



HEALTH INFORMATION TECHNOLOGY (HIT)

STATE MEDICAID HEALTH INFORMATION TECHNOLOGY PLAN (SMHP)

Table of Contents

**Revision History**

<b>Version Number</b>	<b>Date</b>	<b>Reviewer</b>	<b>Comments</b>
1.0	08/31/2011	HIT Steering Committee	Original SMHP Submission to CMS

# Table of Contents

<b>Introduction</b> .....	<b>6</b>
<i>KDHE’s Vision for HIT and the Medicaid EHR Incentive Program</i> .....	7
<i>EHR Program Background</i> .....	8
<i>Overview of Planning Activities</i> .....	9
<i>Overview of the SMHP</i> .....	10
<b>Section A: “As-Is” HIT Landscape for the State Medicaid Agency’s (SMA) EHR Incentive Payment Program</b> .....	<b>12</b>
<i>Current EHR and HIT Adoption (Response to Question #1)</i> .....	14
<i>Access to Broadband Internet (Response to Question #2)</i> .....	27
<i>Federally Qualified Health centers (FQHCs) and Health Resource Services Administration (HRSA) Funding (Response to Question #3)</i> .....	31
<i>Veterans Administration (VA) or Indian Health Services (Response to Question #4)</i> .....	32
<i>Stakeholder Engagement in Existing HIT/HIE Activities (Response to Question #5)</i> .....	34
<i>Current HIE Organizations and Activities in Kansas (Response to Questions # 6, 7 and 9)</i> .....	35
<i>Role of MMIS in Current HIT/E Environment (Response to Question #8)</i> .....	36
<i>Relationship with State Government HIT Coordinator (Response to Question #10)</i> .....	36
<i>Current Department Activities Likely to Influence EHR Incentive Program (Response to Question #11)</i> .....	37
<i>Recent Relevant Changes to State Laws and Regulations (Response to Question #12)</i> .....	37
<i>HIT/E Activities Crossing State Lines (Response to Question #13)</i> .....	41
<i>Current Interoperability Status of State Immunization Registry and Public Health Surveillance Reporting (Response to Question #14)</i> .....	44
<i>Transformation Grant or CHIPRA HIT Grant (Response to Question #15)</i> .....	45
<b>Section B: State’s “To-Be” HIT Landscape</b> .....	<b>46</b>
<i>KDHE’s Goals (Response to Questions #1 and #4)</i> .....	47
<i>MMIS System Architecture and EHR Incentive Program System (Response to Questions #2, 3, and 4)</i> .....	49
<i>Role in Encouraging HIT Adoption and Ongoing Provider Outreach and Education (Response to Questions #5 and 7)</i> .....	50
<i>Leveraging Related Funding Resources (Response to Questions #6 and 9)</i> .....	52

## Table of Contents

<i>Addressing the Unique Needs of Special Populations (Response to Question #8)</i> .....	53
<i>The Need for Additional Legislation (Response to Question #10)</i> .....	54
<b>Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program</b> .....	<b>55</b>
<i>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</i> .....	58
<i>Step 2: Providers will enroll in the CMS Medicare &amp; Medicaid EHR Incentive Program Registration and Attestation System (Response to Questions #1, 16, 17 and 30)</i> .....	60
<i>Step 3: The R&amp;A will provide information to KDHE through MAPIR interfaces about providers who have applied for the incentive program (Response to Questions #14, 18, 20 and 29)</i> .....	62
<i>Step 4: MAPIR runs edits on info from R&amp;A to determine which providers to contact for the application process (Response to Questions #1, 15, 16 and 29)</i> .....	64
<i>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</i> .....	66
<i>Step 6: KDHE reviews pended provider application and attestation and determines eligibility or addresses reasons for suspension (Response to Questions #22 and 28)</i> .....	69
<i>Step 7: If applicable, KDHE denies provider’s application (Response to Questions #1 and 22)</i> .....	71
<i>Step 8: Provider application clears MAPIR system edits and MAPIR generates approval email with program information to provider (Response to Question #4)</i> .....	71
<i>Step 9 : MAPIR interfaces list of providers who pass edits to R&amp;A for final confirmation (Response to Question #1)</i> .....	72
<i>Step 10: KDHE sends approval email to provider with program and payment information (Response to Question #4)</i> .....	72
<i>Step 11: MMIS issues payment and MAPIR submits payment information to the R&amp;A (Response to Questions #23 - 25)</i> .....	72
<i>Step 12: Post-payment oversight and outreach activities (Response to Questions #3, 6 , 7, 8 and 26)</i> .....	73
<i>Step 13: Ongoing technical assistance for adoption, implementation, upgrade and meaningful use of EHR (Response to Questions #8 and 9)</i> .....	74
<i>Step 14: Notification of meaningful use requirements for Year Two and beyond (Response to Questions #10, 11 and 12)</i> .....	75

## Table of Contents

<i>Step 15: Meaningful use payment request or renewal (Response to Questions #9, 12, 13 and 30)</i> .....	76
<b>Section D: The State’s Audit Strategy</b> .....	<b>77</b>
<i>Program Oversight (Response to Questions #1 and 7)</i> .....	79
<i>Methods for Avoiding Improper Payments (Response to Questions #1, 4 and 5)</i> .....	82
<i>Reducing Provider Burden While Maintaining Oversight (Response to Question #6)</i> .....	91
<i>Investigating Fraud and Abuse and Collecting Overpayments (Response to Questions #1 – 3)</i> .....	92
<b>Section E: The State’s HIT Roadmap</b> .....	<b>95</b>
<i>Medicaid Agency Five-Year Roadmap (Response to Question #1)</i> .....	96
<i>KDHE’s Expectations for Provider EHR Adoption over Time and Annual Benchmarks (Response to Questions #2 and 3)</i> .....	105
<i>Annual Benchmarks for Audit and Oversight Activities (Response to Question# 4)</i> .....	106
<b>Appendix I: Glossary of Terms and Acronyms</b> .....	<b>108</b>
<b>Appendix II: SMHP Response Crosswalk</b> .....	<b>114</b>
<b>Appendix III: Physician Survey Results</b> .....	<b>127</b>
<b>Appendix IV: Communications Plan</b> .....	<b>130</b>
<b>Appendix V: Hospital Payment Calculator</b> .....	<b>131</b>

## **Introduction**

The Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF, hereafter referred to as KDHE) is the designated State agency that administers the Kansas Medicaid program. The Kansas Governor's office created the original organization known as the Kansas Health Policy Authority (KHPA) in 2005, but the organization merged as a division under the auspices of KDHE as of July 1, 2011. Kansas has elected to participate in the Medicaid Electronic Health Record (EHR) Incentive Program funded through the Centers for Medicare & Medicaid Services (CMS) and KDHE is leading the development of this State Medicaid Health Information Technology Plan (SMHP).

KDHE is also the State-designated entity for the Office of the National Coordinator for HIT (ONC) Health Information Exchange (HIE) Cooperative Agreement for the State of Kansas. On September 2, 2010, Governor Mark Parkinson appointed a 17-member board to lead the Kansas Health Information Exchange, Inc., a non-profit, public-private corporation that serves as the State-Designated Entity that will lead and coordinate efforts to implement an HIE in Kansas. The Director of the KDHE Division of Health Care Finance serves on the board representing the State Medicaid program.

KDHE plans to implement the Kansas Medicaid EHR Incentive Program in early 2012. This timeframe allows Kansas' eligible providers the opportunity to identify, adopt, implement or upgrade an EHR product to meet the needs of their offices or hospital settings while also maximizing payments available under the Medicaid EHR Incentive Program. Kansas has closely followed the Final Rule, *42 CFR Parts 412, 413, 422, and 495* published July 28, 2010, regarding implementing the American Recovery and Reinvestment Act of 2009 (ARRA) (*Pub. L. 111-5*), in the development of a plan that provides incentive payments for the adoption, implementation, upgrade, and meaningful use of certified EHR technology.

This SMHP describes Kansas's administrative processes and 5-year vision relative to implementing the Medicaid provisions contained in Section 4201 of the ARRA.

## KDHE's Vision for HIT and the Medicaid EHR Incentive Program

KDHE's vision and strategy for implementing HIT initiatives, including the Medicaid EHR Incentive Program, is to pursue initiatives that encourage the adoption of certified EHR technology, promote health care quality and advance HIE capacity in Kansas. KDHE will use the Medicaid EHR Incentive Program to develop a system that supports the secure exchange of health information. The system will improve the efficiency and effectiveness of patient-centric health care for all Kansans. The system will ensure the quality and confidentiality of personal health information and will enable healthcare stakeholders to share data to better coordinate patient care. The system will also support public entities in achieving their population health goals. KDHE's mission for HIT in Kansas is:

*Transform health care in Kansas through the deployment, coordination, and use of Health Information Technology and Health Information Exchange.*

This mission is the result of almost a decade of effort by multiple stakeholders to define HIT and HIE in Kansas. Current HIT and HIE efforts are both promising and challenging due to the rural nature of the State, rural health professional shortages, limited financial and technical resources and incomplete geographic access to internet connectivity and broadband.

Grant funding under ARRA from ONC has helped to reinvigorate HIT efforts in Kansas. KDHE coordinated meetings with stakeholders to review prior efforts and then established collaborative efforts around the creation and implementation of HIE governance, State policy and technical infrastructure that will enable standards-based HIE and further development of an already high performing health care system. Medicaid HIT project staff actively participated in these meetings and collaborative efforts.

