

In order to streamline the application process and reduce the burden on providers for calculating patient volume, NY Medicaid originally proposed an additional patient volume calculation methodology. This methodology sought to screen Medicaid EHR Incentive program applicants during the application process to identify some that could be deemed to meet the required Medicaid patient volume threshold for program eligibility automatically, solely using claims and encounter data already collected by NY Medicaid. In developing this alternate methodology, NY Medicaid planned to rely on the assumption that full-time clinicians have an average of no more than twenty-four patient encounters per day—meaning that over the 90-day reporting period, any provider that averaged seven or more Medicaid claims per business day could be assumed to have met the 30% Medicaid threshold for eligibility in the Medicaid EHR Incentive program. Providers who averaged seven or more Medicaid claims per day during the chosen reporting period (based on data retrieved automatically from the MMIS) would not have been required to submit any further data for the patient volume requirement.

In order to validate the assumptions upon which this automatic patient volume methodology was based, NY Medicaid undertook an effort to conduct field trials of

the methodology with volunteer practitioners and group practices throughout the State. These practitioners agreed to review their billing records and report on the actual number of Medicaid and overall patient encounters per practitioner, as well as the number of days each practitioner was in clinic. In parallel, NY Medicaid conducted a search of MMIS claims history for 2010 to query the number of encounters for each Medicaid provider over all 90-day periods within calendar year 2010. The intent was to compare each 90-day period during which a provider's records review found a sufficient patient volume for eligibility with the outcome of the automatic patient volume calculation for the same period, to determine whether the two methods consistently yielded the same result. NY Medicaid further proposed to collect data during the course of normal post-payment audit activities to validate the use of twenty-four patient encounters per day as a proxy value for the denominator of the automatic patient volume calculation.

In the course of conducting the search of MMIS claims history, it was discovered that the available data sets do not unambiguously associate a given Medicaid fee-for-service claim with the practitioner who rendered the service represented by that claim. For example, it is acceptable practice for group practices and clinics with multiple practitioners who provide care to Medicaid beneficiaries to submit all their Medicaid claims under the provider ID of a supervising physician; in that scenario, a query of MMIS records would misrepresent the number of Medicaid encounters for each provider in that practice (with the supervising physician being found to have many more Medicaid encounters than he/she actually had, and all other providers in the practice being found to have no Medicaid encounters at all). Given this fundamental limitation of the claims data, it is impossible to automatically determine the number of Medicaid encounters for a given provider solely based on data sources available to NY Medicaid, and NY Medicaid therefore withdraws the proposed automatic patient volume calculation method.

The results of the field trials also revealed that the providers' ability to calculate the numerator of the patient volume calculation may be limited when a significant proportion of the provider's patient population is assigned to managed care programs. Specifically, participants in the field trials reported that they were unable to distinguish between managed care patients whose care was paid for by Medicaid (and thus would qualify as Medicaid patient encounters) and those whose care was paid by other sources. NY Medicaid expanded the scope of the data collection effort to identify alternative approaches to calculating patient volume that address this challenge—specifically, to determine whether the Medicaid managed care encounter data reported to NY Medicaid by managed care organizations (and stored in the Medicaid Data Warehouse) could be leveraged to calculate the number of Medicaid managed care encounters for a given provider during his/her chosen

patient volume reporting period. Unfortunately, it was determined that the managed care encounter data shows anomalies similar to those found in the fee-for-service claims data, with some providers found to have far more Medicaid encounters than would be possible for a single practitioner. Presumably, some group practices and clinics are reporting their managed care encounters in an aggregated manner similar to the way they aggregate fee-for-service claims, with a single supervising physician being reported as the rendering provider for all encounters. As a result of these outliers, NY Medicaid cannot rely on the managed care encounter data to make absolute determinations of patient volume (including calculating patient volume on the provider's behalf); however, given that the majority of managed care providers appear to be reporting credible numbers of encounters, this data is still useful as one factor in pre-payment tests of reasonableness.

In the case of providers practicing predominantly in FQHCs/RHCs who seek to qualify under the alternative criteria of 30% "needy individuals," NY Medicaid will encourage providers to collect information from their patients regarding their participation in public assistance programs in order to establish the percentage of their patients who qualify as "needy individuals" according to the definition set forth in the federal rule on the Medicaid EHR Incentive Program. Providers will be reminded that, although they may not meet the 30% Medicaid patient volume threshold, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries do count toward the 30% "needy individuals" threshold.

For the purposes of determining eligibility for participating in the Medicaid EHR Incentive Program using the 20% threshold, NY Medicaid defines "pediatrician" as a physician (M.D. or D.O.) who meets all other criteria for eligibility in the program and additionally satisfies at least one of the following:

- The practitioner is board-certified in General Pediatrics or a pediatric subspecialty by either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP). This certification must be current and in good standing during the entire patient volume reporting period, at the time of attestation, and at the time of each incentive payment.
- The practitioner focuses on treating patients 18 years old and younger, and demonstrates that the majority of care is provided to patients 18 years old and younger. For providers who opt to attest to patient volume using the standard patient volume methodology, "majority of care" is defined as at least 50% of all patient encounters during the patient volume reporting period. For providers who opt to attest to patient volume using the alternative patient volume methodology, "majority of care" is defined as at

least 50% of the total of: (a) all patients current on the provider's patient panel, and (b) all patient encounters for patients not on the provider's patient panel.

In order to minimize the burden on providers for documenting sufficient Medicaid patient volume for eligibility in the Medicaid EHR Incentive Program, group practices and clinics with more than one eligible provider will be allowed to use the aggregate Medicaid and overall patient volume for the entire practice/clinic as a proxy for each provider's individual patient volume. All providers enrolling in the Medicaid EHR Incentive Program from a single practice or clinic must use the same methodology for any given calendar year. In other words, if the first provider enrolling from a clinic/practice attests to individual patient volumes, all providers subsequently enrolling for that calendar year will be required to attest to individual patient volumes, whereas if the first provider attests to overall patient volumes for the clinic/practice as a whole, subsequent providers will be required to attest to the same overall patient volumes rather than being given the opportunity to provide individual patient volumes. Clinics and group practices that opt to use aggregate patient volumes may choose either of the calculation methodologies detailed above (i.e., they may use a simple count of Medicaid patient encounters over the 90-day reporting period as a proportion of overall patient encounters, or they may use the alternate methodology that includes providers' patient panels). Any provider using aggregate patient volumes will additionally be required to attest that use of the aggregate value is appropriate for that provider (e.g., that the provider does not exclusively see Medicare, commercial, or self-pay patients within the practice or clinic patient population). As with individual patient volume attestation, providers using the aggregate practice/clinic patient volumes will be responsible for the accuracy of the attested values, and in the event of an audit will be required to supply documentation of the attested values. Notwithstanding the fact that only some of the providers in a group practice or clinic may qualify for the Medicaid EHR Incentive Program (on the basis of provider type, for example), aggregate values must represent the entire practice's patient volume and not limit it in any way (including not limiting it to only patients seen by eligible professionals).

NY Medicaid recognizes that some practitioners may provide care in more than one practice or location, and in some cases may not have certified EHR technology in all locations. While these practitioners should not necessarily be excluded from participation in the Medicaid EHR Incentive Program, their participation must be consistent with the overall intent of facilitating the adoption and meaningful use of certified EHR technology. Accordingly, eligible providers who practice in more than one location will be required to list all certified EHR systems in use at the various

locations where they provide care, and attest to the fact that at least 50% of their patient encounters occur at locations where certified EHR technology was available at the beginning of the EHR reporting period. Assuming they meet all the other eligibility criteria, providers who so attest will be considered eligible for participation in the program. In this scenario, providers will limit all remaining measures (such as numerator and denominator for meeting meaningful use objectives and clinical quality measures) to those locations equipped with certified EHR technology. Note that in the event an EP provides care at multiple locations, and one of those locations is a group practice or clinic that reports patient volume on an aggregate level as described above, the EP's eligibility with respect to Medicaid patient volume will be determined solely by the aggregate patient volume from the group practice. The EP will still be required to attest that at least 50% of patient encounters occurred at locations where certified EHR technology was available (and remaining measures will be calculated based on all encounters at EHR-equipped locations). This is not expected to have a negative effect on the eligibility of this subset of EPs, since presumably a group practice will only choose to report aggregate patient volume if the aggregate volume exceeds the 30% threshold.

For the purposes of calculating patient volume, a "Medicaid patient encounter" is defined as one or more services rendered on any one day to an individual where Medicaid (or a Medicaid demonstration project under §1115 of the Act) paid for all or part of the service, or all or part of the premiums, co-payments, and/or cost-sharing. Providers will be instructed that they may not count services rendered to Medicaid-eligible patients that were not paid at least in part by Medicaid or a qualified Medicaid demonstration project (or by a private insurance whose premiums are paid all or in part by Medicaid or a qualified Medicaid demonstration project), including services for which a claim was not submitted, payment has been denied, or payment was approved but has not yet been received by the provider. Providers will be instructed that claims for Medicaid beneficiaries that were resolved with no payment to the provider (so-called "zero pay" claims) are not considered Medicaid patient encounters for the purposes of calculating Medicaid patient volume, although NY Medicaid will continue to follow emerging federal guidance on this matter.

With regard to the selection of a representative 90-day period to be used in patient volume calculations, CMS has indicated that no specific standards will be issued as to the definition of "representative." Providers will be responsible for attesting, during the Medicaid EHR Incentive Program enrollment process, that the evaluation period they select to calculate their eligibility would withstand a plain meaning test as representative of overall patient volume. Consistent with guidance issued by CMS, providers will be notified that such plain meaning tests will not penalize the provider for normal seasonal variations in patient volume. For example, a provider whose chosen

90-day period includes an increase in overall patient volume relative to other times of the year due to seasonal flu and vaccinations would still be found to be representative if the increase is consistent with seasonal variations in prior years.

NY Medicaid recognizes that critical access hospitals (CAHs), as a result of their small size and rural nature, may have particular challenges in obtaining the funds necessary to make the transition to certified EHR technology. At the same time, the need to coordinate care among many providers including those that may be widely dispersed geographically means that CAHs represent a particular opportunity for the transition to EHR technology to effect a transformative change in the quality of care provided by these facilities. As a result, NY Medicaid proposes to allow hospitals that meet all other eligibility criteria for the Medicaid EHR Incentive Program to include swing beds in their eligibility and payment calculations wherever these calculations call for the use of Medicaid bed days. According to a recent analysis performed by the Healthcare Association of New York State (HANYS), this clarification would allow five of New York's thirteen CAHs to become eligible for the Medicaid EHR Incentive Program (raising the total number of eligible CAHs from three to eight), thus significantly increasing the amount of financial assistance that the program will deliver to CAHs in the State.

## 6. Verification of patient volume for EPs and acute care hospitals

*What data sources will the SMA use to verify patient volume for EPs and acute care hospitals? Source: CMS SMHP Template Question C.6*

Users who choose to attest using the standard patient volume calculation method will be asked to provide the following pieces of information to establish their Medicaid patient volume:

- The number of patient encounters for Medicaid clients during that period (i.e., the numerator)
- The total number of patient encounters during the same period (i.e., the denominator)

Users who select the option to attest using the alternative patient volume calculation will be asked instead to provide the following information:

- The number of Medicaid patients current on the provider's patient panel during that period
- The number of patient encounters for Medicaid clients *not on the patient panel* during the period;
- The total number of patients on the patient panel during the period

- The total number of patient encounters during the period for patients *not on the patient panel*

NY Medicaid will leverage fee-for-service claims history and managed care encounter data to verify that the number of Medicaid claims submitted by the provider for that date range matches the number of Medicaid patient encounters reported by the provider within an acceptable margin (to be determined). Due to complicating factors such as the possibility of providers receiving Medicaid reimbursement from other states, it is not expected that the number of claims in the MMIS will necessarily match the number of Medicaid patient encounters exactly, so this check will be a measure only of the reasonableness of the provider's attestation. NY Medicaid has no reliable data source that could be used to validate total patient volume, so providers' attestations will be accepted pending post-payment audit.

For providers practicing predominantly in FQHCs/RHCs who seek to qualify under the alternative criteria of 30% "needy individuals," NY Medicaid will identify data available on services that are furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay (as defined by the federal rule on the Medicaid EHR Incentive Program). This data will be used to derive metrics for evaluating the reasonableness of provider attestations as to the proportion of needy individuals among their patient load. For example, NY Medicaid will leverage available data on participation in Medicaid, Child Health Plus, Family Health Plus, supplemental nutrition assistance, and federally-subsidized school breakfast/lunch programs in the areas served by a FQHC or RHC in order to estimate the proportion of needy individuals in the area. They will then compare that estimate to the proportion of needy individuals claimed by providers at that facility.

## 7. Verification of "practices predominantly" requirement

*How will the SMA verify that EPs at FQHC/RHCs meet the practices predominantly requirement? Source: CMS SMHP Template Question C.7*

Under the terms of the Medicaid EHR Incentive Program, a professional who practices predominantly in an FQHC or RHC may qualify for the program if at least 30% of his/her patient volume is attributable to needy individuals (rather than Medicaid clients). The specific meaning of "practices predominantly" is not defined in statute but has been established through federal rule-making as meaning that the clinical location for more than 50% of the eligible professional's total patient encounters over a period of six months is an FQHC or RHC.

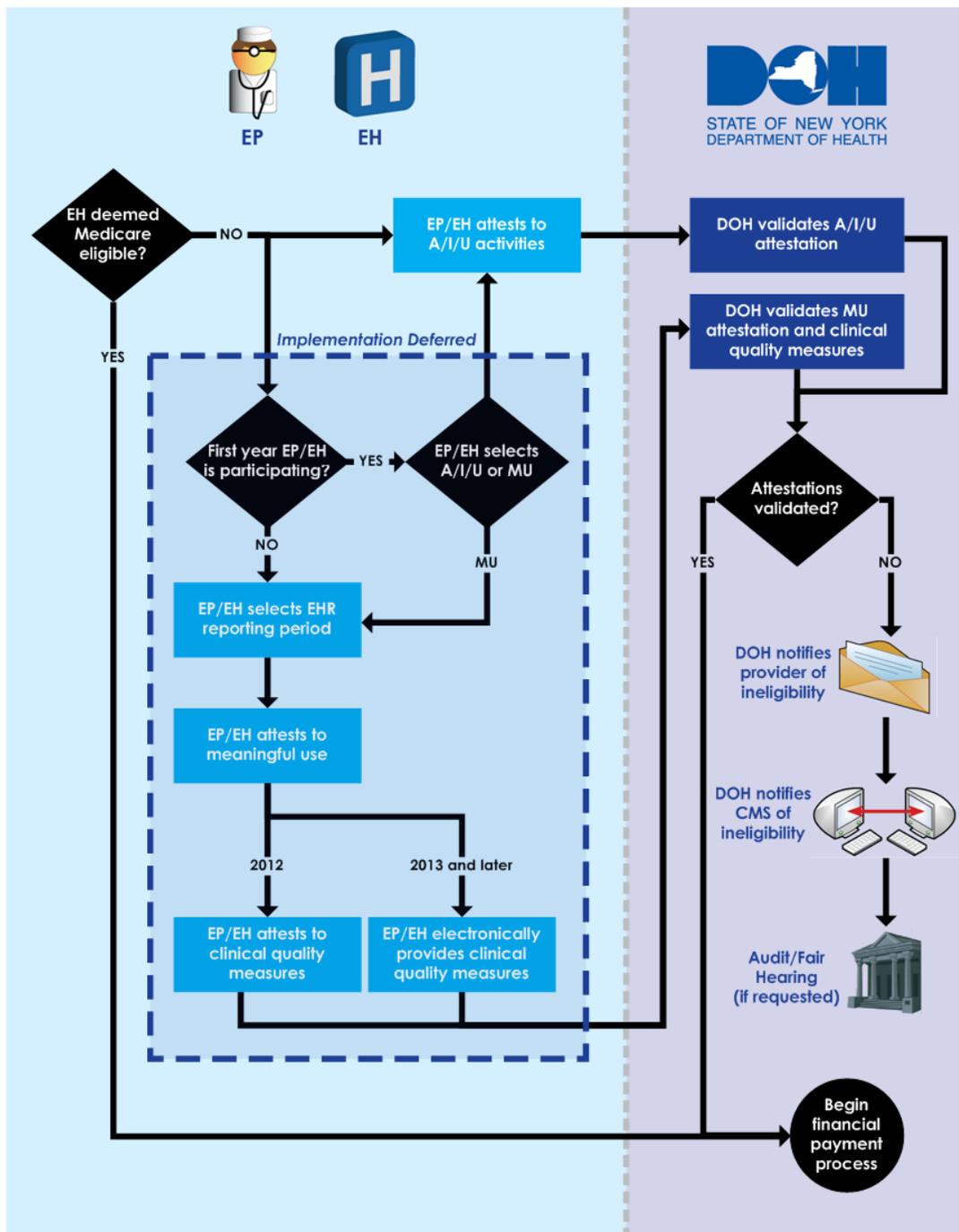
During the eMedNY Medicaid EHR Incentive Program Administrative Support Service application process, users will be asked to provide the following information to establish that they meet the practices predominantly requirement:

- The date range the provider has selected
- The names of any FQHCs or RHCs at which the provider had patient encounters during that period
- The number of patient encounters at FQHCs or RHCs during the period (i.e., the numerator)
- The total number of patient encounters during that period (i.e., the denominator)

The eMedNY Medicaid EHR Incentive Program Administrative Support Service will verify that the date range is a six-month period. Available data on NY Medicaid fee-for-service claims and managed care encounters will also be leveraged to calculate the proportion of Medicaid claims with CMS POS codes of 50 (Federally Qualified Health Center) or 72 (Rural Health Clinic) in the date range chosen by the provider relative to the total number of Medicaid claims for the same period. NY Medicaid would then verify that this proportion is within an acceptable margin (to be determined) of the proportion reported by the provider of overall patient encounters. It is understood that the proportion of overall patient encounters that occurred in a FQHC or RHC will not be exactly the same as the proportion of Medicaid patient encounters in the FQHC/RHC, so this check would be a measure only of the reasonableness of the provider's attestation. NY Medicaid does not have access to reliable data on eligible professionals' total patient volume, so the denominator data provided through self-attestation in the first year will only be verified during post-payment audits.

### **Verification of EHR adoption and meaningful use**

Once a provider's registration in the Medicaid EHR Incentive Program has been approved, the eMedNY Medicaid EHR Incentive Program Administrative Support Service meaningful use process begins for that provider. Contrary to the registration process (which happens only once), the meaningful use process repeats annually for each year of the Medicaid EHR Incentive Program. In the first year, providers will attest to the fact that they undertook the required activities to adopt, implement, or upgrade certified EHR technology. In the second and subsequent years of participation, providers will collect data on meaningful use of their certified EHR technology and will report that data to NY Medicaid using the eMedNY Medicaid EHR Incentive Program Administrative Support Service. The meaningful use process also involves NY Medicaid submitting the adopt/implement/upgrade and meaningful use data to CMS on an annual basis. Exhibit C-3 depicts an overview of the meaningful use process.



**Exhibit C-3** eMedNY Medicaid EHR Incentive Program Administrative Support Service Meaningful Use Workflow

## 6. Verify adopt, implement, or upgrade

*How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers? Source: CMS SMHP Template Question C.6*

During the first year of their participation in the Medicaid EHR Incentive Program, providers who seek to demonstrate eligibility for the Medicaid EHR incentive based on adopt/implement/upgrade activities will be required to attest to the activities they undertook to adopt, implement, or upgrade certified EHR technology. Activities that qualify include:

- Development or upgrade of custom EHR technology with subsequent certification by an ONC-ACTB
- Purchase/acquisition and installation of commercial off-the-shelf certified EHR technology
- Integration of individually certified EHR technology modules
- Testing of the certified EHR technology
- Training in the use of the certified EHR technology
- Business process engineering to integrate the certified EHR technology into the clinical workflow

As part of initial registration with the NLR, providers have the opportunity to specify the CMS EHR Certification ID of their EHR system, but this field is optional and it will not necessarily be validated even if the provider chooses to specify the certification ID. Accordingly, NY Medicaid will require providers to supply the CMS EHR Certification ID during the meaningful use attestation process and attest that this Certification ID reflects a system that is actually being adopted, implemented, or upgraded.

CMS has expressed the intent to develop a system that will allow States to confirm that the CMS EHR Certification ID numbers supplied by providers during the attestation process actually represent valid numbers obtained through the CHPL, and to retrieve the list of certified EHR systems/modules that is represented by the CMS EHR Certification ID. However, this system is not expected to be made available in time to integrate it into pre-payment validation or audit processes before NY Medicaid begins issuing incentive payments. For the time being, validation of provider's attestation as to the CMS EHR Certification ID will be deferred to post-payment audit; once the CMS system becomes available, NY Medicaid will evaluate the possibility of leveraging this system to conduct pre-payment validation.

As is the case with all provider self-attestations, the accuracy of the attestation as to the specific certified EHR system that is being adopted, implemented, or upgraded by each provider is ultimately the responsibility of the provider. Providers will be instructed that it is their responsibility to maintain all applicable records to support their

attestations for a period of no less than six years in the event of post-payment audit. To support attestations to adoption, implementation, or upgrade of certified EHR technology in the first year of participation in the Medicaid EHR Incentive Program, providers should be prepared to supply documentation that, at a minimum, demonstrates either a binding financial commitment (such as a contract) or actual expenditures on adoption, implementation, or upgrade of the EHR technology. In the case of commercial off-the-shelf EHR technology, this documentation should clearly indicate the full name and version of the product in such a way that it can be matched to a specific product or combination of products in the CHPL. Examples of documentation that should be retained and produced upon request include:

- Signed/dated contracts, purchase orders, or receipts for purchase or lease of commercial off-the-shelf certified EHR software or proof of subscription (contracts or paid invoices) to hosted EHR software
- Documentation of expenses incurred in development, testing, maintenance, and upgrade of custom certified EHR systems or modules
- Proof of payment for consulting services related to the selection, acquisition, installation, and setup of certified EHR technology and the successful integration of the certified EHR technology into the clinical workflow
- Purchase agreements or receipts for computer hardware or software required to operate the certified EHR system
- Documentation of expenses incurred in transitioning patient records to the certified EHR system
- Contracts or proof of actual expenditures for testing and/or training for the certified EHR system

Notwithstanding the requirement that they retain documentation of purchase or financial commitment, providers will be advised that simply acquiring certified EHR technology is not sufficient to meet the adopt/implement/upgrade requirements – the software must be in use in clinical practice to count as “adoption”. In addition to providing the required documentation, providers should also be prepared, in the event of post-payment audit, to demonstrate that the certified EHR technology is actually in use in the clinical setting.

## 7. Verify meaningful use for providers' second participation year

*How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation years? Source: CMS SMHP Template Question C.7*

The initial launch of the eMedNY Medicaid EHR Incentive Program Administrative Support Service will support all necessary aspects of the program for providers' first program participation year, including registration, general program eligibility, attestation to adopt/implement/upgrade of certified EHR technology, and incentive payment processing.

Providers seeking to demonstrate meaningful use of certified EHR technology in their second and subsequent program participation years will be required to attest to each individual meaningful use criterion during the eMedNY Medicaid EHR Incentive Program Administrative Support Service meaningful use process. Attestation to meaningful use of certified EHR technology will be enabled by a future update to the eMedNY MEIPASS, the specifics of which (including the processes for verifying provider attestations to meaningful use) will be described in a future update to this NY-SMHP. It is expected that many meaningful use criteria are elements of clinical practice that will be easily reported on from any certified EHR system, so the burden on the provider for reporting this information should be low. For example, the certified EHR system should be able to provide a simple report showing the percentage of unique patients during a given period that had an active medication list.

NY Medicaid will use the data sources at its disposal to verify (or at least establish the reasonableness of) numerator information for meaningful use criteria whenever possible. For example, Medicaid claims data could be used to conduct a test of reasonableness for providers' attestation that they meet the meaningful use criteria for electronic prescriptions; specifically, the proportion of Medicaid claims for prescriptions issued by a given provider that have a prescription origin code of 3 (indicating an electronic prescription)—relative to the total number of Medicaid prescriptions for that provider—would be compared to the provider's attested proportion of prescriptions overall that were issued electronically. If the attested proportion was found to be unreasonably higher than the calculated Medicaid proportion, the provider's application would be flagged for further review.

In accordance with CMS guidance, hospitals registered for both the Medicaid and Medicare EHR Incentive Programs, and deemed to be meaningful users of EHR technology under the Medicare program, will be deemed Medicaid eligible. The eMedNY Medicaid EHR Incentive Program Administrative Support Service will verify Medicare eligibility via the NLR and will adjust the Medicaid meaningful use attestation process appropriately.

## 8. SMA proposing changes to MU definition

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

NY Medicaid will not be proposing any changes to the meaningful use criteria as established in the final rule. However, providers are required by the rule to select, as one of their menu set meaningful use criteria, one of the following public health objectives:

- Capability to electronically submit immunization data
- Capability to electronically submit laboratory results (eligible hospitals only)
- Capability to electronically submit syndromic surveillance data

Each of these objectives requires that the appropriate public health agency has an established infrastructure for receiving the data electronically from practitioner EHR systems. In the absence of such an infrastructure for a given category of public health data, providers will be unable to meet the relevant meaningful use objective.

New York State already has a successful infrastructure for the electronic reporting of pediatric immunizations from EHR systems using HL7 standards-based batch uploads. This batch reporting process is already in use by more than 50 billing and EHR software vendors representing over 650 practices administering 10M of the 17M immunizations reported in the State outside of New York City in 2009. However, no such infrastructure exists for electronic submission of laboratory results or syndromic surveillance data from practitioner EHR systems. Accordingly, NY Medicaid will recommend that providers select the immunization reporting objective. Through the provider outreach and education process, providers will be informed on the requirement to select a public health objective and the current state of the public health reporting infrastructure, and will be advised that the most efficient way to meet the meaningful use requirements will be to select the immunization reporting objective.

If a practice has previously successfully tested with NYSIS or CIR using a specific vendor interface, and is now successfully submitting immunization records to the respective registry using the vendor interface with either the HL7 2.3.1 or HL7 2.5.1 standard, via certified EHR technology, then an eligible professional in that practice can meet the meaningful use measure related to immunization registry reporting. In other words, successful submission of immunization data via certified EHR technology during the EHR reporting period will be considered a “test” for the purposes of the NY Medicaid EHR Incentive Program. Using this protocol, the requirement to perform a formal test with the registry during the EHR reporting period is waived. The respective

registries will validate the interfaces with the newly certified versions of EHR technology products and will publish the lists of validated vendor interfaces on their web sites.

However, if a practice has not previously successfully tested with NYSIS or CIR, then a formal test must be arranged with the respective immunization registry and must occur before or during the EHR reporting period for a given eligible professional in the practice. The formal test must be performed using a validated vendor interface with a certified EHR technology product.

Despite the current lack of infrastructure for electronic submission of laboratory results or syndromic surveillance data from practitioner EHR systems, New York does have successful systems in place for collecting this important public health information. Licensed clinical laboratories under the jurisdiction of New York Public Health Law and Codes, Rules, and Regulations are required to report all pertinent facts to public health authorities whenever an examination on a State resident is performed to determine blood lead level or reveals evidence of a reportable communicable disease, lead poisoning, HIV/AIDS, cancer, or congenital malformation. The Electronic Clinical Laboratory Reporting System (ECLRS), a result of more than \$10M invested over eight years, is the statewide system by which reporting laboratories can electronically transmit this data to the Department (and, ultimately, county health departments and the New York City Department of Health and Mental Hygiene). The 193 participating laboratories submit this data to ECLRS by either direct data entry using a secure web page or by uploading a plain text or HL7 data file, and the results are immediately available to the appropriate State and local public health agencies. In addition to laboratories, ECLRS is also used by 142 of the State's 144 emergency departments (accounting for approximately 98% of emergency department visits in the State) to report incidents of a defined set of syndromes (some syndromes, such as heat-related healthcare visits, are created and monitored on an as-needed basis). Although enabling the submission of laboratory and syndromic surveillance data directly from practitioner EHR systems would provide useful clinical context (such as information about symptoms and date of onset of the illness), the success of ECLRS in gathering actionable public health data directly from the laboratories and emergency departments where the data originate suggests that major modifications to the existing infrastructure are not a high priority.

For more information about the infrastructure currently in place in the State for the collection of laboratory, immunization, and syndromic surveillance data, see the testimony delivered to the ONC HIT Policy Committee's Meaningful Use Workgroup by Dr. Guthrie Birkhead, Deputy Commissioner of the New York State Department of Health, contained in Appendix X ("New York's Public Health Reporting Infrastructure").

## 9. Verify use of certified EHR technology

*How will the SMA verify providers' use of certified electronic health record technology? Source: CMS SMHP Template Question C.9*

The primary method for ensuring that Medicaid EHR Incentive Program participants use certified EHR technology is through a detailed self-attestation process, supported by a verification service made available by ONC.

In each year of their participation in the Medicaid EHR Incentive Program, providers will be required to identify the EHR technology they are using. Certified EHR technology may fall into one of the following categories:

- A single certified commercial off-the-shelf (COTS) EHR system
- A self-developed EHR system certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB)
- A combination of individually-certified EHR modules (COTS, self-developed, or a mix of COTS and self-developed)

Providers will identify the certified EHR technology they are using by providing a CMS EHR Certification ID that uniquely identifies the system or combination of systems and/or modules in use at their location(s). To obtain the CMS EHR Certification ID, providers will be instructed to access the ONC's web-based Certified HIT Product List (CHPL). On the CHPL, the provider will select the specific products in use at his/her location (or locations, in the case of a provider practicing at more than one location); the CHPL interface will then calculate whether the product or products together constitute a complete certified EHR system (meaning that all meaningful use requirements are satisfied by at least one of the products selected). If so, the CHPL will generate the CMS EHR Certification ID for that specific product or combination of modules, and the provider will be responsible for supplying that certification ID to NY Medicaid as part of the attestation to AIU.

CMS has expressed the intent to develop a system that will allow States to confirm that the CMS EHR Certification ID numbers supplied by providers during the attestation process actually represent valid numbers obtained through the CHPL, and to retrieve the list of certified EHR systems/modules that is represented by the CMS EHR Certification ID. However, this system is not expected to be made available in time to integrate it into pre-payment validation or audit processes before NY Medicaid begins issuing incentive payments. For the time being, validation of provider's attestation as to the CMS EHR Certification ID will be deferred to post-payment audit; once the CMS system becomes available, NY Medicaid will evaluate the possibility of leveraging this system to conduct pre-payment validation.

Notwithstanding any efforts on the part of NY Medicaid to verify the validity of the CMS EHR Certification ID, providers will be advised that they are wholly responsible for adopting only ONC-certified EHR technology, and keeping up to date with changes in certification status. This responsibility includes updating EHR systems and modules as certification standards evolve, as well as ensuring that any changes to self-developed EHR technology are properly certified before being put into use in the clinical setting. Providers will be responsible for updating their information in the eMedNY website if they change EHR systems (including if they perform upgrades that materially change system capabilities with respect to meaningful use criteria). NY Medicaid will require that providers obtain the CMS EHR Certification ID from the CHPL each year and provided it to the State as part of the meaningful use attestation. This will ensure that when the certification of a given EHR system expires (as a result of updates to the certification standard), providers still using that system will automatically be made ineligible for future incentive payments unless they attest to upgrading the system to a version that is certified to the new standard.

NY Medicaid recognizes that providers can obtain a CMS EHR Certification ID from the CHPL without providing any proof that the system or modules represented by the certification ID are actually being used in the clinic/practice. At this time, the only method of validating providers' attestations that they have actually adopted, implemented, or upgraded the certified EHR technology represented by the certification ID they have provided will be post-payment audit. NY Medicaid is aware that the State's two RECs already collect a significant amount of information on the certified EHR technology adopted by those providers that sign up for REC assistance; however, due to the lack of alignment of milestones between the REC grant program and Medicaid EHR Incentive Program, the information currently collected by the RECs is not sufficient to validate provider attestations to adoption, implementation, or upgrade of certified EHR technology. In the future, NY Medicaid will work with the RECs to develop a procedure by which the RECs can supply NY Medicaid with information to provide some pre-payment validation of A/I/U attestations by participating practices. Recognizing that the RECs do not wish to be perceived as "policing" the very providers they are attempting to support, the process for using this information will be designed in such a way that it only supports provider attestations and reduces the risk of adverse post-payment audit findings.

## 10. Collection of meaningful use data

*How will the SMA collect providers' meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term and a different approach for the longer-term? Source: CMS SMHP Template Question C.10*

The primary method for collecting providers' meaningful use data (including clinical quality measures) in the second and subsequent program years will be through the eMedNY Medicaid EHR Incentive Program Administrative Support Service meaningful use process. In order to submit their request for incentive payments each year, providers will be required to execute the eMedNY Medicaid EHR Incentive Program Administrative Support Service meaningful use process (by launching the eMedNY Medicaid EHR Incentive Program Administrative Support Service from the eMedNY interface). After prompting the user to verify the existing registration information, a step-by-step meaningful use interview process is displayed, where the user will be required to enter data on each meaningful use criterion (customized to the program year and the number of years the provider has been participating in the program). In the case of meaningful use criteria that are based on proportions of patient encounters, the user will be required to provide both numerator and denominator information to support his/her attestation. As the set of clinical quality measures are refined for future stages of meaningful use, the eMedNY Medicaid EHR Incentive Program Administrative Support Service will be updated to require reporting of these measures by providers in the appropriate years of their participation.

Once the provider has completed the meaningful use process for a given year, the relevant meaningful use data (and clinical quality metrics, if collected) will be transferred to the Center for aggregate analysis of Medicaid EHR Incentive Program success. Between the eMedNY Medicaid EHR Incentive Program Administrative Support Service and the Center, NY Medicaid will have a long-term solution available for the collection of meaningful use data, including the reporting of clinical quality measures. This functionality will be a component of the eMedNY Medicaid EHR Incentive Program Administrative Support Service and will be available in the second year of the Medicaid EHR Incentive Program.

## 11. Data collection and analysis process alignment

*How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA? Source: CMS SMHP Template Question C.11*

CMS, through the implementation of the Children's Health Insurance Program Reauthorization Act (CHIPRA), has put forward a set of voluntary core child health quality measures for states to report on their Medicaid program and State Children's Health Insurance Program (SCHIP). The State currently collects some of these quality measures directly from health insurance companies, and is investigating the possibility of leveraging Medicaid claims data to gather additional quality measures. Although work remains to be done, New York is currently ahead of most other states in the submission of these voluntary clinical quality measures.

Additionally, the State collects clinical quality measures related to managed care plans through the Quality Assurance Reporting Requirements (QARR) program, a set of measures adopted from the NCQA's Healthcare Effectiveness Data and Information Set (HEDIS)—with State-specific quality measures added to address public health issues of particular importance in New York. This data is available directly to healthcare consumers in the State through the eQARR web-based tool.

The State recognizes the value of aligning the various processes by which it collects clinical quality measures, in order to allow meaningful comparisons between the data sets and reduce the burden on providers who may be subject to multiple clinical quality measurement programs. As standards for clinical quality measurement continue to develop (including the development of the clinical quality measures in the second and third stages of meaningful use for the Medicaid EHR Incentive Program), and as the infrastructure for the tracking and submission of clinical quality measures continues to mature with the adoption of EHR technology by providers and the development of a statewide HIE infrastructure, NY Medicaid will continue to evaluate opportunities for streamlining the collection of clinical quality data.

More information will be included in a subsequent update to this SMHP.

## 12. Program administration systems

*What IT, fiscal and communication systems will be used to implement the EHR Incentive Program? Source: CMS SMHP Template Question C.12*

The following systems will be involved in the implementation of the Medicaid EHR Incentive Program:

- **eMedNY** – the State's MMIS; used as a source of provider authentication, demographic data, and routing of incentive payments, as well as providing

an existing channel for communications that will be leveraged for the program

- **eMedNY Medicaid EHR Incentive Program Administrative Support Service** – as a service within eMedNY, the primary vehicle for collecting information from providers, including registration and meaningful use data, and for tracking provider status throughout the program
- **Medicaid Information Service Center** – used as a data source for validating provider attestations; meaningful use and clinical quality data collected during the program will also be stored here for later analysis

Details on the specific ways these systems are involved in the implementation of the program are contained throughout this section of the SMHP.

### 13. IT systems changes

*What IT systems changes are needed by the SMA to implement the EHR Incentive Program? Source: CMS SMHP Template Question C.13*

NY Medicaid expects that minimal changes to existing IT systems will be required in order to implement the Medicaid EHR Incentive Program. The eMedNY Medicaid EHR Incentive Program Administrative Support Service is being developed as a contained service within the overall MMIS environment, with limited and well-defined points of interaction, and will be hosted by CSC – who also host the MMIS – so as to minimize the amount of effort required to implement the necessary external interfaces (primarily with the NLR). Enhancements to the MMIS that are expected to be necessary to implement the Medicaid EHR Incentive Program are listed in part 17 (“Implementation of Medicaid EHR Incentive Program website”).

Where data sources within the Center have been identified as necessary for implementing validation tests on provider input, these data sources will be leveraged using existing data interface processes.

Medicaid EHR Incentive Program payments will be made through the existing channels and methods for Medicaid claims payment, leveraging the services of the existing NY Medicaid fiscal agent (CSC), so no IT systems changes are expected to be necessary to implement the payment part of the program. Providers are currently paid through a combination of electronic funds transfer (EFT) and physical checks. Although all providers are encouraged to sign up to receive payment through EFT, this is not a requirement for participating in the Medicaid EHR Incentive Program.

## 14. IT timeframe for systems modifications

*What is the SMA's IT timeframe for systems modifications? Source: CMS SMHP Template Question C.14*

The eMedNY Medicaid EHR Incentive Program Administrative Support Service development schedule is subject to significant variability depending on the timing of the release of more complete documentation of the NLR protocols and data interchange formats. The current timeline is as follows:

- Requirements development and initial design: Complete
- Additional design: In Progress
- Application development: Mid-2011
- Testing (unit, integration, acceptance): Third Quarter 2011
- General availability: Fourth Quarter 2011

## 15. Interaction with National Level Repository

*When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)? Source: CMS SMHP Template Question C.15*

The system of record for interface between NY Medicaid and the NLR is eMedNY. Under the current timeline for development of the eMedNY Medicaid EHR Incentive Program Administrative Support Service and updates to eMedNY, NY Medicaid has targeted the third quarter of 2011 for initial testing of the interface with the NLR.

## 16. SMA plan for accepting registration data

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

The eMedNY Medicaid EHR Incentive Program Administrative Support Service will support the method of transmitting data specified by CMS in the NLR documentation. According to the current information supplied by CMS, this data transmission will be initiated by the NLR on a daily basis.

## 17. Implementation of Medicaid EHR Incentive Program website

*What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc? Source: CMS SMHP Template Question C.17*

NY Medicaid plans on enhancing their current eMedNY website to provide access to the eMedNY Medicaid EHR Incentive Program Administrative Support Service for

enrollment and attestation of EPs and hospitals. EPs and hospitals will access eMedNY as they do currently and will then be able to access the eMedNY Medicaid EHR Incentive Program Administrative Support Service as needed. The current eMedNY website will make additional program information available to EPs and hospitals. This information will be generated from both NY Medicaid and CMS resources. A description of the potential information available, including educational materials, is included in Appendix XI (“Communication Plan”).

## 18. Anticipated modifications to the MMIS

*Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD? Source: CMS SMHP Template Question C.18*

At this time, NY Medicaid does not anticipate submitting a separate MMIS As Needed APD. Although the majority of the IT systems infrastructure for administration of the Medicaid EHR Incentive Program is represented by the eMedNY Medicaid EHR Incentive Program Administrative Support Service, NY Medicaid expects that only minimal changes to the existing MMIS will be required to support the administration of the program. These changes will be done as operational enhancements at 75% FFP.

For HIT specific activities, the following capabilities are expected to be put into place:

- Updating the current eMedNY website to provide for access to the eMedNY Medicaid EHR Incentive Program Administrative Support Service for registration, attestation, and program information
- Creating system codes to support State and Federal reporting
- Developing operational reports to monitor program activity and facilitate post-payment audit procedures
- Updating 1099 reporting as needed for providers receiving incentive payments

These HIT capabilities will be implemented under the terms of an amendment to the contract with the incumbent MMIS contractor. These changes will be limited to those necessary for administration of the Medicaid EHR Incentive Program and will not include any enhancements whose benefit would be shared among multiple projects. The forthcoming IAPD for the Medicaid EHR Incentive Program will include a detailed breakdown of the activities and cost allocations.

## 19. Provider support

*What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program? Source: CMS SMHP Template Question C.19*

In order to minimize administrative burden, the Medicaid Incentive Payment Program will leverage the call center/help desk infrastructure that is currently being utilized by NY Medicaid for claims processing support to address EP and hospital questions. By leveraging the existing provider support channels, NY Medicaid will enable providers to seek assistance in a familiar environment, thus reducing the burden on providers for participating in the Medicaid EHR Incentive Program.

## 20. Provider appeal process

*What will the SMA establish as a provider appeal process relative to: a) the incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and meaningful use certified EHR technology? Source: CMS SMHP Template Question C.20*

NY Medicaid will have an issue resolution process in place for providers. NY Medicaid will leverage their current provider certification process with the necessary internal controls during the provider application process. The information submitted into the eMedNY Medicaid EHR Incentive Program Administrative Support Service will be the basis for providers to demonstrate eligibility to participate in the program and efforts to adopt/implement/upgrade and meaningfully use certified EHR technology.

If a determination is made by the eMedNY Medicaid EHR Incentive Program Administrative Support Service that the provider is not eligible, and thus cannot receive incentive payments, the provider will be given the opportunity to appeal that determination. A communication will be sent to the provider from the eMedNY Medicaid EHR Incentive Program Administrative Support Service instructing them on their responsibilities in appealing the determination. The appeals process will allow providers to submit documentation and/or object to the proposed action within 30 days. The provider's response and documentation will be reviewed and the eligibility determination will be revised if appropriate. In cases where the eligibility determination was based all or in part on information received from CMS (for example, if payment was denied due to CMS reporting that the provider has already received payment in another state), CMS may be required to supply additional information to support the State's response to the appeal.

Beginning in each provider's first participation year, post-payment audits will be conducted to validate the appropriateness of the payments and verify the self-

attested information provided during the enrollment and registration process. The information provided during self-attestation will be the conduit for providers to receive incentive payments; demonstrate eligibility to participate in the program; and document efforts undertaken to adopt/implement/upgrade and meaningfully use certified EHR technology. The audits for the Medicaid EHR Incentive Program will utilize the standard processes and techniques already in use for Medicaid claims audits.

If, following a post-payment audit, a provider seeks to object to an adverse determination and accompanying proposed action, the provider will be given the opportunity to appeal the determination. The appeals process will allow providers to submit documentation and/or object to the proposed action within 30 days. The provider's response will be considered and a final report issued. If the final report is not acceptable to the provider, they may request an administrative hearing to contest the finding, and a final determination will be made. The planned appeals process for the Medicaid EHR Incentive Program will follow the standard processes currently employed for Medicaid claims appeals.

### **EHR Incentive Payment Processing**

By the conclusion of the eMedNY Medicaid EHR Incentive Program Administrative Support Service meaningful use process, each participating provider will have been designated as either eligible or ineligible for an incentive payment. The third process in the overall Medicaid EHR Incentive Program workflow, the financial payment process, is conducted periodically by NY Medicaid and consists of the calculation and disbursement of incentive payments to all providers who have been designated as eligible for payment in the current year but have not yet received their incentive payment. In this process, NY Medicaid calculates the proper incentive payment amount for each provider (i.e., assigning the appropriate incentive amount for EPs depending on whether they demonstrated 30% Medicaid/need or 20-30% Medicaid patient volume for pediatricians, and calculating the specific incentive amount due to EHs based on hospital statistics). NY Medicaid then re-verifies aspects of the provider's eligibility as needed and, barring the discovery of new eligibility issues, authorizes the State's fiscal agent to disburse the incentive payment as a lump sum via the existing payment infrastructure for fee-for-service Medicaid claims.

For the purposes of calculating incentive program payments to Medicaid hospitals, NY Medicaid will use the data contained in Exhibits 3 and 46 of the Institutional Cost Report (ICR), a uniform report (based on the CMS Form 2552) that is used by New York hospitals to report income, expenses, assets, liabilities and statistics to the Department. The data from the ICR that is used in the calculation of the hospital incentive payment includes only services rendered by the acute care portions of each hospital, specifically excluding sub-acute units such as nursery, observation, psychiatric, and

rehabilitation units. For more details on the methodology that NY Medicaid will use to calculate the hospital incentive payment amount (including the specific locations within the ICR that are used to derive each input to the incentive payment calculation), see Appendix VI (“Hospital Incentive Payment Calculation”).

The following illustrates the hospital payment calculation for a sample hospital located in the City of Albany. This sample calculation uses data from the ICR for the hospital cost reporting period ending in Federal Fiscal Year 2010. For this period, the hospital in question had the following characteristics:

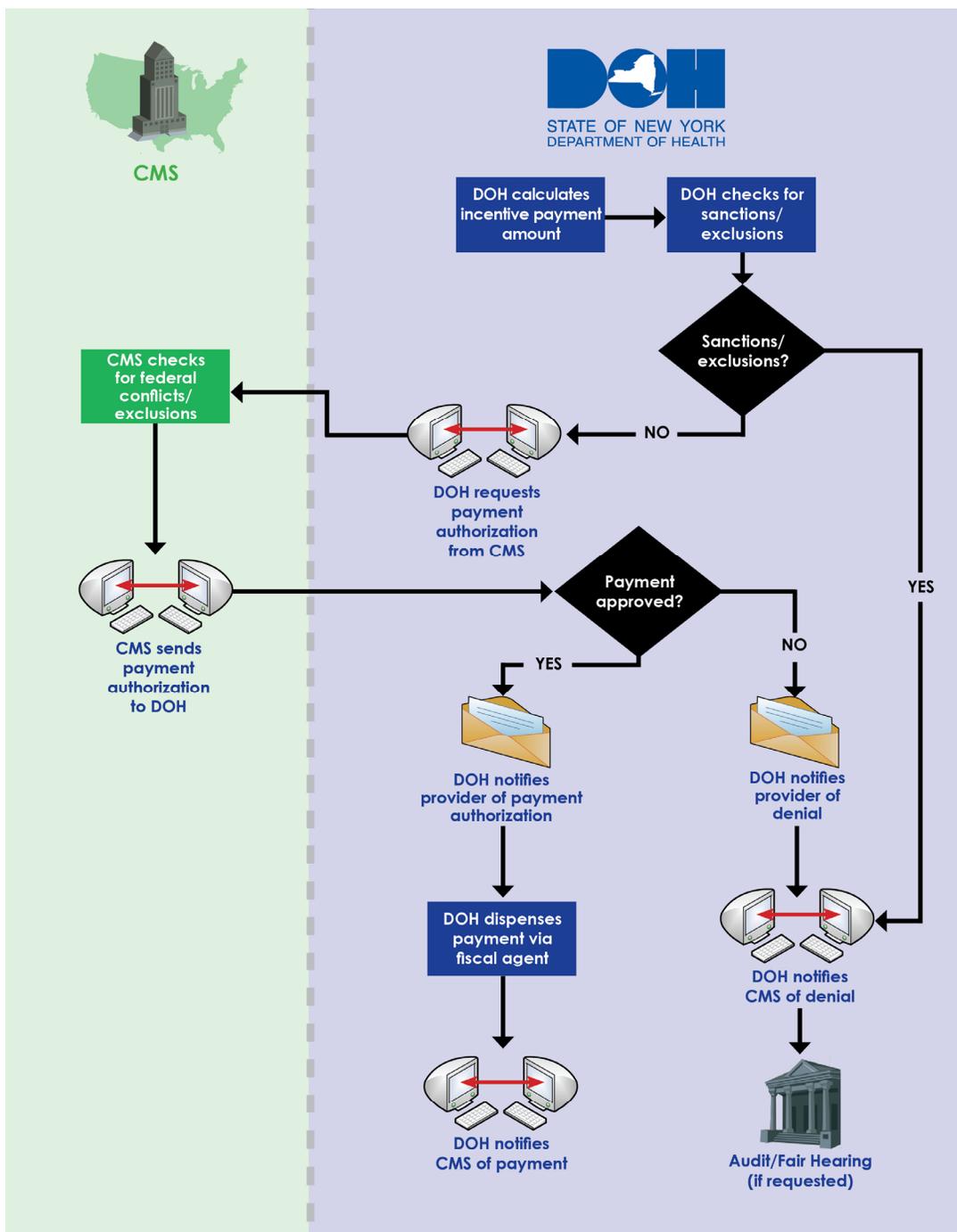
- **Total acute discharges:** 22,779
- **Medicaid acute inpatient bed days:** 16,688
- **Total acute inpatient bed days:** 115,052
- **Total acute charity care charges:** \$2,310,201
- **Total acute charges:** \$644,027,770
- **Growth rate, most recent year:** 0.006184
- **Growth rate, 2nd most recent year:** -0.025693
- **Growth rate, 3rd most recent year:** -0.007093

The average growth rate, defined as the arithmetic mean of the observed growth rates over the previous three years, is -0.008867. The Medicaid Share is calculated at 0.145570. Given these characteristics, the calculation of the annual incentive payment amount for this hospital would be as follows:

	Year One	Year Two	Year Three	Year Four
<b>Estimated Discharges</b>	22,779	22,577	22,377	22,178
<b>Discharge-related Amount</b>	\$4,326,000	\$4,285,602	\$4,245,562	\$4,205,877
<b>Initial Amount</b>	\$6,326,000	\$6,285,602	\$6,245,562	\$6,205,877
<b>Medicaid Share</b>	0.145570	0.145570	0.145570	0.145570
<b>Transition Factor</b>	1	0.75	0.5	0.25
<b>Annual Total</b>	\$920,873	\$686,245	\$454,582	\$225,847

Based on this calculation, the total incentive amount due to the hospital would be **\$2,287,547**, which would be disbursed as 50% (\$1,143,773) in the first year of program participation, 40% (\$915,019) in the second year, and 10% (\$228,755) in the third year. For more details on this sample hospital incentive calculation, including intermediate totals, see Appendix VI (“Hospital Incentive Payment Calculation”).

Exhibit C-4 depicts an overview of the financial payment process.



**Exhibit C-4** eMedNY Medicaid EHR Incentive Program Administrative Support Service Financial Payment Workflow

## 21. Financial compliance

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

The Department utilizes the Leave and Accrual Tracking System (LATS) to track staff time by the hour by project number. The number of hours is then used to allocate Personal Service costs to the correct program accounts so that the Personal Service can be correctly claimed. A unique project identifier will be established to aggregate state staff and track hours against planning estimates. Once the identifier is established, staff will be notified and appropriately instructed in its use. Project management staff will review these records on a regular (minimally quarterly) basis. This will ensure the integrity of the charges and the claims generated. These records will be available for CMS review upon request.

All Medicaid EHR Incentive Program costs will initially be allocated 100% to the Medicaid program. While it currently appears that these costs will be 100% Medicaid, the Department acknowledges that additional programs may be impacted and this may later result in the need to develop a new cost allocation plan in accordance with OMB Circular A-87 principles.

## 22. Frequency for EHR Incentive payments

*What is the SMA's anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)? Source: CMS SMHP Template Question C.22*

For eligible professionals, NY Medicaid plans to disburse Medicaid EHR Incentive Program payments on a monthly basis to all providers who have completed the application and attestation process. The State reserves the right to modify this disbursement schedule based on the level of provider participation. The process for payment disbursement is outlined below.

1. NY Medicaid repeats the basic eligibility verification process to ensure that providers are not sanctioned or otherwise excluded from receiving Medicaid payments. Any providers who are found to be ineligible will not receive incentive payments, regardless of their eligibility status during the reporting period or at the time they completed the attestation process.
2. NY Medicaid transmits a list of qualified providers approved by the State for payment to CMS for payment authorization.

3. CMS, after receiving the list of approved providers payment, performs a search on duplicate payments/history, exclusions, and payments to other states.
4. CMS returns a list of providers who have been approved for payment to NY Medicaid.
5. Providers excluded from incentive payments (as a result of State exclusions or CMS denial) will receive an exclusion notification from NY Medicaid explaining the reason for exclusion. In this case, a provider may begin the appeal process.
6. Through its fiscal agent, NY Medicaid issues incentive payments to the providers approved by CMS. Approved providers receive the entire annual incentive payment (calculated from their patient volume, provider type, costs, and contributions) in a single lump sum.
7. NY Medicaid transmits a list to CMS of payments issued to each provider.

For eligible hospitals, NY Medicaid's incentive payment schedule will be optimized to disburse the total incentive payment amount to each hospital as early in the hospital's participation as possible, while adhering to the restrictions on distribution set forth in the Recovery Act. To this end, the total incentive payment for each hospital will be disbursed in annual lump sum payments over the course of the first three years of the hospital's participation in the Medicaid EHR Incentive Program, according to the following schedule:

- 50% of the total incentive amount in the first year of program participation
- 40% of the total incentive amount in the second year
- 10% of the total incentive amount in the third year

## 22. Process for payment deductions or rebates

*What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate? Source: CMS SMHP Template Question C.22*

Payment processing will be designed to make payments directly to the provider (or an employer or facility to which the provider has assigned payments) without taking any deduction or rebate.

## 23. Process for payments made to entity promoting adoption

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

*Source: CMS SMHP Template Question C.23*

Each provider will be allowed to assign Medicaid EHR incentive payments only to an employer or entity with which the EP has a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services. Providers who choose to assign payments to such an employer or entity will be required to supply the taxpayer identification number (TIN) of the entity and attest that the assignment is appropriate and voluntary. Providers who choose to assign their payment must select a single entity to receive the entire payment: no partial assignment or assignment to multiple entities will be allowed.

At this time, NY Medicaid has not chosen to designate any additional entities promoting the adoption of certified EHR technology to which providers can assign their incentive payments. If, in future years, NY Medicaid chooses to designate any such entities, this NY-SMHP will be updated to describe the process for ensuring that assignments to these entities are voluntary and that no more than five percent of such payments are retained for costs unrelated to EHR technology adoption.

## 24. Process for fiscal arrangements

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

NY Medicaid intends to disburse Medicaid EHR Incentive Program payments directly to providers, regardless of whether they participate in the Medicaid program through fee-for-service, managed care, or a combination of the two. In order to receive incentive payments, providers must be enrolled in NY Medicaid with a valid provider ID number, regardless of whether the provider customarily submits fee-for-service claims. EHR incentive payments will be disbursed to providers using the financial information provided during NY Medicaid enrollment. Since no payments for the Medicaid EHR Incentive Program will be disbursed through managed care plans, the restriction that payments to Medicaid managed care plans not exceed 105% of the capitation rate does not have any effect on the implementation of this program.

## 25. Process for payments being made consistent with the Statute and regulation

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

To ensure consistency with the Statute and regulation, NY Medicaid will utilize federally developed forms and/or worksheets employing an interactive scripting process to provide for appropriate documentation and information from EPs and hospitals in their incentive payment requests. For eligible providers, the eMedNY Medicaid EHR Incentive Program Administrative Support Service will implement business logic to calculate the incentive payment to be no more than 85% of the net average allowable costs determined by the Secretary of Health and Human Services so as to ensure that providers are responsible for the 15% contribution of net average allowable costs. In keeping with the current federal legislation and rulemaking, EPs will not be required to demonstrate the actual costs incurred by the EP for the adoption, implementation, or upgrade of certified EHR technology, nor will they be required to document payments received from outside sources towards the cost of these activities; instead, EPs will be determined to have met the required 15% contribution to the extent that payment to the EP is not in excess of 85% of the net average allowable cost. For hospitals, the eMedNY Medicaid EHR Incentive Program Administrative Support Service will implement business logic to calculate the incentive payment based on discharge information submitted.

## 26. Role of contractors

*What will be the role of existing SMA contractors in implementing the EHR Incentive Program – such as MMIS, PBM, fiscal agent, managed care contractors, etc.? Source: CMS SMHP Template Question C.26*

NY Medicaid will utilize CSC (the eMedNY contractor) for most activities. As stated above, the Administrative Support Service for the Medicaid EHR Incentive Program is being designed as a contained service within eMedNY (NY Medicaid's certified MMIS). At this time, CSC manages the disbursements for NY Medicaid provider claim payments through eMedNY. The eMedNY system is continually evolving to accommodate changes in State and Federal policy/regulations, enhance the editing and implementation of other cost savings measures, and improve the technical architecture that supports transaction processing. Current major projects include support for: HIPAA 5010 transaction modifications; ICD-10 implementation; Medicaid

EHR Incentive Program administration system and payment processing; Medication Therapy Management; e-Prescribing incentives; PCMH incentives; and overhaul of ambulatory and inpatient reimbursement methodologies.

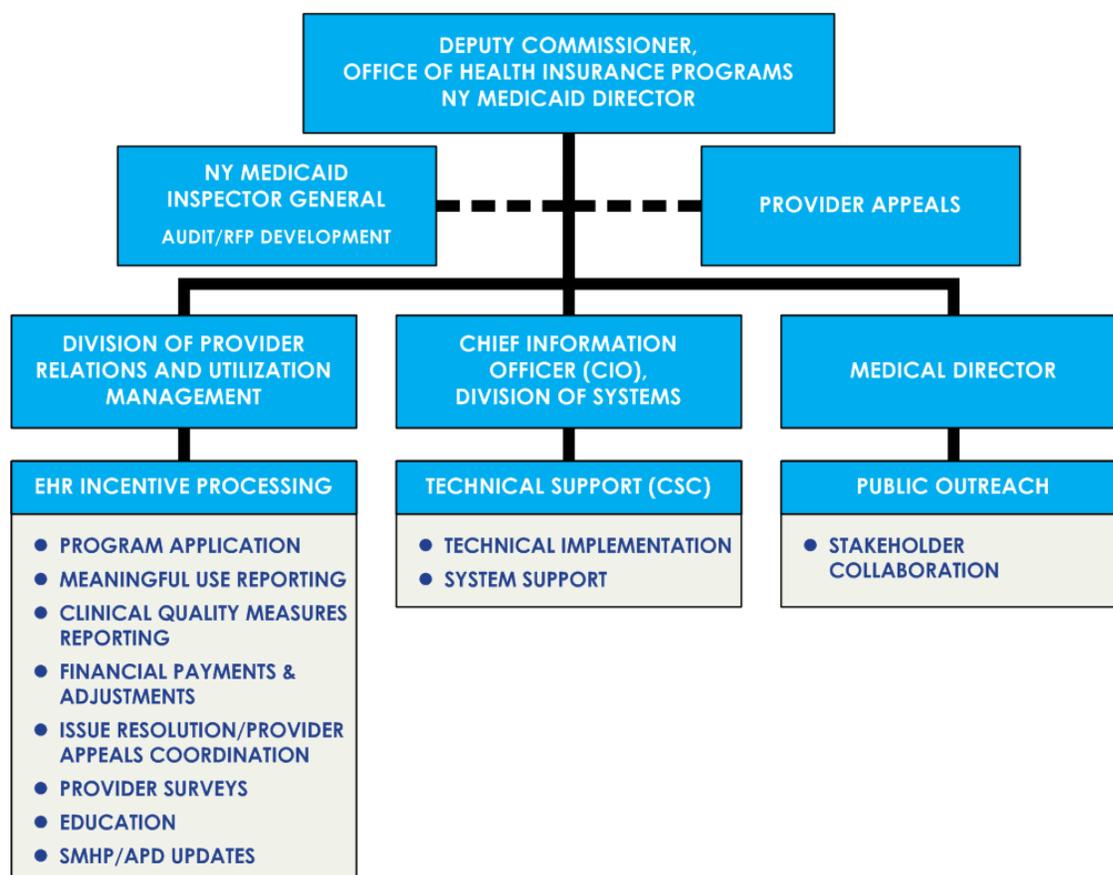
NY Medicaid recently awarded contract services to CMA Consulting to enhance and extend the capabilities currently provided by the MDW. With this project, the MDW will continue to serve as the information integration hub for all program information, providing access to this data as a service within the broader Center. In a future phase of the project, additional healthcare information from human services organizations, such as the Office of Public Health, will be incorporated into the Center. The technical architecture of the Center will substantially conform to Nationwide Health Information Network (NHIN) standards. The enhancements to the current MDW services are underway, with an anticipated completion in summer 2011.

A communication plan will be implemented and commence in fall 2010 to continue adoption efforts and educate EPs and hospitals on the Medicaid EHR Incentive Program. The communication plan has been developed by NYSTEC and NY Medicaid plans to utilize their services, and those of CSC, to execute the necessary activities. The communication plan includes the following components:

- Stakeholder outreach events run jointly with OHITT, Regional Extension Centers (RECs) and professional organizations
- Joint communication distribution with CMS
- Updates and information included in the NY Medicaid Update with special additions as needed
- Continued stakeholder outreach to include face-to-face, conference call, and WebEx meetings

Additional details of the communication plan are included in Appendix XI ("Communication Plan").

Exhibit C-5, below, shows the breakdown of activities within New York's Medicaid EHR Incentive Program between the various departments within the NY Medicaid organizational structure.



