Medicaid and CHIP
Health Information Technology
Stakeholder Feedback Forum

August 3, 2010
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morning Session:</strong></td>
<td></td>
</tr>
<tr>
<td>7:30 - 8:30</td>
<td>Registration (in atrium)</td>
</tr>
<tr>
<td>8:30 - 9:30</td>
<td><strong>Plenary Session:</strong></td>
</tr>
<tr>
<td></td>
<td>• Welcome</td>
</tr>
<tr>
<td></td>
<td>• Overview of Medicaid Electronic Health Record (EHR) Incentive Program</td>
</tr>
<tr>
<td>9:45 - 11:30</td>
<td>Breakout Feedback Session</td>
</tr>
<tr>
<td><strong>Afternoon Session:</strong></td>
<td></td>
</tr>
<tr>
<td>12:00 - 1:00</td>
<td>Registration (in atrium)</td>
</tr>
<tr>
<td>1:00 - 2:00</td>
<td><strong>Plenary Session:</strong></td>
</tr>
<tr>
<td></td>
<td>• Welcome</td>
</tr>
<tr>
<td></td>
<td>• Overview of Medicaid Electronic Health Record (EHR) Incentive Program</td>
</tr>
<tr>
<td>2:15 - 4:00</td>
<td>Breakout Feedback Session</td>
</tr>
</tbody>
</table>
American Recovery and Reinvestment Act

**HIT GOALS**
1. Improve individual & population health outcomes
2. Increase transparency & efficiency
3. Improve ability to study & advance care delivery

---

**Health Information Technology for Economic & Clinical Health (HITECH)**

**HEALTH INFORMATION TECHNOLOGY**
Title XIII
Office of National Coordinator for HIT
($2 billion)

**MEDICARE & MEDICAID HEALTH INFORMATION TECHNOLOGY**
Title VI
Centers for Medicare & Medicaid Services
($36 – 46 billion)

---

**Adoption of EHRs**
- Regional Extension Centers
- Workforce Training

**Exchange of Health Information**
- State Level Health Information Exchange
- Standards & Certification Framework
- Privacy & Security Framework

**Research to Enhance HIT**
- Beacon Communities
- SHARP Research

**Meaningful Use of EHRs**
- Medicare EHR Incentive Program
- Medicaid EHR Incentive Program
Federal Health IT Regulatory Activity

• Electronic Prescribing of Controlled Substances Interim Final Rule
  • Allows the option of e-prescribing controlled substances with the use of two of the following authenticating factors: password, token, or biometric – published March 31, 2010

• Medicare and Medicaid EHR Incentive Program Final Rule
  • Establishes EHR Incentive Program requirements, including criteria for provider eligibility, payment methodologies, meaningful use, and program oversight – published July 13, 2010

• Standards and Certification for EHR Final Rule
  • Establishes the capabilities, standards, and implementation specifications for certified EHR technology to support meaningful use. The Office of the National Coordinator (ONC) for Health Information Technology is accepting applications for authorized testing and certification bodies under a temporary certification program – published July 13, 2010

• Proposed Rule Change to HIPAA
  • Expands rights and restricts certain types of disclosures; requires business associates to be under same rules as the covered entities; sets limitations on the use health information for marketing and fundraising; and prohibits the sale of protected health information – posted for comment July 14, 2010
Statewide Health Information Exchange (HIE) Plan
Statewide HIE Plan

Background

- Funding authority from the American Recovery and Reinvestment Act (ARRA), Section 3013 for planning and implementation grants to states or qualified state-designated entities to facilitate and expand HIE.

- Grant opportunity with ONC.