## EHR Program Background

CMS implemented, through provisions of the ARRA, a program that provides incentive payments to Eligible Professionals (EPs) and Eligible Hospitals (EHs), including Children's and Critical Access Hospitals (CAHs), that participate in Medicare and Medicaid programs and meet EHR incentive program requirements. The incentive payments are not a reimbursement, but are incentives for EPs and EHs to adopt, implement, upgrade, or meaningfully use certified EHR technology. The EPs and EHs participating in the Medicaid EHR Incentive Program may qualify in their first year of participation for an incentive payment by demonstrating that they have adopted (acquired and installed), implemented (trained staff, deployed tools, exchanged data), or upgraded (expanded functionality or interoperability) a certified EHR. Providers who demonstrate meaningful use in the initial year or for an additional five years culminating in 2021 are eligible for incentive payments.<sup>1</sup>

The ONC issued a closely related Final Rule that specifies the ONC's adoption of an initial set of standards, implementation specifications and certification criteria for EHRs. Additionally, ONC issued a separate notice of proposed rulemaking related to the certification of HIT. Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers and state lines; and 4) enable data sharing using State HIE and the Nationwide Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of healthcare nationwide.

KDHE will work closely with federal and state partners to ensure the Kansas Medicaid EHR Incentive Program fits into the overall strategic plan for the State Health Information Exchange Cooperative Agreement Program (State HIE Program), thereby advancing national goals for HIE. The State HIE Program funds states' efforts to rapidly build capacity for exchanging health information across the health care system both within and across states.

---

<sup>1</sup> CMS Office of Public Affairs: *CMS Proposed Requirements for the Electronic Health Records (EHR) Medicaid Incentive Payment Program* (December 30, 2009) 202-690-6145.

## Overview of Planning Activities

This SMHP focuses on efforts necessary to complete the first phase of the State's implementation of the Medicaid EHR Incentive Program. KDHE has been working with its Medicaid Management Information System (MMIS) contractor Hewlett Packard Enterprise Services (HP) and a multi-state collaborative consisting of 13 states to develop and implement the State's system for interfacing with CMS and making incentive payments. This MMIS module is known as the Medical Assistance Provider Incentive Repository (MAPIR).

Modifying the existing MMIS with the MAPIR module will support payments to eligible providers and federal reporting requirements. KDHE will make changes to existing operations to support Medicaid EHR Incentive Program administration. Such changes include training staff within KDHE's business units responsible for operations (help desk, call center, provider outreach and enrollment, administrative review and appeals processing), and payments of provider incentives, financial reporting, auditing oversight and management-contracted activities.

KDHE elected to leverage business processes throughout the agency and, where feasible, integrate the Medicaid EHR Incentive Program into the standard Medicaid IT Architecture (MITA) business processes and KDHE's day-to-day operations. During the Implementation Phase, KDHE will continue to develop state-specific business processes. Examples of these processes would include the Medicaid EHR Incentive Program eligibility process, the process used to calculate Medicaid patient volume, the attestation receipt and validation process, and the provider registration and query functions with the CMS Registration and Attestation System (R&A).

In addition to the above efforts related to the administration of incentive payments, KDHE is planning to complete a technical assessment to identify how KDHE may leverage the State's Medicaid systems to further the utilization of EHR technology to improve the management of care for Kansas Medicaid beneficiaries. The technical assessment is described in Sections B and

E and KDHE anticipates that we will amend this SHMP in the near future based on the results of this assessment.

### Overview of the SMHP

The organization, structure and content of this SMHP follow the template provided by CMS as described below.

**Section A**, the State's HIT "As-Is" Landscape, describes the results of the environmental scan and landscape assessment. Through surveys and discussions with key provider groups, KDHE was able to determine the current extent of EHR adoption by practitioners and hospitals and their readiness and willingness to participate in the Medicaid EHR Incentive Program.

**Section B**, the State's HIT "To-Be" Landscape, describes KDHE's vision for HIT and HIE. KDHE discusses plans for the MMIS and MITA system changes as they relate to administering the incentive program, making payments, and collecting and analyzing the data that will become available once meaningful use is in place, e.g., clinical quality measures.

**Section C**, the State's Implementation Plan, describes the processes KDHE will use to ensure that eligible professionals and hospitals have met Federal and State statutory and regulatory requirements for the Medicaid EHR Incentive Program. As part of the planning process, KDHE has created a roadmap that guides providers through every stage of the incentive program process. The roadmap begins by educating providers about the program to encourage them to register at the CMS R&A website and then apply in Kansas's MAPIR system. The process flow also describes the payment approval process, including informing providers of their application processing status and informing providers of payment eligibility. This section also describes oversight mechanisms, the process for receiving future payments, and the process for educating, informing and providing technical assistance to providers to ensure they remain in the incentive program and become meaningful users.

**Section D**, the State's Audit Strategy, describes the audit, controls and oversight strategy for the State's Medicaid EHR Incentive Program. The MAPIR system will allow providers to apply for

the incentive program and submit all required attestations. MAPIR also uses system edits and checks which are the basis for many of the controls. The system edits and checks will generate lists of providers who KDHE has approved for payment, denied payment or pended for further review.

**Section E**, the State's HIT Roadmap, describes the strategic plan and tactical steps that the KDHE will take to successfully implement the Medicaid EHR Incentive Program and its related HIT and HIE goals and objectives. The Roadmap describes the programmatic goals related to provider adoption, quality, and the administrative processes. This section also describes the measures, benchmarks, and targets that will serve as clearly measurable indicators of progress in achieving overall program goals.

In addition to this introduction and Sections A through E, this document includes a number of appendices and an attachment. Appendix I is a glossary of common HIT terms. Appendix II provides a matrix of SMHP questions and crosswalks to the locations of Kansas' response within the SMHP. Appendix III provides additional information about the Provider Survey for the "As-Is" landscape assessment. Appendix IV is the Communications Plan that describes how KDHE will engage with stakeholders and Appendix includes the Hospital Payment Calculator that CMS has reviewed and approved.

**Section A: “As-Is” HIT Landscape for the State Medicaid Agency’s (SMA) EHR Incentive Payment Program**

This section provides an overview of EHR, HIE and HIT adoption of Kansas providers and information on coordination efforts between State agencies and State HIT resources. This section also includes responses to each of the questions listed in the CMS SMHP template listed below in Table A.1.

**Table A.1: Section A Questions from the CMS SMHP Template**

Please describe the State’s “As-Is” HIT Landscape:	
1.	What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State’s providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the State Medicaid Agency (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.)?
2.	To what extent does broadband internet access pose a challenge to HIT/E in the State’s rural areas? Did the State receive any broadband grants?
3.	Does the State have Federally-Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe.
4.	Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.
5.	What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?
6.	* Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc) of these activities?
7.	Specifically, if there are HIE organizations in the State, what is their governance structure and is the SMA involved? ** How extensive is their geographic reach and scope of participation?
8.	Please describe the role of the MMIS in the SMA’s current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how.
9.	What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use?
10.	Explain the SMA’s relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program.

## Section A: State "As-Is" Landscape

Please describe the State's "As-Is" HIT Landscape:
11. What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years?
12. Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe.
13. Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe.
14. What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)?
15. If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.
* May be deferred. ** The first part of this question may be deferred but States do need to include a description of their HIE(s)' geographic reach and current level of participation.

## Section A: State “As-Is” Landscape

### Current EHR and HIT Adoption (Response to Question #1)

KDHE conducted the following scans and surveys to assess the current state of EHR adoption by Kansas practitioners and by hospitals:

- An Environmental Scan which included State Agencies and large medical facilities (those which currently support Integrated Services Digital Network (ISDN)),
- A Provider Survey which addressed all other potential eligible individual providers and hospitals not involved in the Environmental Scan,
- A second physician-only survey to obtain additional physician survey results.

In addition, KDHE obtained and used information from the 2009 American Hospital Association (AHA) Information Technology survey. All of the results from the surveys, scans, and reports were used to obtain information about provider and hospital opinions, current capabilities and perceived barriers and expectations regarding HIT, HIE and the transformation of healthcare.

The **Environmental Scan**, conducted during the months of June through August of 2010 by KDHE, with assistance from the Kansas Hospital Association (KHA) and Kansas Medical Society (KMS) gathered information from both large medical organizations and targeted State agencies already using HIT, as follows:

- Nine large health systems, representing 22 hospitals, provided information
- State agencies:
  - Kansas Department of Education
  - Kansas Department of Health and Environment
    - Health Occupations Credentialing Unit
    - Immunization Registry
    - Women, Infants and Children
  - Kansas Department of Insurance
  - Kansas Department of Labor - Workmen’s Compensation
  - Kansas Department of Revenue

## Section A: State “As-Is” Landscape

- Kansas Department of Social and Rehabilitation Services
- Kansas Department on Aging
- Kansas Health Policy Authority
  - Provider registries
  - Medicaid Management System
  - Eligibility
- Kansas Employee Health Benefit Plan
- Kansas Secretary of State
- Kansas State Behavioral Sciences Regulatory Board
- Kansas State Board of Pharmacy – Prescription Monitoring Program

KDHE conducted the **Provider Survey** and subsequent “Physician Only” Survey in collaboration with the following organizations:

- Kansas Foundation for Medical Care (KFMC) which is the Kansas Regional Extension Center (REC)
- Kansas Hospital Association (KHA)
- Kansas Medical Society (KMS)
- Kansas Academy of Family Physicians (KAFP)
- Kansas Association of Osteopathic Medicine (KAOM)
- Kansas Chapter of American Academy of Pediatrics
- Greater Kansas City Medical Managers Association (GKCMMA)
- American College of Physicians (ACP)
- Kansas Medical Group Management Association (KMGMA)
- Kansas Medical Group Management Association (KMFMA)

The first survey conducted by KDHE targeted all of Kansas’ approximately 15,000 professionals and hospitals throughout the State who are potentially eligible for the Medicaid EHR incentive program. KDHE conducted the first survey during the months of July and August of 2010.