**Exhibit C-5** Medicaid EHR Incentive Program Activities and Responsibilities

## 27. Assumptions

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

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

*Source: CMS SMHP Template Question C.27*

NY Medicaid is dependent on the following in order to successfully proceed and implement the Medicaid Incentive Payment Program for eligible providers and hospitals:

- Approval of this SMHP and subsequent I-APD requesting funding for the Medicaid EHR Incentive Program
- Availability of NLR for appropriate interoperability testing with the eMedNY Medicaid EHR Incentive Program Administrative Support Service

- Capability of NLR to identify and prevent payments to providers that have registered in multiple states
- Capability of NLR to identify providers who have moved between states and provide incentive payment history to prevent duplicate payments and overpayments
- Capability of NLR to identify providers who have federal sanctions or exclusions to prevent incentive payment processing as appropriate
- Capability of NLR to identify hospitals who have been deemed meaningful users under the Medicare EHR Incentive Program and who are thus exempt from further verification by the State under the Medicaid EHR Incentive Program
- Availability of a finalized NLR to begin the NY Medicaid EHR Incentive Program in a time frame consistent with the general availability of the final eMedNY Medicaid EHR Incentive Program Administrative Support Service
- Availability of certified EHR systems that can be upgraded or implemented in a time frame for EPs and hospitals to achieve meaningful use criteria
- Availability of certified EHR systems registered with the NLR for verification as part of incentive payment processing
- Availability of a national registry (operated by ONC) of certified EHR systems and certified combinations of EHR modules, and the ability to query the registry using standards-based web services to validate the certification status of a given EHR system or combination of modules
- Availability of certified EHR systems to automate required EP and hospital reporting required in support of meaningful use verification, clinical quality reporting, and post-payment audit activities
- Availability of qualified staff to provide adoption advocacy and technical support to EPs and hospitals
- Availability of CMS written guidance (such as FAQs and Fact Sheets) and support personnel at the regional and national level to assist the State with questions and issues relating to implementation of the Medicaid EHR Incentive Program

## SECTION D

# THE STATE'S AUDIT STRATEGY

This section presents a description of audit controls and the oversight strategy to support New York Medicaid's electronic health record incentive payment program.

The Office of the Medicaid Inspector General (OMIG) plays a pivotal leadership role in the state's mission to eliminate and prevent fraud, waste, and abuse in New York's Medicaid program. OMIG works closely with the Department through the Office of Health Insurance Programs, which manages New York's Medicaid program, to ensure the integrity and effectiveness of the Medicaid program. For the Medicaid EHR Incentive Program, OMIG will integrate the audit requirements of the program into their existing audit processes and work plan to ensure proper payments have been made.

The Division of Medicaid Audit (DMA) professional staff conducts audits and reviews of Medicaid providers to ensure compliance with program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and reduce the potential for fraud, waste, and abuse.

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, and penalties, and improves the quality of care for the state's most vulnerable population.

## 1. Methods used to avoid improper payments

*What will be the SMA's methods to be used to avoid making improper payments? (Timing, selection of which audit elements to examine pre or post-payment, use of proxy data, sampling, how the SMA will decide to focus audit efforts etc). Source: CMS SMHP Template Question D.1*

To ensure that proper payments are made throughout the life of the Medicaid Incentive Payment Program, the Department performs the following checks before any payment is issued to a provider:

- At the time of initial enrollment, and for each subsequent request for additional payments, MMIS will be checked to verify provider eligibility in New York State.
- EHR Incentive Payments will be processed by the State's fiscal agent (CSC) through the existing workflow established for Medicaid claims payments,

which already includes pre-payment checks of the Medicaid provider file to ensure recipients are properly licensed and not subject to sanctions or payment restrictions. Utilizing data contained in the MMIS, these pre-payment checks will occur upon provider registration and again before the incentive payment is issued.

- The NLR will be checked to determine if the eligible provider is participating in the Medicare EHR Incentive Program (if appropriate) and to determine if the provider is participating in the incentive program in other states. An audit trail will be maintained containing the date/time of NLR files sent and received.
- Providers will be required to perform self attestation for all information not available for verification in existing DOH systems, to include all meaningful use information.
- Verification that the EHR system for which the incentive payment is requested is an approved system.
- A final verification for payment will be made with the NLR before any payment is issued to ensure the provider is eligible.

## 2. Identification of suspected fraud and abuse

*Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment. Source: CMS SMHP Template Question D.2*

OMIG will provide Post Payment Audits to validate the appropriateness of the payments and verify the self-attested information provided during the enrollment and registration process. The audits performed by OMIG for the Medicaid EHR Incentive Program will utilize the standard processes and techniques currently used by OMIG for their Medicaid audits.

With respect to the Medicaid EHR Incentive Program, it is anticipated that the determinants of risk for audit will not be the same as for overall Medicaid audit determination, since the program will be operating under different parameters and using different metrics. OMIG plans to audit the recipients of EHR Incentive Payments both randomly and through targeted audits. The targeted selection of providers and hospitals for audits may include, but not limited to the following high risk areas/criteria:

- Discrepancies in the patient volume reported by the providers and the claims data available in MMIS

- Providers with Medicaid patient volumes within an OMIG identified percentage of the required volume threshold for program eligibility
- Clinics or group practices where some of the EPs use their individual patient volume for patients seen at the clinic, while others use the clinic-level data
- Unrecognized payment reassignments (NPI/TIN match against MMIS)
- PAs at FQHC/RHCs that are "so led" by a PA
- Recipients dropping out of the program after receiving the first year incentive
- Sanctions, exclusions, loss of licensure and any other prohibitions on receiving federal funds after receiving any incentive payments.
- As part of regular audits and investigations to ensure compliance with Medicaid program requirements
- Any complaint received with regard to fraud or abuse of EHR Incentive Program

Accordingly, OMIG plans to establish a new bureau within DMA dedicated to oversight of the Medicaid EHR Incentive Program. One of the initial tasks of this office will be to determine the programmatic details of program integrity and audit functions, including the determinants of risk for audit. The office will also be responsible for developing programmatic processes for identifying subjects of random (not risk- or event-generated) audits and for developing audit procedures specific to the details of the Medicaid EHR Incentive Program, where the existing audit procedures are not applicable to the program. This office will only engage in activities related to the Medicaid EHR Incentive Program, and the costs for operating this office (detailed in the forthcoming IAPD) will be completely allocated to the program for 90% FFP. More information on the processes and determinants of risk that are developed by this office will be included in subsequent updates to this SMHP. OMIG also receives recommendations for audits from the Office of Inspector General (OIG) within the U.S. Department of Health and Human Services (HHS), as well as oversight agencies, newspaper articles, and our hotline. An integral part of the selection process is a review of oversight agency survey reports or other provider reviews. OMIG uses this information to determine whether to perform an audit, and, if so, the type of audit. For example, OMIG has the option of performing a documentation and coding audit, a clinical audit of fee-for-service providers, or a combination of those audit approaches.

OMIG uses a variety of analytical tools and data mining techniques to identify providers for audit purposes. OMIG utilizes various tools, including Salient, to uncover fraudulent behavior. Salient is designed to uncover patterns, identify geographic trends, and tie different data points together into usable information. OMIG emphasizes claimants' behavior over claims paid and targets those who make multiple attempts to receive payment and seek ways around the prepayment controls designed to protect the Medicaid program. OMIG considers successful initiatives in

Medicaid program integrity in other states, current academic and public policy organization analyses of health care issues, and program ideas and directives from the CMS Medicaid Integrity Program, which has federal responsibility for guiding and overseeing our work. OMIG works closely with the Department, the NYS Department of Law and the NYS Comptroller's offices in identifying program vulnerabilities.

OMIG plans to conduct desk audits and field audits as required. Audits will follow existing OMIG Audit policies for initiation, execution and development of reports and related paperwork. The number of audits will be determined based on the volume of providers receiving Medicaid EHR Incentive Program payments. The type of audit conducted will be determined by the rationale used to select the provider for an audit. Most audits will start as a desk audit to determine the provider compliance with the program requirements. If the findings of a desk audit are insufficient to make a conclusive determination, then a field audit may be initiated to further investigate program compliance. Field audits may also be initiated for a random sample of providers to verify adoption/implementation/upgrade of certified EHR technology.

A field audit begins with OMIG notifying to the provider by sending out a project letter. In 2008, OMIG revised the project letter to require providers to submit certain audit documentation to OMIG within 30 days. This enables OMIG to perform audit procedures prior to beginning the field audit. The information includes audited financial statements, tax returns, a list of related parties, and selected analysis of work. In addition, OMIG directs the provider to notify its outside accountants, in writing, so that OMIG can gain access to their work papers. OMIG will require a copy of provider tax returns and information on its corporate compliance program. OMIG will verify the provider's CMS EHR Certification ID using the CMS developed system once it has become available, to validate the list of EHR systems/modules that comprise the providers EHR system. OMIG will also review enrollment records and require copies of current annual certifications, including the provider's annual electronic certification that they have an effective compliance program.

With respect to the EHR Incentive Program payments OMIG anticipates that required documents may include documents to support adoption, implementation or upgrade of certified EHR systems, information to support patient volume calculation and other attestation requirements. To support attestations to adoption, implementation, or upgrade of certified EHR technology in the first year of participation in the Medicaid EHR Incentive Program, providers should be prepared to supply documentation that, at a minimum, demonstrates either a binding financial commitment (such as a contract) or actual expenditures on adoption, implementation, or upgrade of the EHR technology. In the case of commercial off-the-shelf EHR technology, this documentation should clearly indicate the full name and version of the product in such a way that it can be matched to a specific product or

combination of products in the CHPL. Examples of documentation that should be retained and produced upon request include:

- Signed/dated contracts, purchase orders, or receipts for purchase or lease of commercial off-the-shelf certified EHR software or proof of subscription (contracts or paid invoices) to hosted EHR software
- Documentation of expenses incurred in development, testing, maintenance, and upgrade of custom certified EHR systems or modules
- Proof of payment for consulting services related to the selection, acquisition, installation, and setup of certified EHR technology and the successful integration of the certified EHR technology into the clinical workflow
- Purchase agreements or receipts for computer hardware or software required to operate the certified EHR system
- Documentation of expenses incurred in transitioning patient records to the certified EHR system
- Contracts or proof of actual expenditures for testing and/or training for the certified EHR system

OMIG's document requests may also include audit financial statements, tax returns, related parties, and access to the work papers of independent certified public accountants. This information will facilitate our review and, at times, enable us to reduce our procedure. OMIG will review the provider's compliance plans, interview the compliance officer and, as necessary, inspect auditing, monitoring, and compliance committee reports. Additionally, OMIG will review enrollment records and annual certifications for paper and electronic submission of claims. OMIG will remind providers to retain documentation to support all attestations for no less than six years after each payment year against the possibility of post-payment audit.

Upon completion of a field audit, OMIG will conduct an exit conference with the provider to discuss preliminary findings. Afterward, OMIG will issue a draft audit report that will identify any proposed recoupment and the basis for the action. The provider has 30 days to respond to the draft audit report. If the provider fails to reply within that time frame, OMIG will issue a final report. If the provider objects to the draft audit report, OMIG will consider the provider's response, including any supporting documentation, before issuing a final audit report.

Medicaid overpayments resulting from OMIG audit findings are recovered in full or principally through reductions from the provider's ongoing Medicaid cash flow. Recovery rates are automatically set to 15% of weekly cash flow on eMedNY, but this rate may be increased or decreased based on certain criteria. Standard collection policy is that these debts should be repaid within two years. Providers requesting

reduced collection percentages may be accommodated, assuming the principal component of the debt can still be recovered within two years. Providers documenting financial duress may be granted recovery schedules of up to four years. If the provider becomes an inactive Medicaid biller, the State takes additional collection actions, including sending dunning letters, assigning the debt to another active provider with the same federal tax ID, or eventually referring the debt to the State Attorney General's office for recovery.

OMIG has a system in place to proactively review the operations, licenses, and certifications of Medicaid providers, including scrutinizing provider records through surveillance, forensic accounting of subpoenaed bank records and billings, medical record reviews, witness testimony, site visits, immediate demands for records, and computerized analysis.

The Office of the Medicaid Inspector General (OMIG) will also collaborate with OHIP to verify a provider's eligibility against the MMIS and sanctions records/database prior to payment being issued. As described in the previous section, OHIP will check the NLR, prior to disbursing incentive payments, to verify that a provider is not receiving other Federal funds (for example, that non-hospital providers are not already receiving Medicare EHR Incentive Program payments).

These processes will be combined with routine audit processes post payment to ensure that attestations were accurate, that funds received were expended appropriately, and that HIT/Electronic Health Record (EHR) systems obtained with American Recovery and Reinvestment Act funds were certified.

OMIG anticipates the use of contractors to perform the audits as part of a 3 to 5 person unit that will be established for program oversight. OMIG will leverage functionality that is embedded in the certified EHR systems as part of the audit process to minimize the impact on the providers.

### **3. Tracking total dollar amount of overpayments**

*How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY? Source: CMS SMHP Template Question D.3*

If any overpayments are identified (via post-payment audit, for example), they will be reported on OMIG's Fraud Abuse Comprehensive Tracking System (FACTS) and all existing processes will be followed for the tracking of such recoveries. It is anticipated that a new category or project type will be created on FACTS in an effort to distinctly track HIT activity. The obligation to repay the Federal government its proportionate share of such overpayments will be met by the Department consistent with current procedures.

The Office of the Medicaid Inspector General is in the process of consolidating numerous standalone fraud and audit tracking systems into a single web-based portal system called the Fraud Activity Comprehensive Tracking System (FACTS). FACTS is a highly confidential database of fraud investigations and audit activities used as a provider case tracking system for OMIG.

The application is web based and is accessible in real-time by over 1,200 users across the State in four state agencies (OMIG, Department of Health, Medicaid Fraud Control Unit, and the Office of the State Comptroller). FACTS is a web-based application that was developed using .NET and Oracle. The hardware architecture consists of a fail-over database/application cluster that is located in a controlled server environment at an off-site state office. Full backups are performed on a daily basis, with incremental backups occurring approximately every two minutes. A log of every transaction is kept to assure the integrity of the system. The current system has thirty modules in production.

The FACTS is an electronic drawer, composed of numerous and varying databases, data sources, modules, and interfaces that permits efficient access to current and historical information on all audit and investigative activities involving Medicaid providers and/or recipients. The system centralizes information about investigations and audits, providing a current, accurate, and reliable data source and reducing the time it takes to react to new situations by building a complete history of any prior provider or recipient related activity and making it immediately available to auditors and investigators. Users can collaborate on assignments, and OMIG managers can keep up with audits and investigations in real-time.

This tracking system (FACTS) enables fraud/audit managers statewide to better identify, track, and coordinate Medicaid audits and investigations across New York State. Cases are entered by each regional office and updated by audit supervisors. Each region is responsible for their reviews. The strategy to automate and provide access about audits and investigations to all audit and investigative staff enables sharing and reporting of information. This collaborative effort, through a user friendly electronic case folder system, continues to result in reduced fraud, waste, and abuse in the Medicaid Program. Imaged case documents are available within FACTS and allow all audit and investigative documents to be accessed electronically through FACTS in real-time.

Significant Medicaid Program savings are generated through better identification of provider fraud and abuse and through more timely and efficient coordination of activities by audit and investigative staff. Additionally, coordination of some inter-agency and local district investigations can be achieved through the use of FACTS.

#### 4. Actions taken when fraud and abuse are detected

*Describe the actions the SMA will take when fraud and abuse is detected. Source: CMS SMHP Template Question D.4*

Any fraud will be referred to the New York State Attorney General's Medicaid Fraud Control Unit or appropriate prosecutor. Suspected cases of fraud and abuse (e.g., unacceptable practices under State regulations) will be handled similarly to all other current allegations of fraud and abuse, including the conduct of investigations, issuance of warning letters, imposition of penalties or other sanctions, exclusions and terminations from the Medicaid Program, etc.

#### 5. Use of existing data sources in verifying meaningful use

*Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe. Source: CMS SMHP Template Question D.5*

An analysis is currently underway to map the remaining Meaningful Use criteria to existing data sources such as the MMIS and Medicaid data warehouse to determine the feasibility of leveraging these data sources in the verification process. It is anticipated that there will not be many existing data sources that can be used for verification, since the information collected for meaningful use constitutes new data types. For example, the ability to perform some rudimentary verification checks (such as confirming that an eligible provider was an active Medicaid participant over the reported timeframe) can be accomplished using the existing data found in MMIS; however, data to support the determination of the scale of their Medicaid participation versus their non-Medicaid is not available. Therefore additional research and analysis will be conducted on other data sources to determine the extent of existing data sources that can be leveraged.

#### 6. Use of sampling in audit strategy

*Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?\*(i.e. probe sampling; random sampling) Source: CMS SMHP Template Question D.6*

OMIG will use statistical sampling in both the targeting of applicants for the funds received and any field or desk audit conducted. An analysis of the program participation level will be performed to determine the appropriate sampling methodology to be used.

Various sampling techniques are utilized by OMIG, including random sampling, population or sampling frame, and sampling unit. OMIG utilizes the services of a

recognized statistician to assist in the development of sampling techniques, and analysis and identification of the results of a statistical sample. Information obtained from statistical sampling is now generally accepted. Accounting firms, national healthcare consulting firms, the Department of Health and Human Services, and the Office of the Inspector General (OIG) have historical uses of statistical sampling for audit purposes. In many instances, statistical sampling allows an audit of an account to be conducted that would otherwise be too voluminous or complex to audit in its entirety. Some of the sampling techniques generally used by auditors, including OMIG, are as follows:

- Population or sampling frame—the entire set, made up of individual elements, under consideration: In the context of third-party insurer audits, the population might be the set of all claims made over a certain period of time or the set of all recipients of medical care.
- Sampling unit—the individual elements that comprise the population or sampling frame: In the case of an insurer audit, the sampling unit might be the insurance recipient or the individual insurance claim or transaction.
- Probability sample—a sampling procedure in which the probability that any member of the population will be included in the sample is known in advance: For example, in a simple random sample, each member of the population has an equal chance of being included in the sample. Valid estimation procedures require probability samples.
- Random sample—a group of sampling units from a population where each unit has an equally likely chance of being independently selected from the population or sampling frame.
- Sampling procedure or technique—the method used to select units for inclusion in a probability sample; for instance, choosing every tenth unit (systematic sampling), or using a random number table.
- Estimator—the mathematical rule by which an estimate of some population characteristic is calculated from the sample results.
- Estimate—the value obtained by applying the estimator to the random sample and projecting it to the larger population: A point estimate is an estimate in which a single number is used as an estimate of a population characteristic. An interval estimate is one in which the estimate is given as a confidence interval within which the population characteristic will lie with a certain confidence level.
- Unbiased—an estimator is unbiased if the average value of the estimate, taken over all possible samples, is exactly equal to the true population value.

- Confidence interval, confidence level—the confidence interval is the range of values in which a population characteristic will lie with a given level of certainty (confidence level, expressed in percent). For example, we might be “95 percent confident” that the mean of a sampling frame is between two values, X1 and X2, which are the upper and lower bounds of the confidence interval.

## 7. Reduction of provider burden

*What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc)? Source: CMS SMHP Template Question D.7*

The SMA will incorporate oversight activities into its work plan and include such reviews in routine audit/investigation processes. Some targeting of just HIT/EHR compliance will be conducted as part of the provider's effective Compliance Program pursuant to the requirements of Section 363-d of the Social Services Law.

Existing data sources will be used, in particular the MMIS, to assist OMIG in the validation of provider participation in the Medicaid program. To the extent possible, OMIG will also look at the information contained in the certified EHR systems to determine the ability to leverage the reporting and auditing capabilities provided by those systems.

## 8. Responsibility for program integrity operations

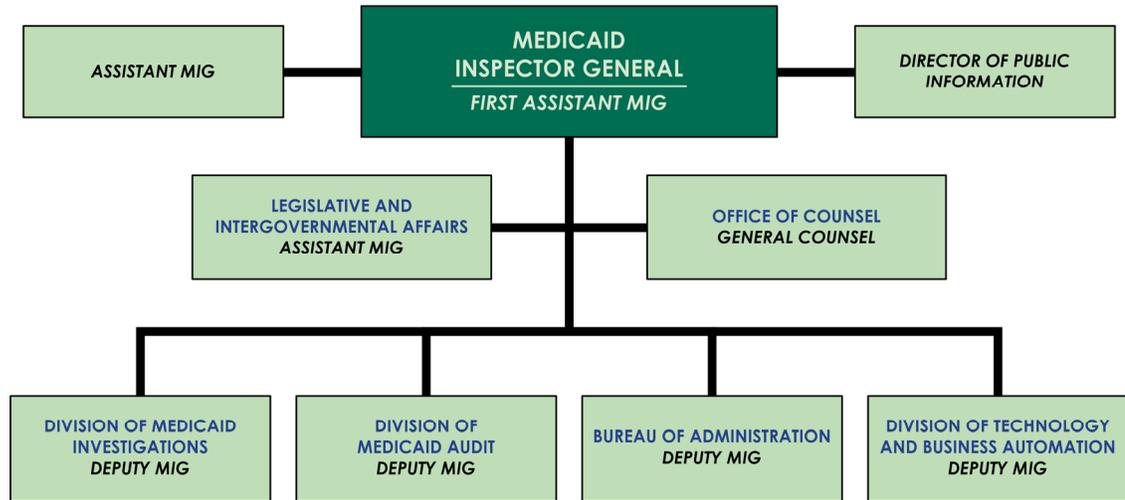
*Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated? Source: CMS SMHP Template Question D.8*

Program integrity (PI) with respect to the EHR Incentive Program is a coordinated effort between OHIP, which conducts screening of applicants prior to the issuance of Medicaid EHR Incentive Program payments to ensure that applicants are properly licensed, not sanctioned or otherwise prevented from receiving federal payments, and leveraging other data sources where available to perform real time tests of reasonableness on provider attestations, and OMIG, which is charged with detecting fraud, abuse, or waste in the Medicaid system and recovering improper payments.

Within OMIG, each division plays a significant role in the PI function, including the Division of Medicaid Audit (DMA), which conducts audits and reviews of Medicaid providers to ensure compliance with program requirements and, where necessary, recovers overpayments; the Division of Medicaid Investigations (DMI), which investigates potential instances of fraud, waste, and abuse in the Medicaid Program;

the Division of Technology and Business Automation (DTBA), which supports the data needs of OMIG through data mining and analysis, and system match and recovery through the use of commercial data mining products and procurement of expert services consultants; and the DOH Office of Counsel, which promotes OMIG's overall statutory mission through timely, accurate, and pervasive legal advocacy and counsel.

Exhibit D-1, below, shows the organizational structure of OMIG as it pertains to the Medicaid EHR Incentive Program:



**Exhibit D-1** OMIG Organizational Structure

With respect to the HIT/EHR, a new bureau within the DMA will take the lead with assistance and support from all of the other divisions.

## SECTION E

# THE STATE'S HIT ROADMAP

This section presents a graphical and narrative pathway clearly illustrating the State's strategy for moving from the "As-Is" HIT landscape described in Section A of this plan to the achievement of the "To-Be" HIT environment envisioned in Section B. This strategic roadmap is based on measurable, annual targets and benchmarks tied to HIT/HIE program goals and objectives.

## 1. NY Medicaid Roadmap

*Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there. Source: CMS SMHP Template Question E.1*

NY Medicaid will seek to improve operations through various activities over the next five years. Activities undertaken by NY Medicaid will emphasize maintaining compliance with Medicaid regulations, improving the technology landscape upon which NY Medicaid operates, and increasing the use of electronic health records and meaningful use among Medicaid providers. Building on the As-Is Landscape discussed in Section A of this SMHP, NY Medicaid will undertake the following:

### **Medicaid Mandates**

NY Medicaid is currently undertaking federally mandated improvements to its MMIS for the NY Medicaid program to remain compliant. In order to prepare for X12 5010, NY Medicaid is building a testing environment on the Medicaid ESB to be available for providers to test claims in summer 2011. This has been a significant effort on the part of NY Medicaid, requiring over 100,000 hours of effort to be X12 5010 compliant by January 1, 2012. Additionally, NY Medicaid is planning their ICD-10 rollout to meet the October 1, 2013 compliance date and will be able to accept both ICD-9 for dates of service prior to October 1, 2013, and ICD-10 for dates of service on October 1, 2013, and thereafter. Some of the ICD-10 work is being done by a vendor (3-M) with respect to our claims bundling and pricing software (APG software from 3M).

### **Current Initiatives Planned and/or Executing**

The Replacement Medicaid Management Information System (R-MMIS) will implement a service oriented architecture (SOA) employing reusable components and services consistent with MITA interoperability standards (as they become available). This architecture supports HIE goals such as the exposure of MMIS services within the broader statewide HIE network infrastructure. Additionally, the R-MMIS will support HIE through the adoption of data representation and interchange standards such as HIPAA 5010, NCPDP D.0 Electronic Data Interchange, and ICD-10. An RFP for the R-MMIS has been published by the Department, with proposals due by October 29, 2010.

The Center implementation will also employ MITA-standard data models and interchange formats, to the extent they are available, in order to provide services to consumers with a consistent representation of health information from disparate sources. The Center will have the capability to provide Medicaid information to

interested parties through targeted data marts. In this capacity, NY Medicaid will engage the Office of Children and Family Services (OCFS) to address populations with unique needs. Both of these initiatives, the R-MMIS and the Center, were documented in NY Medicaid's MITA Transition and Implementation Plan previously submitted to CMS.

The Medicaid Medication History Service emerged from the success of the Medication History Exchange pilot program in 2008 and matured into a service available to Medicaid providers throughout the state as one of the core features of the Medicaid ESB. NY Medicaid is currently involved in several implementations with interested stakeholders to make 180 days of medication history available to them. NY Medicaid believes that making medication history available to clinicians will greatly improve their ability to serve patients, specifically by enabling point-of-care clinical decision support capabilities in EHR systems to reduce the risk of adverse prescription drug interactions. In addition, provided that patient consent is available, clinicians will be able to increase coordination of care activities by sharing medication history information across unaffiliated organizations. NY Medicaid will continue to promote the Medication History Service through planned stakeholder outreach and education activities. As additional stakeholders are identified and brought on board, NY Medicaid will seek to increase the number of participants and set adoption goals accordingly. Updated targets will be included in subsequent updates to this SMHP.

The e-Prescribing Incentive Program instituted by NY Medicaid commenced on May 1, 2010, providing for financial incentives to providers that issue prescriptions electronically and to pharmacies that accept e-prescriptions. Under this program, eligible providers (including physicians, dentists, nurse practitioners, podiatrists, optometrists, and licensed midwives) will receive incentive payments of \$0.80 per dispensed Medicaid ambulatory e-prescription (including refills), and retail pharmacies will receive incentive payments of \$0.20 per dispensed e-prescription. Nationally, e-prescribing has increased significantly over the last few years, with over 190M prescriptions being routed electronically in 2009—a 181% increase over 2008. NY Medicaid has been tracking e-prescriptions since January 1, 2010, and during the first six months of 2010 NY Medicaid has logged over 1.6M e-prescriptions. With the e-Prescribing Incentive Program in place, NY Medicaid expects e-prescriptions to average 10% of all Medicaid prescriptions for the year ending April 30, 2011, increasing to 20% for the year ending April 30, 2012, and 30% for the year ending April 30, 2013. Additional targets will be established based on results and marketing of e-prescribing through continued stakeholder and education activities. Updated targets will be included in subsequent updates to this SMHP.

The Patient-Centered Medical Home projects that NY Medicaid has chosen to promote will seek to strengthen the physician-patient relationship and quality of care

(especially at transitions in care) by promoting improved access, coordinated care, and enhanced patient/family engagement. Effective July 1, 2010, NY Medicaid provides financial incentives to office-based physician and registered nurse practitioner practices, Federally Qualified Health Centers (FQHCs), and Diagnostic and Treatment Centers (D&TCs) recognized by NY Medicaid and the NCQA as operating a PCMH. Additional detail on NY Medicaid's PCMH initiative, developed jointly between NY Medicaid and OHITT, can be found in Section A of this SMHP (The State's As-Is HIT Landscape Assessment). Initial findings are expected to show improved results in quality of care, chronic disease care and prevention outcomes, but realizing long-term benefits will require significant effort by physician practices and in delivery of physician/patient education. NY Medicaid will continue promotion efforts through stakeholder outreach and education activities and will reevaluate the success of the program as progress and results are made available. Updated goals and future activities to encourage adoption will be included in subsequent updates to this SMHP.

#### **HIT/E Activities**

In order to manage the Medicaid EHR Incentive Program, NY Medicaid will implement a Medicaid EHR Incentive Program Administrative Support Service. The application, currently under development through the joint efforts of the Department, NYSTEC, and Computer Sciences Corporation (CSC), is a contained service within eMedNY that will be responsible for applications for program participation, establishment of eligibility and payments, and collection of meaningful use data. The eMedNY Medicaid EHR Incentive Program Administrative Support Service will leverage existing data sources (such as the state MMIS) and contractor arrangements (such as the existing contract with CSC) to provide claims payment services to streamline the implementation of the program and reduce the burden on the eligible professional or institution for participating. Additional details on the eMedNY Medicaid EHR Incentive Program Administrative Support Service are provided throughout Section C: The State's Implementation Plan of this SMHP. A key component of the eMedNY Medicaid EHR Incentive Program Administrative Support Service will be the seamless interface with the NLR. Based on our current schedule and the availability of the NLR, NY Medicaid has targeted the third quarter of 2011 to participate in NLR testing.

## NY MEDICAID HIT ROADMAP

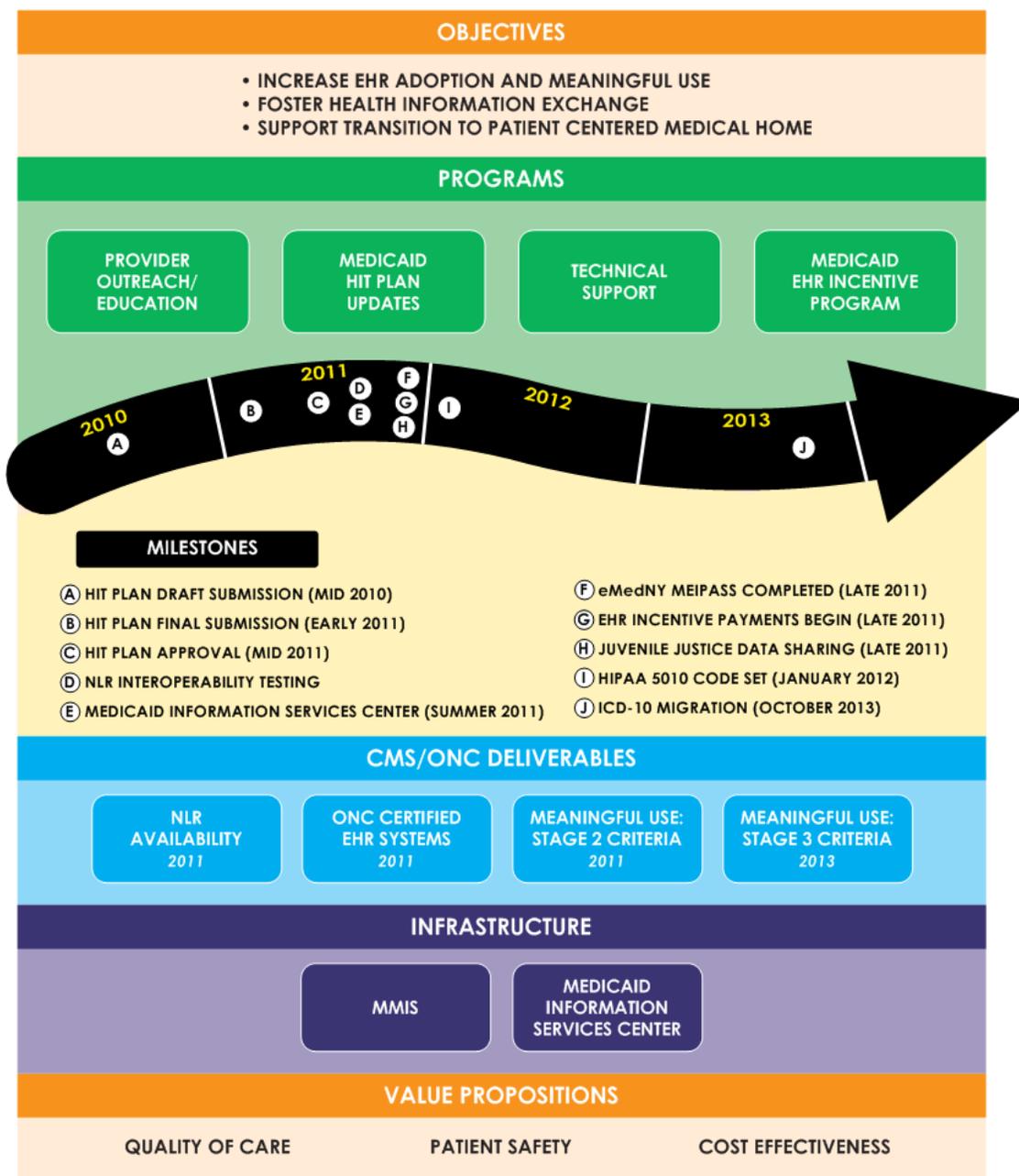


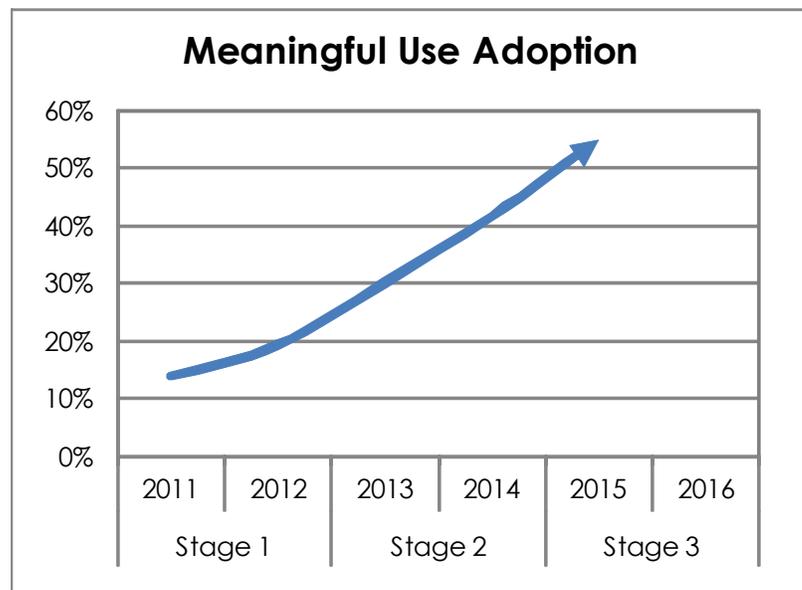
Exhibit E-1 The State's HIT Roadmap

## 2. Expectations for EHR adoption

*What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type? Source: CMS SMHP Template Question E.2*

Based on a 2006 NYS physician assessment, it is estimated that approximately 11.25% of NYS providers would be eligible to participate in the Medicaid EHR Incentive Program. Of these individuals, some eligible professionals may choose not to

participate in the Medicaid Incentive Payment Program and those that do may not achieve meaningful use. Based on this information, NY Medicaid has set EHR technology adoption goals targeting those clinicians who plan to participate in the incentive program and meet meaningful use. We believe that a reasonable goal is that 10–20% of eligible professionals and hospitals that enroll in the Medicaid EHR Incentive Program by December 31, 2011 will reach Stage 1 meaningful use goals by December 31, 2012, increasing to 20–30% by December 31, 2013. Additional outreach and education activities, as discussed in our Communication Plan (see Appendix XI, “Communication Plan”), will be employed to increase adoption of EHR technology among eligible providers over the life of the Medicaid EHR Incentive Program. Targets will need to be revisited annually to gauge success and recast as appropriate. In addition, targets will need to be reevaluated as Stage 2 and Stage 3 meaningful use criteria and measures are released. NY Medicaid will perform subsequent environmental scans to assess the readiness of the provider community in incorporating and meeting additional meaningful use criteria. Based on Stage 1 criteria, NY Medicaid’s initial goal for adoption progression is depicted below.



**Exhibit E-2** New York’s Goal for Meaningful Use of EHRs

NY Medicaid anticipates that the further development of goals and objectives for the adoption of EHR technology will be significantly informed by the outcome of the eligible professional/hospital surveys (currently underway) as well as the stakeholder outreach and communications campaigns planned for the fall of 2010. Future updates to this SMHP will include more refined adoption goals based on these activities and preliminary figures regarding the level of participation in the Medicaid EHR Incentive Program.

### 3. Annual benchmarks

*Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario. Source: CMS SMHP Template Question E.3*

NY Medicaid will seek to increase the number of providers participating in EHR technology and meaningful use by orchestrating its Communication Plan (see Appendix XI, "Communication Plan") and ongoing activities with RECs. The Communication Plan will target Medicaid providers specifically through currently established communication networks. Providers will receive regular and special updates in the DOH Medicaid Updates accessible on the Department's website. Providers will be invited to participate in webinars, conference calls, face-to-face meetings, conferences, and other events promoting EHR and meaningful use. In addition, NY Medicaid will continue to work with OHITT and New York's RECs in conducting joint "New York EHR Meaningful Use Summits" similar to the successful series conducted in the spring and fall of 2010. A description of these "Summits" is contained in Section A of this SMHP. As described previously, it has been estimated that 11.25% of physicians in New York State would be eligible for the Medicaid EHR Incentive Program. Although this estimate did not include hospitals, the much larger population of physicians relative to hospitals (approximately 80,000 and 230, respectively) means that the estimate would not be expected to change if hospitals were included. Based on this estimate, NY Medicaid believes that a reasonable goal is that 10–20% of eligible professionals and hospitals that enroll in the Medicaid EHR Incentive Program by December 31, 2011 will reach Stage 1 meaningful use goals by December 31, 2012, increasing to 20–40% by December 31, 2013. Targets will need to be set for the remaining years of the Program based on experience and the results of provider and hospital registration activities and achievement of meaningful use. Updated targets will be contained in subsequent submissions of this SMHP.

NY Medicaid is currently providing incentives for e-prescriptions and has been tracking e-prescription activity since January 1, 2010. To date, NY Medicaid has tracked approximately 1.6M e-prescriptions, representing more than 7% of all Medicaid prescription claims for the period. With national e-prescribing activity increasing significantly, NY Medicaid is looking to increase participation and distribution of incentives through their e-Prescribing Incentive Program. Accordingly, NY Medicaid plans to achieve average annual e-prescriptions of 10% by April 30, 2011, increasing to 20% by April 30, 2012, and 30% by April 30, 2013. In order to track these goals, NY Medicaid has created automated reports documenting overall monthly activity on e-prescriptions. For tracking at the provider level, a prescriber's NPI is required and reportable to validate the number of e-prescriptions submitted as part of their meeting

the 40% threshold for meaningful use. Additional targets will be established based on results and marketing of e-prescribing through continued stakeholder and education activities. Updated targets will be included in subsequent updates to this SMHP.

#### **4. Audit and oversight benchmarks**

*Discuss annual benchmarks for audit and oversight activities. Source: CMS SMHP Template Question E.4*

For the Medicaid Incentive Payment Program, OMIG will integrate the audit requirements of the program into their existing audit processes and work plan to ensure that proper payments are made. OMIG plays a pivotal leadership role in the state's mission to eliminate and prevent fraud, waste, and abuse in New York's Medicaid program. OMIG will provide post-payment audits to validate the appropriateness of the payments and verify the self-attested information provided during the enrollment and registration process. The audits performed by OMIG for the Medicaid Incentive Payment Program will utilize the standard processes and techniques used by OMIG for their Medicaid audits. Audit candidates will be identified as they are currently, using a variety of analytical tools, data mining techniques, and audit recommendations received by OMIG. It is anticipated that the number of audits will not incrementally increase, but rather that the requirements of each audit conducted will be updated to include verification of certified EHR technology and achievement of meaningful use criteria.

# APPENDIX I

# GLOSSARY OF TERMS

<b>AAP</b>	American Academy of Pediatrics
<b>ARCHIE</b>	Adirondack Regional Community Health Information Exchange
<b>ARRA</b>	American Reinvestment and Recovery Act
<b>BA</b>	Business Architecture
<b>BHIX</b>	Brooklyn Health Information Exchange
<b>BIP</b>	Broadband Incentive Program
<b>BTOP</b>	Broadband Technology Opportunities Program
<b>CAHPS</b>	Consumer Assessment of Healthcare Providers and Systems
<b>CBOC</b>	Community-Based Outpatient Clinics
<b>CAH</b>	Critical Access Hospital
<b>CCD</b>	Continuity of Care Document
<b>CCI</b>	Comprehensive Community Infrastructure
<b>CHCANYS</b>	Community Health Care Association of New York State
<b>CHIP</b>	Children's Health Insurance Program
<b>CHIPRA</b>	Children's Health Insurance Program Reauthorization Act
<b>CHITA</b>	Community Health Information Technology Alliance
<b>CHPL</b>	Certified Health IT Product List
<b>CIO/OFT</b>	Chief Information Officer and Office for Technology
<b>CMS</b>	Center for Medicare and Medicaid Services
<b>COTS</b>	Commercial Off The Shelf
<b>CPRS</b>	Computerized Patient Record Service
<b>CSCIC</b>	Cyber Security and Critical Infrastructure Coordination
<b>DAW</b>	Dispense As Written
<b>DMA</b>	Division of Medicaid Audit
<b>DMI</b>	Division of Medicaid Investigations
<b>DOHMH</b>	Department of Health and Mental Hygiene
<b>DSL</b>	Digital Subscriber Line
<b>DTBA</b>	Division of Technology and Business Automation
<b>D&amp;TC</b>	Diagnostic and Treatment Center
<b>ECLRS</b>	Electronic Clinical Laboratory Reporting System
<b>EDI</b>	Electronic Data Interchange
<b>EHR</b>	Electronic Health Record
<b>ESB</b>	Enterprise Service Bus
<b>ETL</b>	Extraction/Transformation/Load
<b>FACTS</b>	Fraud Abuse Comprehensive Tracking System
<b>FCC</b>	Federal Communications Commission
<b>FPA</b>	Family Planning Advocates
<b>FQHC</b>	Federally Qualified Health Center

<b>FMS</b>	Financial Management System
<b>GNHYA</b>	Greater New York Hospital Association
<b>HAC-CNY</b>	Health Advancement Collaborative of Central New York
<b>HANYS</b>	Healthcare Association of NYS
<b>HCA</b>	Home Care Association of New York State
<b>HEAL</b>	Health Care Efficiency and Affordability Law
<b>HEDIS</b>	Healthcare Effectiveness Data and Information Set
<b>HHS</b>	Department of Health and Human Services
<b>HIT</b>	Health Information Technology
<b>HIE</b>	Health Information Exchange
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HIT/E</b>	Health Information Technology/Exchange
<b>HITSP</b>	Health Information Technology Standards Panel
<b>HIXNY</b>	Healthcare Information Xchange of NY
<b>HPCANY</b>	Hospice and Palliative Care Association of New York State
<b>HPA</b>	New York State Health Plan Association
<b>HRSA</b>	Health Resources Services Administration
<b>HTTP</b>	Hypertext Transfer Protocol
<b>ICD</b>	International Classification of Diseases
<b>ICR</b>	Institutional Cost Report
<b>IHA</b>	Iroquois- Healthcare Alliance
<b>IHS</b>	Indian Health Service
<b>IPTV</b>	Internet Protocol Television
<b>kbps</b>	kilobits per second
<b>LIPIX</b>	Long Island Patient Information eXchange
<b>Mbps</b>	Megabits Per Second
<b>MDW</b>	Medicaid Data Warehouse
<b>MEIPASS</b>	Medicaid EHR Incentive Program Administrative Support Service
<b>MEVS</b>	Medicaid Eligibility Verification System
<b>MHIE</b>	Medicaid Health Information Exchange
<b>MHPI</b>	Medication History Pilot Interface
<b>MIG</b>	Medicaid Integrity Group (CMS)
<b>MITA</b>	Medicaid Information Technology Architecture
<b>MMIS</b>	Medicaid Management Information System
<b>MOU</b>	Memorandum of Understanding
<b>MSSNY</b>	Medical Society of the State of New York
<b>NAAC</b>	Net Average Allowable Cost
<b>NCPDP</b>	National Council for Prescription Drug Programs
<b>NCQA</b>	National Committee for Quality Assurance

<b>NESCO</b>	New England States Consortium of Systems Organization
<b>NHIN</b>	National Health Information Network
<b>NLR</b>	CMS National Level Repository
<b>NPA</b>	Nurse Practitioner Association of New York State
<b>NPI</b>	National Provider Identifier
<b>NTIA</b>	National Telecommunications and Information Association
<b>NYACP</b>	New York Chapter of the American College of Physicians
<b>NYAHS</b>	NYS Association of Homes and Services for the Aging
<b>NYCDOHMH</b>	New York City Department of Health and Mental Hygiene
<b>NYCLIX</b>	New York Clinical Information Exchange
<b>NYC REACH</b>	New York City Regional Electronic Adoption Center for Health
<b>NYeC</b>	New York eHealth Collaborative
<b>NYSAFP</b>	New York State Academy of Family Physicians
<b>NYSALM</b>	New York State Association of Licensed Midwives
<b>NYSHCP</b>	New York State Association of Healthcare Providers
<b>NYSDA</b>	New York State Dental Association
<b>NYSDOH</b>	New York State Department of Health
<b>NYSHealth</b>	NY Health Foundation
<b>NYSHFA</b>	New York State Health Facilities Association
<b>NYSSPA</b>	New York State Society of Physician Assistants
<b>OASAS</b>	Office of Alcoholism and Substance Abuse Services
<b>OCFS</b>	Office of Children and Family Services
<b>OHIP</b>	Office of Health Insurance Programs
<b>OHITT</b>	DOH Office of Health Information Technology Transformation
<b>OHSM</b>	DOH Office of Health Services Management
<b>OIG</b>	Office of Inspector General
<b>OLTC</b>	DOH Office of Long Term Care
<b>OMH</b>	Office of Mental Health
<b>OMIG</b>	Office of the Medicaid Inspector General
<b>OMRDD</b>	Office of Mental Retardation and Developmental Disabilities (now OPWDD)
<b>ONC</b>	Office of the National Coordinator of Health Information Technology
<b>ONC-ATCB</b>	ONC-Authorized Testing and Certification Body
<b>OPH</b>	DOH Office of Public Health
<b>OPWDD</b>	Office for People With Developmental Disabilities (formerly OMRDD)
<b>ORH</b>	DOH Office of Rural Health
<b>OS</b>	Office of Science

<b>OTDA</b>	Office of Temporary and Disability Assistance
<b>P-APD</b>	Planning Advance Planning Document
<b>PCIP</b>	Primary Care Information Project
<b>PCMH</b>	Patient Centered Medical Home
<b>PCP-PCMH™</b>	Physician Practice Connections® - Patient-Centered Medical Home Program
<b>PDQ</b>	Patient Demographics Query
<b>PHSP Coalition</b>	New York State Coalition of Prepaid Health Services Plans
<b>PHI</b>	Protected Health Information
<b>QARR</b>	Quality Assurance Reporting Requirements
<b>REC</b>	Regional Extension Center
<b>RFP</b>	Request for Proposals
<b>RHIO</b>	Regional Health Information Organization
<b>R-MMIS</b>	Replacement Medicaid Management Information System
<b>RPMS</b>	Resource and Patient Management System
<b>RUBaN</b>	Rural Upstate Broadband Actualization Network
<b>RUS</b>	Rural Utilities Service
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration
<b>SCHIP</b>	State Children's Health Insurance Program
<b>SHIN-NY</b>	Statewide Health Information Network for New York
<b>SMA</b>	State Medicaid Agency
<b>SOA</b>	Service Oriented Architecture
<b>SOAP</b>	Simple Object Access Protocol
<b>SPARCS</b>	Statewide Planning And Research Cooperative System
<b>SS-A</b>	State Self-Assessment
<b>SSL</b>	Secure Sockets Layer
<b>STHL</b>	Southern Tier HealthLink
<b>SUNY</b>	State University of New York
<b>THINC</b>	Taconic Health Information Network and Community
<b>TIP</b>	Transition and Implementation Plan
<b>UHF</b>	United Hospital Fund
<b>UHP</b>	Urban Health Plan
<b>UJAFEDNY</b>	United Jewish Appeal Federation of NY
<b>VA</b>	Veterans Administration
<b>VistA</b>	Veterans Health Information Systems and Technology Architecture
<b>VNSNY</b>	Visiting Nurse Service of New York



## APPENDIX II

# GENERAL INITIATIVES FOR HIT/HIE

This appendix describes HIT/E programs and initiatives that, although they exist outside the sphere of influence of NY Medicaid, are relevant to the implementation of the Medicaid EHR Incentive Program. They are presented here as an overview only; for more detailed information on these programs and other statewide HIE initiatives, please see the statewide HIT plan currently under development by OHITT.

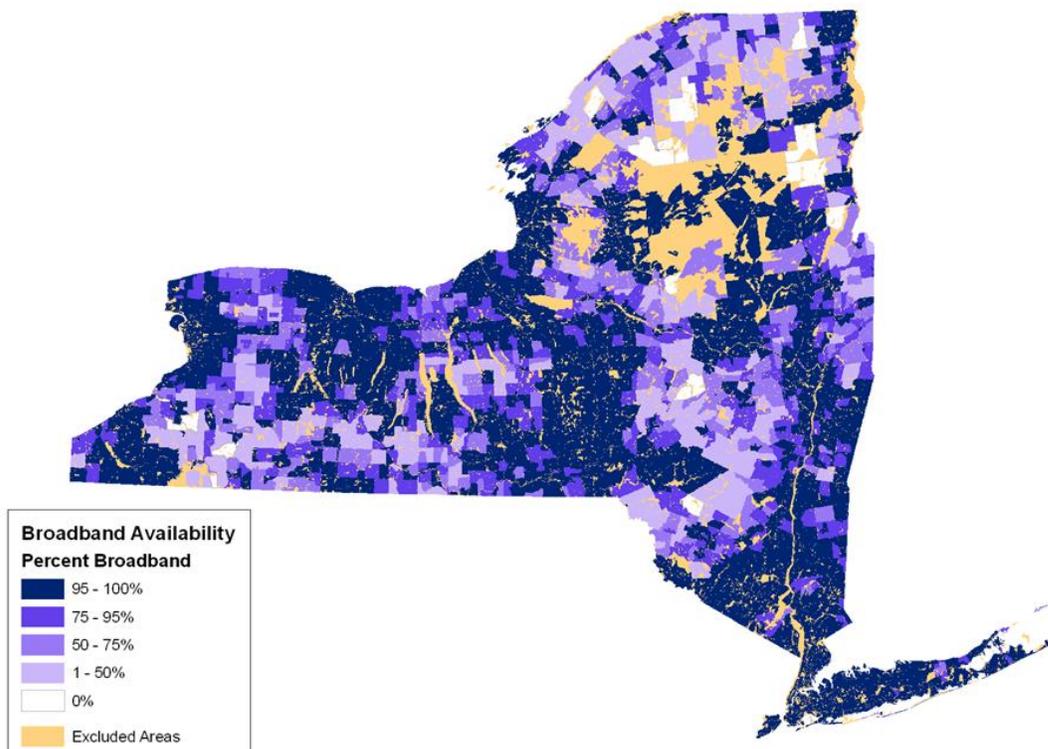
## 1. Broadband Access Study (NYS CIO/OFT)

In 2009, the Office of the New York State Chief Information Officer and Office for Technology (CIO/OFT) released the results of an effort on the part of the NYS Council for Universal Broadband to map the estimated availability of wired broadband internet access (including DSL and cable modem service) throughout the State. The study applied a predictive model to public information sources and did not rely on data from internet service providers.

The study estimated that broadband internet access is available to approximately 98% of New York's nearly 19.5 million residents. However, according to 2008 population estimates by the U.S. Census Bureau, 2.38 million of these residents—more than 12%—live in rural areas, and the study estimated that broadband internet access was only available to 86% of those residents, as opposed to nearly 100% of residents in urban areas. Furthermore, some of the most rural counties in the State have estimated broadband access rates as low as 73%. This suggests that while broadband internet access is unlikely to be a barrier to HIT/E activities in most areas, New York—like most states—will have broadband access challenges in certain locations.

Recognizing that more rigorous and detailed information on broadband access was needed, the NYS Office for Cyber Security and Critical Infrastructure Coordination (CSCIC) has embarked on a project funded by the National Telecommunications and Infrastructure Association (NTIA) to further study broadband access and infrastructure and to enable the mapping of New York's unserved and underserved areas. This effort will incorporate data from many sources, including proprietary data from internet service providers and validation by telephone and internet-based surveys. The results of this study are not yet available but will be incorporated into future updates to this plan when they are made available.

Exhibit II-1, below, shows the geographical distribution of broadband access predicted by the original CIO/OFT study. (Source: NYS Office of Cyber Security and Critical Infrastructure Coordination, 2009)



**Exhibit II-1** Predicted Broadband Availability

Although the study did not specifically align the definition of “availability” with the definitions jointly established by the Rural Utilities Service (RUS) of the U.S. Department of Agriculture and the NTIA of the Department of Commerce, the current state of DSL and cable-modem internet service is such that only households determined by the study not to have broadband service available are likely to fall into the RUS/NTIA categories of “unserved” or “underserved.” Under these definitions, areas are classified as “unserved” if less than 10% of households in the area have access to “facilities-based, terrestrial broadband service” of at least 768 kbps downstream and 200 kbps upstream; areas are defined as “underserved” if they meet any of the following three criteria:

- Less than 50% of households have access to “facilities-based, terrestrial broadband service” of at least 768 kbps downstream and 200 kbps upstream
- No fixed or mobile broadband service provider offers service of at least 3 Mbps downstream
- Forty percent or less of the households in the area subscribe to broadband service

To ensure that the most pressing broadband needs across all sectors are identified and that programs and investments are coordinated to address priority broadband needs, the Council for Universal Broadband published the State's first New York State Universal Broadband Strategic Roadmap in June 2009. This broadband strategy document:

- Presents New York State's case, vision, strategic goals, and guiding principles for NYS Universal Broadband Strategy
- Describes the major components of the New York State Universal Broadband Policy
- Outlines the State's strategic governance structure to provide oversight for implementing the universal broadband policy
- Describes the State's broadband grant program to foster public/private partnerships to provide innovative solutions for achieving and sustaining universal broadband access
- Presents recommended next steps and an implementation timeline for development of the comprehensive universal broadband strategy
- Presents the strategic alignment between the Federal Broadband Stimulus Programs and Policies and the New York State Universal Broadband Strategy to optimize federal funding opportunities across the State

## **2. Broadband access grants**

One of the objectives in developing the New York State Universal Broadband Strategy was to optimize the use of federal funding opportunities in support of programs that will have the greatest impact on the availability of broadband internet access throughout the State. One federal funding source targeted in the strategy is the American Reinvestment and Recovery Act (the "Recovery Act"), which appropriated \$7.2B for projects to expand broadband access and adoption in communities across the U.S. The expected benefits include increased job opportunities, greater investment in technology and infrastructure, and long-term economic benefits. Recovery Act funds are available through two programs:

1. The Broadband Initiatives Program (BIP), administered by RUS, issues loans and grants for broadband infrastructure projects in rural areas.
2. The Broadband Technology Opportunities Program (BTOP), administered by the NTIA, provides grants to fund comprehensive broadband infrastructure projects, public computer centers, and sustainable broadband adoption projects.

Broadband USA, the web portal shared by RUS and the NTIA to streamline the application process for obtaining Recovery Act funds, received more than 100 grant

applications for projects in New York from State and local agencies and non-profit organizations during the first (summer 2009) funding round; some twenty of these dealt, in whole or in part, with access to healthcare information. A summary of the grant applications that were funded is shown below.

Project/Applicant	Award Amount
ION Upstate New York Rural Broadband Initiative ION Hold Co., LLC	\$39,724,614
New York Computer Centers: Broadbandexpress@yourlibrary New York State Education Department	\$ 9,521,150
21st Century Information and Support Ecosystem: Make It Easy Where You Are One Economy Corporation	\$28,519,482
NYC Connected Learning New York City Department of Information Technology and Telecommunications	\$ 22,162,825
Franklin County, NY Broadband Initiative Slic Network Solutions	\$ 4,262,642 (Grant) \$ 1,066,000 (Loan)

**Table II-1** Recovery Act Broadband Grants (First Round)

A second application round for the NTIA/RUS grants is currently underway.

### 3. HRSA funding for FQHCs

The following table shows the Federally Qualified Health Center (FQHC) networks that received grants from the Health Resources Services Administration (HRSA) in the Health Information Technology category. For more information on the role FQHCs play in statewide HIE and adoption of EHR technology, please see the statewide HIT plan under development by OHITT.

Grantee	Award No.	Year	Grant Amount
Charles B. Wang Community Health Center	H2LCS18155	2010	\$994,800
Community Health Care Association of NYS	H2LCS18172	2010	\$2,999,983
	H2LIT16632	2009	\$478,125
Finger Lakes Migrant Health Care Project	H2LCS18162	2010	\$997,832
The Institute for Family Health	H2LCS18144	2010	\$825,709
	H2LIT16609	2009	\$190,542
	H2LIT16867	2009	\$615,706

**Table II-2** Summary of HIT Grants Issued to New York FQHCs by HRSA

#### 4. Coordination with VA and IHS

The Veterans Health Administration of the Department of Veterans Affairs operates twelve medical centers, forty-eight Community-Based Outpatient Clinics (CBOCs), and sixteen Vet Centers throughout the State. The VA operates a custom EHR, the Computerized Patient Record Service (CPRS), as part of the overall Veterans Health Information Systems and Technology Architecture (VistA). In operation since 1997, the CPRS supports healthcare operations and clinical decision making by providing capabilities such as:

- Real-time access to patient demographics, allergies, medications, clinical history, and laboratory results, including access to clinical data from other VA facilities
- Automatic notification of significant events directly to clinicians
- Decision support during the order entry process to alert the clinician of possible conflicts and negative interactions between orders
- Clinical reminders to support preventive care plans and ensure timely interventions

An initiative is currently underway to advance VistA toward an idealized health information system known as HealthVet. This initiative includes HIT/E components to support healthcare data aggregation and research; patient access to healthcare data, information, and self-assessment tools; and improved data exchange with healthcare providers.

The Indian Health Service (IHS) has two tribal outpatient clinics in New York (Oneida Indian Nation Health Program in Oneida, and St Regis Mohawk Health Services in Akwesasne) that use EHRs as part of the IHS clinical information system called RPMS

(the Resource and Patient Management System). This system was originally based on the VHA's CPRS and still shares some components with VistA. Capabilities of the RPMS EHR system include:

- Initiating and tracking consults and referrals
- e-Prescribing
- Direct ordering, notification, and results retrieval for laboratory and diagnostic imaging
- Clinical decision support

When contacted as part of the stakeholder outreach program, the IHS responded that they will be interested in collaborating with the New York State Department of Health (the Department) in the future as additional clinical data becomes available through the Center.

## **5. Existing HIT/E stakeholders outside NY Medicaid**

### **Office of Health Information Technology Transformation**

Established in 2007 as a division of the Department of Health, the Office of Health Information Technology Transformation (OHITT) is charged with coordinating health IT programs and policies across the public and private healthcare sectors. The Deputy Commissioner of OHITT is designated as the state HIT coordinator. The goals of OHITT are to enable improvements in healthcare quality, increase affordability, and improve healthcare outcomes for New Yorkers. In this leadership role, OHITT creates and advances the necessary governance structure, policies, technical services, and informatics infrastructure to ensure that health IT services can be implemented in a coordinated and secure manner based on New York State Health IT Policy for both the public and private sectors. Within the Department, OHITT works closely with all offices and program areas to ensure that program priorities for health IT are surfaced and addressed in a balanced and transparent way. Recently, OHITT has facilitated the development and deployment of health IT governance for public health in cooperation with the Office of Public Health (OPH) and the Office of Science (OS). OHITT will facilitate similar planning within and between offices in the Department in the near future. As part of the Office of Health Insurance Programs (OHIP), Medicaid is included in governance activities.

### **New York eHealth Collaborative**

The New York eHealth Collaborative (NYeC) is a statewide public-private partnership and governance body playing an integral role in advancing New York State's health IT strategy. NYeC's key responsibilities include:

- Convening, educating, and engaging key constituencies, including healthcare and health IT leaders across the state
- Facilitating a two-tiered governance structure for interoperable HIE through the proposed Statewide Health Information Network for New York (SHIN-NY) that includes (at the state level) setting health information policies, standards, and technical approaches and (at the regional and local level) implementing such policies by regional health information organizations (RHIOs) and community health information technology alliances (CHITAs)
- Evaluating and establishing accountability measures for New York State's health IT strategy

### **New York Health Information Technology Evaluation Collaborative**

The New York Health Information Technology Evaluation Collaborative (HITEC) is a multi-institutional, academic collaborative of New York State institutions including Cornell University, Columbia University, the University of Rochester, the University of Buffalo, and the State University of New York at Albany, and serves in a research and evaluative role with respect to health IT initiatives in New York State. HITEC was formed to evaluate and develop evaluation instruments for health IT initiatives, including interoperable health information exchange and EHR adoption across the State.

HITEC is providing RHIOs with standardized surveys, standardized outcome measures, consulting on study design and other research methods for evaluation, statistical consulting, data analysis, and reports summarizing each RHIO's findings (with anonymous comparisons to other RHIOs). HITEC will also conduct cross-RHIO evaluations, thereby generating more generalizable findings. Regional and national dissemination of these findings will be a top priority.

HITEC is also facilitating evaluations of the impact of HIE on consumer expectations of and satisfaction with HIE (including any concerns about privacy and data security), providers' use of and satisfaction with HIT and HIE, including unintended consequences and effects on workflow, patient safety and healthcare quality, and financial impact (i.e., return on investment from the perspectives of providers, health plans and large employers) as driven both by efficiency and safety/quality savings. HITEC will lead some of the first data-driven evaluations of the impact of HIE on healthcare. The results of these evaluations will inform HIE adoption and provide insights into the impact of state policy on HIT adoption and HIT-related changes in healthcare.

