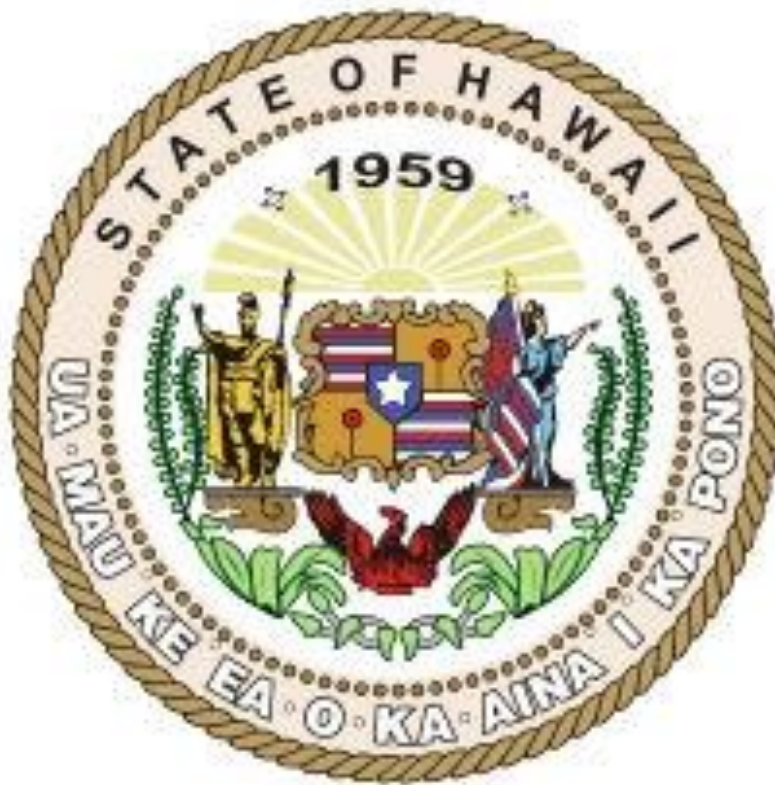


State of Hawai`i  
Department of Human Services

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*State Medicaid Health Information Technology  
Plan*

December 3, 2014





## *Document Approvals and History*

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**Project Name: State Medicaid Health Information Technology Plan Development**  
**Document Name: State Medicaid Health Information Technology Plan**

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Annual SMHP-U Submission v3.0	July 29, 2014	Updated SMHP for annual submission.
Updated Annual SMHP-U Submission v3.1	December 3, 2014	Updated Annual SMHP-U addressing CMS comments.



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## Attachments

Attachment A: MQD Professional EHR Survey  
Attachment B: MQD Hospital EHR Survey  
Attachment C: EHR Memo Survey



## **1. BACKGROUND**

### **1.1. Introduction**

The Med-QUEST Division of the Hawai'i Department of Human Services (MQD) plans to promote the adoption and meaningful use of certified electronic health record (EHR) technology by participating in the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record Incentive Payment Program. To accomplish this goal, MQD has planned a phased implementation strategy. The strategy aims to contribute to improved patient outcomes and reduce health care costs through health information technology (HIT) adoption by providers. In addition to participating in the EHR Incentive Payment Program, MQD will promote adoption of HIT by implementing improved state HIT systems for the development of statewide HIT infrastructure.

The State Medicaid HIT Plan (SMHP) was developed collaboratively by MQD and its stakeholders, which included the Governor's Office of Health Care Transformation, the Office of Information Management and Technology (OIMT), the Hawai'i Health Information Exchange (HHIE), and the Hawai'i Pacific Regional Extension Center (HPREC). In 2010, MQD began the SMHP process by conducting a series of interviews with key stakeholders and data gathering. Then, MQD conducted educational sessions for staff and reviewed business processes to assess the capability for making EHR incentive payments and meeting the federal requirements for the program. As a result of these assessments, MQD procured an EHR Incentive Payment Program solution that will accept provider registrations from CMS, allow Hawai'i eligible professionals (EP) and eligible hospitals (EH) to attest to program eligibility, and verify eligibility. The original SMHP was approved by CMS on April 22, 2013. A subsequent update was approved on December 31, 2013. The update incorporated the information regarding the implementation of the process for making EHR Incentive Payments to eligible Medicaid providers. This update to the SMHP provides information regarding the strategic planning to implement Stage 2 of meaningful use, promote electronic health technology for Hawai'i providers, and develop sustainable clinical information exchange.

The following sections provide a summary of the process MQD followed to complete the annual update to the SMHP.

### **1.2. Planning Process Summary**

#### **1.2.1. "As-Is" Landscape**

The As-Is section provides information regarding the current HIT/HIE landscape in Hawai'i. MQD gathered information from HHIE and the Governor's office as well as conducted telephonic interviews and online research. MQD also conducted an analysis of Medicaid provider types and volume of providers who may be eligible for the incentives using the Medicaid data warehouse. Furthermore, MQD collected data from the State Level Registry (SLR) and conducted an environmental scan using data from surveys distributed to Hawai'i providers. The results of this data gathering effort are detailed in Section 2.



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

The To-Be section of the SMHP provides a vision for MQD HIT/E goals and objectives for the next five years. The information was updated from information gathered through interviews with MQD staff and OIMT staff, along with coordination of long term objectives with the HPREC, the State Department of Health and the HHIE. The overall MQD vision includes a future system architecture that is designed to support MQD’s long term information technology goals of achieving meaningful use of clinical data through sustainable clinical information exchange.

### **1.2.3. Administration and Oversight Plan**

The State’s Administration and Oversight Plan (Plan) provides MQD’s strategy for implementing the business processes to assure that Hawai‘i providers have met the federal eligibility requirements for the incentive payments. The Plan was developed by gathering information through a series of key interviews with MQD, including their Administration Office, Finance Office, Health Care Services Branch, Program Integrity Office, and Systems Office, as well as with OIMT staff. Since the original SMHP submission, MQD has procured a vendor that can provide the technology and resource support for the EHR Incentive Payment Program. MQD is implementing the EHR Incentive Program and has paid eligible professionals and eligible hospitals.

### **1.2.4. Audit Strategy**

The Audit Strategy provides a description of the pre-payment verification processes and the pre- and post-payment audit processes that MQD has implemented since the program began. These processes include program monitoring and controls that are in place to identify and report fraud and abuse. Since the EHR Incentive program has been implemented, MQD reviewed and evaluated its current Audit Strategy that includes program integrity processes and financial controls. MQD also evaluated its appeals process for applicability to the EHR Incentive Payment Program. The updated Audit Strategy is found in Section 5.

### **1.2.5. Roadmap**

The Roadmap section of the SMHP provides annual measurable targets that are tied to goals for MQD. The Roadmap provides narrative and graphical pathway that shows where MQD is starting from (As-Is) and where it plans to be in five years and how it plans to achieve the goals and objectives. The Roadmap was developed and subsequently updated through interviews with MQD, along with an extensive examination of the As-Is and the To-Be, and in alignment with the draft of the State of Hawai‘i IT Strategic Plan, developed by OIMT.



## 2. “AS-IS” LANDSCAPE

### 2.1. Current Extent of EHR Adoption by Eligible Professionals and Eligible 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*

The Med-Quest Division of the Hawai‘i Department of Human Services (MQD) completed an estimate of the number of eligible professionals (EP) and eligible hospitals (EH) using data from the Medicaid data warehouse. Table 2-1 provides the unique counts of the numbers of EPs. Based on this information, MQD completed estimation using the CMS method outlined in the Federal Register published on July 28, 2010. MQD estimated that 30% of all physicians and 60% of pediatricians will meet eligibility threshold requirements. MQD further estimated that there will be 36% of EPs who are eligible who request incentive payments in the first year of the program. In addition, MQD estimated that 50% of pediatricians will achieve the 30% eligibility requirements and 50% who are eligible between 20 and 30% Medicaid patient volume. Based on the calculations MQD has estimated that 540 EPs will qualify in year one and in the subsequent five years a total of approximately 1450 providers will participate.

As of July 21, 2014, the following cumulative numbers for the Hawai‘i State Level Registry for the Medicaid EHR Incentive Program have been reported.

Participants Submitted	Participants Approved	Participants Rejected	Participants Pended	D16 Request	D16 Response	Payment Processed	Payment Processed (\$)	D18 Confirm Sent
274	228	4	129	229	221	202	\$9,929,257.37	202

**Table 2-1: Total Number of Medicaid Providers**

Provider Type	Unique Count
Dentist	432
Doctor of Medicine	3773
Doctor of Osteopathy	190
Optometrist	214
Registered Nurse Practitioner	226
Pediatrician (MD + DO)	285
Physician Assistant leading an FQHC	1
Total	5121



Hawai'i estimates that all of the 14 acute care hospitals and 9 critical access hospitals (CAHs) will participate in this program.

To date, one of the primary drivers in the adoption of EHRs by practitioners and hospitals in Hawai'i has been the Hawai'i Pacific Regional Extension Center (HPREC), operated by the Hawai'i Health Information Exchange (HHIE) and funded through a Cooperative Agreement from the DHS Office of the National Coordinator for Health IT (ONC), which is focused on assisting providers in the adoption of certified electronic health record (EHR) technology. Today, over 880 providers are enrolled in the Hawai'i Pacific Regional Extension Center (REC), 764 have implemented certified EHRs and over 338 providers are now eligible for Medicaid EHR incentive payments. According to data obtained from the REC, over 30 different EHR systems have been implemented in primary care practices in the state, with the leading certified EHR systems being eClinicalWorks, GE Centricity, Allscripts, and Epic. Research conducted by SK&A for the REC in September 2013 stated that 52 percent (1,422 / 2715) of Hawai'i's office based physicians had adopted a "basic" EHR, which includes functionalities in the following areas of health care and administrative data: patient demographics, patient problem lists, electronic lists of medication taken by patients, clinical notes, orders for prescriptions, laboratory results viewing, and imaging results viewing.

Additionally, through February 2014, the Hawai'i Health Information Exchange (HHIE) had over 900 users with clinical practice users spanning 27 categories. These HHIE members and participants are focusing on utilizing certified EHR systems and the interoperable exchange of data to support the Meaningful Use (MU) criteria.

## **2.2. Health Care Provider-Based Environmental Scan**

MQD conducted an environmental assessment to evaluate Hawai'i Medicaid providers' readiness to adopt, implement, or upgrade, or meaningfully use EHRs and apply for incentive payments. This assessment describes the findings regarding Hawai'i providers' HIT and HIE landscape.

### **2.2.1. EHR/HIE Adoption Initial Outreach and Data Gathering**

The environmental assessment was conducted during the months of March and April 2014. The methods used to conduct the scan included a review of existing documentation on provider EHR adoption and patient information exchange. A provider survey was conducted to capture additional relevant data.

### **2.2.2. Provider Surveys**

MQD distributed surveys to potential eligible professionals (EPs) and eligible hospitals (EHs) to better understand their EHR and HIE adoption status, eligibility, and intent to apply for incentive payments. The surveys were additionally intended to provide MQD with information on provider barriers to EHR and HIE adoption and to identify the education and resource needs of providers regarding EHR adoption and meaningful use.

The provider surveys were developed based on existing EHR surveys conducted in other states and on the national level and were refined to meet Hawai'i's specific needs. Key stakeholders were involved in the development, distribution, and promotion of the provider surveys. The EP and EH surveys are presented in Attachments A and B, respectively. The methodology and significant findings from the surveys are presented in the following sections.



### 2.2.3. EHR Survey Methods

The EP and EH EHR surveys were launched in March of 2014. The EP EHR surveys consisted of 38 multi-part questions and the EH EHR survey consisted of 35 multi-part questions, both in multiple choice and text entry format, concerning the present and planned use of HIT among EPs and EHs in the State of Hawai'i. To minimize data, skip logic was designed into the survey as appropriate.

MQD posted the surveys on their website, specifically under the Electronic Health Record (EHR) Incentive Program page, at

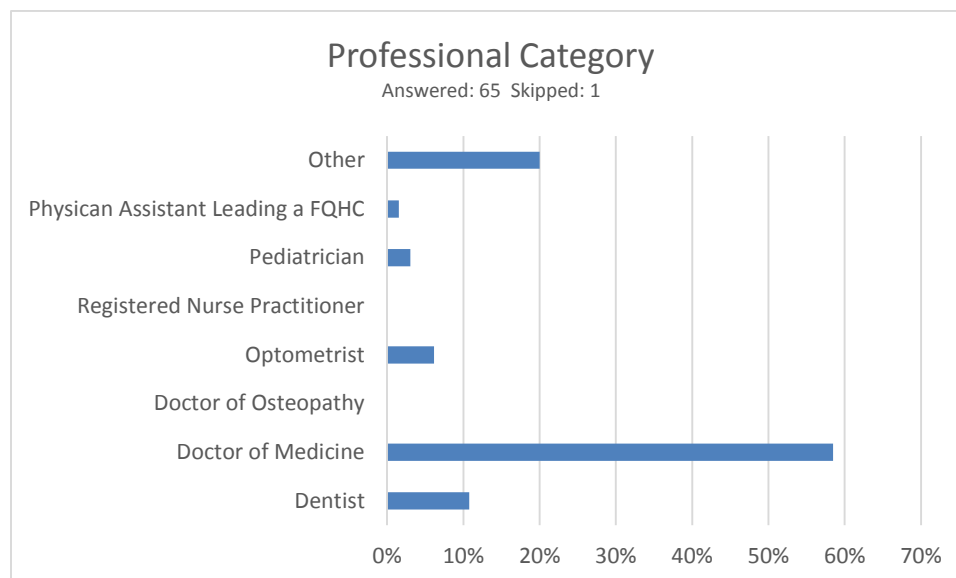
<http://www.med-quest.us/providers/ElectronicHealthRecordIncentiveProgram.html>.

To encourage survey participation, a memorandum was mailed on behalf of Kenneth Fink, MQD Division Administrator, to Hawai'i Fee-For-Service Providers. The mailing list consisted of over 6000 providers. The memorandum can be found in Attachment C. In addition, the provider survey was advertised by the Regional Extension Center (REC) and the SLR (State Level Registry) Helpdesk.

### 2.2.4. EHR Survey Findings

#### Survey Participant Overview

The EP EHR survey resulted in a total of 66 responses, and the EH EHR survey resulted in a total of 7 responses. Of the EP responses, a majority were completed by Doctors of Medicine.



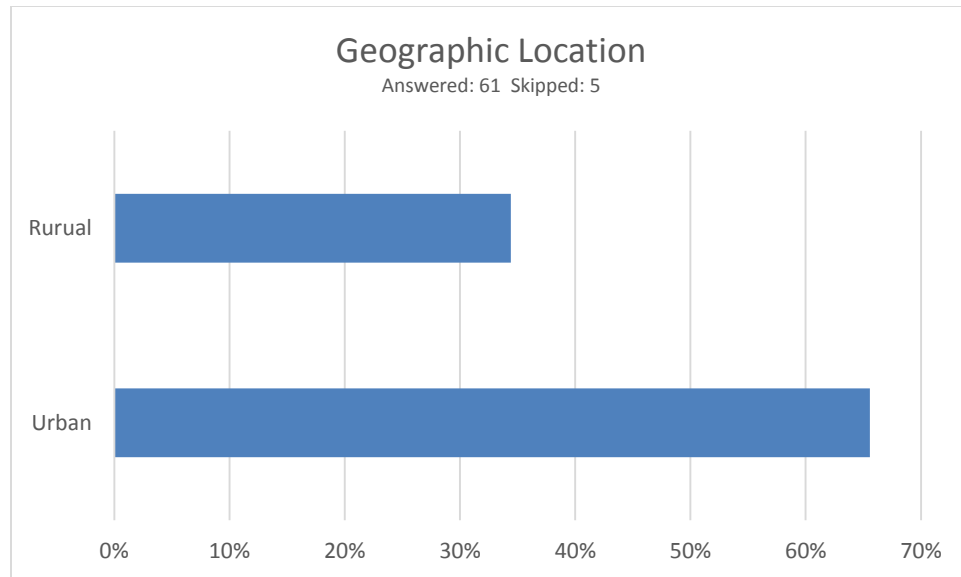
Of the EH responses, five provided the following names:

- Kona Community Hospital
- Alcoholic Rehab. Services of Hawai'i
- Queen's Medical Center
- Honolulu Sports and Spine Surgery Center

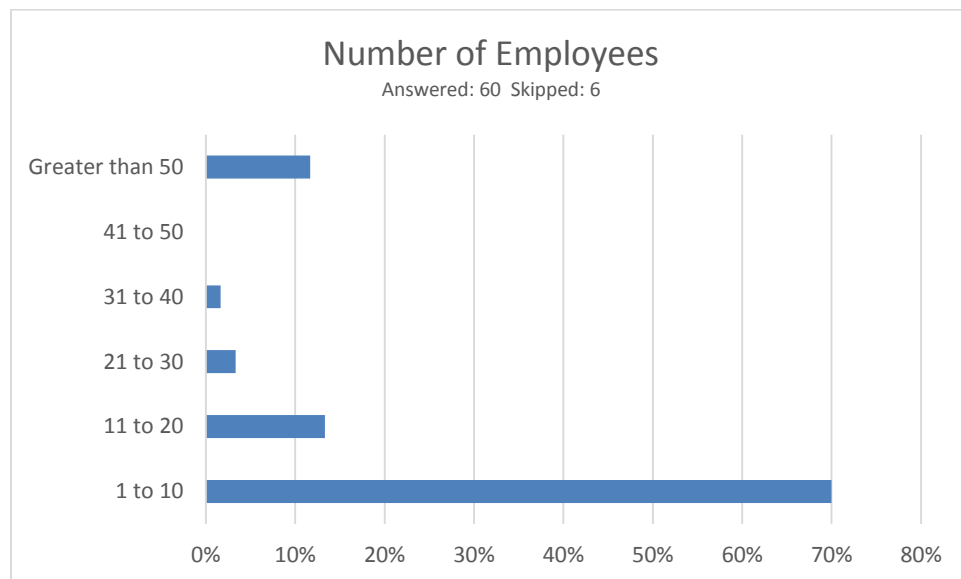


- Kahi Mohala

The EPs who responded were primarily from urban areas.