## Section A: State “As-Is” Landscape

The second KDHE survey was a “Physician Only” survey that KDHE conducted in January and February of 2011. Additional information is included in Appendix III.

The following describes the results of the Environmental Scan, Provider Survey and information obtained from the American Hospital Association (AHA) 2009 Information Technology Hospital Survey.

### *Hospital EHR Adoption*

The information showed that 78 percent of Kansas hospitals that participated in either the HIT Provider survey or the AHA 2009 survey reported some use of EHR technology. Most of the hospitals responded that they use one EHR vendor.

**Table A.2: Hospitals Using EHR**

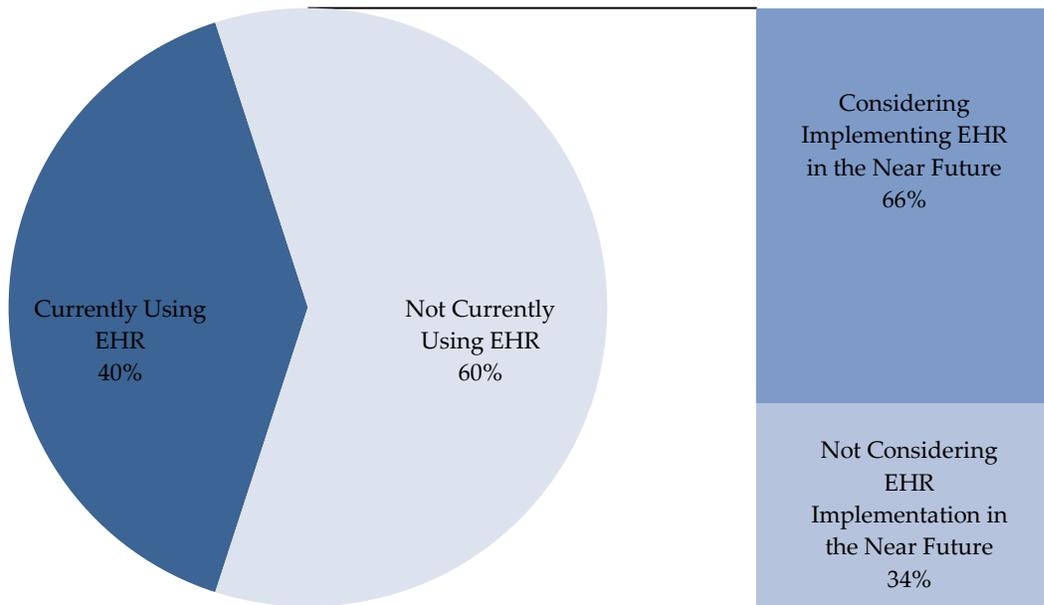
EHR Vendor	Number of Responses	Percent of Responses
A mix of products from different EHR vendors	14	14
Primarily one EHR vendor	62	62
Self-developed EHR	4	4
<i>EHR Usage Findings</i>	78	78
No response	21	21

## Section A: State “As-Is” Landscape

### *Eligible Professionals EHR and HIT Adoption*

The KDHE Provider Survey reported that 40 percent of respondent practices currently use EHRs. Of the 60 percent of respondents not currently using EHRs, 66 percent are seriously considering implementation.

**Figure A.1: Current and Future Use of EHR**



Note: The KDHE Provider Survey yielded 1,322 responses or an 8 percent response rate. The confidence levels associated with these results are described in Appendix III.

Due to the low response rate from the providers, KDHE has been working with ONC and CMS to better establish EHR adoption goals as Kansas’s adoption rates, reported above, appear higher than National Estimates in Table A.3.

**Table A.3: National Estimates of EHR Adoption Rates**

Source	Practitioners	Adoption Rate
<b>Ambulatory Practitioners (Provider Practices)</b>		
2008 Harvard Medical School study	Office-based physicians	17 percent using EHRs
CDC’s 2010 National Ambulatory Medical Care Survey (preliminary results) <sup>2</sup>	U.S. physicians	24.9 percent reported having basic EHR systems 10.1 percent reported having a fully functional EHR system.
National Ambulatory Care Survey for 2008 <sup>3</sup>	Overall ambulatory practitioners	38 percent using EHRs in 2008 44 percent in 2009*Preliminary
<b>Hospitals</b>		
American Hospital Association <sup>4</sup>	All acute care hospitals	8.7 percent in 2008 reported using basic or comprehensive electronic records 11.9 percent in 2009 reported using basic or comprehensive electronic records

*Environmental Scan Results*

The Environmental Scan includes results from external large, collaborative health systems and State agencies. Figure A.2 provides a breakdown of respondents to the Environmental Scan.

---

<sup>2</sup> Chun-Ju Hsiao, et al. *Electronic Medical Record/Electronic Health Record Use by Office-based Physicians: United States (2009 and Preliminary 2010)*. *Electronic Medical Record/Electronic Health Record Use by Office-based Physicians: United States (2008 and Preliminary 2009)*.

<sup>3</sup> Ibid.

<sup>4</sup> American Hospital Association and *New England Journal of Medicine* (June 18, 2008).

## Section A: State “As-Is” Landscape

**Figure A.2: Environmental Scan Respondents**

<p>Large Independent/Government Systems – Multi-provider (hospital/clinic/etc.) organizations with a focus on a specific population.</p>	<ul style="list-style-type: none"> <li>•Veterans Administration</li> <li>•Department of Defense</li> <li>•Kansas Corrections</li> </ul>
<p>Shared Hospital EHR Hosting – Multiple providers use the same typical ASP model of EHR deployment through a service center.</p>	<ul style="list-style-type: none"> <li>•Participants in out-of-state Health Centered Controlled Network (EHR Hosting) – Flint Hills Community Health Center</li> </ul>
<p>Regional Exchanges – Health information organizations with primary responsibility to facilitate exchange between non-related/non-owned organizations</p>	<ul style="list-style-type: none"> <li>•Kansas City Bi-State Health Information Exchange</li> <li>•Wichita Health Information Exchange</li> <li>•Lewis and Clark Health Information Exchange</li> <li>•Nebraska Health Information Exchange</li> </ul>
<p>Quality Reporting – Organizations that collect data, report and performance quality improvement.</p>	<ul style="list-style-type: none"> <li>•Kansas Foundation for Medical Care (Kansas QIO)</li> <li>•Kansas City Quality Improvement Collaborative</li> <li>•Kansas Quality Collaborative (KMS and KHA)</li> </ul>
<p>Telemedicine – Medical consultation and other services beyond baseline EHR or HIE.</p>	<ul style="list-style-type: none"> <li>•Univeristy of Kansas Medical Center</li> <li>•Pioneer Health Network</li> </ul>
<p>Health Plans/Private Payers</p>	<ul style="list-style-type: none"> <li>•Blue Cross Blue Shield of Kansas</li> <li>•Blue Cross Blue Shield of Kansas City</li> <li>•United Healthcare</li> <li>•Coventry/Preferred Health</li> </ul>
<p>Integrated Delivery Networks or Large Hospital and/or Ownership GroupsMulti-hospital and other diverse settings where technology decisions are made at a corporate level and data is shared between these providers because of a common referral process. Integrated Delivery Networks (IDN) in Kansas includes:</p>	<ul style="list-style-type: none"> <li>•Via Christi Health System (IDN)</li> <li>•Hospital Corporation of America (HCA) (IDN)</li> <li>•University of Kansas Hospital (IDN)</li> <li>•Great Plains Health Alliance (ownership/management)</li> <li>•St. Lukes Health Systems (IDN)</li> <li>•Stormont Vail Health Care (IDN)</li> <li>•Hays Medical Center (IDN)</li> <li>•Catholic Health Initiatives (ownership/joint purchasing)</li> <li>•Sisters of Charity of Leavenworth (ownership/joint purchasing)</li> </ul>

## Section A: State “As-Is” Landscape

The Environmental Scan information from the nine Integrated Delivery Networks (IDNs) in Kansas focused on the types of health data collected, especially the collection of personal health information, the current capabilities of systems to exchange data and their ability to share a common master patient index. Information regarding the IDNs Service Area Participation in HIE is included in Table A.4.

Of the nine IDNs identified in Kansas, five currently support the exchange of information between providers and organizations within their hosting network. Three additional IDNs are considering implementing an exchange.

Table A.4, below, describes the usage of HIE services in either the inpatient or outpatient settings.