## 6. HIE organizations in the State

### Regional Health Information Organizations (RHIOs)

Underlying the SHIN-NY, and central to its successful future implementation, are RHIOs. New York's RHIOs, working under the NYeC umbrella, and with their stakeholders and constituents, must create an environment that assures effective health information exchange, both organizationally and technically, through a sound governance structure. RHIOs are required to participate in the statewide collaboration process managed by NYeC, setting statewide policy guidance, and must implement and ensure adherence to such guidance. Serving as trusted brokers, RHIOs are multi-stakeholder collaborations that enable the secure and interoperable exchange of health information with a mission of governing its use in the public's interest and for the public good by supporting improvements in healthcare quality, affordability, and outcomes. In consideration of these obligations, RHIOs are conferred benefits in terms of eligibility for grants, contracts for services, and access to various data sources, both public and private.

Currently, there are twelve state-designated RHIOs:

- Bronx RHIO
- Brooklyn Health Information Exchange (BHIX)
- E-Health Network of Long Island
- Health Advancement Collaborative of Central New York (HAC-CNY)
- Healthcare Information Xchange of NY (HIXNY)
- HEALTHeLINK
- Interboro RHIO
- Long Island Patient Information eXchange (LIPIX)
- New York Clinical Information Exchange (NYCLIX)
- Rochester RHIO
- Southern Tier HealthLink (STHL)
- Taconic Health Information Network and Community (THINC)

The following tables show the current level of HIE activity conducted by hospitals and physicians via RHIO participation in each geographic region, along with the projected level of participation by August 1, 2011, after the completion of projects funded under the HEAL 5 state grant program

Region	Number of Hospitals	Access Data		Supply Data	
		Present	Future	Present	Future
Western New York	31	14 (45%)	16 (52%)	14 (45%)	16 (52%)
Central New York	51	19 (37%)	25 (49%)	16 (31%)	25 (49%)
Capital Region	29	7 (24%)	9 (31%)	7 (24%)	9 (31%)
Hudson Valley	36	0 (0%)	7 (19%)	0 (0%)	7 (19%)
Long Island	23	14 (61%)	23 (100%)	14 (61%)	23 (100%)
New York City	62	14 (23%)	31 (50%)	20 (32%)	30 (48%)
<b>Overall</b>	<b>232</b>	<b>68 (29%)</b>	<b>111 (48%)</b>	<b>71 (31%)</b>	<b>110 (47%)</b>

**Table II-3** Hospital Participation in RHIO-Mediated HIE

Region	Number of Physicians	Access Data		Supply Data	
		Present	Future	Present	Future
Western New York	3546	400 (11%)	550 (16%)	400 (11%)	550 (16%)
Central New York	7143	831 (12%)	2000 (28%)	125 (2%)	820 (11%)
Capital Region	3768	400 (11%)	680 (18%)	455 (12%)	680 (18%)
Hudson Valley	7388	147 (2%)	407 (6%)	0 (0%)	407 (6%)
Long Island	9954	40 (0%)	1017 (10%)	30 (0%)	917 (9%)
New York City	31948	124 (0%)	2187 (7%)	677 (2%)	2154 (7%)
<b>Overall</b>	<b>63747</b>	<b>1942 (3%)</b>	<b>6841 (11%)</b>	<b>1687 (3%)</b>	<b>5528 (9%)</b>

**Table II-4** Physician Participation in RHIO-Mediated HIE

### Community Health Information Technology Adoption Collaboratives (CHITAs)

CHITAs are community-based collaborations of clinicians and providers in a defined care coordination zone with a mission to advance the adoption and effective use of interoperable EHRs. The State of New York is currently funding nine CHITAs to ensure that effective adoption and use of interoperable EHRs results in patient care improvements. CHITAs will facilitate the provision of adoption and support services, such as workflow re-design and process and quality interventions and improvement. In contrast to RHIOs, which must be independent, not-for-profit entities, CHITAs are

informal collaborations of provider participants in a care coordination zone for sharing software, technical services, and clinical services, and ensuring groups of clinicians realize up-front and consistent value from interoperable EHRs.

### **Healthcare Professionals**

Healthcare professionals are currently engaged in HIT/E activities through the use of electronic prescribing and, in some cases, as early adopters of EHR technology. E-prescribing continues to gain in adoption; according to the 2009 National Progress Report on E-Prescribing, prepared by e-prescribing vendor Surescripts, more than twelve times as many new e-prescriptions were issued in New York in 2008 as in 2006 (although e-prescriptions still only made up 3.51% of all prescriptions issued in 2008).

## **7. Activities currently underway to facilitate HIE/EHR adoption**

In 2004, the New York State legislature passed the Health Care Efficiency and Affordability Law for New Yorkers (often referred to as "HEAL NY"). One of two primary objectives of the HEAL NY program is the implementation of a 21st-century health information infrastructure to support the delivery of high-quality care. Under the HEAL NY program, the Department has supported four competitive grant rounds for health IT projects:

- The HEAL NY Phase 1 Health IT grant awards, announced on May 24, 2006, distributed \$52.9M among twenty-six projects, including funding for nine of the existing RHIOs.
- The HEAL NY Phase 5 grant awards, announced on March 28, 2008, distributed a total of \$105.7M among nineteen projects. These projects are ongoing, with completion expected by August 1, 2011, and are building the foundation for the SHIN-NY.
- The HEAL NY Phase 10 grant awards were announced on September 25, 2009, to nine projects totaling \$140M. Through HEAL 10, the coordination of clinical care will be supported by connecting these care givers through a Patient Centered Medical Home (PCMH) model and the implementation of interoperable health record systems (EHRs) that are linked through the SHIN-NY.
- The HEAL NY Phase 17 grant awards, announced in September, 2010, distributed an additional \$109M to eleven projects. HEAL 17 represents an extension of the efforts to promote the PCMH model and the adoption of interoperable EHR systems.

### **HEAL NY PHASE 1**

HEAL 1 sought to develop projects that would assist in building an infrastructure in New York State to share clinical data information among patients, providers, payors, and public health entities; support the statewide adoption of systems compatible with the Strategic HIT; and be able to be a part of the planned national network for sharing patient data. Successful projects developed community-wide clinical information data exchanges, supported the creation of e-prescription capabilities and furthered the use of electronic medical records (EMRs). These awarded projects were the precursor to the existing RHIOs.

### **HEAL NY PHASE 5**

The strategic focus of the HEAL NY Phase 5 Health IT grant program was to advance New York's health information infrastructure – organizational, clinical, and technical – to support improvements in healthcare quality, affordability, and outcomes for all New Yorkers. In support of HEAL 5, NY Medicaid developed the Interoperable Electronic Health Records (EHRs) Use Case for Medicaid. The use case focused on sharing Medicaid information, including medication and visit histories, with community clinicians in a health information exchange environment, including electronic prescribing to support clinical decision making and improve care coordination. To view the use case in its entirety, see Appendix IV ("Interoperable EHR Use Case for Medicaid").

As part of the development and implementation of New York's health information infrastructure, NY Medicaid will undertake the following for the benefit of its enrollees: (1) technical solutions designed in partnership with qualified HIT entities will bring Medicaid data to the EHR at the point of care to support clinical decision making by practitioners; and (2) enhanced interoperable sharing of clinical data between practitioners via EHRs across New York State will further support the provision of comprehensive care management and coordination of care. Of the nineteen HEAL 5 projects, thirteen will be implementing this use case.

### **HEAL NY PHASE 10**

New York State's HEAL NY Phase 10 will promote coordination of clinical care by connecting care givers through a Patient Centered Medical Home (PCMH) model and the implementation of interoperable health record systems that are linked through the SHIN-NY. HEAL 10 will support inclusion of all types of healthcare providers, including physician practices and clinics, hospitals, nursing homes, and other long-term care facilities, home care providers, and others. The patient is the center of this coordinated care model, and projects will also include health IT enabling patients to interact with their care givers in a safe and secure environment. More than 3,000 healthcare providers, 1,500 primary care providers and 500,000 patients will experience improved

care coordination as part of this grant program. Of the total healthcare providers participating, more than 2,600 (87%) are Medicaid providers. These projects will allow the State to gain critical knowledge and experience in many challenging aspects of implementation including the area of meaningful use.

### **HEAL NY PHASE 17**

The strategic focus of HEAL 17 is to continue to advance New York's health information infrastructure based on clinical and programmatic priorities and specific goals for improving quality, affordability and outcomes. Community-based HIT projects funded by HEAL NY Phase 17 grants will improve care coordination and management through a model encompassing the full continuum of care at the community level including mental health, long term care and home health care providers supported by the implementation and effective use of interoperable health information infrastructure. The patient is the center of this coordinated care model and projects will also include health IT for patients to be involved with all of their care givers in a safe and secure environment. Health care reforms focused on with HEAL 17 are based on the Patient Centered Medical Home (PCMH) model. Coordination of clinical care will be supported by connecting these care givers through a PCMH model and the implementation of interoperable health record systems (EHRs) that are linked through the Statewide Health Information Network for New York (SHIN-NY). Funded projects will participate in the statewide collaborative process already underway through New York eHealth Collaborative (NYeC) to further advance policies and requirements to continue to promote information technology in New York.

### **Statewide Collaborative Process**

The Statewide Collaborative Process (SCP) has been employed to collaboratively develop common policies and procedures, standards, technical approaches, and services for New York's health information infrastructure. The SCP has been facilitated by NYeC and has included participants from the Department, HEAL NY awardees, and other stakeholders. Within the SCP, decisions were made and recommendations advanced in a collaborative, consensus-based manner through a fully open, transparent process. The SCP is largely driven by the efforts of four collaborative work groups, recommending policies and procedures, standards, technical approaches, and services. The four work groups are: (1) Clinical Priorities; (2) Privacy and Security; (3) Protocols and Services; and (4) EHR Collaborative.

A critical component for the adoption of HIE has been the development of a consent process. The Privacy and Security work group built upon the activities of a long-standing development process that began in 2006 with the Health Information Security and Privacy Collaboration (HISPC). The HISPC project consisted of two phases. Phase I involved a complete assessment of health privacy legal and policy issues in

New York. Phase II focused on the development of a consumer consent solution through a standardized consent process that would be a comprehensive set of health information privacy and security policies. A resulting model consent form was developed and is currently available for use by qualified HIT entities.

### **Primary Care Information Project**

Located in the New York City Department of Health and Mental Hygiene (DOHMH)—and supported by a combination of city, state, federal, and private funds—the Primary Care Information Project (PCIP) seeks to improve population health in disadvantaged communities in New York City through the use of HIT. In March 2007, the City initiated a \$20M contract with a commercial EHR vendor (eClinicalWorks) and embarked on a year-long collaborative development process. The “Take Care New York” EHR includes standardized clinical data elements, registry functions for patient recall and anticipatory care, automated clinical quality measurement, decision support tools, and patient self-management tools. The City is granting eligible practices (primary care providers with more than 10% Medicaid and uninsured patients) a package of software and services including licenses, onsite training, data interfaces, and two years of maintenance and support. High-volume Medicaid providers can receive additional subsidies for hardware purchase and installation. Practices must contribute \$4,000 per provider to a quality improvement fund and must bear the costs of hardware, network infrastructure, and productivity loss during training, go-live, and evaluation. The PCIP’s 2010 objectives include the extension of prevention-oriented EHRs to 2,500 primary care providers and two million patients in 2010.

### **Beacon Community Program**

As part of the Recovery Act Beacon Community Program, the Western New York Clinical Information Exchange received \$16M to help achieve meaningful and measurable improvements in healthcare quality, safety, and efficiency in their communities. Beacon Communities will use health IT resources within their communities as a foundation for bringing doctors, hospitals, community health programs, federal programs, and patients together to design new ways of improving quality and efficiency to benefit patients and taxpayers. Additionally, Beacon Communities will be expected to access existing federal programs that are working to promote health information exchange at the community level.

The Western New York Clinical Information Exchange will utilize clinical decision support tools, such as registries and point-of-care alerts and reminders and innovative telemedicine solutions, to improve primary and specialty care for diabetic patients, decrease preventable emergency room visits, hospitalizations, and re-admissions for patients with diabetes and congestive heart failure or pneumonia, and improve immunization rates among diabetic patients.

## Regional Extension Centers (RECs)

New York has received funding for two Regional Extension Centers (RECs) to provide EHR adoption support services to providers, with an initial focus on "priority" primary care providers working in small practices or treating underserved populations. The first REC is operated by NYeC and provides services to practices throughout the entire state of New York, with the exception of New York City's five boroughs. The other REC, operated by the Primary Care Information Project, supports the providers of New York City. The REC programs offer statewide EHR adoption services that will supply providers with the knowledge, training, and confidence needed to successfully select and deploy an EHR and use health information meaningfully.

As certified Regional Extension Centers, New York's RECs provide:

- Tailored, personal services to help transform practices
- Consultative services to help providers choose the right EHR software and hardware for their needs
- Discounted pricing and terms from preferred vendors to ensure that EHR purchases and implementation are cost effective and meet the needs of primary care practices
- Clinical and administrative workflow analysis and redesign to make providers meaningful users of EHRs
- Highly skilled project management to oversee the adoption and transformation process
- Training for providers and staff
- Assistance with connectivity and interoperability (including electronic exchange of lab test data, e-prescribing, and connecting with other clinicians and hospitals)
- A roadmap and support to get practices and their providers to qualify for Medicare, Medicaid, and other incentives

## 8. HIT/E activities across State borders

The Electronic Clinical Laboratory Reporting System (ECLRS) provides laboratories that serve New York State with a single electronic system for secure and rapid transmission of reportable disease information to the Department, county health departments and the New York City DOHMH. The ECLRS has developed interstate lab report bi-directional transmission with New Jersey and Ohio to replace paper reports and is planning to work with more border states for bi-directional data exchange.

New York participated in initial meetings with New England States Consortium of Systems Organization (NESCO) to discuss potential shared development of services and had initial meetings with various states, including New Jersey, Connecticut,

Vermont and Massachusetts. Although there are not yet firm plans for collaboration on specific interstate programs or services, we continue to meet with other states to explore opportunities, explore plans for multi-state deployment of services that are of mutual interest, and address interstate policy issues as part of individual interstate projects leveraging any national level policies.

Assembled by the National eHealth Collaborative, a team consisting of public and private entities, will begin the groundwork of documenting the requirements of a Consent Engine that will enable the electronic reconciliation of consent requirements as a “resource” that can inform any “exchange process” in a technology agnostic way informed by the taxonomy and grammars currently employed for similar processes over the internet today. Several states are participating in this project, including California, Indiana, New York, North Carolina, Tennessee and Virginia. Private sector partners include Quest Diagnostics, Surescripts, Kaiser, BHIX, LabCorp, MedPlus and the Indiana Health Information Exchange. Not only is there a need for a centralized resource to provide information regarding disclosure decisions, but ideally this information would be provided electronically in a technology-neutral manner to improve the efficiency of interstate exchange of PHI. In the absence of a uniform law, adopted across the nation, there is a need for alternate solutions.

## **9. Interoperability of immunization and public health databases**

The NYS Office of Public Health (OPH) has adopted a Public Health Information Management Master Plan designed to improve population health and patient clinical care through public health information system integration and electronic information exchange with the healthcare community. The Public Health-HIE Initiative Charter defines the initiative being proposed to operationalize this master plan and coordinate OPH's participation in HIE initiatives to ensure public health practice operates effectively and efficiently. The initiative focuses on the coordination of OPH's participation in the HIE, both organizationally and technically, to ensure that the scope and priorities align and support public health practice effectively and efficiently.

Within the Department, OHITT will be working closely with OPH and the Office of Science (OS) to ensure that public health program health IT priorities are coordinated closely with other state and federal health IT initiatives.

While offering tremendous opportunities, new initiatives/funding opportunities also create significant demands. A coordinated effort is needed to ensure effective Public Health participation in these efforts. By working closely with OHITT, OPH and OS public health programs will be integrated into a governance and technical infrastructure that effectively leverages existing resources linking the various parallel public health IT activities and formulating a shared vision for public health. Immunization and public

health surveillance databases, as focus areas for meaningful use, are prioritized candidates for this process, and activities to integrate them are underway.

Historically, the development of systems for the electronic collection of child health data in New York has followed a localized “stove pipe” approach focused on individual program priorities and funding availability; consequently, the State currently has no consistent framework or standards for the integration of child health data from disparate sources. The Child Health Information Integration (CHI<sup>2</sup>) project is an effort on the part of OPH to develop a “Virtual Child Health Record” that incorporates standardized information from newborn genetic and hearing screening, immunization, lead screening, early intervention, WIC, Medicaid, vital statistics, and other data sources. This integrated data set will supply healthcare providers with a more complete view of their patients’ healthcare history, as well as support public health outcomes such as: better identification and monitoring of different child health status “profile” populations; identification and follow-up of specific child health areas of need; and more targeted and effective planning for children’s healthcare programs and services. For more information on the CHI<sup>2</sup> project, see Appendix XII (“CHI<sup>2</sup> Project Documents”).

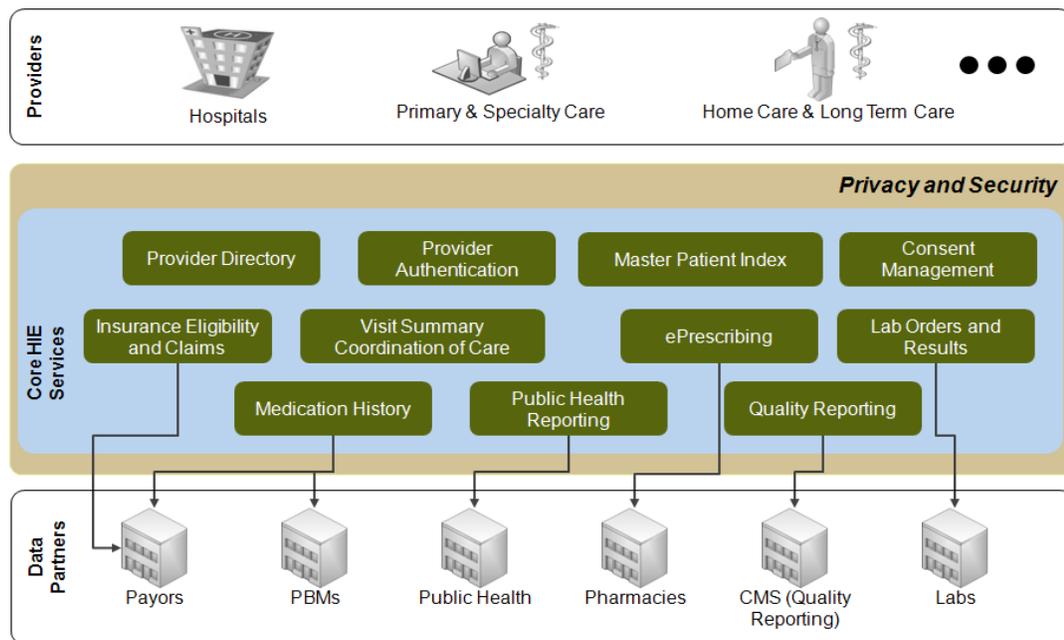
## **10. Populations with unique needs**

Work to address the special needs of children and the potential to positively affect care outcomes through the use of HIE will continue as part of the CHI<sup>2</sup> program, with expansion of the program’s scope anticipated both latitudinally (i.e., increasing the scope of information to be gathered and integrated) and longitudinally (i.e., increasing the scope and duration of initiatives to leverage the information gathered through the program). NY Medicaid is also actively working with HRSA to develop initiatives that leverage HIT/E to promote effective treatment and management of heritable disorders and genetic diseases identified during the newborn genetic screening process.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is in the process of assembling a multi-state collaborative to create an open source electronic health record to integrate behavioral health with primary care for individuals with mental and substance abuse disorders. The four-year \$150 million project will develop and implement behavioral health workflows, such as mental health, addictive services, prevention, methadone and buprenorphine dispensing and script writing, child welfare health interface, criminal justice/drug court interface, and child welfare. The NYS Office of Alcoholism and Substance Abuse Services (OASAS) is in discussions with SAMHSA to participate in this collaborative to encourage the adoption of certified EHR technology among behavioral health professionals throughout the state.

## 11. Future HIT/E Activities

In complement to Medicaid-specific activities, the OHITT and NYeC are developing statewide services that will benefit NY Medicaid providers and patients. These statewide services will be accessible by all providers, not just those delivering Medicaid services. Statewide services under consideration include provider directory, master patient index, lab orders and results, quality reporting, and others. NY Medicaid will be both a contributor to, and recipient of, information via these statewide services. For example, NY Medicaid owns the claims data comprising medication history information and can contribute this information to the statewide service. With respect to quality reporting, NY Medicaid will be a recipient of information and will construct the Medicaid Information Services Center infrastructure to receive quality metric information from the statewide service. These potential services are depicted in Exhibit II-2.



**Exhibit II-2** Statewide HIE Services

## **APPENDIX III**

# **SURVEY OF ELIGIBLE PROFESSIONALS/HOSPITALS**

In July/August 2010, OHIP conducted web-based surveys of eligible professionals and hospitals to evaluate the current extent of EHR adoption. This appendix describes the survey methodology, including the complete set of survey questions and a discussion of the preliminary analysis of response data conducted for the purpose of inclusion in this SMHP. Subsequent updates to the SMHP will include a complete survey report, including final analysis of the response data.

## SMHP DOH Eligible Provider Survey

### **1. Introduction**

#### **Purpose**

The American Recovery and Reinvestment Act of 2009 (ARRA) was enacted on February 17, 2009. One of the many measures included in the ARRA is intended to preserve and improve affordable health care by establishing incentive payments to eligible professionals and eligible hospitals to promote the adoption and meaningful use of interoperable Health Information Technology (HIT) and qualified Electronic Health Records (EHR). Expanded use of HIT and EHR will improve the quality and value of American health care.

We encourage you to complete the survey; the results will be used as input to the New York State Medicaid Health Information Technology Plan (SMHP). Each state is required to submit an SMHP in preparation for incentive payments. Through your participation, The New York State Department of Health may elicit responses from Eligible Professionals who are current New York State Medicaid providers to develop an 'As-Is' landscape and 'To-Be' roadmap of HIT/EHR use in NYS.

#### **Survey Instructions**

This survey should be filled out by an individual Eligible Professional (EP), or their designated representative. Please bear in mind, all answers must be representative of the current and planned practices of one (1) Eligible Professional.

An Eligible Professional as defined by the American Recovery and Reinvestment Act of 2009 is any one of the following:

- Physician
- Dentist
- Certified Nurse-Midwife
- Nurse Practitioner and
- Physician Assistant practicing in a Federally Qualified Health Center or Rural Health Clinic that is led by a Physician Assistant

The information provided by the respondent will not be used in determining a provider's eligibility for HITECH ACT Incentives. You are encouraged to complete this survey however there will be no penalty for not participating.

#### Survey Information

- The survey should take approximately 15-30 minutes to complete.
- There are 36 Questions within this survey.
- Please complete each page in a timely manner.
- If you must leave the survey for 30 minutes or more, be sure to click "Save and Continue Later."
- Once you click "continue," your answers for that page are final.
- Please do not use browser "forward" and "back" buttons.
- Questions marked with a \* are required.
- Hover-over highlighted terms or click on footnotes to view definitions.

Have survey questions or need help?

- First try our [Frequently Asked Questions \(FAQ\)](#)
- Please call: 1-866-401-0813
- Availability: Monday-Friday from 8am-5pm

Thank You for participating.

## Disclaimer

Neither the New York State Department of Health (NYS DOH), nor any of our affiliates, nor any of our or their service providers warrant that this online website or any function contained in this website will be uninterrupted or error-free.

Any feedback submitted to NYS DOH will be treated as non-confidential and information you choose to provide may be used and distributed by NYS DOH for any purpose without restriction. Survey results will be reported in aggregate with no identifying contact information shared with any external parties.

1. Disclaimer Terms Verification:

- I Agree
- I Do Not Agree

2. Please provide clinician's contact information below:

- \* Name:
- \* Address:  
Address 2:
- \* City\Town:
- \* State:
- \* ZIP:
- E-mail Address:
- \* Phone Number:

2.b Please provide respondent's information:

- \* Business name:
- \* Job Function:

2.c Provider Credentials:

(MD, DDS, DO, NP, CNM, PA, Other, None)

3. Do you currently use a Computer-Based System<sup>2</sup> to record and update a patient's Electronic Health Record<sup>3</sup>?

- Yes
- No

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<sup>2</sup> *Computer-Based System*: Any system which uses a microprocessor or computer for controlling or executing the task it is designed to perform can be called a computer based system.

<sup>3</sup> *Electronic Health Record*: Electronic version of a patient's medical history that is maintained by the provider over time and that may include all of the key administrative clinical data relevant to that person's care under a particular provider.

## 2. Meaningful Use

Does the Eligible Professional perform the following:

4. Electronically record demographics<sup>4</sup> for more than 50% of unique patients<sup>5</sup>.
  - Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
5. Electronically record and chart changes in vital signs<sup>6</sup> for more than 50% of unique patients<sup>4</sup>.
  - Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
6. Electronically record smoking status for more than 50% of all unique patients<sup>5</sup> 13 years of age or over?
  - Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
7. Electronically maintain an active medication list<sup>7</sup> for more than 80% of all unique patients?
  - Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
8. Electronically maintain an active medication allergy list<sup>8</sup> for more than 80% of all unique patients<sup>4</sup>?
  - Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.

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4 Demographics Includes all of the following: Preferred language, gender, race, ethnicity and date of birth.

5 Unique Patients: An individual patient seen multiple times during the EHR reporting period is only counted once.

6 Vital Signs Includes all of the following for age 2 and over: Height, weight and blood pressure, BMI (calculate and display), growth and BMI charts for children 2–20 years (plot and display).

7 Active Medication List: At least one medication entry (or an indication of "none" if the patient is not currently prescribed any medication).

8 Active Medication Allergy List: At least one medication allergy entry (or an indication of "none" if the patient has no medication allergies).

9. Electronically provide clinical summaries<sup>9</sup> to patients for more than 50% of all office visits within 3 business days?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
10. Electronically complete medication reconciliation<sup>10</sup> for more than 50% of transitions of care<sup>11</sup> in which the patient is transitioned into the care of the EP?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
11. Electronically complete summary of care record<sup>12</sup> for more than 50% of transitions of care<sup>11</sup> and referrals?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
12. Provide more than 50% of all patients who request it, an electronic copy of their health information<sup>13</sup> within 3 business days?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
13. Provide more than 10% of all unique patients electronic access<sup>14</sup> to their health information<sup>13</sup> within 4 business days of the information being available to the EP?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.

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9 Clinical Summaries: A summary of updated medication list, laboratory and other diagnostic test orders, procedures and instructions based on clinical discussions that took place during the office visit.

10 Medication Reconciliation: The process of identifying the most accurate list of all medications the patient is taking, including medication name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.

11 Transitions of Care: The transfer of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc.) to another or from one EP to another.

12 Summary of Care Record: A record that can be provided through an electronic exchange, accessed through a secure portal, secure e-mail, electronic media such as a CD or USB memory devices, or printed copy.

13 Health Information: A record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.

14 Electronic Access: Electronic access may be provided by a number of secure electronic methods (for example, Personal Health Record, user account and password on a patient portal, CD/DVD, USB drive).

14. Send reminders for preventative/follow up care to more than 20% of all unique patients<sup>4</sup> according to the patient's preference<sup>15</sup>.
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
15. Use e-prescribing<sup>16</sup> for more than 40% of all permissible prescriptions<sup>17</sup>?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
16. Use Computerized Physician Order Entry (CPOE)<sup>18</sup> for more than 30% of orders?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
17. Electronically maintain at least one entry in a problem list<sup>19</sup> of current and active diagnoses on more than 80% of all unique patients<sup>4</sup>?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
18. Electronically generate at least one report during the EHR reporting period listing patients with a specific condition?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
19. Electronically incorporate more than 40% of all clinical laboratory test results into the EHR?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.

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<sup>15</sup> Patients Preference: The patient's choice of delivery method between Internet based delivery or delivery not requiring Internet access.

<sup>16</sup> E-prescribing: Electronically prescribing medication.

<sup>17</sup> Permissible Prescription: Refers to the current restrictions established by the United States Department of Justice on the electronic prescribing of controlled substances.

<sup>18</sup> Computerized Physician Order Entry (CPOE): Provider's use of computer assistance to directly enter medical orders (for example, medications).

<sup>19</sup> Problem List: A list of current and active diagnoses, as well as past diagnoses relevant to the current care of the patient.

20. Electronically implement 1 clinical decision support<sup>20</sup> rule relevant to specialty of high clinical priority along with the ability to track compliance with that rule?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
21. Electronically perform drug-drug and drug-allergy checks?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
22. Electronically exchange key clinical information<sup>21</sup> among providers of care and patient-authorized entities?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
23. Electronically submit data to immunization registries and actually submit when required and accepted?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.
24. Electronically provide syndromic surveillance data<sup>22</sup> to public health agencies?
- Yes
  - No – BUT I PLAN to implement within the next 5 years
  - No – AND I DO NOT PLAN to implement within the next 5 years
  - I Don't Know.

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20 Clinical Decision Support: Health Information Technology functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person specific information, intelligently filtered and organized, at appropriate times, to enhance health and healthcare.

21 Key Clinical Information: For example, problem list, medication list, allergies, and diagnostic test results.

22 Syndromic Surveillance Data: Monitoring of the frequency (e.g., the number or rate of episodes) of illnesses with a specified set of clinical features (e.g., fever and respiratory complaints, vesicular skin rashes, diarrhea, etc.) in a given population (e.g., members of a health maintenance organization, residents of a given geographic region, etc.), without regard to the specific diagnoses, if any, that are assigned to them by clinicians.

### 3. Technology Infrastructure

25. Are you currently using High Speed Internet<sup>23</sup> service at your primary practice location<sup>24</sup>?
- Yes
  - No – High Speed Internet is not Available
  - No – High Speed Internet is Available
  - I Don't Know.
26. Do you currently exchange patient Electronic Health Records with: (check all that apply)
- Clinics
  - Laboratories
  - Hospitals
  - Insurance Companies
  - Regional Health Information Organizations
  - Other \_\_\_\_\_
  - No, we currently don't exchange patient Electronic Health Records
27. In what year do you plan to procure, purchase, and implement a computer-based Electronic Health Record system?
- Currently have EHR in operation
  - 2010
  - 2011
  - 2012
  - 2013
  - 2014
  - 2015
  - No Current Plans

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<sup>23</sup> High Speed Internet (also referred to as Basic Broadband): Per FCC, is defined as data transmission speeds exceeding 768 kilobits per second (Kbps), or 768,000 bits per second, in at least one direction: downstream (from the Internet to the user's computer) or upstream (from the user's computer to the Internet).

<sup>24</sup> Primary Practice Location: The business address used on your National Provider Identification (NPI) application.

#### 4. EP Demographics

28. Is your primary practice location<sup>24</sup> a Federally Qualified Health Center<sup>25</sup> or a Rural Health Center?
- Yes
  - No
29. At your primary practice location do you treat patients from another State/Country?
- No
  - I Don't Know
  - Yes. The list of State(s) and/or Country(ies) are: \_\_\_\_\_
30. What percentage of all your patients visits, over a continuous 90 day period are billed through Medicaid? (estimates are acceptable)
- 0-9% of visits
  - 10-19%
  - 20-29%
  - 30-39%
  - 40-49%
  - 50-59%
  - 60-69%
  - 70-79%
  - 80-89%
  - 90-99%
  - 100% of visits
31. May we contact you directly if there are any questions regarding your survey answers?
- Yes
  - No
- If yes, please select contact preference:
- Mail
  - Phone
  - E-Mail
  - Other \_\_\_\_\_
32. If such a group were convened, would you be interested in participating in a Focus Group regarding the subject matter of this survey?
- Yes
  - No
33. Enter the Eligible Professionals 10 digit National Provider Identification (NPI)Number \_\_\_\_\_

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<sup>25</sup> *Federally Qualified Health Center (FQHC)*: FQHCs are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless.

34.

- a) Do you plan to apply for the ARRA, Medicaid and/or Medicare incentive payment program?
- Medicaid
  - Medicare
  - None
  - We Don't Know
- b) If you selected "Medicaid" in question 33a, in which year do you plan to apply for the Medicaid incentive payment program?
- 2011
  - 2012
  - 2013
  - 2014
  - 2015
  - I Don't Know

35. Select your Association affiliation:

- American Academy of Pediatrics (AAP)
- Community Health Care Association NYS (CHCANYS)
- Family Planning Advocates of NYS (FPA)
- Fidelis Care NY
- Greater New York Hospital Association (GNYHA)
- Healthcare Association of NYS (HANYS)
- New York Association of Homes & Services for the Aging Association (NYAHSa)
- Indian Health Service (IHS)
- Iroquois Healthcare Alliance (IHA)
- Managed Care Medical Directors Association (NAMCP)
- Medical Society of the State of New York (MSSNY)
- Nurse Practitioner Association NYS (NPA)
- NYS Health Foundation (NYSHealth)
- NY Chapter of the American College of Physicians (NYACP)
- NY Health Plan Association (HPA)
- NYS Academy of Family Physicians (NYSAFP)
- NYS Association of Licensed Midwives (NYSALM)
- NYS Association of Healthcare Providers (NYSHCP)
- NYS Dental Association (NYSDA)
- NYS Society of Physicians Assistants (NYSSPA)
- Prepaid Health Services Plans (PHSP)
- Primary Care Information Project (PCIP)
- United Hospital Fund (UHFNYC)
- United Jewish Appeal Federation of NY (UJAFEDNY)
- Urban Health Plan (UHP)



- Visiting Nurse Services of NY (VNSNY)
- None
- Other: \_\_\_\_\_

36. Please state any additional comments you have on the DOH SMHP survey in comment box provided below:

#### ***4. Closing***

Thank you for participating in this survey. Your responses help us provide critical input to the New York State Medicaid Health Information Technology Plan (SMHP). We greatly appreciate your time and feedback.

Additional ARRA information can be found at: NYSDOH ARRA Resource Page  
(<http://www.health.state.ny.us/regulations/arra/>)

# SMHP DOH Survey for Medicaid Eligible Hospitals

## 1. Introduction

### Purpose

The American Recovery and Reinvestment Act of 2009 (ARRA) was enacted on February 17, 2009. One of the many measures included in the ARRA is intended to preserve and improve affordable health care by establishing incentive payments to eligible professionals and eligible hospitals to promote the adoption and meaningful use of interoperable Health Information Technology (HIT) and qualified Electronic Health Records (EHR). Expanded use of HIT and EHR will improve the quality and value of American health care.

We encourage you to complete the survey; the results will be used as input to the New York State Medicaid Health Information Technology Plan (SMHP). Each state is required to submit an SMHP in preparation for incentive payments. Your response will be used by the New York State Department of Health to develop an 'As-Is' landscape and a 'To-Be' roadmap of HIT/EHR use in New York State. There are substantial monetary incentives available to NYS Eligible Hospitals to help offset the cost of implementation and meaningful use of certified EHR technology.

### Survey Instructions

This survey should be filled out by an individual with authority to do so on behalf of the Eligible Hospital and who has knowledge of the Hospital's current and planned HIT/EHR practices. The American Recovery and Reinvestment Act of 2009 defines Medicaid Eligible Hospitals as either of the following:

- An Acute Care Hospital
- A Children's Hospital

The information provided by the respondent will not be used in determining a hospital's eligibility for The Health Information Technology for Economic and Clinical Health (HITECH) Act Incentives. You are encouraged to complete this survey however there is no penalty for not participating.

### Survey Information

- The survey should take approximately 15-30 minutes to complete.
- There are 34 Questions within this survey.
- Please complete each page in a timely manner.
- If you must leave the survey for 30 minutes or more, be sure to click "Save and Continue Later."
- Once you click "continue", your answers for that page are final.
- Please do not use browser "forward" and "back" buttons.
- Questions marked with a \* are required.
- Hover-over highlighted terms or click on footnotes to view definitions.

**Have survey questions or need help?**

- First try our Frequently Asked Questions (FAQ)
- Please call: 1-800-278-3960
- Availability: Monday-Sunday from 8am-8pm

Thank You for participating.

## Disclaimer

Neither the New York State Department of Health (NYS DOH), nor any of our affiliates, nor any of our or their service providers warrant that this online website or any function contained in this website will be uninterrupted or error-free.

Any feedback submitted to NYS DOH will be treated as non-confidential and information you choose to provide may be used and distributed by NYS DOH for any purpose without restriction. Survey results will be reported in aggregate with no identifying contact information shared with any external parties.

1. Disclaimer Terms Verification:

- I Agree
- I Do Not Agree

2. Please provide your Contact Information below:

- \* Respondent's Name:
- \* Hospital name:
- \* Respondent's title/job function:
- \* Address:  
Address 2:
- \* City\Town:
- \* State:
- \* ZIP:
- \* E-mail Address:
- \* Phone Number:

3. Does this hospital currently use a Computer-Based System<sup>1</sup> to record and update a patient's Electronic Health Record<sup>2</sup>?

- Yes
- No

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<sup>1</sup> Computer-Based System: Any system which uses a microprocessor or computer for controlling or executing the task it is designed to perform can be called a computer based system

<sup>2</sup> Electronic Health Record: Electronic version of a patient's medical history, that is maintained by the provider over time, and may include all of the key administrative clinical data relevant to that person's care under a particular provider

## 2. Meaningful Use:

Does the hospital perform the following:

4. Electronically check insurance eligibility for at least 80% of all unique patients<sup>3</sup> admitted?
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
5. Electronically submit at least 80% of all Medicaid claims filed?
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
6. Electronically record demographics<sup>4</sup> for at least 80% of unique patients<sup>3</sup> admitted.
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
7. Electronically record and chart changes in vital signs<sup>5</sup> for at least 80% of unique patients<sup>3</sup> admitted.
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
8. Electronically record smoking status for 80% of all unique patients<sup>3</sup> admitted who are 13 years of age or older?
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.

---

<sup>3</sup> Unique Patient: An individual patient admitted to the hospital multiple times during the EHR reporting period is only counted once

<sup>4</sup> Demographics Includes all of the following: Preferred language, insurance type, gender, race, ethnicity, date of birth, and date and cause of death.

<sup>5</sup> Vital Signs Includes all: Height, weight and blood pressure, BMI (calculate and display), growth and BMI charts for children 2–20 years (plot and display).

9. Electronically maintain an active medication list<sup>6</sup> for at least 80% of all unique patients<sup>3</sup> admitted?
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
10. Electronically maintain an active medication allergy list<sup>7</sup> for at least 80% of all unique patients<sup>3</sup> admitted?
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
11. Electronically provide a copy of their discharge instructions and procedures to 80% of all discharged patients who request one?
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
12. Electronically complete medication reconciliation<sup>8</sup> for at least 80% of relevant encounters<sup>9</sup> and transitions of care<sup>10</sup>?
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
13. Electronically complete summary of care record<sup>11</sup> for at least 80% of transitions of care and referrals?
  - Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.

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<sup>6</sup> Active Medication List: At least one medication entry (or an indication of "none" if the patient is not currently prescribed any medication)

<sup>7</sup> Active Medication Allergy List: At least one medication allergy entry or (an indication of "none" if the patient has no medication allergies)

<sup>8</sup> Medication Reconciliation: The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.

<sup>9</sup> Relevant Encounters: Any encounter which in the hospital's judgment performs a medication reconciliation due to new medication or long gaps in time between patient encounters or other reasons determined by the hospital.

<sup>10</sup> Transitions of Care: The transfer of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc.) to another or from one eligible professional to another.

<sup>11</sup> Summary of Care Record: A record that can be provided through an electronic exchange, accessed through a secure portal, secure e-mail, electronic media such as a CD or USB memory devices, or printed copy.

14. Provide at least 80% of all patients who request it, an electronic copy of their health information<sup>12</sup> within 48 hours?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
15. Use Computerized Physician Order Entry (CPOE)<sup>13</sup> for at least 10% of orders?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
16. Electronically maintain an up-to-date problem list<sup>14</sup> of current and active diagnoses based on ICD-9-CM<sup>15</sup> or SNOMED CT<sup>16</sup> on at least 80% of all unique patients<sup>3</sup> admitted?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
17. Electronically generate at least one report during the EHR reporting period listing patients with a specific condition?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
18. Electronically incorporate at least 50% of all clinical laboratory test results in the EHR?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.

---

12 Health Information: A record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, radiology reports, and discharge summary and procedures.

13 Computerized Physician Order Entry (CPOE): Provider's use of computer assistance to directly enter medical orders (for example, medications)

14 Problem List: A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.

15 ICD-9-CM: International Classification of Diseases, 9th Revision, Clinical Modification.

16 SNOMED CT: Systemized Nomenclature of Medicine – Clinical Terms.

19. Electronically implement 5 clinical decision support rules relevant to the clinical quality metrics, specialty or high hospital priority, including diagnostic test ordering, along with the ability to track compliance with those rules?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
20. Electronically perform drug-drug, drug-allergy, and drug-formulary checks?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
21. Electronically exchange key clinical information<sup>17</sup> among providers of care and patient authorized entities?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know
22. Electronically submit data to immunization registries?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
23. Electronically submit reportable lab results (as required by state or local law) to public health agencies.
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.
24. Electronically provide syndromic surveillance data<sup>18</sup> to public health agencies?
- Yes
  - No – BUT WE PLAN to implement within the next 5 years
  - No – AND WE DO NOT PLAN to implement within the next 5 years
  - WE Don't Know.

---

<sup>17</sup> Key Clinical Information: For example discharge summary, procedures, problem list, medication list, allergies and diagnostic test results.

<sup>18</sup> Syndromic Surveillance Data: Monitoring of the frequency (e.g., the number or rate of episodes) of illnesses with a specified set of clinical features (e.g., fever and respiratory complaints, vesicular skin rashes, diarrhea, etc.) in a given population (e.g., members of a health maintenance organization, residents of a given geographic region, etc.), without regard to the specific diagnoses, if any, that are assigned to them by clinicians.

### 3. Technology Infrastructure

25. Are you currently using High Speed Internet<sup>19</sup> service at your hospital<sup>20</sup>?

- Yes
- No – High Speed Internet is not Available
- No – High Speed Internet is Available
- We Don't Know.

26. Do you currently exchange patient Electronic Health Records with: (check all that apply)

- Clinics
- Laboratories
- Hospitals
- Insurance Companies
- Regional Health Information Organization
- Other \_\_\_\_\_

27. In what year do you plan to procure, purchase, and implement a computer based Electronic Health Record system?

- Currently have EHR system in operation
- 2010
- 2011
- 2012
- 2013
- 2014
- 2015
- No Current Plans

---

<sup>19</sup> High Speed Internet: Per FCC (2009), "Basic Broadband" is defined as data transmission speeds exceeding 768 kilobits per second (Kbps), or 768,000 bits per second, in at least one direction: downstream (from the Internet to the user's computer) or upstream (from the user's computer to the Internet).

<sup>20</sup> Primary Practice Location: The business address used on your National Provider Identification (NPI) application.

#### ***4. Eligible Hospital Demographics***

28. Is your primary hospital location<sup>24</sup> :

- An Acute Care Hospital?
- A Children's Hospital
- Other

29. At your primary hospital location do you treat patients from other States or Countries?

- Yes
- No
- We Don't Know
- Please list the State(s) and/or Country(ies) \_\_\_\_\_

30. What percentage of all your patient admissions, over a continuous 90 day period are billed through Medicaid?

- 0-9% of visits
- 10-19%
- 20-29%
- 30-39%
- 40-49%
- 50-59%
- 60-69%
- 70-79%
- 80-89%
- 90-99%
- 100% of visits

31. May we contact you directly if there are any questions regarding your survey answers?

- Yes
- No

If yes, please select contact preference:

- Mail
- Phone
- E-Mail
- Other \_\_\_\_\_

32. Would you be interested in participating in a Focus Group regarding the subject matter of this survey, if such a group were convened?

- Yes
- No

33.

a) Does your hospital plan to apply for the ARRA, Medicaid and/or Medicare incentive payment Program?

- Medicaid
- Medicare
- Both Medicaid and Medicare
- None
- We Don't Know

b) If you selected "Medicaid" or "Both Medicaid and Medicare" in question 33a, in which year do you plan to apply for the Medicaid incentive payment program?

- 2011
- 2012
- 2013
- 2014
- 2015
- We Don't Know
- We Don't Know

34. Select your Association affiliation. (Please check all that apply)

- Adirondack Regional Community Health Information Exchange (ARCHIE)
- American Academy of Pediatrics (AAP)
- Brooklyn Health Information Exchange (BHIX)
- Community Health Care Association of New York State (CHCANYS)
- Empire Justice
- Family Planning Advocates (FPA)
- Fidelis Care NY
- Greater New York Hospital Association (GNYHA)
- Health Advancement Collaborative of Central New York (HAC-CNY)
- Healthcare Association of NYS (HANYS)
- Healthcare Information Xchange of New York (HIXNY)
- HEALTHeLINK
- Home Care Association of New York State (HCA)
- Hospice and Palliative Care Association of New York State (HPCANYS)
- Interboro RHIO
- Iroquois-Healthcare Alliance (IHA)
- Legal Aid Society
- Long Island Patient Information Exchange (LIPIX)
- Medicaid Matters
- Medical Society of the State of New York (MSSNY)
- New York Chapter of the American College of Physicians (NYACP)
- New York Clinical Information Exchange (NYCLIX)
- New York eHealth Collaborative (NYeC)
- New York Health Foundation (NYSHealth)
- New York State Academy of Family Physicians (NYSAFP)
- New York State Association of Healthcare Providers (NYSHCP)
- New York State Association of Homes and Services for the Aging (NYAHSa)

- New York State Association of Licensed Midwives (NYSALM)
- New York State Coalition of Prepaid Health Services Plans (PHSP Coalition)
- New York State Dental Association (NYSDA)
- New York State Health Facilities Association (NYSHFA)
- New York State Health Plan Association (HPA)
- New York State Society of Physician Assistants (NYSSPA)
- Nurse Practitioner Association New York State (NPA)
- Primary Care Information Project (PCIP)
- State University of New York (SUNY)
- Suffolk County Health Services
- Taconic Health Information Network and Community (THINC)
- United Hospital Fund (UHF)
- United Jewish Appeal Federation of NY (UJAFEDNY)
- Urban Health Plan (UHP)
- Visiting Nurse Services of NY (VNSNY)
- None

35. Please state any additional comments you have on the DOH SMHP survey in comment box provided below:

Comment

Box: \_\_\_\_\_

## ***4. Closing***

### **Thank You**

Thank you for participating in this survey. Your responses help us provide critical input to the New York State Medicaid Health Information Technology Plan (SMHP). We greatly appreciate your time and feedback.

Additional ARRA information can be found at: NYSDOH ARRA Resource Page (<http://www.health.state.ny.us/regulations/arra/>)



## APPENDIX IV

# INTEROPERABLE EHR USE CASE FOR MEDICAID

The following Interoperable Electronic Health Records Use Case for Medicaid was developed in support of the HEAL 5 round of the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) program.

**Interoperable Electronic Health Records (EHRs)  
Use Case for Medicaid  
(Medication History, Patient Visit History, Demographics,  
Procedure and  
Diagnosis Data, Clinical Data)**

**Version 1.0**

## 1. Executive Summary

**Background:** New York State Department of Health (NYSDOH) is the single state agency with responsibility to administer New York's Medicaid program. Medicaid is the single largest payer of health care services in New York State, covering 4.5 million people and underwriting almost one-third of all health care costs in the state. NYSDOH seeks to ensure that all 4.5 million New Yorkers covered by Medicaid receive high quality, cost effective care. To advance that goal, NYSDOH will employ a multi prong strategy that includes establishing interoperable health information exchange (HIE) capabilities to enable providers that contract with Medicaid to provide coordinated care to their Medicaid patients. Medicaid expects that these exchanges will lead to improved quality of care for its enrollees, especially those with chronic illnesses and multiple comorbidities.

As part of the development and implementation of New York's health information infrastructure, the Medicaid EHR use case consists of two components: (1) technical solutions designed in partnership with regional health information organizations (RHIOs) will bring Medicaid data to the electronic health record (EHR) at the point of care to support clinical decision making by practitioners; and (2) enhanced interoperable sharing of clinical data between practitioners via EHRs across New York State will further support the provision of comprehensive care management and coordination of care. Health information exchange (HIE) of medication and visit history data for Medicaid patients will be available to clinicians to further comprehensive care management capability. Clinically relevant information not previously available will permit providers to take into account a greater spectrum of patient need. For example, the ability to retrieve visit and discharge history will enable clinicians to identify prior ER visits and hospital inpatient admissions, thereby allowing the practitioner to request records from those encounters in order to provide a more comprehensive history of their Medicaid patient's prior diagnoses and care. The ability to retrieve lab results ordered by other practitioners will eliminate needless duplication of testing and will reduce management delays caused by lack of availability of the data. The ability to review the Medicaid beneficiary's adjudicated pharmacy claims will assist in the reconciliation of the beneficiary's medication list, now a national patient safety goal (JCAHO). When used in combination with decision support systems, such data can be invaluable in identifying adverse drug interactions, drug-disease interactions, drug-laboratory interactions, and age-specific dosing issues. Identifying such issues at the point of care can assist in improvement of patient safety and quality of care. In addition, the exchange of critical clinical information between providers, including laboratory results, hospital discharge summaries, immunization data, notification of clinical services (e.g., Emergency

Department visits, diagnosis of pregnancy/prenatal care), clinical problem lists, history and physicals, and clinical care plans will enable care coordination between and among clinicians and if used by clinicians can help improve the quality of care. Clinicians participating in this use case will be required to demonstrate that they are using an interoperable, CCHIT-certified electronic health record in combination with the data exchange resources (as elaborated in this use case) to improve the quality of care rendered to their Medicaid patients and to provide comprehensive care coordination for their Medicaid patients. The evaluation of funded projects will focus on demonstrating improvements in both care coordination and quality clinical outcomes for Medicaid recipients.

**Broad Area:** Support the implementation of CCHIT-certified electronic health records in combination with interoperable health information exchange in New York

State (NYS) to enable providers to improve both care quality and care coordination for Medicaid beneficiaries.

**Specific Use Case Area:** There are two components in this use case. Under the first component, NYSDOH shares patient procedures, diagnoses, visit history, demographics, laboratory results (\*) and medications discernable from Medicaid claims with clinicians at the point of care via EHRs using standardized Medicaid-to-clinical-system transaction exchange, which includes sharing record locator information with Regional Health Information Organizations (RHIOs). Under the second component, practitioners involved in the care of a beneficiary utilize interoperable EHRs via the SHIN-NY to share clinical data with each other. Data to be shared includes, but is not limited to, laboratory results, hospital discharge summaries, immunization data, notification of clinical services (e.g., Emergency Department visits, diagnosis of pregnancy/prenatal care), clinical problem lists, history and physicals, and clinical care plans.

(\*)Note: sharing of lab data from NYSDOH is tentative and contingent upon implementation of a mandatory reporting requirement.

## 2. Description of EHR Use Case for Medicaid

We have developed this use case to test different mechanisms by which the medical history of Medicaid patients is transmitted to practitioners on a real time basis and to determine the extent to which practitioners use this information to improve the value of the care delivered to Medicaid patients.

This use case has been developed in conjunction with NYS Medicaid program staff in the Office of Health Insurance Programs (OHIP). It describes the process or interaction that each primary stakeholder will invoke in the capture, discovery, anonymization, pseudonymization (where appropriate), aggregation, validation and transmission of relevant patient care and hospital resource data.

The use case addressed in this document encompasses two components.

The first component is for the exchange of patient demographics, procedures, diagnoses, visit history, medication history, laboratory results, eligibility and formulary data from NYSDOH and its authorized Medicaid HIE partners to EHRs of practitioners / clinicians treating Medicaid beneficiaries. Requests for this data via the Statewide Health Information Network (SHIN-NY) would be authenticated by NYSDOH, and responded to via standardized electronic data interchange responses, built on existing and emerging National Health Information Network (NHIN) standards. The use case covers the ability of a clinician at the point of care to request and receive the above listed information sets about a patient for whom Medicaid is the payer. The use case also addresses the evaluation of effectiveness of these exchanges for Medicaid beneficiaries who are in long term care settings, and for those beneficiaries with a combination of mental illness and multiple chronic conditions. The Medicaid HIE use case defines scenarios intended to set statewide interoperable exchange standards and to improve the care received by the Medicaid population.

Under the second component, using RHIOs as intermediaries, practitioners share clinical data via their EHRs, including laboratory results, hospital discharge summaries, immunization data, notification of clinical services (e.g., Emergency Department visits, diagnosis of pregnancy/prenatal care), clinical problem lists, history and physicals, and clinical care plans with other practitioners. The intent is to encourage the electronic exchange of critical clinical information between practitioners to improve the

coordination of care and quality of clinical outcomes. Clinicians / practitioners who participate in this use case are expected to utilize interoperable CCHIT-certified EHRs in combination with health information exchange technology to improve both the quality of care delivered and degree of care coordination provided to their Medicaid patients. The successful projects that are funded under this use case will be evaluated in terms of demonstrating actual improvements in both care coordination and quality clinical outcomes for Medicaid recipients.

### 3. Scope of EHR Use Case for Medicaid

This use case will present the Medicaid HIE workflow, perspectives, and pre- and postconditions. The grant projects will iteratively refine this document and maintain it so that it can be translated into technical requirements.

This use case is composed of two components. The first component primarily includes the actions that are required for RHIO participants at the point of care to see specific patient care information that NYSDOH has on file about a Medicaid recipient, improving the coordination and quality of care for that recipient. However, the policies, processes and standards may be applicable to other use cases, including but not limited to Public Health for Health Information Exchange, Quality Reporting for Outcomes, and Connecting New Yorkers to Clinicians.

The use case scope includes the following:

1. Data collected from Medicaid claims, integrated with data from other sources, covering visit history in inpatient, outpatient and/or long term care settings, physician offices, pharmacies and labs. Clinical data exchanged includes: patient demographics; medication history; visit history; procedures, diagnoses and laboratory results; administrative data exchanged includes eligibility for benefits and Medicaid formulary
2. Institutional and community based service providers who have clinical data of significance to Medicaid
3. The authorized local, regional state, and federal personnel who monitor and administer medical assistance payments under Title XIX of the Social Security Act.

The second component primarily includes the HIE capabilities that are required for practitioners / clinicians, using RHIOs as intermediaries, to share critical clinical data including laboratory results, hospital discharge summaries, immunization data, notification of clinical services (e.g., Emergency Department visits, diagnosis of pregnancy/prenatal care), clinical problem lists, history and physicals, and clinical care plans.

### 4. Stakeholders for EHR Use Case for Medicaid

RHIOs	Clinicians/Practitioners
Healthcare service organizations	Laboratory organizations
Medicaid	Medicaid beneficiaries
Other government and private organization	Consumers
Health Information Service Providers	

### 5. Pre-Conditions

Pre-conditions are the conditions that must be in place before the start of the use case. These include, but are not limited to, the state of a stakeholder, data that must be available somewhere, or an action that must have occurred. This section also

includes triggers for the initiation of the use case and discussions of important assumptions made about the use case during its development.

1. Established technical, clinical and organizational infrastructures to support the ability to respond to patient-level transactional inquiries (the only function routinely supported by most RHIOs designed for clinical data exchange). This includes the ability to implement eMedNY application program interfaces (APIs).
2. Procedures and agreements supporting data exchange including privacy protections, security and confidentiality protocols, secondary data uses and appropriate data sharing agreements/business associate agreements.
3. Agreements to abide by Medicaid data and messaging standards.
4. Maximum effort to assure data quality, integrity, privacy and security.
5. RHIO's ability to electronically request and receive pertinent Medicaid data in a secure and timely fashion, using to be defined data exchange and vocabulary standards.
6. RHIO's ability to contract with NYS Medicaid and execute a data exchange Agreement
7. RHIO includes clinical affiliates who are enrolled NYS Medicaid providers in good standing
8. Participating practitioners / clinicians are willing and committed to use CCHIT certified interoperable electronic health records in combination with health information exchange technology to improve both the quality of care delivered and degree of care coordination provided to their Medicaid patients. Clinicians agree to participate in a rigorous evaluation of the project to demonstrate these improvements. For this purpose, clinicians agree that relevant charts of Medicaid recipients will be made available to the contracted project evaluator for review.
9. In the event that participating practitioners do not currently have access to CCHIT-certified interoperable electronic health records, it is permissible for the applicant to simultaneously apply to the EHR grant category under this HEAL NY Phase 5 program (see section 2.4 in the Request for Grant Applications: "Pilot Implementations of Community-wide Interoperable EHRs (EHR)."

#### **6. Post-Conditions**

Post-conditions are the conditions that will be a result or output of the use case. This includes, but is not limited to, the state a stakeholder upon conclusion of the use case, data that was created or now available, and identification of actions that may serve as preconditions for other use cases.

1. RHIOs will be able to automatically exchange patient demographics, procedures, diagnoses, medication and visit history, lab results, eligibility and formulary data, and other clinical data including hospital discharge summaries, immunization data, notification of clinical services (e.g., Emergency Department visits, diagnosis of pregnancy/prenatal care), clinical problem lists, history and physicals, and clinical care plans.
2. Data messages will be formulated following a standard structure, coding, and minimal required set of information.
3. Data will be transmitted in real-time, when feasible, but with a periodicity of no longer than 24 hours. The key exception to this is receiving the Medicaid Formulary which is published as a monthly batch file.
4. RHIOs will support the privacy and security of patient health information and will be contracted with NYS Medicaid to ensure that all security and privacy requirements are enforced and audited.

5. Appropriate entities (i.e., practitioners enrolled in the Medicaid program) are authorized and authenticated to send or receive data.
6. System transactions are auditable.
7. Clinicians will routinely use CCHIT-certified interoperable electronic health records and health information exchange technology to improve both the quality of care delivered and degree of care coordination provided to their Medicaid patients. This will be demonstrated through a rigorous chart review process by the contracted project evaluator.

### **7. Details of Use Case Scenarios and Perspectives**

The following entity-driven perspectives will be part of the use case:

1. *Regional Health Information Organizations* denote an electronic network for exchanging health and patient information among providers.
2. *The New York State Department of Health* is the single state agency in NYS with the statutory authority to administer the Medicaid program.
3. *New York local governments*, including 62 county departments of social services, the New York City Department of Health and Mental Hygiene (NYCDOHMH), and the New York City Human Resources Administration (HRA) have the major responsibility for establishing eligibility for Medicaid benefits at the local level.,
4. *Consumers* include any New Yorker who might be in need of, or benefit from, public health services.
5. *Practitioners / clinicians* who will use CCHIT-certified interoperable electronic health records and health information exchange technology to improve both the quality of care delivered and degree of care coordination provided to their Medicaid patients.

Data flow models required to accomplish this use case is described in the following scenarios.

1. *Request Patient Records From Medicaid*: To support requests for records, RHIO connected systems use their respective Record locator services to select a Medicaid Continuity of Care Document (CCD) Record, including in the request which portion(s) of the record they wish to retrieve – Demographics, Procedures, Diagnoses, Medications, Visits and/or lab results. Medicaid responds to the request with the selected record in the HL7 CCD format. The records, data flow diagrams and details of the exchange are included in the Office of National Coordinator EHR-Emergency Responder detailed use case, included as Appendix I.

2. *Prescribe Medicines for Medicaid Beneficiaries*: To support prescribing activities, physician systems exchange X12 270/271 transactions to get the Medicaid recipient ID. Physician systems incorporate the Medicaid recipient ID into an NCPDP 8.1 (SCRIPT) standard request for Medication History, Medicaid response with an NCPDP 8.1 Medication History response. Physicians interact with the Medicaid-supplied formulary (see #1 above) through their ePrescribing applications to select an appropriate drug based on formulary status and issue a prescription electronically to the pharmacy. The records, data flow diagrams and details of the exchange are included in the New York State DOH

Medication History Implementation Guide, included as Appendix II.

3. *Exchange of Clinical Data between Practitioners*. Where applicable, the project must employ national data formatting standards. To the extent that standards are not already in development or do not exist, applicants may propose and test a new standard.



## APPENDIX V

# STAKEHOLDER OUTREACH

Between February and June 2010, NY Medicaid conducted a series of stakeholder outreach meetings with State agencies and stakeholder organizations to educate them on the current status of the Medicaid EHR Incentive Program and to solicit input on EHR adoption incentives, the current state of stakeholder adoption, and needs for future educational outreach. The following appendix contains the formal feedback provided to NY Medicaid as a result of those outreach meetings.