- Coordinated effort between HHSC’s Office of e-Health Coordination and Texas Health Services Authority.
Statewide HIE Plan Timeline

- February 2009 – ARRA passed.
- October 2009 – Texas application submitted.
- March 2010 – Texas award of $28.8 million over four years announcement released.
- August 2, 2010 – Draft Texas HIE plans published for public comment.
- August 16, 2010 – Comments due.
- September 1, 2010 – Final target submission date for plans.
Statewide HIE Plan

Collaborative Planning Process

• Workgroups
  • Governance and Finance
  • Technical Infrastructure
  • Privacy and Security
  • EHR Adoption and Consumer Engagement

• Strategic and Operational Plans
  • Environmental Scan
  • Governance
  • Finance
  • Business and Technical Operations
  • Policy and Legal
Texas Health Information Technology Regional Extension Centers

Four Texas Regional Extension Centers ready to provide support services to Primary Care Practitioners

Please visit for more information on the Texas Regional Extension Centers:
http://www.txrecs.org/
Four Centers Available to you:

- **CentrEast Regional Extension Center**
  - Contact: Teneka Duke
  - Program Manager
  - 979-862-5001
  - [http://centreastrec.org](http://centreastrec.org)

- **Gulf Coast HITECH Extension Center**
  - Contact: Pamela Salyer
  - Program Director
  - [http://www.uthouston.edu/gcrec](http://www.uthouston.edu/gcrec)

- **North Texas Regional Extension Center**
  - Contact: Mike Alverson
  - Director
  - 972-717-4279
  - [http://www.ntrec.org](http://www.ntrec.org)

- **West Texas Health Information Technology Regional Extension Center**
  - Contact: Susan McBride
  - Founding Director
  - 806-743-1338
  - [http://WTxHITREC.org](http://WTxHITREC.org)
Support Services Provided by the Texas Regional Extension Centers

Support Services for:

- EHR Implementation
- Education and Training
- Project Management
- Incentives
- Meaningful Use
The Texas RECs Commitment

HITREC Supports PCPs in Getting to Meaningful Use

Clinical Viewer

GATEWAY

HIE

GATEWAY

Laboratory

HIS

CIS

LIS

RAD

Physician's Practice

EMR

EMR

Clinical Viewer

Clinical Viewer

Clinical Viewer
State Medicaid Health Information Technology Plan (SMHP) and EHR Incentive Program
EHR Incentive Program and Meaningful Use

- Final federal rules on the EHR Incentive Program—including meaningful use (MU) criteria—released July 13, 2010

- An eligible provider and hospital will be considered a meaningful EHR user if they meet the following three requirements:
  1. Demonstrates the use of certified EHR technology in a meaningful manner.
  2. Demonstrates that certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of health care.
  3. Using its certified EHR, submits information on clinical quality measures and other measures as specified.

- MU criteria to be defined in stages:
  - Stage 1 criteria in current proposed rule.
  - Stage 2 criteria to be defined in 2013.
  - Stage 3 criteria in 2015.
State Medicaid Health Information Technology Plan

• The SMHP provides a common understanding of the activities that Medicaid will be engaged in over the next five years relative to implementing Section 4201 of ARRA.

• CMS is interested in how Medicaid plans to:
  • Make provider incentive payments.
  • Monitor the payments.
  • Coordinate with the Statewide HIE planning initiative and Regional Extension Centers (RECs) supported by ONC.
  • Integrate other Medicaid HIT projects and initiatives.

• CMS expects annual and as-needed updates to keep it informed as the SMHP evolves.
Medicaid serves a population of approximately 3.6 million unique clients per year and an average of 2.7 million in any given month.

The percentage of Medicaid clients in managed care was 71 percent in 2008.

Medicaid accounted for 25 percent of the appropriated Texas budget for the 2006-2007 biennium.

29 percent of Medicaid budget spent on children in 2007.

$21 billion (all funds) spent for Medicaid in federal fiscal year 2007.

$1.9 billion in total Medicaid payments (all funds) to nursing homes in federal fiscal year 2007.

$2.1 billion in total Medicaid payments made to hospitals in federal fiscal year 2007 (excluding disproportionate share hospital [DSH] and upper payment limit payments).
As Is Landscape

- Conduct an environmental scan and assessment of current practitioner and hospital EHR capabilities.
- Consider federally qualified health center (FQHC), rural health clinic (RHC), Veterans Administration and Indian Health Service clinical facilities with EHR capabilities; describe any health IT funding.
- Describe role of Medicaid Management Information Systems (MMIS) in current health IT environment.
- Assess and describe broadband internet access, including grants.
- Explain Medicaid’s relationship with Statewide HIE planning initiative and RECs supported by ONC and other programs.
- Describe the interoperability status of the state’s immunization registry and public health surveillance reporting database(s).
- Describe any activities that will encourage adoption of EHRs; consider health care service access that crosses state borders.
As Is Landscape

- Medicaid is conducting a survey, in coordination with the statewide HIE and the four Health IT RECs, directed to hospitals and all providers in the eligible professional category.