**Table A.4: Usage in Various Areas of the IDN**

HIE Service Area Usage	Inpatient Usage Percentage	Outpatient Usage Percentage
Provider Directories	33	33
Enterprise Master Patient Index	33	33
Patient Demographics	33	33
Patient insurance information	33	33
Patient problem lists	33	33
Patient allergy lists	33	33
Patient medication lists	22	22
ePrescribing support	0	11

Section A: State “As-Is” Landscape

HIE Service Area Usage	Inpatient Usage Percentage	Outpatient Usage Percentage
Electronic orders for laboratory tests	33	33
Orders for radiology tests	33	33
Viewing Lab results	33	33
Viewing Imaging results	33	33
Clinical notes	0	22
Reminders for guideline-based interventions and/or screening tests	0	22
Clinical summaries or discharge instructions	0	22
Secure provider to provider messaging	0	11
Secure patient to provider messaging	0	11
Provider Directories	33	33
Enterprise Master Patient Index	33	33
Patient Demographics	33	33
Patient insurance information	33	33
Patient problem lists	33	33
Patient allergy lists	33	33
Patient medication lists	22	22

Of the nine IDNs, seven of their health information systems support Health Level Seven (HL7), the global authority on standards for interoperability of health information technology. Two IDNs regularly report quality data to CMS through a computerized system and one IDN reports public health data electronically. None of the IDNs currently submit data to an immunization registry electronically, although, three IDNs are capable of submitting data to an immunization registry.

## Section A: State “As-Is” Landscape

One IDN currently connects to the Lewis and Clark Information Exchange (LACIE), Relay Health HIE and NHIN. The remaining IDNs are planning to connect to the NHIN. Table A.5 below lists how the IDNs not currently connected to the NHIN are planning to do so in the future.

**Table A.5: Connection to NHIN**

Connections	Number of Responses
Secure connection directly through NHIN Connect	0
Use the specifications from the NHIN Direct project	1
Connect through an HIE/HIO	2
Connect through your EHR vendor	2
Unsure at this time	5
Other, please specify	1 (Epic- Care Connect)

Six of the IDNs not connected to a HIE stated that limited resources are a main barrier to participation. Table A.6 shows other reasons listed by the IDNs.

**Table A.6: IDN Barriers to Health Information Exchange Participation**

Barriers to Participation in HIE	Number of Respondents
Limited funds	5
Limited resources	6
Product does not support	1
Vendor does not support	2
Limited broadband access	0
No barriers	0
Privacy and security concerns including HIPAA	2

Section A: State “As-Is” Landscape

Barriers to Participation in HIE	Number of Respondents
Too many other higher priorities	2
Need states plan for HIE to be finalized	0
Timing of National role out	2
Other	3
<b>Note: In the Environmental Scan, the providers could select more than one barrier. This resulted in a total greater than the 9 ISDN organizations reflected in Table A.6 above.</b>	

Tables A.7 through A.11 reflect findings from the KDHE Provider Survey (which included hospitals and eligible professionals), the “Physician Only” extended survey, and information obtained from the 2009 AHA Information Technology survey.

Table A.7 provides an overview of current practitioner participation rates in HIE. Four percent of Medicaid providers currently participate in an HIE; however, in another provider survey conducted by KDHE in 2010, eight percent of providers reporting participating in a HIE.

**Table A.7: Practitioner Participation in HIE**

HIE Participation	Percent of Practices that participate
Participates in HIE	4
No	66
Did not respond	30

Respondents to the KDHE provider survey identified funding as the biggest barrier to participation in HIE, followed by limited resources as shown in Table A.8; respondents to the KDHE provider survey also listed funding as the single largest barrier to joining an HIE (23 percent).

**Table A.8: Hospitals and Eligible Professionals Barriers to Health Information Exchange Participation**

Barriers to participation in HIE	Percent of Respondents
Limited funds	23
Other*	21
Limited resources	18
Legal, privacy and security concerns, including HIPPA	15
No barriers	14
Current EHR system	11
EHR vendor does not support HIE	5
Limited broadband access	1
"Other" responses included: "don't know", "what is HIE", "HIE not available", "HIE not yet chosen", lack of administrative support, no EHR to share, costs too much, lack of computer knowledge, close to retirement, lack of internet access and that the hospital is unwilling.	
Note: The question regarding barriers in the survey was not mandatory so Table A.* above reflects only information from those providers who shoes to respond to this question.	

*EHR Incentive Payment Sources*

Based on the results above, KDHE is expecting strong demand from hospitals and providers for EHR Incentives. According to the 2009 AHA IT survey, as shown in Table A.9, more than 40 percent of respondent hospitals intend to seek both Medicare and Medicaid incentive payments.

**Table A.9: Hospital Plans to seek EHR incentive payments**

Type of EHR Incentive Payment	Percent of Hospitals
Select Both	42
Select Medicare Only	15
Select Medicaid Only	3

## Section A: State “As-Is” Landscape

Type of EHR Incentive Payment	Percent of Hospitals
Select Unsure	6
No Selection	33

When asked in the KDHE surveys why they might not seek incentive payments through either Medicare or Medicaid, the most popular responses included:

- Need for further information (32 percent)
- Implementation Guidelines/Requirements (15 percent)
- Unsure of what EHR system to purchase (13 percent)
- Limited access to capital funding (13 percent)

The responses to the same question in the 2009 AHA survey were similar. The most popular responses included:

- Difficulty meeting meaningful use criteria (11 percent)
- Cost including acquisition and maintenance (10 percent)
- Unsure about certification process (10 percent)

Further, the results of the Provider Survey, as shown in table A.3, indicated that 32 percent of surveyed providers plan to seek EHR Incentive funding from Medicaid. As hospitals and providers continue to show strong interest in applying for EHR Incentives, this information assists KDHE in estimating the number of incentive payments.

**Figure A.3: EHR Incentive Funding**

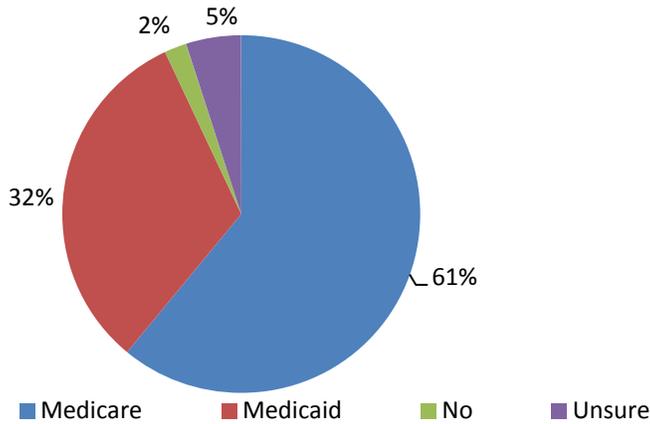


Table A.10 below lists the number of providers that KDHE estimates will be eligible for the Medicaid EHR Incentive Program.

**Table A.10: Estimates of Number of Providers Eligible for Medicaid EHR Incentive**

Provider Type	Number of Providers
Physician MD/DO	900
Nurse Practitioner	70
Dentist	20
Nurse Midwife	10
Acute Care Hospital	32
Critical Access Hospital	29
Children’s Hospital	2

KDHE will support providers by conducting education and outreach efforts to inform providers about EHR incentive eligibility and the application process.

## Section A: State “As-Is” Landscape

### Access to Broadband Internet (Response to Question #2)

Access to a broadband internet connection is a concern of providers throughout the State. The ability to exchange health information is dependent on provider’s adoption of EHR technology within their location, a broadband connection to transfer information and an HIE solution to secure data exchange. Both rural and urban providers have a need for a strong broadband infrastructure to share data between rural primary care providers and urban centers that may provide specialty care, for example.

According to the Provider Survey, fiber optic cable is the most frequently used internet connection technology for respondents; followed by T-1, cable modem and DSL modem technologies. In the additional Provider Survey conducted by KDHE in 2010, the most frequently used internet connection was DSL (32 percent), followed by cable (20 percent).

**Table A.11: Type of Internet Access at the Point of Care in your Location(s)**

Connection Type	Frequency	Percent of Responses
Fiber Optic Cable	87	19
T-1	80	18
Cable	66	15
DSL	59	13
Do not have internet access	11	2
Dial up	5	1
Satellite	0	0
FIOS	0	0
Other	0	0
Do not know	51	11
Did not respond	94	21

## Section A: State “As-Is” Landscape

Improving provider connectivity and expanding broadband capabilities has been a focus in Kansas for many years. Kan-ed is the statewide initiative charged with developing broadband capabilities for hospitals, K-12 schools, universities, and libraries. The Kansas Legislature established Kan-ed, located within the Kansas Board of Regents, in 2001. Kan-ed receives input on operations and direction via a 12-member advisory committee called the Kan-ed Advisory Committee.

Of 153 hospital institutions eligible for Kan-ed membership, 133 are active members. Table A.11 below identifies Kan-ed members by hospital type. Member hospitals receive connectivity incentives for connecting to the Kan-ed network, which provides a secure platform for health information exchange. Presently, only hospitals can connect to the network but they are currently considering policies that would allow healthcare providers across the State to connect. A common statewide network platform would enhance efficiency and cost effectiveness of HIE.

Kan-ed also supports EMResource, a web-based program that serves as a real-time communication tool for hospitals. EMResource provides information about hospital emergency department status, hospital patient capacity, availability of staffed beds and available specialized treatment capabilities. Currently, 127 Kan-ed member hospitals use EMResource.

**Table A.12: Kan-ed Membership and EMResource Users by Hospital Type**

Hospital Type	Number Eligible Kan-ed Members	Number of Active Kan-ed Members	Number of EMResource Users
Critical Access	83	83	83
General	49	43	43
Special	17	4	1
Psychiatric/Mental Health	4	3	0
<b>Total</b>	<b>153</b>	<b>133</b>	<b>127</b>

## Section A: State “As-Is” Landscape

The data above represents Kan-ed Membership hospitals and not Critical Access Hospitals. The data includes 146 hospitals that were included in the Kan-ed Telemedicine Capacity and Readiness Survey.