## NY Medicaid Stakeholder Outreach Summary

Organization	Received Briefing	Provided Feedback
AAP (American Academy of Pediatrics)	X	X
AHCP (Association of Healthcare Providers)	X	X
CHCANYS (Community Health Care Association NYS)	X	X
Empire Justice Center/Legal Aid Society(joint)	X	X
Family Planning Advocates	X	X
Fidelis Care NY	X	
GNVHA (Greater New York Hospital Association)	X	X
HANYS (Healthcare Association of NYS)	X	X
HealthLink	X	X
Home Care Association of NYS	X	
Managed Care Medical Directors	X	
Medicaid Matters	X	
MSSNY (Medical Society of the State of New York)	X	X
NPA (Nurse Practitioner Association NYS)	X	X
NYACP (New York Chapter of the American College of Physicians)	X	X
New York Diabetes Coalition	X	X
NYeC (New York eHealth Collaborative)	X	X
NYS Association of Homes, Services for the Aging and Hospice Association	X	
NYS Coalition of PHSPs (Prepaid Health Services Plans)	X	
NYS Dental Association	X	X
NYS Health Foundation	X	X
NYS Health Plan Association		
NYSAFP (New York State Academy of Family Physicians)	X	X

Organization	Received Briefing	Provided Feedback
NYSALM (New York State Association of Licensed Midwives)	X	
NYSHFA (NYS Health Facilities Association)	X	
NYSSPA (New York State Society of Physician Assistants)	X	
PCIP (Primary Care Information Project)	X	
Rochester Regional Health Information Organization	X	X
Suffolk County Health Services	X	
SUNY (Universities)	X	X
Taconic Health Information Network	X	X
The Hospice Association	X	
UHF (United Hospital Fund)	X	
United Jewish Appeal Federation of NY	X	X
Urban Health Plan	X	
VNSNY (Visiting Nurse Service of NY)	X	X





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**American Academy of Pediatrics –  
District II, New York State**

April 13, 2010 | 10 a.m.–12 p.m.  
New York State Department of Health  
99 Washington Avenue  
Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the American Academy of Pediatrics (AAP), District II, New York State. Comments were received on April 13, 2010, at the NYS Department of Health in Albany, NY. The AAP is a professional organization representing the interests of approximately 5,050 pediatricians throughout 50 counties in upstate New York. In attendance were:

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **American Academy of Pediatrics, District II, New York State**

George Dunkel, Executive Director

Elie Ward, Director of Policy and Advocacy

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant

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## American Academy of Pediatrics – Background

The American Academy of Pediatrics has approximately 60,000 members in the United States, Canada, Mexico, and many other countries. Members include pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. The AAP was founded in June 1930 by 35 pediatricians who met in Detroit, Michigan, in response to the need for an independent pediatric forum to address children’s needs. When the AAP was established, the idea that children have special developmental and health needs was a new one. Preventive health practices now associated with child care – such as immunizations and regular health exams – were only just beginning to change the custom of treating children as “miniature adults.” The mission of the AAP is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. The AAP, District II, New York State, cares for the State’s 4.98 million children.

## Special Patients – Special Needs

A recurring theme heard from among clinicians regarding Electronic Health Records is that not all record keeping is created equal. Patients are different, so the means by which physicians or other care givers maintain accurate health records will be different too. George Dunkel, Executive Director of the AAP’s New York Chapter, said, “The development of electronic health records must recognize that

“The development of electronic health records must recognize that pediatricians need child-specific record-keeping.”

George Dunkel



pediatricians need child-specific record-keeping. Children are not small adults. They have a lot of issues regarding their health, so HIT efforts need to recognize a child-specific portion for record-keeping and transmission.”

## **Creating Links Among Links**

New York State is in the process of implementing, and has completed, several central database repositories of pediatric information. These are solid steps forward in providing empirical data and records on critical public health issues. New York AAP physicians already submit data to the systems below:

**New York State Immunization Information System (NYSIIS)** - A central repository of all immunization activities for persons less than 19 years of age. Providers are required to report all immunizations.

**NeoNatal Registry** - Health information on the birth of every child in New York State.

**Bright Futures EMR** - A national project underwritten by the Department of Health and Human Services and coordinated through the AAP’s national office. Bright Futures seeks to improve the health of all children in the U.S. through education and the coordination and standardization EHR protocols.

**Public Health Records** - New York State pediatricians are required to upload vital patient information to myriad databases overseen by NYS DOH Public Health.

**Billing Systems** - submitting Medicaid and private payer claims is an all-electronic process.

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“Two issues are important to AAP members: interfacing with existing record-keeping and electronic billing, and the ability to upgrade. It should not be a static platform.”

Elie Ward

Members of the New York State Chapter of the AAP clearly want ease and seamlessness among the EHR and related electronic reporting that they are currently doing. “Two issues are important to AAP members,” explained

Ms. Ward. “Interfacing with existing record-keeping and electronic billing, and the ability to upgrade. It should not be a static platform.” For example, the Bright Futures program is a national effort. New York State’s standards, protocols, and procedures should shadow similar national initiative. “We want to avoid working at a certain level with the federal government and then at another level here in New York State,” said Ms. Ward.

### **Cost-effective and affordable**

A common barrier is cost. Members of the New York State Chapter of the AAP see cost as an issue regarding their ability to implement mature EHR systems.





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**New York State  
Association of Health Care Providers,  
Inc. (HCP)**

April 15, 2010 | 10:30 - 11:00 a.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the New York State Association of Health Care Providers, Inc. (HCP). Comments were received on April 15, 2010, at the NYS DOH in Albany, NY. HCP is a trade association representing more than 500 offices of Licensed Home Care Service Agencies, Certified Home Health Agencies, Long Term Home Health Care Programs, Hospices, and health-related organizations (HROs) across New York State. HCP and its members take a leadership role in raising awareness about the value and cost effectiveness of home and community-based services. In attendance were:

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair; Medical Director

### **NYS Association of Health Care Providers, Inc.**

Christina Miller-Foster; Assistant Director of Public Policy

Christine Johnston; Executive Vice President

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP; Program Consultant

Peter Poleto; Account Executive

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## New York State Association of Health Care Providers, Inc. (HCP) - Background

The New York State Association of Health Care Providers, Inc. represents more than 500 home care and home care-related organizations throughout New York State. Headquartered in Albany, NY, and working through regional chapters, HCP is a leading voice for home health care providers. HCP's mission includes providing educational and informational resources to the home health care industry; soliciting legislative and regulatory support in issues affecting the health care industry; supporting the development of sound business practices; and promoting home care and community-based programs to carry the industry into the future.

*HCP represents more than 500 home and community-based care offices across New York State, including:*

- *Licensed Home Care Services Agencies*
- *Certified Home Health Agencies*
- *Long-Term Home Health Care Programs*
- *Hospices*

### Home Care – Not all EHR is Created Equal

EHR adoption in home care settings faces a unique challenge. Home care agencies lack a bricks and mortar infrastructure. Services are delivered off-site, and communication with physicians and other providers is via phone, fax, or hard copy. EHR implementation models typically reflect data exchange from a clinical setting to a central repository. This often leaves home care agencies overlooked when EHR policy, procedure, and funding are under consideration. Nevertheless, HCP members have been on the leading edge in the use of telemedicine and telemonitoring. Collecting, analyzing, and responding to patients' vitals from their home is a life-saver, literally. Christine Johnson, Executive Vice President of HCP, puts it this way, "We've seen some amazing results in the use of telemedicine and telemonitoring in the home setting. It limits re-admission, and I think in the coming years, we're going to see more and more use of that technology. Investment in any of these new technologies is great for homecare."

*"We had one provider that showed reduced unplanned hospitalizations by eighty percent of their patients who are on telemonitoring devices."*

*Christine Johnson*

According to Ms. Johnson, telemedicine and telemonitoring are relatively easy for home care agencies to implement. Providers can ramp up use of the telemetry devices a few units at a time. EHR adoption, on an organizational level, is another

matter. Because of the cost, the network infrastructure, software, training, and related implementation requirements are beyond the means of most home care agencies. Ms. Johnson said, “Electronic health records have been a little bit more of a daunting challenge. Providers tell us, ‘It’s easy to look at the telemedicine because I can do it in small bites. To go into electronic health records, I have to do it all at once. I can’t stick

*“Making the data more available to more people is really at the crux.”*

*Christine Johnson*

my toe in the water. I have to make a significant investment to purchase.’ It’s in the millions of dollars even for a midsized agency.”

Compounding the upfront cost of EHR implementation, home health care agencies face another challenge, getting reimbursed properly for using the technology. Health care in general is labor intensive; even more so with home health care where there are no large pieces of durable medical equipment, laboratories, or diagnostic imaging displays. Dollars spent are truly spent on care, not infrastructure. Past policy has viewed EHR incentives and reimbursement as infrastructure, and not so much the person *using* it. “The ability to access funds and reimbursement that deals with patient care is burdensome,” explains Ms. Johnson. “Access to capital is very much different.”

## Some New Developments

Regarding the use of telemedicine/telemetry, and related personal EHR tools, AHP sees the following as holding a great deal of promise for home care patients and the industry as a whole:

- **Centralized data** – An accessible data mart of a patient’s history, instantly accessible so that real-time information such as vitals can be tracked and provided to care givers.
- **Graphing** – Improved user interfaces and dashboards make interpretation easier for mobile caregiver.
- **Research** – A safe, secure, but appropriately accessible repository could be accessed for research and completing trending analysis on diabetes, hypertension, and other common health problems.
- **Policy following data** – Home care is often overlooked in health care policy decisions. The work of home care providers and its impact on cost, quality of life, and purpose cannot be overstated. Subsequently, future policy decisions regarding EHR must take into account where the data is coming from (i.e., the patient’s home) and reflect the characteristics of home health care.



**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**Community Health Care Association  
of New York State  
(CHCANYS)**

March 29, 2010 | 11:30 a.m. – 12:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the Community Health Care Association of New York State. CHCANYS is the advocacy group for Community Health Centers (CHCs) in New York State. In attendance were:

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **Community Health Care Association of New York State**

Kate Breslin, Director of Policy  
Lisa Perry, Program Director – IT Special Projects  
Sandy Worden, Director of IT

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant  
Peter Poletto, Business Architect

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## New York State Community Health Centers – Overview



New York State is home to 59 Federally Qualified Health Centers (FQHCs), commonly referred to as Community Health Centers or CHCs. FQHC is a designation by the Health Resources and Services Administration (HRSA), which allows FQHCs to receive grant funding to provide medical care to medically underserved individuals. CHCs provide medical care at more than 400 sites in urban, suburban, and rural settings throughout New York State. CHCs provide comprehensive services including primary care, OB/GYN, pediatric, geriatric, mental health, wellness, radiology, laboratory services, dental and other services. The Community Health Care Association of New York State (CHCANYS) is the advocacy group for CHCs in New York State.

### Summary Overview

- Electronic Health Record implementation for CHCs began in 2005.
- Of 445 community health locations, more than half now maintain electronic health records - another 20% have implementation in progress.
- Nine health centers in Brooklyn are coming live with their Regional Health Information Organization (RHIO).
- CHCs participate in both upstate and New York City Regional Health Information Technology Extension Centers (RHITECs).
- CHCANYS has been aggressively seeking grant funding from the Primary Care Development Corps, the Altman Foundation, and the New York State Health Foundation.

### Physician Assistants as Eligible Providers

Currently, the proposed ruling from the Center for Medicaid Services does not include Physician Assistants (PAs). With nearly 140 PAs practicing in CHCs throughout New York State, CHCANYS believes it was Congress's intent to include PAs.



## Meaningful Use Disconnect

Current meaningful use measures, still being defined by the Center for Medicaid Services, propose that patient interactions be reported based on individual provider, not the total aggregate of care provided to Medicaid members. This proposed process will be burdensome to CHCs and will likely reduce proper and fair funding levels. Medical care in CHCs is often provided by multiple care givers, including physicians, physician assistants, nurse practitioners, and other specialists, such as pediatricians or gynecologists. Individual care givers may not see patients at the 30% level required for funding, while others may be at far higher percentage. Because of the community it serves, an entire CHC taken in aggregate will surely have a 30% Medicaid case load.

## Clinical Decision Support Rules

Regarding meaningful use, CMS is requiring each provider to make no fewer than five clinical decisions in the first year of use through EHR. With multiple providers in CHCs, tracking this is very burdensome, and CHCANYS believes that using an aggregate tracking figure would achieve the same result and would not place undue hardship on the CHC.

## Payment Mechanism

Medicaid incentive payments will be distributed in two fundamental ways. The first is directly to providers. Providers can keep the incentive payments or assign the funds over to their practice. The second method will be payments made directly to a hospital. Community Health Centers fall into the former method. However, the nature of care and operations (multiple providers, varied services) mean that some CHCs operate more like a hospital than a medical practice. CHCANYS believes this is an area for consideration and requests that CMS consider allowing some CHCs to receive incentive payments in a model similar to hospitals.

Further, CHCANYS has commented to CMS that incentive payments should not be offset by other funding sources, such as HRSA grants.

## Security Risk Analysis

CHCANYS has identified the need for a clear definition for security standards and practices.

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**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**Empire Justice Center/  
Legal Aid Society**



## Introduction

The American Recovery and Reinvestment Act (ARRA) signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document summarizes a memo (dated May 21, 2010) from Trilby de Jung, Health Law Attorney for the Empire Justice Center and Lisa Sbrana, Supervising Attorney of the Health Law Unit at The Legal Aid Society to Dr. James Figge, Medical Director of OHIP. This document represents the sum and substance of the feedback from these two organizations regarding the Provider Incentive Payment Program.



## Background



Empire Justice is a statewide, multi-issue, multi-strategy public interest law firm focused on changing the “systems” within which poor and low income families live. With a focus on poverty law, Empire Justice undertakes research and training, acts as an informational clearinghouse, and provides litigation backup to local legal services programs and community based organizations. As an advocacy organization, Empire Justice engages in legislative and administrative advocacy on behalf of those impacted by poverty and discrimination. As a non-profit law firm, Empire Justice provides legal assistance to those in need and undertake impact litigation in order to protect and defend the rights of disenfranchised New Yorkers.



The Legal Aid Society is a private, not-for-profit legal services organization, the oldest and largest in the nation, dedicated since 1876 to providing quality legal representation to low-income New Yorkers. It is dedicated to one simple but powerful belief: that no New Yorker should be denied access to justice because of poverty. The Society handles 300,000 individual cases and matters annually and provides a comprehensive range of legal services in three areas: the Civil, Criminal and Juvenile Rights Practices. Unlike the Society's Criminal and Juvenile Rights Practices, which are constitutionally mandated and supported by government, the Civil Practice relies heavily on private contributions.

## Definition of Meaningful Use

The Meaningful Use rules proposed by CMS promise significant improvements to the health care system and represent a careful balancing of the need to improve quality, safety and patient engagement without unduly burdening providers and hospitals. The proposed rules could go further, however, in harnessing health information technology to better connect low-income patients and families to the health care system and better connect patient information across providers. We hope New York State can implement the rules proactively, as a means of incentivizing providers to inform and educate their patients, as well as coordinate care.



## **Communicating with Patients**

To maximize the opportunity for patients to learn what is most critical about their own health needs, and then act upon that information in a proactive way, all patients should be offered access to their EHR, rather than making access to information subject to patient request.

When services are provided in an outpatient setting, all patients should be offered access to clinical summaries prior to leaving the office. When services are provided by hospitals, patients should be offered access to discharge instructions prior to leaving the hospital. For those patients who request their EHR outside the context of an office visit or hospitalization, we urge CMS to consider decreasing the lag time for these situations from 96 hours to the 48-hour time frame required when a patient requests a copy of their medical information under the the Health Information Portability and Accountability Act (HIPAA).

Additionally, in order to ensure that all patients can make use of access to information from their EHR—including low-income, immigrant, elderly, and other vulnerable groups which tend to have limited access to the Internet—printed formats must be made available. Similarly, it is critically important to make information from the EHR available in languages other than English.

Patients will need educational resources in order to place their personal health information in context and understand the choices available. we feel that the decision to exclude patient education resources from the proposed rule is a mistake. The inclusion of patient resources in EHR would help ensure that patients receive accurate, safe, and reliable information relevant to their individual health needs.

## **Communication and Coordination between Providers**

Adoption of EHR technology promises to provide an effective means to ensure communication between providers to truly coordinate care, eliminate conflicting diagnoses, reduce medical errors and duplicative tests, and eliminate conflicting treatment regimens.

The specific provider communication requirements in the proposed rules make significant headway in improving care coordination, but we would urge New York State to take several additional steps to ensure that data-sharing among providers is effective in meeting patients' needs:



- When patients request a copy of their health records, the patient is often charged a fee for copying and mailing these paper records. We recommend that New York include measures that prevent providers from charging for copying and mailing when the information is transmitted electronically.
- We support the requirement that eligible providers and hospitals test their EHR system's capacity to electronically exchange key clinical information. New York State should raise the threshold from one successful test to a higher number of successful exchanges.
- Patients themselves are a valuable source of information about their own medical histories. New York should establish a standard procedure for patients to provide information for and/or correct errors in their health record by contacting their provider.

## Data Collection

We strongly endorse the federal requirement that providers and hospitals record patient demographic data, including race, ethnicity, preferred language, and gender. While we support the requirement in the proposed federal rule that providers and hospitals generate lists of patients by specific conditions for use in reduction of disparities, we think New York should be more specific and require that such lists be stratified by race, ethnicity, preferred language and gender. We also encourage New York to include a requirement that eligible providers and hospitals report a demographic profile of their patients.

EHR technology affords the opportunity to lay the groundwork for a broader database of patient experience. At a minimum, we believe patient and caregiver email addresses should be an element of the patient demographic data collection requirement. We also recommend that providers and hospitals be required to attest to the percentage of their patients that have been asked about their experience of care, and document the number of EHRs that have included this critical data.

## Conclusion

As advocates for low-income consumers, we are excited about the opportunity to help shape the requirements for meaningful use of EHR. The EHR incentive program has the potential to significantly advance the goal of creating a patient-centered health care system, a system that would truly facilitate effective communication between patients and providers, allow patients to become active participants in their own care, coordinate care and reduce existing disparities in the healthcare system.

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**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**Family Planning Advocates**

June 29, 2010 | 3:15 – 3:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from Family Planning Advocates of New York (FPA). FPA is a statewide membership organization dedicated to protecting and expanding access to reproductive health services.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director

### **Family Planning Advocates of New York**

M. Tracey Brooks, President and CEO

Georgana Hanson, Associate Director, Governmental Affairs

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O’Leary, PMP, Consultant

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## Family Planning Advocates – Background



Family Planning Advocates (FPA) of New York State is a non-profit statewide membership organization dedicated to protecting and expanding access to reproductive health services. FPA represents more than 200 family planning centers, including 11 Planned Parenthood affiliates, county family planning centers, and freestanding and hospital-based family planning facilities. Most FPA members are New York Safety Net providers. Nearly 90 percent of FPA-member patients have incomes below 150 percent of the federal poverty level. Medicaid patients comprise 30-54 percent of all FPA-member patients. FPA actively engages in policy analysis, legislative work, coalition building, and educational efforts.

### Current EHR Efforts by Family Planning Providers

Although New York State has made significant efforts to implement EHR technology, most of the state's family planning providers were unable to access the funding the state made available. Despite the challenges, there are providers who are entering into collaborate efforts to implement HIT. For example, seven upstate New York Planned Parenthood affiliates are collaborating on an integrated system of EHR software. When complete, fifty centers will be linked together. FPA members from the Mid-Hudson Valley to New York City are initiating a similar project. However, many smaller family planning providers are finding the transition to EHR out of reach, and the incentive funding will not reach the health centers to offset the costs.

### Incentivizing Meaningful Use

The current eligibility criteria for obtaining the incentive payments for implementing HIT will be difficult for many FPA members to meet. The current incentive payment structure, which focuses on individual providers versus health centers, fails to implement the culture change the program is intended to create. Many family planning centers employ physician assistants (PAs), who currently do not qualify for incentive funds. Further, many employ physicians and mid-level clinicians who work part-time. This is particularly

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challenging given the fact that part-time providers may not meet the Medicaid visit threshold required for the incentive payment or may be obligated to give the incentive payment to their other employer. M. Tracey Brooks, President and CEO of FPA, explained further, “Adoption of EHRs and meeting meaningful use standards will require a significant investment. This investment will be budgeted by the chief executive officer. It is important, when able, that the state invest and incentivize the health center culture change from the top down.”

## **Affordability**

FPA noted that regional extension centers have been mentioned as a potential conduit for both information exchange and technical assistance to providers and hospital systems. FPA members have found the costs of affiliating with a regional extension center to be prohibitive. It is FPA’s hope that should the state pursue the use of the regional extension centers for data exchange and technical assistance, funds will be allocated to ensure the affordability of entering into those partnerships.

## **Patient Confidentiality**

A cornerstone of family planning health services is patient confidentiality, particularly among minors. FPA members have decades of experience in providing comprehensive reproductive healthcare in settings that preserve and protect privacy rights. FPA requests that special consideration be afforded to ensuring the privacy of patients who access confidential reproductive healthcare services, including adolescents and women who access abortion care. As Ms. Brooks put it, “As we move to electronic medical records, the patient still has the ability to control her care. If she chooses to keep her records confidential, that must be respected. Electronic medical records shouldn’t be the place where we gather data to force people to do things regarding their own healthcare choices and decisions. That’s why this confidentiality piece is so important to our providers.”

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**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**Greater New York Hospital Association**

April 9, 2010 | 12 - 1:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the Greater New York Hospital Association (GNYHA). The GNYHA represents the clinical, financial, operational, and legislative interests of nearly 300 hospitals, long-term care facilities, and similar healthcare operations throughout the greater New York City area, New Jersey, Connecticut and Rhode Island.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **Greater New York Hospital Association**

Zeynep Sumer, Vice President, Regulatory and Professional Affairs  
Elizabeth R. Wynn, Vice President, Health Finance and Reimbursement

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant

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## Greater New York Hospital Association – Introduction

The Greater New York Hospital Association’s mission is to advocate, on behalf of its members and the communities they serve, for improved access to high-quality, cost-efficient healthcare and for the tools and resources to provide it. The GNYHA works to support the sound management of healthcare resources and to defend the hospital industry. Providing feedback to the Office of Health Insurance Programs were Zeynep Sumer and Elizabeth R. Wynn.

### Collaboration

The Greater New York Hospital Association noted for the New York State Office for Health Insurance Programs (OHIP) the breadth and depth of past and current work from the Office for Health Information Technology and Transfer (OHITT), the Regional Health Information Organizations (RHIOs), and the New York eHealth Collaborative (NYeC).

*“We estimate about 59% of New York State’s hospitals are participating in a RHIO. But of that 59%, 77% report they’re not actively exchanging data. So, there’s a lot of work to be done.”*

*Zeynep Sumer*

The pace of work from these and other groups has left member hospitals in the GNYHA serving multiple masters, as each funding opportunity or local or regional Health Information Technology (HIT) effort has slightly different expectations, standards or policies. Ms. Sumer encouraged OHIP to continue to find collaboration among

the HIT groups in New York State.

### Meaningful Use and the Certificate of Need (CON) Process

Among the proposals from the Center for Medicaid and Medicare Services (CMS) is the notion of linking meaningful measures among hospitals with the Certificate of Need process. Hospitals are already purchasing and implementing Electronic Health Records (EHR) technologies that meet certification standards, and the systems are comprehensive. The solutions accomplish far more than simple point-to-point data transfer. Further, the CON process front loads activities and responsibilities typically accomplished throughout an

implementation or transition phase. For example, the CON process requires hospitals to be a member of a RHIO, but if the hospital has yet to implement EHR, there is no real reason to join a RHIO while the hospital is ramping up and building capacity. As Ms. Sumer said, “We estimate about 59% of New York State's hospitals are participating in RHIO. But of that 59%, 77% report they're not actively exchanging data. So, there's a lot of work to be done.”

The GNYHA and its members agree that current meaningful use measures, as suggested by CMS, are too aggressive and beyond the capacity of the industry to meet within current time frames. Instead, the GNYHA proposes a flexible approach, one in which CMS identifies a full set of meaningful use, and then hospitals agree to a schedule based on individual capacity and special circumstances. Fundamentally, the schedule does not change. The metrics don't change; the end result is the same, but by giving hospitals a “cherry picking option,” implementation is less strained and smoother.

## Capital Funding

Upfront investment in EHR solutions is not insignificant for hospitals. Easily, \$10 to \$20 million is required simply to get started. However, the incentive payment program operates as reimbursement; hospitals must purchase a system before being eligible for funding. The GNYHA encourages OHIP to continue to work with CMS and others at the federal level on additional funding that would help under write or off set a hospital's initial investment.

*“In our discussions with both House and Senate staff, we do believe that the original intent was to recognize individual campuses, and not to disadvantage any one provider relative to the other.”*

*Elizabeth Wynn*

## Payment Processes

The GNYHA requests that CMS and others make allowances regarding payment to hospitals with multiple campuses. This contradiction between Medicaid ID and Medicaid provider number is confusing. The GNYHA recommends that incentive payments be campus-specific.

Further, the GNYHA recommends that OHIP work with CMS on similarly flexible payment processes that allow hospitals to take full advantage of the funding streams while maintaining momentum in meaningful use.

## Educational Support

Ms. Sumer and Ms. Wynn recommended to OHIP that one counter to the current confusion and other unknowns regarding the incentive payment program is a series of educational forums and ongoing support. “It may make sense to have certain pieces of HIT education occur in a group setting,” said Ms. Sumer. “Perhaps just a discussion of tools, vendor contracting, and the like. Our members would certainly welcome that.”





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**Healthcare Association  
of New York State (HANYS)**



## Introduction

The American Recovery and Reinvestment Act (ARRA) signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document is an abridged version of a letter (dated March 12, 2010) from the Healthcare Association of New York State (HANYs) to CMS. This document represents the sum and substance of HANYs remarks regarding the Provider Incentive Payment Program. The letter was signed by HANYs President Daniel Sisto and represents recommendations from HANYs' HIT Strategy Group. Additional information is included from a letter (dated August 16, 2010) from HANYs to David Whitlinger, Executive Director of the New York eHealth Collaborative regarding regional health information exchanges.



## HANYS – Background



### Healthcare Association of New York State

The Healthcare Association of New York State (HANYS) is the only statewide hospital and continuing care association in New York State, representing more than 550 non-profit and public hospitals, nursing homes, home care agencies, and other health care organizations.

HANYS' comments focus on the following issues pertaining to the Medicare and Medicaid EHR Incentive Program NPRM:

- Providing flexibility in the framework of meaningful use;
- Delaying automated reporting of quality measures to federal fiscal year (FFY) 2013, and other quality reporting recommendations;
- Broadening the definitions of hospitals and physicians eligible for the Medicare and Medicaid EHR incentive program so that:
  - Multi-campus hospitals sharing a single Medicare provider number are eligible as individual institutions;
  - CAHs with a Medicaid volume of 10% or more are eligible for the Medicaid incentive program; and
  - Physicians delivering at least 10% of their services as ambulatory visits are considered eligible for the incentive program, even if that care takes place in a hospital-affiliated clinic or outpatient department;
- Addressing technical payment issues to ensure maximum effectiveness of ARRA capital investment in EHR technology; and
- Ensuring Medicaid hit incentive program requirements mirror those for the Medicare program.

## Flexibility Must Characterize the Framework of Meaningful Use

HANYS believe the approach of increasing requirements over time has merit, as do most of the specific requirements themselves. The proposed meaningful use framework would, however, set the all-or-nothing bar unreasonably high. The impractical approach fails to recognize the important work hospitals are doing now to use EHR systems to improve the quality of patient care. Currently, New York hospital EHRs with functionalities less numerous than, or different from, those spelled out in the proposed rule are yielding significant improvements in the delivery of patient care—improvements that are meaningful for patients.

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As HANYS and HANYS' HIT Strategy Group commented to the National Coordinator for Health Information Technology, David Blumenthal, M.D., regarding the HIT Policy Committee's draft definition of meaningful use released last June:

*Meaningful use should not have to be achieved by following only one, linear pathway. Hospitals will come into the road of adopting EHR technology from many onramps. Allowing flexibility in the design of the varied phases of meaningful use would enable hospitals to best meet the needs of their patient populations and their institutional quality goals. To ensure quality improvement, there needs to be cohesiveness and harmony among the different EHR functionalities hospitals implement. Ultimately, it is for the patient that EHR adoption and use should be "meaningful."*

## **Hospital EHR Adoption Strategy Generally Requires Gradual System Installation**

Flexibility in meeting the proposed requirements of meaningful use is necessary. CMS' rigid framework for achieving meaningful use, where all EHR functionality and quality reporting criteria must be met before a hospital could qualify for the incentive program, belies the reality of how New York hospitals procure, install, and use EHR systems. In general, hospitals in New York State tend to put in place EHR systems in a manner that is gradual, fitting the quality improvement goals of the institution within an environment of limited financial resources.

## **The Nascent State of EHR Adoption in New York Hospitals**

Flexibility is needed in CMS' final rule establishing the meaningful use requirements for the practical reason that the distance from current level of EHR adoption in New York hospitals to meeting all proposed EHR functionality and quality measurement requirements is far too great to be considered reasonably achievable within the tight timeframe prescribed by ARRA.

## **EHR Vendors Need Time to Improve Products, Train Staff, Gear Up for Hospital Installations**

Flexibility in meeting the proposed meaningful use requirements is also critical because the vendor marketplace is ill-prepared to meet the EHR functionality and quality reporting requirements put forward in the proposed rule. There is not a single vendor in the country whose products are currently able to meet the EHR requirements set out in the proposal. Vendors and providers do not yet know

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which will be the certifying body for EHR systems or what will be the full certification process to be spelled out by the Office of the National Coordinator.

In New York State, 34% of hospitals report a lack of adequate IT staff as a major barrier to EHR adoption.

An academic medical center in New York has just begun the process of installing inpatient EHR systems developed by a well-regarded vendor. The hospital reports the vendor's informatics staff as being inexperienced. This may speak to the challenges vendors have in hiring informatics staff with a depth of knowledge and skill.

## **The Short ARRA Timeline; Providers Will be Racing to Avoid Deep Medicare Cuts**

It is reasonable to expect that as demand for vendor products and services increase pursuant to the passage of ARRA, system installation time and challenges will likely grow.

## **We Endorse AHA's Alternative Approach to Defining and Achieving Meaningful Use**

The AHA alternative limits the number of objectives that must be met in each successive period, building up to a system that meets 34 clinical care objectives by the time incentive payments are no longer available, which is 2017.

This alternative is built on a belief that, to be successful in achieving an e-enabled health care system that promotes good health and excellent health care, the EHR incentive programs must be:

- Flexible enough to support organization-specific HIT implementation strategies that build on strategic quality improvement goals, capital investment planning, careful approaches to positive work process change, and staff and physician readiness;
  - Incremental, to follow the HIT adoption process;
  - Focused on objectives that promote improved patient safety and quality, according to evidence; and
  - Achievable, even by those who are furthest behind today.
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## **1. Establish the Full Scope of Meaningful Use Objectives Up Front**

While the list of objectives required would remain relatively unchanged over the coming years, the scope of their use should accelerate, so that:

- levels of use increase over time (such as increased use of CPOE);
- use of structured data increases over time; and
- information exchange increases over time.

## **2. Lengthen the Timeframe for Achieving the Ultimate Vision for Meaningful Use**

To support incremental adoption, the goal line for meeting full meaningful use should be extended to 2017 and encompass four phases of increased functionality and use (2011-2012, 2013-2014, 2015-2016, and 2017).

## **3. Take a Phased, Flexible Approach to Defining Meaningful Use**

CMS should take a phased approach where hospitals can be considered meaningful users by meeting fewer requirements in the early years of the program, but building toward achieving the full set of meaningful use objectives over time. We recommend the following path:

- FFYs 2011-2012—Meet at least 25% of the objectives
- FFYs 2013-2014—Meet at least 50% of the objectives
- FFYs 2015-2016—Meet at least 75% of the objectives
- FFY 2017—Meet substantially all of the objectives

For small hospitals with fewer than 100 beds—one-fifth of New York State hospitals—that face special challenges in HIT adoption in addition to the omnipresent challenges hospitals throughout New York face accessing capital, we recommend that the share of objectives be lower in the first three stages:

- FFYs 2011-2012—Meet at least 15% of the objectives
  - FFYs 2013-2014—Meet at least 30% of the objectives
  - FFYs 2015-2016—Meet at least 60% of the objectives
  - FFY 2017—Meet substantially all of the objectives
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#### **4. Establish a Meaningful Use Technical Expert Panel**

CMS should establish a Meaningful Use Technical Expert Panel with significant representation from hospitals and eligible professionals at various stages of implementation.

#### **Our Recommendation: Flexibility Needed in the Meaningful Use Framework**

We strongly urge CMS to adopt the AHA alternative approach. ARRA gives the Secretary of Health and Human Services (HHS) authority to define meaningful use. Therefore, CMS has the authority to adopt alternative timeframes and requirements that more closely match a realistic implementation timeline.

#### **Delaying Automated Reporting of Quality Measures to FFY 2013 and Other Meaningful Use Quality Reporting Recommendations**

HANYS and HANYS' HIT Strategy Group believe it is critical that the implementation of any quality reporting requirements for hospitals, whether through VBP or EHRs, rely on fully vetted and consensus-based quality measures.

#### **Our Recommendation: Delay Automated Reporting of Quality Measures to FFY 2013 and Other Meaningful Use Quality Reporting Recommendations**

We strongly urge clinical quality measure reporting through EHRs be delayed until at least FFY 2013 so that the measures to be collected can be re-specified, tested, and implemented.

In addition, we endorse AHA's other recommendations relative to the clinical quality measures proposed for the HIT incentive program including:

- Only measures chosen for use in the Medicare pay-for-reporting program should be considered for implementation in the EHR incentives program;
- Measures should be selected for their potential to advance patient care and with the consultation of quality reporting stakeholders, namely NQF and HQA;
- Measures selected for the EHR incentive programs should be comprehensively tested in the field to ensure that they are thoroughly specified, clinically valid when the data are collected through an EHR system, and feasible to collect; and



- Measures should be phased in over time in clinically-related measure sets to allow for a smooth transition.

## **Allow Hospitals that Share Medicare Provider Numbers to Participate in the HIT Incentive Program**

Background: ARRA defines hospitals eligible for the HIT incentive program as “subsection (d)” hospitals. Current law defines subsection (d) hospitals as general, acute care, short-term hospitals. ARRA’s use of the term subsection (d) provides CMS with much flexibility as to how to identify hospitals eligible for the HIT incentive program.

CMS’ Proposal: CMS has proposed to provide incentive payments to hospitals as distinguished by provider number on the cost report. Therefore, incentive payments for eligible hospitals would be calculated based on the provider number used for cost reporting purposes, which is the CMS certification number (CCN) of the main provider.

## **Our Recommendation: Ensure All Hospitals Are Eligible for the Incentive Program**

We recommend CMS use an alternative to the Medicare provider number to identify hospitals eligible for the HIT incentive program that would appropriately allow the flow of federal stimulus funding in the form of separate HIT incentives to individual hospitals of multi-campus hospital systems.

- A distinct Medicare provider number;
- A distinct emergency department; or
- A distinct state hospital license.

## **Allow Physicians to Appropriately Be Considered Eligible Professionals to Participate in the HIT Incentive Program**

CMS has proposed to define hospital-based eligible professionals (for both Medicare and Medicaid purposes) as those who furnish at least 90% of their services in an inpatient hospital, outpatient hospital, or emergency department setting.



## **Our Recommendation: Allow Physicians Who Primarily Deliver Care in Hospital Affiliated Outpatient Clinics to Be Eligible for the Incentive Program**

In addition to the above recommendation, HANYS also endorses AHA's additional recommendations related to eligible professionals including the importance for CMS to:

- Make hospital-based determinations and notify professionals of their status before the start of the payment year;
- Give professionals the opportunity to review determinations and challenge those they believe are in error; and
- Allow professionals the right to petition for a change in their hospital-based status when there is a material change in their organizational affiliation.

## **Allow CAHs to be Eligible for the Medicaid HIT Incentive Payments**

CMS has proposed to define an acute-care hospital eligible for the Medicaid EHR incentive payments as a health care facility where the average length of patient stay is 25 days or fewer, and that has a Medicare CCN that has the last four digits in the series 0001 through 0879. CMS' interpretation of hospitals eligible for the Medicaid EHR incentive program excludes CAHs because all CAHs have a Medicare CCN with the last four digits in the series 1300 through 1399—a range of Medicare CCNs that would not be eligible for Medicaid incentives as proposed by CMS.

HANYS believes CAHs should be eligible for both the Medicare and Medicaid Incentive Programs.

## **Technical Payment and Operational Issues**

CMS' proposed rule to implement the Medicare and Medicaid HIT incentive program for hospitals includes many technical and operational payment issues. HANYS below offers recommendations on these technical issues for which HANYS either recommends CMS use an alternative approach or seeks clarification. If not addressed, these technical issues could cause significant problems with implementation of the HIT incentive program and could slow access to HIT incentive payments for hospitals that are able to qualify as meaningful users.

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## **Effect of the Medicaid HIT Incentive Payments on the Medicaid UPL Cap and Medicaid DSH Cap Limits**

The CMS proposal does not address the relationship of Medicaid HIT incentive payments to states' upper payment limit (UPL) calculations or to Medicaid Disproportionate Share Hospital (DSH) payment limits.

To avoid unintended consequences that could offset the value of Medicaid HIT incentive payments by causing reductions in other Medicaid funding mechanisms, we urge CMS to consider Medicaid incentives as separate and apart from other Medicaid program payments for patient care and specify that they will not be included in any calculation of total Medicaid payments for the purpose of determining Medicaid shortfalls, DSH payments, UPLs, or any general Medicaid program service.

## **Ensuring the Medicare HIT Incentives are Paid as Lump Sum Payments to Qualifying Hospitals**

CMS has proposed to require fiscal intermediaries (FIs)/Medicare Administrative Contractors (MACs) to distribute on an "interim basis" the Medicare HIT incentive payments to hospitals that have qualified as meaningful users of HIT.

We, along with AHA, urge CMS to clarify that the Medicare HIT incentive payments the FIs/MACs will distribute to qualifying meaningful users of HIT will be lump sum payments. Providing the Medicare HIT incentive payments in the form of a lump sum is especially important for hospitals and CAHs that are currently installing or upgrading systems to project the value of the HIT incentives and opportunities to obtain future lending.

## **Ensuring the Timeliness of the Medicare HIT Incentive Payments**

In the proposed rule, CMS does not set forth a timeframe in which a hospital or CAH can expect to receive the Medicare HIT incentive payments once the FI/MAC has all the supporting documentation that demonstrate a hospital is a meaningful user of HIT.

We join AHA in asking CMS to be consistent by making incentive payments within the same timeframes as incentive bonus payments.

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## **Cost Report Period**

CMS has proposed to estimate a hospital's Medicare HIT incentive discharge-related amount based on cost report data using a hospital's discharges from the hospital fiscal year (FY) that ends during the FY prior to the HIT incentive payment year. A hospital's final Medicare HIT incentive discharge-related amount would be determined and settled based on its cost report from the FY that ends during the HIT incentive payment year.

We join AHA in urging CMS to estimate a hospital's discharge-related amount based on its most recently filed cost report, and not based on the cost report that ends during the FY prior to the payment year.

## **Calculation of the Charity Care Ratio to Adjust the Medicare Share**

ARRA provides for an adjustment to the HIT incentive payment calculation to exclude charges related to charity care in determining the denominator of the Medicare and Medicaid share fraction. This adjustment has the effect of increasing a qualifying hospital's or CAH's incentive payments. To implement this provision, CMS has proposed to use data to be submitted on the revised and yet-to-be-released cost report worksheet on Hospital Uncompensated Care (Worksheet S-10).

HANYS is concerned that hospitals with cost reporting periods beginning on January 1, 2010 will not have the opportunity to report charity care data for the first year of the HIT incentive program. Specifically, New York State cost reports ending in FFY 2011 (October 1, 2010 through September 30, 2011), which CMS proposes to use to determine the final discharge-related amount for FFY 2011 incentive payments, would run from January 1, 2010 through December 31, 2010. We strongly urge CMS to make changes to Worksheet S-10 retroactive to cost reports beginning on or after October 1, 2009 to remedy the timing of the HIT incentive payments and reporting of charity care charges.

## **State Flexibility for Calculation of the Medicaid Patient Volume Threshold**

Under ARRA, Medicaid HIT incentives are available to qualifying hospitals that are acute care hospitals with at least 10% of volume attributable to Medicaid patients.

We join AHA in thanking CMS for allowing the states flexibility for calculation of the hospital 10% Medicaid patient volume threshold and we urge CMS to

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provide states with the maximum flexibility allowed to determine the Medicaid patient volume threshold.

## **Reconciliation of Medicare HIT Incentive Payments for CAHs**

Under ARRA, CAH Medicare HIT incentive payments will equal the Medicare share of their reasonable costs incurred for the purchase of certified EHR technology. CAHs will be paid through an interim payment subject to reconciliation.

We support AHA's recommendation urging CMS to promptly issue an interim final rule on the Medicare cost report that would include proposed changes to allow CAHs to appropriately report and capture EHR costs for the purposes of the Medicare HIT incentive payments.

## **Medicare Appeals Process**

CMS is proposing that state agencies develop an appeal process in which Medicaid providers will have the ability to appeal various state determinations and decisions in regards to EHR incentive payments.

We join AHA in urging CMS to implement a Medicare appeal process similar to its proposal of the state Medicaid appeals process under 495.370.



## **Retention Period**

CMS has proposed that qualifying hospitals must maintain evidence of qualification of the HIT incentive payments for ten years after the date they register for the incentive program.

We join AHA in urging CMS modify the retention period for evidence of qualification to receive incentive payments to five years, which is consistent with other retention requirements.

## **Medicaid HIT Incentive Program**

We are recommending to OHITT and OHIP the same priorities we have included below in these comments to CMS. We urge CMS to require a framework for the Medicaid HIT Incentive Program that will:

- Provide the maximum allowable Medicaid incentive payment up front; and
- Require **no** additional meaningful use requirements beyond what CMS determines, and accept the federal determination of a hospital's attestation of meaningful use as sufficient for Medicaid meaningful use determination.

## **Require States to Provide the Maximum Allowable Medicaid Incentive Payment Up Front**

As required by ARRA, CMS' proposed rule allows states the flexibility to push HIT federal stimulus funding to hospitals early in the program, but does not require states to do so.

We join AHA in urging CMS to require states to pay hospitals the maximum incentive payments possible in their first two payment years—that is, 50% of the hospital's aggregate incentive payment in the first year and another 40% in the second year.

## **Require NO Additional Meaningful Use Requirements Beyond What CMS Determines**

CMS has proposed to create a definition of meaningful use for the Medicare HIT incentive program that would also serve as the minimum standard for the Medicaid program.

We join AHA in commending CMS for its efforts to ensure consistency in the EHR incentive program across Medicare and Medicaid. The requirements under

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the proposed rule are complex and will be extremely challenging for hospitals to meet, particularly under the suggested timelines. We join AHA in urging CMS to implement a common definition of meaningful use for the Medicare and Medicaid HIT incentive programs and NOT approve any additional state criteria.

## **The Need for Flexibility in the Design of Regional HIE Infrastructure**

Since its inception, NYeC, in conjunction with OHITT and with the support and investment of the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY), has led the development of numerous regional HIEs and governance bodies throughout New York State. These Regional Health Information Organizations (RHIOs) and Community Health Information Technology Adoption collaboratives (CHITAs) are thus far considered the technological underpinnings of the developing Statewide Health Information Network for New York (SHIN-NY). Many hospitals and health systems in New York are participants in their community RHIOs and CHITAs, enabling improvements in the delivery of patient care.

RHIOs and CHITAs have suited many communities in New York well. In other communities, HIT stakeholders are looking to newer models of regional HIE infrastructure to enable the exchange of electronic health data and connectivity to SHIN-NY. These models include Health Information Organizations, which may be built by hospitals to support the coordination of patient care among community providers. We believe that ensuring flexibility in the way in which a community builds its HIE infrastructure so that it is sustainable and intuitive to the community's providers, patients, and other stakeholders will, in the long run, build the strongest foundation for SHIN-NY. We strongly encourage NYeC to adopt a position of flexibility in the design of the regional HIE infrastructure that facilitates connectivity to SHIN-NY.

## **Conclusion**

- HANYS' member hospitals throughout New York State are encouraged by the prospect of achieving meaningful use status and thereby benefitting from the rewards of Medicare and Medicaid EHR incentive payments. The lack of access to capital, endemic in New York State, particularly during this time of economic recession, is the heaviest encumbrance hospitals bear to achieving greater levels of HIT adoption.
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**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**HEALTHeLINK**

May 7, 2010 | 2:15 - 2:45 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from HEALTHeLINK™. HEALTHeLINK™ is collaboration among physician, hospital, and insurance organizations to share clinical information in efficient and meaningful ways to improve the delivery of care, enhance clinical outcomes, and control healthcare costs throughout the Western New York region.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **HEALTHeLINK™**

Daniel Porreca, Executive Director

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant

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## HEALTHeLINK™ – An Overview



HEALTHeLINK™ is a collaboration among physician, hospital, and insurance organizations to share clinical information in efficient and meaningful ways to improve the delivery of care, enhance clinical outcomes, and control healthcare costs throughout the Western New York region. HEALTHeLINK™ is a not-for-profit organization. HEALTHeLINK™ supports and is working toward the vision of creating community-based virtual medical records and other clinical applications. Achieving that vision means:

- Medical professionals will have access to information they need to treat quickly and safely
- Duplicate tests and procedures will be avoided
- Medical information can speak for a patient in an emergency
- Quality, safety, and efficiency will help control healthcare costs

The following are comments from Mr. Daniel Porreca, Executive Director of HEALTHeLINK™, in response to the New York State Department of Health Office of Health Insurance Programs (NYS DOH OHIP) presentation regarding the Medicaid Incentive Payment System.

### Leveraging Investments

“I appreciate the opportunity to provide feedback. We need to leverage all the investments made to date by New York State and the local community stakeholders from both a policy and technology perspective in RHIOs. RHIOs have developed a significant relationship with the providers in their communities, and it's important in ensuring physicians' understanding and leverage the services available to them in order to meet the overall objectives of these funding opportunities. To date, there's been close to \$50 million invested in Western New York on administrative and clinical data exchanges, not counting the recent Beacon Award. I believe we need to leverage that investment to the maximum and take advantage of what has already been accomplished. I also believe we should leverage the RHIOs for authentication services, for providers in their communities, as RHIOs have that ability to get that last mile, right into the physician office.”



## Medicaid's Involvement

“The health plans in Western New York have been a key partner in making investments in both administrative and clinical exchanges. They recognize that these efforts will help the community by both improving quality and lowering cost. Both of which are good for their businesses. I encourage Medicaid to join the collaboration. In other communities, health plans are not as committed to the health information technology efforts, and to the extent Medicaid can impress and influence participation with those reluctant to participate, it would provide a tremendous boost.”

## Coordination with Regional Extension Centers

“I strongly suggest dollars being invested through Medicaid by the Office of the National Coordinator (ONC) Health Information Exchange (HIE) supplement the Regional Expansion Center dollars, thereby maximizing the opportunity for provider practices.”

## Medicaid Certified / Data Models

“Among the statewide strategies being considered is the notion of certifying RHIOs as Medicaid Service Bureaus. Following a credentialing process outlined and prescribed by the New York State Commissioner of Health, RHIOs could position their strategies as an overall component of the Medicaid landscape. HEALTHeLINK™ welcomes this approach and suggests that among their strongest value is their knowledge of local providers, local hospitals, and local payers.”

“Among the various data models and data sharing constructs, HEALTHeLINK's hybrid federated model provides quick access to patient information and flexibility in maintenance. Currently, HEALTHeLINK™ has 1.7 million results and reports being added monthly, with more than 28 million total reports to date.”





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**Medical Society of the  
State of New York**

June 16, 2010 | 9:30 - 11 a.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the Medical Society of the State of New York (MSSNY). MSSNY is an organization of approximately 30,000 licensed physicians, medical residents, and medical students in New York State.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **Medical Society of the State of New York**

Eileen Clinton, Education Specialist and Project Coordinator  
Elizabeth Dears-Kent, Vice President for Legislative and Regulatory Affairs  
Igor Kraev, MD, Ellis Hospital Medical Director Informatics  
John Maese, MD, Private Practitioner  
Regina McNally, MSSNY Staff  
Ron Pucherelli, HIT Project Coordinator  
Zebulon Taintor, MSSNY Volunteer

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant  
Kevin Owens, Consultant

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The Medical Society of the State of New York (MSSNY) is an organization of approximately 30,000 licensed physicians, medical residents, and medical students in New York State. MSSNY is a non-profit organization committed to representing the medical profession and advocating health-related rights, responsibilities and issues. MSSNY strives to promote and maintain high standards in medical education and in the practice of medicine in an effort to ensure that quality medical care is publicly available.

### Medicaid Threshold a Hurdle

MSSNY encourages the New York State Department of Health, Office of Health Insurance Programs (OHIP) to revisit with the Center for Medicare and Medicaid Services (CMS) the currently proposed 30% threshold to receive Medicaid monies. As pointed out by MSSNY, New York State physicians, until recently, received among the lowest Medicaid reimbursement rates in the country. These low rates pushed more physicians away from Medicaid; and so the available pool of physicians who have a 30% Medicaid patient load and can qualify for the provider incentive programs under Medicaid is very low.

*“Physicians would benefit greatly from additional outreach efforts like seminars, webinars, conferences and the like.”*

*Elizabeth Dears-Kent*

### Outreach/Education is Critical

As Elizabeth Dears-Kent said, “Physicians would benefit greatly from additional outreach efforts like seminars, webinars, conferences and the like. There are many moving parts to the incentive program, and more and continued information can only have a positive impact.” With OHIP assistance and support, MSSNY would like to provide educational programs to physicians. Continuing education for physicians and other providers is similarly critical. “Doctors train to be doctors,” commented Dr. Igor Kraev, “They do not train to be chief technology officers.” MSSNY encouraged OHIP to consider a long-range and comprehensive outreach and education program for providers regarding the use of and issues surrounding Electronic Health Records (EHR).

## EHR's Impact on a Medical Practice

MSSNY provided feedback based on first-hand experience with EHR and the unforeseen impact it can have on a medical practice. First, installation is burdensome. It can cost more than \$225 simply to establish a connection between a computer and server. Installing and maintaining an EHR network is not like other office systems. Vigorous security, constant upgrading, reliable backup, and business continuity, these and other responsibilities require physicians and their staff to entirely rethink office operations.

MSSNY believes physicians will require more time than most speculate to reach a comfort level regarding technology adoption and integration. Consequently, MSSNY supports a delay in the penalties associated with this program.

*“Doctors train to be doctors. They do not train to be chief technology officers.”*

*Igor Kraev, MD*

The current wave of EHR activity has vendors scrambling to meet demand. They simply do not have enough players to put on the field. Smaller practices or clinics where the EHR profit margin is slim are overstepped in favor of larger facilities such as hospitals and large established medical practices. As Dr. John Maese said, “Even if a practice has the funds and logistics to install a system, it’s tough finding someone to do it.”

## Outside In

Dr. Kraev supports a “public system” approach to EHR implementation. Rather than several independent systems that seek interoperability, a generic approach where physicians “buy-in” would offer advantages. Similar to subscribing to cable television or public water, an EHR public infrastructure could be built as a similar model. Dr. Kraev put it this way, “The goal of a physician is to practice medicine, not to build an EHR infrastructure.”\*

## Consistency in Meaningful Use

MSSNY wants to ensure consistency in meaningful use. Whatever ultimately become the criteria, MSSNY believes Medicaid and Medicare should adopt the same

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standards with regard to functionality for meaningful use and for the specific requirements of the CCD or CCR. Further, physicians who are early adopters of EHR should not be penalized if their particular system is later found noncompliant with various meaningful use criteria. Physicians could become disenchanted with the program, for this reason MSSNY restates its position for delaying any penalties associated with non-adoption.

MSSNY agrees with the OHITT that the current incentive payment program is a moving target with many many details to be defined. Currently, MSSNY finds the incentive payment system a little confusing and chaotic.

### Smaller Practices Need Special Attention

MSSNY is concerned that sole practitioners or others in similarly small practices could be overlooked in favor of larger practices or hospitals. “We really need to make sure that we acknowledge the small practice and their challenges and make things simple enough that a small practice can implement,” said John Maese, MD. “That's really where care is delivered in New York State.” Further, MSSNY encourages and supports EHR compliance that is in concert and harmony with New York State’s eMedNY program.

### Coordinate Education

MSSNY encourages New York State to partner with stakeholders, such as MSSNY, to avoid redundancy in educational programs. Information should fill gaps, compiling a full spectrum of education. A range of challenges regarding technology need to be addressed. History suggests that when education is provided it is concentrated on one particular area, neglecting others. MSSNY represents doctors in all medical specialties, making it an important partner.

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\* This quote is attributed to Dr. Kraev and does not represent the opinion of MSSNY.



**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**The Nurse Practitioner  
Association New York State**

April 21, 2010 | 10 – 10:45 a.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from The Nurse Practitioner Association New York State (NPA). NPA is a membership organization dedicated to promoting quality healthcare through the empowerment of nurse practitioners and the profession.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **The Nurse Practitioner Association New York State**

Thomas Nicotera, MHHA, JD, Director of Membership and Public Affairs

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant  
Peter Poletto, Business Architect

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## The Nurse Practitioner Association New York State – Introduction

The Nurse Practitioner Association New York State (NPA) is a member organization dedicated to promoting high standards of healthcare delivery through the empowerment of nurse practitioners and the profession throughout New York State. The NPA was formed in 1980 and has grown steadily in membership and activity. Currently, the NPA has more than 2,700 members from nearly every county in New York State. Providing feedback to the New York State Department of Health, Office of Health Insurance Programs (OHIP), was Thomas Thomas Nicotera, MHHA, JD, Director of Membership and Public Affairs.

### Survey Results

In April 2010, the NPA distributed an electronic survey to its membership regarding Electronic Health Records (EHR) and related Health Information Technology (HIT) issues. More than 2,700 surveys were distributed, and 171 were returned. The benchmark question, as described by Mr. Nicotera, asked nurse practitioners (NP) if their practice had a 30% level of service to Medicaid members. Fifty-eight percent indicated that their practice did meet the 30% level of care required by the Center for Medicare and Medicaid Services in order to receive incentive payments. The majority of respondents indicated that among their needs regarding EHR were technical support, hardware and software upgrades, and similar technical assistance. Similarly, respondents indicated that over the next five years, education, training, and funding would comprise the bulk of their EHR implementation workload.

Among the other responses was that 82% of the respondents would be willing to take advantage of grant opportunities to implement EHR in their practice.

### Education and Information

Nurse practitioners provide care in a variety of settings, including free-standing clinics and hospitals. Among the outreach efforts by the NPA will be informing hospital-based NPs of the details of the incentive payment program.

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**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**New York State**

**Health Foundation**

April 8, 2010 | 12:45 - 1:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the New York State Health Foundation.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **New York State Health Foundation**

Deborah Zahn, MPH, Senior Policy Director, Diabetes Policy Center

### **New York State Technology Enterprise Corporation (Program Consultants)**

Peter Poletto, Business Architect

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The New York State Health Foundation (NYSHealth) is a private, statewide foundation that aims to improve New York's healthcare system by expanding health insurance coverage, containing healthcare costs, increasing access to high-quality services, and addressing public and community health.

## Reaching Out

The New York State Health Foundation has reached out to numerous organizations regarding Health Information Technology. They have had conversations with providers, the Academy of Physicians, payers, and others. NYSHealth reminded OHIP that technology is an ongoing process requiring regular updating and maintenance.

## A Patient-Centered Approach

Regarding meaningful use, NYSHealth encouraged OHIP to consider patient-centered measures that look at patient outcomes. NYSHealth's work with diabetes intervention is a good example of a patient-centered effort that tracks a great deal of information that ultimately improves the patient's life, while dramatically reducing costs.

Another benchmark offered up by NYSHealth was the patient-centered medical home model advocated by NCQA. Physicians receiving any kind of incentive payment are under a heavy reporting burden, often providing the same information over and over again to different agencies. By aligning efforts, this administrative burden can be lifted, and subsequently, more providers will come on line with the program.



## Funding

NYSHealth supports the notion of funding RHITECs with administrative funding and including training on the Wagner chronic disease model, as well as how to build a patient-centered medical home. As Deborah Zahn said, “There has to be some type of knowledge and skills enhancement and development relative to quality improvement.”





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**New York Chapter of the American  
College of Physicians**

**(NYACP)**

April 6, 2010 | 11:00 a.m. – 1:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the New York Chapter of the American College of Physicians (NYACP). The NYACP is a membership organization dedicated to advancing the specialty of Internal Medicine in New York State. Among the NYACP's primary functions is assisting members and patients through advocacy, education, networking, and communication. In attendance were:

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **New York Chapter of the American College of Physicians**

Louis Capponi, MD, Chapter Member and Practicing Internist  
Jennifer Keefer, M.D., 3<sup>rd</sup>-Year Resident - Internal Medicine  
Linda A. Lambert, CAE, Executive Director  
Babette M. Peach, Director of Advocacy and Communications

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant

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## New York Chapter of the American College of Physicians – Overview



The mission of the New York Chapter of the American College of Physicians (NYACP) is to advance the specialty of Internal Medicine in New York State by assisting members and patients through advocacy, education, networking, and communication. Among the goals of the NYACP is to:

- Advocate responsible positions on individual health and on public policy relating to health and on public policy relating to healthcare for the benefit of the public, our patients, the medical profession and our members;
- Serve the professional needs of the membership, support healthy lives, improve the practice environment for physicians, and advance internal medicine as a career;
- Promote and conduct research to enhance the quality of practice, the education and continuing education of internists, and the attractiveness of internal medicine to physicians and to the public;
- Recognize excellence and distinguished contributions to internal medicine; and
- Unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members, and our profession.

The following is a summary of statements regarding the Medicaid Incentive Payment System by Louis Capponi, MD.

### Comments

I've been a practicing general internist in the state for the past sixteen years, and a member of the college for my entire medical career. In addition to my current role as the co-chair of the Health Information Technology Steering Committee of the New York ACP, I've spent the last six years immersed in health information technology through my position as the chief medical informatics officer for the New York City Health and Hospitals Corporation. Through both of these activities I've become very familiar with health information technology.

The New York Chapter of the American College of Physicians represents twelve thousand internal medicine doctors in New York State. The chapter focuses on disseminating information and fostering discussing on scientific, economic, and social issues related to the practice of internal medicine. The chapter has a long history of advocating on behalf of physicians, and supporting excellence in patient

care. The college also has a long history of credibility with its members. They turn to us as the premier medical education resource, and value the guidance offered relating to advocacy and to social and economic issues in medicine. The New York chapter shares many goals with our parent organization, the American College of Physicians, including the promotion and conduct of research to enhance quality of practice, ongoing education of internists, and promotion of careers in internal medicine to physician trainees. The chapter recognizes excellence and distinguished contributions to internal medicine by individuals and organizations, and advocates for personal and public health practices to support wellness.

## New Challenges and Opportunities in Health Care

During the next decade, clinical medicine will experience a transformation on a scale not imaginable in previous history. Rapid advances in clinical genetics will impact care with the same order of magnitude that the introduction of antibiotics and immunizations did in the last millennium. The clinical decisions we make will be informed by the widespread availability of genotyping and high-dimensional genetic statistics. Such technologies will not only allow for better population-based screening efforts but will also enable a personalized approach to care, an approach based on the person's genome and epi-genome to direct therapeutic decisions. We will see the expansion of microbial cancer and other databases, which will allow more precise diagnoses and more targeted therapies. As these technologies develop, physicians will require information systems which are nimble enough to take advantage of this evolving field. Sophisticated terminology services will likely be

“More than ever, physicians will need real time, clinically relevant information, not only to improve safety, lower costs, and improve outcomes, but also to increase patient satisfaction.”

Louis Capponi, MD

necessary, as will access to external supercomputing resources, and complex decision-support schemas. The New York ACP wants our members to be ready for such innovations, and we strongly believe that health information technology is a prerequisite to leverage scientific advances of tomorrow.

In addition to the clinical imperatives, the revolution in healthcare will focus on patient choice and consumerism. More than ever, physicians will need real-time, clinically relevant information, not only to improve safety, lower costs, and improve outcomes, but also to increase patient satisfaction. We will need tools to interact with patients virtually, for simple issues, and be able to spend more time with patients face-to-face for complex ones. We'll need systems to support asynchronous communication for routine matters, and faster access for urgent ones. Basic office

functions, though necessary, are no longer adequate to sustain a practice in today's healthcare economy. Advanced functions are needed to automate simple activities, execute complex protocols, and monitor multistep processes through functionality known in other fields as business process management tools. Such tools examine new and existing data on a patient, or a population of patients, in real time, and can apply protocols over an extended period of time. As the patient's condition or status changes, a new rule or protocol can be activated with the aim of guiding care to the expected outcome. Workflow can be applied to clinical and nonclinical aspects of care. For example, a patient on an anti-psychotic might be expected to have a neurological check for side effects every six months. However, if the patient's exam is abnormal, a reassessment may be needed in an earlier period. If the patient has not been seen within the expected time frame, the workflow engine could alert a care coordinator to reach out to the patient and make sure he or she does not fall through the cracks.

We applaud and support the efforts of our state and the federal governments with regard to HIT. Notwithstanding this great potential, the New York ACP is also familiar with the huge challenges faced by physicians, especially those in small and

solo practices, during the early stage of technology adoption. And it is with this perspective that we submit our comments to CMS for the American Recovery and Reinvestment Act incentive program, and also appreciate the opportunity to speak with you and convey that perspective today.

“Once a practice gets comfortable with HIT, they rarely revert back to a paper process.”

Louis Capponi, MD

## Meaningful Use – More Time is Required

The New York Chapter of the American College of Physicians believes that the time frame for adoption of technology is unrealistic under this program. The final rule requires meaningful use by the last quarter of FY 2011, which is now just 18 months away. In order for a technology rollout to be successful, the bar should initially be set at a modest level. This approach will encourage adoption and provide the important positive initial experiences so vital to success. Once a practice gets comfortable with HIT, my experience is that they rarely revert back to a paper process. However, if the initial experience is too disruptive, it can result in a failed implementation, and the consequence of that is a lot of future resistance.