Most practice sites that responded to the survey were relatively small, consisting of 1 – 10 employees.



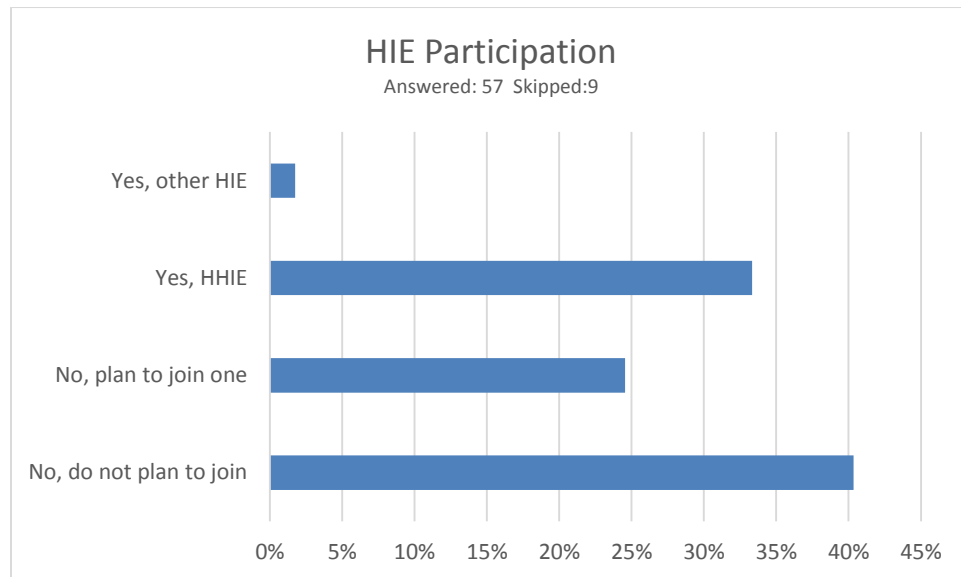
### EHR Status

Approximately 70% of the providers that responded to the EP survey have an EHR, and of the organizations with an EHR, nearly all of them had a certified EHR.



## HIE Participation

Participation in a HIE varies amongst the EP survey participants. Approximately 40% of the responders do not plan on joining a HIE, while nearly 60% are either participating in the HHIE or are planning on joining a HIE.



The EH survey response rate, while small (5 that responded), was encouraging. Three of the hospitals are participating in the HHIE, while the other two are planning on joining an HIE.

## Medicaid EHR Incentive Program Findings

When EPs were surveyed on if they plan on applying for EHR incentive payments, approximately 47% of the responders indicated that they were unsure/undecided or were not planning on applying for incentive payments. The overriding reasons were that EPs needed more information about incentives and the cost associated with qualifying for EHR incentive payments.

Answer Choices	% (number of responses)
Need more information about incentives	48% (13)
Unsure what system to buy	11% (3)
Poor internet connectivity	11% (3)





Security and privacy requirements	15% (4)
Cost	30% (8)
Do not meet Medicare or Medicaid eligibility requirements	15% (4)
Other	30% (8)

Similarly, the majority of EHs that were unsure or undecided about applying for EHR incentive payments responded that they needed more information about incentives.

### Conclusions / Limitations

Due to the low response rate of the report, the data cannot be deemed statistically significant. Any analysis from the environmental scan survey is not representative of the Hawai'i provider population. Rather, the results are planned to be used for informative and descriptive purposes, rather than predictive and representative analysis. The limitations of the survey can be attributed to several causes listed below.

- Time constraints and resource availability – The time, costs and resources required to conduct a survey representative of an entire population can be significant, especially when it comes to successfully marketing the survey and engaging participant interest.
- Unique population – The State of Hawai'i's unique geographical landscape make it difficult to target a certain population.
- Limited distribution channels – The surveys' primary source of distribution was electronically through MQD's websites. As a result, providers without internet access were excluded from participation. This limitation may have been exacerbated because of Hawai'i's sparsely populated rural areas that are faced with broadband challenges. Additional distribution channels, such as through mail and the phone, would have increased the sample size.
- Survey length and complexity – The survey set out to capture much information about Hawai'i's HIT landscape, but in doing so it may have dissuaded providers from participating due to the length and detailed nature of the surveys.

This EP and EH EHR surveys will serve as a stepping off point for future surveys. Understanding Hawai'i's unique provider landscape is a challenging task that will require more focused questioning to a smaller, more targeted population.

### 2.3. Broadband Access Challenges to HIT/E 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*



The unique features of Hawai'i and its large number of sparsely populated rural areas pose challenges to the successful adoption of certified EHRs. In an examination conducted by the Hawai'i Broadband Task Force ending in 2009, it was found that broadband Internet access covered about 99 percent of Hawai'i's population. Coverage, however, remains a distinctively urban phenomenon, and network speeds significantly lag behind mainland counterparts. In a 2008 Akamai report, Hawai'i was ranked 49<sup>th</sup> out of 50 states in overall network speed and ranked last among states with broadband subscribers with effective speeds that exceed 5 Mbs. Lower bandwidth can pose a challenge to those providers who will be utilizing Software as a Service (SAAS) -based certified EHRs, and for connectivity and interoperability with trading partners, such as a local health information exchanges (HIEs) or the State Health Information Exchange (State HIE), for data exchange. Rural areas specifically require improvement to bring them up to acceptable broadband standards.

Plans to increase broadband capacity have been undertaken. In 2007, Hawai'i was the recipient of a federal grant up to \$4.9 million over three years to build a broadband network linking 96 rural and urban health care providers throughout Hawai'i and the Pacific island region. The project's area extends 6,200 miles from the continental U.S. to American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands (CNMI). The endeavor, termed The Pacific Broadband Telehealth Demonstration Project, is meant to connect over 90 health care providers to the State of Hawai'i Telehealth Access Network (STAN) with its high-speed capacity of up to 1 billion bytes per second. Additionally, many health care providers will qualify for the Rural Health Care Program established by the Federal Communications Commission (FCC) under the Telecommunications Act of 1996 for long-term network connectivity.

The Pacific Broadband Telehealth Demonstration Project has over 109 hospitals, clinics and health services facilities connected to the state network and are fully operational. Currently, each connection is funded through pilot program funding, with matched contributions from participating facilities for the costs of implementing new technology. The Pacific Broadband Telehealth Demonstration Project is researching a sustainability plan in which the project is seeking to leverage existing American Reinvestment and Recovery Act funds in addition to other funding sources for a continued matching program for ongoing technical operations. Eventually, the Pacific Broadband Telehealth Demonstration, in partnership with the State of Hawai'i Telehealth Access Network and the University of Hawai'i, will transition maintenance costs and responsibilities to each site, leveraging economies of scale, with continued support to facilities using a coordinated project team aimed at helping sites reach goals to share information, coordinate efforts and evaluate various technical options and pricing.

In addition to these activities Governor Neil Abercrombie has launched a major economic development initiative to provide statewide access to affordable ultra-high-speed Internet by 2018. The "Hawai'i Broadband Initiative" is essential to build a vibrant and sustainable economy and workforce in Hawai'i and improve the quality of life for residents. The Hawai'i Broadband Initiative seeks in part to improve medical services by developing an integrated health information network that can securely exchange EHRs. The Initiative has four goals:

1. Ensure ubiquitous access to world-class gigabit-per-second broadband service at affordable prices throughout Hawai'i.
2. Increase the use of ultra-high-speed broadband services and applications for economic development, healthcare, education, public safety, governmental efficiency and civic engagement.



3. Reduce Hawaii's barriers to global participation and ensure equitable access for all our islands, including the most remote areas of the state.
4. Develop and implement a modern regulatory and permitting environment that supports and advances investment in broadband infrastructure and public services.

The Hawai'i Broadband Initiative is being led by the Department of Business Economic Development and Tourism (DBEDT) and the Department of Commerce and Consumer Affairs (DCCA) and is supported by the state's Chief Information Officer, and the University of Hawai'i.

## **2.4. 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*

Community Health Centers (CHCs), also known as Federally Qualified Health Centers (FQHCs), form a community-based non-profit network that serves approximately 30 percent of the Hawai'i population and of Hawaii's Medicaid population. The FQHCs are funded primarily by third-party payers, with the single largest source of support being Medicaid. FQHCs also benefit from ongoing section 330 grant support from the federal Health Resources and Services Administration (HRSA) and the State of Hawai'i.

Fourteen FQHCs are distributed across six islands and care for approximately 125,000 people to whom they provide medical, dental, and mental health care services, as well as 340B prescription drug pricing and a variety of other support and prevention-oriented services. The clinics directly employ approximately 150 medical clinicians, 35 dentists and hygienists, and 40 mental health providers. Certified EHRs are in the process of being implemented at all 14 FQHCs: four employing NextGen (the longest established); six GE Centricity; three eClinicalWorks; and one SageIntergy. MQD expects 220 EPs to attest from FQHCs. At this time, most FQHCs in Hawai'i have received HRSA funding to support their EHR acquisitions. FQHCs do participate in the HHIE and have a representative on the HHIE Board of Directors.

In addition to the CHCs, Hawai'i has several Rural Health Clinics (RHCs), including Ka'u Hospital Rural Health Clinic in Pahala on Hawai'i Island and Molokai General Hospital Rural Health Clinic in Kaunakakai on Molokai. These RHCs are located in rural, medically underserved areas and receive separate reimbursements under the Medicare and Medicaid programs.

## **2.5. 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*

The State of Hawai'i does not have any Indian Health Service clinical facilities; however, healthcare services for veterans constitute a distinct portion of Hawaii's health care activity. The VA Pacific Island Health Care System (VAPIHCS) provides ambulatory and aging care through clinics located on Oahu, Kauai, Maui, Hilo and Kona (located on Hawai'i Island), the U.S. Territory of Guam and American Samoa, and has outreach clinics on Molokai and the Commonwealth of the Northern Mariana Islands (CNMI). The mission of VAPIHCS is to provide care for 127,600 veterans residing in the Pacific.



Approximately 60-70 percent of veterans receive at least part of their care through community providers. On Oahu, VAPIHCS utilizes the Tripler Army Medical Center (TAMC) for inpatient care; however, roughly half of all veteran clinical consultations on Oahu are delivered by community providers. On the neighboring islands, the VA Clinics are completely dependent on the surrounding health care community for the provision of emergency services, hospitalization, laboratory, radiology, and specialty consultations.

The VA has completely converted to the use of a VA EHR, and as such, no paper charts are employed. As a result, health care information generated outside the VA must be re-entered into VA electronic systems. Within Tripler Army Medical Center (TAMC), information is viewed through the Janus system, a browser-based dual provider view that displays Composite Health Care System (CHCS) data from the Department of Defense (DoD) and Computerized Patient Record System (CPRS) Veterans Health Information Systems and Technology Architecture (VistA) data from the VA in a single, chronologically sorted view.

Hawai'i is an integral part of the Army's Telemedicine and Advanced Technology Research Center (TATRC), an organization that is fully committed to the creation of cutting-edge bedside technologies that can deliver real-time data and better clinical decision support. Furthermore, TATRC has been active in participation in the Nationwide Health Information Network (NwHIN) and the federal Virtual Lifetime Electronic Record (VLER) program.

TAMC is the DoD tertiary care facility within the Pacific Basin. Its mission is to ensure the readiness of the Armed Forces through the delivery of health care, which it accomplishes by providing acute and tertiary care to all eligible personnel along with the highest level of graduate medical education, and by conducting clinical research to support its graduate medical education role. TAMC's beneficiary population includes 156,000 potential patients living in the state of Hawai'i. Its close association with the Department of Veterans Affairs brings to its catchment another approximately 127,600 eligible patients.

TAMC and the other DoD military treatment facilities on the island of Oahu have used electronic clinical and medical record systems since 1990. Usage features a robust ambulatory EHR that shares clinical documentation and patient data across the DoD worldwide. The inpatient system has been in use for the past two years. Both ambulatory and inpatient systems have used Computerized Provider Order Entry (CPOE) for most of their lifespan. The emergency department uses a state-of-the-art commercial emergency department information system. Digital radiography has been used for the past 15 years. The global DoD ambulatory EHR supports approximately 77,000 active users, averages 140,000 new encounters per day, and maintains clinical data on 9.6 million beneficiaries.

Data sharing among the DoD and VA sites has been critical for the co-management of shared patients. TAMC has supported telemedicine for many years, ranging from intensive care medicine support in the Far East (eICU), pediatric and adult specialty remote consultation, and more recent experience with tele-traumatic brain injury and tele-behavioral health support.

The VA is actively working with the HHIE and the Pacific Territories to coordinate and send clinical summaries between federal and non-federal health care providers using the nationally-compliant Direct Secure Messaging (the Direct Project). The goal of Direct Messaging is to support healthcare information sharing between physicians with and without an HEHR. This includes the referral use-case between providers in the community and the VA.



## 2.6. 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*

The current HIT/E environment involves the engagement and collaboration of a range of stakeholders. In order to ensure the successful adoption of EHR, the State of Hawai'i continually coordinates with statewide, urban/rural, large/small organizations, and consumers/providers. State authorities include the Hawai'i Health IT Committee (HHITC), and in particular the State Healthcare Transformation Coordinator, who functions as the State HIT Coordinator and participates in multiple State Designated Entity (SDE) activities, including attending and contributing to various committee meetings throughout the strategic planning process. The State is developing its Medicaid HIT/E plan with SDE input.

Stakeholder input is central to all aspects of the strategic planning process. Several stakeholder meetings have been essential in emphasizing the organization's engagement in, or readiness for, EHR adoption. The ongoing collaboration of MQD with the SCCHIT, the HHIE, and other stakeholders will be included in the annual update submission to the approved SMHP.

## 2.7. 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*

MQD's relationships with other HIT/E entities are largely around governance. Statewide HIT/E initiatives in Hawai'i are governed by the SCCHIT. The Committee is comprised of the State HIT Coordinator, the State CIO, the Hawai'i Department of Health, the Hawai'i Division of Commerce and Consumer Affairs, the Director of the Department of Human Services, the Med-QUEST Division Administrator, the Department of Business, Economic Development and Tourism (DBEDT), the Director of the Employer-Union Health Benefits Trust Fund (EUTF), and the CIO for the Hawai'i Health Systems Corporation (HHSC).

MQD, through the coordination activities of the State Healthcare Transformation Coordinator's office and the Office of Information Management and Technology (OIMT) is committed to engaging in a collaborative process in the promotion of HIT/E adoption among providers and other stakeholders within Hawai'i.

## 2.8. 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*

In September 2009, the Governor of Hawai'i designated the HHIE, a 501(c)(3) non-profit organization, as the SDE to apply for, develop, and implement a statewide health information exchange through the U.S. Department of Health & Human Services, Office of the National Coordinator for Health Information Technology, State Health Information Exchange Cooperative Agreement Program. HHIE selected the HIE vendor Medicity through a rigorous community-participatory based RFP process, and is currently in a phased implementation of the Medicity HIE platform. Phase I is the ONC Direct-compliant Secured Messaging system, and Phase II will be transactional based. The State HIE Plan is publically available at



<http://www.hawaiihie.org/programs/state-hie-cooperative-agreement-program>. As previously mentioned, the HHIE also operates the Hawai'i Pacific Regional Extension Center (HPREC) Cooperative Agreement Program funded by the U.S. Department of Health and Human Services, Office of the national Coordinator for Health Information Technology.

The purpose of the HHIE is to:

- Achieve widespread and sustainable HIE within Hawai'i through the meaningful use of electronic health records (EHRs).
- Establish and implement appropriate governance, policies, and network services within the national framework to build connectivity between and among health care providers.
- Improve the capability of providers to actively exchange health care data focusing specifically on electronic order and receipt of labs and test results as well as e-prescribing.
- Develop and implement up-to-date privacy and security requirements for HIE.
- Organize directories and technical services to enable interoperability within and across states and remove barriers that may hinder effective HIE.
- Coordinate with Medicaid and state public health programs to enable information exchange and support monitoring of provider participation in the HIE.
- Convene health care stakeholders who can provide support for a statewide approach to HIE.

Through February 2014, the Hawai'i HIE had over 900 users with clinical practice users spanning 27 specialties. The HHIE has also facilitated the following<sup>1</sup>:

- Recruited over 600 PCPs and Specialists and helped them with EHR selection and implementation.
- Addressing the governance, legal, policy and technical issues that impede the adoption of exchanging health information among providers; and
- Deployed Direct Secure Messaging to the community, and development of interfaces with labs, hospital systems, and health plans. Currently, the HHIE has 177 provider participants in the Phase I – Direct Secure Messaging services, with a target of 250 physicians onboard by June 2014.