Connect Kansas is an additional Kansas broadband project commissioned by the Kansas Department of Commerce to work with all broadband providers in the State of Kansas to create detailed maps of broadband coverage in order to accurately pinpoint remaining gaps in broadband availability in Kansas. The maps represent the coverage areas of 79 Kansas broadband providers.

This analysis included the use of a geo-processing tool that analyzes Census Block demographics with the aggregated broadband service overlay from the provider data. Figure A.4 provides a geographic overview of current broadband activity in Kansas.

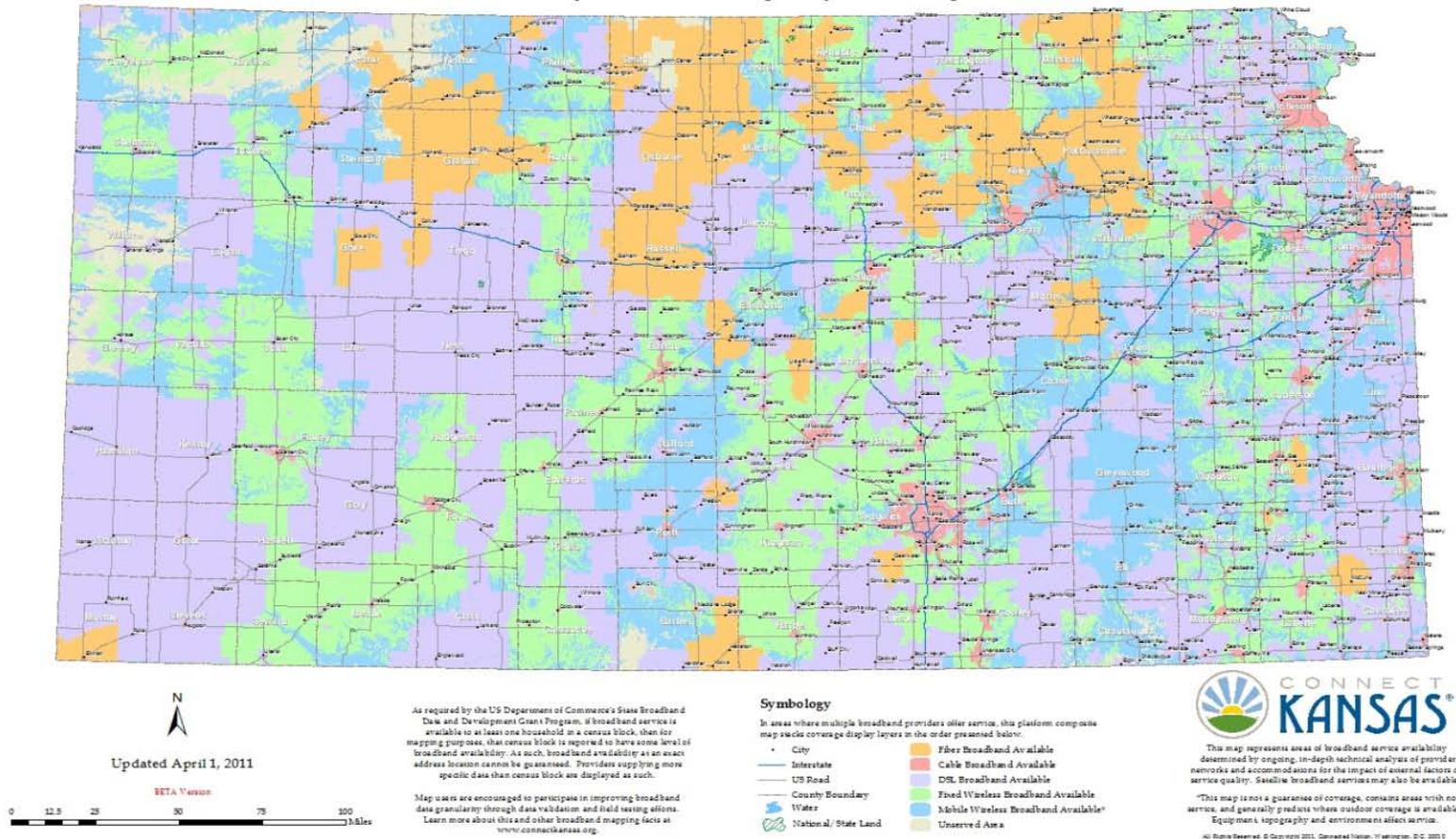
Section A: State "As-Is" Landscape

Figure A.4: Broadband Service Inventory

# Broadband Service Inventory for the State of Kansas

Advertised Speeds of at Least 768 kbps Downstream and 200 kbps Upstream

Submit questions or recommended changes to: [maps@connectkansas.org](mailto:maps@connectkansas.org)



## Section A: State “As-Is” Landscape

### Federally Qualified Health centers (FOHCs) and Health Resource Services Administration (HRSA) Funding (Response to Question #3)

Currently, there are 15 FQHCs operating in Kansas:

- Center for Health and Wellness, Wichita
- Community Health Center of Southeast Kansas, Pittsburg
- First Care Clinic, Hays
- Flint Hills Community Health Center, Emporia
- GraceMed Health and Dental Clinic, Wichita
- Health Ministries Clinic (Look Alike), Newton
- Heart of Kansas Family Health Care, Great Bend
- Hunter Health Clinic, Wichita
- Kansas Statewide Farmworker Health Program, Topeka
- Konza Prairie Community Health Center, Junction City
- PrairieStar Community Health Center, Hutchinson
- Salina Family Healthcare Center, Salina
- Shawnee County Health Agency, Topeka
- Swope Health Services, Kansas City
- United Methodist Mexican American Ministries, Garden City

Several of the above organizations have received HRSA grants such as the Capital Improvement Program (CIP) that health centers can use for infrastructure improvements such as EHR adoption and other HIT investments. For the most up-to-date information available, reference <http://granteefind.hrsa.gov>

In addition to FQHC grants, KDHE received more than \$3 million in Small Rural Hospital Improvement Program (SHIP) grants from HRSA in FY 2008, 2009 and 2010. The SHIP program is authorized by section 1820(g)(3) of the *Social Security Act* to help small rural hospitals pay costs related to the implementation of prospective payment systems, purchase computer software and hardware that would protect patient privacy, reduce medical errors and

## Section A: State "As-Is" Landscape

support quality improvement, educate and train hospital staff on computer information systems to protect patient privacy, help reduce medical errors and support quality improvement. The SHIP program allows funds to purchase equipment and software for regulatory compliance and improvements that can be cost-prohibitive for small hospitals.

In addition to HRSA grants, following is pertinent information regarding other grants received in Kansas:

- The University of Kansas Medical Center Research Institute received \$330,000 in Telehealth Resource Center Grant funds from the Office of Rural Health in 2009 and \$495,000 through the Telehealth Network Grant Program in 2010. The Telehealth Resource Center Grant supports the establishment and development of Telehealth Resource Centers. The University of Kansas Medical Center Research Institute uses monies from the Telehealth Network Grant Program to expand access, coordinate and improve the quality of health care services, improve and expand the training of health care providers, and expand and improve the quality of health information available to health care providers, patients, and their families with telehealth.
- The U.S. Department of Health and Human Services awarded \$1.7 million in February 2011 to the Kansas REC at the Kansas Foundation for Medical Care, Inc. The funds will help Kansas' 95 critical and rural hospitals adopt EHRs. The REC works with health care providers to navigate the maze of selecting a software vendor for EHRs and provides other technical assistance. The REC is also collaborating with the KHA to deliver services to eligible hospitals. This funding is part of a \$12 million federal program administered by the ONC and funded under ARRA.

### Veterans Administration (VA) or Indian Health Services (Response to Question #4)

There are three VA facilities located in Leavenworth, Topeka and Wichita, and 17 community-based outpatient clinics throughout the State.

## Section A: State “As-Is” Landscape

The Indian Health Service currently operates EHRs in some of its clinics. Kansas is included in the Oklahoma City Area Indian Health Service, which serves Oklahoma, Kansas and portions of Texas. There are four formal tribal nations located within the State.

- The Iowa Tribe of Kansas and Nebraska, located in White Cloud, Kansas, currently uses the Resource and Patient Management System (RPMS) EHR system. The primary care clinic on the reservations and is lead by the U.S. Surgeon General’s office.
- The Prairie Band Potawatomi Nation, located in and around Mayetta, Kansas adopted the RPMS system. The primary care clinic on its reservation and is funded by the federal Indian Health Service and supported, in part, by the tribes.
- The Kickapoo Tribe in Kansas is located near Horton, Kansas is currently remodeling its clinic and acquiring an EHR. The tribe has a primary care clinic on its reservation and is funded by the federal Indian Health Service and supported, in part, by the tribes. At the time of the survey, it was performing manual recordkeeping.
- The Sac and Fox Nation of Missouri in Kansas and Nebraska is one of three federally recognized American Indian tribes of the Sac and Meskwaki (Fox) peoples. Its offices are located in Reserve, Kansas. They use White Cloud, Pottawatomi or Kickapoo health clinics, above, along with other local public health clinics.

## Section A: State "As-Is" Landscape

- The Haskell Indian Nation University, located in Lawrence, Kansas, uses the Indian Health Service clinic in Lawrence, Kansas and supports Hunter Health Clinic, a FQHC and safety-net clinic in Wichita, Kansas. Haskell serves the educational needs of American Indian and Alaska Native people from across the United States.