Successful HIT adoption requires adequate time for practices to redesign workflow and adjust to the new technology. At the same time, the practice must safely see as many patients as possible. Most physicians do not have the technology skills needed to electronically run their offices. Some do not even bill electronically themselves, let alone have the capacity to install and maintain the complex EHR system. Even with

stimulus dollars, practices with limited financial and technology resources will not be able to undergo an abrupt transition. Physicians deliver care on a daily basis, and along with nurses are the ultimate and principal users of technology in healthcare. Our membership ranges from the solo practice to a large multi-specialty group. And physicians are in a unique position to provide and comment and provide direction. We seek to create the best environment and to maximize adoption of health information technology to deliver the highest quality of care. Yet, if implementation of meaningful use proceeds at the pace currently envisioned, there will not be time to benefit from such experience and participation, and physician satisfaction and adoption, and the overall impact of the implementations, will suffer.

### Small Practices – Bigger Challenges

It's important to recognize that in small practices, the physician is also in essence the chief technology officer. If the transition to meaningful use is too demanding, many physicians will choose not to adopt technology, or may consider early retirement, unfortunately exacerbating the shortage of physicians, particularly in primary care. To complicate matters we believe that the vendor community lacks the human capital necessary to respond to the increased demand for software and hardware

“... in small practices the physician is also in essence the chief technology officer.”

Louis Capponi, MD

installation. The low supply of skilled technicians and other workers is having an unintended consequence already being felt by physicians, in the form of

competition for vendor attention. We believe increased demand will provide an economic opportunity for vendors in the face of limited supply. Larger practices will have greater response from vendors, and the least profitable small practices will be the last on the vendor's list to implement, and the least likely to get to meaningful use in time. We strongly support and are encouraged with the efforts of NYeC, the PCIP and the P Collaborative and others, who can play an important role in implementation, and particularly if those programs don't burden practices with additional conditions of participation beyond those of meaningful use.

The New York ACP believes that setting compliance thresholds is not reasonable or necessary. And a number of the measures require some manual activity in order to submit the meaningful use measure that's articulated, at least in the current rule. For example, one of the measures requires the physicians to be commenting or reporting on their electronic prescribing percentage rate. But in order to do that, you have to manually count manual prescriptions. And so the burden is on the practice to actually have a separate process to track a denominator in a setting where we're

really trying to encourage electronic transition and electronic reporting. So, we think that those additional burdens on the providers will actually become impediments to adoption. We want to avoid those types of indicators, both as they relate to the meaningful-use criteria and as they relate to quality metrics. Practices should not have the burden of tracking the denominators manually, or tracking any indicators manually. Instead, the indicators should be chosen which are completely electronic and can be generated without any additional efforts.

Conceptually, meaningful use is an electronic version of the principals of the patient-centered medical home. Physicians know from experiences with those practices which have transitioned to the medical-home model, that it is an expensive, labor-intensive, and complex transformation, and beyond the reach of most practices without appropriate funding of extra services. Given the already poor reimbursement for primary care, appropriate funding is essential to sustain those efforts. The improvements in quality care that all stakeholders seek to achieve for patients will only occur when we reach critical mass with as many physicians and hospitals as possible on line. When groups of physicians are dissuaded by standards that are too difficult to achieve, society misses out on the opportunity to improve care. Facilitating maximum participation by all practicing physicians will only strengthen success.

“When groups of physicians are dissuaded by standards that are too difficult to achieve, society misses out on the opportunity to improve care.”

Louis Capponi, MD

## The Medicaid Gambit

While the ARRA program includes Medicaid patients, there remain significant financial burdens and barriers to most practices in New York State that care for Medicaid populations. We applaud the efforts of the state to provide enhanced Medicaid reimbursement under the patient-centered medical homes model, and in other initiatives for diabetes and asthma care. However, the gap between Medicaid and other payers remains high, with New York State having ranked forty-seventh lowest among all states with regard to Medicaid fee-for-service payments in the past. Within the last two years the state has committed additional resources to invest in Medicaid fee-for-service rate increases. But those investments have only gotten primary care fees to approximately sixty percent of the Medicaid fees. There will be

another three-year gap until the federal requirement for states to pay a hundred percent of Medicare rates kicks in, long after the ARRA incentive program became available. Medicaid patients continue to be in need of additional primary care and access.

Certainly, ARRA incentives for Medicaid providers are attractive. However, the threshold for qualifying under Medicaid requires that thirty percent of the total practice is Medicaid. That level is too high in New York State, because of its historic underpayment of Medicaid fees. Only eleven percent of New York State physicians would meet this threshold, and therefore, only a small percentage may be able to get funding through this program under Medicaid. The New York Chapter of the American College of Physicians believes that some of the meaningful-use criteria proposed by CMS will not result in significant care improvements.

### Standardization is Key

“NYACP recommends to CMS that certification require EMR vendors to provide standard interconnectivity interfaces as part of the basic package, once those are defined.”

Louis Capponi, MD

Electronic copies of records for patients, as currently defined in the proposed rule, require that physicians give a copy of the patient's medical record electronically on request. The intent of this requirement is noble; however, we are very concerned that in the absence of a standard for distribution, and a lack of standard security protocol, such an electronic and portable copy may not be usable as intended. The record might not function

properly, or in the future be compatible with other systems. For example, a patient with a new cardiac stent may be discharged today with an electronic copy of their hospitalization on a USB drive. The patient carries it with them for three years. One day she visits an ER with chest pain. If the USB drive was supplied before standards are set, and it is not backwards compatible, the patient will have held the belief that they had an accessible file when, in fact, they do not.

For security purposes, in some hospitals the USB ports are locked down so as to prevent personal health information from leaving the hospital. Consequently, such a practice also prevents the information from being uploaded for review. We recommend deferring implementation of the electronic or portable copy of the patient's records until standards for portable patient records are defined and implemented.



The challenge is that vendors will attempt to connect with those PHRs in a variety of ways. Some of those providers will be correct, and some of those vendors will be correct, and some of them will not. Once the standards are applied, those who are not will have to switch. And that is a concern as well.

With regard to medication reconciliation, the industry continues to struggle to identify the best practice in medication reconciliation. Absent a best practice, we believe it's premature and counterproductive to hard-wire such a complex process, without knowing the best approach and the impact of the process on patient care and outcomes. We urge CMS to remove this requirement for eligibility, and recommend that funding be identified to study medication reconciliation, and also to identify best practices to follow in the future.

### Pending Standards, Architectures Require Attention

Meaningful use requires significant interconnectivity, and it is crucial that a standard architecture be constructed in order for information transfer to be successful. At this time, most health exchanges are not capable of completing this task, and the standards are still evolving. The burden will be placed on physicians to purchase interfaces which may not be active in the future. We recommended to CMS that certification require EMR vendors to provide standard interconnectivity interfaces as part of the basic package, once those are defined.

Internet access. Even in New York City, access to high-speed Internet is difficult for some clinics, and for many inner-city neighborhoods. For rural areas in upstate New York and western New York, that's the case as well. National focus on creating an Internet gateway for healthcare is one that should be supported, and one that we would support in New York State.

“Consumers live in the age of information, and by and large, they expect that their doctors will have the necessary information to treat them. They also expect, however, that their information will remain private.”

Louis Capponi, MD

### Patient Privacy

My experience has been that most administrators and lawyers worry more about privacy than patients do. When a patient is in the emergency room with their relative who's sick, the last thing they want to hear is that they need to go across town to get a copy of an X-ray report, while their loved one lays on a cold gurney. Consumers live in the age of information, and by and large, they expect that their doctors will have the necessary information to treat them. They also expect, however, that their information will remain private. Information about even sensitive

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topics such as mental illness is vital to accurate diagnosis, prescribing of medications, safely composing a plan of care that's realistic for the patient, and ensuring that the appropriate level of follow-up is available to match the patient's needs and resources. Patients with mental illnesses and other sensitive conditions need to be educated about privacy as well. They need to know that as medications become more complex,

“Communication with patients is more efficient when the whole picture is available at the time of communication.”

Louis Capponi, MD

it's more important than ever for doctors to have a complete picture prior to initiating treatments. Similarly, doctors and other healthcare workers need to be educated about how and when to access sensitive information.

We also need to be vigilant about carefully reviewing and sharing sensitive information. The New York ACP can play a vital role as a partner with the New York State Department of Health in educating physicians around privacy and security. We can all agree that timely communication of abnormal results with patients and other caregivers is a primary patient-safety concern. The proposed rule equates each case by requiring patients to have their results within ninety-six hours of availability for a subpopulation who want to access results electronically. But this is regardless of the patient's clinical context. The challenge of such a mandate is that clinical situations are different. Many tests require several weeks to complete, particularly pathology reports and tests. Communication with patients is more efficient when the whole picture is available at the time of communication. This way, not only the abnormalities, but the plan to address them, can be conveyed. Absent this, communication becomes piecemeal.

When a doctor issues a verbal order to a nurse, the nurse now repeats that order back to the doctor. And that's a standard process, and a process that's becoming adopted more widely. And so, when a resident gives a verbal order to the nurse on the unit, the nurse repeats that order back, and then the resident confirms it. What we don't have are standard communication processes with patients. So, I might present information about medications to a patient in a different way than to my nurse, and then in a different manner than to the pharmacist. I think that's where we have to work first, identify a standard communication process. And then build in electronic supports of that process, both in patient portals and in the things that we give patients electronically. But absolutely everybody needs to be working together,

## Quality Metrics

Quality metrics tell part of a complex story about the effectiveness of care. More importantly, quality metrics spark the important dialogue necessary to focus individuals to take action. Information generated from electronic systems can be analyzed on a large scale, allowing for better understanding of the areas where medicine is most successful, and those where improvement is possible. However, quality measurement is a complex task requiring a significant investment in time and infrastructure. The New York Chapter of the American College of Physicians believes that the recommended quality measures must be reconsidered. The steps to ensure accurate quality data are approximately fourfold: Harmonizing of standard measures across states, payers, and government agencies; testing the methodology for collection of data; reviewing it for integrity and accuracy; and then assessing if the measures have had the proven impacts on outcomes. This is a commitment of time that extends far beyond the technology. Furthermore, ongoing effort is required to maintain the integrity as the underlying systems are enhanced. For example, if a new template is added to a system, like a progress note or a nurse's note, we need to incorporate and to ensure that the data on that new template is accounted for in the quality report, otherwise it will be missing. This is an important and non-trivial task, and it's an area that I have personally had quite a bit of experience in.

Data collection needs to be actionable, and root-cause analyses need to occur so improvements in quality of care will occur. Data should not be collected simply because it can be collected. Only meaningful data should be collected for meaningful use. Therefore, in the early phases of adoption, subspecialties should not have to report quality metrics unless they are truly meaningful. Instead, emphasis should be placed on ensuring that consultation reports are sent to the referring physician in a timely manner. Quality metrics for subspecialists needs to be developed and vetted in order to assure that data collection will improve outcomes, and this will take some time.

“Data should not be collected simply because it can be collected. Only meaningful data should be collected for meaningful use.”

Louis Capponi, MD

Several of the indicators require access to information from across different providers and locations. For example, measures regarding stroke care incorporate information from two sources at least: the inpatient EMR and the outpatient EMR. How will the eligible provider be accountable for activity in hospitals, particularly when the patient receives emergency care at hospital where they don't admit patients? Moreover, how will that information get into the eligible provider's electronic health record for quality indicator computation? In the early phases of ARRA, physicians

should be reporting on metrics and data which they have within their own systems, and not require information from other systems. We recommended that in the first phase of meaningful use, a minimum number of indicators be required. This will give eligible providers time and experience with these new processes and maximize the potential for success. Additional measures should be added as the program matures.

“It is not the data that is collected, but the analysis of that data that really makes the difference.”

Louis Capponi, MD

It is not the data that is collected, but the analysis of that data that really makes the difference. Many practices are not versed in management techniques, such as lean thinking and six sigma principles. And these processes need to be incorporated into practice to leverage the technology and produce redesign. The New York Chapter of the

American College of Physicians believes that there are significant opportunities to align the incentive program requirements with HIT requirements of other emerging incentive programs. We appreciate that funds are being distributed for the incentive program, and that they serve as a subsidy, but are not reflective of the true costs of implementation. Therefore, we strongly urge that New York State not expand functionality requirements beyond those required under ARRA. Doing this will only complicate and frustrate providers. For example, vendors, given the opportunity to charge additional fees for state versions of software, will simply pass this cost onto physicians. Additional costs are unsustainable for physicians facing inadequate reimbursement rates, fee cuts associated with the Medicare sustainable growth rate formula, the SGR formula, and other increasing practice overheads and costs. Variation between state and federal programs will be counterproductive to the overall goal of full adoption, and we strongly suggest that the principle of uniform requirements between state and federal programs apply not only to ARRA but to any program involving health information technology in the state, such as e-prescribing or patient-centered medical homes.

## The Needs of Hospital-Based Providers

The New York State Chapter of the American College of Physicians believes that omission of an incentive program for hospital-based physicians and house staff will reduce the effectiveness of electronic medical records. The NYACP is concerned that the incentive program excluded these providers. These physicians work in emergency departments, in hospitals, and also in hospital ambulatory care. If such

providers are not using technology, then the community-based eligible providers won't benefit from the flow of information across these settings. This has a significant impact on care transitions, as we've discussed, not only from inpatient to ambulatory but across all transitions of care. Similarly, it's our belief and recommendation that physician-training programs and their associated faculty medical practices be considered as a crucial part of this incentive program. Physicians in training should be heavily exposed to the benefits of this program, and/or an integral part of their clinical experience, both in acute- and ambulatory-care settings. This will allow them to understand the value of health information technology, and will prepare them to participate when starting their own practice or joining an existing practice.

Finally, physicians who are new to practice, along with many special physicians, work in multiple locations, among them private practices, clinics, and hospitals. When a physician practices in multiple settings, the incentive dollars should be made available to the smaller practice, which requires considerable technical and financial resources to implement the technology. The ARRA allows Medicaid incentive programs for hospitals to be released in advance of full implementation, and we support this approach and suggest that this same approach be extended to all eligible providers. With the front-loading of incentives, we believe that there will be an increase in adoption rates by providing more of the capital necessary to bring the system up. And this would result in greater data availability and more value to physicians and to consumers.

## National Standards

“... physician-training programs and their associated faculty medical practices should be considered a crucial part of this incentive program.”

Louis Capponi, MD

Privacy is a very important consideration when it comes to health information; however, maintaining privacy in a health information exchange that spans across the country will require a common set of rules and regulations. Today, the rules governing privacy are different from state to state, presenting major obstacles. In this state, there are significant differences even between programs, such as general medicine and behavioral healthcare. There

needs to be a national standard which all states adhere to. Only then will the industry invest the necessary research and development dollars to meet the standard so that the interstate data transfer, as well as transfer within the state, can be accomplished in a seamless and private manner.

## Authentication

When aligning technology solutions, one of the most important considerations, and often one of the most difficult, is creating mechanisms to authenticate users in an easy and straightforward manner. In the information age of today, we all have many user names and passwords, and we all would probably agree we don't need any more. Thus when considering how eligible providers will communicate with each other across the state, we should strongly consider leveraging existing infrastructures. The New York State government has already created the Health Provider Network, which is not only an excellent source of information and alerts, but also has a tested and true model, and is already up and running. We suggest using this existing infrastructure for authentication, to health information networks and reporting systems; however, we caution that the means to access such a system must be user-friendly and should not create additional barriers.

As a general internist practicing in primary care, I am constantly reminded of the inextricable connection between access to a patient's comprehensive health information in providing safe and effective and patient-centered care. Each week in clinic I see firsthand the challenges that ordinary people face in trying to manage facts about their health, particularly when they have complicated medical histories and chronic conditions such as diabetes or mental illness. Several months ago, a patient with manic depression came to me complaining of abdominal pain. She told me she had inflammatory bowel disease, a very serious condition. She said she had been treated at another facility, and she asked me to check her records, because she was hospitalized there about a year ago. I was fortunate in that case, because I happened to be on the staff at that particular hospital, and I had access electronically to her record. I read that she had been given a complete diagnostic work-up, and I discovered that her diagnosis was not inflammatory bowel disease as she described; rather, it was a far less dangerous condition, irritable bowel disease. When she had told this to other providers in the past, she received unnecessary medications such as steroids. Indeed, I would have sent her to the hospital if it were not for the additional information that I was able to access via the computer. I discussed her actual diagnosis with her, which she then recalled. And I also explored other possible reasons for her increase in abdominal pain. It turns out she had just changed jobs and was under an unusual amount of stress. This caused the same symptoms as in the past. And we discussed this, and I

“As a general internist practicing in primary care, I am constantly reminded of the inextricable connection between access to a patient's comprehensive health information in providing safe and effective and patient-centered care.

Louis Capponi, MD

prescribed a medication for anxiety. Together, we were able to prevent an emergency room visit and a possible hospital admission.

As in many healthcare contexts, the most vulnerable patients in society are also the individuals most in need of access to computer technology, either directly or indirectly. The uninsured, underinsured, and the elderly are more likely to have chronic illnesses, to receive services in emergency rooms, and experience fragmentation of care. The physicians and organizations who serve these individuals are highly likely to benefit from a connected health information system, which can provide continuity of information to support the continuity of care. This group of patients is less likely to have computers in their home, or to have high-speed Internet access, yet they're the most in need of computer-assisted learning intervention, such as video education in multiple languages, or healthcare portals to help them manage chronic illnesses like diabetes and asthma, or medication schedules that are complicated. As a society, we need to address this digital divide by providing better access to computers and Internet connections, so that this group can benefit maximally from HIT.

In summary, the New York Chapter of the American College of Physicians strongly believes that the acquisition and use of health information technology will revolutionize healthcare systems by providing physicians with real-time clinically relevant information necessary to improve patient safety and to lower costs. The leadership and the support for health information technology in New York State has been exemplary, and the members of the New York ACP are optimistic that this investment can improve the health and wellbeing of all the people living in this great

“...the acquisition and use of health information technology will revolutionize healthcare systems...”

Louis Capponi, MD

state. We believe there are significant opportunities to align the incentive program requirements with other HIT requirements as they emerge, and we strongly recommend setting the goals that are attainable by the vast majority of physicians and will maximally benefit the patients. We strongly believe that the New York Chapter of the American College of Physicians can play a significant role by providing the tools and resources necessary to educate physicians on

how to successfully adopt health information technology. We appreciate the opportunity to comment, and we look forward to providing ongoing collaboration to ensure our shared objectives and an orderly transition and a transformation of healthcare, and that providers with the greatest leap to adoption, those in small private practices or solo practices, be assisted and be able to get incentives as necessary.





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**New York Diabetes Coalition**



## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document is a summary of a written statement (dated March, 2010) by the New York Diabetes Coalition. This document represents the sum and substance of the Diabetes Coalition's position regarding the Provider Incentive Payment Program. The letter was signed by the NY Diabetes Coalition's Chair, Dr. Bob Morrow, Associate Clinical Professor, Department of Family and Social Medicine, Montefiore Medical Center, Albert Einstein College of Medicine.

## NY Diabetes Coalition – Background



The NY Diabetes Coalition (NYDC) is an organization of Health Plans, Professional Academies, Public Health Departments, and 90 other organizations. Our mission is to seek agreement on diabetes care guidelines among our disparate members, and to provide support for diabetes care.

## Importance of Registries

Registries help make possible the implementation of a chronic care model, and are an important part of practice transformation to the patient centered medical home. One of our current projects is the deployment of prompting diabetes registries to small and medium practices to help them achieve a more structured care plan for their patients. This registry is Internet based, and provides real time practice assistance, as well as practice based data to plan and improve care of the practice's population. This registry project is funded by the New York State Department of Health.

An important part of 'meaningful use' is the ability to follow patients and their care, and to prompt healthcare providers to develop strategies to improve that care in a measurable way. Our experience with the diabetes registry is that its implementation is not only natural and straightforward, but also helpful in developing team practice and team initiatives, through easy implementation of standing orders for care, testing, and treatment. Data is available for all members of the treating team. Data is also easily exchanged between care givers inside and outside the practice. This open exchange appears to improve health care outcomes in our preliminary analysis, and that of others.

## Registries Should Be a Foundation of HIT Implementation

We feel strongly that such Internet based registries should be the foundation of HIT implementation, and not an afterthought for electronic records based on billing and coding. Indeed, by making interoperable, open code registries the center of practice HIT, the informatics actually make ongoing care easier and more efficient, rather than the record being a stumbling block to daily care.

The experience so far in our registry project convinces us that such an open code, interoperable approach is practical and inexpensive, and very practice-friendly. It does not impede practice flow. Training is helpful, and we have developed

educational modules to encourage the chronic care approach and use of registries, but the learning curve is rather short and easy.

We hope that this approach to HIT gets a careful evaluation by the Center for Medicare and Medicaid Services and the NYSDOH eHIT Initiative. We are enthusiastic about the planned HIT I-APD request for an approval of 90% FFP from CMS to support the implementation of the NY-SMHP and incentive program. We strongly encourage that these funds focus on practice and provider education as to the uses of HIT to improve care, and not simply how to use an electronic record to function as a record-keeping document. We hope that you can draw on our experience in training providers to implement registries, and our training to providers to manage the care of the more difficult to manage patients. The NYDC stands ready to assist in this process in New York State.



**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**New York eHealth Collaborative**

March 17, 2010 | 11:20 – 11:30 a.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the New York eHealth Collaborative (NYeC). NYeC was founded by New York State healthcare leaders as a public/private partnership to serve as a focal point for healthcare stakeholders to build consensus on state health IT policy priorities and collaborate on state and regional health IT implementation efforts. In attendance were:

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **New York eHealth Collaborative**

David Whitlinger, Executive Director  
Paul Wilder, Program Specialist

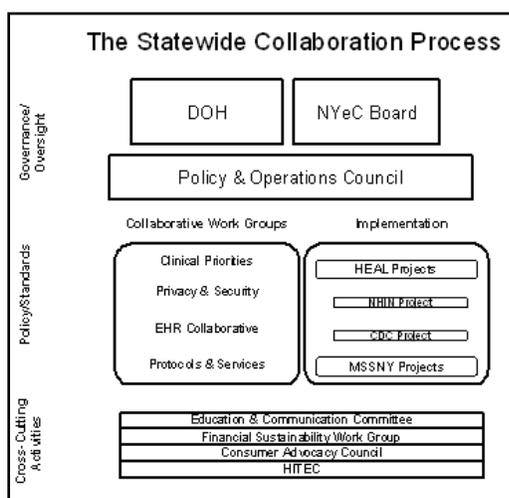
### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant  
Tom Kasky, Project Manager

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## The NYeC Governance Structure

The New York eHealth Collaborative (NYeC, pronounced “nice”), was formed in December 2006 as a public/private partnership whereby the Department of Health could work in a collaborative fashion with the private entities in healthcare IT policy and technical structures. The Department of



Health and the NYeC Board of Directors work very closely in managing the NYeC organization. A Policy and Operations Council participates from all across the state and represents many different constituents and different aspects of healthcare.

## Collaborating

NYeC works through a collaborative process with its different work groups. From community-based providers to technical architecture staff to payers, all groups provide input to various issues like security, privacy, or governance. The output from those discussions are often use cases or specific requirements. This drives discussions resulting in formal policy, procedure, or governance structure. As NYeC Executive Director David Whitlinger puts it, “Collaboration is a key aspect of this organization. It has allowed all the EHR players to collaborate together and get different viewpoints put into policy. The results are well vetted throughout the community, and well accepted by the community, because they've been borne out of the community.”

## Aligning w/NYS Medicaid Processes

NYeC is the state-designated entity for developing the New York State Health Information Technology (HIT) plan. NYeC will be collaborating with the Office of Health

“Collaboration is a key aspect of this organization.”

David Whitlinger

Insurance Programs (OHIP) on their State Medicaid Health Information Technology Plan (SMHP). The NYeC-authored HIT plan will lay the overall landscape of HIE in New York State and will identify the roles of Regional Health Information Organizations, (RHIOs), Regional Extension Centers (RECs), and other groups. The New York State Medicaid program is similarly authoring their HIT plan and will focus exclusively on Medicaid-as-a-payer in the HIE landscape. The two organizations are actively working together on their respective HIT plans to avoid redundancy in approaches.

## Meaningful Use

Among the requirements for Eligible Providers (EP) to receive continued Medicaid incentive payments is their achieving meaningful use of HIT. Other EPs, not necessarily those receiving Medicaid payments, must achieve certain levels of meaningful use as well. NYeC is ready to partner with OHIP to collaborate on tracking mechanisms, criteria levels, and the like for all New York State providers.

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**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**New York State Dental Association**

April 21, 2010 | 3:00 – 3:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the New York State Dental Association (NYSDA), a constituent of the American Dental Association. NYSDA was established by an act of the New York State Legislature in 1868 as the professional association for dentistry. NYSDA represents more than 14,000 dentists throughout New York State.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **New York State Dental Association**

Mark J. Feldman, DMD, Executive Director  
Judith L. Shub, PhD, Assistant Executive Director

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant  
Peter Poletto, Business Architect

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## New York State Dental Association – Background



The New York State Dental Association (NYSDA) represents the interests of more than 14,000 dentists in New York State (76% of practicing dentists in the state). NYSDA focuses on legislative affairs, business development, and clinical and educational programs that promote the art and science of dentistry. Providing feedback to the New York State Office for Health Insurance Programs (OHIP) were the organization's Executive Director, Dr. Mark Feldman, and Assistant Executive Director, Judith L. Shub. Dr. Feldman's and Ms. Shub's comments are summarized below.

### Eligibility

The Medicaid Incentive Payment System (MIPS) is targeted to provide funding to Eligible Providers for the reimbursement of Health Information Technology purchases. Currently under the plan, dentists are considered Eligible Providers, be they hospital-based, clinic-based, or some other model. However, to actually receive incentive payments, a dentist's total number of patient encounters must be at 30%, a level viewed as limiting by many dentists.

NYSDA is concerned about the threshold criteria for eligibility, which will minimize the number of dentists who will be eligible for this stimulus funding. NYSDA recognizes that these eligibility limitations, and the resulting small number of practices in the information network, will compromise the project's potential effectiveness overall.

*“On the referral cross back, one of the things we've been developing nationally and implementing state-by-state is a greatly simplified caries assessment tool that will be available to pediatricians.”*

*Mark J. Feldman, DMD*

### The Right Kind of Information for Quality Dental Care

The kind of information dentists need to access in a statewide network is unique given the nature of their care. Dr. Feldman and Ms. Shub provided feedback regarding possible links to oncology, cardiology, blood disorders, and most certainly fluoride treatments. As Ms. Shub explained, “We're seeing increasing research suggesting simple diagnostic tests through saliva for a variety of cancers and other ailments. A system that enabled physicians and dentists to access that kind of patient information would be extremely significant.” Further, approximately 40% of all children in New York State are Medicaid members, so information regarding fluoride treatments and sealants is critical.

*“We’re seeing increasing research suggesting simple diagnostic tests through saliva for a variety of cancers and other ailments. A system that enabled physicians and dentists to access that kind of patient information would be extremely significant.”*

*Judith L. Shub, PhD*

## Upgrades

Dental software, whether for clinical purposes or billing, is very specialized, and dentists are cautious about new implementations and the expectant shelf life of any new system. The current MIPS strategy is to support these purchases

and provide for upgrades and changes. The New York State Dental Association encourages OHIP to continue to support this strategy. Current Medicaid billing and dental procedure codes and patient verification systems need to be aligned.

## Reaching Out to Dentists

NYSDA has developed an online survey tool to collect information from their members regarding Health Information Technology. Combined with similar outreach efforts, NYSDA is well positioned to help OHIP move forward with a State Medicaid Health Information Technology Plan that supports the special needs of dentists and dental patients.





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**New York State**

**Academy of Family Physicians**

March 25, 2010 | 9- 9:30 a.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH) Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the New York State Academy of Family Physicians (NYAFP) NYAFP promotes family practice among medical students and has worked to enhance and improve the quality and stature of family medicine.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **New York Academy of Family Physicians**

Dr. Vito Grasso, Executive Vice President

Dr. Robert Morrow, Practicing Physician

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant

Peter Poletto, Business Architect

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## New York State Academy of Family Physicians – Background

The New York State Academy of Family Physicians (NYSAFP) is the New York State Chapter of the American Academy of Family Physicians. The Academy has promoted family practice among medical students and has worked to enhance and improve the quality and stature of family medicine. NYSAFP has worked successfully for the development of family medicine at medical schools and hospitals throughout New York State. NYSAFP has developed programs for the clinical and leadership development of residents and young family physicians. Providing feedback to the New York State Department of Health, Office of Health Insurance Programs, were Dr. Vito Grasso, and Robert Morrow, MD.

### Two Primary Issues

Dr. Vito Grasso, “We support using federal funding from the Recovery Act to facilitate the adoption of health information technology. There are two major issues however. First is the overall cost of purchasing and implementing the health information technology. Secondly, the thirty percent Medicaid required to qualify for the incentive payments is too high. Only eleven percent of medical practices in New York meet this threshold. The low reimbursement level and administrative requirements associated with the program make it unattractive for physicians to participate in Medicaid. The economic incentives contemplated by the proposal are unlikely to provide a sufficient inducement for practices to participate in the program or to expand their Medicaid patient panel.”

*“We like the idea of a data warehouse and the availability of data to providers.”*

*Dr. Vito Grasso  
Executive Vice President, NYSAFP*

“Additionally, many practices are in regions where there is not a large enough Medicaid population to expand their Medicaid base if they desired to do so. This is particularly true for suburban practices.”

## Cost can be Prohibitive

“The high cost of acquiring and implementing Health Information Technology (HIT) has been the greatest barrier for small-to medium-size practices, and they comprise the majority of practices in family medicine in New York. Even for those practices that meet the thirty percent threshold, it's not clear that the proposed incentives cover enough of the actual cost of acquiring and implementing HIT. Furthermore, the taxable nature of the funds reduce the amount of subsidy actually available. That's another reason we support the use of state administrative funds to provide technical assistance to practices.”

## Data Warehouses are Promising

“We like the idea of a data warehouse and the availability of data to providers. I think that's a sound idea, to provide the value-added benefit for practices. It would ultimately become an inducement to practices to participate.”

Dr. Robert Morrow, “The data that would be extremely helpful would be the pharmaceutical data, what the patients have ordered, what they have last taken, and who provided it. It would be of remarkable assistance. Data on recent testing done by laboratories or radiology facilities would also be extremely helpful. Administrative data on use of services such as physical therapy, and mental health, if legally possible, would be helpful. And of course, if that data could be fleshed out by some meaningful summaries that would be extremely helpful.”

*“The major flaw is the lack of communication between hospitals and healthcare practices...”*

*Dr. Robert Morrow  
Member, NYSAFP*

## Interoperability is Key

“The major flaw is the lack of communication between hospitals and healthcare practices, both in terms of admission to the hospital and in terms of information on discharge. That information should, by law, be available and readily accessible to the attending physician of record, but is rarely so. And obtaining that data usually requires extensive delays and obstacles, hiding under the guise of HIPAA, which of course, is an inappropriate use of that federal law. This has led to not only duplication of services, but to that which we are all worried about, which is hospital readmissions. The data warehouse should focus on pharmaceuticals, on consultations, on laboratories and diagnostic services, but should have a primary role in integrating hospital admission and discharge data with the primary care role.”

“There is an overarching need to train practices, and the use of federal funds and state funds to do so would be extraordinarily helpful. The training should be done in ways that integrate those practices' information systems, and not just set up separate systems that are Balkanized and separated. No disrespect to the Balkans.”

“As the Chairperson of the New York Diabetes Coalition and the person responsible for our project to install Internet-based diabetes registries in practices throughout New York State, my and our experience has been that the use of interoperable data is substantially helpful. The data should be based on interoperable and non-proprietary code. It's easy to exchange data with such groups as health plans and public health officials, and certainly groups that are monitoring quality. So there should be an effort to develop HIT support for the

*“ We have discovered that registries are a vital part of supporting patient-centered medical homes.”*

*Dr. Robert Morrow  
Member, NYSAFP*

interoperable aspects of health information technology, and not simply the installation of prepackaged proprietary technology that doesn't talk to each other. An example of this is my personal practice in the Bronx. If my patient goes to one hospital system, where I have access to their records, I

am able to quickly and easily see his or her hospital information. But if he or she happens to go to any of the thirty other systems that I do not have access to, it requires extraordinarily heavy lifting in order to get that information, because the code is written in a proprietary manner and does not allow access.”

“Our experience with RHIOs in my area of New York is that they have not been very successful. I'd make a strong push that the state use its ability to bring groups together to find the interoperable kernel of code necessary to be financially supported. We have discovered in our project that registries are a vital part of supporting patient-centered medical homes. The key element here is you can't have a patient-centered medical home without a way of taking care of patients with chronic illnesses who are seen over time, and whose care requires the coordination of many providers. This is best done through a health information technology that is based on registry technology and not on billing technology.”

## Meaningful Use

“We hope the new meaningful use definitions will encourage and support registry-based information technology and information sharing, so that practices can work together in caring for patients, as they move from practice to practice.”

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“The technology to develop modular interoperable health information technology is available, and it's being developed in many circles now that meaningful use has been expanded. I encourage the state to take a role in this.”





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**Rochester Regional Health  
Information Organization**

April 19, 2010 | 3 – 3:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the Rochester Regional Health Information Organization. In attendance were:

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **Rochester Regional Health Information Organization**

Edward Kremer, Executive Director

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant  
Peter Poleto, Business Architect

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## Rochester Regional Health Information Organization (RHIO) – Background

Rochester RHIO is a secure electronic health information exchange (HIE) providing authorized medical providers access to test results, lab reports, radiology results, medication history, insurance eligibility, and more. The nonprofit, community-run organization was created to give healthcare providers fast access to accurate information about patients so everyone can receive the best care possible. Twenty healthcare organizations in the Greater Rochester area provide patient information, including hospitals, reference labs, insurance providers and radiology practices. Rochester RHIO is one of 300 health information exchanges in development nationwide. Created in 2006 with a \$4.4 million state grant and \$1.9 million in funds from local businesses, hospitals, and health insurers, Rochester RHIO is expected to lower health care expenses over time.

### **RHIOs in New York State – One Perspective**

Edward Kremer, Executive Director of the Rochester RHIO, provided the following narrative as feedback to the New York State Department of Health, Office of Health Insurance Programs.

“In reviewing both the architectural plans and the five-year roadmap provided by the Office of Health Insurance Programs, it is clear that the NYS Department of Health, Office of Health Insurance Programs is seeking to address the quality in health system efficiencies that affect all New Yorkers. Unfortunately, the proposed architectural approach and five-year plan do not appear to significantly leverage the substantial efforts that the Department of Health, communities across the state, health providers, and other payers have engaged in over the last five years through the Heal New York Program.”



“Starting in 2006, there has been a historic undertaking to connect clinical data sources and healthcare providers across the State of New York to create a patient centered information network. Federal funding, state funding, and community funding from employers, hospitals, and commercial health plans came together to realize the vision very similar to that currently proposed by the Office of Health Insurance Programs. Central to this office was the statewide discussion related to a host of privacy and policy issues related to health information exchange. Hundreds of people were involved in these policy discussions over the last five years, and thousands of software engineers, project managers, quality analysts, privacy officers, and staff and physician offices, hospitals, laboratories, radiology practices, long-term care facilities, home care agencies, and payers have worked to establish these health information exchange services across the state. These already established HIE services cover not only commercially insured patients but Medicaid patients as well. They provide services to patients as they move throughout the community and across types of health insurance coverage.”

“This more holistic patient centered capability is already provided by regional HIEs and follows patients as they move between Medicaid programs and commercial insurance programs. Leveraging these regional exchanges would avoid creating a separate but equal landscape that could both slow physician adoption and create unintended disparities in care. The current ARRA funding represents a similarly historic event to further improve the health information landscape in New York. But it should be utilized in such a way that leverages these existing state and community HIE efforts. In what is already a challenging state fiscal environment, we must be careful to avoid duplicative efforts that would exacerbate our state's ongoing budgetary shortfalls. Instead of replicating existing HIE efforts, each entity in the state health information ecosystem should look to establish additional capabilities that it is uniquely positioned to provide.”

“To that end, we suggest that instead of the proposed Medicaid effort to establish a new state database of laboratory and radiology tests, Medicaid efforts will be better served by connecting some of the two hundred public health databases that are often not

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readily available to healthcare providers. Medicaid efforts could additionally be focused on creating an inventory of the information and interoperability gaps for truly transformational care for Medicaid patients. The state could then work with the regional entities to facilitate and, where possible, assist with the funding the interoperability information flow and analytics to build a foundation for continued quality improvement programs for Medicaid patients. This approach will provide for both state level and regional quality improvement programs.”

“Currently, the Rochester RHIO has negotiated ongoing commercial and self-funded payer support through a claim surcharge for each payer's covered members. Following the success of this approach, other regional health information exchanges in upstate New York are pursuing a similar model. We also urge Medicaid to consider the same underwriting approach that in turn would allow clinical information to flow from the RHIOs to the New York State Office of Health Insurance Programs.”

“To best leverage the already substantial state investment in HIEs and the increasing information available through these regional services, we suggest that OHIP rethink both the architectural approach and its five-year patient centered Medicaid plan and seek to support much of its information access through existing state funded RHIOs. This approach would demonstrate to the Federal Office of the National Coordinator that New York was serious about creating a sustainable and coordinated health information exchange ecosystem, one that would yield the greatest value for its citizens and most cost effectively.”

“The original vision of the HEAL program was, in large measure, to improve healthcare quality and health system efficiency for Medicaid patients. HEAL funded RHIOs were to be the conduit for participants to access the state Medicaid medication history database. We urge OHIP to return to that vision and make regional information exchanges a cornerstone of their five-year plan and integrate their efforts into a single, more inclusive statewide health information technology roadmap. These comments again were approved by all of the board members of the Rochester RHIO and, again, we thank you for providing the opportunity to comment on the plans as you were working through them.”

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“In regards to the Rochester RHIO’s data architecture, we have what’s called a hybrid federated model where we do have some data in the middle. A lot of our data sources are federated. But we’re already moving towards building more traditional services for quality improvement programs. Our architecture is based on a domino software framework from I.B.M.”

## Credentialing

The Office of National Coordinator has proposed a credentialing process wherein RHIOs would be enrolled in Medicaid as a specialized type of service bureau for HIE activities. In response, Mr. Kremer said, “The additional rigor of credentialing the RHIOs is where we’re all moving forward to. I think solidifying that community trust model through credentialing makes perfect sense.”

## Medication History

Currently, the New York State Medicaid program collects medication history. Data represents six months worth of medication history for Medicaid members. Mr. Kremer was asked if RHIOs would find this kind of data valuable and of use to their members.

“I believe so. The more we can build toward a comprehensive patient medication list is helpful, particularly for transition activities where the patient is moving from one location to another. Further, if we can avoid creating duplicate data we’re all in better shape. The more we can provide physicians with a single source to get a comprehensive patient view, the better off we are.”





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**State University of New York**



## Introduction

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This document summarizes the written comments (dated May 10, 2010) prepared by the State University of New York (SUNY) in response to the briefing given by OHIP. This document represents the sum and substance of the feedback from SUNY regarding the Provider Incentive Payment Program.



## Background

The national transition to health information technology (HIT) through implementation of electronic health records (EHRs), automated medication dispensing systems, and personal health records (PHR) creates an opportunity to enhance disease pattern recognition, optimize diagnostics included in clinical decision support, and increase patient safety through evidence-based prescription of medications.

## SUNY Experience with Patient Centered Medical Home (PCMH)

The SUNY-NYSDOH Medicaid Initiative is built on the HEAL 10 initiative that established a Patient Centered Medical Home (PCMH) and a corresponding data warehouse that collects data in real-time from an integrated EHR network. From a clinical management perspective the PCMH is an important advance that promotes quality care, patient safety and patient-centered disease management. The challenge for clinical and translational researchers, and more recently implementation science investigators, is to design novel approaches that utilize the wealth of health information in the data warehouse to conduct comparative effectiveness research to inform evidence-based guidelines and reimbursement policies. The SUNY-NYSDOH Medicaid Initiative seeks to expand existing Medicaid databases and registries to include patients with hypertension, diabetes and diabetes resulting in a Hypertension, Diabetes and Renal Disease (HDR) Management and Outcomes Registry. The enhanced registry will provide an HIT infrastructure with excellent environment to conduct HIPAA compliant, comparative effectiveness research protocols that will incorporate evidence-based medical care and also evaluate optimal use of HIT to attain improved clinical and economic outcomes.

The technology enhancements that will result in the SUNY-NYSDOH Medicaid Initiative Registry will provide an innovative approach to including primary care practice sites in the conduct of comparative effectiveness research. The important NIH Roadmap initiatives that have encouraged translational research at the community level, the recent emphasis on implementation science and the existing network of practice-based research networks have a common need for a health information technology architecture that facilitates applied research while considering the challenges to completing this research in a primary care practice environment. The enhancements will provide new insight into the design of prospective, randomized longitudinal assessment protocols using an enhanced registry. In addition, the enhanced registry that is linked with health information exchange will allow more comprehensive datasets to be developed that will facilitate improved feedback of prescription refill rates, patient education needs,

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health literacy concerns and online health status management. From the reimbursement perspective, the research conducted within the enhanced registry will allow for ongoing evaluation of the financial impact of disease management and treatment plans and their relationship to overall resource planning and allocation, to achieve quality health outcomes. The enhanced registry will provide new opportunities to develop models for integration with a patient safety organization (PSO), and in collaboration with statewide network partners, access novel disease management approaches while also fostering continuous quality improvement. This approach will also inform other AHRQ PSOs as new informational technology strategies are evaluated so that the larger national network can benefit from the innovations in the SUNY-NYSDOH Medicaid Initiative and enhanced registry approach.

## **Medication History**

NYSDOH currently has the ability to access an adjudicated medication history from the pharmacy data system. However, this dataset is not always complete and, moreover, is not organized in a manner that readily provides salient information to the clinician. SUNY could provide guidance and input on, first, how to include OTC as well as complementary and herbal medications, in order to arrive at a meaningful and adjudicated medication history; second, through its resources at the College of Pharmacy at the University at Buffalo, provide input on appropriate data flow for these data; and third, this College of Pharmacy is also positioned to participate in the development of a meaningful clinical presentation of medication history.

## **SUNY Expertise in Clinical Decision Support System (CDSS)**

A semantic-based clinical decision support system (CDSS) is currently being developed at the New York State Center of Excellence in Wireless and Information Technology (CEWIT) at Stony Brook University. This system provides an advanced, bidirectional, rich audiovisual interface that transforms data into easily interpreted, uncluttered, and directly actionable information. Clinical data is processed and presented visually using text, anatomic models, images, and icons in a way that provides maximal cognitive support to the clinicians, provides clinical clarity, and guides clinical actions. Actions can directly be initiated by voice, touch, or gesture, in response to the information displayed; for some information, a recommended course of action based on the information selected can guide the physician and decrease the time to action. By presenting information as directly actionable items, the system results in “the right thing, at the right time, in the right place, and in the right way.”

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## Adoption of Meaningful Use

Under the Health Information Technology Evaluation Collaborative, SUNY's Center for Health Workforce Studies (CHWS) conducts periodic surveys of hospitals and a sample of ambulatory physicians to evaluate progress in HIT adoption in the state. These surveys could be augmented to include questions tailored to DOH's needs for effective planning and implementation of HIT/HIE. In addition, the Center surveys physicians and dentists at re-registration; surveys of nurse practitioners, physician assistants and midwives will shortly be added. All of these surveys could be adapted to gather information of value to DOH. The inclusion of appropriate HIT questions on the re-registration surveys could support long-term monitoring of these providers on their use of HIT. In addition, this could provide an important opportunity for trend analysis of HIT adoption that considers the influence of factors such as geography, specialty, and setting on use rates. SUNY's CHWS could also conduct surveys of providers who receive funding under the Medicaid HIT Incentive Program to learn about their experience. Information from this survey could inform future efforts to provide HIT incentives to eligible providers.

## Outcomes Analysis

It is of paramount importance to assess the outcome of the statewide HIE/HIT initiatives and how these facilitate the delivery of evidence-based medicine. The EHRs impact on improving care coordination and patient safety, and on reducing the overall cost to deliver healthcare need to be analyzed.

SUNY recommends that additional pilot studies be conducted with selected practices to evaluate the quality metrics that can be developed as a core component of the EHR. Currently a study is underway at SUNY Buffalo to measure healthcare outcomes using values from routine blood chemistry tests. This novel approach provides a mathematical metric based on objective measures of illness which generates an illness complexity score, which permits more realistic grouping of patients within cohorts of similar severity, and which relates significantly to overall cost of care. As noted above, SUNY has extensive experience in this area of research and can make available practices that are sufficiently advanced in their adoption of EHR to serve as pilot sites.

## Security

The proposed plans emphasize securing patient data using data encryption. We believe adopting more advanced encryption standards (e.g., 256-bit) need not be postponed for a future date but could be implemented earlier, as these offer

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significant advantages compared to 128-bit protocols, and are already widely adopted standards.

## **System Models**

The decision on whether to adopt a centralized or decentralized (i.e. federated) model, or a hybrid one to certain extent, should be made as early as possible in HIE planning. Specifics such as how to facilitate interoperability and support efficient exchange of large amount of patient data, including radiographic images, need to be addressed. We think it is a very good idea to establish the RHIOs as both data clearinghouses and service bureaus. The importance and broad impact of RHIO interoperability warrants additional review, perhaps in a separate planning document, focusing just on this topic so that the vision, objectives and road map of expanding and improving the RHIOs are very clear.





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**Taconic Health Information Network  
and Community (THING)**

April 22, 2010 | 11:30 a.m. – 12:00 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the Taconic Health Information Network and Community (THINC). THINC is developing and implementing solutions which address the key components necessary for successful and sustainable health IT adoption.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **Taconic Health Information Network and Community**

Susan Stuard, Executive Director

### **New York State Technology Enterprise Corporation (Program Consultants)**

Brad Duerr, Program Consultant  
Donna O'Leary, PMP, Program Consultant  
Peter Poleto, Business Architect

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## THINC – Background



The Taconic Health Information Network and Community, or THINC, is a not-for-profit corporation dedicated to improving the quality, safety, and efficiency of healthcare for the benefit of the people of the Hudson Valley region of New York State. THINC's primary purpose is to advance the use of Health Information Technology (HIT) through the sponsorship of a secure Health Information Exchange (HIE) network, the adoption and use of interoperable Electronic Health Records (EHR), and the implementation of health improvement activities, including public health surveillance and reporting, pay for performance, and other quality improvement initiatives.

### Build On Existing Infrastructure

Among THINC's recommendations for the Medicaid Incentive Payment System (MIPS) Program is to continue to utilize the State Health Information Network for New York (SHIN-NY) that was jointly sponsored and developed by the New York State Department of Health (DOH) and the New York eHealth Collaborative (NYeC). SHIN-NY meets two important goals for Medicaid in its State Medicaid Hit Plan (SMHP). First, SHIN-NY is compliant with the Federal National Health Information Network (NHIN) standards developed by the Office of the National Coordinator for HIT at the U.S. Department of Health and Human Services. By utilizing SHIN-NY, Medicaid can ensure that its health information exchange development efforts are in line with, and anticipatory of, Federal requirements.

*By utilizing SHIN-NY, Medicaid can ensure that its health information exchange development efforts are in line with, and anticipatory of, Federal requirements.*

Secondly, SHIN-NY is a key piece of the state HIE plan developed by NYeC and DOH. Harmonization of Medicaid's efforts with SHIN-NY simultaneously ensures harmonization of the SMHP with the state HIE plan. Further, THINC recommends leveraging the RHIO's efforts to reach providers. Medicaid's flexible approach to health information exchange by sponsoring connections both directly to providers and their EHRs and to RHIOs is promising. There is concern, however, that smaller physician practices, hospitals, health centers, and long-term care facilities may not have the financial resources and leverage over their EHR vendors to undertake direct integration with Medicaid.

## Security Standards – A Shifting Landscape

Maintaining a secure exchange is similarly a challenge for smaller providers. THINC encourages Medicaid to leverage the RHIOs as a means to connect these smaller providers to their RHIOs. As explained by THINC's Executive Director, Susan Stuard, "Like many other RHIOs, we already have SHIN-NY compliant connections established with smaller providers. This equips providers to start to address Medicaid's security requirements."

*"Like many other RHIOs, we already have SHIN-NY compliant connections established with smaller providers. This equips providers to start to address Medicaid's security requirements."*

*Susan Stuard,  
Executive Director, THINC*

## Align Efforts Among Users

An unprecedented level of state and federal activity in the HIT and HIE arenas over the last year has created a temporary lack of alignment among state-sponsored efforts. Under the HEAL program, regions formed RHIOs to support SHIN-NY. Separately, providers have been asked to undertake direct reporting to public health

agencies, and Medicaid has been sponsoring a health information exchange strategy that appears to view RHIOs and SHIN-NY as somewhat of a last resort. This lack of alignment is confusing for providers, RHIOs, and other healthcare stakeholders. THINC asks Medicaid to use the SMHP as an opportunity to achieve alignment among state efforts.

## RHIOs and Credentialing

Among the statewide strategies being considered is the notion of certifying RHIOs as Medicaid Service Bureaus. Following a credentialing process outlined and prescribed by the New York State Commissioner of Health, RHIOs could position their strategies as an overall component of the Medicaid landscape. THINC welcomes this approach and further encourages NYS Medicaid to explore multiple strategies regarding HIE.



## Centralized Database, Federated Database – Options for the Future

Another NYS Medicaid EHR strategy is the establishment of a centralized database of Medicaid clinical data, such as lab results and radiographic images. Another idea springing from the provider community is an all-payer/all-patient solution. Both approaches offer advantages, and both come with logistical and technical hurdles. THINC's position on this particular issue is that an all-payer/all-patient model is perhaps the best model for providers, patients, and others. However, establishing such a database is a herculean task that is, at best, five to ten years out. Instead, THINC encourages a phased approach where tangible deliverables regarding meaningful use can be realized in a closer, tighter timeframe. As Susan Stuard explained, "In our pavilion, the healthcare space is best achieved in an interim approach. Get the success under your belt, then move on and build on it with lessons learned."

*"In our pavilion, the healthcare space is best achieved in an interim approach. Get the success under your belt, then move on and build on it with lessons learned."*

*Susan Stuard,  
Executive Director, THINC*





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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**UJA-Federation of New York**

April 26, 2010 | 11:45 a.m. – 12:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act, (ARRA) signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve “meaningful use” of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the United Jewish Appeal (UJA) Federation of New York. The UJA is a philanthropic organization supporting those in need, uniting and strengthening Jewish people in unity and inspiring passion for Jewish life and learning.

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis Johnson, HIT Policy Coordinator

### **New York State Department of Health – Office of Health Information Technology Transformation (OHITT)**

Roberto Martinez, MD, Medical Director

### **UJA-Federation of New York**

Edie Mesick, State Government Relations Executive  
Jonas Waizer, PhD, CEO, F•E•G•S Health and Human Services System

### **New York State Technology Enterprise Corporation (Program Consultants)**

Donna O'Leary, PMP, Program Consultant  
Peter Poletto, Business Architect

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## United Jewish Appeal – Background



The UJA-Federation of New York has the support of 65,000 donors and brings impact to a multitude of issues that matter to Jews and all New Yorkers. The UJA regularly sponsors symposiums and conferences to stay abreast of changing needs. Drawing on cutting-edge research and guiding new research, the UJA stays positioned to respond quickly to unforeseen crises and opportunities. The UJA has built a network of more than 100 human-service, education, and community agencies. Providing feedback to the New York State Office for Health Insurance Programs (OHIP) were Edie Mesick and Dr. Jonas Waizer.

## Serving Those in Need

Ms. Mesick, “The UJA Federation is a major Jewish philanthropy. Our mission involves caring for those in need. We support a network of more than one hundred nonsectarian, nonprofit human service organizations and healthcare organizations in New York City, Westchester, and Long Island, which together serve over a million residents. As I begin my formal comments, I want to acknowledge the visionary leadership that New York State has shown in its ongoing efforts to improve our healthcare system, and in particular, New York

*“Our collective goals are higher quality of care, fewer duplicative tests, fewer co-pays, and lower costs.”*

*Edie Mesick*

State Department of Health's commitment to building a Health Information Technology system. We very much appreciate the communication that you have provided to us, Dr. Figge. We appreciate the communication and the accessibility that the DOH Office of Health Information Technology Transformation (OHITT), the New York eCollaborative (NYeC), and the State Department of Health Office of Health Insurance Programs have provided to us.”

“We also appreciate the opportunity to grow in our understanding of the potential value of our participation in the Health Information Technology transformation. I'm glad to hear that there is also a broader application for this communication process going directly into OHITT and NYeC. We have been meeting with them, and we note the appropriateness of the coordination among your offices.”



## Home Care, Long-Term Care – Major Focus

“We understand New York State actually has been very active in this arena for a number of years, and it was only about a year and a half ago when ARRA funding started to make us aware of the really significant effort underway across the nation and in New York State to use information technology to improve healthcare delivery and to improve healthcare outcomes using technology in the form of electronic health records. The result, reaching our collective goals, is higher quality of care, fewer duplicative tests, fewer co-pays and lower costs. Both federal and New York State governments have really focused this Health Information Technology system transformation on hospitals and physicians. However, UJA Federation believes that the community-based mental hygiene, home care, and long-term care programs must also be a major focus of this effort, especially because these programs are specialized in serving patients and clients that are high cost drivers in the system and will transition between the various levels of healthcare settings.”

*“UJA Federation believes that the community-based mental hygiene, home care, and long-term care programs must also be a major focus.”*

*Edie Mesick*

“Both the patients and the public will be well served to include these sectors in the planning and the development of Health Information Technology systems and networks. To be a little more specific, it is the role of our agencies to follow the patients into the community and to reduce re-hospitalization. There is a real positive impact on the cost in using community outpatient services in reducing inpatient use.”

## EHR Where it can Help the Most

“We reduce re-hospitalization. And the mentally ill and medically compromised are among the heavy users of Medicaid resources. Their focus of service is the community, and it is very much in the State's best interest for community providers to be tied into the regional health information organizations and in the Health Information Exchange systems if there really is to be meaningful use of data in terms of more efficient and more effective care. Our community-based organizations can help with compliance for patients in the plans to keep them, as they're discharged from hospitals, from returning to hospitals. Seeing information in real time, the discharge plan, the prescriptions that are prescribed, when the next doctor appointment is scheduled, and our community-based organizations work in assisting those patients to those next

steps in their healthcare will obviously have real value to the patient, to the quality of care, and cost to the system.”

“We think it's also very important that other providers know that our community-based organizations are on the team and are very much serving these patients. Just as hospitals and physicians have required public funding to help them make a transition, we know our network agencies and others across the state also have similar challenges in making this transformation to electronic information.”

## Building Capacity

*“Real-time information about whether or not a script was picked up, whether the doctor appointment was attended. . . this is the kind of information that would be immediately available to our community-based provider.”*

*Eddie Mesick*

“Initially, funding support is needed for capital purchases, for training, and for other pay to play participation costs. This will help build our capacity to the point where we can be participants in this era of coordinated patient care, electronic linkages, and accountability. At the same time, we urge you to recognize that there has to be a way to assure coverage of ongoing costs as well. Many of our providers, because

they are serving Medicaid patients, are dependent upon public funding and reimbursement. It's absolutely essential that there be something built into the system that recognizes that this is a new layer of cost that will have tremendous payback, but how it's paid for on an ongoing basis will also need to be addressed.”

“We wholeheartedly support your stated goals. These are worthy goals for New York State: to support Health Information Technology implementation, to incentivize the meaningful use of electronic health records, to incentivize e-prescribing, and finally to improve the quality of care. Again, it is essential that these goals in New York State, and at the national level, be expanded to include applications for our community-based mental hygiene, home care, and long-term care sectors. And we note that there has been some publicity recently for opportunities to assure this at the national level, and we applaud that.”



## Incentive Payments

“Regarding the Medicaid requirement for incentives for physicians to participate, the minimum of thirty percent that’s outlined, we believe that this should be thirty percent of the number of patients served. This is really a critical point from the community-based perspective since the nature of their work is outpatient. Using total revenue simply would not work.”

“We very much appreciate and support your intention to establish an as-is landscape assessment. This is essential. It is needed immediately as well in the community-based mental hygiene, home care, and long-term care sectors, and we look forward to working with you to help you to establish that assessment.”

“Regarding Medicaid data, we want to emphasize how absolutely essential this component is for improving coordination and quality of care in health outcomes. For example, real-time information about whether or not a script was picked up, whether the doctor appointment was attended, this is the kind of information that would be immediately available to our community-based provider. It would allow for immediate follow-up as opposed to a lapse, and this is obviously going to make a real difference in the quality of care.”

*“Financial support and incentives for providers to participate in e-prescribing is also very important.”*

*Edie Mesick*

“We recognize that financial support and incentives for providers to participate in e-prescribing is also very important, and we are excited to participate in that as well. We think this will have an immediate payoff in coordination and quality care and health outcomes. And we note that this is particularly true for patients that have dual eligibility for both Medicaid and Medicare where we can see that there can be different doctors providing the same or different medications with the same or different timeframes or dosages.”

## Feedback from a Direct Provider

Providing feedback to OHIP was Dr. Jonas Waizer of the F·E·G·S Health and Human Services System. The F·E·G·S Health and Human Services System meets the needs of the Jewish and broader community through a diverse network of high quality, cost-efficient health and human services F·E·G·S is one of the largest and most diversified not-for-profit health and human services organizations in the United States. The F·E·G·S touches the lives of over 100,000 people – some

10,000 each day – at more than 300 locations throughout New York City and Long Island, providing a comprehensive array of services that create opportunities and improve the lives of others.

Dr. Waizer, “F.E.G.S. is a not-for-profit health and human service system. We run ten mental health clinics around New York City. We're also out on Long Island. We run day programs for people with mental illness and for those with developmental disabilities. We run residential programs. We have twelve hundred people living in residences all on Medicaid. We have forty plus physician and nurse practitioner prescribers. We have over 120 people who are reimbursed through Medicaid for case management, intensive case management, supportive case management, all levels of case management, teams in support of community treatment. All of these people, in one way or another, deal with individuals who are coming out of state psychiatric hospitals, general psychiatric hospitals, general hospital psychiatric units, and prison. And the focus is to provide them with direction so that they take the prescriptions that they receive from clinics, go to the pharmacies, maintain the treatment regimen that prevent readmissions to hospitals and re-incarceration because they have become psychiatrically fragile once again.”

### Avoiding Costly Emergency Room Charges

“F E G S has a chronic illness demonstration project grant to help 750 people in two different contracts achieve a level of community integration and stability so that they don't overtax and overuse the emergency rooms of hospitals. In the last year, we've joined the Long Island RHIO, the southwest Brooklyn RHIO, and the Bronx RHIO. In each case, we were invited to join the RHIO because the hospitals also see the value of having a community provider that focuses on case management, residential aftercare, and support to the mentally ill and the developmentally disabled. Our network focuses on some of the most fragile, because they're people not only with medical disabilities, but also mental illness. And many of the people that become part of our case management targets are people with multiple disabilities, including substance abuse as well as mental illness and medically compromised.”

“We all have rudimentary electronic health records. We all bill Medicaid electronically, but we've never had the incentives and the wherewithal to develop the kind of computer systems that the hospitals are building. “

*“We're very excited about the RHIO platform. We think it has great promise.”*

*Dr. Jonas Waizer*



Technology is vital for us; we're a low-cost system. We're a relatively low-cost system, so small investments in our system may have big impact. We're not looking for the kind of investments that the hospitals have received. We would like to follow the engineering plan which invests more of the patient care in our system by having some infrastructure to support that patient care through improved I.T.”

## e-Prescribing

Regarding electronic prescriptions, or e-Prescribing, Dr. Waizer said, “We have more than 40 physicians who would be eligible for e-Prescribing. And to give you a sense of it, our physicians have patients who are given psychotropics extensively, and many of them use two or three prescriptions, maybe even four or five, because we deal with the chronically mentally ill who have many side effects, and it is quite a medical management problem. And so we do see the merit of e-prescribing. Currently, we are building the capital to purchase e-Prescribing.”





**New York State Department of Health  
Medicaid Incentive Payment System (MIPS)  
External Stakeholder Feedback**

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## **Visiting Nurse Service of New York**

February 19, 2010 | 11:30 a.m.–12:30 p.m.

New York State Department of Health

99 Washington Avenue

Albany, New York

## Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the Visiting Nurse Service of New York. Comments were received on February 19, 2010, at the NYS Department of Health in Albany, NY. The Visiting Nurse Service of New York offers a wide range of home health-care services, including medical nursing, management of chronic conditions, and care to meet the needs of every generation, from at-risk infants to those at the end of life. The Visiting Nurse Service of New York provides services to residents in Manhattan, Brooklyn, Queens, Bronx, Staten Island, Nassau County, and Westchester County. In attendance were:

### **New York State Department of Health – Office of Health Insurance Programs**

James J. Figge, M.D., M.B.A., Chair Medical Director  
Phyllis E. Johnson, HIT Policy Coordinator

### **Visiting Nurse Service of New York**

Elizabeth L. Buff, Sr. Vice President for Quality  
Thomas Check, Sr. Vice President and CIO  
Judy A. Farrell, MPA Associate Director of Government Affairs

### **New York State Technology Enterprise Corporation (Program Consultants)**

Jack Menzies, Information Security Consultant  
Donna O'Leary, PMP, Program Consultant  
Peter Poleto, Account Executive

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## Visiting Nurse Service of New York (VNSNY) - Background

The Visiting Nurse Service of New York is the largest not-for-profit home care provider in the country. With more than 3,500 nurses and therapists, all throughout New York City, Westchester, and Nassau Counties, they serve more than 30,000 patients, more than all the hospitals in New York City, on any given day. A mobile workforce with computer

The VNSNY cares for more than 30,000 patients at any given time.

technology makes it possible. With 138,000 patients a year, as many as 22,000 different physicians are signing orders. This requires a great deal of coordination with physicians and other providers. Subsequently, the VNSNY collects *a lot* of patient information.