The State HIE planning activities are overseen by the SCCHIT. As described above, the MQD Administrator is a member of the SCCHIT. The SCCHIT monitors and assists in the development and adoption of the State Plan and approved the plan before it was submitted to the Office of the National Coordinator for Health Information Technology (ONC).

In addition to the Statewide HIE, there are private and regional exchanges operating in the State. On Maui, the Wellogix EHR system was utilized for data exchange in a pilot program enabling a limited

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<sup>1</sup> Provided by the State of Hawai'i Health Care Innovation Plan





exchange of data between some Maui Memorial Medical Center systems, CLH, and within practices of the Maui Medical Group. Although the Wellogic pilot phase ended in September 2010, lessons learned will be applied and existing data exchange elements will be sought to be repurposed.

In May 2010, the University of Hawai'i, Hilo College of Pharmacy, became the recipient of the \$16 million Hawai'i County Beacon Community Consortium (HCBCC) award from the U.S. Department of Health and Human Service Office of the National Coordinator of Health Information Technology (ONC). Supported by a broad coalition of users and other stakeholders on Hawai'i Island, the goal of the HCBCC is to "implement a region wide health information exchange and patient health record solution and utilize secure, Internet-based care coordination and telemedicine tools to increase access to specialty care for patients with chronic diseases such as diabetes, hypertension, and obesity in this rural, health-professional shortage area." Organized around Microsoft's Amalga system and the Wellogic System, the HCBCC program is also conceived as a cornerstone in the national movement to ensure that patients have a medical home. The HCBCC Program is viewed as a catalyst for linking these endeavors within an overall health care environment that is primarily rural, highly extended, and historically bereft of a sufficient health work force. Health information exchange between rural areas and urban centers is viewed as a primary leveraging tool in this challenging environment.

The North Hawai'i Health Information Exchange (NHHIE), funded by HCBCC, on the Hawai'i Island was formed recently and is governed by the North Hawai'i Community Hospital utilizing the Wellogic EHR system. With the goal of providing comprehensive "one-patient-one-record" access to patient information across all venues of care, NHHIE has combined the efforts of a broad stakeholder coalition that includes the North Hawai'i Community Hospital, Waimea area providers, the Hamakua Health Center, the two primary labs (CLH and DLS), the East Hawai'i Independent Physicians Association, Surescripts, Wellogic, and eQHIP.

In addition, Hawai'i Pacific Health (HPH) has an existing exchange today, through their Epic EHR system that was originally comprised of four islands, four hospitals, three employed physician groups, and one independent practice of 24 physicians. The HPH has further expanded to include ten additional practices and Queen's Medical Center in 2011. Together, these practices and hospitals serve about half of the State's population.

## **2.9. 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 Hawai'i Prepaid Medical Management Information System (HPMMIS) supports Hawai'i's medical enrollments, encounter and claims processing. The HPMMIS is supported by the Arizona Health Care Cost Containment System (AHCCCS) under an Interstate Agreement, and is a legacy mainframe system. Its role consists primarily of collecting and storing eligibility data from Hawai'i's recently implemented eligibility system, Kauhale On-Line Eligibility Assistance (KOLEA) System, processing enrollment, and managing per member per month capitation calculations. HPMMIS processes Fee for Service (FFS) claims from registered health care providers and collects service encounter data from Health Plans. Despite not being compatible with CMS/Center for Consumer Information and Insurance Oversight (CCIIO) technical architecture, HPMMIS is still stable and meets current operating needs. To meet



PPACA requirements, the HPMMIS will be modified to receive enrollment information from the Solution.

To date, HPMMIS does not align with or advance the Medicaid Information Technology Architecture (MITA) maturity for business, architecture, and data. The goal is to support MITA initiatives that provide a common framework to focus on opportunities to build common services by decoupling legacy systems and processes that are inherent in HPMMIS. The State completed a MITA 3.0 Self-Assessment in 2013 (except for member eligibility and enrollment processes), and the results showed that MQD is generally at a low level of maturity. Additional staffing, training, and data is necessary to support program functionality.

MQD plans to mature business areas in the next five years, and expects to be evaluating their MMIS needs in the near future. MQD will look carefully at how the activities surrounding HIT/E, the EHR Incentive Program, and the concept of Meaningful Use will support and enhance MQD's MITA transition plans and will describe those findings in subsequent submissions of the SMHP.

## **2.10. 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*

The HHIE, the Hawai'i Pacific Regional Extension Center (HPREC), and other organizations such as the Hawai'i Island Beacon Community (HIBC) project are all playing important roles in several endeavors, including, but not limited to, EHR vendor selection and group purchasing, clinical and administrative workflow design, privacy and security best practices, meaningful use gap analysis for EHR, and connecting healthcare providers through the HIE. MQD so far has played a role in these activities through its participation, especially through the EHR Incentive Program.

Separate from the HPREC communication activities, MQD, through its SLR vendor, has employed several communication services in order to effectively communicate with providers about the Hawai'i Medicaid EHR Incentive Program. Outreach and education activities include:

- Delivering an announcement memo to potential EHR Incentive Program participants introducing the program and the steps required for registration and attestation.
- Conducting stakeholder information presentations for EPs, EHs, and Groups via virtual conference. These presentations served to introduce the Medicaid EHR Incentive program and walk providers through the attestation process.
- Launching an EHR Incentive Program Provider Outreach Page that serves to educate and guide the provider community through the Medicaid EHR Incentive Program application process. This page can be accessed at <http://hi.arryaincentive.com/> and contains useful tools including an eligibility calculator, jump start page, program workbooks for eligible professionals, eligible hospitals, and group administrators, frequently asked questions (FAQs), a link to the CMS R&A, and a link to the Hawai'i SLR.
- Launching a Contact Center where trained SLR Help Desk staff can be reached by phone or email to provide answers to specific enrollment, validation, and incentive questions.
- Updating the MQD website to announce the go live of the SLR web application.





- Deploying a field representative to conduct outreach and education to the provider community.
- Holding recurring meetings with the REC.

The HHIE, especially through the HPREC, has also been very active in promoting the use of EHR systems in Hawai'i. The HPREC provides a number of important technical assistance services to Hawai'i providers, including:

- EHR vendor selection and group purchasing
- Clinical and administrative workflow redesign
- Privacy and security best practices
- Meaningful use gap analysis for EHR incentives
- Help connecting to the IZ and HIE

The HPREC has helped over 400 of their 650 providers implement certified EHR systems. And of the 400 providers that have implemented EHRs, many are eligible for the Medicaid EHR Incentive Payments.

The HIBC project, with funding through ONC grants, is intended to improve overall access to primary care/specialty and behavioral health services, improve clinical outcomes by measuring specific clinical objectives (i.e. hypertension), reduce health disparities on Hawai'i Island, and promote the adoption of EHR technology. HIBC provides technical assistance to provider practices, in collaboration with the HPREC, including setup and troubleshooting for EHR technology, business and workflow assessments and clinical redesign. The HIBC project has primarily worked with 188 primary care doctors as well as the three hospitals located on the island of Hawai'i, and HIBC estimates that 78 of those 188 providers may be eligible for Medicaid EHR Incentive Payments.

## **2.11. 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*

MQD has been a key member of the State Coordinating Committee for HIT (SCC) since its inception, and MQD was closely involved in the designation of HHIE as the state-designated entity and review and approval of HHIE's state plan for HIE. (HHIE happens to be both the SDE and REC for Hawai'i.) MQD continues to be actively engaged with the SCC, which is led by the State HIT Coordinator. Because the State HIT Coordinator is also the State Healthcare Transformation Coordinator, residing in the Governor's office, HIT/HIE is a major component of the State's healthcare transformation plan. MQD is working closely and collaboratively with the State HIT Coordinator/Healthcare Transformation Coordinator and with the SDE/REC to ensure alignment. MQD regularly meets with the State HIT Coordinator, as well as the State OIMT staff to collaborate and plan efforts for State and MQD infrastructure, provider outreach, provider education, and the adoption of certified EHRs. By collaborating with the State OIMT staff and the State HIT Coordinator, along with the HHIE and REC, MQD is attempting to maximize resources and efforts while minimizing any duplication of effort across these departments and programs.



MQD is currently evaluating its ability to support the HHIE by considering a request for 90/10 federal funding to support Medicaid providers via the build-out of health information technology. This would not be intended to become a long term piece of HHIE's sustainability strategy, but rather to achieve the technology and business infrastructure necessary to effectively on-board Medicaid providers and assist with meaningful use of EHRs. In addition, the technological built-out of interfaces and a master client patient index would provide clinical data from Medicaid providers to MQD, via the HHIE, thereby supporting future phases of MITA and CMS requirements to utilize clinical data. These one-time investments, in alignment with the goals of MQD MU, would build HHIE network capacity to further more rapid adoption of EHRs, and foster community value of a sustainable clinical information exchange. MQD and HHIE will continue to collaborate on this initiative through data gathering meetings, and an update will be included in the annual submission of the approved SMHP. Hawai'i

## **2.12. 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*

One component that will influence the direction of the EHR Incentive Program over the next five years from a technical standpoint is the Hawai'i Prepaid Medical Management Information System (HPMMIS). HPMMIS supports Hawai'i's medical enrollment, encounter, and claims processing functions and is managed by the Arizona Health Care Cost Containment System (AHCCCS) for Hawai'i under an Interstate Agreement. Like HAWI, the HPMMIS is a legacy mainframe system and is not compatible with CMS seven standards and conditions; however, it is stable and meets current operational needs. In the future the HPMMIS will need to be modified to meet MITA and PPACA requirements, as well as support the State Level Repository (SLR) for attestation and payment of provider incentive payments.

The State OIMT is also planning major upgrades to the State infrastructure and the inter/intra agency connectivity and communication/messaging methodology. Aligning decisions on the SLR and the MMIS with activities undertaken by the State OIMT, as well as the backend connectivity to support other agencies (Public Health, etc.) and external trading partners (HHIE, etc.), will be important. MQD is actively working with OIMT to coordinate efforts, plan accordingly to support future infrastructure (both at MQD and at OIMT), and limit any duplication of efforts. Leveraging funds from the ONC HIE grant, the HHIE has built up capabilities to support Direct Secure Messaging among providers. Currently, over 290 providers and organizations, with over 600 users, are participating in Direct Secure Messaging. In addition, the HHIE has leveraged ONC funding to build a statewide community master patient index.

As the State implements efforts to transform healthcare delivery, HIT/E will provide the foundation. New models of care, innovative organization and delivery systems, and new payment methodologies will require access to and use of clinical information. A first step is to leverage the EHR incentive program to have providers interface with HHIE. This can occur by requiring that the provision of required information occur to or through HHIE. A next step may be the health home Medicaid State Plan option that incorporates the required use of an EHR. Future steps could include financial incentives based on clinical performance.



### 2.13. 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*

The State plans to review in conjunction with the State HIT Coordinator all State statutes and rules that may affect the EHR Incentive Program.

HB1957, also known as the Harmonization Bill, was signed into law as Act 315 by Governor Neil Abercrombie on July 10, 2012. The purpose of this act is to improve access to information necessary for the effective treatment of patients and the improvement in the health of the overall population of the state of Hawai'i. Prior to HB 1957, the State had robust requirements around what clinical information was permitted to be shared and under what circumstances. These requirements created a barrier to useful exchange; this bill harmonized existing State requirements by aligning clinical information permissions with the Health Insurance Portability and Accountability Act (HIPAA), which provides appropriate Federal governance regarding the appropriate use and disclosure of personal health information (PHI).

With the passage of Act 315, the barriers to HHIE's integration with other state/regional HIEs and connection to NwHIN for national exchange are greatly reduced. Without the passage of the act, creating data use and reciprocal support agreements (DURSAs) between states would have been extremely challenging, and may have even prohibited interstate clinical information exchange within Hawai'i. Act 315 creates the ability for HHIE to explore interstate exchange with protections that align with federally-mandated governance of PHI, which is essential to creating a longitudinal care record for all citizens captured in the HHIE.

### 2.14. 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*

The State of Hawai'i provides healthcare for large areas of the Pacific, including the other United States Territories and Commonwealths (Guam, CNMI, and American Samoa). Hawai'i is known across the Pacific as a source of quality healthcare services, and as such, collaboration and coordination with the efforts in Guam, CNMI, and American Samoa have been of importance.

Approximately 3.3% of Hawai'i Medicaid patients receive services out-of-state. The Medicaid EHR Incentive Program implementation in Hawai'i will provide infrastructure for collecting electronic clinical data. This foundation will promote electronic exchange for longitudinal care records of Hawai'i Medicaid patients receiving services out-of-state.

HHIE is working with the VA and with the Pacific Territories. HHIE and the VA have also discussed using NwHIN CONNECT (Exchange) for more system-to-system electronic exchange of clinical healthcare information to provide more timely care and support the MU criteria throughout the U.S. Pacific region. HHIE and the Guam, American Samoa, and CNMI HIEs are all planning to have Direct Messaging interoperability (HISP to HISP) to allow for referral use-cases, the exchange of clinical information, and the support of MU interoperability criteria.



## 2.15. 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*

The Department of Health (DOH) has deployed an NwHIN Exchange (CONNECT) Gateway and an Enterprise Service Bus (ESB) behind the Gateway (thereby allowing for the routing of messages, etc. internally at DOH), and is planning to interface with HHIE (utilizing the State Hub for secure data exchange). This interface between DOH and HHIE will facilitate the ability for HHIE providers to directly share data and have direct reporting capabilities to DOH databases and programs, such as immunization registries, public health surveillance and reporting, etc. DOH is in the process of evaluating using the NwHIN Exchange (CONNECT) Gateway to connect to the Center for Disease Control and Prevention (CDC), as well as potentially supporting the Direct Project to streamline provider reporting directly to DOH (using Direct Secure Messaging). DOH currently uses Public Health Information Messaging Services (PHIN-MS) to interface with CDC. Conforming these interfaces to the use of NwHIN CONNECT is pending CDC approval and funding.

MQD will continue to coordinate with DOH and HHIE to ensure that immunization data can be integrated with HHIE and into provider certified EHR technologies natively in the EHR (as providers adopt and implement certified EHRs). MQD will also work with HHIE and DOH so reporting and surveillance programs can be integrated into certified EHR technologies, allowing providers seamless access to this data within the certified EHR. By integrating MQD, DOH and HHIE, the State can leverage and integrate this data and data reporting capabilities to as many providers (and certified EHR systems) as possible.

## 2.16. 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*

Under the Health Information Technology Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009, the HHIE received funds through the Office of the National Coordinator for Health Information Technology (ONC). HHIE was awarded \$5,603,318 for the establishment of the statewide health information exchange and also awarded \$6,548,775 to establish the HPREC. The University of Hawai'i, Hilo College of Pharmacy, became the recipient of the \$16 million Hawai'i County Beacon Consortium (HCBC) award from the ONC. The grant is provided through ONC's Hawai'i Pacific Regional Extension Center (REC). The funds help support health centers with the adoption of HIT to support long-term improvements in quality of care, health outcomes, and cost efficiencies.

Additionally, the MQD as the single state Medicaid agency was the recipient of two Medicaid Transformation Grants awarded under the Deficit Reduction Act of 2005. The purpose of one of the grants, the Hawai'i Open Vista Application Service Provider Network (HOVAN), was to create an open source EHR in an Application Service Provider (ASP) environment for clinics serving large Medicaid populations. The purpose of the other grant, the Hawai'i Enhanced Electronic Health Record and Information Exchange (E-EHRIEX), was to establish the infrastructure and protocols for the electronic submission and exchange of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) information with providers. Federal funding for both grants has formally concluded and continued activity has been severely reduced due to the lack of sustainable funding. EHRs implemented using the



HOVAN grant continue to be utilized and expanded based on available funding. In the E-EHRIEX project, the web interface for the submission of EPSDT information was taken down due to low provider utilization, however, the database developed to collect the EPSDT information is still operational and updated manually from paper forms.

In 2013, the State of Hawai`i received a Model Design Award through CMS' State Innovation Models (SIM) Initiative. The SIM initiative is designed to improve health system performance through the development and testing of state-based models for multi-payer payment and health care delivery system transformation. Through the SIM Design Award, Hawai`i has formulated a State Health Care Innovation Plan laying out a state-specific path to achieving the goals of the SIM Initiative. Based on the efforts by the SIM Design Award, Hawai`i intends to apply for a SIM Testing Award to better and more quickly implement and evaluate the impact of the transformation roadmap detailed in the State of Hawai`i Health Care Innovation Plan.



### 3. “TO-BE” HIT LANDSCAPE

#### 3.1. 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*

MQD is focused on the adoption of certified Electronic Health Record technologies by providers in Hawai'i. MQD will continue with current and future coordination with the Hawai'i HIE's statewide HIE efforts, as well as its HPREC efforts, to assist eligible providers achieve the adoption of certified EHRs and MU. MQD anticipates that approximately 1450 EPs, 14 acute care hospitals and 9 CAHs will qualify and apply for the incentives over the course of the program.

While MQD will incentivize meaningful use of EHRs through the Medicaid incentive program and other efforts such as the health home, MQD must continue to accommodate providers who do not implement EHRs. Hawai'i has a provider shortage, and MQD has a responsibility to make every effort to preserve access.