KDHE attended the National Indian Health Board (NIHB), which represents Tribal governments, at meetings in September of 2010 and June 2011. KDHE will continue communications with NIHB on HIT issues affecting the tribes.

### Stakeholder Engagement in Existing HIT/HIE Activities (Response to Question #5)

In Kansas, there is a great deal of interest in HIE and the EHR incentive program. KDHE has met with the KHA, Kansas Foundation for Medical Care (KFMC), KMS and other providers and health organizations. KDHE has participated directly in meetings, workgroups and stakeholder outreach efforts. While stakeholders are familiar with the planning efforts for the EHR incentive program and with the activities underway by the REC, there is still a need to orient specific communication to the broad spectrum of health organizations and professionals.

To respond to this need, KDHE will distribute education and outreach materials to stakeholders and will provide information explaining the EHR incentive program, benefits and requirements of the program. KDHE will also provide educational and technical assistance about adoption, implementation, upgrade and meaningful use of EHRs. KDHE will tailor communications efforts to specific audiences, including:

- Providers, both adopters and non-adopters of EHR
- Provider's gatekeepers and influencers (e.g., office managers)
- Hospital staff (e.g. Chief Financial Officers, Chief Information Officers)

Additionally, KDHE has placed a link to the materials prepared by CMS related to the EHR Incentive Program, links to other resources, and reference materials on its website.

## Section A: State “As-Is” Landscape

### Current HIE Organizations and Activities in Kansas (Response to Questions # 6, 7 and 9)

To accomplish the HIE planning process; KDHE has involved a broad range of stakeholders through various organizations and activities as described below.

#### *Kansas Health Information Exchange, Inc. (KHIE)*

Governor Mark Parkinson created the KHIE and its Board of Directors by *Executive Order 10-06* to assure the statewide provision of HIE services in Kansas. KHIE has the responsibility of approving Health Information Organizations (HIOs) in the State as well as setting policy for the facilitation of HIE in the State. The Board of Directors has 17 members, with representatives from the provider community, payer organizations, hospitals, consumers, employers, academia, the REC, pharmacy and government. A number of advisory committees have been created by the Board to help it achieve its goals and to help it continue providing a strong stakeholder involvement in HIE development in the State. KHIE will focus on policy development and governance of HIE in the State.

#### *Health Information Exchange Activities*

HIE development is shared by a diverse range of stakeholders across Kansas. To enable statewide interoperability of healthcare data, Kansas has aligned a number of concurrent projects through a coordinated approach. This coordinated approach includes the participation of the KHIE, REC, Medicaid and at least two HIE technology partners in the State.

Currently, there are two Regional HIOs providing technology services in Kansas:

- The Kansas Health Information Network is a collaborative, provider-led HIO solution originally formed by the KMS and the KHA. Currently, KHIN has a number of planned community-based HIOs which provide core HIT functionality. These include the Wichita HIE, eHealth Align in Kansas City and the Rural Health Information Network.

## Section A: State “As-Is” Landscape

- The Lewis and Clark Health Information Exchange (LACIE), initiated by the Heartland Health System and located in St. Joseph, Missouri is the second technology provider. The exchange is currently expanding participation to include a number of Kansas providers.

Two health systems, the University of Kansas Medical Center and Pioneer Health Network, also incorporate Telemedicine, medical consultation and other services beyond baseline EHR or HIE.

### Role of MMIS in Current HIT/E Environment (Response to Question #8)

KDHE intends for the MMIS to fully comply with standards as required under Title II, subtitle F, sections 261 through 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191; the Medicaid Enterprise Certification Toolkit; the ASC X12 Version 5010/National Council for Prescription Drug Programs (NCPDP) Version D.0; and the International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) standards, as required by Federal Register Vol. 74, No. 11 / Friday, January 16, 2009 / Rules and Regulations. KDHE is responsible for the SMHP.

The current MMIS contract will expire in 2015. KDHE is currently exploring options for reprocurement that will consider the Medicaid enterprise as a whole. Kansas is currently developing a Statement of Work for a detailed technical analysis of Medicaid Systems and the abilities of those systems to support meaningful use of EHRs and integrate with Kansas’ HIE to manage the care Medicaid beneficiaries receive. The technical analysis will provide more information on leveraging current Medicaid systems to further enhance the use of the HIE and EHRs to manage the care of Medicaid beneficiaries and will impact MMIS and MITA activities going forward.

### Relationship with State Government HIT Coordinator (Response to Question #10)

The State HIT Coordinator plays an important role in bringing together the executive branch of State government, public and private stakeholders, health agencies, State agencies and other organizations and individuals with an interest in HIE. The State HIT Coordinator will be the primary liaison with the State and is the Executive Sponsor of the SMHP development.

## Section A: State “As-Is” Landscape

### Current Department Activities Likely to Influence EHR Incentive Program (Response to Question #11)

Kansas is also in the process of updating its Medicaid eligibility system. The new eligibility system may allow for expanded use of the system to other eligibility programs in Kansas. KDHE submitted an Advanced Planning Document (APD) to CMS on June 6, 2011 and CMS granted conditional approval on June 29, 2011. The Kansas Medical Eligibility Determination System (K-MED) APD states:

*“The goal of the Kansas Medical Eligibility Determination (K-MED) project is to modernize the KDHE Medicaid eligibility determination practices through business process design supported by an integrated ‘customer centric Medical Eligibility Determination system. All Medicaid program eligibility cases will be supported by this integrated, customer-centric services model. K-MED will serve as the “medical eligibility system of record” for all users in need of consolidated, current, and historical Medicaid program eligibility information.*

*The K-MED solution will include core functionality to allow for expanded use of the system to other eligibility programs and services, including those managed and administered outside of KDHE. The system must allow for some shared functionality, such as a common user-interface and data base structure, but also serve the unique needs of individual programs. Other agencies will be able to build on the K-MED platform to administer their programs.”*

The architecture of the K-MED system allows for a broad based leveraging of resources across a number of additional State systems, including the possibility of providing some base demographic services related to HIE. In the future, Kansas may consider using the K-MED system in interfacing with the future Kansas HIE or to use K-MED as the System of Record for the Kansas Master Patient Index that will be part of the Kansas HIE systems specifications.

### Recent Relevant Changes to State Laws and Regulations (Response to Question #12)

In the 2009 Legislative session, the Kansas Senate passed a resolution recognizing the need to harmonize state law to promote the use of HIT and HIE. In accordance with this resolution, KDHE (as the State-Designated Entity) charged the Legal Workgroup with assisting in the completion of the work initiated three years earlier by HISPC in Kansas. The Legal Workgroup was comprised of more than twenty-five attorneys and privacy subject matter experts. KDHE

## Section A: State “As-Is” Landscape

identified members of the Workgroup based on the diverse organizations they represented and their previous experience in identifying Kansas privacy and security issues related to HIT and HIE.

The Legal Workgroup leveraged earlier findings by the HISPC collaborative project. Prior to the 2009 Legislative session, HISPC compiled a list of Kansas statutes potentially implicated in the transition to electronic health information technology and information exchange. HISPC organized these statutes to facilitate their analysis and subsequent modernization to accommodate and promote HIT and HIE. Broadly categorized, these issues included:

- Legal recognition of EHR systems
- Record retention requirements
- Consents and universal authorization – (*eHAC consensus on Kansas Opt-out*)
- Legal structure of health information exchanges
- Patient rights
- Limitation of provider liability
- HIPAA preemption analysis

The primary outcome anticipated from the Legal Workgroup was the creation of proposed legislation entitled *The Kansas Health Information and Technology Exchange Act*, which addressed the three legal impediments to the implementation and widespread use of HIT and HIE in Kansas as described in Table B.2.

Section A: State “As-Is” Landscape

Table B.2: Legal Impediments to Implementation and Use of HIT and HIE in Kansas

Impediments to HIT Implementation	Description of Impediment	Proposed Solution
<p><b>Inconsistent State Privacy Laws</b></p>	<p>The federal HIPAA Privacy Rule preempts all state health information privacy laws unless a particular law affords greater privacy protection for an individual. Since the HIPAA Privacy Rule took effect in April 2003, providers have struggled with this preemption analysis, often unable to determine whether a particular use or disclosure of protected health information is prohibited under state law while permitted under the HIPAA Privacy Rule. Consistent and understandable privacy rules are critical to the widespread use of HIEs; otherwise, providers will be reluctant to include a patient’s information in the HIE for fear of potential liability and disciplinary action.</p>	<p>The Legal Workgroup recommended aligning state law with the HIPAA Privacy Rule. This action potentially would be accomplished by incorporating into state law the specific provisions of the HIPAA Privacy Rule regarding individuals’ access to their PHI, safeguarding PHI and uses and disclosures of PHI. Rather than attempting to repeal or amend the dozens of state statutes and regulations that address this subject, the proposed legislation would afford providers immunity from liability if they adhere to the aforementioned provisions of the HIPAA Privacy Rule. The current state statutes and regulations would remain on the books, but there would be no consequences for a violation.</p>
<p><b>Gaps in state law regarding identification of personal representatives.</b></p>	<p>Kansas law provides little direction on the question of who can act on behalf of an incapacitated adult, deceased individual or minor with respect to a range of health care decisions.</p>	<p>The Legal Workgroup recommended the creation of a priority list for providers to follow in the event that providers must require another individual to act on behalf of a patient lacking decision-making capabilities.</p>
<p><b>Need for HIE ground rules</b></p>	<p>The Kansas HIT Exchange Act will be the primary outcome of the Legal Workgroup and will address inconsistent state privacy laws, gaps in state law regarding identification of personal representatives, the consensus for an opt-out consent model in Kansas, and the need for HIE ground rules concerning disclosure of PHI to the HIE.</p>	<p>The Legal Workgroup considered appropriate safeguards relating the inclusion of an individual’s PHI in an HIE, and devised the following strategy. One of KHIE’s roles will be to establish standards for an HIE to qualify as a State-approved HIE. One such standard would require HIEs to enter into participation agreements with the providers who submit patients’ information to the HIE. Those participation agreements would require providers to give written notice to any individual whose PHI the provider wishes to include in the HIE. Such notice would inform the individual of his or her right to withhold some or all of his or her PHI from the HIE, or restrict disclosures of certain types of PHI (mental health treatment records, for example). The provider would be obligated under the</p>