“Because we have so much patient information, we’re able to analyze it currently and retrospectively,” says Thomas Check, Sr. Vice President and CIO for the VNSNY. “To find the most effective clinical interventions, we make sure the care we’re delivering to the patient meets quality standards, which makes us a good partner for demonstrations.”

## The Case for Home Care and Information Coordination

A large number of VNSNY patients are Medicaid beneficiaries with complex medical needs and multiple chronic conditions. Patients require treatment for more than one condition, hence the need for home care. To understand these conditions and apply evidence-based practice, interventions, and assessment, all VNSNY nurses have laptop computers, as do rehab therapists and social workers.

With so many patients, in so many locations, with innumerable conditions and care plans, maintaining patient health status is critical. Core to that maintenance is a patient-centered medical home. The VNSNY can often fulfill many of the functions of the patient-centered medical home, where a physician is formally providing that structure.

“We see the patient-centered home as an opportunity to improve outcomes and reduce utilization by coordinating the care using evidence-based practice and engaging the patient.”

Thomas Check

## RHIOs and the Case for Sharing EHR

Regional Health Information Organizations, a product of previous New York State EHR funding, serve as regional providers of EHR transactions and database management. This just-in-time service is a lifeline between the VNSNY and its patients.

“We are members of four RHIOs in New York City, as well as LIPIX on Long Island,” says Thomas Check. “We’re finding that connecting through those RHIOs is more effective for the provider, and we believe it will also be a more effective way to disseminate material through the state enterprise service bus. And it’s actually one of the things I think the RHIOs can excel at.”

“We know that our patients see value in health information exchange.”

Thomas Check

The local focus of RHIOs makes them a perfect match for the VNSNY’s care plans and patient demographics. The RHIOs are able to work collaboratively with the VNSNY and others, making the implementation of EHR a solid map point on the horizon. One example would be patient consent to merge their information into the greater universe of EHR, RHIOs, and the like. The VNSNY was able to negotiate a common consent form among four RHIOs. In turn, this makes patient participation easier.

Ninety percent of VNSNY patients see value in health information exchange. Among patients in long-term Medicaid-funded programs, ninety-five percent agree to share their information. To-date the VNSNY has submitted data on more than 70,000 consented patients.

## Patient Centered Medical Homes –Home Care Implications

VNSNY patients have complex needs; they are more susceptible to condition deterioration, inpatient admissions, and Emergency Department (ED) visits, all of which can be expensive and can actually complicate their condition. If a patient enters the ED and the physician does not know the patient's history, it's hard to get the right intervention.

“During a homecare episode, we’re in the home seeing the patient much more frequently than the patient is going to be in the doctor's office, so we’re getting more real-time information. We’re giving more current intervention and coaching to the patient.”

VNSNY Staffer

Fully half of all VNSNY patients have had data uploaded to the regional RHIO from more than one source (hospital, medical center, community health center), so it's clear that people are getting care from more than one location.

A Patient-Centered Medical Home (PCMH) is one solution worth investigating, and experience suggests that the VNSNY has the background to fill this need. Fully half of all VNSNY patients have had data uploaded to the regional RHIO from more than one source (hospital, medical center, community health center), so it's clear that people are getting care from more than one location. The PCMH acts as the catch-all for these patients, or as Thomas Check puts it, "Mostly we see the patient-centered home as an opportunity to improve outcomes and reduce utilization by coordinating the care using evidence-based practice and engaging the patient."

Keeping a PCMH up-to-date requires constant monitoring; intermittent notes from a primary care physician or a specialist are too few and far between. Here, home-care providers are especially important. During a home-care visit, providers are in the home seeing the patient much more frequently, getting more real-time information, giving more current intervention and coaching. For example, among the first things a VNSNY provider does is complete a medical reconciliation. A home-care patient may have numerous prescriptions from numerous providers. The VNSNY nurse enters those into the tablet computer, where software runs a review for potential conflicts. Further consultation with the physician resolves any issues with the regimen.

### The Transitional Care Model – VNSNY's Approach for Planned Care

The VNSNY's Transitional Care Model is a plan for providing care to a patient as he or she moves from one setting to another. Typically, this move is from the hospital or ED to home, a nursing home, or a long-term care setting. Or, the patient may simply be moving from independent living into a new home with a loved one. Regardless, a great deal of information must move with the patient. What level of care was provided in the clinical setting? What were the discharge orders? Medications? As Elizabeth L. Buff, Sr. Vice President for Quality for the VNSNY puts it, "From the patient's perspective, why did they go to the hospital? Often what we see is a diagnosis that isn't related to what the patient believes they went for. And that often helps us understand what we need to do for interventions."

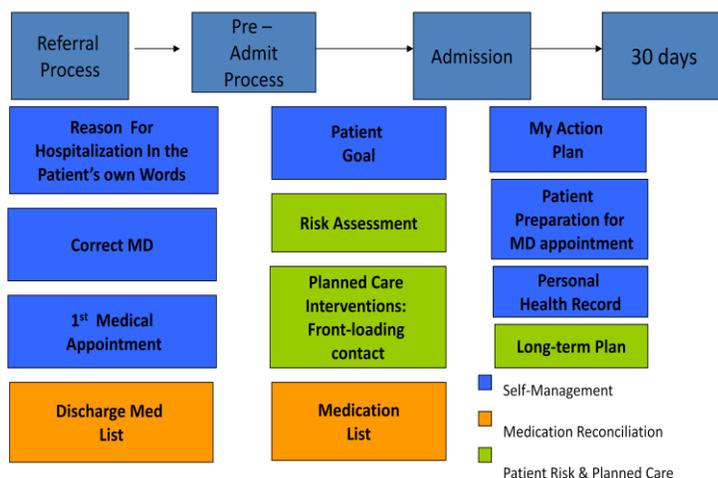
The Transitional Care Model has three components: 1) self management, actions the patient is ultimately responsible for; 2) medication reconciliation, includes medication lists and discharge medication lists; and 3) planned care, like risk assessments and long-term planning. The last two components likely involve several providers, such as hospitalists and specialists; all the clinicians involved with caring for the patient. The flow of information, *timely* information, is critical for care and avoiding rehospitalization. For

“It just would be wonderful if it was all electronic communication from provider to provider and to patient. I can't think of a better way.”

Elizabeth Buff

example, the admitting physician may not have written the discharge plan, and the physician doing follow-up will almost certainly be a third player in the process. Literature has shown that if a patient receives a follow-up appointment within the first two weeks of discharge, rehospitalization is avoided. “So, we want that appointment,” remarks Elizabeth Buff. “And particularly for our Medicaid recipients who are taken care of,

### VNSNYS' Transitional Care Model



in large part, by hospital practices. We need to know who the doctor is.”

Among the more critical pieces of information that care givers need is the patient's medication list. Ideally, the patient has this list, but that's not always the case. Having this information available via EHR is one solution. Further, care plans and symptom management strategies, all the information a patient needs, could be readily available to the home care professional via EHR.

Ms. Buff explains, “Within the first thirty days of the transition, we work with the patients and give them the tools to avoid going back to the hospital. We help them prepare for their physician visits, with items like their medication list and care plan. And we have found the communication between the patient, our clinicians in the field, and others is the right mix for patient care and planning. It just would be wonderful if it was all electronic communication from provider to provider and to patient. I can't think of a better way.”



## APPENDIX VI

# HOSPITAL INCENTIVE PAYMENT CALCULATION

The following appendix details the data sources and methodology that will be used in calculating incentive payment amounts for eligible hospitals under the Medicaid EHR Incentive Program.

## 1. Introduction

The American Recovery and Reinvestment Act of 2009 ("the Recovery Act") establishes a Medicaid EHR Incentive Program to provide financial incentives to health care providers who adopt and become meaningful users of electronic health records. The Recovery Act amends the Medicaid statute to provide for a 100 percent Federal financial participation (FFP) match for State expenditures for provider incentive payments to encourage Medicaid health care providers to purchase, implement, and operate certified electronic health record (EHR) technology.

Under the terms of the Recovery Act and subsequent federal rulemaking, Eligible Hospitals (including acute care and children's hospitals) that adopt, implement, upgrade, or meaningfully use certified EHR technology may be eligible to receive incentive payments over a three-year period based on a payment formula that begins at \$2 million and adjusts based on number of discharges, amount of charity care, and the proportion of bed days attributable to Medicaid beneficiaries.

This report describes the methodology that NY Medicaid proposes to use to calculate the incentive payment amount to be distributed to each eligible hospital. This methodology is adopted in compliance with subsection (f) (5) of Section 1903 of the Social Security Act (42 U.S.C. 1396b), as well as the rules promulgated in 42 CFR § 495.310(f). This proposed methodology is subject to approval by CMS and should not be considered final until such time as CMS has issued formal approval.

Eligible Professionals (including physicians, nurse practitioners, certified nurse-midwives, dentists, and some physician assistants) may also receive incentive payments under a different formula; these incentive payments are outside the scope of this report.

## 2. Definitions

The following terms have specific meaning within the context of the NY Medicaid EHR Incentive Program. All subsequent references to these terms should be interpreted as strictly conforming to the definitions shown below.

### **Eligible Hospital**

The HITECH act defines an eligible hospital as "a subsection (d) hospital." Subsequent federal rulemaking defined eligible hospitals according to the last four digits of the hospital's CMS Certification Number (formerly known as Medicare Provider Number or OSCAR number). For the Medicaid EHR Incentive Program, an eligible hospital is either an acute care hospital (meaning "those hospitals with an average patient length of stay of 25 days or fewer, and with a CCN that falls in the range 0001-

0879 or 1300-1399.") or a children's hospital (defined as "a hospital that is separately certified as a children's hospital, with a CCN in the 3300-3399 series and predominantly treats individuals under the age of 21").

In addition to the requirement that the hospital must be certified as an acute care facility in order to be eligible to participate in the EHR Incentive Program, CMS defines the eligible hospital as specifically the portions of the hospital that provide acute care services. Where aspects of participation in the EHR Incentive Program require the use of statistics on the eligible hospital (such as the number of inpatient bed days, discharges, or charges), these statistics must strictly exclude any portions of the hospital that provide sub-acute care. In particular, CMS has clarified certain portions of the hospital that are not deemed to provide acute care services and must not be included in these statistics, including:

- Nursery units (although acute care units for newborns such as neonatal intensive care units would be included in the eligible hospital)
- Observation units
- Rehabilitation, psychiatric, and long term care units
- Swing beds, in the case when the swing bed is used to provide sub-acute skilled nursing care (note that when the swing bed is used to provide acute inpatient care, such services are included in the eligible hospital)

### **Institutional Cost Report (ICR)**

The Institutional Cost Report is a uniform report used by New York hospitals to report income, expenses, assets, liabilities, and statistics to the Department of Health. The ICR is based on the current version of the CMS Form 2552, with state-specific additions. It is submitted annually by each hospital.

### **Base Year**

The base year is the hospital reporting year used to determine eligibility of a hospital for participation in the NY Medicaid EHR Incentive Program, which forms the basis for deriving the statistics that will determine the amount of the incentive payments the hospital is eligible to receive.

According to rules promulgated by CMS, the data used in calculating eligibility and incentive payment amounts is drawn from the "hospital cost report for the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the payment year." Due to the timing of New York's reporting requirements for healthcare facilities, the Department of Health has determined that for hospitals participating in the Medicaid EHR Incentive Program in Federal Fiscal Year 2010-2011 (October 1, 2010–September 30, 2011), the base year will be 2009 and all statistics for the base year will be drawn from the 2009 Institutional Cost Report.

### 3. Data Element Descriptions

The following is a detailed description of each data element that is used in the calculation of the NY Medicaid EHR Incentive payment amount for each eligible hospital.

#### 1 Program Participation Year

The number between 1 and 4 (inclusive) used in calculating the total amount of the hospital's incentive payment. According to statute, the incentive payment is theoretically calculated over a four-year period, with the payment amount varying based on the program participation year.

Note that in practice, the four-year calculation is entirely based on data available in the first program participation year.

**Source:**

- Derived from program participation

#### 2 Total Acute Discharges

The number of discharges from the Eligible Hospital for a given reporting year.

**Source:**

- Exhibit 3 of the Institutional Cost Report, Class Code 0090, Line 008
- Exhibit 3 of the Institutional Cost Report, Class Code 0090, Line 007

**Derivation:**

- Subtract Line 007 from Line 008.

**Required for:**

- The base year (e.g., 2009)
- The first year prior to the base year (e.g., 2008)
- The second year prior to the base year (e.g., 2007)
- The third year prior to the base year (e.g., 2006)

### 3 Medicaid Acute Inpatient Bed Days

The number of bed days in the Eligible Hospital for the reporting year that were paid all or in part by the New York Medicaid fee-for-service program, or by a managed care organization under contract with New York Medicaid for a Medicaid beneficiary. According to 1903(t)(5)(C) of the Social Security Act (42 U.S.C. 1396b) and 42 CFR § 495.310(g)(2)(iii), this figure must strictly exclude any inpatient bed days attributable to “individuals with respect to whom payment may be made under Medicare Part A” as well as “individuals who are enrolled with a Medicare Advantage organization under Medicare Part C”, regardless of whether the services rendered to such individuals were paid all or in part by Medicaid. In addition, so-called “zero-pay” claims (where the patient was an eligible Medicaid beneficiary but Medicaid did not issue a payment for any reason) must be excluded.

**Source:**

- Exhibit 3 of the Institutional Cost Report, Class Code 0693, Line 008
- Exhibit 3 of the Institutional Cost Report, Class Code 0693, Line 007

**Derivation:**

- Subtract Line 007 from Line 008.

**Required for:**

- The base year (e.g., 2009)

### 4 Total Acute Inpatient Bed Days

The total number of bed days in the Eligible Hospital for the reporting year (including all payment sources and uncompensated care).

**Source:**

- Exhibit 3 of the Institutional Cost Report, Class Code 0694, Line 008
- Exhibit 3 of the Institutional Cost Report, Class Code 0694, Line 007

**Derivation:**

- Subtract Line 007 from Line 008.

**Required for:**

- The base year (e.g., 2009)

## 5 Total Acute Charges

The total dollar value of all acute care charges in the Eligible Hospital for the reporting year.

**Source:**

- Exhibit 46 of the Institutional Cost Report

**Derivation:**

- Gross acute inpatient charges, less inpatient charges for sub-provider I, sub-provider II, and newborn.

**Required for:**

- The base year (e.g., 2009)

## 6 Total Acute Charity Care Charges

The total dollar value of all acute care charges attributable to charity care in the Eligible Hospital for the reporting year.

**Source:**

- Exhibit 46 of the Institutional Cost Report

**Derivation:**

- Gross acute inpatient charity care charges, less inpatient charity care charges for sub-provider I, sub-provider II, and newborn

**Required for:**

- The base year (e.g., 2009)

## 7 Growth Rate

The rate of growth in discharges for the Eligible Hospital in one year, expressed as a ratio of the number of total discharges (see line 2) in a given year to the number of total discharges in the previous year, minus one. Thus, the growth rate is positive if the hospital had more discharges in the subsequent year, zero if the hospital had the same number of discharges in the two years, and negative if the hospital had fewer discharges in the subsequent year.

**Source:**

- Derived from other data elements

**Derivation:**

- Divide the total number of discharges in the given year by the total number of discharges in the previous year, then subtract one.

## 8 Average Growth Rate

The arithmetic mean of the growth rate (see line 7) in each of the three most recent reporting years (measured from the previous year). For example, for base year 2009, the Average Growth Rate is the average of the following three growth rates:

- The growth rate from reporting year 2008 to reporting year 2009
- The growth rate from reporting year 2007 to reporting year 2008
- The growth rate from reporting year 2006 to reporting year 2007

If discharge data is not available for the four most recent reporting years, the average growth rate will be calculated based on the maximum number of years available. For a hospital with no discharge history prior to the most recent reporting year, the average growth rate will be assumed to be zero.

### Source:

- Derived from other data elements

### Derivation:

- Add the three consecutive growth rates and divide by three.
- If fewer than three consecutive growth rates are available, add the available growth rates together and divide by the number of growth rates available.
- If no growth rates are available, the average growth rate is defined to be zero.

## 9 Estimated Acute Discharges

The estimated total number of discharges from the Eligible Hospital for a given future year, calculated using the assumption that the Growth Rate in future years will be exactly equal to the Average Growth Rate observed in the base year.

### Source:

- Derived from other data elements

### Derivation:

- For year 1, the Estimated Acute Discharges is equal to the Total Acute Discharges (line 2) in the base year.
- For years 2–4, the Estimated Acute Discharges is equal to the Estimated Acute Discharges in the previous year, plus the Estimated Acute Discharges in the previous year times the Average Growth Rate (line 8).

## 10 Adjusted Acute Discharges

The number of estimated discharges that are eligible for the discharge-related adjustment as defined by 42 CFR § 495.310 (g)(1)(i)(B). According to that regulation, the discharge-related adjustment is:

- For the first through 1,149th discharge, \$0.
- For the 1,150th through the 23,000th discharge, \$200.
- For any discharge greater than the 23,000th, \$0.

**Source:**

- Derived from other data elements

**Derivation:**

- Subtract 1,149 from the Estimated Discharges (see line 9) for the given year.
- If the resulting value is:
  - Less than or equal to 0, the Adjusted Discharges is equal to 0.
  - Greater than 0 but less than 21,851, the Adjusted Discharges is equal to Estimated Discharges minus 1,149.
  - Greater than or equal to 21,851, the Adjusted Discharges is equal to 21,851.

## 11 Transition Factor

A scaling figure specified in the original legislation that is applied to each annual incentive payment amount.

**Source:**

- HITECH act and subsequent regulations (see 42 CFR § 495.310 (g)(1)(iii))

**Derivation:**

- For the first program participation year, the Transition Factor is equal to 1.
- For the second program participation year, the Transition Factor is equal to  $\frac{3}{4}$ .
- For the third program participation year, the Transition Factor is equal to  $\frac{1}{2}$ .
- For the fourth program participation year, the Transition Factor is equal to  $\frac{1}{4}$ .

#### 4. Hospital Incentive Payment Formula

The standard form of the hospital incentive payment calculation, as given in 42 CFR § 495.310(f), is as follows:

$$I = \sum_{y=1}^4 \left[ \$2,000,000 + \$200(D_y) \right] \times \left( \frac{m}{b \times \frac{t-c}{t}} \right) \times T_y$$

**Exhibit VI-1** Standard form of the hospital incentive payment calculation

Where:

- I* is the total incentive amount the hospital is eligible to receive over the entire course of the incentive program.
- y* is the incentive program participation year (see Data Element Description, line 1).
- D<sub>y</sub>* is the Adjusted Acute Discharges from the Eligible Hospital in the given program participation year (see Data Element Description, line 10).
- m* is the total number of Medicaid Acute Inpatient Bed Days in the Eligible Hospital in the base year (see Data Element Description, line 3).
- b* is the total number of Acute Inpatient Bed Days in the Eligible Hospital in the base year (see Data Element Description, line 4).
- t* is the total amount of the Eligible Hospital's Acute Charges in the base year (see Data Element Description, line 5).
- c* is the total amount of the Eligible Hospital's Acute Charity Care Charges in the base year (see Data Element Description, line 6).
- T<sub>y</sub>* is the transition factor for the given program participation year (see Data Element Description, line 11).

The following is an alternate form of the hospital payment calculation which will be used by NY Medicaid in some settings where the calculation is likely to be done manually (for example, in paper-based worksheets for estimating the incentive payment). The advantage of this alternate form, which is mathematically equivalent, is that it does not involve complex fractions and is thus easier to compute by hand and express in worksheet form.

$$I = \sum_{y=1}^4 \left[ \$2,000,000 + \$200(D_y) \right] \times \left( \frac{m}{b} \right) \times \left( \frac{t}{t-c} \right) \times T_y$$

**Exhibit VI-2** Alternate form of the hospital incentive payment calculation

## 5. Hospital Incentive Disbursement Schedule

Although the calculation of the aggregate EHR hospital incentive amount is based on a theoretical four-year period of participation in the incentive program, states are given flexibility to define the way the aggregate incentive amount is broken down into payments as well as the schedule for making these payments. The limitations of this flexibility are set in federal rulemaking at 42 CFR § 495.310(f) which specifies the following conditions:

- (1) The payment is provided over a minimum of a 3-year period and maximum of a 6-year period.
- (2) The total incentive payment received over all payment years of the program is not greater than the aggregate EHR incentive amount, as calculated under paragraph (g) of this section.
- (3) No single incentive payment for a payment year may exceed 50 percent of the aggregate EHR hospital incentive amount calculated under paragraph (g) of this section for an individual hospital.
- (4) No incentive payments over a 2-year period may exceed 90 percent of the aggregate EHR hospital incentive amount calculated under paragraph (g) of this section for an individual hospital.
- (5) No hospital may begin receiving incentive payments for any year after 2016.
- (6) A multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating payment.

New York has opted to make use of this flexibility to provide the maximum possible incentive payments to hospitals as early as possible in their program participation. Specifically, New York will disburse the aggregate EHR incentive payment to hospitals as follows:

- In the first year, 50% of the aggregate incentive amount.
- In the second year, 40% of the aggregate incentive amount.
- In the third year, the remaining 10% of the aggregate incentive amount.

The incentive payments will be disbursed in annual lump sum payments after the hospital completes all necessary registration and attestation and the State has successfully validated all aspects of the hospital's application.

## 6. Sample Hospital Incentive Payment Calculation

The following illustrates the hospital payment calculation for a sample hospital located in the City of Albany. For the purposes of this sample, the hospital is assumed to have demonstrated that it meets all eligibility criteria based on a reporting period in FFY 2010-2011 (thus, the Base Year is 2009). The hospital reported the following statistics:

Description	Source	Value
2009 Total Discharges	2009 ICR, Exhibit 3, Class Code 0090, Line 008	25,066
2009 Nursery Discharges	2009 ICR, Exhibit 3, Class Code 0090, Line 007	2,287
<b>2009 Total Acute Discharges</b>		<b>22,779</b>
2009 Medicaid Inpatient Bed Days	2009 ICR, Exhibit 3, Class Code 693, Line 008	17,284
2009 Medicaid Nursery Bed Days	2009 ICR, Exhibit 3, Class Code 693, Line 007	596
<b>2009 Medicaid Acute Inpatient Bed Days</b>		<b>16,688</b>
2009 Total Inpatient Bed Days	2009 ICR, Exhibit 3, Class Code 694, Line 008	120,381
2009 Total Nursery Bed Days	2009 ICR, Exhibit 3, Class Code 694, Line 007	5,329
<b>2009 Total Acute Inpatient Bed Days</b>		<b>115,052</b>
<b>2009 Total Acute Charges</b>	2009 ICR, Exhibit 46	<b>\$644,027,770</b>
<b>2009 Total Acute Charity Care Charges</b>	2009 ICR, Exhibit 46	<b>\$2,310,201</b>
2008 Total Discharges	2008 ICR, Exhibit 3, Class Code 0090, Line 008	24,922
2008 Nursery Discharges	2008 ICR, Exhibit 3, Class Code 0090, Line 007	2,283
<b>2008 Total Acute Discharges</b>		<b>22,639</b>
2007 Total Discharges	2007 ICR, Exhibit 3, Class Code 0090, Line 008	25,642
2007 Nursery Discharges	2007 ICR, Exhibit 3, Class Code 0090, Line 007	2,406
<b>2007 Total Acute Discharges</b>		<b>23,236</b>
2006 Total Discharges	2006 ICR, Exhibit 3, Class Code 0090, Line 008	25,636
2006 Nursery Discharges	2006 ICR, Exhibit 3, Class Code 0090, Line 007	2,234
<b>2006 Total Acute Discharges</b>		<b>23,402</b>

The results of intermediate calculations are shown below.

$$\text{Medicaid Share} = \frac{m}{b \times \frac{t-c}{t}} = \frac{16,688}{115,052 \times \frac{\$644,027,770 - \$2,310,201}{\$644,027,770}} \approx 0.145570$$

$$\text{2009 Growth Rate} = \frac{2009 \text{ Total Acute Discharges}}{2008 \text{ Total Acute Discharges}} - 1 = \frac{22,779}{22,639} - 1 \approx 0.006184$$

$$\text{2008 Growth Rate} = \frac{2008 \text{ Total Acute Discharges}}{2007 \text{ Total Acute Discharges}} - 1 = \frac{22,639}{23,236} - 1 \approx -0.025693$$

$$\text{2007 Growth Rate} = \frac{2007 \text{ Total Acute Discharges}}{2006 \text{ Total Acute Discharges}} - 1 = \frac{23,236}{23,402} - 1 \approx -0.007093$$

$$\begin{aligned} \text{Average Growth Rate} &= \frac{2009 \text{ Growth Rate} + 2008 \text{ Growth Rate} + 2007 \text{ Growth Rate}}{3} \\ &\approx \frac{0.006184 + -0.025693 + -0.007093}{3} \approx -0.008867 \end{aligned}$$

Based on the Average Growth Rate calculated above, the table below shows the Estimated Acute Discharges and Adjusted Acute Discharges for each of the four program participation years.

Program Participation Year	Estimated Acute Discharges	Adjusted Acute Discharges
1	22,779	21,630
2	22,577	21,428
3	22,377	21,228
4	22,178	21,029

The table below shows the calculation of each annual incentive amount and the total incentive amount over the four-year program participation period.

Program Participation Year	Calculation	Annual Incentive Amount
1	$[\$2,000,000 + (\$200 \times 21,630)] \times 0.145570 \times 1$	\$920,873
2	$[\$2,000,000 + (\$200 \times 21,428)] \times 0.145570 \times 1$	\$686,245
3	$[\$2,000,000 + (\$200 \times 21,228)] \times 0.145570 \times 1$	\$454,582
4	$[\$2,000,000 + (\$200 \times 21,029)] \times 0.145570 \times 1$	\$225,847
<b>Total</b>		<b>\$2,287,547</b>

Finally, the table below shows the disbursement schedule over the four-year program participation period.

Program Participation Year	Proportion	Incentive Payment
1	50%	\$1,143,773
2	40%	\$915,019
3	10%	\$228,755
4	0%	\$0



## **APPENDIX VII**

# **MEDICAID UPDATE ON E- PRESCRIBING INCENTIVE**

In April, 2010, NY Medicaid issued the following guidance on the e-prescribing incentive program as a “special update” edition of its monthly Medicaid Update newsletter.

## New York Medicaid Electronic Prescribing Incentive Program: Final Guidance

**Effective May 1, 2010**, New York Medicaid will provide incentives to encourage electronic prescribing (e-prescribing). As described in the New York State fiscal year 2009-2010 Health Budget, eligible Medicaid prescribers can receive an incentive payment of \$0.80 per dispensed Medicaid e-prescription, and eligible retail pharmacies can receive \$0.20 per dispensed Medicaid e-prescription.

The long-term goals of the program are to reduce medication errors, encourage pharmaceutical practices that produce better patient outcomes, and yield savings. The following guidance is intended to assist prescribers and pharmacies to prepare for participation in the program. This program guidance will be updated as necessary to incorporate new Federal rules regarding electronic prescribing.

### Electronic Prescription Definition

New York State Pharmacy Regulations (<http://www.op.nysed.gov/prof/pharm/part63.htm>) recognize two distinct types of electronically-transmitted prescriptions:

- **a prescription transmitted electronically by facsimile;**
- **a prescription transmitted electronically by means other than facsimile; such non-facsimile prescriptions are required by regulation to be electronically encrypted, meaning protected to prevent access, alteration or use by any unauthorized person.**

The New York Medicaid e-prescribing incentive program applies only to the second type of electronic transmission (non-facsimile). For the purposes of the incentive program, an electronic prescription (e-prescription) is defined as:

**a prescription created electronically and transmitted via encrypted, interoperable computer-to-computer electronic data interchange in machine-readable (non-facsimile) format that is compliant with Medicare Part D data standards and requirements <sup>(1)</sup> and New York State Pharmacy Regulations.**

The e-prescription must originate from the prescriber's computer system (an electronic health record, electronic medical record, or stand-alone e-prescribing software) and must be transmitted to the retail pharmacy's computer system. It is permissible to employ the services of an intermediary or e-prescribing network to transmit the e-prescription. The guidance in this document applies only to non-facsimile electronic transmission, and is not intended to address prescriptions that are transmitted electronically by facsimile.

## Eligible Participants: Prescribers

To be eligible for incentive payments, practitioners must be legally authorized to prescribe in New York State, must have an *individual* National Provider Identifier (NPI) number, and must be enrolled in the New York Medicaid Fee-for-Service (FFS) program as a billing practitioner.

### Eligible Professions Include:

- Physician (MD, DO)
- Dentist
- Nurse Practitioner
- Podiatrist
- Optometrist
- Licensed Midwife (includes nurse midwife and certified midwife with prescriptive privileges).

Practitioners must have a valid 10-digit NPI number on file with New York Medicaid. To apply for an individual NPI number, please visit:

<http://www.cms.hhs.gov/NationalProvIdentStand/>.

Individually assigned NPI numbers must be used to receive the incentive. Group, practice, and facility level NPI numbers may not be used with e-prescriptions in New York Medicaid.

Please note that all checks will be made out to the individual prescriber and sent to the payment address associated with the prescriber's individual NPI number. Therefore, it is imperative that the practitioner's Medicaid enrollment file has correct information regarding the payment address that is linked to the practitioner's individual NPI number. For questions regarding a practitioner's enrollment file, please contact the eMedNY Call Center at (800) 343-9000.

To enroll in New York Medicaid FFS, please visit:

<http://www.emedny.org/info/ProviderEnrollment/index.html>.

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## Requirements for Practitioners to Participate in the New York Medicaid e-Prescribing Incentive Program

- **Must be legally authorized to prescribe in New York State.**
- **Must have an *individual* NPI number on file with New York Medicaid.**
- **Must be enrolled as a billing practitioner in New York Medicaid FFS.**
- **Must provide a correct payment address to be linked with the individual NPI number.**

### Eligible Participants: Pharmacies

In order to receive incentive payments, a retail pharmacy must be enrolled in New York Medicaid FFS, and its NPI number must be on file with New York Medicaid.

Enrolled hospital-based outpatient retail pharmacies and freestanding clinic-based retail pharmacies are eligible to participate in the program. To enroll in New York Medicaid FFS, pharmacies should visit:

<http://www.emedny.org/info/ProviderEnrollment/index.html>.

To confirm information in a pharmacy's enrollment file, please contact the eMedNY Call Center at (800) 343-9000.

### Eligible e-Prescriptions

E-prescriptions must be approved by a Medicaid FFS-enrolled billing practitioner legally authorized to prescribe in New York State, while functioning within his or her scope of practice. The prescribing practitioner is responsible for review of clinical edits, and for final sign-off on the e-prescription before transmitting the e-prescription to a retail pharmacy. It is not permissible for a practitioner to delegate these responsibilities to non-qualified office staff (e.g., an employee or agent who cannot legally prescribe in New York State). The practitioner who signs off on the e-prescription must be identified by his or her individual NPI number on the e-prescription. Currently, New York State law prohibits e-prescribing of controlled substances. Updated guidance will be provided in the event that e-prescribing of controlled substances is permitted at a future date in New York.

New York State Pharmacy Regulations require that electronically transmitted prescriptions must contain the signature, or the electronic equivalent of a signature, of the prescriber. To satisfy this regulation, New York Medicaid requires that the electronic software generating the e-prescription must be certified by a certifying organization recognized by the Federal government. Additionally, New York Medicaid requires that e-prescribing software must incorporate logical access controls that restrict access to the e-prescribing functions of the software.

The Federal government has recognized the Certifying Commission for Health Information Technology (CCHIT) as a valid certification organization for Electronic Health Records (EHRs) and stand-alone e-prescribing software. The Office of the National Coordinator for Health Information Technology has recently announced a new Federal certification program for EHR technology as authorized under the HITECH / American Recovery and Reinvestment Act (ARRA).<sup>(2)</sup> New York Medicaid will publish an updated list of federally-recognized certifying organizations for EHRs and e-prescribing software as additional information becomes available.

Only legally authorized prescribers are permitted to access those e-prescribing functions that enable final sign-off and transmission of the prescription. The final electronic sign-off is the legal equivalent of a signature, and indicates that the clinician has accepted responsibility for the contents of a prescription. At a minimum, access to those functions must be protected by a user name and password. New York Medicaid will accept such controls to satisfy the electronic

signature requirement at the present time. However, New York State agencies are evaluating the feasibility of implementing cryptographic digital signatures for practitioners. Further guidance on this topic will be provided in a future Medicaid Update.

To qualify for an incentive payment, the e-prescription must be encrypted and transmitted electronically to the retail pharmacy according to Medicare Part D standards. Faxed prescriptions do not qualify for the New York Medicaid incentive payment, even if the fax is computer-generated. While faxed prescriptions are legal in New York State, the incentive program is designed to encourage electronic prescribing practices conforming to national standards to ensure interoperable data exchange between the prescriber's computer and the retail pharmacy computer system.

The electronic transaction must conform to Medicare Part D standards and requirements.<sup>(1)</sup> It should be noted that the HITECH incentive program for the adoption and meaningful use of certified electronic health record technology also requires adherence to Medicare Part D standards and requirements.<sup>(2)</sup> Medicare currently requires the use of the National Council for Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT standard Version 8.1. Medicare may soon advance to NCPDP SCRIPT standard 10.6. New York Medicaid will publish an advisory notice in the Medicaid Update should this occur.

All e-prescriptions must contain the required NCPDP 8.1 data fields. Additionally, Medicare Part D standards require that all e-prescriptions include the prescriber's individual NPI number. Practitioners are urged to consult with their software vendors to ensure that their software is certified by an organization recognized by the Federal government, and to ensure that the software is Medicare Part D compliant. It is recommended that the prescriber's individual NPI number be automatically populated on the e-prescription to avoid transcription errors that could occur with manual entry of the 10-digit number.

E-prescriptions for the New York Medicaid program not conforming to these national standards may be rejected by pharmacists as invalid e-prescriptions. It is the prescriber's responsibility to ensure that the correct NCPDP data fields and **individual** NPI number have been provided on the e-prescription. Only e-prescriptions dispensed in the retail setting are eligible for the incentive program. E-prescriptions for use in the inpatient setting, long-term care setting (when the cost of the pharmaceutical is already included in the long-term care rate), or for administration in the clinic or physician office are not eligible.

### Eligible Beneficiaries

The e-prescription must be written for a beneficiary who is enrolled in Medicaid FFS, Medicaid Managed Care, or Family Health Plus. The beneficiary must be eligible for services at the time the e-prescription is written, and also at the time the prescription is filled at the pharmacy.

## Pharmacy Claim Must Be Paid by New York Medicaid

For the incentive to be payable, the prescribed item must be a prescription medication on the New York Medicaid formulary (i.e., the New York State Department of Health List of Medicaid-Reimbursable Drugs, available at: <http://www.emedny.org/info/formfile.html>) and must be identified by a National Drug Code (NDC). Over-the-counter medications and pharmacy supplies are not eligible for the incentive program (even if listed on the List of Medicaid-Reimbursable Drugs). The prescription itself is not required to contain the NDC, as this code is usually assigned by the pharmacy. The pharmacy claim corresponding to the e-prescription must be paid by New York Medicaid before the incentive payment can be applied. Denied pharmacy claims will not be processed for the incentive payment for either the prescriber or pharmacy. Furthermore, claims that are paid by Medicare Part D plans or other payers are not eligible for the incentive (unless Medicaid also makes a partial payment [e.g., co-payment or secondary payment] on the claim).

### Prior Authorization

Certain items on the New York State Department of Health List of Medicaid-Reimbursable Drugs require prior authorization. Before transmitting the e-prescription, it is the prescriber's responsibility to ensure that prior authorization has been obtained. A data field is available within the NCPDP 8.1 standard for transmitting the 11-digit prior authorization number with the e-prescription (NCPDP field DRU - 080).

### The Prescribed Item Must Be Dispensed to the Beneficiary

The incentive payments for both the prescriber and pharmacy are payable only if the prescribed item is picked up or delivered to the beneficiary within 14 days of being filled. If the item is not picked up or delivered within 14 calendar days, the pharmacy is required to void the claim (if already submitted) by day 15 (or the next business day). The voided claim will automatically void the incentive payments.

### Refills

One original fill and up to five (5) refills within 180 days are **each** eligible for an incentive payment to both the prescriber and pharmacy, provided that the refilled item is picked up by or delivered to the beneficiary. This represents a maximum payment of \$4.80 to the prescriber, and \$1.20 to the pharmacy. The 180-day limit for refills is calculated with respect to the date the e-prescription was written. The date on which a given e-prescription was written must be reported on each related pharmacy claim in NCPDP field 414-DE.

## Requirements for Intermediaries and Electronic Prescribing Networks

Intermediaries and networks that electronically route e-prescriptions from the prescriber's software to the retail pharmacy computer system must ensure that their procedures are compliant with Medicare Part D standards and that they can transmit all required NCPDP data fields as well as the prescriber's individual NPI number. Intermediaries and electronic prescribing networks must comply with all applicable Federal and New York State rules and standards for data security and privacy. Per New York State Pharmacy Regulations, intermediaries and electronic prescribing networks must employ electronic encryption technology ensuring that the e-prescription is protected to prevent access, alteration or use by any unauthorized person. Hence, encryption and message authentication are required and must be according to algorithms approved by the National Institute of Standards and Technology (NIST), and the Office of the National Coordinator for Health Information Technology.<sup>(2)</sup> Intermediaries and electronic prescribing networks must implement strong policies and procedures regarding identity management, authentication and access control to ensure that only authorized users may transmit and receive e-prescriptions.

### Special Requirements for Pharmacies

**Effective January 1, 2010**, all Medicaid pharmacy claims for e-prescriptions must include the number "3" in the NCPDP Prescription Origin Code field (i.e., NCPDP field 419-DJ). To qualify as an electronic prescription, the prescription must be created electronically on the prescriber's e-prescribing system and must be transmitted to the retail pharmacy computer system via encrypted, interoperable computer-to-computer electronic data interchange in machine-readable (non-facsimile) format that is compliant with Medicare Part D standards and requirements<sup>(1)</sup> and New York State Pharmacy Regulations. New York State regulations are available for viewing at:

<http://www.op.nysed.gov/prof/pharm/part63.htm>.

Prescription Origin Codes
0 = Not Specified
1 = Written
2 = Telephone
3 = Electronic
4 = Facsimile

Although New York is initially only requiring use of the field for e-prescriptions, it is the State's intent to mandate use of the Prescription Origin Code for all Medicaid prescription claims effective **July 1, 2010**. After July 1, 2010, pharmacy claims that do not have a valid entry in this field will be denied.

Pharmacies are urged to consult with their software vendors to facilitate auto-population of this field with a "3" upon processing a valid Medicare Part D-



compliant e-prescription. The NCPDP allowable entries are outlined in the box above. Medicare also requires implementation of the prescription origin code field as of January 1, 2010.<sup>(3)</sup>

Pharmacies must report the prescriber's identity on all pharmacy claims in NCPDP field 411-DB (i.e., Prescriber ID). For a given e-prescription, New York Medicaid expects that the prescriber's individual NPI number will be reported on each related pharmacy claim in NCPDP field 411-DB. New York Medicaid expects that the corresponding Prescriber ID Qualifier will be reported as "01" in NCPDP field 466-EZ, indicating that the Prescriber ID is an NPI number.

### **Incentive Payments**

The pharmacy incentive payment will be reported separately from the dispensing fee on the 835 remittance. The prescriber's identity will be captured from the pharmacy claim (as the individual NPI number). Prescriber incentives will be bundled into quarterly payments. These will initially be processed off-line, but will eventually transition to the New York Medicaid MMIS system (eMedNY)

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## **APPENDIX VIII**

# **AHRQ CASE STUDY ON E- PRESCRIBING INCENTIVE PROGRAM**

In July, 2010, the Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services developed the following case study on NY Medicaid's e-Prescribing Incentive Program.

## Case Study: Developing an Electronic Prescribing Incentive Program: Lessons Learned from New York Medicaid

**Prepared for:**

Agency for Healthcare Research and Quality  
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540 Gaither Road  
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**Report Contract No. HHS2902007-10079T**

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**AHRQ Publication No. 10-0066-EF**



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**HEALTH IT**



## **Case Study: Developing an Electronic Prescribing Incentive Program: Lessons Learned from New York Medicaid**

### **Agency Overview**

New York State's Medicaid program is the second largest in the country, covering more than 4.5 million New Yorkers (23% of the population). 69% of New York's beneficiaries are enrolled in a managed care program. The State's Medicaid program is administered by the Office of Health Insurance Programs (OHIP) under the Department of Health. The State's CHIP program, Child Health Plus, is separate from Medicaid and enrolls an additional 365,000 children.

### **Project Background**

In summer 2008, New York Medicaid began developing an electronic prescribing (e-prescribing) incentive program aimed at reducing medication errors, encouraging practices that support better patient care and outcomes, and reducing costs. Effective May 1, 2010, New York Medicaid is offering incentives to encourage Medicaid providers to use e prescribing. For each electronically prescribed medication, prescribing clinicians will receive \$0.80 and the pharmacy will receive \$0.20, contingent upon the patient picking up the prescription. This program is the result of 2 years of work by OHIP staff, working in collaboration with a wide range of stakeholders, to complete preliminary research, obtain legislative support, and implement the program.

### **Project Details**

#### ***Planning Process***

Work to develop the e-prescribing incentive program began in summer 2008, led by OHIP. A working group, including representatives from Medicaid, the Office of Health Information Technology Transformation (OHITT), the New York State Education Department (New York State Board of Pharmacy), and the Office of Public Health, met during 2008 to brainstorm parameters for the incentive program.

The committee completed extensive research prior to developing the program, including conducting an extensive literature review and financial modeling to predict cost savings. The committee looked exclusively at the cost savings associated with avoiding medication errors. (For the purposes of the analysis, they did not consider what additional cost savings might accrue as a result of increased formulary compliance.) The committee estimated that each prescription transmitted electronically would save the agency \$1.82, which includes the decrease in medication errors and costs of printing official New York paper prescriptions. The total cost savings were estimated based on the total volume of prescriptions dispensed.

The committee proposed that the cost savings be shared across three entities: the Medicaid agency, the prescribing clinician, and the pharmacy, with the prescribing physician receiving \$0.80 per prescription and the pharmacy receiving \$0.20 per dispensed prescription. This allocation was made with the knowledge that the pharmacies benefit from the increased efficiency associated with the transition to e-prescribing and that the pharmacy incentive would largely need to cover the transaction costs charged by e-prescribing networks and intermediaries, while prescribing clinicians would be responsible for a greater investment in technology. Pharmacies and prescribing clinicians also receive an additional incentive for refill prescriptions. For example, if a patient has a refillable prescription, the pharmacy receives the \$0.20 incentive for up to five refills, or a total of \$1.20 for the prescription. Prescribing clinicians would receive up to \$4.80. If the patient does not pick up the medication, the incentive is not paid. Pharmacies are paid immediately as an add-on to the dispensing fee, and enrolled prescribing clinicians will receive a bundled payment quarterly.

The legislation authorizing the incentive program was passed as part of the 2009–2010 budget with broad bipartisan support. The legislation passed successfully and relatively easily due to several factors: extensive research the committee completed before drafting the legislation; careful review of the costs and benefits of e prescribing (and presenting this information in a comprehensible and effective manner); and presentation of the solution as a win for all three parties (Medicaid, prescribing clinicians, and pharmacies). Although there was some debate about the allocation of the incentives, the research results allowed the committee to argue effectively for the structure they originally proposed.

### ***Implementation Process***

Following the passage of the budget and the legislation authorizing the incentive program, implementation efforts began in summer 2009.

Implementing the program required significant interaction with a wide range of stakeholders. To ensure alignment within the regulatory environment, the agency hosted scores of meetings with the Office of the Medicaid Inspector General (which oversees audits of pharmacies), the Bureau of Narcotic Enforcement, and the State Pharmacy Board, all of which are involved with the regulation of certain aspects of the prescribing process and pharmacists' conduct. Similarly, to ensure alignment across various constituencies, the agency hosted regular meetings with industry representatives, government officials, a major national intermediary, technical staff, policy experts, and lawyers.

During the initial rollout, it became clear that there was substantial confusion as to what e prescribing actually entails. For example, there was extensive discussion about whether electronic faxes counted as e-prescribing (e.g., if the fax was sent and received via computer.) After much discussion, the pharmacy and medical societies accepted the definition put forth by the agency.<sup>1</sup> Faxes are still a legal method of transmitting prescriptions, but faxed prescriptions do not qualify for incentive payments. In addition, pharmacy software vendors were not uniformly aware of Medicare Part D standards that had recently come into effect, requiring the use of a prescription origin code and the prescriber's individual national provider identifier (NPI). The agency also encountered resistance from the State medical society regarding the use of the NPI in the e prescribing program.

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<sup>1</sup> New York Medicaid defines e prescribing as: "a prescription created electronically and transmitted via encrypted, interoperable, computer-to-computer electronic data interchange in machine readable (non-facsimile) format that is compliant with Medicare Part D data standards and requirements and New York State Pharmacy Regulations." For additional information, please see the April 2010 New York State Medicaid Update, available at [http://www.health.state.ny.us/health\\_care/medicaid/program/update/2010/2010-04\\_special\\_edition.htm](http://www.health.state.ny.us/health_care/medicaid/program/update/2010/2010-04_special_edition.htm)

Once the definition for e-prescribing was settled, the agency turned to the logistics of implementing the program, specifically, how would the pharmacies report the receipt of electronic prescriptions to receive the incentive payment? Coincidentally, Medicare Part D requires what is called a “prescription origin code” that identifies how a prescription was transmitted.<sup>2</sup> In order to receive the incentive payment, the prescription origin code as reported on the corresponding pharmacy claim would have to denote an electronic prescription (e.g., list a prescription origin code of 3). The State was able to leverage the fact that Medicare already announced that it would require a prescription origin code effective January 2010; by requiring it for Medicaid pharmacy claims as well, the agency was able to achieve compliance with all vendors in New York. As of July 1, 2010, Medicaid will deny pharmacy claims that are submitted without a valid prescription origin code.

New York Medicaid also strategically mandated the use of Medicare Part D data standards, thereby pushing the software industry toward a universal standard in New York. This strategy harmonizes nicely with the Office of the National Coordinator for Health Information Technology interim final rule (IFR) for the Health Information Technology for Economic and Clinical Health Act (HITECH) program, which also requires the adoption of Medicare Part D data standards for the HITECH Medicare and Medicaid incentive programs. Hence, eligible professionals who participate in the New York Medicaid e prescribing incentive program will have a jumpstart on meeting the e prescribing component of meaningful use once the HITECH program goes live.

### **Next Steps**

As the program moves forward, New York Medicaid will continue to address authentication issues and review other potential changes to the Federal regulatory environment that may impact the program, including DEA’s final rule related to the electronic prescription of controlled substances.

### **Lessons for Other Agencies**

New York Medicaid’s success in building the incentive program was supported by the extensive research that was completed at the outset. The research enabled them to quantify the costs and savings of the incentive program and provided a neutral point of reference when questions arose about how the incentives should be structured. The research also proved useful in discussions with members of the State Assembly and Senate by allowing New York Medicaid to present the situation as a win-win-win for the State, providers, and pharmacies.

Intensive, repeated stakeholder engagement was also a key component to the success of the program. Because of the diverse, and at times divergent, interests of the stakeholder groups, frequent meetings were required to share concerns and make revisions to the program that were palatable and feasible for all parties.

Finally, New York Medicaid leveraged work at the Federal level, specifically the Medicare Part D standards. Since the prescription origin codes were already slated to be required for Medicare claims, it was straightforward for pharmacy software vendors to use the same standards for Medicaid claims as well. The vendor community was pleased with this requirement because it did not require compliance with a second set of standards.

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<sup>2</sup> The reference codes are numbered 0 through 4 and include not specified, written, telephone, electronic, and facsimile.



### **Additional Information**

For additional information about this case study, please contact Medicaid-SCHIP-HIT@ahrq.hhs.gov or call 1-866-253-1627.

## **APPENDIX IX**

# **MEDICAID UPDATE ON PCMH INCENTIVE**

In December, 2009, NY Medicaid issued the following guidance on the Statewide Patient-Centered Medical Home Incentive Program as a “special update” edition of its monthly Medicaid Update newsletter.

## December 2009 Special Edition Announcing New York Medicaid's Statewide Patient-Centered Medical Home Incentive Program

**Chapter 58 of the Laws of 2009 authorized the New York State Department of Health (NYSDOH) to implement an initiative to incentivize the development of patient-centered medical homes to improve health outcomes through better coordination and integration of patient care for persons enrolled in New York Medicaid.**

### **Definition of a Medical Home:**

The American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA), have jointly defined the medical home as a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team, which also may include roles for nurse practitioners or physician assistants, is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians.

### **NCQA Physician-Practice Connections - Patient Centered Medical Home Program (PPC®-PCMH™)**

New York Medicaid has chosen to adopt medical home standards that are consistent with those of the National Committee for Quality Assurance's (NCQA) Physician Practice Connections® - Patient-Centered Medical Home Program (PPC-PCMH™). The PPC-PCMH™ is a model of care that seeks to strengthen the physician-patient relationship by promoting improved access, coordinated care, and enhanced patient/family engagement.

A medical home also emphasizes enhanced care through open scheduling, expanded hours, and communication between patients, providers and staff. Care is also facilitated by registries, information technology, health information exchange and other means to ensure that patients obtain the proper care in a culturally and linguistically appropriate manner.

The NCQA PPC®-PCMH™ program assesses whether practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC®-PCMH™ standards emphasize the use of systematic, patient-centered, coordinated care management processes.

NCQA has designed a recognition program to objectively measure the degree to which a primary care practice meets the operational principles of a patient-centered medical home. The NCQA program features three tiers of medical home recognition. Achievement of a given tier is dependent upon a point-scoring system

whereby points are awarded if the practice has achieved competency in a given business/practice management process.

- Level 1 functions as the basic tier and can be achieved without deploying electronic health records (EHR).
- Level 2 requires some electronic functions.
- Level 3 requires a fully functional EHR.

PPC®-PCMH™ includes nine standards that medical practices must meet, including use of patient self-management support, care coordination, evidence-based guidelines for chronic conditions and performance reporting and improvement. To be recognized as a patient-centered medical home, practices need to demonstrate the ability to meet the criteria of these standards (i.e. achieve a minimum of 25 points out of 100 to attain the first of three levels of recognition) and specifically pass at least five of the following 10 elements:

- **Written standards for patient access and patient communication;**
- **Use of data to show standards for patient access and communication are met;**
- **Use of paper or electronic charting tools to organize clinical information;**
- **Use of data to identify important diagnoses and conditions in practice;**
- **Adoption and implementation of evidence-based guidelines for three chronic conditions;**
- **Active patient self-management support;**
- **Systematic tracking of test results and identification of abnormal results;**
- **Referral tracking, using a paper or electronic system;**
- **Clinical and/or service performance measurement, by physician or across the practice;**
- **Performance reporting, by physician or across the practice.**

PPC®-PCMH™ content and scoring is outlined in the following charts. For more information, providers are encouraged to visit the NCOA Website at <http://www.ncqa.org/>.

PPC-PCMH Scoring		
Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 - 100	10 of 10
Level 2	50 - 74	10 of 10
Level 1	25 - 49	5 of 10
Not Recognized	0 - 24	<5

**Levels:** If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements do not Qualify.

**PPC - PCMH Content and Scoring**

Standard 1: Access and Communication <b>A. Has written standards for patient communication"</b> <b>B. Uses data to show it meets its standards for patient access and communication**</b>	Pts <b>4</b> <b>5</b> 9	Standard 5: Electronic Prescribing A. Uses electronic system to write prescriptions B. Has electronic prescription writer with safety checks C. Has electronic prescription writer with costs check	Pts 3 3 2 8
Standard 2: Patient Tracking and Registry Functions A. User data system for basic patient information (mostly non-clinical data) B. Has clinical data system with clinical data in searchable data fields C. Uses the clinical data system <b>D. Uses paper or electronic-based charting tools to organize clinical information**</b> <b>E. Uses data to identify important diagnoses and conditions in practice**</b> F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	Pts 2 3 3 <b>6</b> <b>4</b> 3 21	Standard 6: Test Tracking <b>A. Tracks tests and identifies abnormal results systematically**</b> B. Uses electronic systems to order and retrieve tests and flag duplicate tests	Pts <b>7</b> 6 13
Standard 3: Care Management <b>A. Adopts and implements evidence-based guidelines for three conditions**</b> B. Generates reminders about preventive services for clinicians C. Uses non-physician staff to manage patient care D. Conducts care management, including care plans, assessing progress, addressing barriers E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities	Pts 3 4 3 5 5 20	Standard 7: Referral Tracking <b>A. Tracks referrals using paper-based or electronic system**</b>	Pts <b>4</b> 4

<p>Standard 4: Patient Self-Management Support</p> <p>A. Assesses language preference and other communication barriers</p> <p><b>B. Actively supports patient self-management**</b></p>	<p>Pts</p> <p>2</p> <p>4</p> <hr/> <p>6</p>	<p>Standard 8: Performance Reporting and Improvement</p> <p><b>A. Measures clinical and/or service performance by physician or across the practice**</b></p> <p>B. Survey of patients' care experience</p> <p><b>C. Reports performance across the practice or by physician**</b></p> <p>D. Sets goals and takes action to improve performance</p> <p>E. Produces reports using standardized measures</p> <p>F. Transmits reports with standardized measures electronically to external entities</p>	<p>Pts</p> <p>3</p> <p>3</p> <p>3</p> <p>2</p> <p>1</p> <hr/> <p>15</p>
		<p>Standard 9: Advanced Electronic Communications</p> <p>A. Availability of interactive Website</p> <p>B. Electronic Patient Identification</p> <p>C. Electronic Care Management Support</p>	<p>Pts</p> <p>1</p> <p>2</p> <p>1</p> <hr/> <p>4</p>

## Medical Home Incentive Payments

Upon federal approval, office-based practitioners (physicians and registered nurse practitioners) and Article 28 clinics recognized by NCQA's PPC-PCMH™ will receive additional payment for primary care services provided to Medicaid beneficiaries. The enhanced payment will be associated with the provider's or clinic's NPI and will be paid through eMedNY for Medicaid fee-for-service patients and by health plans for those enrolled in Medicaid Managed Care or Family Health Plus. The implementation date will be announced when federal approval is granted. Billing guidance will be provided in a future edition of the Medicaid Update once federal approval is received.

Consistent with NCOA recognition levels, there will be three levels of incentive payments for fee-for-service providers as illustrated in the chart below. Claims with appropriately coded Evaluation and Management (E&M) codes 99201-99205, 99211-99215, or Preventive Medicine codes 99381-99386, 99391-99396 will be eligible for an enhanced payment, commensurate with the level of NCOA recognition received by the provider. NCOA recognized providers that participate in Medicaid and Family Health Plus health plans will receive details on the payment amounts they can expect for services provided to plan enrollees.

**Fee-for-service add-on incentive payment amounts for providers achieving patient-centered medical home recognition are as follows:**

Setting	Level I	Level II	Level III
Article 28 clinics	\$5.50	\$11.25	\$16.75
Office-based practitioners*	\$7.00	\$14.25	\$21.25

\* includes physicians and registered nurse practitioners.

***The following example illustrates how the incentive will work:***

- *The Medicaid fee for an office visit claim with E&M code 99203 is **\$56.93**.*
- *A physician with Level 3 designation will be reimbursed **\$78.18 (\$56.93 + \$21.25)**.*
- *A physician with Level 2 designation will be reimbursed **\$71.18 (\$56.93 + \$14.25)**.*
- *A physician with Level 1 designation will be reimbursed **\$63.93 (\$56.93 + \$7.00)**.*

*New York Medicaid will end payments for Level 1 recognition after December 2012.*

### **Fee-for-Service Billing Requirements:**

**Office-based practitioners will receive the medical home add-on payment when they fulfill the following requirements:**

1. *In an individual provider's practice the billing practitioner must be designated as a New York Medicaid Medical Home (Level 1, Level 2, or Level 3);*
2. *In a practitioner group practice the group NPI (National Provider Identifier) and the billing practitioner NPI must be designated as a New York Medicaid Medical Home (Level 1, Level 2, or Level 3);*
3. *The claim must contain, and the service provided must be consistent with, one of the following Evaluation & Management codes (E&M) 99201- 99205, 99211- 99215; or one of the following Preventive Medicine codes 99381- 99386, 99391- 99396. The place of service coded on the claim must be office (POS '11').*

### **Article 28 Clinics - OPD, D&TC and FQHCs**

**The medical home designation will be associated with each clinic on a site-specific basis. Clinics will receive the medical home add-on when they fulfill the following requirements:**

1. *The billing clinic (site-specific) must be designated as a medical home (Level 1, Level 2, or Level 3);*
2. *Claims must contain, and the service provided must be consistent with, one of the following Evaluation & Management codes (E&M) 99201- 99205, 99211- 99215; or one of the following Preventive Medicine codes 99381- 99386, 99391- 99396.*

In the event that both a practitioner working in a clinic (who submits a professional claim) and the clinic have a medical home designation, only the clinic will receive the enhanced payment.

New York Medicaid providers participating in the Adirondack Medical Home Demonstration Project are not eligible for enhanced payment through the Statewide Patient-Centered Medical Home Program.

### Questions/Information

For more information on how to achieve NCQA certification as a NCQA *PPC-PCMH™*, providers should contact NCQA Customer Support at (800) 839-6487, or visit the NCQA Website at <http://www.ncqa.org>. Since New York Medicaid is recognized as a sponsoring organization, providers will receive a 20 percent discount from NCQA toward the cost of the *PPC-PCMH™* application. Questions regarding New York Medicaid's Patient-Centered Medical Home initiative may be directed to the Office of Health Insurance Program's Division of Financial Planning and Policy at (518) 473-2160.

Please contact the Bureau of Managed Care Finance at (518) 474-5050 with any questions regarding health plan medical home payments for network providers.

May 2010

## Statewide Patient Centered Medical Home Program Receives Approval For Office-Based Practitioners, FQHCs, and D&TCs

Incentive payments to office-based physicians' and registered nurse practitioners' practices, Federally Qualified Health Centers (FQHCs), and Diagnostic and Treatment Centers (D&TCs) recognized by New York State Medicaid and the National Committee for Quality Assurance (NCQA) as Physician Practice Connections-Patient Centered Medical Homes (PPC®-PCMH™), will commence for visits performed on or after July 1, 2010.

NCQA will provide a monthly list of PPC®-PCMH™ recognized providers to New York Medicaid for use in claims processing. PPC®-PCMH™ incentive payments for Article 28 hospital outpatient departments (OPDs) are pending CMS approval. Providers will be notified in a later edition of the Medicaid Update when approval is finalized.

To ensure receipt of incentive payments, recognized providers must make certain that NCQA has the 4-digit extension of the zip code (zip+4) for each practice site certified by NCQA as a patient centered medical home. Also, in an individual provider's practice, the individual practitioner's billing National Provider Identifier (NPI) must be on file with NCQA. Office-based practitioners that are part of a group practice must also have their group practice NPI (practice site NPI) on file with NCQA. Article 28 facilities must have their billing NPI (practice site NPI) on file with NCQA. Failure to provide a practice site NPI (practitioner group NPI or clinic NPI) and the zip+4 of each recognized service location, will jeopardize incentive payments by New York Medicaid. Practitioner groups and clinics can e-mail their practice site NPI (Medicaid billing NPI#) and their zip+4 information to NCQA at: [ppc-pcmh@ncqa.org](mailto:ppc-pcmh@ncqa.org).

### **For recognized providers to receive fee-for-service incentive payments from New York State Medicaid, the following conditions are required:**

#### Office-Based Practitioners:

- Claims must include one of the following evaluation and management codes: 99201- 99205, 99211- 99215 or preventive medicine codes: 99381-99386, 99391-99396;
- The place of service coded on the claim must be office (11);
- In an individual provider's practice, the individual practitioner's billing NPI must be included on the claim; and
- In a group practice, both the group NPI and the billing practitioner's NPI must be included on the claim.

#### Article 28 Clinics (OPDs, D&TCs and FQHCs):

- Claims must include one of the following evaluation and management codes: 99201- 99205 or 99211- 99215 or preventive medicine codes: 99381-99386, 99391-99396;
- In a clinic, the billing clinic's NPI must be included on the claim;
- For both office-based practitioners and Article 28 clinics, it is critical that the claim include the zip+4 for the NCQA recognized location.

Notes:

- Practices with Registered Nurse Practitioners (RNPs), including Article 28 facilities and office-based practitioners, must include the RNPs on their NCQA PPC®-PCMH™ application. This will allow Medicaid to properly process Patient Centered Medical Home incentive payments for primary care nurse practitioner services.
- In the event that both a practitioner working in a clinic (who submits a professional claim) and the clinic have a medical home designation, only the clinic will receive the enhanced payment.
- New York State Medicaid providers participating in the Adirondack Medical Home Demonstration Project are not eligible for incentive payments through the Statewide Patient Centered Medical Home Program.