The State's Hawai'i Healthcare Transformation Initiative (HHTI), coordinated by the Governor's Healthcare Transformation Coordinator, is a public-private partnership with leading healthcare industry stakeholders that is developing an integrated healthcare system strategy. One of HHTI's key priorities is HIT/E, which provides the infrastructure that will enable payment reform and innovative delivery models. MQD already requires value-driven healthcare provisions in its managed care contracts, and the implementation of an advanced analytics and data management strategy that incorporates clinical data will enable better predictive modeling, acuity-adjusted payment, and gain-sharing.

As the State's single largest purchaser of healthcare, through its employee health insurance programs, the State can support and leverage Medicaid's investment in HIT/E. By developing infrastructure that enables public health reporting on clinical data, the State can better understand disease burden and cost drivers. This information will not only influence payment reform and clinical interventions, but it will also be essential to informing population-based and public health interventions.

MQD is currently collaborating with the State OIMT staff on the State Infrastructure Plan to develop an integrated infrastructure including the implementation of a clinical data exchange system, including a clinical data Enterprise Service Bus (ESB) and a clinical data repository. This integrated infrastructure, including collaboration between MQD and OIMT, other State Agencies, the HHIE, other state trading partners, and Federal Agencies, will allow for interoperability, re-usability of infrastructure and non-duplication of efforts

#### 3.2. 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*

Electronic access to timely and relevant clinical information is the foundation for healthcare transformation and will require widespread adoption of HIT/E. A sustainable HIE is a critical component





toward this goal, and MQD is dependent upon its success. However, from a Medicaid perspective, IT systems must support the continuum of operations which also include: eligibility, enrollment, payment, measurement/analytics, and partnership/intervention

As MQD is in the process of procuring an Enterprise Service Bus (ESB) for the Eligibility and Enrollment (E&E) project to support administrative transactions, MQD will also procure an ESB for clinical data exchange, and then perform integration of the clinical data ESB with the E&E ESB to create an integrated, multi-functional ESB for MQD. MQD is in the process of procuring one total ESB to support both the E&E project and the clinical data exchange project, and MQD is interested in leveraging existing technologies and systems.

As the next phase of the ESB project, MQD would work in collaboration with the State OIMT to integrate the multi-functional ESB for MQD into the State ESB ('State Hub'), acting as a component of the State ESB/State Hub. The State OIMT department could host and provide services (personnel, knowledge, some support, upgrades, expertise with vendors, etc.) on the State ESB, which would include the multi-functional MQD ESB. As MQD has limited technical staff and resources, partnering with the State OIMT provides a level of technical expertise, integration expertise, support, maintenance, and interoperability expertise to MQD and the required ESB goals and functionality.

MQD currently does not have a clinical data repository, nor associated analytics engines or components, and as such plans to procure a clinical data repository, an eMPI, and develop an advanced data analytics strategy that includes data management and analytical tools. This clinical data repository, with associated eMPI and analytics, would then be connected to and integrated with the MQD ESB, as a component of the State OIMT ESB and infrastructure, and would interface with the State's HIE. The State OIMT could provide similar functions as described for the ESB.

The eMPI component of the clinical data repository would allow for patient matching, thereby allowing for the exchange of CCDAs (and associated clinical data) with external trading partners, including HHIE, and other State Agencies, as well as the ability to match and merge patient information, clinical data, and other important data. This ability to match and merge clinical patient data, including CCDAs, could allow MQD to have a comprehensive clinical data record for patients and a true clinical data repository. The impact of this clinical data record and clinical data repository would be the ability to run analytics and queries on the clinical data in support of coordination of care and other programs (such as patient-centered medical homes, Medicaid ACOs, and other payment model innovations).

The analytics components and tools, when coupled with the matching process of the eMPI, in the clinical data repository could allow MQD and others (state health-related agencies and partners, as appropriate) to run queries and research functions on the clinical data, including matched and merged patient data (CCDs, etc.). This ability to provide analytics and research are planned to be used by MQD and others to target at risk populations, provide quality information on the state of the healthcare ecosystem in Hawai'i and the Pacific, and provide true data mining opportunities to support future programs and initiatives. Data extracted by the analytics components will be used for a multitude of services and systems, including Medicaid ACO, payment innovations, metrics and measurements of the delivery system, building a statewide report card for healthcare and public health, and monitoring for fraud, waste, and abuse.



### 3.2.1. MMIS Updates

HPMMIS currently supports Hawaii's Medicaid health plan enrollment, encounter, and claims processing functions and is managed and operated by the Arizona Health Care Cost Containment System (AHCCCS) for Hawai'i under an Interstate Agreement known as the Hawai'i Arizona PMMIS Alliance (HAPA). MQD has completed its MITA 3.0 SSA in 2013 (except for member eligibility and enrollment processes) documenting the business needs and direction for the future of Hawaii's MMIS. The SSA provides the framework with which to evaluate the future of the HPMMIS and the Arizona relationship. Possible scenarios would include continuing the HAPA partnership with Arizona for the HPMMIS and upgrading/replacing the HPMMIS or procuring and implementing a new, stand-alone, MMIS for Hawai'i only. In this effort, MQD will enter into discussions with the State OIMT, CMS, Arizona, and other stakeholders, on the best strategy to meet the business needs of MQD and bring the MMIS in compliance with CMS Standards and Conditions for enhanced funding. All the MMIS options and alternatives will be evaluated along with the SLR, to ensure a coordination of the MMIS and SLR, and to also ensure no disruption in the SLR or the incentive payment program. These alternatives will be documented in an IAPD with the plans for upgrading, modifying or replacing the HPMMIS in the FY2016 timeframe.

### 3.3. 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*

MQD implemented a State Level Repository (SLR), for the purpose of interfacing providers with the MQD IT Systems as it relates to the EHR Incentive Payment Program. Some of the functionalities included in the SLR are:

- Web access;
- Simple registration and attestation process;
- Interface with the R&A;
- Help/guidance for provider;
- Meaningful User library/guidance;
- Reporting capability; and
- Payment and recoupment tracking.

This has allowed Medicaid providers to register for the program, report their progress on the Meaningful Use of certified EHR technology, and receive their EHR Incentive payments. The HPREC is also a resource to eligible providers.

### 3.4. 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*





Currently, HHIE, the state-designated entity, is an independent non-profit with a broad governance structure to include hospitals, health plans, independent physicians, business, consumers, and ancillary providers (labs and pharmacy). The State Healthcare Transformation Coordinator, who is also the State HIT Coordinator, is a non-voting board member of HHIE. The State is actively working with HHIE to explore governance alternatives that more closely align HIE with the State and facilitate sustainability. The State believes that standards setting pertaining to HIE is a State function; however, successful HIT/E requires public-private partnership. Future state direction will further delineate the responsibilities for HIE governance and policy-setting under common frameworks aligned with ongoing HIE operations. The offices of the State Healthcare Transformation Coordinator, MQD, and the State CIO's OIMT are aligning strategies for HIT/E planning and policy, alongside state partners to achieve information exchange development goals.

### 3.5. 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*

MQD is focused on supporting and promoting the adoption, implementation, and upgrade (AIU) of certified EHR systems by the eligible providers in Hawai'i. MQD also will be supporting the achievement of meaningful use by providers through the incentive program. MQD has also supported communication and outreach activities as part of the SLR solution.

These activities, separate from the HPREC communication activities, are meant to spread awareness to providers of the incentives available for A/I/U and MU of certified EHR technology, and include:

- Delivering an announcement memo to potential EHR Incentive Program participants introducing the program and the steps required for registration and attestation.
- Conducting stakeholder information presentations for EPs, EHs, and Groups via virtual conference. These presentations served to introduce the Medicaid EHR Incentive program and walk providers through the attestation process.
- Launching an EHR Incentive Program Provider Outreach Page that serves to educate and guide the provider community through the Medicaid EHR Incentive Program application process. This page can be accessed at <http://hi.arraincentive.com/> and contains useful tools including an eligibility calculator, jump start page, program workbooks for eligible professionals, eligible hospitals, and group administrators, frequently asked questions (FAQs), a link to the CMS R&A, and a link to the Hawai'i SLR.
- Launching a Contact Center where trained SLR Help Desk staff can be reached by phone or email to provide answers to specific enrollment, validation, and incentive questions.
- Updating the MQD website to announce the go live of the SLR web application.
- Deploying a field representative to conduct outreach and education to the provider community.
- Holding recurring meetings with the REC.

MQD will include information on the MQD website regarding how to participate in this program. Working with its SLR contractor, MQD focuses on education, outreach, and alignment with the goals of the HHIE HPREC activities, under the greater strategic direction of the State HIT Coordinator's health transformation priorities. MQD is focused on making incentive payments, participating in the HIE



activities in Hawai'i, and will update the State HIT Plan accordingly (working in concert with the State HIT Coordinator) to reflect these activities.

MQD has included value-driven healthcare requirements in its managed care health plan contracts. An increasing percentage of the provider networks must be on value-based contracting, and this contracting may include increased reimbursement for providers with EHRs. As MQD pursues the health home State Plan option, EHR use and clinical data reporting are expected to be required. The State is developing policies to further encourage EHR use, including provider reporting of Immunization and Syndromic Surveillance data to the DOH through the HHIE.

### **3.6. 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*

Community Health Centers (CHCs), also known as Federally Qualified Health Centers (FQHCs), are important stakeholders in the Hawai'i healthcare ecosystem. As the FQHCs do not currently have any HRSA funding, collaboration and integration of the FQHCs is critical to the Meaningful Use of certified EHRs, and coordination of care in Hawai'i. MQD plans to assist the FQHCs in the integration of the FQHCs EHRs into the HHIE by providing resources to support this integration to ensure the FQHCs gain access to the HHIE and any future MQD clinical data exchange solution, and also to facilitate bi-directional clinical data exchange, public health reporting, and the Meaningful Use of certified EHRs.

### **3.7. 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*

As a result of the SLR procurement, MQD provides technical assistance to providers via training and outreach events. The SLR contractor's Communication Plan that is currently being implemented includes multiple provider outreach methodologies in coordination with the REC. One of the most effective methods is the monthly roundtable event with MQD and the SLR contractor and the REC. Another effective assistance method is the call center. MQD has aligned these strategies with the work of the State HIT Coordinator, working in conjunction with the HPREC and HHIE activities.

MQD is planning on working with Medicaid providers to help facilitate interfaces from the provider's certified EHRs and Laboratory Information Systems (LIS) to the HHIE. The goal of these Medicaid provider interfaces is to facilitate the backend connectivity of these Medicaid providers, and such interfaces would allow for bi-directional clinical data exchange from the clinical data repository, through the HHIE, to the Medicaid provider, and back again to the clinical data repository.

### **3.8. 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*

There are many populations served by MQD that have unique needs, and all will benefit from providers' use of HIT/E. These populations include children, individuals with limited English proficiency, those



with developmental disabilities, substance abuse issues, behavioral health issues, serious mental illness, and homeless individuals. Outreach and education will target providers that serve a high percentage of these populations, namely pediatricians and FQHCs. These patient segments are of particular need for improvements in transitions of care. Forthcoming efforts to enhance transitions and improve outcomes, including patient-centered medical homes, will assist these populations. We will work directly with providers but also through their professional organizations including the Hawai'i chapter of the American Academy of Pediatrics and the Hawai'i Primary Care Association.

### **3.9. 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*

MQD as the single state Medicaid agency was the recipient of two Medicaid Transformation Grants awarded under the Deficit Reduction Act of 2005. The first information grant created an open source EHR in an Application Service Provider (ASP) environment for clinics serving large Medicaid populations. The second grant established the infrastructure and protocols for the electronic submission of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) information from providers. Although Federal funding for both grants has formally concluded and continued activity has been severely reduced due to the lack of sustainable funding, it is the State's intent to leverage the accomplishments of both grants. This will include exploring ways the HOVAN Grant's EHRs can be expanded and sustained, as well as developing an approach for integrating the data and electronic submission protocols developed for the E-EHRIEX in Hawai'i's HIE environment.

### **3.10. 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*

MQD does not anticipate the need for new amendments to State legislation or the need for new legislation to implement the EHR Incentive Program. Participants in the EHR incentive program will be required to comply with all federal and State of Hawai'i privacy and security requirements. MQD reviewed the state regulations and is able to implement the EHR Incentive Program with the current regulatory environment.



## **4. ADMINISTRATION & OVERSIGHT OF THE MEDICAID EHR INCENTIVE PROGRAM**

### **4.1. Overview**

The following section provides the steps that Med-Quest Division of the Hawai'i Department of Human Services (MQD) plans to follow to ensure proper administration and oversight of the Hawai'i Medicaid Electronic Health Record (EHR) Incentive Program. MQD has contracted with a SLR vendor to provide a multi-client, configurable off-the-shelf state level repository (HI SLR) solution. The HI SLR vendor is contracted to handle the business administration and technical program management of the EHR Incentive Program, as well as act as the MQD Fiscal Agent.

### **4.2. 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 Hawai'i Medicaid EHR Incentive Program plans to verify non-sanctioned, properly licensed and qualified providers by checking both national and state exclusion databases, as described below.

#### **4.2.1. National Level Exclusions**

All Eligible Professionals (EPs) and Eligible Hospitals (EHs) are required to begin registration for the Medicaid EHR Incentive Program at the national level using the CMS Registration and Attestation System (R&A). The R&A serves as a national database for all EHR Incentive Program registrations and attestations, which includes interfaces to all state level repositories as well as the Death Master File and Office of the Inspector General Federal databases. Once an EP or EH has registered at the national level using the R&A, an exclusions check will be run by the R&A to ensure that registrants are not subject to Federal exclusions and have not received a duplicate EHR incentive payment for the current program year. Excluded providers at the national level will not be sent to the HI SLR for state level attestation.

#### **4.2.2. State Level Exclusions & Licensing**

The MQD Finance Office serves as the state-level program integrity office for the Medicaid program and houses information on state-sanctioned Hawai'i providers. Current vocational and professional licensing information for providers in Hawai'i can be found in the State of Hawai'i Department of Commerce and Consumer Affairs Professional and Vocational Licensing Division (DCCA-PVL) database. Using this information, currently captured within the HPMMIS, the HI SLR will be responsible for verifying that providers are not sanctioned and are properly licensed/qualified for participation in the Medicaid EHR Incentive Program using automated interfaces and/or manual verifications.

#### **4.2.3. Qualification of Providers**

The MQD Health Care Services Branch performs provider enrollment in the Medicaid program. These processes, and the data already contained in the HPMMIS, will be leveraged to ensure that only eligible Medicaid providers can enroll in the Hawai'i Medicaid EHR Incentive Program through the HI SLR.



### **4.3. 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*

Verification that EPs are not hospital-based, as defined in C.F.R. §495 section 1861(r), will be accomplished through the manual review of completed attestations. Once an EP has submitted their attestation for review, as part of the verifications process, the EP’s place-of-service (POS) code will be researched using their HPMMIS encounters and claims history. This function is included in the HI SLR Solution Suite.

### **4.4. 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*

One of the features of the HI SLR will be to establish a directory of Medicaid providers that could be eligible for and attest to Medicaid EHR Incentive payments based on credentials, Medicaid activity, and receipt of R&A registration information. To help establish this directory, MQD plans to leverage current applicable state systems, including the DCCA-PVL database and the MQD Finance Office database, to match to the HPMMIS database for the creation of an individual HI SLR Provider Master File (PMF). The HI SLR PMF data will subsequently be matched to on-boarded R&A data passed to the HI SLR, in which a series of automated and manual validations will occur, as described below.

#### **4.4.1. Automated Verifications**

The HI SLR Solution Suite includes a variety of automated verifications that must be passed for providers to continue through the attestation process. When the user saves the initial registration information, the National Provider Identifier (NPI), professional license number and tax identification number (TIN) are validated against the PMF. Additionally, the system validates the provider’s enrollment status against the PMF to ensure the provider is in an eligible status for participation in the program and is not listed as deceased or permanently sanctioned in HPMMIS.

The HI SLR is configured to receive aggregate encounters and claims data by provider NPI, place of service, and date of service. The aggregate encounters and claims data for the 90-day representative period can then be used to assist in validating the Medicaid encounters documented by the provider during the attestation process, as well as validating that fewer than 90 percent of the provider’s encounters occurred in an inpatient hospital or emergency room setting.

In addition to verification against the PMF, the HI SLR has been configured to automate several prepayment verifications on information entered by the provider during attestation. The HI SLR incorporates hard stops to verify that all information entered by providers aligns with program rules and that required documents are attached.

The HI SLR will automatically verify the following items during the attestation process:

- Eligibility reporting period using dates entered by the provider;
- (EHs only) – Average Length of Stay is less than 25 days;



- Medicaid patient volume (or Needy Individual Patient Volume) using numerator and denominator;
- ONC EHR certification number by matching the provider certification number with the ONC Certified HIT Product List;
- A/I/U criteria or MU criteria, depending upon the attestation type; and
- Provider NPI and SSN/TIN and payee NPI and SSN/TIN with the PMF.

Providers will be required to upload documentation in support of many of these items prior to proceeding in the HI SLR as well. If any one item cannot be verified, then the attestation will stop and the provider will not be able to proceed until corrected.

In the final step of attestation in the HI SLR, providers are required to submit an attestation agreement document. MQD currently uses a comprehensive attestation document that ensures MQD and CMS that the provider meets the requirements for eligibility and incentive payment. The attestation agreement will be automatically generated from the information entered into the HI SLR by the provider and will vary based on provider type.