- Surveys will be used:
  - To meet program planning requirements.
  - As a benchmark for program evaluations.

- Surveys disseminated in early July 2010 with preliminary results and analysis in August 2010.

- Medicaid is seeking the support of committee members and professional associations to encourage completion of the survey.
# To Be Landscape
## New Capabilities

<table>
<thead>
<tr>
<th>System</th>
<th>Description</th>
</tr>
</thead>
</table>
| Medicaid Eligibility and Health Information Services (MEHIS) | • will replace the current paper Medicaid identification form with a permanent plastic card  
• automate eligibility verification  
• provide a claims-based EHR for Medicaid clients  
• offer an e-prescribing tool  
• establish a foundation for future HIE  
• target implementation is May 2011 |
| Medicaid electronic prescribing (e-Rx)           | • designed to get Medicaid formularies and medication history into e-prescribing programs  
• support meaningful use objective of information exchange |
| Medicaid HIE Pilot                               | • will exchange medication history data with regional health information exchange organizations          |
To Be Landscape
Medicaid Enterprise Vision

1. Texas HHSC will become a value purchaser of health care quality and outcomes by supporting and “e-enabling” these capabilities
   a) Develop value purchaser capabilities.
   b) Utilize clinical decision support capabilities to analyze Medicaid health care administrative and clinical data from across the state and enterprise and to meaningful use patient summary information to improve health care delivery and cost effectiveness.
   c) Establish and maintain a comprehensive and robust provider network capable of providing quality care based on population needs, unique care conditions, and locus of service needs.
   d) Implement effective and efficient primary and integrated care approaches.
   e) Ensure the secure and private exchange of health care information across the Medicaid enterprise consistent with national standards, including specialty providers.
   f) Increase health care coverage through insurance exchanges under national health reform that effectively enrolls new clients in Medicaid or other health care coverage and ensures timely access to quality care.
To Be Landscape Provider Level Vision

2. Improve the health and well-being of citizens of Texas through the widespread adoption and meaningful use of certified EHRs to:
   
a) Improve quality, safety, efficiency, and reduce health disparities.
   
b) Engage patients and families in their health care.
   
c) Improve care coordination.
   
d) Ensure privacy and security protection for personal health information.
   
e) Improve population and public health.
EHR Incentive Program Overview

• Payment is an incentive for using certified EHRs in a meaningful way
  • Not a reimbursement and not intended to penalize early adopters.
• First year payment can be received in 2011 through 2016
• Final payment can be received up to 2021
• Eligible professionals must meet certain criteria:
  • Eligible provider type.
  • Medicaid patient volume thresholds.
  • MU of certified EHRs for at least 50 percent of patient encounters during the reporting period.
EHR Incentive Program
Enrollment Process

Provider Registers with CMS at the National Level Repository (NLR)

Forwarded to HHSC
Providers receive an automated mailing giving web link and emphasizing importance of enrolling with Medicaid before applying

Provider fills out online application attesting to all eligibility criteria

Provider fills out

Provider does not fill out – but registers with NLR

HHSC confirms licensed and unsanctioned

Yes
No – Reject
EHR Incentive Program Payment Process

HHSC reviews attested volume and compares reported information to Medicaid data sources

| Volume Sufficient | Volume fails validity check – request additional support | Volume insufficient – Reject |

Adopt, Implement and Upgrade (AIU) – Year 1 only

| Purchase/Upgrade Verified | No documentation provided – Request | Does not meet AIU – Reject |

Meaningful Use (MU) and Clinical Quality Measures (CQM) – Year 2 and beyond

| Attest and submit to MU/CQM measures | Attest MU but did not provide CQM – Request CQM | MU/CQM not met – Reject |
EHR Incentive Program
Payment Process