**For recognized providers to receive incentive payments for Medicaid and Family Health Plus managed care enrollees the following applies:**

- Providers must be designated as the enrollee's primary care provider.
- Office-based practitioners and Article 28 clinics will receive incentive payments for Medicaid and Family Health Plus managed care enrollees directly from the managed care plan. Providers with questions regarding the frequency or basis of payment to be received from their health plans should contact the plans directly.
- The State will make available to health plans a monthly file from NCQA with updated provider recognition data to enable plans to identify which of their contracted providers are eligible to receive the enhanced payment.
- Upon implementation, providers will be eligible to receive payment from health plans the first month in which the provider is listed on the monthly file of NCQA recognized providers posted on the HPN. There is no requirement to modify contracts between health plans and providers related to Medical Home.
- To ensure receipt of incentive payments from health plans, providers must make certain that NCQA has the 4-digit extension of the zip code (zip+4) for each practice site certified by NCQA as a patient centered medical home.
- The State will make payments to Medicaid Managed Care plans for the sole purpose of the health plan making enhanced payments to contracted office-based physicians/practices and Article 28 clinics that meet New York's medical home standards and provide primary care services to persons enrolled in Medicaid Managed Care and Family Health Plus.
- Payment from the State to Managed care plans will be made on a Per Member Per Month (PMPM) basis depending upon a providers NCQA recognition level equal to \$2.00 (level 1), \$4.00 (level 2), or \$6.00 (level 3) for each enrollee whose designated primary care physician and/or nurse

practitioner has received recognition as a Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH).

- Medical Home payments to health plans are a pass-thru to providers therefore prompt payment requirements do not apply to the distribution of Medical Home funds.

**Questions/Information:**

For additional information on how to achieve NCQA certification as a NCQA PPC®-PCMH™ provider, please contact the NCQA Customer Support Center at (888) 275-7585, or visit the NCQA Website at: [www.ncqa.org](http://www.ncqa.org). Since New York State Medicaid is recognized as a sponsoring organization, providers will receive a 20 percent discount from NCQA toward the cost of the PPC®-PCMH™ application. For additional information please review the December 2009 Special Edition of the Medicaid Update, available online at:

[http://nyhealth.gov/health\\_care/medicaid/program/update/2009/2009-12spec.htm](http://nyhealth.gov/health_care/medicaid/program/update/2009/2009-12spec.htm). or contact the Division of Financial Planning and Policy at (518) 473-2160. Please contact the Bureau of Managed Care Finance at (518) 474-5050 with any questions regarding health plan medical home payments for network providers.

**Required NCQA Disclaimer:**

The Physician Practice Connections-Patient Centered Medical Home (PPC®-PCMH™) Recognition Program is developed, owned, and managed by the National Committee for Quality Assurance (NCQA). To learn more about the PPC®-PCMH™ Recognition Program, refer to the program's Website at <http://www.ncqa.org/tabid/631/Default.aspx>. NCQA is not involved in any determination of clinician incentive payments under the NY State Medicaid Medical Home Program.

## APPENDIX X

# NEW YORK'S PUBLIC HEALTH REPORTING INFRASTRUCTURE

This appendix contains the written testimony delivered by Dr. Guthrie Birkhead, Deputy Commissioner of the New York State Department of Health, to the ONC HIT Policy Committee's Meaningful Use Workgroup on July 29, 2010. Dr. Birkhead's testimony describes the infrastructure currently in place in the State that facilitates the collection of laboratory, immunization, and syndromic surveillance data.



***Testimony By:***

***Guthrie Birkhead, M.D., M.P.H.  
Deputy Commissioner  
New York State Department of Health***

***Presented to:***

***HIT Policy Committee  
Meaningful Use Workgroup***

***Panel 1: Achieving population health through  
meaningful use: How do governmental public  
health agencies view the process to date?***

***Thursday, July 29, 2010  
Washington, D.C.***

My name is Guthrie Birkhead and I am the Deputy Commissioner for Public Health at the New York State Department of Health (NYS DOH). Thank you for the opportunity to speak this morning on the opportunities and challenges presented to State health departments and other public health agencies in aiding providers in achieving meaningful use (MU) of Electronic Health Records (EHR). The perspective I bring to you today is that of the public health practitioner in a State Health Department where we have the statutory authority and responsibility to collect key health information on individuals to guide immediate public health program responses, for example to follow up on a reportable communicable disease case, and also to aggregate individual health data to better gauge the health of the population to guide and evaluate public health programs and policies. We also have a role to communicate critical public health information, for example diagnosis and treatment of diseases of public health interest, to practitioners, local public health departments and the public.

At the New York State health department, we have recognized the importance of gathering electronic data in the three areas of interest today: clinical laboratory results of public health interest, childhood immunizations, and emergency department syndromic data, for over a decade. We have invested a tremendous amount of effort and funding to develop these systems. We now have in place universal electronic systems that achieve data collection in all three areas with a degree of timeliness and accuracy that generally meets our current programmatic needs. For example, New York's Electronic Clinical Laboratory Reporting System (ECLRS) annually collects hundreds of thousands of clinical laboratory results on reportable communicable diseases to trigger follow-up field

investigations to determine the source of infection and prevent further spread. In the recent H1N1 pandemic, New York's syndromic surveillance system collected on a daily basis the number of emergency department visits for influenza-like illness from almost all EDs in the state, providing vital situational awareness of where the pandemic was in the state and which communities were being impacted. And New York's Immunization Information System (NYSIIS) is utilized by over 90% of pediatric providers in New York to record childhood immunizations. We have invested a lot in assuring the quality of the data we are receiving in these systems and understanding their timeliness. These systems are in use everyday driving, guiding and informing our public health programs. I would point out that these systems are working today for the most part without any direct link to patient electronic health records.

That said, we recognize the tremendous opportunities offered by tapping into patient electronic health records (EHRs) for public health reporting and data aggregation purposes. For example, in the reportable communicable disease programs, access to EHR data could provide additional clinical information like symptoms and data of illness onset that is normally only collected through intensive field work by public health staff. In syndromic surveillance, the ability to pull final diagnosis and other detailed clinical information like laboratory test results from the emergency department EHR could greatly improve the granularity and specificity of the data, which are now crude and non-specific. In the immunization registry area, we know that it is a barrier for providers to use the immunization system which is separate from their office information systems and EHRs if they have them. The ability to move data on immunizations from provider EHRs

to the state registry and back again, would greatly improve the utility of the system to pediatric providers.

Current advances in HIT today, such as the collection, aggregation, and transmission of EHR data, offer tremendous opportunities for improvement in public health practice and population health. Public health agencies have and must continue to assess their internal infrastructure, policies, and workforce capability to determine how best to integrate HIT into programs, policy and practice. To benefit from the opportunities HIT offers, significant changes will be necessary in (1) current public health information technology infrastructure and procedures, (2) public health law, regulations, and/or policies, and (3) workforce IT and data management and analysis skills.

First a quick overview of what is before we move on to what can be. Under traditional public health surveillance we begin with a patient seeking medical care. Next clinical findings and clinician diagnosis are documented in the medical record. A laboratory or other diagnostic test may be ordered to confirm the clinical confirmation. Both the healthcare provider and laboratory determine if the suspected or confirmed disease, condition, or organism is on the current list of diseases or conditions that are reportable to public health. Reporting of the disease/condition/organism by the laboratory and or healthcare provider is made via paper, telephone, and fax or electronic means to the State health department and in turn the local health department where the patient resides. The local health department initiates appropriate follow-up according to NYSDOH/CDC guidelines. Follow-up activities may include contacting the healthcare provider for additional information as necessary and interviewing the patient for

information that was not available from the provider. Patient level data is reported to NYSDOH; de-identified data may be reported to CDC (e.g., nationally-notifiable diseases). Traditional public health reporting, as described above takes time, with a typical reporting lag-time of days to weeks. New York has and will continue to implement technologic advances that permit efficient, effective, and secure transfer of confidential healthcare information that is necessary to ensure the health of the public.

### **State Priorities that Impact Public Health**

Rapidly expanding healthcare and public health data and information systems development require an effective and dynamic information management approach to accomplish appropriate, expedient, and user-friendly access to trustworthy data necessary to improve public health practice and the health of the population. Disparate (e.g., paper and PC-based, and point-to-point) data collection, management, and exchange approaches will not be sufficient to meet the needs of public health programs.

These factors have created a need to move public health information management to the next level – one in which information stores are planned and designed to interoperate and deliver information quickly, completely and in the correct and consistent context. This information must support public health objectives and allow different programs to communicate and share data in a common vernacular. Information development initiatives and enhancements must be prioritized based on public health impact, return on investment, executive support and synchronicity with a Master Plan that clearly defines public health information strategies and priorities.

## **New York's Public Health Information Infrastructure**

In New York we have more than 50 unique data collection systems for reportable conditions to ensure both accuracy and timeliness of information reported to us. These systems are part of the NYSDOH infrastructure which is comprised of three domains, each tailored to the specific information exchange needs of the intended audience: the Health Information Network (HIN) is the web 'portal' by which Local Health Departments (LHDs) gain access to data; the Health Provider Network (HPN) is the portal by which the clinical/health provider organizations access the system and the Health Alert Network (HAN) is a third domain that provides health alerts for Public Health Preparedness for both the HIN and HPN. Together, these systems comprise the Health Commerce System, an integrated and user-friendly portal for accessing a variety of public health applications available to state and local health department practitioners. Both the HIN and the HPN are web portals that can be accessed anywhere in the State where web services are available. However, these systems are not currently interoperable with commercially-available electronic health records.

## **New York's Electronic Data Systems**

New York currently receives data from multiple health partners and has the ability to analyze and receive data and provide feedback to LHDs, hospitals, healthcare providers and other partners. However, none of the systems currently in place connect directly to EHRs. The current NYSDOH electronic data systems used for public health activities listed in the Final Rule EHR Incentive Program are:

- 1. Electronic Clinical Laboratory Reporting System;**

2. **Syndromic Surveillance; and**
3. **Immunization Registry.**

Each of these systems is described below:

### **1. Electronic Clinical Laboratory Reporting System**

New York Public Health Law and Codes, Rules and Regulations require licensed clinical laboratories to report all pertinent facts to public health authorities whenever an examination on a New York resident is performed to determine blood lead level or reveals evidence of a reportable communicable disease, lead poisoning, HIV/AIDS, cancer, or congenital malformation.

NYSDOH had invested more than \$10 million over eight years in the statewide Electronic Clinical Laboratory Reporting System (ECLRS). As an early adopter of Health Level 7 (HL7), Logical Observation Identifiers Names and Codes (LOINC), and Systematized Nomenclature of Medicine (SNOMED) standards, ECLRS was developed to utilize these standards. We will, however, need to enhance our internal processes and provide training to staff to transition from HL7 2.3 TO 2.5 messaging as outlined in Stage 1 meaningful use for electronic laboratory reporting to public health.

ECLRS provides laboratories that serve New York State residents with a single electronic system for continuous, secure and rapid transmission of this information to the New York State Department of Health (NYSDOH), all 57 county health departments and the New York City Department of Health and Mental Hygiene (NYCDOHMH). There

are currently 193 laboratories reporting. They access the HPN to submit data by either direct data entry via a secure web page or uploading an ASCII or HL7 data file. Results are immediately made available to the appropriate local health departments and NYSDOH program public health practitioners via the HIN.

In addition to improving timeliness and completeness of reporting, ECLRS has enhanced public health surveillance by improving the accuracy of reports, which facilitates the identification of true emergent public health problems. However, limited clinical information is available through laboratory reporting. Since the public health follow-up for additional clinical information from the provider is a resource intensive, manual process for both healthcare and public health, a recommendation would be for the EHR transmission to include data in common to these reportable conditions and work toward providing disease-specific data, based state and national standardized report forms.

## **2. Syndromic Surveillance**

Syndromic surveillance monitors real-time health-related data that precedes diagnosis. The overlying goals are to:

1. Monitor general community health trends and track level of disease, like influenza, in the community.
2. Identify an outbreak sooner than physician and laboratory reporting. Characterize the geographic and temporal spread of an outbreak after initial detection.
2. Provide objective evidence that an outbreak may not be occurring.

3. Help sustain a strong ongoing relationship between public health and clinical medicine and increase communication.

All emergency departments in New York State (NYS), excluding New York City (NYC), are required to participate in the New York State Department of Health (NYSDOH) syndromic surveillance system. NYSDOH used CDC preparedness funding to establish the capability in the hospital setting to transmit emergency department (ED) data to NYSDOH. We currently collect patient level (ED) data from 142 of 144 total hospitals. Data are de-identified but include the patient's medical record number should re-identification be necessary. The data, which can include HL 7 messages, are transmitted from the hospital EDs via ECLRS. New York routinely monitors Fever, Respiratory, Gastrointestinal (GI), Asthma, Neurological, Rash, Carbon Monoxide Poisoning, and Hypothermia syndromes. New syndrome definitions, such as heat-related healthcare visits, are created and monitored on an as-needed basis. The estimated state population, excluding NYC, is 11 million. Approximately 98% of ED visits are captured by the system.

Statewide Medicaid sales of over-the-counter (OTC) and prescription medications are also reported to the NYSDOH. This data, grouped into 18 drug categories, is reported to the NYSDOH syndromic surveillance system and is monitored daily. Medicaid covers 34% of the NYC population and up to 20% of the residents in the 57 counties outside of NYC.

These data are continually analyzed to assist with the earliest possible identification, monitoring, and response of disease outbreaks or other events of public

health significance. Results of our analyses including, long and short-term trend graphs and patient listings by syndrome, hospital, county and region, are available for viewing by local and state public health on the HIN and participating hospitals on the HPN. New York also reports daily its fever syndrome counts to DISTRIBUTE, the syndromic surveillance project under expansion by CDC to provide a more comprehensive and detailed situational awareness of geographic and age-specific patterns of influenza-like illness.

Actual uses of syndromic surveillance in NYS include:

- Identification of pertussis outbreaks by analyzing prescriptions for selected antibiotics.
- Monitoring of seasonal and pandemic influenza and influenza-like illness trends in the community.
- Retrospective and prospective data review when investigating suspected outbreaks. Lack of supportive evidence has been able to increase public reassurance about the existence or magnitude of the event.

At a minimum, NY needs to continue to receive on a daily basis, from all hospitals, patient level data, including medical record number, to continue our current operations. The ability to receive additional data elements, such as discharge disposition and diagnosis, when available could improve the specificity of our analysis.

NY is prepared to receive HL7 2.3 messages from hospitals. As with ECLRS, we would need to enhance internal operations to process HL7 2.5. New York does not currently have a mechanism to receive syndromic surveillance data from individual

medical providers. The amount of data that public health will likely receive from the private setting may be an initial challenge in terms of processing, validating, analyzing, and interpreting the data. Further development of detailed standards for clinical data related to public health as well as standards for aggregation of data for public health purposes is urgently needed in order to integrate these standards in EHR systems and health data exchange.

### **3. New York State Immunization Information System (NYSIIS)**

The New York State legislature passed the Immunization Registry Law, effective January 2008, which requires health care providers to report all immunizations administered to persons less than 19 years of age, along with the person's immunization histories, to the New York State Department of Health using the a web-based immunization information system .

The goal of the immunization information system is to establish a complete, accurate, secure, real-time immunization medical record that is easily accessible and promotes public health by fully immunizing all individuals appropriate to age and risk. Providers have access to consolidated and accurate immunization records of their patients, receive clinical decision support in complying with an increasingly complex vaccination schedule and can use NYSIIS to manage their vaccine inventory.

We have begun to collect immunization data into NYSIIS by batch uploads from EHRs. We currently have certified 56 billing and EHR software vendors representing over 650 practices administering 10 million of the 17 million immunizations reported in the state outside New York City last year to report data to NYSIIS by batch upload.

Additional practices served by these vendors are not yet online because they have older versions of the software or do not wish to pay the vendor for this service. In addition, we are exchanging immunization data with 8 large managed care plans to enable them to calculate immunization quality measures on their insured children. These systems are not yet bidirectional or real time, but we are working to achieve those goals so that providers can benefit from scheduler, practice assessment and other functions built into NYSIIS.

### **Actions Toward a More Integrated Approach to Data and Information Sharing**

In preparation for full implementation of HER and HIT the New York State Department of Health has initiated work on a plan to identify priorities, opportunities, needs and resource demands facing public health in light of rapidly growing healthcare and public health data sources, information technology development, and interoperability standards. We have identified several priorities for public health systems integration including the Universal Public Health Node (UPHN), the Statewide Health Information Network for New York (SHIN-NY); the Child Health Information Integration (CHI<sup>2</sup>) Project; continued development of New York's Immunization Registry (NYSIIS) and Lead Registry; newborn metabolic screening and newborn hearing screening reporting; and Infectious Disease Reporting integration to include the Electronic Clinical Laboratory Reporting System (ECLRS), the Communicable Disease Electronic Surveillance System (CDESS), the Outbreak Management System (OMS), Sexually Transmitted Disease Management Information System (STD-MIS) and Syndromic Surveillance. In addition we have identified a need to integrate Chronic Disease/Environmental Health Data Systems including the Behavioral Risk Factor

Surveillance System (BRFSS), the Cancer Registry, the Dementia Registry, the WIC data system and the Body Mass Index Reporting System.

While these efforts are in the developmental stage they are acknowledged as critical to New York's future public health information system development and integration to improve the prevention, identification and response to diseases and other threats to the health of the public through access to and sharing of data

The most advanced of these efforts is the Child Health Information Integration or CHI<sup>2</sup>. Using the NYSIIS, the immunization information system platform, we will soon make available to providers all laboratory tests for childhood lead poisoning and the results of newborn hearing screening. The mission of this database is to create a single system that is able to link numerous information systems that contain child specific data. The CHI<sup>2</sup> project will integrate multiple datasets within various DOH programs serving children in New York. Initially the system will include data from the Statewide Perinatal Data System (SPDS); Neonatal Intensive Care Unit (NICU); New York State Immunization Information System (NYSIIS); Newborn Bloodspot Screening (NBS), Newborn Hearing Screening (NHS); Lead Screening (Leadweb); and New York Early Intervention System (NYEIS). Long-term plans envision incorporating additional data from the Congenital Malformations Registry (CMR), the Statewide Planning and Research Cooperative System (SPARCS), the Women Infants and Children system (WICSys) and Medicaid – EmedNY. (In New York there are at least 22 different datasets that contain information on maternal and child health populations).

This integrated information system leveraging the UPHN, will link child healthcare information across multiple data sources and will result in improved outcomes for the delivery of health care to children. The CHI<sup>2</sup> Project will create an HIE solution that follows federal and state guidelines for meaningful use and enables consistency when utilizing data which should improve public health function, integration, evaluation and research. The ability to link child healthcare information across multiple data sources will create a number of beneficial outcomes for the delivery of health care to children in New York State, such as identification and monitoring of different child health status “profile” populations; identification and follow-up of individual children with specific health needs; and identification and assessment of public health needs and issues.

By ensuring that partners, including providers and RHIOs, are assured access to a unified data base of child health information available to the state health department, we hope to reduce duplication of effort, provide data sharing capability, and permit data from the emerging EHR systems and RHIOs to be transmitted and received, with the ultimate goal of improving child health. This is the ultimate meaningful use.

Another public health goal in New York that is heavily reliant the ability to exchange health information relates to Newborn Metabolic Screening and linking this screening to long-term follow-up care, assistance and public health program interventions. These interventions involve testing, diagnosis, education, referrals, treatment, and evaluation, extending beyond infancy and requiring extended collaboration and communication among multiple clinical care and public health groups throughout a child’s lifespan. New York has embarked on an ambitious HIE initiative intended to improve the newborn screening short-term follow-up system through

enhanced health information exchange among the newborn screening program, birthing hospitals, medical home/community-based practices, and subspecialists; develop and implement a system of long-term follow-up (LTFU) for Cystic Fibrosis (CF) and the inherited metabolic diseases (IMD) and integrate NBS short and long-term data and information exchange activities within an interoperable, standard model for meaningful HIE. Data from the following systems will be integrated as a beginning to accomplishing this effort: the Statewide Perinatal Data System, which includes the birth certificate, Newborn Bloodspot Screening, Newborn Hearing Screening, the NICU Module, NYS Immunization Information System and the Early Intervention System

### **Current Experience in New York with Data Exchange with EHRs**

In New York we are taking initial steps to foster data exchange with EHRs. We are making a nearly \$1 billion public and private investment in the Statewide Health Information Network for New York, or SHIN-NY, including fostering the development of regional health information organizations. To align with that effort, New York is now testing the Universal Public Health Node (UPHN), a system designed to leverage local health information exchanges across the state for public health functions. While the UPHN is not yet operational, we have begun to collect immunization data into NYSIIS by batch uploads from EHRs. We currently have certified 56 billing and EHR software vendors representing over 650 practices administering 10 million of the 17 million immunizations reported in the state outside New York City last year to report data to NYSIIS by batch upload. Additional practices served by these vendors are not yet online because they have older versions of the software or do not wish to pay the vendor for this

service. In addition, we are exchanging immunization data with 8 large managed care plans to enable them to calculate immunization quality measures on their insured children. These systems are not yet bidirectional or real time, but we are working to achieve those goals so that providers can benefit from scheduler, practice assessment and other functions built into NYSIIS.

The Universal Public Health Node (UPHN), a collection of services and operational policies designed to fulfill designated public health reporting and monitoring objectives, is narrowly intended to describe the relevant interactions between Health Information Exchange partners such as Regional Health Information Organizations (RHIOs) and the New York State Department of Health (NYSDOH). In the larger context, UPHN transactions will support activities and interactions with other entities and health information exchanges, such as local health departments (LHDs) within New York, the Centers for Disease Prevention (CDC), healthcare data sources (e.g. – hospitals, physician practices, etc.), and healthcare consumers. Ultimately, the goals of the UPHN are to streamline health care provider interactions with public health and facilitate the integration of otherwise “siloes” public health information systems.

### **Lesson’s Learned**

New York is fortunate to have successful systems in place that we can build upon as we move to increased use of HIT. Lessons learned that may be instructional for all jurisdictions and as future meaningful use definitions evolve include the following:

1. Public health must adopt standards to assure that our data needs are met within the broader context of EHR development. More specifically, public health uses of

data are important at both the individual patient level as well as in an aggregated form. The ability to aggregate and analyze relies on standard encoding of data and widespread acceptance and adoption of the data standards. Consistent application of standards for reporting of data is critical to ultimate utility of the data.

2. Public health agencies and providers are both stakeholders; agencies as the repositories of the information for use in policy and programmatic development and providers as the individuals faced with reporting the data and to whom consistent and coordinated reporting will result in ease of reporting, reduced duplication and reduced workload. Involvement of all impacted parties throughout the developmental cycle is critical to ensure that the needs of all are understood and to ensure acceptance of new systems.
3. Pilot testing to identify issues, assess data validity, accuracy and timeliness and to apply lessons learned is a critical developmental phase.
4. An incremental rollout plan helps to ensure that appropriate support can be provided to new users and that lessons learned and best practices can evolve.
5. New York's current reporting systems have been extensively validated in terms of data integrity, content and usefulness to the Department. Any new configuration for data collection through EHRs will require extensive validation to ensure that the integrity and content of the data meets Department standards.
6. The number of data provider interfaces associated with each application and the time required to validate each interface is significant and must be accounted for.

For example, New York receives laboratory results via ECLRS from 200+ laboratories. It took a year to validate the data and certify just the first 30 providers.

7. Ongoing communication, comprehensive documentation and training are essential elements for successful implementation. Public health must be prepared to provide user support on public health aspects of data reporting and utilizations. In New York the initial implementation of ECLRS required over 60 training sessions across the state.
8. As these systems continue to evolve they will require ongoing support and maintenance including funding to support these systems during the developmental process. As we look to the future, capturing a significant amount of data, we must consider overhead costs associated with disk storage; data retention and archive requirements and ongoing monitoring required to identify equipment issues and disk storage availability.
9. Data needs to be treated as an asset. Ongoing Data Management activities are needed to review, analyze and conduct quality assurance – all additional costs to system development.

### **Barriers to Meaningful Use of Public Health Data**

Our goal in New York is creation of systems that facilitate effective data reporting, collection and analysis that supports New York’s public health goals as enumerated in our “Prevention Agenda”

([http://www.nyhealth.gov/prevention/prevention\\_agenda/](http://www.nyhealth.gov/prevention/prevention_agenda/)). The Prevention Agenda” identifies the following ten priorities for improving the health of all New Yorkers:

- Access to Quality Health Care
- Chronic Disease
- Community Preparedness
- Healthy Environment
- Healthy Mothers, Healthy Babies, Healthy Children
- Infectious Disease
- Mental Health and Substance Abuse
- Physical Activity and Nutrition
- Tobacco Use
- Unintentional Injury

Data are available to support and guide some of these priorities but we are a long way from a complete, comprehensive, timely and accurate health care information system that supports all of these goals. For example, while the existing syndromic surveillance system does a good job in supporting community preparedness and response to infectious disease, there is much more that could be accomplished with EHR including the ability to receive additional data elements such as discharge disposition and diagnosis, which would improve the specificity of our analysis. Moreover, as additional information is captured and communicated, the systems for validating, analyzing, and interpreting significantly larger data sets must be revised and improved to meet this challenge.

I would like to highlight three specific barriers as we move ahead to more fully utilize health information exchange with EHRs for public health purposes to achieve meaningful use of health data.

First, public health needs to broaden its thinking on new uses of data which will be available as a result of health information exchange with EHRs. Progress towards achieving public health goals such as reducing obesity, diabetes and cardiovascular disease might be better measured through collecting clinical information from EHRs such as height, weight, diabetic control and blood pressure. At this time, public health chronic disease programs are not equipped to receive or analyze this type of clinical information and have no experience in using such data to inform and evaluate public health programs. New ways of thinking, new analytic techniques to manage this potentially vast amount of information, and additional resources will be needed to achieve these capabilities.

A second challenge is the lack of funding to support upgrading public health data systems to keep pace with the advances in technology. While we are spending billions in New York to develop EHRs, the statewide health information network, and the public health node on that network, the resources to upgrade public health to integrate with these systems are lacking. In addition, current public health data system funding is “siloes” with each discrete program area funded separately for system development and upgrades. Since these categorical funds often come from the federal government, changes in federal funding rules to allow more cross program flexibility will be important. An example is the recent announcement of HL 7 2.5.1. Just in the area of laboratory reporting alone, we have multiple data systems including communicable disease, HIV, childhood lead, and cancer reporting that will need to be upgraded to handle HL 7 2.5.1 messaging. The

ability to collaborate across programs in this upgrade process will greatly speed the process. These systems will greatly benefit from the new world of interoperable systems, but we need to flexibility in our funding streams to “think outside the silo” and to support data exchange development leveraging the efforts of other public health programs.

Finally, it is important to note that existing public health reporting systems will need to be maintained until there are proven reliable replacement systems available. We will need to be assured of the quality, validity and timeliness of new data sources before we can fully transition public health programs to them. As a result, for a period of time simultaneous maintenance of multiple existing systems along with integration of multiple new data streams will be necessary until all data providers are successfully reporting through new data infrastructures. Until the transition is complete, public health reporting for healthcare providers will be both complex and costly.

#### Recommendations for the Future:

As I have discussed, New York has a significant investment in multiple electronic health information systems. The emergence and adoption of EMR systems and the ability to access those data through health information exchange will open the door to a wide range of data, much of which is currently unavailable to public health agencies, and has the potential for making a significant impact on the meaningful use of these data for public health purposes.

I offer the following recommendations to the committee for you to consider in supporting the involvement of public health in meaningful use of EHR data exchange:

1. Continue to actively engage public health agencies and professionals to assure that HIT goals can be achieved, can be sustained, and are useful for public health program purposes.
2. Develop and promote national standards for health information exchange that have been widely vetted in the PH community. Data standards need to take into account public health data needs, which require both individual level data as well community-level (aggregate), and need to assure that the data are valid, accurate and timely. Resources will be needed to assure the validation of these new data sources and collection methods.
3. Help assure that federal funding for categorical public health programs are flexible enough allow cross-program collaboration initiatives such as New York is undertaking in its CHI<sup>2</sup> initiative.

### Closing

As I think about the technology and workforce changes facing public health, the words of Dr. David Blumenthal, published in the July 13 NEJM article resonate with me: “The speed of ascent must be calibrated to reflect both the capacities of providers who face a multitude of real world problems and the maturity of the technology itself”. Public health needs to be actively engaged to ensure that we do not merely receive EHR data but that the information exchange and resulting data is of acceptable quality and can be managed within the walls of public health such that it supports and improves public health practice. Until this is established, improvements in population health resulting from public health practice will not be possible. Thank you.

# APPENDIX XI COMMUNICATION PLAN

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## 1. Executive Summary

The Stakeholder Outreach and Education plan is an output and clarification of Task 3, Conduct Provider Outreach, of the State Medicaid Health Information Technology Plan (SMHP) project. During Task 3, numerous stakeholder briefing presentations were provided, feedback was received, and final comments posted on the Department of Health website. Task 3 touched a diverse sampling of Medicaid providers and stakeholders. Throughout the process, several common themes and messages clearly emerged. Specifically:

- Stakeholders universally expressed a common need for more and continued information from NY Medicaid regarding:
  1. Meaningful Use
  2. How to apply for the incentive
  3. Where to locate bona fide educational and informational materials for stakeholder organizations to disseminate to their membership
- Stakeholders emphasized the importance of continued collaboration activities between OHIP and OHITT.

The Stakeholder Outreach and Education plan meets the above needs of the provider community through a coordinated effort of outreach meetings, collaboration with stakeholder groups, new media, and conventional communication vehicles. It aligns with and meets CMS stated goals of providing stakeholder outreach.

## 2. Strategic Objectives

**Core Objectives** - fundamental efforts of the plan.

- Increase the provider community's awareness and understanding of the EHR Incentive Program.
- Develop and launch a communications campaign for CMS-developed materials.
- Complement CMS materials with New York State specific materials.
- Develop and launch informational events, such as meetings and conferences.
- Leverage online tools like webinars and social media.

**Benefit Objectives** - outcomes or benefits of the efforts above.

- CMS will have tangible and measureable evidence of NY Medicaid's efforts to promote the Medicaid EHR Incentive Program to hospitals and eligible providers.
- Track progress of outreach initiatives by comparing baseline 2010 EP/EH survey findings with future findings.
- Regular, up-to-date and easily understood information will be delivered to the New York State Medicaid provider community.
- Increased awareness and comprehension of the Medicaid EHR Incentive Program will boost the number of applicants and decrease both helpdesk calls and negative feedback from advocacy and stakeholder organizations.
- NY Medicaid will demonstrate its priority for the Medicaid EHR Incentive Program to the New York State Medicaid provider community.
- OHIP, OHITT, and CMS will demonstrate their collaborative efforts to the provider community.
- NY Medicaid will position itself as a liaison between the New York State Medicaid provider community and CMS.

### 3. Audience Segmentation

Targeted audiences for the Stakeholder Outreach and Education plan include:

- Non-hospital based physicians
- Nurse Practitioners
- Dentists
- Certified Midwives
- Physician Assistants serving in a Federally Qualified Health Center (FQHC)
- New York State licensed acute care hospitals, critical access hospitals, and children's hospitals
- Stakeholder groups – for a complete list of groups that have been identified; see Appendix V (“Stakeholder Outreach”)

#### 4. Audience Profile

An audience profile typically begins with research, learning what the audience needs to know about the product or service being marketed. Fortunately, this very big step has already been completed. Audience profiles have already been collected or are in process via the following channels:

- Stakeholder briefings and feedback provided to NY Medicaid
- Survey results and data received from the forthcoming NY Medicaid survey

Environment – Where the audience is	Interest – that which motivates the audience	Key Messages – addressing the environment and interests
<p>EPs are time crunched.</p> <p>Overloaded with current information, rely on staff to filter and prioritize.</p> <p>EPs and EHs are hungry for reputable sources of comprehensive information.</p> <p>EPs are <b>not</b> CIOs, nor typically technologically savvy.</p> <p>Small and medium-sized hospitals need the same level of support that small practices do, as they are also without IT support.</p> <p>Already operate in a regulated, systemized field with 100% oversight.</p>	<p>Fear: most providers are afraid of change and need information to persuade and guide them through the process.</p> <p>Rational Approaches: Providers are, for the most part, independent, analytical thinkers.</p> <p>Desire to improve and maintain Market Share and Quality Outcomes: "If HIT helps me make better decisions, if it helps my patients, I support it."</p> <p>Ease: Desire path of least resistance.</p> <p>"How do I continue to meet meaningful use?"</p> <p>"Where can I get more staff training?"</p> <p>Use the existing HIE channels, desire for improved HIE channels.</p>	<p>"Eligible Providers and Hospitals can apply to NY Medicaid for ARRA HITECH incentive payments through the following steps ..."</p> <p>"Here are the sources for help and assistance."</p> <p>New York State – specific information along with information from CMS and others in easy-to-understand language.</p> <p>NY Medicaid assists EPs and EHs in the constant effort to improve efficiency and patient care.</p> <p>"In concert with RHIOs and OHITT, here are the educational and informational resources you need"</p>

**Table XI-1** Sample Audience Analysis

## 5. Selected Quotes and Feedback from Presentations

*"... physician-training programs and their associated faculty medical practices should be considered a crucial part of this incentive program."*

Lois Capponi, MD  
New York Chapter – American College of Physicians

"Physicians would benefit greatly from additional outreach efforts like seminars, webinars, conferences and the like."

Elizabeth Dears-Kent  
Medical Society State of New York

"Our lessons learned revealed a misconception that hospitals have HIT departments and CIOs and they're going to be fine in regards to implementing HIT. Not true. Hospitals do not have the resources to implement. I propose funding be funneled into creating a forum where hospitals can tell us what they need."

Zeynep Sumer  
Greater New York Hospital Association

"Among the outreach efforts by the NPA will be informing hospital-based NPs of the details of the incentive payment program."

Thomas Nicotera, MHHA, JD  
Nurse Practitioner Association New York State

## 6. Deliverables

The efforts below can be completed solely or in concert with OHITT, CMS, and similar HIT partners. To emphasize the outreach and partnership strategy, various stakeholders will be approached to partner with NY Medicaid, NYSTEC, and OHIP on the delivery. The list below is proposed, and NYSTEC will work with NY Medicaid to clarify and confirm deliverables.

Deliverable Communication Vehicle	Description	Key Performance Indicators (KPI)
OHIP Web Site	Static, need-to-know information will be continually updated on the DOH OHIP website. Specific links to CMS sites, Frequently Asked Questions (FAQs) and related information will be provided.	Visitors per month Average time on site Number of e-mails sent to OHIP for more information
CMS materials w/ a local clarification for New York State	Handouts, flyers, etc. of easy-to-understand information on the EHR Incentive Program.	Number of materials distributed to audience members
Online Webinar	To respond dynamically to stakeholders' questions, a series of online webinars will provide a forum for stakeholder inquiries. Using online tools (WebEx, and others) a calendar of meetings will be presented and marketed to stakeholders.	Number of webinars Questions, surveys, and anecdotal feedback
Specific Meetings	Nothing connects with customers like face-to-face meetings. A pre-packaged PowerPoint presentation, handouts, and related materials will be provided on an as-needed basis for stakeholders.	Number of meetings Anecdotal feedback Number of questions received/answered

**Table XI-2** Stakeholder Outreach and Education deliverables

Deliverable Communication Vehicle	Description	Key Performance Indicators (KPI)
Participate in Stakeholder Meetings	A number of key stakeholder organizations hold regular and/or annual meetings. This forum is the target audience for the NYS DOH message regarding the EHR Incentive Program. Attendance at and especially speaking roles at these meetings will provide value.	Number of meetings Anecdotal feedback Number of questions received/answered
Social Media: Facebook™ Twitter™ Blogs Real Simple Syndication LinkedIn™	<p>Among the content distributed via this method:</p> <ul style="list-style-type: none"> <li>▪ The Marketing Communications Campaign's presentation and webinar schedules</li> <li>▪ Updates and clarifications of the Final Rule</li> <li>▪ Updates from CMS, CCHIT and other oversight agencies on issues such as technology certifications, vendor updates, Meaningful Use criteria, payment information, and the like</li> <li>▪ Current information regarding Regional Health Information Organizations (RHIOs), Health Information Organizations (HIOs), Regional Extension Centers (RECs), and other outreach groups</li> <li>▪ Twitter is an especially valuable resource for immediate alerts regarding an update to the Department's website with the direct link to the EHR Incentive Payment Program information</li> </ul>	<p>Number of members or followers</p> <p>Number of blogs posted</p> <p>Number of comments received</p>

**Table XI-2** Stakeholder Outreach and Education deliverables (cont.)



## APPENDIX XII

# CHI<sup>2</sup> PROJECT DOCUMENTS

This appendix contains organizational and descriptive documents for the Child Health Information Integration (CHI<sup>2</sup>) initiative currently underway by the NYS Office of Public Health (OPH) to improve population health and patient clinical care through public health information system integration and electronic exchange of information on child health within the healthcare community.

## 1. **Presentation to the ASTHO Immunization Registry Summit**

The following slides were part of a presentation titled "Incorporation of Registries in Electronic Health Records (and vice versa)," developed by the New York State Office of Public Health. The presentation was delivered to the Association of State and Territorial Healthcare Officials (ASTHO) at their Immunization Registry Summit on August 4, 2010, by Gus Birkhead, the Deputy Commissioner of OPH.

# **Incorporation of Registries in Electronic Health Records (and vice versa)**

**ASTHO Immunization Registry Summit  
Wednesday, August 4, 2010  
Crystal City, VA**

*Gus Birkhead, M.D., M.P.H.  
Deputy Commissioner, Office of Public Health  
New York State Department of Health*

## **NYS IIS History**

- New York State (outside of New York City)
  - Voluntary participation since 1994.
  - Regional registry model
  - Legacy system required installation of software and updates on each office computer.
  - Individual consent required.
- New York City has mandatory registry (NYCIR) since 1997.

## **NYS Public Health Law 2168**

- Effective January 1, 2008,
- Mandatory reporting by health care providers of immunizations given to persons age <19 years.
- Consent not required
- Past immunization history must be reported if not previously reported.
- With written consent, immunizations given to persons 19 years and older can be reported.
- Vital records birth certificate information, including immunizations administered at birth, “seed” the NYSIIS.
- Allows NYSIIS – NYCIR data exchange

## NYIIS Implementation

**As of May 1, 2010:**

- 3.1 million patients
- 36.4 million immunizations
- 9,200+ individual users
- 3,100+ health care provider practices
- 1,500+ schools

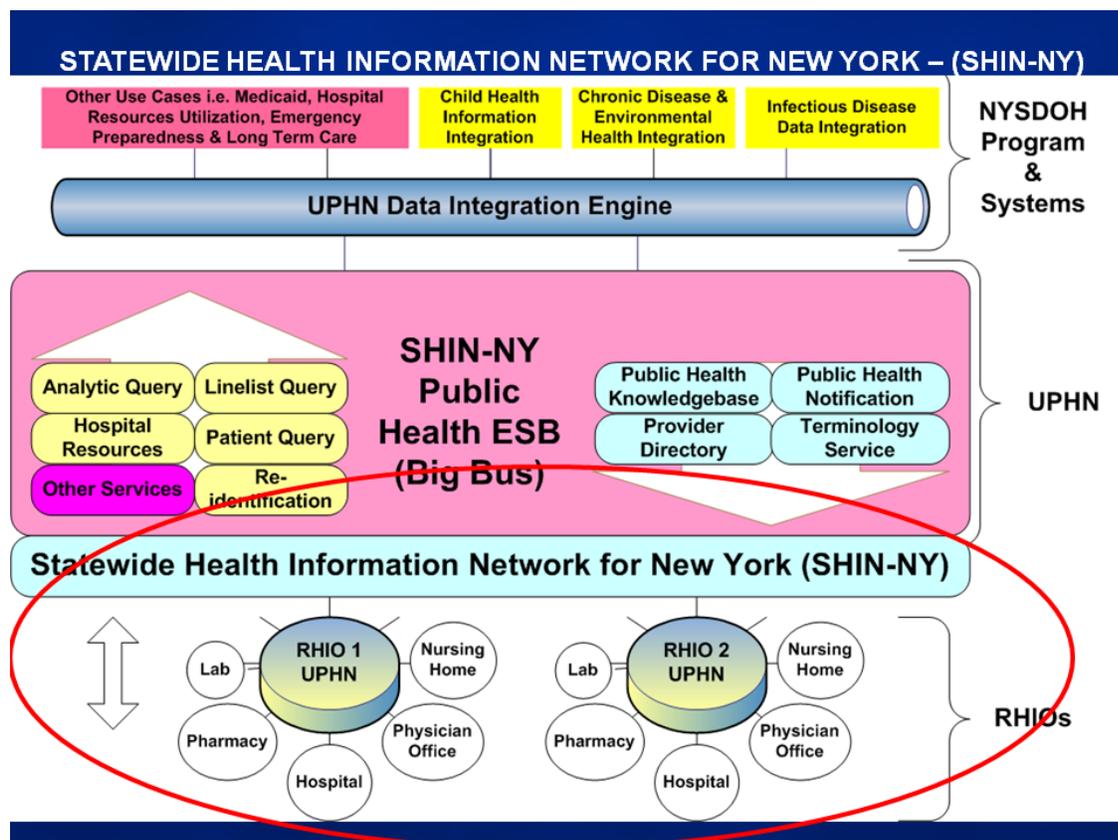
**Coverage: 78.7% of NYS children (outside of NYC) age <6 years have  $\geq 2$  shots in NYSIIS**

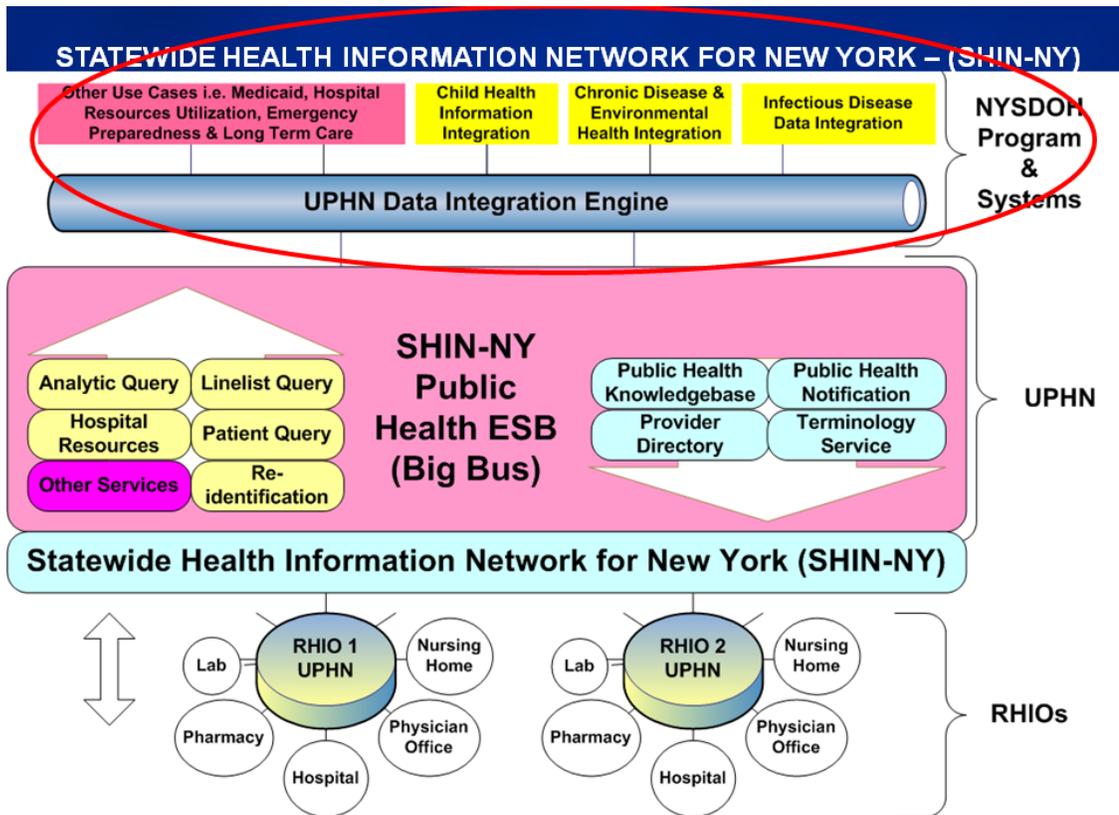
## NYSIIS Implementation and EHRs

- **NYSIIS accepts standard HL-7 messages via batch load from EHRs**
  - Certified 56 vendors serving 664 practices, plus 141 practices using in house systems. 10 million of the 17 million annual transactions.
  - An additional 18 vendors are in process of certification
  - Exchanging with 8 managed care plans for HEDIS
- **Barriers:**
  - Not bi-directional or real time.
  - Not automated.
  - Vendor by vendor/practice by practice set up.
  - Not all practices served by certified vendors have current EMR software or are willing to pay for NYSIIS service.
  - New version of HL7 2.5.1 requires upgrading NYSIIS and vendor software.

## Link NYSIIS to the New State HIE Infrastructure

- \$1 billion public and private investment in the Statewide Health Information Network for New York, or SHIN-NY;
- Testing the Universal Public Health Node (UPHN), a system designed facilitate bi-directional data between State DOH and local health information exchanges across the state for public health functions;
- Replace batch uploads to NYSIIS from EMRs.



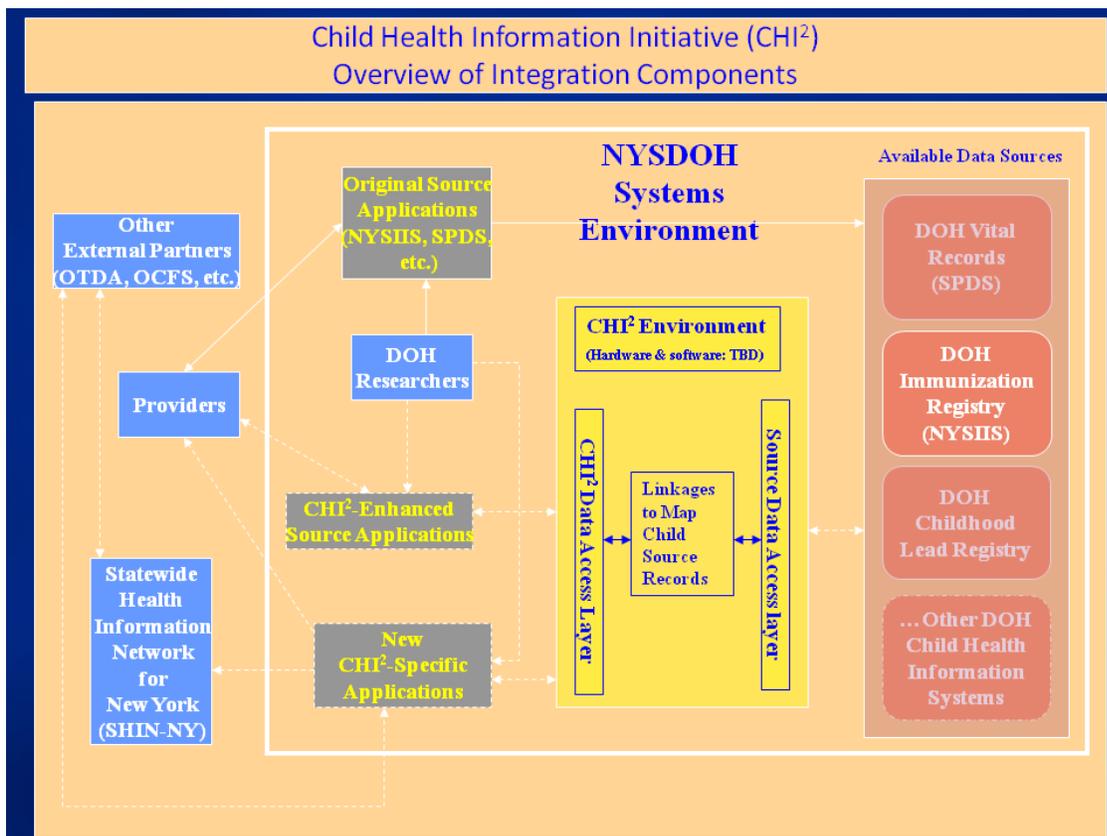


## Child Health Information Integration Project – CHI<sup>2</sup>

- Integrate child health data held by state health department, to benefit providers, PH programs and children.
- Initially use NYSIIS as a base
  - Lead laboratory results
  - Newborn hearing screening results
- Develop an integrated system built on the statewide information infrastructure:
  - Newborn Metabolic Screening Program
  - Early Intervention (0-3 yrs) – 75,000/year
  - WIC (pregnant women and kids age 0-5) –
  - SPARCS Hospital discharge incl. ED visits
  - eMedNY Medicaid billing system

# CHI<sup>2</sup> Vision

- **Physician with patient**
  - Immunizations
  - Lead
  - Newborn screening
  - WIC services
  - Pharmacy history
  - Early intervention program services
  - Pharmacy utilization
  - Etc.
- **PH Program Manager**
  - Follow up kids with conditions of public health interest (lead)
  - Quality monitoring
  - Monitor population health
- **PH Administrator**
  - Program monitoring and administration
  - Reimbursement
- **PH Researcher**
  - Conduct studies to create generalizable knowledge
- **Parents/families**
  - Assurance of complete medical history
  - Maximize care
  - Minimize unnecessary or dangerous care



## **Principles for CHI<sup>2</sup> Development**

- Maximize the use of the existing information infrastructure
- Develop a standard infrastructure that promotes everyday use, access and data sharing
- Improve bidirectional communication
- Employ standards to assure a seamless flow of information

## **Approaches to Support IIS Development and Integration**

- ARRA: Funds used to accelerate work on a universal public health node to connect internal and external systems together
- Health Care Reform - Meaningful use criteria, guidance and funding to support enhanced ability for clinical data to be reported, aggregated and analyzed for public health purposes.
- Statewide IT policy planning

## **Public Health, HIE and EHRs – Factors to Consider**

- Broader thinking by Public Health about the potential for new uses of data;
- Overcome barriers of silo funding/thinking;
- Funding to support system upgrades is critical; for example funding is needed to upgrade to HL 7 2.5.1
- New system must be developed with interoperability in mind.
- Public Health will need to operate dual systems (current and new HIE-based systems) until HIE-based systems are validated and all providers have access.

## **Recommendations for Federal Agencies to Support Public Health HIE**

- Actively engage public health to assure that HIT goals and standards can be achieved and are useful for public health program purposes.
- Develop national standards for HIE that have been widely vetted in the PH community.
- Assure data from HIE are valid, accurate and timely. Resources will be needed to assure this validation.
- Assure that federal funding for categorical public health programs is flexible enough allow cross-program collaboration such as New York is undertaking in its CHI2 initiative.

## 2. Project Charter

<i>Purpose:</i>	<i>Provides authority to establish the project and secures commitment for the resources required to complete the initiation of the project.</i>
<i>Target Audience:</i>	<i>Project Sponsor should indicate acceptance of the Project Charter by signing the form. It is unwise to proceed with the project without complete agreement on the content of the charter with the sponsor.</i>

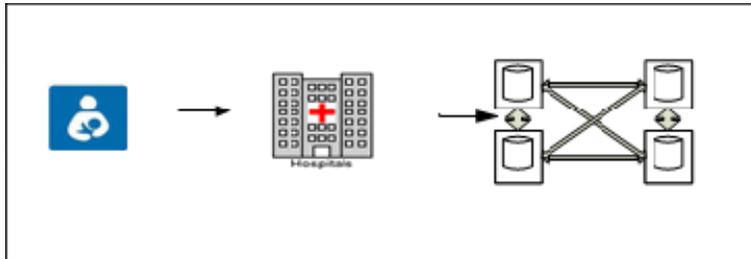
PROJECT IDENTIFICATION	
<b>Project Name:</b>	Child Health Information Integration (CHI <sup>2</sup> )
<b>Project Sponsors:</b>	Guthrie Birkhead, Rachel Block
<b>Project Directors:</b>	Brian Scott, Marilyn Kacica
<b>Project Coordinator:</b>	Robert Fletcher
<b>Project Manager:</b>	Chris Wisniewski
<b>Date:</b>	

Project Description
<b>Project Background, NEED and VISION:</b>
<p><b>Background and Need</b></p> <p>The delivery of health care in New York State occurs in many different settings, from physicians' offices to hospitals, and from Manhattan to rural upstate towns. There is a crucial need for timeliness and standardization of data to transmit relevant information to healthcare providers in a clinically useful form. Reconfiguration of the healthcare system through efforts like the Federal HIT and State HEAL NY initiatives places higher demands on information sharing as patients are cared for in different settings based on their changing clinical needs. This diversity of settings, along with the increased mobility of the patient population, requires that standards be put in place so those providers can easily and securely access healthcare information. (Source: NYSDOH Heal NY RGA)</p> <p>Historically within DOH the development environment for systems and applications with child health data has not been based on enterprise standards which would allow easy and secure access. Rather, application development for the collection of child health data followed a localized stove pipe approach focused on individual program priorities and funding availability. DOH currently has no consistent framework or standards for defining child health data structures.</p> <p><b>Vision</b></p> <p><b>Virtual Child Health Record</b></p> <p>The CHI<sup>2</sup> Project will create a solution that follows federal and state guidelines. DOH programs will have consistency when utilizing data which should improve public health function, integration, evaluation and research.</p> <p>The Child Health Information Integration project will enable the integration of datasets within various Department of Health (DOH) programs serving children in New York. An integrated information system has the potential to dramatically increase the public health benefit and efficiency of the many governmental programs overseen by DOH. External partners including</p>

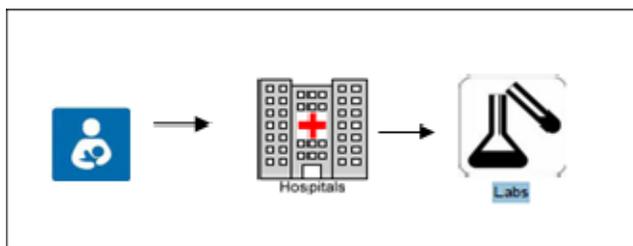
healthcare providers and Regional Health Information Organizations will have access to better child health data leading to improved patient care.

Below is **just one of many possible scenarios** highlighting some of the ways in which the CHI<sup>2</sup> project might benefit children’s health care in New York State<sup>1</sup>:

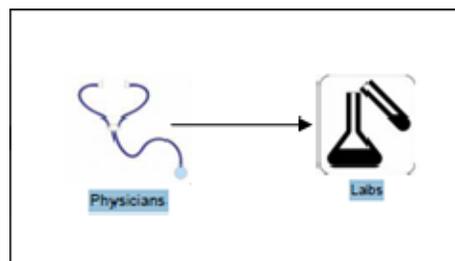
1. A child is born and is admitted to the Neonatal Intensive Care Unit (NICU) due to transient tachypnea and poor O2 saturation following delivery.
  - o The child’s details are added into the Hospital’s systems and all the systems of DOH that capture the new born child data (CHI<sup>2</sup> System).



2. The child is determined to have no recurrent problem and is transferred to newborn nursery for routine hospital care and Hepatitis B vaccine is administered.
3. The newborn blood spot screening (heel stick) is performed, the vital statistics work book is completed and the child is discharged from the hospital.
4. The newborn blood spot screening samples are sent to Wadsworth laboratories for examination and an appointment is made with the family’s pediatrician Dr. Goodfriend for a 1-week well child visit at his private practice office in the community.

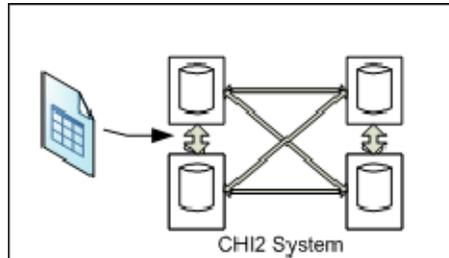


5. Dr. Goodfriend is notified by Wadsworth Laboratory of a positive screen for congenital hypothyroidism (CH).

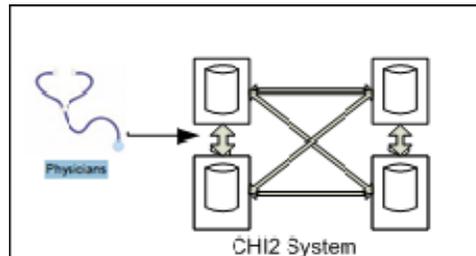


<sup>1</sup>Material provided by CHI<sup>2</sup> Requirements Workgroup in their document entitled “CHI2 Requirements Case Scenario.”

6. The child is taken to Dr. Goodfriend for the 1-week well child visit. Dr. Goodfriend tells the family about the positive newborn CH test, orders follow-up labs and draws all the necessary blood samples at the clinic.
  - o Dr. Goodfriend accesses the CHI<sup>2</sup> data system and verifies that the Hepatitis B vaccine was administered in the hospital.
7. Several days later, the pediatrician's office calls the family to let them know that the follow-up laboratory tests were all within normal limits and the child does not have CH, and documents the outcome in the CHI<sup>2</sup> system.



8. After a few months the family moves to a different county. The child is taken to a new pediatrician, Dr. Wellness for a six month visit.
  - o Dr. Wellness accesses the CHI<sup>2</sup> system and confirms that the child's immunizations are previously up to date.



The ability to link maternal and child healthcare information across multiple data sources will create a number of beneficial outcomes for the delivery of health care to mothers and children in New York State, such as identification and monitoring of different child health status "profile" populations; identification and follow-up of specific child health areas of need; and more targeted and effective planning for children's healthcare programs and services.

There is a crucial need to integrate the information obtained through various different programs within DOH. Currently, pediatricians across the state have no comprehensive source of information on the services provided to their patients by DOH programs. An integrated system would bring together newborn screening, newborn hearing screening, immunization, lead screening, early intervention, WIC, Medicaid, vital statistics and other data sources needed by healthcare providers to provide quality care to children into one interface to be viewed by clinicians. This integrated system would also be available for DOH managers and researchers to improve the public health utility of their efforts.

Some additional examples of scenarios and benefits which would be enabled by the CHI<sup>2</sup> system include:

- The ability for newborn screening staff to follow the clinical course of a premature infant admitted to a neonatal intensive care unit to ensure proper testing has been completed.

- Alerts provided to immunization program staff for WIC recipients who are not up-to-date with immunizations or lead screening.
- Notification of the healthcare provider regarding early intervention program recipients who have not had a blood lead level test.

**Project Timeframe:**

*Provide the expected timeframe of the project.*

The project will be completed in three phases, according to the following target timeframes:

<b>Phase/Stage</b>	<b>Target Timeframe</b>
Phase 1	7/09 – 7/10
System Initiation	7/09 – 8/09
System Requirements Analysis	8/09 – 7/10
Phase 2	7/10 – 7/11
System Design	7/10 – 1/11
System Construction	1/11 – 7/11
Phase 3	
System Acceptance	7/11 – 10/11
System Implementation	10/11 – 6/12

**Project mission:**

*Describe the mission of the project.*

Provide a solution that enables the NYSDOH to link systems containing child specific data. This solution will avoid duplication of effort, provide compatibility and data sharing capability, and receive data from the emerging electronic medical records (EMR) systems and RHIOS that the department is supporting through the HEAL-NY grants. It will provide for sharing integrated child data held by the department with health care providers, in a manner consistent with public health laws, for the purpose of providing high quality health care to their patients.

**Project objective(s):**

*Describe the objective(s) of the project*

- Achieve economies of scale in infrastructure-complexity reduction with inherent life cycle cost savings in development, training, and operation
- Design, develop, and deliver a solution that is extensible and capable of being used and evolved for all applications/programs with child specific data
- Provide integrated information on children involved in two or more programs, reduce redundant person information storage and greatly benefit DOH
- Develop a solution that is flexible enough to work under a variety of conditions and constraints that will complement, not hinder, applications/programs.
- Make the solution affordable; the cost of creating and operating it should outweigh the risk of not implementing it.
- The solution will leverage the existing DOH system infrastructure.
- The solution will be compliant with Federal, State, and CDC requirements.
- The solution will be real-time or near real-time, providing timely access to the data.
- The solution will be usable on a state-wide basis, eliminating the problems inherent with deployment of multiple incompatible environments
- The solution will address privacy, confidentiality, the laws/rules/regulations/policies/procedures governing access data.

**Critical Success Factors:**

*Provide a list of outcomes that must be achieved in order for the project to be considered a success.*

The CHI<sup>2</sup> solution will:

- Accommodate the operational needs of all applications/programs with child specific data.
- Be adaptable to changing directives issued related to Federal and State laws, regulations, and policies.
- Be adaptable to the available technology and individual preferences of Regional Health Information Organizations (RHIOS) and local Electronic Medical Records (EMR).

- Be affordable.
- Be easily maintained.
- Be widely used because it offers benefits.
- Provide metrics.
- Ensure data integrity and be as accurate as possible.
- Be stable with little time lost caused by unavailability, poor performance, or missing data.
- Be able to interface with CDC.
- Be user friendly and require minimal training by end users.