Section A: State "As-Is" Landscape

Impediments to HIT Implementation	Description of Impediment	Proposed Solution
		<p>participation agreement to adhere to any such patient directive. Hence, a provider would enjoy immunity relating to any disclosure to an HIE, provided that such disclosure is made to a State-approved HIE, that the provider afforded proper notice to the individual, and that the provider adhered to any written directive from the patient</p>

## Section A: State “As-Is” Landscape

The Kansas Health Information Technology and Exchange Act was signed into law in May 2011 as part of House Bill 2182. The Kansas Health Information Technology and Exchange Act harmonizes Kansas health information laws with federal HIPAA Privacy and Security Rules in preparation for the exchange of confidential clinical information contained in electronic health records. This should eliminate a significant barrier to the broad use of technological advancements supporting the appropriate and secure collection, use, and exchange of protected health information. The Act will greatly assist the new Kansas Health Information Exchange, Inc., which is charged with overseeing the development of a statewide health information exchange.

### HIT/E Activities Crossing State Lines (Response to Question #13)

Kansas residents seek and receive healthcare services across state lines. KDHE monitors HIT and HIE activities that may affect Medicaid recipients and encourages secure data exchange. The following activities are currently underway:

The Lewis and Clark Health Information Exchange in St. Joseph, Missouri (discussed in the response to question #5 above) intends to provide exchange services across four states including; Kansas, Missouri, Iowa and Nebraska.

Another organization that works with bordering states is the Kansas Health Information Network (KHIN). KHIN’s mission is to improve health care quality, coordination and efficiency through the exchange of health information at the point of care utilizing a secure electronic network provided by a collaboration of health care organizations. Through their work in the Kansas City area, KHIN has repeatedly performed outreach to Missouri and Nebraska state systems and providers.

Kansas has also been working with other states’ HIE systems, specifically those in Missouri and Nebraska, to assure that the exchange of information is as safe and private as possible. Kansas

## Section A: State “As-Is” Landscape

is involved in discussion to determine if there are any leveraging opportunities across state lines. Kansas will continue to foster interstate privacy and security policy harmonization.

Since June of 2006, Kansas has participated in Health Information Security and Privacy Collaboration, a federally funded effort to identify common solutions to privacy and security issues related to electronic HIE. Kansas has also participated in the Harmonizing State Privacy Law Collaborative and the Consumer Education and Engagement Collaborative initiatives of HISPC.

The purpose of the Harmonizing State Privacy Law Collaborative is to support the implementation of both intrastate and interstate electronic HIE by assisting states in identifying, analyzing and reforming their laws as they relate to the adoption of HIE. Extensive discussions and activities with stakeholders during the first phase of the Harmonizing State Privacy Law Collaborative determined that an overall lack of clarity in legal standards, and in interpretation of those standards, has created multiple barriers to the adoption of HIE. Harmonizing State Privacy Law Collaborative developed a set of analytical tools and a narrative guide to support the harmonization process.

One of these tools is the result of work conducted by the Kansas Legal Workgroup in 2007. The tool is designed to be used by individual states to facilitate discussion about laws or gaps in law that may present barriers to the adoption of HIE within the state. The tool helps to facilitate discussions about the feasibility of a potential legal change in terms of need, cost, ease of reaching consensus and impact on privacy.

The HISPC Consumer Education and Engagement Collaborative was a multi-state effort to educate consumers and engage them in the implementation of HIE. The Consumer Education and Engagement Collaborative states were diverse in their resident populations and healthcare resource needs. The Kansas Consumer Education and Engagement Collaborative targeted residents of rural Kansas and focused on the following goals:

- Identify rural consumers' HIE and HIT privacy and security education needs and solicit feedback on preferences in regards to dissemination of messages. Collaborate

## Section A: State “As-Is” Landscape

with other states to advance education of consumers on HIE and HIT privacy and security issues.

- Search for, customize, develop, and refine educational materials for informing consumers in rural Kansas about privacy and security of HIT and HIE. Pilot test select resources from the toolkit developed. Make an educational tool kit available to the CEEC and others through a Web portal.
- Develop a communication plan to disseminate the targeted messages on HIE and HIT privacy and security and to evaluate the impact of the HIT and HIE privacy and security education materials.
- Collaborate with other states to catalog relevant materials and tools, and to develop a glossary on HIT and HIE privacy and security terms through the State Health Policy Consortium Project.

Kansas participates in the Midwest Consortium, a group of Midwestern universities, whose intent is to expand on ONC’s and RTI International 2006–2009 research entitled *Privacy and Security Solutions for Interoperability Health Information Exchange* (HISPC 1.0). The Midwest Consortium is a grant project committed to working collaboratively to solve interstate data exchange issues. Additionally, the Consortium aims to provide a proven set of tools for use as working examples by other states.

Kansas is also part of the MAPIR Collaborative. The MAPIR Collaborative consists of 13 states that all use the HP Enterprise Services MMIS. The MAPIR module will serve as the interface between the Kansas MMIS and the CMS R&A. Kansas shared in the costs of developing the core MAPIR system and participates in the MAPIR Steering Committee. The MAPIR Collaborative works together not only on the MAPIR system but also collaborates on operational issues related to the Medicaid EHR Incentive Program. For example, the MAPIR

## Section A: State “As-Is” Landscape

Collaborative shares resources and tools related to “go-live” and will soon form a Community of Practice that CMS and its technical assistance contractor will facilitate.

### Current Interoperability Status of State Immunization Registry and Public Health Surveillance Reporting (Response to Question #14)

The Kansas Immunization registry (KANSAS WebIZ), operated and maintained by KDHE, has enrolled more than 1.3 million patients, tracking more than 9 million immunizations across 205 provider offices statewide. The registry continues to expand.

KDHE also supports two state disease registries: The Kansas Cancer Registry and the Kansas Diabetes Quality of Care / Chronic Disease Electronic Management System. The Kansas Cancer Registry is the only population-based source of information on cancer incidence in the State of Kansas. The Kansas Diabetes Quality of Care / Chronic Disease Electronic Management System Project pilot was launched in 2004 by KDHE’s Diabetes Prevention and Control program in more than 90 diverse healthcare clinic sites across the State. The project is currently collecting quality of care diabetes data to guide care improvements for Kansans with diabetes. The project uses CDEMS, a public domain software program, to collect patient and clinic level data at each site. The goal is to transform the currently essentially reactive health system to a proactive system designed to keep individuals as healthy as possible.

KHIE and its partners will continue to rely on integration with a variety of external organizations. Organization examples include suppliers of direct services, such as SureScripts or other medication history data providers, State agencies, such as KDHE and its KANSASWebIZ (immunization registry) program, and other health information organizations.

KHIE will also develop an assessment of risks associated with statewide HIE along with a plan to mitigate and manage these risks. To ensure the risk management plan is comprehensive, KHIE will include the HIT Coordinator, approved HIOs, REC and Medicaid in the development of the plan.

## Section A: State "As-Is" Landscape

### Transformation Grant or CHIPRA HIT Grant (Response to Question #15)

In January 2007, Kansas received \$906,664 to improve preventive care services for disabled Kansans served by the Medicaid program. The money funded a two-year pilot program that provided case managers at selected Community Developmental Disability Organizations and Community Mental Health Centers with a computerized system and training to help them more efficiently deliver preventive services. In part, the grants were intended to support and expand the use of electronic health records to improve care and reduce medical errors.

CMS awarded Kansas a \$1.2 million federal Children's Health Insurance Program Reauthorization Act (CHIPRA) bonus grant in August of 2011. Kansas used two thirds of this funding to hire temporary employees to reduce the Medicaid backlog and the remaining third of the funding towards the Children's Health Insurance Program (CHIP) funding shortfall. Kansas also recieved a second CHIPRA award which will be applied to the CHIP funding shortfall.

## Section B: State's "To-Be" HIT Landscape

### Section B: State's "To-Be" HIT Landscape

This section responds to each of the questions listed in the CMS SMHP Template and provides an overview of KDHE's "To-Be" landscape as it implements the Medicaid EHR incentive program and moves towards achieving its HIT and HIE vision.

**Table B.1: Section B Questions from the CMS SMHP Template**

Please describe the State's "To-Be" HIT Landscape:	
1.	Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc.
2.	*What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locator Service?
3.	How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?
4.	Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA's HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.
5.	What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?
6.	** If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption?
7.	** How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?
8.	** How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?
9.	If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.?
10.	Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.
	* May be deferred. ** The first part of this question may be deferred but States do need to include a description of their HIE(s)' geographic reach and current level of participation.