Verify ongoing payment eligibility – Year 2 and beyond

Verified costs and other criteria
Insufficient documentation provided – Request
Does not meet – Reject

Payment calculated

Provider paid
## Eligibility: Patient Volume

<table>
<thead>
<tr>
<th>Provider</th>
<th>Minimum Medicaid Patient Volume Threshold</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>30%</td>
<td>if the Medicaid EP <em>practices predominantly</em> in a Federal Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC)</td>
</tr>
<tr>
<td>- Pediatricians</td>
<td>20%</td>
<td>— 30% <em>needy individual</em> patient volume threshold</td>
</tr>
<tr>
<td>Dentists</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Certified Nurse Midwives</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Physician Assistants (PAs) when practicing at an FQHC/RHC that is led by a PA</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospitals</td>
<td>10%</td>
<td>Not an option for hospitals</td>
</tr>
<tr>
<td>Children's Hospitals</td>
<td>No requirement</td>
<td></td>
</tr>
</tbody>
</table>
## Eligible Provider Estimates

<table>
<thead>
<tr>
<th>Eligible Provider Types</th>
<th>Enrolled Medicaid Providers</th>
<th>Potentially Eligible*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Hospitals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care</td>
<td>1480</td>
<td>310</td>
</tr>
<tr>
<td>Critical Access</td>
<td>77</td>
<td>TBD</td>
</tr>
<tr>
<td>Children’s</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td><strong>Eligible Professionals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>32,453</td>
<td>TBD</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>5,122</td>
<td>3,150</td>
</tr>
<tr>
<td>Dentists</td>
<td>5,431</td>
<td>3,400</td>
</tr>
<tr>
<td>Certified Nurse Midwives</td>
<td>186</td>
<td>150</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>3,545</td>
<td>TBD</td>
</tr>
<tr>
<td>Physician Assistants that leads an FQHC or RHC</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>FQHC/RHC (64 grantees operating multiple sites)</td>
<td>304 sites</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* Estimate of eligible providers are based on a preliminary counts of enrolled Medicaid providers, claims history and eligibility criteria from the NPRM.
Proposed Process for Provider Eligibility

- Goal is to complete application reviews within 90 days.
- As applications come in, the clock starts based on when documentation is complete.
- Requests for additional information issued within 60 days.
- For eligible professionals, a single application must show sufficient Medicaid practice volume, EHR costs, and EHR use.
- For hospitals, a single application must show sufficient Medicaid practice volume, incentive formula, and EHR use.
Proposed Process for Provider Eligibility

• All providers will attest to their number of patient encounters by payor source for:
  • Medicaid fee-for-service.
  • Medicaid managed care listed by managed care plan.
  • Primary Care Case Management (PCCM) payments.
• In order to facilitate pre-eligibility verification and post-payment audits as necessary, will require the “90-day” period for demonstrating EP Medicaid share to equate to three full calendar months.
• Encounters will be defined around count of claims and encounters per performing provider.
Patient Volume Calculation

- Defined “encounter” for three scenarios:
  - Fee-for-service.
  - Managed care and medical homes.
  - Hospitals.
- Two main options for calculating patient volume:
  - Encounters.
  - Patient panel.
- State picks from these or proposes new method for approval. May use approved approach of another state.
Entities Promoting the Adoption of EHRs

• States may designate entities “promoting the adoption.”

• EPs may voluntarily assign their incentive payments to these entities.

• Promotion would include:
  
  • Enabling and oversight of the business operational and legal issues involved in the adoption and implementation of EHR and/or the secure exchange and use of electronic health information.
  
  • Maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by EPs.

• Required transparency guidelines for selection.
EHR Incentive Program
Payment Process

• Ensure that there is no duplication of Medicare and Medicaid incentive payments to EPs.

• Ensure that incentive payments are made for no more than six years and that no EP or hospital begins receiving payments after 2016.

• Ensure that incentive payments are not paid at amounts higher than 85 percent of the net average allowable cost of certified EHRs and do not exceed yearly maximum allowable payment thresholds.

• Ensure timely and accurate payments to EPs and hospitals.