#### **4.4.2. Manual Verifications**

The HI SLR staff conducts thorough pre-payment verifications, therefore, attestations that are flagged as potentially fraudulent within the HI SLR will be reviewed more carefully. Furthermore, as a part of every pre-payment validation, self-reported Medicaid encounters will be checked against the HPMMIS database of claims and encounters to determine reasonableness of provider eligibility.

Given that the HI SLR cannot automatically verify all information, the manual verification process for all providers includes:

- Ensuring that all documentation attached is correct and accurate as described by the HI SLR;
- Verifying that the certified EHR technology contract is valid within the last 12 months;
- Ensuring that the attestation agreement is signed and valid according to MQD regulations; and
- (For MU only) verifying required documents are attached and appropriate for chosen MU measures.

All attestations found without proper documentation attached will be pended and a notice identifying the missing or incorrect information will be sent to the provider's e-mail address with instructions on how to correct.

#### **4.5. Communication with Providers**

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

Provider communication is essential to participation in the Hawai'i Medicaid EHR Incentive Program. Effective provider communication ensures that providers are compliant with program rules and regulations as laid out by MQD and CMS. A variety of methods will be used for initial outreach to providers, including leveraging current state activities around implementation of HIT by utilizing the





HHIE, the REC, and the Hawai'i Primary Care Association (HPCA), for communication of the program timeline, eligibility requirements, and milestones.

MQD offers an EHR Incentive Program Provider Outreach Page (POP) that serves to educate and guide the provider community through the Medicaid EHR Incentive Program application process. This page can be accessed at <http://hi.arraincentive.com/> and contains useful tools including an eligibility calculator, jump start page, program workbooks for eligible professionals, eligible hospitals, and group administrators, frequently asked questions (FAQs), a link to the CMS R&A, and a link to the Hawai'i SLR. Included on the POP is a toll-free Help Desk telephone number, where trained SLR Help Desk staff can be reached to provide answers to specific enrollment, validation, and incentive questions.

Direct communication to providers regarding the status of their attestation and subsequent payment is handled by the service contract as part of the HI SLR. The HI SLR notifies providers via email when significant milestones have been met within their attestation review, such as submission, approval and payment distribution. HI SLR staff are responsible for communicating with providers around specific details of their attestation, including improperly completed attestations, pended attestations, and additional information needed.

#### **4.6. Methodology for Calculating Patient Volume**

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

MQD will consider patient volume calculations for EP attestations using either individual patient encounters or patient panels. The HI SLR will assist the EP in calculating patient volume by collecting a numerator and denominator for Medicaid patient encounters/panels, needy individual patient encounters/panels (if applicable), and total encounters/panels, respectively. Acute Care Hospitals and Critical Access Hospitals will be required to attest to their Medicaid and total discharges.

All patient encounters used to calculate Medicaid patient volume (EPs and EHs) or needy individual patient volume (EPs only), for the purposes of determining eligibility, must be calculated using a 90-day representative, continuous period within the preceding calendar year or within the preceding 12 month period from the date of the attestation; this is known as the Eligibility Reporting Period. Please note that the numerator and denominator of all Medicaid patient volume calculations must come from the same 90-day period while calculating patient volume. Hawai'i has some flexibility in defining the approach for patient volume determination, as described above, but all approaches need to be approved by CMS prior to implementation. At this time, Hawai'i has not chosen to implement a non-standard methodology for calculation of patient volume.

##### **4.6.1. EP Individual Encounter Definitions**

EPs must prove eligibility in each year of participation in the Medicaid EHR Incentive Program by calculating Medicaid patient volume. EPs using individual encounters for the purpose of calculating Medicaid patient volume will perform patient volume calculations by dividing total Medicaid encounters (numerator) by total patient encounters (denominator). Table 4-1 outlines the individual encounter formula for EPs.



**Table 4-1: EP Individual Encounter Formula**

Provider Type	Formula
EP	$\frac{\text{Total Medicaid Patient Encounters}}{\text{Total Patient Encounters}}$

A Medicaid encounter for an EP is defined as services rendered to an individual on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes encounters for dual-eligible individuals (i.e. eligible for both Medicare and Medicaid), as well as zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate CHIP programs. Total patient encounters include all individuals in which services were rendered on any one day.

EPs practicing predominately in a Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) have the option of using needy individual encounters for the purposes of calculating Medicaid patient volume. EPs practicing predominately in an FQHC or RHC can calculate Medicaid patient volume by dividing total needy individual patient encounters (numerator) by total patient encounters (denominator). Table 4-2 outlines the individual encounter formula for FQHCs and RHCs.

**Table 4-2: FQHC/RHC Encounter Formula**

Provider Type	Formula
FQHC/RHC	$\frac{\text{Total Needy Individual Patient Encounters}}{\text{Total Patient Encounters}}$

A needy individual patient encounter for EPs practicing predominately in an FQHC or RHC is defined as services rendered to an individual on any one day where:

- Title XIX Medicaid or Title XXI funding, out-of-state Medicaid programs or a Medicaid or CHIP demonstration program approved under section 1115 of the Act paid for all or part of the service or paid all or part of the individual's premiums, co-payments and cost-sharing;
- The services were furnished at no cost (agreed upon prior to the services being rendered by the EP); or
- The services were paid for at a reduced cost based on a sliding scale established by the EP and determined by the individual's ability to pay.

Total patient encounters include all individuals in which services were rendered on any one day.

#### **4.6.2. EP Patient Panel Encounter Definitions**

EPs choosing to calculate Medicaid patient volume using the panel method require a numerator and denominator that differ from the individual encounter method. EPs calculating patient volume using the panel method will do so by dividing total Medicaid patient panel encounters (numerator) by total patient panel encounters (denominator). Table 4-3 outlines the patient panel formula for EPs.





**Table 4-3: EP Patient Panel Formula**

<i>Provider Type</i>	<i>Formula</i>
<b>EP</b>	$\frac{\text{Total Medicaid Patients Assigned to EP's Panel + Unduplicated Medicaid Encounters}}{\text{Total Patients Assigned to EP + All Unduplicated Patient Encounters}}$

For the purposes of performing this calculation, the following definitions apply:

- A Medicaid panel encounter is defined as the total number of Medicaid patients assigned to an EP's panel in any qualifying Eligibility Reporting Period, when at least one Medicaid encounter took place with the Medicaid patient in the twenty-four (24) months prior to the chosen Eligibility Reporting Period, plus unduplicated Medicaid encounters in the same Eligibility Reporting Period; and
- A total patient panel encounter is defined as the total number of patients assigned to an EP's panel in any qualifying Eligibility Reporting Period, when at least one encounter took place with the patient in the twenty-four (24) months prior to the chosen Eligibility Reporting Period, plus unduplicated patient encounters in the same Eligibility Reporting Period.

EPs practicing predominately in an FQHC or RHC that choose to calculate Medicaid patient volume using the panel method require a numerator and denominator that differs from the individual encounter method. EPs calculating Medicaid patient volume, utilizing needy individual encounters and the panel method will do so by dividing total needy individual patient panel encounters (numerator) by total patient panel encounters (denominator). Table 4-4 outlines the patient panel formula for FQHCs and RHCs.

**Table 4-4: FQHC/RHC Patient Panel Formula**

<i>Provider Type</i>	<i>Formula</i>
<b>FQHC/RHC</b>	$\frac{\text{Total Needy Indiv. Patients Assigned to EP's Panel + Unduplicated Needy Indiv. Encounters}}{\text{Total Patients Assigned to EP + All Unduplicated Patient Encounters}}$

For the purposes of performing this calculation, the follow definitions apply:

- A needy individual patient panel encounter is defined as the total needy individual patients assigned to the EP's panel in any qualifying Eligibility Reporting Period, when at least one needy individual encounter took place with the patient in the twenty-four (24) months prior to the Eligibility Reporting Period chosen, plus unduplicated needy individual encounters in the same Eligibility Reporting Period;
- A total patient encounter is defined as the total number of patients assigned to an EP's panel in any qualifying Eligibility Reporting Period, when at least one encounter took place with the patient in the twenty-four (24) months prior to the chosen Eligibility Reporting Period, plus unduplicated patient encounters in the same Eligibility Reporting Period.

#### **4.6.3. Group Practice/Clinic Medicaid Patient Volume Calculations**

Group practices or clinics may be allowed to calculate Medicaid patient volume at a group practice or clinic level, given that they meet the criteria determined by MQD and CMS for the use of group Medicaid



patient volume. To use group Medicaid patient volume in accordance with regulations, the group practice or clinic must ensure the following:

- The clinic or group practice's patient volume is appropriate as a patient volume calculation methodology for all EPs participating;
- There is auditable data to support the patient volume calculation methodology;
- All EPs in the group practice or clinic must agree to use the same methodology for the payment year for the purposes of calculating patient volume;
- The clinic or group practice uses the entire patient volume and does not limit the patient volume calculations in any way; and
- If an EP works in more than one practice and clinic, then the practice or clinic patient volume calculation should only include those encounters associated with the group practice or clinic attesting with the EP, and not the EP's outside encounters.

#### **4.6.4. Calculating Medicaid Patient Volume - EHs**

EHs must determine eligibility for each year of participation in the Medicaid EHR Incentive Program by calculating Medicaid patient volume. EHs will divide the total Medicaid encounters in any qualifying Eligibility Reporting Period (numerator) by the total encounters in the same Eligibility Reporting Period (denominator).

$\frac{\text{Total Medicaid Patient Encounters}}{\text{Total Patient Encounters}}$
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A Medicaid encounter for an EH is defined as services rendered to an individual on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes encounters for dual-eligible individuals (i.e. eligible for both Medicare and Medicaid), as well as zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate CHIP programs.

Total patient encounters include all unique patients in which services were rendered on any one day, regardless of payer.

Please note that EH's Medicaid patient volume, calculated to determine eligibility for the program, may differ from cost report data used for EHR Incentive payment calculation.

#### **4.7. Verification of Patient Volume**

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

The HI SLR vendor is responsible for validating patient volume as reported by EPs, EHs, and Groups. Self-reported information will be compared to the HPMMIS data warehouse as a test of reasonableness.



#### **4.7.1. Verifying Eligible Professionals Patient Volume**

Data reported by EPs and group practice or clinics of EPs will be validated using a comparison to HPMMIS claims data. Claims data found in the HPMMIS will be compared to the self-reported numerator for a determination of reasonableness. The denominator is more difficult to calculate given its relation to the number of hours work by an EP within a given Eligibility Reporting Period. Although there are average estimates for the number of encounters an EP may be able to report within a given year, final denominator comparisons will be done during post-payment audits. The numerator comparisons will be used as a basis for determining validity pre-payment.

EP Medicaid patient volume calculations utilizing needy individual patients will be more challenging to validate given that needy individual encounters are not recorded in a state claims database, such as the HPMMIS. To capture Needy Individual Patient Encounters, the HI SLR requires the EP to select an option indicating the EP practices predominantly in a FQHC or RHC. Once the EP selects the practices predominantly option, the entry field to capture the Other Needy Individual Patient Encounters is required. Since Medicaid encounters are already captured elsewhere, the Other Needy Individual Patient Encounters are defined as patients furnished uncompensated care by the provider or patients furnished services at either no cost or on a sliding scale for the selected reporting period. To reduce the burden upon providers MQD will validate EPs using needy individual encounters in post-payment audits by placing them into the high-risk stratum, as described in Section 5- Audit Strategy.

#### **4.7.2. Verifying Eligible Hospitals Patient Volume**

For Acute Care Hospitals and Critical Access Hospitals, Medicaid encounters will be validated using HPMMIS data as well as cost report information. The denominator will be more difficult to verify with HPMMIS data; however, the cost reports submitted with EH attestations can provide adequate information to determine the reasonableness. The numerator comparison and the reviewer's determination of reasonableness, will be the basis for verifying pre-payment EH Medicaid patient volume.

### **4.8. 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*

FQHCs and RHC EPs submit encounters on a clinic-level in the State of Hawai'i. Therefore, MQD will rely on post-payment auditing to verify that an EP practices predominately – greater than 50% of total encounters - in an FQHC or RHC during the eligibility reporting period – 6 months from the previous calendar year or 12 month period preceding attestation – submitted in each program year.

### **4.9. Verification of Adopt, Implement, Upgrade (Program Year 1)**

*How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers? Source: CMS SMHP Template Question C.8*

Eligible providers, including EPs and EHs, will be required to attest to the adoption, implementation or upgrade (AIU) of certified EHR technology as defined in the Final Rule, 42 C.F.R. §495.302:



- *Adopt.* Acquire, purchase or secure access to certified EHR technology
- *Implement.* Install or commence utilization of certified EHR technology such as staff training, EHR data entry, and establishment of data exchange agreements.
- *Upgrade.* Expand certified EHR functionality, such as staffing, maintenance, and training, or upgrade existing EHR technology to Certified EHR Technology.

During the attestation process in the HI SLR, the provider is required to supply the following attestation information to qualify for an AIU incentive payment:

- Select Adoption, Implementation, or Upgrade;
- Provide a brief textual description of how the provider meets the criteria for Adoption, Implementation, or Upgrade of certified EHR technology;
- Attach external documents supporting Adoption, Implementation, or Upgrade of certified EHR technology. MQD prefers that a signed contract is uploaded demonstrating proof of a fiscal relationship between the vendor and the EP/EH. In instances in which a signed contract is not applicable MQD will accept other documentation, including but not limited to, a vendor invoice, an End-User License Agreement (EULA), or other evidence that sufficiently demonstrates AIU.
- Certified EHR Technology: Enter ONC certification code. CMS publishes a list of codes identifying all ONC certified EHR technology products. During attestation the provider must enter the code from its EHR vendor to identify the EHR.
- Attestation Agreement: Sign and attach an Attestation Agreement indicating AIU. Attestation Agreement must be executed by the Eligible Provider or the designated representative of an Eligible Hospital. The EHR Incentive Payment will be made to the designated payee as referenced on the Attestation Agreement. It is the responsibility of the provider to verify accuracy of information contained on the Attestation Agreement, including the designated Payee.

#### **4.10. Verify Meaningful Use (Program Years 2-6)**

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

It is expected that providers will enter Meaningful Use (MU) data by objective and clinical quality measure (CQM) electronically into their attestation. Automated technical validations will conduct the first round of validations of data, using parameters set forth by the federal rule.

In addition to self-reported information it is expected that providers will upload proof of MU objectives and CQMs via supporting documentation. The HI SLR will allow providers to directly enter MU reporting and CQM attestation data or upload CQM measures from their .xml files created in their certified EHR technology.

#### **4.11. Proposed Changes to Meaningful Use 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.10*



MQD does not plan to make any changes to the MU definition as finalized by CMS. MQD has decided that the Medicaid criteria finalized by CMS are sufficient for the purposes of the Hawai'i Medicaid EHR Incentive Program and its current goals.

#### **4.12. Verify Provider's Use of Certified EHR Technology**

*How will the SMA verify providers' use of certified electronic health record technology? Source: CMS SMHP Template Question C.11*

The HI SLR verifies that providers are using certified EHR technology through a variety of validation steps laid out in requirements of the HI SLR, including:

- Requiring the CMS certification number be entered during attestation,
  - To subsequently be automatically certified with the ONC CHPL website;
- Matching the CMS certification number entered by the provider to the supporting documentation required to prove EHR Certification (i.e. contract, license agreement, etc.) during pre-payment review; and
- Utilizing on-site audits as post-payment audits for providers deemed "high risk",
  - The definition of high risk criteria can be found in Section 5.

#### **4.13. Collection of Meaningful Use & CQM 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.12*

The HI SLR will collect MU Data, including all CQM data. The web-based application is able to accept information on providers' attestations to MU, including numerators and denominators for core and menu objectives as well as CQM measures. This information will be sent as part of a provider's attestation to the HI SLR staff for review prior to payment.

In the long-term, MQD will explore the development of CMS requirements, functionalities made available to other states, and functionalities to make reporting less burdensome upon providers. This could potentially include batched data files being sent through the HI SLR in .xml format, automated detection of electronic exchange capabilities to a provider's certified EHR technology, interfacing with the HHIE, etc. MQD will work in collaboration with the HI SLR vendor and other states to determine long-term goals for the collection of MU and CQM data, while continuing to collaborate with state-wide stakeholders to achieve Hawai'i's goals. Changes to the long-term strategy will be reflected in future SMHP updates.

#### **4.14. 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.13*



MQD has not completed its State Medicaid HIT planning effort around incorporation of other clinical quality improvement programs into the overall HIT effort. MQD will update CMS in the next annual SMHP update on progress in clinical quality program alignment. Until a critical mass of providers is exchanging clinical information, the available data will be interesting, but perhaps limited due to distribution of Medicaid beneficiary care by providers and potential selection bias for those providing clinical data.

## **4.15. Program Implementation & Administration Systems**

*What IT, fiscal and communication systems will be used to implement the EHR Incentive Program? Source: CMS SMHP Template Question C.14*

The HI SLR will offer all functions required for the administration of the EHR Incentive Program. The HI SLR will include:

- A web-based application for interface with the R&A;
- Automated functionalities for the calculation and file creation of incentive payments;
- Fiscal Agent responsibilities;
- Communication tools in which HI SLR staff can provide guidance to attesting providers and their authorized representatives; and
- Pre-payment review services for the review and approval of attestations for release to pay.