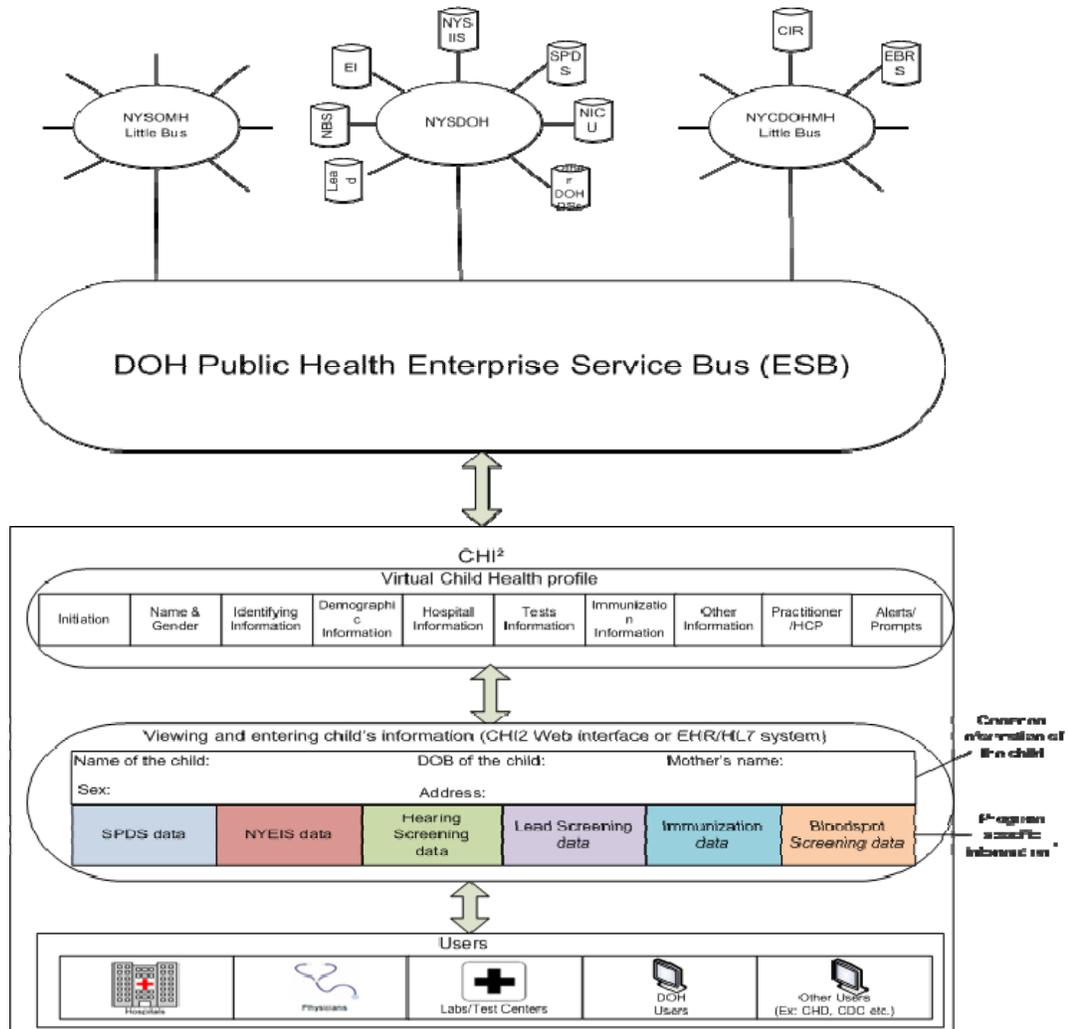
#### Constraints:

- Identification of funding for Phases 2 and 3 (Design, Build, Acceptance and Implementation)
- Lack of DOH staff for Phases 2 and 3
- Project must cross organizational and functional boundaries to be successful. Existing “silos” and independent organization structure within DOH could make coordination and communication across units difficult.
- Lack of existing unified data messaging, infrastructure and technical architecture standards.
- Phase I will include :
  - SPDS (Birth Certificate) - ISHSG
  - NYSIIS (CCH - Division of Epidemiology)
  - Newborn Bloodspot Screening System (Wadsworth Center)
  - Newborn Hearing Screening (CCH-DFH)
  - Lead Web
- Future phases will possibly include but not be limited to the following list of applications:
  - Non-birth certificate items in SPDS (CCH - DFH)
  - Childhood Lead Registry (CCH-DFH)
  - NYEIS - New York Early Intervention System (CCH-DFH)
  - WICsys (CCH-Nutrition)
  - Medicaid/Child health Plus (OHIP)
  - Managed Care Encounter data (OHIP)
  - EmedNY (OHIP)
  - SPARCS inpatient and ED
  - Congenital Malformations registry (CEH)
- Will use the PHIN standards required by CDC.
- Will address disaster recovery requirements

### 3. Project Software Approach

#### Functional Architectural Design of CHI<sup>2</sup>

The following functional architecture describes our understanding of the CHI<sup>2</sup> business and system requirements and presents a business-oriented design to address those requirements. The functional architecture is intended to provide a “bird’s eye” view of our solution without delving into the technical intricacies associated with implementation.



\* Program specific information Access to this part of the information is based on the user's role and access permissions

Exhibit XII-1 CHI<sup>2</sup> Functional Architecture

#### CHI<sup>2</sup> – Overview and Usage Scenario

#### CHI<sup>2</sup> Virtual Child Health Index Concept Description

The central concept of the CHI<sup>2</sup> system is called the **Virtual Child Health Index (VCHI)**.

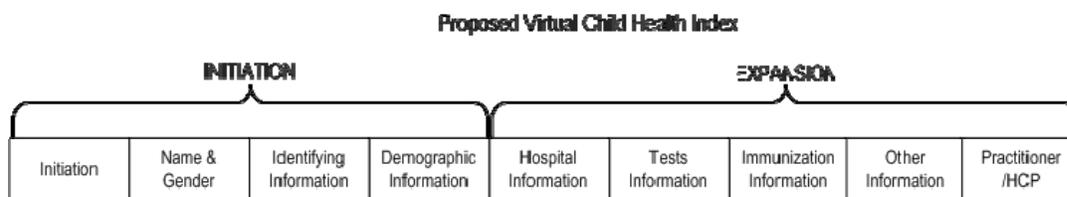
The CHI<sup>2</sup> VCHI acts as an index of all child health data contained within DOH source system databases. It maintains connections to all data elements designated as making up one or more of the sections of the VCHI. This index constantly monitors the connected source system databases and ensures that it is linked to the most accurate and up-to-date versions of all data.

The VCHI can be utilized in the following ways:

- **Direct viewing, entering, management or analysis of child health data** – this is accomplished by use of a web interface (through a web browser).
- **Bidirectional transfer of child health data** – this is accomplished by use of a standards-based (system to system) data transfer capability. Specific data to be transferred is identified and programming is done on both the CHI<sup>2</sup> and source system ends to enable data to be sent back and forth.

In both instances, users can perform the following functions:

- **Viewing** – users are able to log on to the web interface and/or utilize an existing clinical documentation system -- such as a hospital or medical practice electronic health record system (EHR) -- enter a set of search criteria and view child health data (existing information contained within DOH source systems) linked through the VCHI.
- **Entering** – users are able either to enter new information about a child with no existing VCHI (thus initiating a new VCHI for the child) or they can add new information to one or more sections of a child's existing VCHI. Users also have the ability to enter info here which is currently only able to be entered through individual source systems.
- **Management/Analysis** – DOH program staff, hospital staff and health care provider staff will be able to log on to the web interface. They will be able to run pre-created and ad-hoc reports and utilize data management functions related to display of data in the web interface and viewing, creation and management of trigger-based alerts.



**Exhibit XII-2** Proposed Virtual Child Health Index

The following section provides further illustration of the VCHI concepts based on specific scenarios related to how the system could be used.

### **CHI<sup>2</sup> System Use Scenario**

The CHI<sup>2</sup> Virtual Child Health Index enables the various users of the CHI<sup>2</sup> system to efficiently and effectively enter, view, edit and manage their child health data. To illustrate this we will review the following scenario.

#### **Scenario Overview**

This scenario describes a typical path a child might take through the healthcare system, from newborn to their one year old lead screening. The scenario is made up of four high-level steps, each of which is accompanied by an illustration and some detailed steps. The scenario is not intended to include every step in the child's journey but instead highlights certain steps for illustrative purposes.

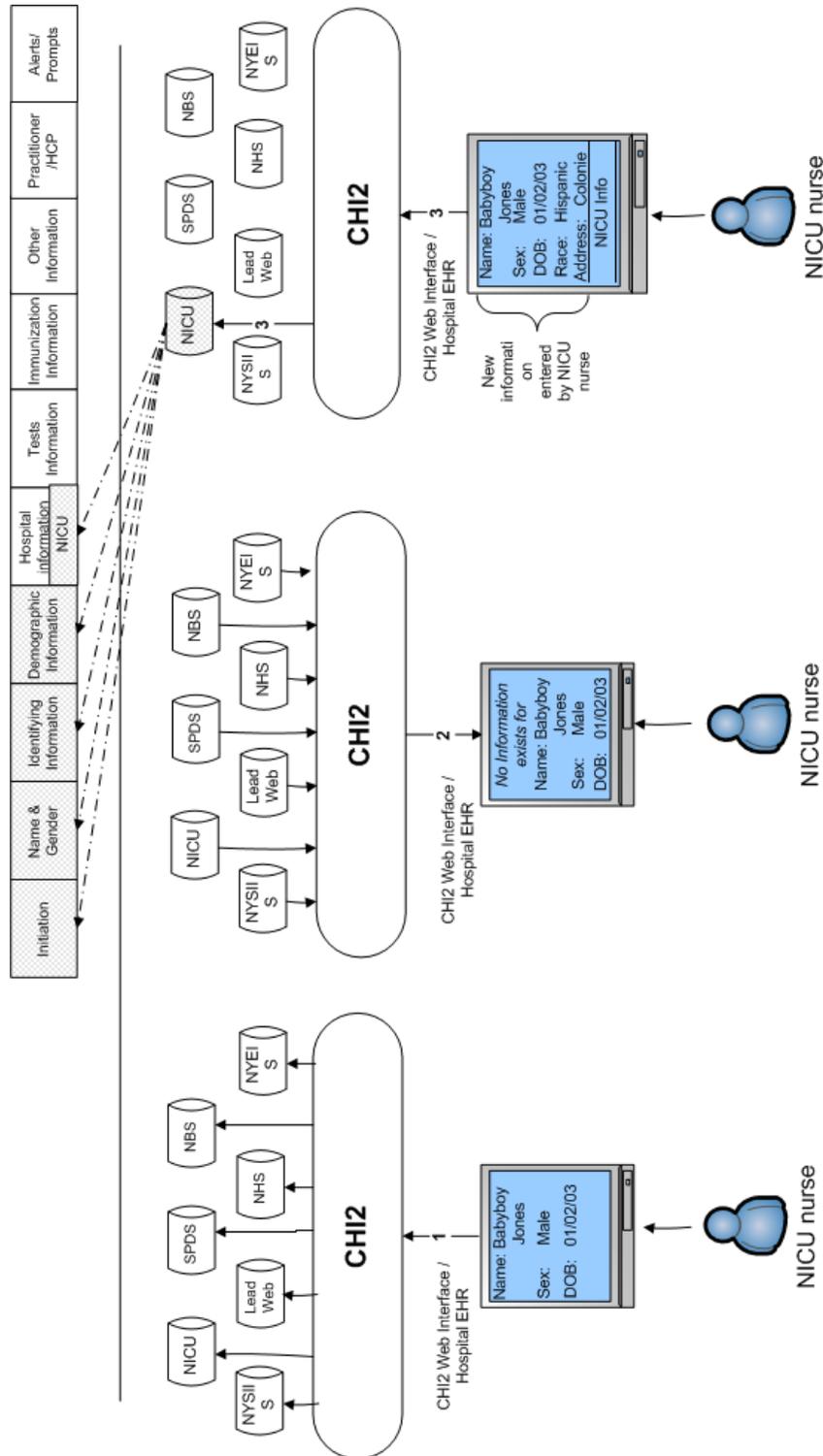
#### **Scenario High Level Steps**

1. A child is born and enters the NICU.
2. Newborn bloodspot screening is performed.
3. The child visits the pediatrician and receives a lead screening test as part of 1 year old well child visit.
4. Local Health Department lead program staff members update their data using CHI<sup>2</sup>.

On the following pages we will examine each high-level step in more detail.

**NOTE: All numbers on the diagrams below correspond to and are explained by the numbered detailed steps below the diagrams.**

# 1. A child is born and enters the NICU (Record initiated).

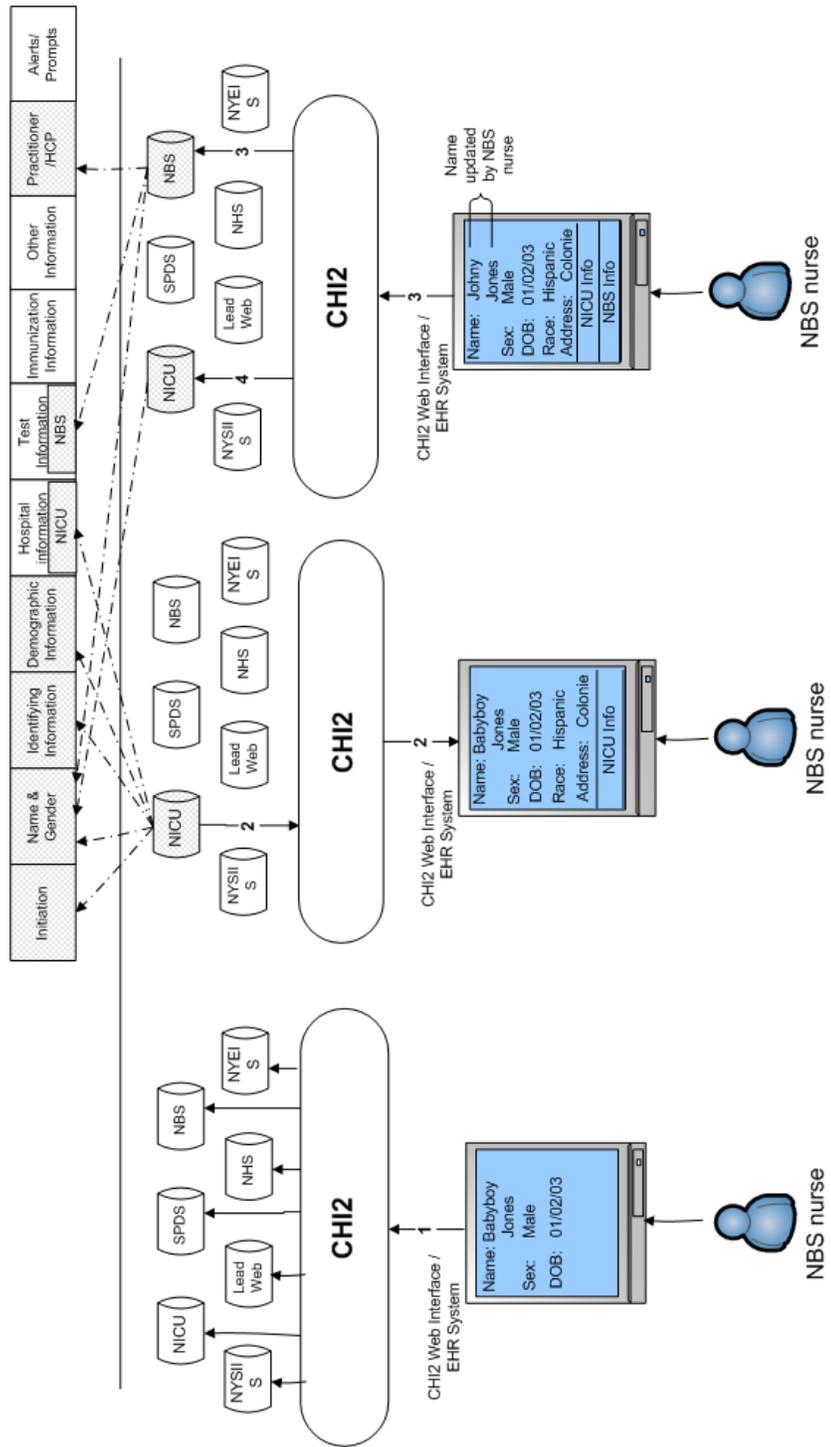


**Exhibit XII-3** CHI<sup>2</sup> System Use Scenario 1: Record Initiated

### Detailed Steps

1. The NICU nurse enters identifying criteria for the child into the CHI<sup>2</sup> web interface or hospital EHR system.
2. CHI<sup>2</sup> determines that there is no existing information about the child in any DOH source systems.
3. The nurse enters any new information about the child into the web interface or hospital EHR system causing CHI<sup>2</sup> to transfer that information to the appropriate DOH source systems and create a Virtual Child Health Profile for that child

**2. Newborn bloodspot screening is performed (Data quality and timeliness).**

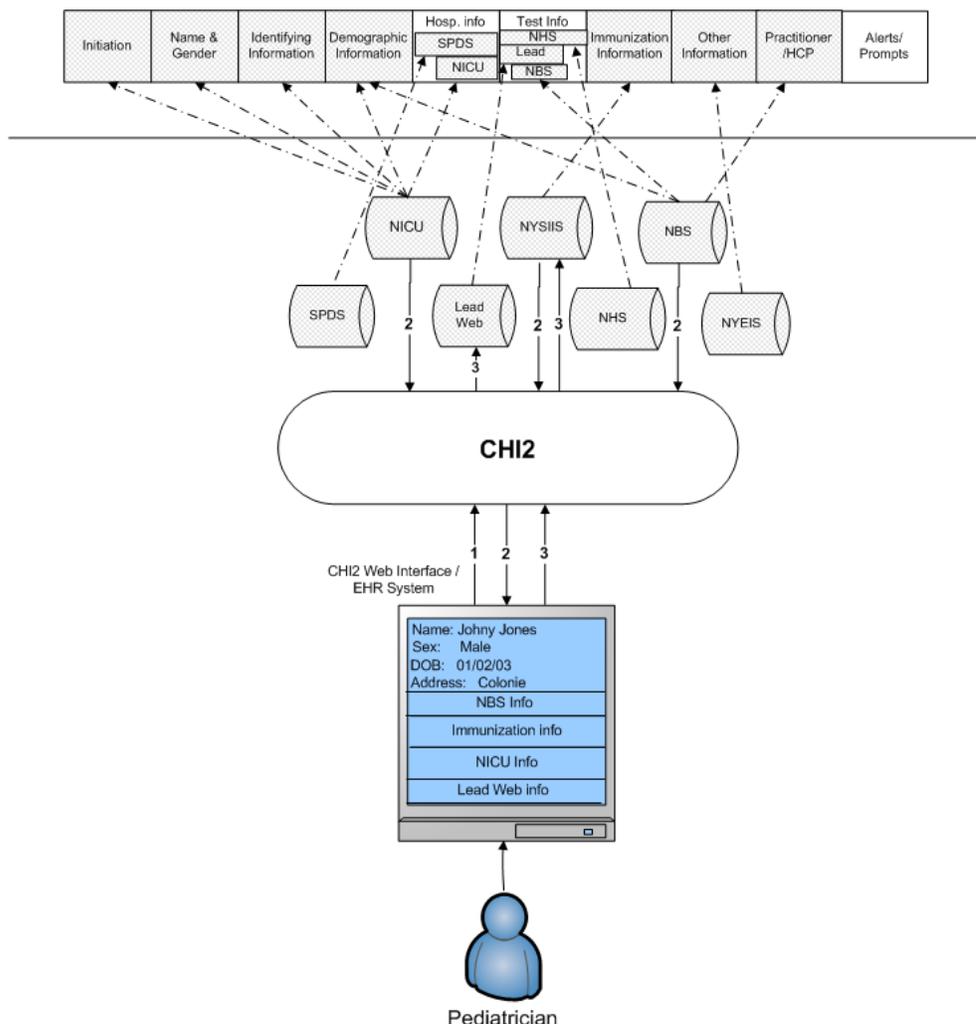


**Detailed Steps**

1. The NBS nurse enters certain identifying criteria for the child into the CHI<sup>2</sup> web interface or hospital EHR system.
2. CHI<sup>2</sup> determines that there is an existing Virtual Child Health Profile for that child and displays the information (pulled by CHI<sup>2</sup> from NICU and/or other DOH source systems) about the child on the web interface screen or in the hospital's EHR system (where possible).
3. The NBS nurse enters the child's updated name and bloodspot screening information into the web interface or hospital's EHR system and CHI<sup>2</sup> transfers that information to the appropriate DOH source systems.
4. The NICU system receives a notification that the child's name has been updated.

**Exhibit XII-4** CHI<sup>2</sup> System Use Scenario 2: Data Quality and Timeliness

### 3. The child visits the pediatrician and receives a lead screening test as part of 1 year old well child visit (Clinical care)

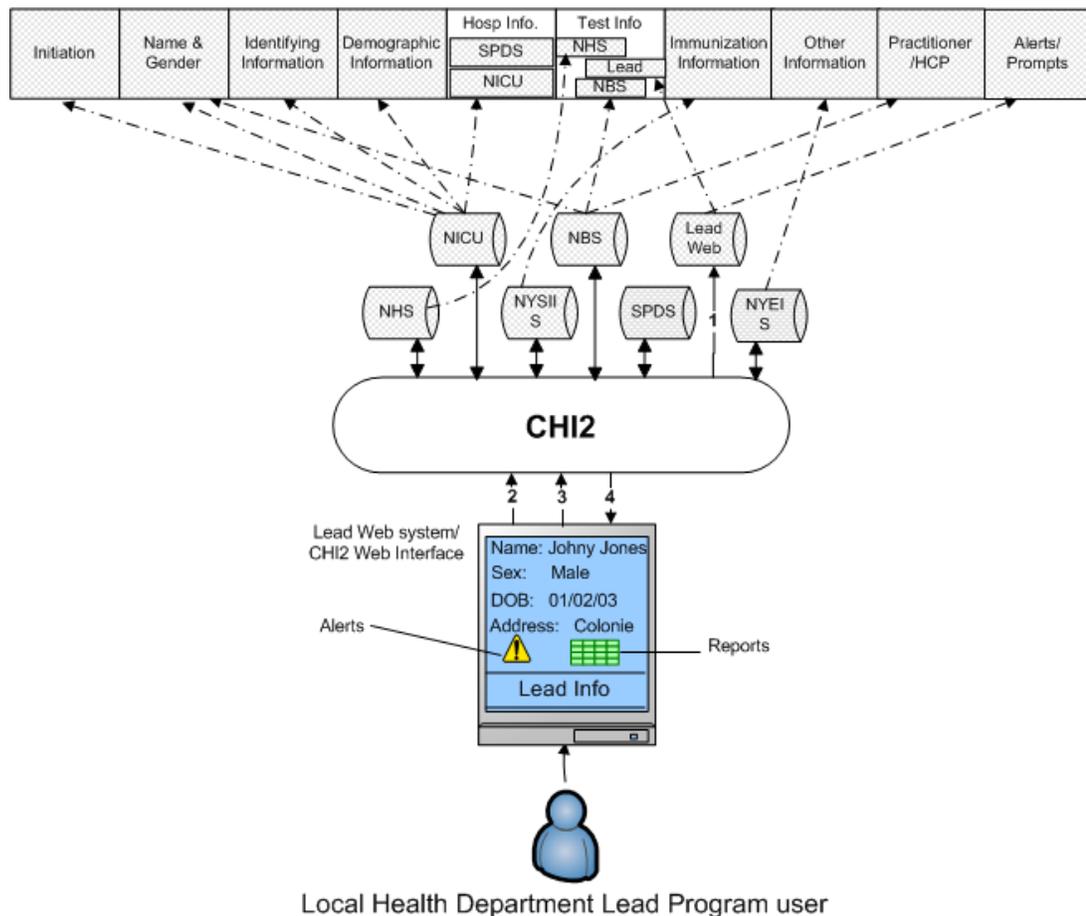


**Exhibit XII-5** CHI<sup>2</sup> System Use Scenario 3: Clinical Care

#### Detailed Steps

1. The pediatrician enters identifying criteria for the child into the CHI<sup>2</sup> web interface or the practice EHR system.
2. CHI<sup>2</sup> determines that there is an existing Virtual Child Health Profile for that child and displays the information about the child on the web interface screen or practice EHR system. This information confirms that the child is up to date on immunizations but is due to receive 12 month immunizations and a routine 1 year old Blood Lead test.
3. The pediatrician performs the lead screening test using a portable analyzer in his office, administers 12 month immunizations and enters the test results and immunization information into the web interface or practice EHR system. CHI<sup>2</sup> transfers that information to the appropriate DOH source systems.

#### 4. Local Health Department lead program staff members update their data using CHI<sup>2</sup> (Public Health)



**Exhibit XII-6** CHI<sup>2</sup> System Use Scenario 4: Public Health

##### Detailed Steps

1. A Lead program user accesses Leadweb to view information about children requiring follow up in their county and notes some missing addresses.
2. The Lead program user utilizes CHI<sup>2</sup> to obtain addresses for these children and activates an option to populate these missing addresses from CHI<sup>2</sup> into Leadweb.
3. While in CHI<sup>2</sup>, the Lead program user also selects and customizes the following reports and alerts:
  - A daily alert for any children with new reports of BLL greater than or equal to 45 mcg/dL.
  - A monthly list report of children age 13 months or older who have not received a 1 year old Blood Lead test.
4. CHI<sup>2</sup> gathers a list of children who meet the criteria of the alert, notifies Lead of this list of children, and gives Lead the option to import the addresses of these children into the Leadweb database for follow up.

## **CHI<sup>2</sup>—Core Business Services**

The CHI<sup>2</sup> base application Core Business Services will provide three major groupings of components. These components combine with a range of business and technical infrastructure services and a set of administration functions to provide support for the CHI<sup>2</sup> business processes.

In the following paragraphs, we summarize the numerous business processes that the CHI<sup>2</sup> framework will provide. During our implementation it will be necessary to identify the data elements that need to be added and the workflows, security profiles, tasks, and work allocations that need to be configured for the solution. The business functions are divided into different components, elements and functions within the business architecture.

CHI<sup>2</sup> will provide a set of flexible processes that cover the core business areas for the set of CHI<sup>2</sup> Initial Focus systems including connections to associated external health care providers. These processes address processing of child health data, creation of a virtual child health profile and management and analysis of child health data. In addition, CHI<sup>2</sup> will provide administrative functions, allowing administrators to create and maintain the operational environment.

Exhibit XII-7 describes the CHI<sup>2</sup> components and business services depending on the user's roles and access permissions.

components	Processing Child Health Data	Virtual Child Health Index	Management of Child Health Data	Administration
elements	<ul style="list-style-type: none"> <li>• Web interface/ Web Interface</li> <li>• Bi-Directional (System-System) Transfers</li> <li>• Source Systems</li> </ul>	<ul style="list-style-type: none"> <li>• Creation</li> <li>• Management</li> </ul>	<ul style="list-style-type: none"> <li>• Business Rules</li> <li>• Analysis</li> <li>• Notification</li> </ul>	<ul style="list-style-type: none"> <li>• Sites</li> <li>• Users</li> <li>• Access</li> </ul>
functions	Manual data entry and modification (CHI2 web interface; source systems)	"First in" initiation of profile	Enterprise business rules creation	Definition of sites with access to the system
	Pre-population of source system data fields (based on business rules)	"Assembly line" addition of further data	Ad-hoc reporting	Definition of individual users with access to the system
	Data collection & distribution to/from source systems (based on business rules)	Integrated view of all child health data	Pre-developed reporting	Definition of a variety of access profiles related to ability to use all aspects of system
	Automated data collection/ distribution from/to provider EHR systems	Elimination of duplicate data entry	Ad-hoc data analysis – cross-system analysis utilizing all available data fields	
		User modifiable display of profile elements with "drill down" into further details	Event and/or business rules-based alerts	
		On-demand view of current child health data		

**Exhibit XII-7** Summary of the Child Health Information Integration (CHI<sup>2</sup>) Components and Business Services

The main components and related business services proposed for CHI<sup>2</sup> include:

- **Processing Child Health Data.** This component facilitates the collection, distribution, importing and exporting of child health data both to and from existing NYSDOH source systems and to and from healthcare provider electronic medical record (EMR) systems. The system will provide the ability for three types of data entry and access:
  1. **Manual** – this may be either via a web-based interface which will provide a consolidated view of all relevant child health data or via one or more of the existing NYSDOH Initial Focus source systems.

2. **Automated** – this will be via direct system to system connections utilizing the NYS Universal Public Health Node, the Enterprise Service Bus, and the SHIN-NY architecture.
3. **Semi-Automated** – this will be via an automated connection for some data and a manual connection for data which cannot be automatically transferred.
- **Virtual Child Health Profile.** This component of the system creates a virtual child health profile which pulls in real time and on demand the most current and accurate medical information on any given child. Further, the system will provide the ability for any new information added to any source system regarding any given child to be automatically provided and populated (based on user-defined business rules) within all other source systems containing information on that child. This will provide an integrated view of all relevant health data for a child that can be expanded, contracted or drilled down into based on user preference. Sections of the Virtual Child Health Profile include:
  1. **Initiation** – this part of the profile initiates the child's unique identifier in the CHI<sup>2</sup> system. This entry is used to link all other relevant child health data (contained within the NYS DOH source systems) together and to allow the user to view it in one location. This is performed through a “first in” mechanism, meaning that a unique ID is generated for a child as soon as CHI<sup>2</sup> determines that no other data exists for that child in any of the source systems. From this point forward all future data entered regarding that child (from any source system) is added to the child's virtual profile in an “assembly line” fashion.
  2. **Name and Gender** – this part of the profile contains information on the child's name and gender. Any updates to this information are also provided to all CHI<sup>2</sup> source systems.
  3. **Identifying Information** – this part of the profile contains the date of birth, race and ethnicity details for the child. Any updates to this information are also provided to all CHI<sup>2</sup> source systems.
  4. **Demographic Information** – this part of the profile contains the parent's address and contact information. Any updates to this information are also provided to all CHI<sup>2</sup> source systems.
  5. **Hospital Information** – this part of the profile contains information related to the child's stay in a hospital or birthing facility such as perinatal information and NICU details (if applicable).
  6. **Tests Information** – this part of the profile contains details related to newborn hearing screening testing and results, details related to

newborn bloodspot screening testing and results and details related to lead screening/testing and results.

7. **Immunization Information** – this part of the profile contains details related to immunizations administered to the child (Hep B, etc).
  8. **Other Information** – this part of the profile contains details related to early intervention, referrals, etc.
  9. **HCP** – this part of the profile contains details related to treatment, check-ups and physical examinations the child has received from his/her physician. It also contains any anticipatory guidance that should be given to the family of the child by the HCP.
- **Management of Child Health Data.** The Data Management component of the system provides the ability to analyze, report on and make more effective use of child health data. There will be three main elements to this component:
    1. **Business Rules** – this element provides a foundation of rule-driven configuration options for users of the system. Users will be able to create a robust set of rules which will allow them to customize the behavior of the system to their own needs related to data processing, management, display, analysis and notification. For example, rules and combinations of rules and triggers may be created to address any of the following situations (and many more):
      - To enable automatic import of specific data elements based on certain trigger events
      - To automatically create a specific report containing certain data elements and to email that report for review to specific people in a specific order
      - To enable alerts to specific users based on the creation, deletion or change in specific data elements
      - To run certain calculations on specific data elements and then import those calculated elements into specific source systems
    2. **Analysis** – this element enables system users to generate a rich set of reports in support of more effective and efficient decision-making and improved knowledge about children in the system. Reports may be generated in ad-hoc fashion, allowing access (based on roles and appropriate security measures) to all of the data elements in the system for generation of one-off reports, pivot tables, charts, etc. There will also be a set of pre-defined reports available to each of the various system users, to be defined during implementation. All reports may also be

created, manipulated, and distributed in whole or in part through use of the system's business rules engine (described above).

3. **Notification** – this element provides the capability of notifying (in a manner to be determined during system design) system users of the occurrence of trigger events (e.g. the existence, modification, movement or other manipulation of one or more system data elements, reports, etc in isolation or in combination with others). Trigger events and the system behaviors associated with them may be defined through use of business rules.
  - **Administration.** The Administration component allows administrators to create and maintain information relating to the operation of the system including system-wide functions. It provides functions for maintaining a broad range of system facilities including users, workgroups, agency and organization structures, security profiles, and batch processes.

All of this functionality comes with standardization in the tools, architecture, and configuration that will allow for easier support and maintenance. The benefits the CHI<sup>2</sup> solution offers to the Department are elaborated in the next section, along with a matrix linking the listed benefits to the high level and detailed requirements listed in the sections that follow.

#### 4. CHI<sup>2</sup> Benefits

1. Provides bi-directional flow of information between DOH systems and HCP's EHR systems.
2. Unification of collection of individual level data – streamlining reporting / reducing reporting burden – unifying data fields and categories
3. Eliminates duplicate submission of data and data redundancy
4. Provides seamless flow of information between jurisdictions (e.g. between providers, across counties, RHIOS, states, etc.) – standardized data
5. Links events of public health significance in child's life (e.g. immunizations, lead tests, EI services, asthma events)
6. Electronic access to the child's medical history providing a comprehensive view and enabling better care and long-term follow-ups on specific conditions – improving patient care
7. Integrates location data to assess environmental risks (such as for cancer registry, use of geographical coding, etc.)
8. Specific public health goals that may be achieved via CHI<sup>2</sup> use by providers (ability to influence practices of providers, improve enrollment in programs, guide behavior, etc.)

9. To help find children you might have missed within your program
10. To help you improve the quality of your data – both within a system and across systems – harmonization of standards

The following table lists the various users identified as receiving benefits from CHI<sup>2</sup>. It also indicates which of the benefits listed above applies to each user and maps the benefits to their corresponding high level and detailed functional requirements. This ensures that all CHI<sup>2</sup> requirements address specific defined benefits and that each benefit accrues to specific defined users.

Users	CHI <sup>2</sup> Benefit ID	High Level/Functional Requirement ID	Detail/Specific Requirement ID
Hospitals, Labs/Test Centers, HCP, DOH, Other Agencies Users	1	HR1	PR1-PR6
Hospitals, , DOH	2,3	HR2-HR4	VR1.1-VR1.3, VR20.1-VR20.8, VR30.1-VR30.8, VR31.1-VR31.8
DOH, Other Agencies Users	4	HR5-HR6	VR1-VR110, UR1.1-UR1.10,UR2.1- UR2.7,UR3.1-UR3.3, UR4,UR4.1,UR5
HCP, DOH,	5	HR7-HR8	VR120-VR123
Hospitals, Labs/Test Centers, HCP, DOH, Other Agencies Users	6	HR9-HR12	UR4.1,UR4.2 UR1.1-UR1.10, UR2.1-UR2.7, UR3.1-UR3.3, UR5, VR1-VR110
HCP	7	HR13	VR62.8
HCP, DOH,	8	HR14	VR62.8.1, VR 110.2
DOH	9	HR15-HR16	VR60.2.2, VR60.4, VR60.4.1, VR61.4,VR61.4.1, VR70.1.4,VR70.1.5, VR110.3, VR120-VR123
DOH	10	HR17	VR1-VR110

**Table XII-1** CHI<sup>2</sup> Benefits Matrix

## 5. Process Flow Diagrams

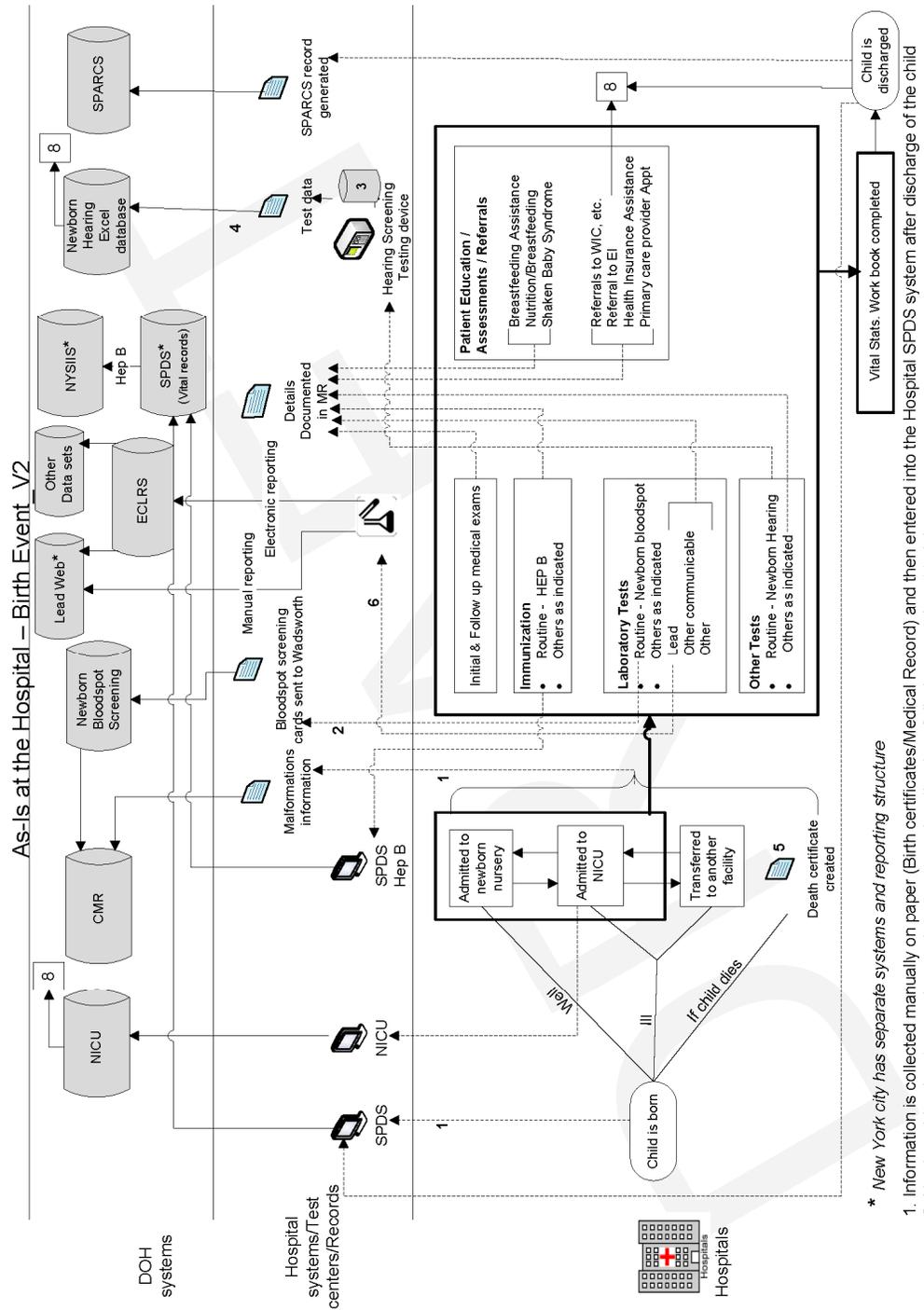
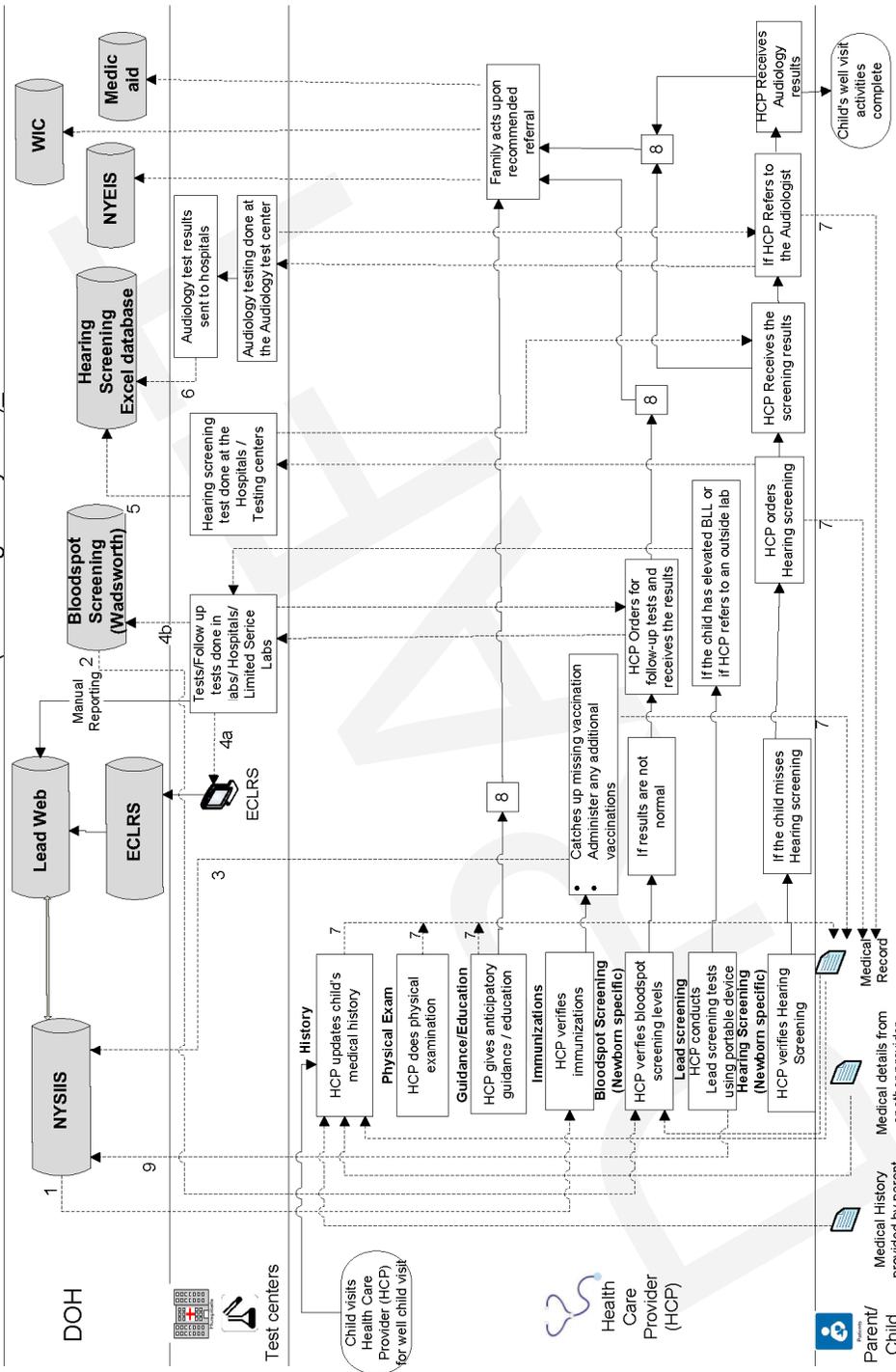


Exhibit XII-8 As-Is at the Hospital – Birth Event

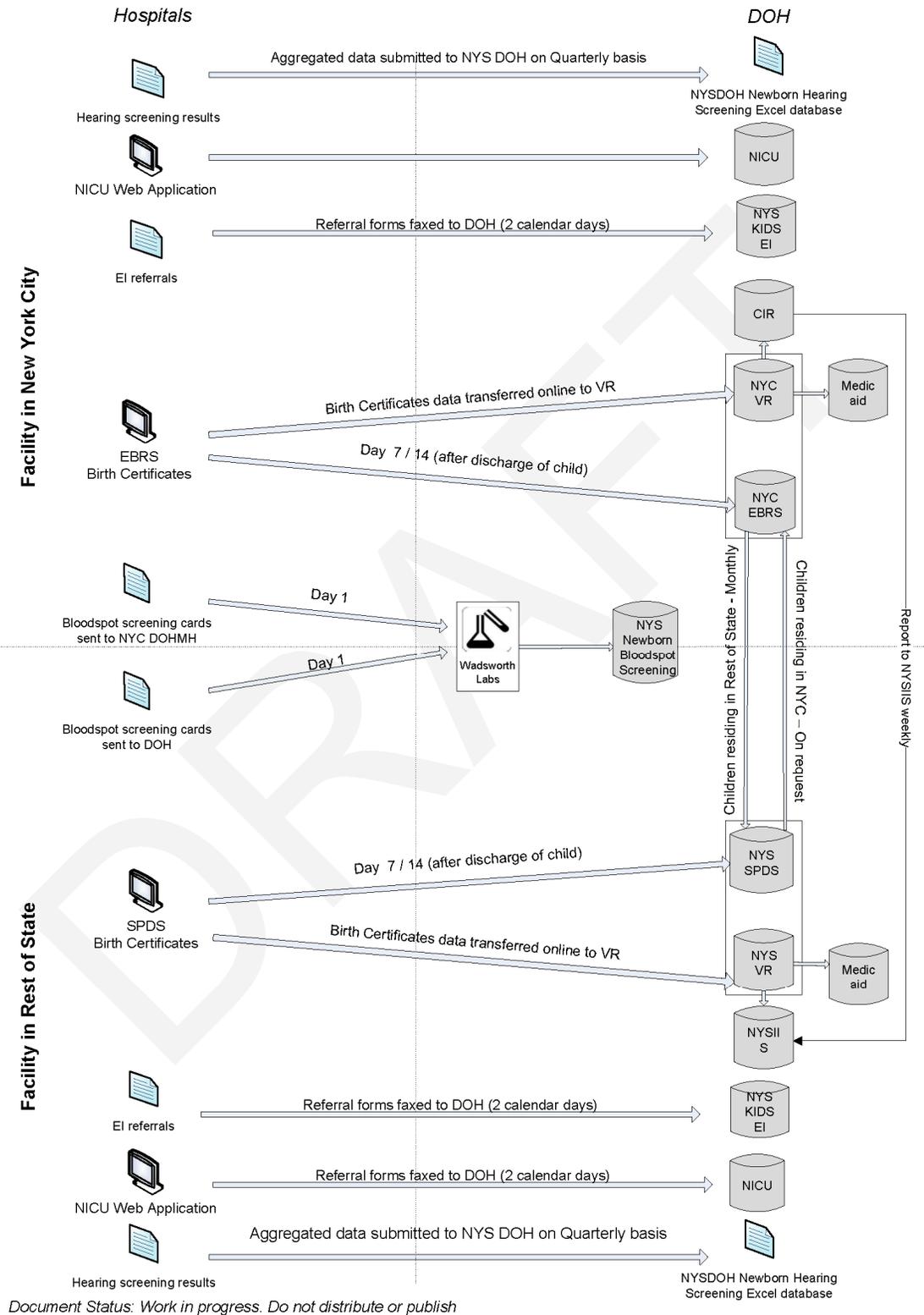
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As-Is Well Child visit (Child's age 0-3 years )\_V2



1. Health Care Provider (HCP) logs into NYSIIS and reads the immunization history
2. Newborn bloodspot screening results are obtained by pediatrician
3. Additional vaccinations administered information will be sent to NYSIIS
- 4a. Reportable communicable diseases and lead
- 4b. Reportable diagnostic information for children with confirmed positive
5. Hearing Screening test results submitted to DOH by Hospitals / Testing centers
6. HCP documents the data in the Medical Record
7. HCP performs a blood lead screening test in office using a point of care device then these test results are reported into NYSIIS
8. Referral to EI is made if the child's condition falls under the EI risk criteria
9. Referral to EI is made if the child's condition falls under the EI risk criteria

Document Status: Work in progress. Do not distribute or publish



**Exhibit XII-10 As-Is Data Flow Diagram**

Proposed Virtual Child Health Profile – At the Hospital (Birth event initiation)\_v2

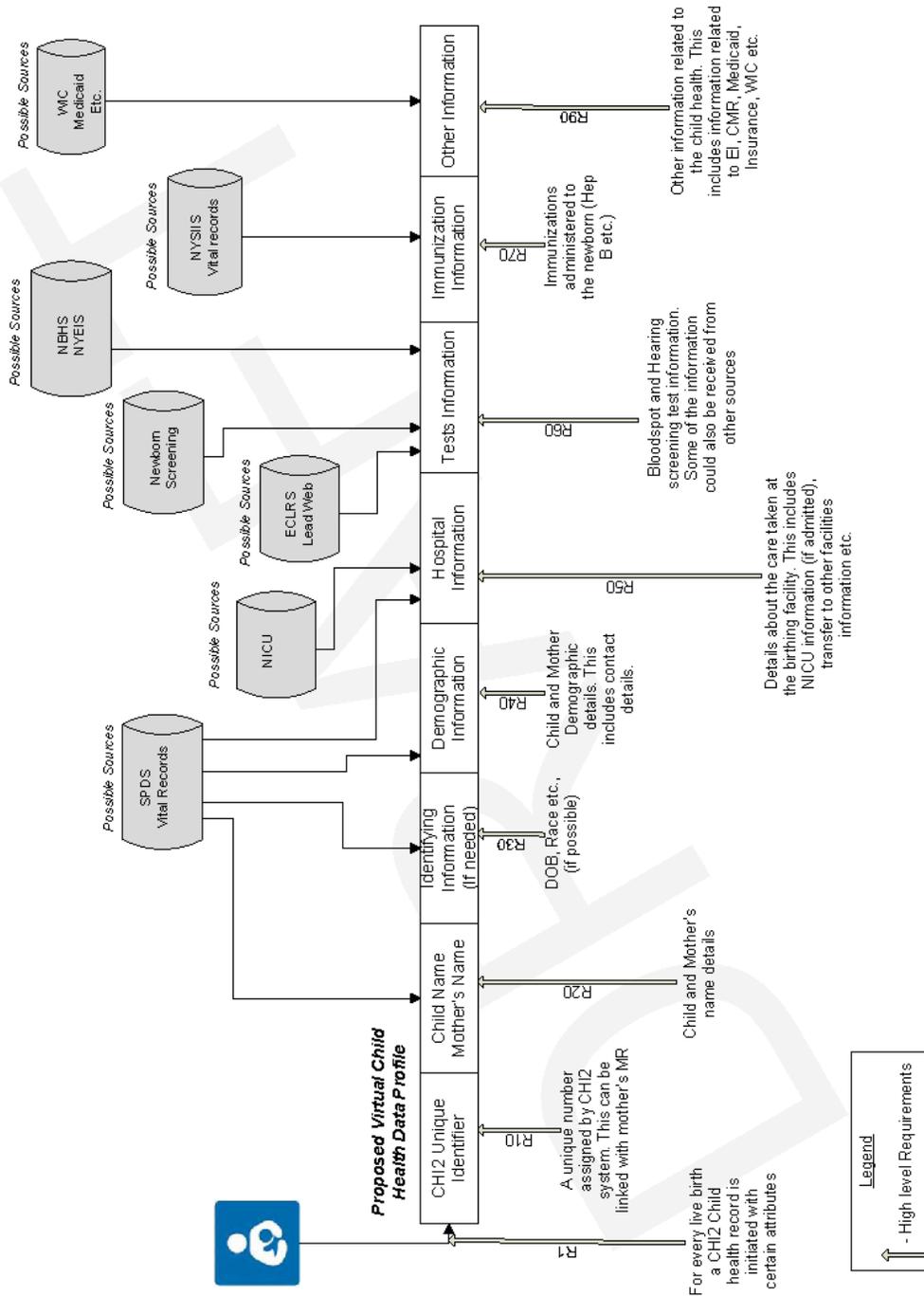


Exhibit XII-11 Proposed Virtual Child Health Profile – At the Hospital (Birth Event Initiation)

Proposed Virtual Child Health Profile – At the Health Care Provider\_V2

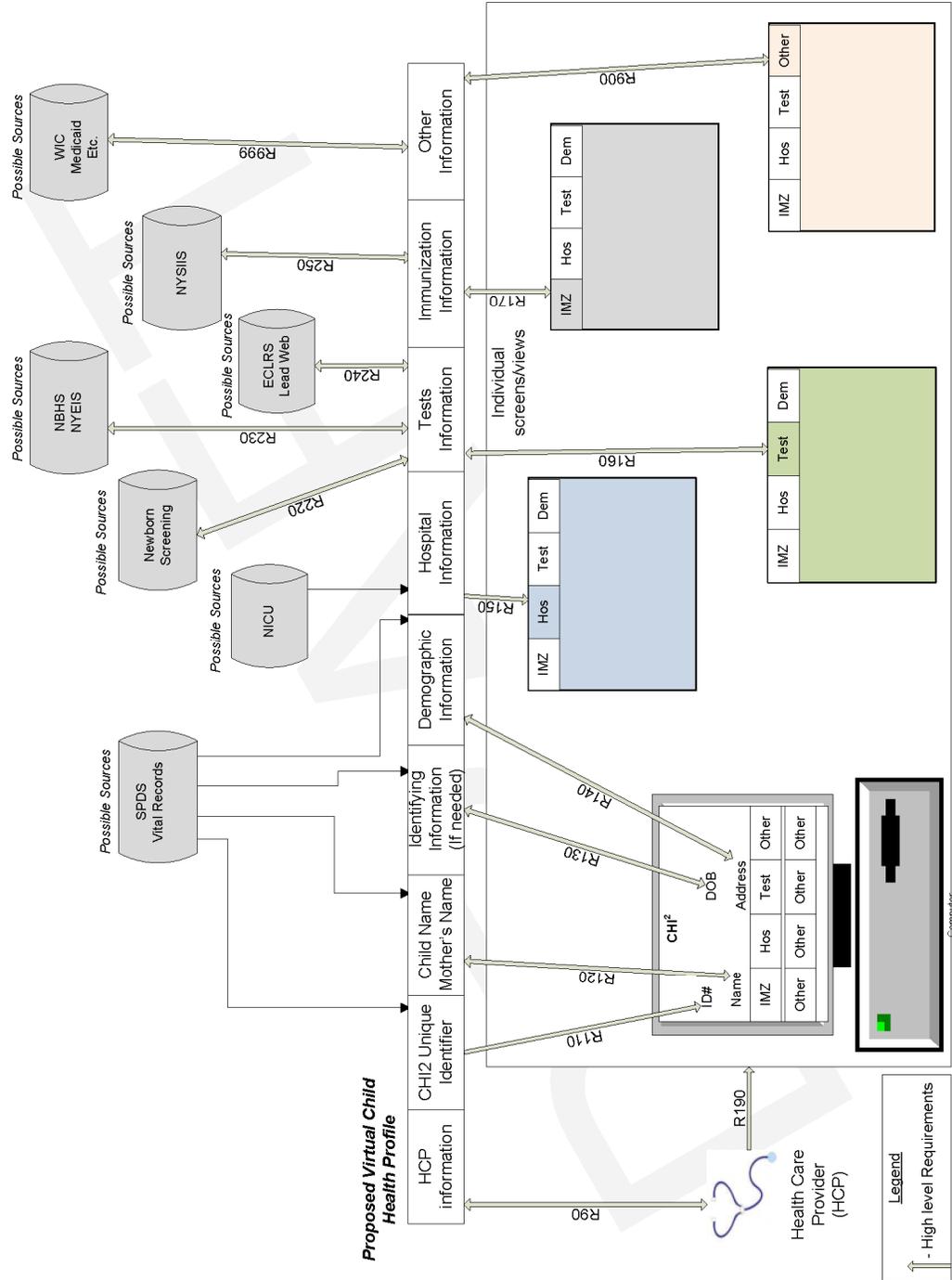


Exhibit XII-12 Proposed Virtual Child Health Profile – At the Health Care Provider

Evolution – Current projects

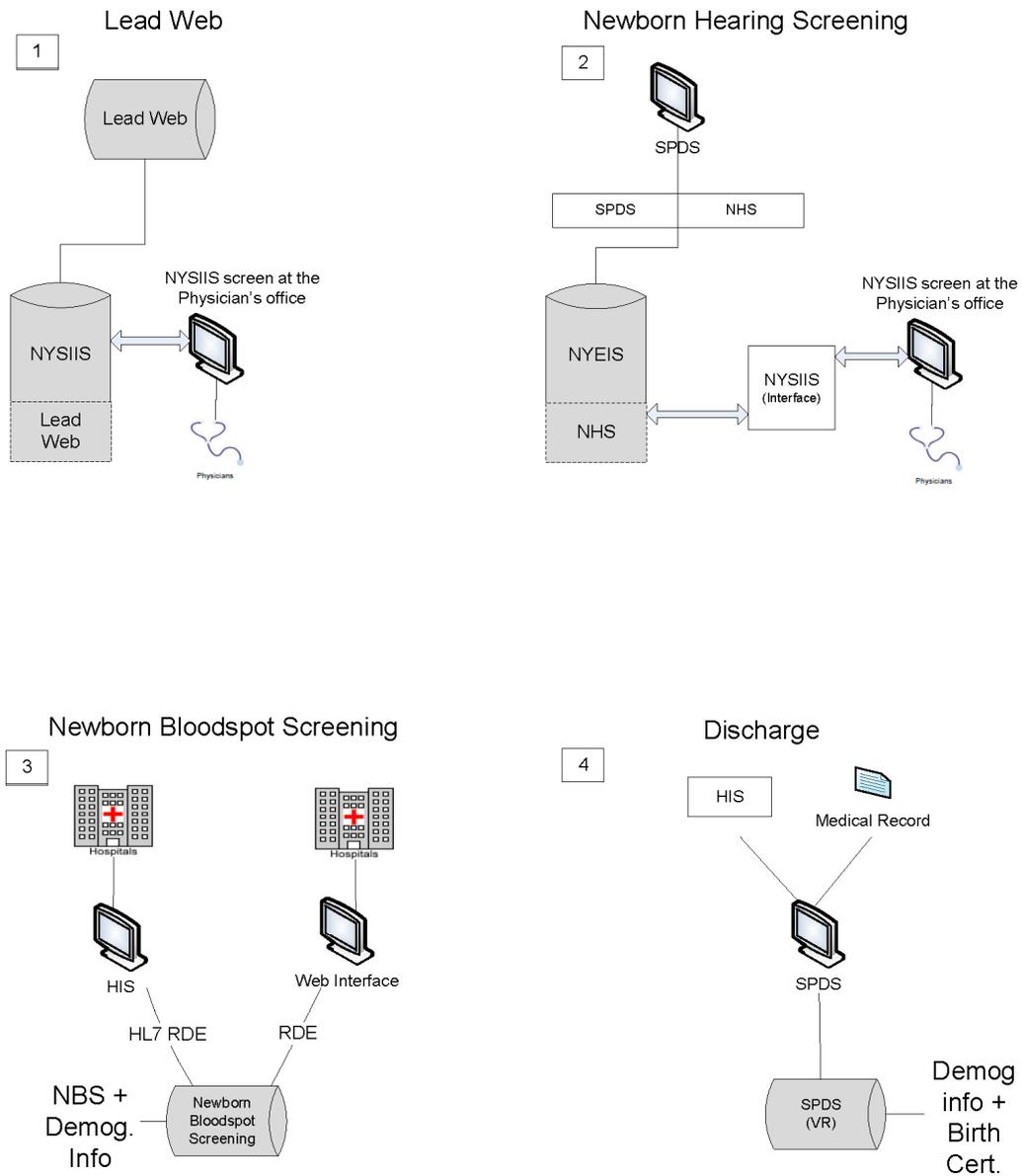
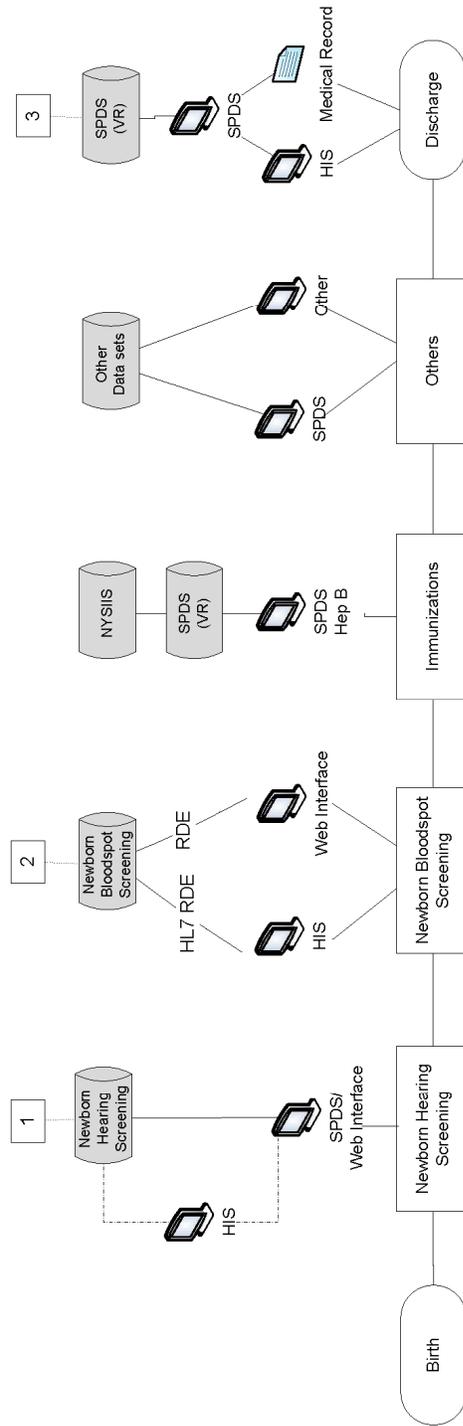


Exhibit XII-13 Evolution – Current projects

Possible approach (Example)



1. Since Newborn Hearing Screening happens before other screenings, NHS can initiate the record (with or without demographic information)

2. Before entering the NBS screening information and RDE, verify if NHS has initiated a record for that child and update that record with NBS information.

- If NHS does not initiate the record or if the NHS information has not been entered, then NHS and NBS with RDE could be entered at the same time.

3. On discharge hospital staff enters the birth certificate information and demographic information in SPDS. If the demographic information entered through NHS and NBS RDE is made available to the hospital staff through SPDS (NBS RDE information is shared at the back end with SPDS), then the staff need not enter the demographic information again. Hospital staff can edit or update the existing information (demographic) available.

NHS – Newborn Hearing Screening  
NBS – Newborn Bloodspot Screening  
RDE – Remote Demographic Entry

Exhibit XII-14 Possible approach (example)