• Ensure that any monies paid inappropriately will be recouped and federal financial participation (FFP) is repaid.
# Incentive Payments for Eligible Professionals

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$21,250</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2019</td>
<td></td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2020</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$8,500</td>
<td>$8,500</td>
</tr>
<tr>
<td>2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$8,500</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
<td>$63,750</td>
</tr>
</tbody>
</table>
Proposed Payment Process for EPs

• Provide option for EPs practicing in a group to impute the group’s Medicaid share for their individual application, referencing the group’s tax identification number (TIN), but under the individual provider’s national provider identifier (NPI).
  • Will require EPs to attest that this is the only group TIN that they are applying under.
  • Still requires an individual online application/attestation for each provider claiming incentives, but can be batched together by TIN.
• One time per year with annual payment dates staggered monthly.
• For part-time providers, if the attested total billing is less than the amount of the incentive they are trying to claim, will require submission of Form 1099 and documentation of the nature of the provider’s engagement with the group or clinic.
Incentive Payments for Eligible Hospitals

• Medicaid hospital incentive payments based on a formula similar to Medicare hospital methodology.

• A product of the overall EHR amount multiplied by the Medicaid share.

• Payment is calculated, then disbursed over three to six years.

• Payments in any one year cannot exceed 50 percent of the total payment cap and payment in any two years cannot exceed 90 percent of this limit.

• Data to be derived from the hospital cost reports and other auditable data sources.

• Will propose that hospitals attest regarding their own most recent fiscal year (which will overlap with the most recent federal fiscal year).
Incentive Payments for Eligible Hospitals

The basic calculation—performed for each of four projected years:

\[
$2,000,000 + \frac{200}{\text{discharge}} \\
\text{(for number of discharges between 1,150 to 23,000)} \\
\times \\
\text{transition factor based on the hospital’s current payment year} \\
\times \\
\text{provider’s average annual rate of growth} \\
\text{for the most recent 3 year period} \\
\times \\
\text{Medicaid share} \\
\text{(12 month Medicaid bed days ÷ total bed days} \times \text{(total charges - charity care)} ÷ \text{total charges})
\]
Proposed Payment Process for Hospitals

- One time per year with annual payment dates staggered monthly.
- Payment will be made in the first monthly date after incentive is approved.
- Medicaid has the flexibility to spread out hospital incentive payments over as few as three or as many as six years.
  - Texas proposes to use a five year payout for the incentives according to the following schedule:

<table>
<thead>
<tr>
<th>Five Year Payout Schedule for Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>40%</td>
</tr>
</tbody>
</table>
Provider Appeals

Medicaid needs to ensure that appeal processes are established for and consistent with all criteria, including verification of:

- Provider eligibility determinations.
- Incentive payments and amounts.
- Demonstration of efforts to adopt, implement or upgrade and meaningful use eligibility.
Proposed Process for Oversight and Auditing

Four stages of review and appeals for eligibility:

1. Attestation.
2. Compare attestation to Medicaid data sources for that provider.
   - Additional information (e.g., billing data) needed for significant discrepancies.
3. If information provided is inconsistent with Medicaid data or other third party data source, application is rejected and providers will have the opportunity to file an initial appeal to TMHP.
   - TMHP will have two EHR application adjudication entities, one to conduct initial eligibility determinations and another to conduct appeals.
4. If TMHP rejects appeal, the final appeal will be to HHSC’s Medicaid/CHIP Health IT division.
Roadmap to MU

• MU of a certified EHR requires:
  • Use of certified EHRs in a meaningful manner such as e-prescribing.
  • That the certified EHR is connected in a manner that provides for the electronic exchange of health information to improve the quality of care.
  • In using this technology, the provider submits information on clinical quality measures (CQM) and such other measures selected by the Secretary of HHS.
Applicability of MU Objectives and Measures

• Some MU objectives are not applicable to every provider’s clinical practice, thus they would not have any eligible patients or actions for the measure denominator.

Examples:
• Dentists who do not perform immunizations.
• Certified nurse midwives who do not prescribe medications.