### **4.15.1. Making Payments**

The financial payments for the EHR Incentive Payments will be handled through the current existing fiscal agent functionalities. As part of the HI SLR requirements, it must be able to interface effectively with the fiscal agent system for the creation and processing of payment files outside of the HPMMIS. EHR Incentive Payments will be processed and paid in the same fashion that other Medicaid claims are paid to Medicaid providers.

## **4.16. Required IT Systems Changes**

*What IT systems changes are needed by the SMA to implement the EHR Incentive Program? Source: CMS SMHP Template Question C.15*

MQD has contracted with the HI SLR vendor to provide a multi-client, configurable off-the-shelf SLR Solution Suite for providers to complete state-level attestations and request payments upon successful approval of attestation information.

### **4.16.1. Core Elements of the HI SLR**

As core functions, the HI SLR includes, but is not limited to:

- File exchange with the R&A;
- Structured Query Language (SQL) database maintained by the HI SLR;





- Import/export process for the exchange of data (.xml to conform with CMS schema);
- Provider data exchange between R&A and HI SLR;
- Payment data exchange between R&A and HI SLR;
- Provider data exchange between HI SLR and HPMMIS for attestation validation;
- Payment data exchange between HI SLR and the Fiscal Agent;
- Provider data exchange between HI SLR and DCCA-PVL for provider validation; and
- Attestation acceptance using requirements outlined in the CMS Final Rules.

#### **4.16.2. Design Elements of the HI SLR**

The HI SLR will provide capabilities including, but not limited to the following:

- Provide outreach and attestation support to providers throughout the duration of the program;
- Include a provider-facing website with information on the program, including Federal and State requirements;
- Determine eligibility based on entered, calculated and validated data;
- Automatically calculate and validate patient volume by provider type;
- Calculate resulting incentive payment according to attestation information and program compliance;
- Document, track and validate provider and reviewer activity, including denial, appeal, audit, returned and adjusted attestations;
- Accept, store, and validate AIU and MU information;
- Create reports based upon MQD priorities, including, but not limited to, registration, attestation completion, payment, audit activity and patient volume;
- Maintain an active data repository with history and archive availability.
- Create notifications to providers throughout current attestations;
- Create notifications to other State and Federal systems regarding provider payments issued; and
- Support MQD in attestation review and approval for payment.

#### **4.17. IT Timeframe for Systems Modifications**

*What is the SMA's IT timeframe for systems modifications? Source: CMS SMHP Template Question C.16*

MQD has opened the AIU attestation functionality within the HI SLR for payment year one, as well as the functionality allowing the attestation to MU. MQD allows both AIU and MU functionality within program year one understanding that many providers attesting with the Medicare EHR Incentive Program may be looking to switch to the Medicaid EHR Incentive Program for their payment year two.

Between December 2012 and October 2013, MQD has focused on:





- Procuring, configuring and implementing the HI SLR, including technical, fiscal and service components;
- Developing interface capability for registration, eligibility and attestation through the R&A and the SLR;
- Opening registration and attestation to the Hawai'i Medicaid EHR Incentive Program for AIU and MU through the web-based applications; and
- Making year one payments to providers that successfully attest.

#### **4.18. Timeline for CMS R&A Interface Testing**

*When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (R&A)? Source: CMS SMHP Template Question C.17*

The CMS R&A Interface testing was successfully completed in July 2013.

#### **4.19. Timeline for HI Provider R&A Registration**

*What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS R&A (e.g. mainframe to mainframe interface or another means)? Source: CMS SMHP Template Question C.18*

MQD has begun receiving CMS R&A registrations in September 2013.

#### **4.20. Hawai'i 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.19*

MQD offers a Medicaid EHR Incentive Program Provider Outreach Page (POP) that serves to educate and guide the provider community through the Medicaid EHR Incentive Program application process. This page can be accessed at <http://hi.ara incentive.com/> and contains useful tools, including an eligibility calculator, jump start page, program workbooks for eligible professionals, eligible hospitals, and group administrators, frequently asked questions (FAQs), a link to the CMS R&A, and a link to the Hawai'i SLR.

##### **4.20.1. Website Content**

The Hawai'i Medicaid EHR Incentive Program webpage gives providers an in-depth overview of what is required for successful attestation to the Hawai'i Medicaid EHR Incentive Program. The webpage includes the following resources:

- Key program information;
- Federal and State links and resources;
- Link to the HI SLR for attestation;
- Provider eligibility calculation worksheets;



- Hawaii Medicaid EHR Incentive Program Provider Manual;
- Hospital incentive payment calculation worksheets;
- Attestation checklists, including an explanation of each step necessary to complete each type of attestation from registration to payment;
- Links to help text and contact information for Hawai'i Medicaid EHR Incentive Program-related questions, including general programmatic information and attestation guidance; and
- Frequently asked questions.

#### **4.20.2. Website Maintenance**

As part of the HI SLR contract, the vendor is tasked with maintaining the Provider Outreach website by:

- Updating the Hawai'i Medicaid EHR Incentive Program webpage as requested by MQD;
- Creating communication materials for the webpage;
- Serving as the primary contact on the webpage for provider questions and clarifications; and
- Assisting providers with navigating the webpage for required program materials.

#### **4.21. 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.20*

No HPMMIS modifications are planned to allow payment.

#### **4.22. 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.21*

A call center specific to the Hawai'i Medicaid EHR Incentive Program was established by the HI SLR vendor. There is the potential for providers to call the Hawai'i Medicaid EHR Incentive Program with REC questions; therefore, REC contact numbers will be provided to the HI SLR help desk staff once the call center is implemented to ensure seamless transitions.

#### **4.23. EHR Incentive Program 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.22*

MQD will follow its current appeal processes for providers as established in the Medicaid Provider Manual Chapter 2.11 as revised in April, 2010.



#### **4.24. Accounting Practices for HITECH Provisions and MMIS FFP**

*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.23*

MQD will submit the CMS 64.10 report. This report will be based on the activities undertaken by MQD to administer the payments, and a separate line item that will account for the payments made through the HPMMIS.

#### **4.25. Frequency of EHR Incentive Payment Distribution**

*What is the SMA's anticipated frequency for making EHR Incentive payments (e.g. monthly, semi-monthly etc.)? Source: CMS SMHP Template Question C.24*

MQD has been making EHR Incentive payments on a weekly basis to EPs and EHs that have successfully attested to the program.

#### **4.26. Incentive Payment Assurance without Deduction or Rebate**

*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.25*

The HI SLR requirements include a process for assuring that a provider (or employer facility to which the provider has assigned payment to) receives the incentive payment directly without any deduction or rebate. In the event that a provider assigns their payment to an employer facility or other designee, their relationship with that designee will be researched during the attestation and review process as follows:

- The HI SLR will automatically validate that the designee is an active Medicaid provider/site by querying the HPMMIS enrollment files; and
- HI SLR review staff will investigate that the provider has a previously established relationship with the designee using HPMMIS.

#### **4.27. Assurance of Incentive Payments to Agencies 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.26*

At this time, MQD has not chosen to designate any entities promoting the adoption of certified EHR technology to which providers can assign their incentive payments. If MQD elects to designate an adoption entity, 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 will be reviewed and summarized in the annual SMHP update.



#### **4.28. Assurance of MCO Capitation Rate per C.F.R. Part 438.6**

*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.27*

MQD does not plan to disburse incentive payments directly to Managed Care Organizations. To assure compliance with MCO Capitation Rate per C.F.R. Part 438.6, incentive payments will only be paid directly to eligible professionals.

#### **4.29. Assurance Incentive Payments Calculations are Consistent with Statute and Regulation**

*What will be the process to assure that all hospital calculations and EP payment incentives are made consistent with the Statute and regulation? Source: CMS SMHP Template Question C.28*

The HI SLR includes automated and manual processes for calculating EP and EH incentive payments using the standards outlined in the federal regulations found at 42 CFR Part 495. MQD, with support from the SLR vendor, conducts oversight to ensure that providers meet all program requirements before payments are made, including:

- Compliance based upon their participation year;
- Enrollment eligibility criteria;
- Patient volume requirements;
- EP and EH incentive payment calculations remain consistent with CMS rules;
- A/I/U and MU requirements are met prior to payment;
- Monitoring and validation information; and
- A process for combating fraud and abuse.

##### **4.29.1. EP Incentive Payment Calculation**

EP incentive payments will be calculated using 100% of the eligible amount (or, in the case of Pediatricians with less than 30% Medicaid volume, two-thirds of the eligible amount). Based upon provider license and attestation requirements, the formula required by the Final Rule will be automated within the web-based attestation application. An incentive payment report will be accessible by the EP, MQD and/or contracted reviewers showing the attestation information used to calculate the EP's incentive payment.

##### **4.29.2. EH Incentive Payment Calculation**

EHS will be required to enter relevant cost report information as a part of their attestation. The HI SLR will use this information in the formula, as mandated by the regulation, to calculate the EH's incentive payment amount automatically. An incentive payment report will be accessible by the EH, MQD



contracted reviewers, and show the step-by-step calculation of the EH's payment. Please refer to Appendix A – EH Payment Calculation Worksheet for an example of how HI EH incentive payments will be calculated.

#### **4.30. Role of Existing SMA 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.29*

MQD has contracted with a SLR vendor for EHR Incentive Program SLR Implementation and Fiscal Agent Operations.

##### **4.30.1. Existing MMIS Contractor**

The current HPMMIS contractor will be used to track and report on provider claims utilization for the purposes of creating the HI SLR PMF and validating Medicaid patient volume.

##### **4.30.2. New SLR Contractor**

All tools necessary for administration and oversight, including technical specifications, program outreach, attestation processing, and fiscal agent responsibilities are included in the HI SLR contract. Specifically, this includes:

- A technical solution to support integration with the R&A and the HPMMIS;
- A technical solution for the purposes of accepting, tracking and storing attestation information;
- A service-based solution for the purposes of supporting MQD in administration and oversight of the Hawai'i Medicaid EHR Incentive payments;
- A service-based solution for the purposes of supporting MQD in communicating with providers at all stages of participation in the Hawai'i Medicaid EHR Incentive Program; and
- A fiscal agent to support the interfaces between the HPMMIS and the web-based application.

#### **4.31. Hawai'i 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). Source: CMS SMHP Template Question C.30*

MQD has made the following assumptions for this update of the SMHP.

- Certification and implementation of EHR systems will be timely in keeping with the incentive program schedule.
- CMS will allow adequate adjustment periods for processes affected by rule changes to the EHR incentive program.



- Timing of plans outlined in the SMHP are dependent on the SLR vendor's ability to perform SLR upgrades and modifications to align with CMS rules and regulations, such as the 2014 CEHRT Flexibility Rule, and any future changes to said rules and regulations.



## 5. AUDIT STRATEGY

### 5.1. 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 Section D*

The following section provides the process that MQD follows to avoid making improper payments. Section 5.2 provides the pre-payment validations, including updating the pre-payment validations currently being performed under the HI SLR contract. Section 5.3 provides the risk assessment process and post-payment audit plans.

### 5.2. Pre-Payment validations

#### 5.2.1. Step 1 – Provider Registers for EHR Incentive Program with CMS

The Hawai'i EPs and EHs start the registration process with the CMS Registration and Attestation System. The CMS Registration and Attestation (R&A) System is the national database for all EHR Incentive Program applications and communicates with all state level repositories, or attestation processing systems. A provider must register with CMS before s/he may attest for an EHR incentive payment with the State of Hawai'i. CMS performs the following verifications before an application may be submitted to the State:

- EPs must file using their Web user accounts. The National Plan and Provider Enumeration System (NPPES) restricts the creation of Web user accounts to one account per SSN for individuals;
- EHs must file using their CMS Certification Number (CCN). CMS validates that the CCN is within the approved ranges and restricts a hospital to one application per CCN. Hospitals with different CCNs for each location may apply for an EHR incentive payment for each location/CCN;
- EPs assigning their payment may only select their chosen payee from a dropdown list within the application. The professional must be affiliated with the group in the Medicare Provider Enrollment, Chain, and Ownership System to be included in the professional's dropdown list. (This affiliation does not impact the statistics that a professional uses to attest for Medicaid patient volume.); and
- EPs are checked by the CMS application to verify:
- The professional's provider type is one of the eligible provider types based on the provider's choice of program (Medicare or Medicaid); and
- The provider has not been excluded by CMS or another state. Excluded providers will not be sent to the State. State reason codes that do not exclude the provider from the Medicare and/or Medicaid programs will be sent to the State.





### **5.2.2. Step 2 – CMS Notifies State**

CMS sends an electronic transaction called a B-6 from the CMS R&A to the Hawai'i State Level Repository (HI SLR) notifying the State that a provider has registered and meets the Federal-level requirements.

### **5.2.3. Step 3 – State Match Process Begins**

Using the provider and payee NPIs provided in the CMS registration, corresponding demographic information is queried and pulled from the Medicaid Enrollment, Verification, and Credentialing (EVC) system into and displayed with CMS demographic information for providers and State staff to verify.

### **5.2.4. Step 4 – Provider Attestation Instructions**

Hawai'i provides attestation to A/I/U or MU by accessing the HI SLR. EPs and EHs both access the login page from <https://hi.ara incentive.com/>. Once EPs/EHs have registered for a HI SLR login and logged into the application, they may begin their attestation and track their progress using a dashboard, provided as the first page on the HI SLR. Furthermore, detailed user manuals for EPs, EHs and Group Representatives can be found in the HI SLR attestation application.

#### **EPs Instructions**

EPs will be required to follow a five-step process in the HI SLR to successfully complete their attestation and submit to MQD for review and verification. EPs will be required to verify or enter the following information:

- Step 1:
  - Verify CMS data is correct;
  - Attest to inpatient hospital service, pediatrician status, and requirement to read the Hawai'i Medicaid Electronic Health Record Program Provider Manual;
  - Enter Medicaid provider ID number;
  - Enter license number and Professional Licensing Board;
  - Identify Regional Extension Center (REC) Affiliation; and
  - Verify Payee Medicaid ID; and
  - Enter the contact person's name, phone number and email address.
- Step 2:
  - Accept or opt-out of Group eligibility (only if a Group has identified the EP);
  - Enter representative period for eligibility;
  - Enter Medicaid encounters and total encounters;
  - Select FQHC or RHC status; and
  - Upload supporting documentation.
- Step 3:
  - Attest to A/I/U or MU of Certified EHR;



- Enter EHR Certification Number; and
- Attest to adopt, implement or upgrade *or* attest to Meaningful Use objectives and measures.
- Step 4: Review and sign attestation agreement.
- Step 5: Submit Program Year Attestation to MQD for review.

EPs may also be considered part of a Group, in accordance with Hawai'i Medicaid EHR Incentive Program policies. Groups are required to provide the same information for each EP, but may do so as a "Group Representative", using a Group Representative login to the HI SLR.

### **EHS Instructions**

EHS will be required to follow a five-step process in the HI SLR to successfully complete their attestation and submit to MQD for review and verification. EHS will be required to verify or enter the following information:

- Step 1:
  - Verify CMS data is correct;
  - Attest to the requirement to read the Hawai'i Medicaid Electronic Health Record Program Provider Manual; and
  - Enter the contact person's name, phone number and email address.
- Step 2:
  - Enter representative period for eligibility;
  - Enter Medicaid discharges and total discharges for the representative period;
  - Enter total discharges for a full hospital fiscal year;
  - Enter total patient bed days for a full hospital fiscal year;
  - Enter average length of stay (ALOS);
  - Enter current cost report year;
  - Enter discharges for the last four years of available data;
  - Enter total discharges from the current cost report year;
  - Enter total Medicaid inpatient bed days from the current cost report year;
  - Enter total Medicaid managed care inpatient bed days from the current cost report year;
  - Enter total inpatient bed days from the current cost report year;
  - Enter total hospital charges from the current cost report year;
  - Enter total charges attributable to charity care from the current cost report year; and
  - Upload supporting documentation.
- Step 3:
  - Attest to A/I/U or MU of Certified EHR;
  - Enter EHR Certification Number; and
  - Attest to adopt, implement or upgrade *or* attest to Meaningful Use objectives and measures.
- Step 4: Review and sign attestation agreement.



- Step 5: Submit Program Year Attestation to MQD for review.

#### 5.2.5. Step 5 – Provider Attests

The provider electronically attests through the Hawai'i SLR solution and electronically submits their attestation to MQD for review and validation. The provider's attestation includes the information described in Section 5.2.4, provided either to the CMS R&A System or to the HI SLR directly.

Once the provider has electronically submitted the attestation, claims information is retrieved from the State data warehouse and the provider's EHR Product Certification ID is electronically verified via an interface between the HI SLR and the Office of the National Coordinator for Health IT's Certified Health IT Product List (ONC CHPL).

The provider then prints and signs the completed attestation form and mails it to the State, per state policy. Once HI staff receives the signed hard-copy attestation form from the provider, it is reviewed for completeness by the contracted HI SLR vendor.

This combined information is stored in the HI SLR solution where it is used throughout the pre-payment validation process. Provider information and the results of all validation activities are recorded in the HI SLR solution.

#### 5.2.6. Step 6 – HI SLR Vendor Validations

HI MQD has contracted with the HI SLR vendor to perform pre-payment validations on provider attestations. Prior to payment, the HI SLR vendor validates the information to which the provider attested using the electronic attestation found within the HI SLR. Specifically, the HI SLR vendor validates the following items, per provider type.

EPs	EHs
<ul style="list-style-type: none"><li>• Permissible Provider Type</li><li>• Provider's Medicaid Status</li><li>• Payee Address</li><li>• Hospital-Based Status</li><li>• Providers Claiming Needy Individual Encounters</li><li>• Patient Volumes</li><li>• Eligibility Workbook</li><li>• Contract Verification</li><li>• Attestation Agreement</li><li>• Hardcopy Signed Attestation Agreement</li></ul>	<ul style="list-style-type: none"><li>• C5 Verification</li><li>• Payee Address</li><li>• Eligibility Workbook Verification</li><li>• Cost Report Verification</li><li>• Contract Verification</li><li>• Attestation Agreement</li><li>• Hardcopy Sign Attestation Agreement</li></ul>

Per the Pre-Payment Validation Manual, compiled by the HI SLR vendor and approved by MQD, demographic information on the provider and payee is checked to ensure the information provided to



CMS and that which the State has on file match. If HI SLR vendor staff indicates a match, a transaction is automatically sent from the HI SLR to CMS; if a match is not found, HI SLR vendor staff will begin an outreach cycle to allow the provider to update the information, after which a transaction is sent to CMS and a denial is issued (see step 10).

All attested information is then reviewed for completeness and accuracy. The numerator of the patient volume calculation, indicating Medicaid or Needy Individual patient volume, is checked against the provider's claims history in the State's data warehouse. If attesting using the group methodology for calculating patient volume, a check is performed to verify the provider's affiliation with the group as of the date of attestation. A license check is done to ensure there are no public actions against the provider. The Hawai'i Prepaid Medicaid Management Information System (HPMMIS) is utilized to ensure the provider is active and to determine hospital-basis. In the event that a provider is determined to perform greater than 90% of their services as inpatient hospital services, the provider is requested to provide additional information to support their purchase of an EHR without assistance from the hospital.

#### **5.2.7. Step 7 MQD Finance Payment Calculation Check for EHs**

HI SLR vendor staff complete a payment check for EHs utilizing the cost report on file with Medicaid. The HI SLR automatically calculates the payment amount for EHs but HI SLR vendor staff perform a manual calculation to ensure the electronic calculator from the HI SLR is accurate.

#### **5.2.8. Step 8 - MQD Validations**

HI SLR vendor staff perform a series of checks to ensure the provider is eligible for payment, prior to issuing the sending to MQD for final approval to pay. MQD has final approval to pay provider on all attestations and records their approval in a Status Log spreadsheet, posted onto the HI SLR SharePoint site. All items checked are recorded in the HI SLR and any issues that are noted are recorded in the Status Log, which is sent to MQD for final resolution – either denial or approval.

#### **5.2.9. Step 9 – Program Integrity Validations**

As a last check, Program Integrity reviews the provider information to ensure the provider is in good standing. Providers that are not in good standing require additional review or may be denied payment.

#### **5.2.10. Step 10 – State Payment Decision**

All provider attestations must pass the required pre-payment verification processes, as described in steps 6-9, before the provider is approved for payment.

If all units determine a provider to be eligible for payment, the HI SLR vendor sends a D-16 payment request to CMS. CMS will validate that:

- The provider has not been paid or scheduled to be paid by another state;
- The provider has not been paid or scheduled to be paid by Medicare;
- The provider has not been excluded by OIG;
- The Provider is not listed on the national death registry; and



- The Provider's application status is showing active (not open, modified, or cancelled).

If CMS sends a D-16 response authorizing payment, the HI SLR vendor sends a payment approval request to MQD Finance Office. A payment approval is then sent back to HI SLR vendor. The SLR vendor will submit a payment file to the FA for disbursement of payment. Upon notice of payment from the FA, the HI SLR sends a D-18 transaction to CMS to indicate the payment was made to the provider.

If CMS sends a D-16 response indicating "do not pay," HI SLR vendor staff either performs provider outreach (if the reason can be corrected by the provider; e.g., CMS registration "in progress") or proceeds with documenting and advising of denial of payment (if the reason cannot be corrected by the provider; e.g., CMS advises that the provider received a payment from another state for the same program year).

If MQD determines, upon final review, that a provider to be ineligible the application is considered under an informal reconsideration and review. A MQD panel completes the reconsideration. The reconsideration panel includes the initial reviewer; a provider relations representative and program integrity staff person. The staff responsible for the preliminary decision to deny will present the reason for recommended denial to the panel and the panel will complete the reconsideration. In the event the panel determines to uphold the preliminary decision to deny, the application is sent to the Medicaid Director for a final decision. The Medicaid Director will approve the denial or ask the panel to reconsider its decision. When a denial occurs, MQD sends a certified letter to the provider indicating the reason for denial and outlining the provider appeal rights.

### **5.3. Identification of Suspected Fraud and Abuse**

*Describe the methods the SMA will employ to identify suspected fraud and abuse. 2. 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.1*

The following sections describe the methods for post-payment audits. HI MQD is in the process of procuring a post-payment auditor to conduct post-payment audits and will update this section once an auditor has been contracted.

#### **5.3.1. Risk Categories and Identifiers for Post Payment**

HI MQD staff will complete a risk assessment process designed to identify those EPs and EHs who pose the highest risk. At the completion of the risk assessment process, HI MQD staff will create Risk Categories and their associated risk identifiers. Risk identifiers are identifiable characteristics used to categorize a provider into a particular risk category. Risk Categories and their associated risk identifiers are a fundamental part of the post payment review process. These are needed in order to establish which providers to review and what percentage of providers to review.

#### **EP Risk Categories**

The risk category to which a provider is assigned will be determined by the highest (riskiest) identifier associated with the provider. The risk categories, identifiers, and review thresholds for EPs are outlined below.

#### **Low Risk:**



- Medicaid or Needy Individual encounters reported are within 15% of State data claims data figure; or
- Medicaid patient volume greater than or equal to 40% (use provider's attested numbers).

Review Threshold: 2 to 5% of EPs assigned to this category will be subject to review.

**Medium Risk:**

- Medicaid or Needy Individual encounters reported are within 30% of State data claims data figure;
- Medicaid patient volume less than 40% (use provider's attested numbers);
- Pediatricians qualifying with patient volume threshold less than 25%;
- Provider not enrolled and participating in the Medicaid Program prior to January 1, 2011 (both group and individuals methodology);
- Attested numerator outside of 75% of average numerator (above or below).

Review Threshold: 6 to 10% of EPs assigned to this category will be subject to review.

**High Risk:**

- Multiple attestation submissions within the payment year;
- Three or more medium risk identifiers;
- Attested Numerator value less than 100 encounters; or
- Adverse audit outcome by OIG or Program Integrity.

Review Threshold: 20 to 50% of EPs assigned to this category will be subject to review.

**EH Risk Categories**

The risk category to which a provider is assigned will be determined by the highest (riskiest) identifier associated with the provider. The risk categories, identifiers, and review thresholds for EHs are outlined below.

**Low Risk:**

- Medicaid patient volume information reported by the hospital is within 5% of State data claims data figure:
  - Uses reported patient volume numerator from selected 90-day reporting period; and
  - Uses Medicaid data warehouse claims number for the same 90-day period; or
- Medicaid patient volume information as determined by the hospital calculator and attestation is greater than 15%, as reported on the cost report:
  - Uses 12-month Medicaid cost report figures to calculate Medicaid patient volume based on non-HMO inpatient days.

Review Threshold: 5 to 25% of the EHs that are assigned to this category will be subject to review.



**Medium Risk:**

- Medicaid patient volume information reported by the hospital are outside 5% of State data warehouse claims data figure:
  - Uses reported patient volume numerator from selected 90-day reporting period; and
  - Uses Medicaid data warehouse claims number for the same 90-day period; or
- Medicaid patient volume is less than 15%, as reported on the cost report:
  - Uses 12-month Medicaid cost report figures to calculate Medicaid utilization based on non-HMO inpatient days.

Review Threshold: 25 to 50% of the EHs that are assigned to this category will be subject to review.

**High Risk:**

- Less than four (4) years of data to calculate the growth factor in the incentive payment calculations;
- Adverse audit outcome by OIG, Program Integrity, or CMS (Medicare EHR Incentive Program) within the past 3 years from the date of attestation; or
- Largest incentive payments received (greater than or equal to \$3 million).

Review Threshold: Up to 100% of the EHs that are assigned to this category will be subject to review.

Based on the results of the audits during the initial 90 days of audits, MQD may make adjustments to the risk identifiers, risk categories, and the percentage of providers to audit. The flexibility to make adjustments to the EP and EH audit strategies will be an important part of the EHR audit program.

Selection for AIU and MU audits will utilize the same risk categories, risk identifiers, and random sampling percentages. Adjustments may also need to be made to the identifiers once more is learned as to which attestation measures are indicative of increased risk.

### **5.3.2. Audit Planning Procedures**

All EHs and EPs will be candidates for post-payment audits. Post payment audit candidates will be decided using the risk assessment process detailed above. Post-payment audits will be conducted as desk and/or onsite reviews.

The purpose of Adopt/Implement/Upgrade (AIU) review is to:

- Obtain documentation supporting eligibility assertions made by EPs and EHs and/or view or run reports that support patient volume (if conducting an onsite visit); and
- Obtain documentation showing proof of certified EHR technology and/or witness the certified EHR technology if conducting an onsite visit.

The purpose of Meaning Use (MU) reviews is to:





- Obtain documentation supporting eligibility assertions made by EPs and EHs and/or view or run reports that support patient volume (if conducting an onsite visit); and
- Obtain documentation, view reports and/or run reports during onsite visit, which provide reasonable assurance that EPs “meaningfully used” certified EHR technology.

HI MQD staff will use standardized tools to capture all general elements of the review as well as those elements specific to AIU and MU reviews. Table 5-1 provides the payment audit verification elements.

**Table 5-1: Payment Audit Verification Elements**

Payment Validation:	EPs	EHs
1. The correct amount was paid for the payment year, as stated in CMS’s Final Rule	✓	✓
2. The payment amount was made to the correct NPI, as stated in the attestation record	✓	✓
3. The provider was paid \$21,250 for the initial year and \$8,500 for the 5 remaining payment years unless the EP is a Pediatrician attesting to less than 30% Medicaid patient volume	✓	
4. The pediatrician was paid \$14,167 for the initial year and \$5,667 for the 5 remaining payment years if the provider met the less than 30% but greater than 20% patient volume threshold	✓	
5. The provider payments did not exceed the maximum incentive payment allowed of \$63,750 or \$42,500 for Pediatricians with a Medicaid or Needy Individual patient volume of less than 30% but greater than 20%	✓	
6. No provider was paid more than once in a payment year	✓	✓

### 5.3.3. Desk and Onsite Audits

AIU & Meaningful Use Audits:

- **Pass or Fail** – all audits will receive either a “pass,” indicating the provider has successfully met the necessary AIU or MU requirements reviewed in the audit, or “fail,” indicating that some requirements reviewed were not met.
- **AIU Audits** – desk audits will be utilized as the first level of an audit for all providers. If a provider “fails” a desk audit or an auditor deems it necessary, an onsite audit may be conducted (i.e., a provider sends in documentation verifying patient volume threshold, but the documentation does not appear to be an EHR report).
- **Meaningful Use Audits** – onsite audits will be utilized as the primary means of MU audits. At such time that desk audits are deemed appropriate for MU audits, they will be conducted; i.e., Meaningful Use measures will be best verified by running or viewing reports from the provider’s certified EHR technology.



## **Desk Audit**

The auditor will have a number of options when conducting a desk audit:

- Issue Pass or Fail;
- Request additional information; or
- Initiate an onsite audit to further clarify or validate AIU or MU requirements.
  - In the event a provider does not provide additional information as requested within 10 days, HI MQD will consider the audit as failed and either initiate an onsite audit or proceed to recoup payments made.

Audit candidates will be required to provide documentation used in the preparation of AIU or Meaningful Use attestation to substantiate compliance. Documents may be as simple as proof of possession of certified EHR technology, or it may include detailed reports supporting AIU or Meaningful Use.

## **Onsite Audit**

Onsite audits may include a demonstration of the certified EHR system verifying the EHR technology is in use and is what was attested to; a review of source material, proving patient volume threshold numbers; a review of material, proving AIU or Meaningful Use; and/or running reports that substantiate compliance.

## **Desk Audit Procedures**

- 1) Generate a list of providers to audit and gather background information for each provider including:
  - Risk Category;
  - Risk Identifiers met;
  - Background information from the Medicaid provider file (e.g. previous audit outcome(s), money owned, etc.); and
  - Attested information.
- 2) Send a certified form letter to the provider notifying him/her of the audit and how to comply.
  - Follow up with provider for re-request of information if not received within 10 business days.
- 3) Process/document/store information received from provider.
- 4) Audit information for proof of patient volume threshold and AIU or MU:
  - Potentially follow up with provider to clarify or obtain additional information as needed.
- 5) Document/track audit results (pass/fail and comments).
  - Send a certified form letter notifying the provider of the results of the audit.



- If the provider documentation raises concern, initiate onsite audit (send a certified form letter to provider). If conducting field audit as a result of unsatisfactory information during a desk audit, follow Onsite Audit Procedures below starting with step 2.

### Onsite Audit Procedures

- 1) Generate a list of providers to audit and gather background information for each provider including:
  - Risk Category;
  - Risk Identifiers met;
  - Background information from the Medicaid provider file (e.g. previous audit outcome(s), money owned etc.); and
  - Attested information.
- 2) Send a certified form letter to provider notifying him/her of the audit, how to comply and date/time of when onsite audit will take place.
- 3) Visit site and verify:
  - If AIU, information found unsatisfactory in desk audit.
  - If MU:
    - Provider information used in the attestation process: name, tax id, NPI, address;
    - Certified EHR technology is in use;
    - Medicaid or Needy Individual patient volume (numerator) - run report and/or review documentation;
    - Total patient volume (denominator) - run report and/or review documentation;
    - A sample of Meaningful Use measures are the same as what was attested - run report and/or review documentation;
    - A sample of clinical quality measures are the same as what was attested - run report and/or review documentation; and
    - EHR transaction history confirming exchange of clinical information.
- 4) Document/Track audit results (pass/fail and comments).
  - Send a certified form letter notifying the provider of the results of the audit.

## 5.4. 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.2*

HI MQD will use the current MMIS reporting tools to track and monitor overpayments. The contracted fiscal agent has responsibility for the Hawai'i Medicaid provider payments and uses its payment cycle process to assure payments are made correctly. The contracted fiscal agent will follow its regular payment process, credit balance recovery process and workflows.



## 5.5. Actions Taken When Fraud and Abuse Is Detected

*Describe the actions the SMA will take when fraud and abuse is detected. Source: CMS SMHP Template Question D.3*

Once MQD determines that a provider was improperly paid an EHR incentive payment, it will follow its standard recoupment process currently in place. The initial notification of improper payment will include instructions for the provider to submit payment to repay the improperly paid funds. If payment is not received within the designated time period, the MMIS payment system will be requested to withhold future Medicaid payments to the provider to offset any funds owed by the provider in question.

Fraud and abuse prevention includes previously described pre-payment verification and audit activities with additional investigation that starts at the conclusion of the initial pre and post-payment audit processes. When MQD Investigator determines that there is an issue related to payment that is more than a provider's mistake or error then the provider is referred to the Attorney General's Medicaid Fraud Control Unit (MFCU) for investigation. The MFCU has specific authority to investigate and prosecute Medicaid fraud and abuse using search warrants and administrative document request. The MFCU may determine settlements, obtain judgments and convictions and recover criminal and civil restitution, fines, penalties and costs.

## 5.6. 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.4*

Yes. MQD plans to leverage existing data sources in conjunction with the required documentation for MU attestations. Initial data sources are the MMIS, providers' accounting/billing systems, and Hawai'i Medicaid cost reports. In accordance with CMS FAQ 10771, for hospitals filing the 2552-96 cost report, the authorized data sources are total discharges, Medicaid days, Medicaid HMO days, total inpatient days, total hospital charges, and charity care charges. For hospitals filing the 2552-10 cost report, the authorized data sources are total discharges, Medical days, total inpatient days, total charges, and charity care charges. Additional data sources include on-site and desk audits of provider EHR systems. Providers will be required to provide reports published from the EHR system.

## 5.7. 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.5*

Yes. See desk and onsite audit section for sampling methodology.

## 5.8. 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.6*



The State of Hawai'i conducts program integrity and provider oversight following regulatory requirements and guidance from CMS. The oversight of the EHR incentive payments will follow standard audit procedures as outlined in this Audit Strategy, and do not believe this process will increase provider burden. The Audit Strategy places the majority of the work on MQD and seeks to limit the burden on the provider to the extent possible. Efforts to reduce provider burden include utilizing existing data sources and information prior to requesting data from EPs and EHs and requesting additional data only as a last resort to verify/validate numerators to which the provider has attested.

## **5.9. 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*

Under the direction of the Division Administrator, the Finance Office coordinates, manages and administers the Division's fiscal, procurement, financial integrity activities, payment error rate measurement (PERM) activities and budget activities for the Department's continuum of quality health care and health insurance programs including preventive services, acute care services, primary care services and long-term care services. The Finance Office serves as the Division's principal staff resource on fiscal activities and serves as the Division's representative, liaison, and coordinator in fiscal and financial matters. The Finance Office develops, implements, and maintains standard accounting procedures in accordance with State and Federal accounting policies and procedures.