• In these cases, the eligible professional or hospital would be excluded from having to meet that measure.
Measures for Stage 1 Meaningful Use

- **20 measures for EPs**
  - Must meet **15** from “core set”.
  - Must select **5** of 10 from “menu set”.
- **19 measures for eligible hospitals**
  - Must meet **14** from “core set”.
  - Must select **5** of 10 from “menu set”.
- EPs must report total of **6** CQMs
  - Blood pressure reading.
  - Tobacco status.
  - Adult weight screen and follow up or alternate if not applicable.
  - 3 from list of clinical measures of the provider’s choice.
  - 4 CQM overlap with CHIPRA initial core set
- Hospitals must report **15** CQMs
States’ Flexibility to Revise Meaningful Use

- Medicaid can seek CMS approval to require four MU objectives as core measures for providers:
  - Generating lists of patients by specific conditions for quality improvement, reduction of disparities, research or outreach.
  - Submit electronic data on immunizations to registries.
  - Submit electronic data on reportable lab results to public health agencies.
  - Submit electronic syndromic surveillance data to public health agencies.
- Can specify for providers how to test the data submission and to which specific destination.
- Medicaid is still determining options as whether or not to require these MU measures.
Proposed Plan to Meaningful Use

• Establish a Medicaid Quality Outcomes workgroup to streamline and align current outcome measures and prioritize quality improvement initiatives and strategies. The workgroup will:
  • Obtain stakeholder input.
  • Address current and future data analytical staff capabilities.
  • Identify the need for decision support system capabilities to produce data driven decisions and improve health outcomes, care quality, and cost efficiency.

• HHSC plans to:
  • Collect and verify meaningful use quality data through a single point of entry for client and provider data.
  • Simplify provider reporting to the extent possible.
  • Begin data collection in 2012.
Adoption Rate and Provider Participation

A baseline for provider adoption of EHR technology and participation in the incentive program will be established in 2011.

- Subsequent years will have projected target adoption rates.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>2011 Baseline (Estimate)</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>EH - Acute Care</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
<td>70%</td>
</tr>
<tr>
<td>EH – Children’s Hospital</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>85%</td>
</tr>
<tr>
<td>EP – Physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP – Pediatrician</td>
<td>5%</td>
<td>10%</td>
<td>25%</td>
<td>45%</td>
</tr>
<tr>
<td>EP – CNMs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP – Nurse Practitioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP – PAs when practicing at an FQHC/RHC</td>
<td>3%</td>
<td>10%</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>EP – Dentists</td>
<td>3%</td>
<td>6%</td>
<td>8%</td>
<td>15%</td>
</tr>
</tbody>
</table>
Provider Outreach and Education

- Use a variety of communication methods to reach providers and other stakeholders around the state.
- Provide information regarding the incentive payment process and details via web site, call centers, and presentations.
- Leverage existing communication channels and build additional ones as appropriate.
- Develop webinars and other web-based educational materials for convenient access.
- Develop the communication strategy and structure for ongoing outreach and education.
Provider Outreach and Education Methods

• Medicaid Bulletin
  • e-newsletter now includes an “Health IT corner”
• HHSC websites (i.e., TMHP, Office of e-Health Coordination) and related links (e.g., CMS)
  • Health IT page
  • Contact Us form
• Communication through professional associations
• Health IT Regional Extension Centers (RECs)
• Provider presentations that are convenient, accessible and flexible to schedules
Key Considerations in Communication Plan

- Consistency of information across communication channels and with CMS.
- Coordination of information across Health IT and HIE organizations in Texas, especially the four RECs.
- Accuracy and timeliness of information in a dynamic environment.
- Responsiveness to provider questions and concerns.
- Other considerations.
Provider Outreach

Important Links

Medicaid EHR Incentive Program Information
www.tmhp.com

Texas Regional Extension Centers
www.txrecs.org

Texas Health Services Authority
www.thsa.org

Medicaid Provider Survey
Practitioner:  www.surveymonkey.com/s/593369B
Hospital:  www.surveymonkey.com/s/WKB2JFR
Feedback Submissions after Today’s Forum

Send written feedback, input, and questions to:
MedChipEHRIncentive@hhsc.state.tx.us

STARTING AUGUST 9, 2010:
Send feedback, input, and questions to:
EHRprogram@TMHP.com