## 6. HIT ROADMAP

### 6.1. HI 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**

MQD plans to move from the current, As-Is environment to the To-Be environment through various activities over the next several years. MQD will initially focus on the adoption of certified EHR systems by providers, as well as upgrading and implementing new technologies to support meaningful use (MU), and supporting the exchange of clinical data in Hawai'i.

MQD has deployed the HI SLR, and will focus on continued collaboration with the HHIE and the HPREC. MQD supported provider outreach, training, and education will foster the adoption of certified EHR systems by providers, with a focus on MU.

By implementing new technologies, in collaboration with the State OIMT, MQD will be able to organize, store, and analyze clinical data, including clinical data for Medicaid beneficiaries. By also deploying the interoperability and connectivity needed to exchange and retrieve this clinical information (including in collaboration with HHIE, other Pacific HIEs, other State Agencies, and other stakeholders), a more timely access to clinical data will be available to MQD and Medicaid providers, thereby improving the quality and coordination of care in Hawai'i and in the Pacific.

#### 6.1.1. Medicaid Mandates

MQD has conducted a MITA 3.0 State Self-Assessment (SSA), to document the business needs and direction for the future of the MMIS. MQD will use the MITA 3.0 SSA to make the appropriate decisions as to the next phase of the HPMMIS and overall MMIS strategy. MQD has procured the HI SLR to shorten the implementation time for the EHR Incentive Payment Program and support those providers seeking to qualify for MU. MQD will continue to collaborate with the HHIE and the HPREC, and focus on provider outreach, training, and education to foster the adoption of certified EHR systems.

#### 6.1.2. Current Initiatives Planned and/or Executing

Beyond the aforementioned SSA and implementation of the EHR Incentive Program, MQD is coordinating with the State OIMT to ensure all technologies acquired and implemented not only accomplish MQD goals and directives, but also are in coordination with State programs and the overall vision for the State (including SOA-based platforms, MITA compliancy, etc.).

The planned clinical data repository, associated eMPI, related interfaces to key stakeholders, coordination with the HHIE, the Department of Health, the Department of Public Safety, Corrections Division (note: Corrections Division has deployed a certified EHR at this time), and integration of the MQD ESB with the OIMT ESB and overall infrastructure will allow for a coordinated IT infrastructure for both MQD and the State (including OIMT). This careful coordination of technologies and resources will ensure that there is not a duplication of effort between MQD and OIMT, and that stakeholders who can benefit from the interoperability of clinical data have access to said data.



### **6.1.3. HIT/E Activities**

MQD will continue to work with stakeholders to ensure their partnership, participation, and integration into active programs and systems development, including directly supporting the adoption of certified EHR systems in Hawai'i. MQD will continue coordination with OIMT to allow for a completely integrated process of deploying key HIT technologies such as the MQD clinical data repository, ESB, eMPI and other systems, integration of critical trading partners and data such as laboratories and laboratory data, and integration to support other state agencies. Further planning and discussions are ongoing with these stakeholders and OIMT to ensure a coordinated approach and a non-duplication of effort and systems.

MQD will utilize the jointly developed MQD - OIMT infrastructure to support data exchange and interoperability with other HIEs and federal agencies, including potentially supporting the Department of Defense (DoD) and the Veterans Administration (VA), two key stakeholders in the State healthcare community. Support for interoperability with other Pacific HIEs and the California HIE are under consideration.

MQD has identified major activities, beginning in Fiscal Year 2014, to accomplish the goals and objectives outlined in the SMHP and IAPD. Key Activities and Milestones by Fiscal Year are detailed in Table 6-1: HIT/HIE Roadmap.





Table 6-1: HIT/HIE Roadmap

State of Hawaii MQD Roadmap Timeline in Hawaii (State) Fiscal Years	2013 FY		2014 FY				2015 FY				2016 FY				2017 FY			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
<b>System Procurement, Project, or Implementation</b>																		
Submit SMHP, IAPD to CMS and Receive Approval																		
Complete MQD SLR RFP																		
Procure and implement MQD SLR																		
Begin planning on migration to To-Be infrastructure following Roadmap																		
Finalize HIE IAPD, submit to CMS and Receive Approval																		
Begin staffing planning for MQD including consulting and PMO, per IAPD																		
Coordinate MQD infrastructure, deployments, and staffing with State OIMT																		
Accept and approve AIU payments for providers																		
Accept and approve MU payments for providers																		
Procure consulting services and staffing for MQD, including PMO and IV&V																		
Implement PMO for MQD Procurements and IV&V																		
Procure and implement MQD ESB																		
Procure and implement MQD Clinical Data Warehouse																		
Procure and implement eMPI																		
Integration of MQD infrastructure with OIMT infrastructure, infrastructure coordination																		
Implement interfaces to HHIE to support clinical data exchange with MQD Warehouse																		
Interface/integration to MQD MMIS/MES for clinical/administrative data support																		
Interface/integration to the Department of Health for clinical data exchange																		
Refresh of deployed hardware, in coordination with OIMT																		
Interface/integration to federal agencies in coordination with HHIE																		
Interface/integration to other Pacific HIEs and California HIE, in coordination with HHIE																		



## 6.2. 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*

MQD estimates that a total of 1,450 EPs will be eligible for incentive payments throughout the course of the program, and 36% of all EPs are anticipated to request and receive incentive payments in the first year of the program for A/I/U. For the first year of the program, Hawai'i has had 278 submissions applications and has processed 220 payments. As HIT initiatives continue to gain momentum in Hawai'i, and more providers adopt certified EHR systems, MQD expects that nearly the entire eligible population will apply for, and receive, incentives by 2016. Specific annual benchmarks by provider type are broken down in tabular format below (see Table 6-2: Annual A/I/U Attestation Benchmarks by Eligible Provider Types). MQD makes the following assumptions in determining the A/I/U Benchmarks:

- The adoption benchmarks are estimated by calendar year (CY); and
- Approximately 15% of all EPs in Hawai'i are estimated to have previously attested to MU through the Medicare EHR Incentive Program and therefore will no longer qualify for A/I/U incentive payments.

**Table 6-2: Annual A/I/U Attestation Benchmarks by Eligible Provider Type**

Provider Type	CY 2013	CY 2014	CY 2015	CY 2016	Total
Eligible Professionals	540	230	230	230	1230 (85%)
Eligible Hospitals	9	3	0	0	12 (85%)
Critical Access Hospitals	6	2	0	0	8 (85%)

MQD has found, as expected, that eligible hospitals and critical access hospitals will be more knowledgeable about the program and therefore have a higher rate of participation up-front than EPs. However, MQD continues to expect that EHs and critical access hospitals will be in Stage 2 of MU; and therefore will have already adopted certified EHR systems.

Adoption rates and MU attestation forecasts will be included in subsequent SMHP updates, as necessary.

## 6.3. 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*

Performance measures of the Medicaid EHR Incentive Program include:

- Successful A/I/U attestations;



- Successful MU attestations;
- Number/type of providers' successfully paid; and
- Total dollar amount of incentives paid.

MQD estimates that a total of 1,450 EPs and 23 EHs are eligible to apply for and receive Hawai'i Medicaid EHR Incentive Program payments. By 2016, it is expected that nearly 100% of those eligible providers will have attested to either A/I/U and/or MU.

#### **6.3.1. A/I/U Attestations**

MQD has measured Medicaid EHR Incentive Program success in the first year through completed A/I/U attestations. Specific MQD goals for A/I/U attestations for program year 2013-2016 can be found in Table 6-2: Annual A/I/U Attestation Benchmarks by Eligible Provider Type. As of July 10, 2014, MQD has received A/I/U submissions from 2 EHs and 150 EPs for EHR Incentive Payments through the attestation process.

#### **6.3.2. Meaningful Use Attestations**

Based on experiences shared by another state, MQD assumes that 15% of all eligible providers in Hawai'i will have previously attested to MU of certified EHR systems under the Medicare EHR Incentive Program. Given that providers that have previously attested to MU are no longer eligible to attest for A/I/U, the measures of success for first-time MU attestations to the Hawai'i Medicaid EHR Incentive Program are outlined below in Table 6-3: Annual MU Attestation Benchmarks by Eligible Provider Type. MQD expects that the eligible hospitals and critical access hospitals will attest to MU as soon as possible given that Medicare reimbursement penalties go into effect in federal fiscal year 2015 for dual-eligible hospitals and eligible professionals receiving Medicare reimbursements. As of July 10, 2014, MQD has received MU submissions from 7 EHs and 22 EPs for EHR Incentive Payments through the attestation process.

**Table 6-3: Annual MU Attestation Benchmarks by Eligible Provider Type**

Provider Type	CY 2013	CY 2014	CY 2015	CY 2016	Total
Eligible Professionals	0	120	100	0	220 (15%)
Eligible Hospitals	2	0	0	0	2 (15%)
Critical Access Hospitals	1	0	0	0	1 (15%)

#### **6.3.3. Number/Types of Providers Successfully Paid**

MQD will report on a quarterly basis the number and types of providers that have been successfully paid for either A/I/U or MU on MQD's Medicaid EHR Incentive Program website. Subsequent SMHP updates will also contain metrics around number/types of providers successfully paid by program year.



#### 6.3.4. Total Dollar Amount of Incentives Paid

MQD will report on a quarterly basis the total incentive paid out for either A/I/U or MU on MQD's Medicaid EHR Incentive Program website. Subsequent updates will also contain metrics around total incentives paid out by program year.

### 6.4. Audit and Oversight Benchmarks

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

As described in the Audit Strategy section of the SMHP, MQD plans to have a robust pre-payment verification process to mitigate risk of fraud and abuse. All attestations will be subject to numerous pre-payment, automated and manual verifications. Once approved, all attestations will also be subject to a post-payment risk assessment and, based upon results, will be placed in risk strata for selection of post-payment audit.

Using the Hawai'i SMHP Audit Strategy as a guide for setting audit and oversight metrics, MQD has determined that 100% of attestations will undergo rigorous pre-payment verifications and 100% of approved attestations will undergo a post-payment risk assessment for audit selection. For more detail regarding pre-payment verification procedures and risk assessment criteria, please refer to Section 5 – Audit Strategy. MQD plans to procure an EHR Incentive Payment Program auditor in calendar year 2014. MQD will audit AIU and MU beginning in 2015.

#### 6.4.1. Audit Benchmarks

MQD has determined that exact numbers of post-payment audit benchmarks will be determined by the provider population and their resulting risk stratum assignment. Specific audit benchmarks (broken down by percentages of risk strata population) are outlined in Table 6-4: Post-Payment Audit Benchmarks by Provider Type. As noted above, 100% of providers will be subject to a risk assessment, followed by placement into one of the following risk strata: low, medium or high. A percentage of providers within each risk stratum will then be randomly chosen for post-payment audit as noted in Table 6.4. The risk strata criteria can be found in Section 5.3 – Risk Categories and Identifiers for Post-Payment.

As outlined in Table 6.4, regardless of a provider's risk stratum assignment, the attestation type (i.e. A/I/U versus MU) determines whether the provider will undergo a desk or onsite audit. A provider attesting to A/I/U will be subject to a desk audit 100% of the time. In the case that a provider "fails" an A/I/U desk audit, the provider will automatically become subject to an onsite audit. Providers attesting to MU will automatically become subject to an onsite audit, unless a desk audit is deemed sufficient on a case-by-case basis.

**Table 6-4: Post-Payment Audit Benchmarks by Provider Type**

Provider Type	Risk: Low	Risk: Medium	Risk: High	Desk	Onsite
Eligible Professional	2-5% *	6-10% *	20-50%	100% A/I/U	100% MU & "Failed" A/I/U
Eligible Hospital	5-25% *	25-50%	100% *		

\*Percentage of providers within strata population that will be selected for post-payment audit.



## **Appendix A – EH Payment Calculation Worksheet**

The overall EHR incentive payment amount is based upon the sum of four years payment. The payment amount for each year is the product of three factors:

- An Initial Amount;
- The Medicaid Share; and
- A Transition Factor applicable to each of the four years.

The initial amount includes a base amount of \$2,000,000 and a discharge-related amount, which provides an additional \$200 for estimated discharges between 1,150 and 23,000 discharges. For the first payment year, data on hospital discharges from the most recent continuous 12 month period for which data are available prior to the payment year must be used as the basis for determining the discharge-related amount. To determine the discharge-related amount for the three subsequent payment years used to calculate the overall EHR amount, the number of discharges will be based on the average annual growth rate for the hospital over the most recent three years of available data.

The steps below detail the how the overall EHR incentive payment is calculated by applying the initial amount, the Medicaid share, and the transition factor. The numbers used do not represent the actual hospital discharges and incentive payments of the State of Hawai'i, and are used solely for the purpose of demonstrating how EHR incentive payments for EHs are calculated.

### **Step 1 – Calculate Growth Rate**

The annual growth rate applied to the subsequent three years is calculated by taking the average of the most three years of discharges demonstrated in Figure 1.



**Figure 1: Growth Rate Calculation**

	Total Discharges (Source: Medicare Cost Report Worksheet S-3, Part I, col. 15, line 14)		Previous Year		Difference		Previous Year		Percent Change		Years of Data		Average Growth Rate
Base Federal Fiscal (FF) Year	17,500	-	17,000	=	500	÷	17,000	=	0.029				
1st Previous FF Year	17,000	-	16,500	=	500	÷	16,500	=	0.030				
2nd Previous FF Year	16,500	-	16,000	=	500	÷	16,000	=	0.031				
3rd Previous FF Year	16,000								0.091	÷	3	=	<b>3.03%</b>

## Step 2 – Calculate Initial Payments

The initial payments are calculated by applying the average growth rate (3.03%) to the total discharges of the current year and subsequent years in order to get the adjusted discharges. For each discharge between 1,150 and 23,000, the discharge rate is added to the base amount. This amount is then get multiplied by a prorated amount of 75% in year 2, 50% in year 3, and 24% in year 4 to account for the yearly and overall initial EHR payment, as demonstrated in Figure 2.



**Figure 2: Initial Payment Calculation**

	Total Discharges		Average Growth Rate		Adjusted Discharges		Allowed Discharges (max=21,851)		Discharges Rate		Discharge Cost		Base Amount		Transition Factor		Initial EHR Payment
Year 1 (Base Year)	17,500	+	0	=	17,500		16,350	×	\$200	=	\$3,270,000	+	\$2,000,000	×	1	=	\$5,270,000
Year 2	17,500	+	3.03%	=	18,031		16,881	×	\$200	=	\$3,376,126	+	\$2,000,000	×	0.75	=	\$4,032,094
Year 3	18,031	+	3.03%	=	18,577		17,427	×	\$200	=	\$3,485,469	+	\$2,000,000	×	0.50	=	\$2,742,735
Year 4	18,577	+	3.03%	=	19,141		17,991	×	\$200	=	\$3,598,128	+	\$2,000,000	×	0.25	=	\$1,399,532
<b>Note:</b> There is no discharge allowance for discharges less than 1,150 and more than 23,000 (23,000 - 1,149 = 21,851).													<b>Overall EHR Amount: \$13,444,360.75</b>				

### Step 3 – Calculate Medicaid Share

Once the overall EHR amount is calculated, the Medicaid share is determined as demonstrated in Figure 3.

**Figure 3: Medicaid Share Calculation**

	Total Charges		Charity Care Charges		Total Charges		% of Noncharity Charges		Total Inpatient Days		Adjusted Inpatient Days		Medicaid Inpatient Days FFS		Medicaid Inpatient Days MC		Adjusted Inpatient Days		Medicaid Share
	(Source: Medicare Cost Report Worksheet C, Part I, col. 8, line 200)		(Source: Medicare Cost Report Worksheet S-10, col. 3, line 20)						(Source: Medicare Cost Report Worksheet S-3 part I, col. 8, line 1, 2 + lines 8-12)				(Worksheet S-3 part I, col. 7, line 1 + lines 8-12)		(Source: Medicare Cost Report Worksheet S-3 part I, col. 7, line 2)				
Base Yr	\$5,000,000.00	-	\$1,000,000.00	÷	\$5,000,000	=	0.80	×	50,000	=	40,000		1,750	+	1,350	÷	40,000	=	7.75%

### Step 4 – Calculate the Aggregate Amount

The Medicaid share is then applied to the overall EHR amount to get the aggregate EHR amount, as demonstrated in Figure 4.





Figure 4: Aggregate EHR Amount Calculation

	Overall EHR Amount		Medicaid Share		Aggregate EHR Amount
Base Yr	\$13,444,361	×	7.75%	=	<b>\$1,041,937.96</b>

### Step 5 – Apply HI Hospital Incentive Payout Schedule

The final step is to apply the HI payout percentage established in the SMHP to the aggregate EHR incentive payment amount in order to get the annual incentive payment, as demonstrated in Figure 5.

Figure 5: Incentive Payment Payout Schedule

	Aggregate EHR Amount		Payout Percentage		Annual Incentive Payment
Year 1	\$1,041,938	×	50%	=	<b>\$520,968.98</b>
Year 2	\$1,041,938	×	40%	=	<b>\$416,775.18</b>
Year 3	\$1,041,938	×	10%	=	<b>\$104,193.80</b>
					<b>\$1,041,937.96</b>