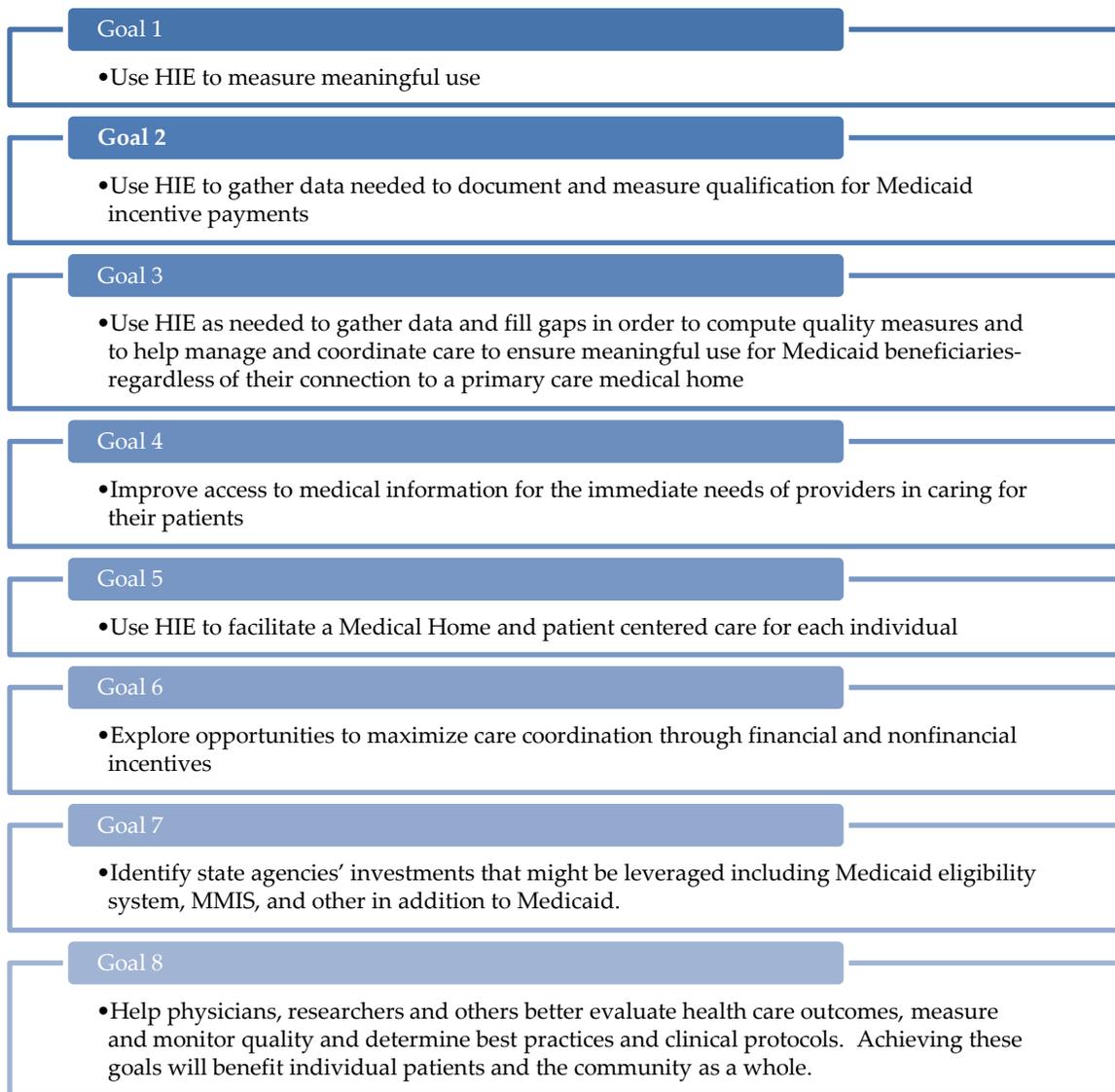
## Section B: State's "To-Be" HIT Landscape

### KDHE's Goals (Response to Questions #1 and #4)

This section provides an overview of KDHE's vision of how HIT adoption will support KDHE's overarching HIT goal to promote and achieve widespread adoption and meaningful use of HIT. This goal places emphasis on the use of technology to exchange health information, improve health care delivery and implement a medical home for all Medicaid recipients. The Kansas Medicaid program currently covers nearly 14.9 percent of the Kansas population and KDHE expects the Medicaid program to grow significantly following implementation of coverage expansions in 2014. Encouraging Kansas Medicaid providers to adopt HIT will improve healthcare for all the Medicaid clients these providers serve.

KDHE's long-term goal is to have 100 percent of eligible Kansas Medicaid providers adopt EHRs. The ultimate goal of the Kansas HIT Initiative is to continue to provide quality services to Medicaid consumers. Figure B.1 describes KDHE's other goals concerning HIT.

**Figure B.1: KDHE's HIT Goals**



Reaching these goals is an incremental and collaborative effort that involves participation by a broad range of stakeholders.

KDHE participated actively in the development of the statewide HIE plan. On June 30, 2010, Governor Mark Parkinson initiated the process of forming KHIE through an Executive Order. KHIE is a public-private partnership charged with overseeing federally sanctioned HIE efforts in the state. KDHE sits on the KHIE Board of Directors and works with the state HIE

## Section B: State's "To-Be" HIT Landscape

coordinator, the KHIE, and a wide range of stakeholders to lead the state to meeting their HIE goals.

### MMIS System Architecture and EHR Incentive Program System (Response to Questions #2, 3, and 4)

The MMIS and the State's Data Analytical Interface (DAI) system will send requests for services and receive administrative and clinical data necessary for incentive payments through the HIE. Information received by the MMIS/DAI will include patient data used to measure quality improvement and administrative data. KDHE will also be able receive information directly from the Nationwide Health Information Network as necessary for treatments, payment or administrative activities. The DAI is an integrated multi-layer decision support system that includes MMIS data as well as State Employee Health Plan data and data from Kansas insurance carriers. The DAI is ancillary to the MMIS and serves to meet some Kansas MMIS reporting functions. The DAI is partially funded with enhanced MMIS-related federal financial participation.

Kansas will re-evaluate and enhance the current Medicaid/DAI operations in light of the Medicaid EHR Incentive Program, including an enhancement of the MMIS/DAI architecture to support the exchange of healthcare data and to meet all HITECH goals. Kansas' current MMIS fiscal Agent contract with HP Enterprise Services, should the State exercise all of the optional extension years, expires June 2015. In the meantime, Kansas intends to modify and enhance the MMIS to use the new K-MED system to replace all or part of the current Kansas MMIS Beneficiary subsystem.

All MMIS/DAI system development related to HIT will be coordinated with ongoing federal initiatives, especially those changes associated with 5010, ICD-10, the Patient Protection and Affordable Care Act and the development of the Medicaid Information Technology Architecture. In addition, KDHE is concurrently developing a Scope of Work to obtain a detailed technical analysis of Medicaid Systems and the abilities of those systems to support meaningful use of EHRs and integrate with Kansas' HIE to manage the care Medicaid beneficiaries receive.

## Section B: State's "To-Be" HIT Landscape

For its Medicaid EHR Incentive Program, KDHE is coordinating with 12 other states to develop the MAPIR application that applicants will use to apply for incentive payments. The MAPIR system will both track and act as a repository for information related to payment, applications, attestations, oversight and functions. The MAPIR system will interface with both the MMIS Provider Portal and the CMS R&A for:

- Medicaid provider information data, e.g., provider files, sanctions, licensure, claims
- Information concerning the provider that registered for payment at the R&A stored in federal databases, e.g., restrictions, incentive program participation in other states and Medicare, etc.
- Information collected from providers as they apply to participate in the incentive (NPI, Payee Tax Identification Number)

In addition, MAPIR will contain a series of edits and checks used during the provider application process, e.g., confirmation of R&A information, patient volume and attestations. Section C and Section D include information regarding the application, attestation and eligibility process and describes how KDHE will use MAPIR in program oversight and auditing.

As allowed in the final rule, Kansas will pay Hospital EHR incentive payments over three years, 50 percent of the total incentive in Year 1, 30 percent in Year 2 and the remaining 20 percent in Year 3.

### Role in Encouraging HIT Adoption and Ongoing Provider Outreach and Education (Response to Questions #5 and 7)

KDHE is currently involved in several education and outreach efforts that will continue during the Medicaid EHR Incentive Program lifespan.

Providers have received information and are familiar with the planning efforts for adoption of EHRs and HIE; however, there is still need to orient specific communications to the broad spectrum of health organizations and professionals. Consequently, KDHE will continue to

## Section B: State's "To-Be" HIT Landscape

work with the REC to carry out the communication plan. Section C includes a more detailed discussion of planned communications.

The REC in Kansas will be responsible for providing education, outreach and technical assistance to help providers in the geographic service areas selected successfully implement and reach meaningful use of certified EHR technology. The REC will also help providers achieve, through appropriate available infrastructures, exchange of health information in compliance with applicable statutory and regulatory requirements and patient preferences. KDHE has and will maintain a relationship with the REC through periodic meetings and joint participation in KHIE activities. KDHE intends to work with the REC to explore options for focused work with Medicaid providers.

In addition, Kansas Medicaid HIT project staff members participate in the monthly Kansas Health Information – Coordination Team (KHI-CT) meetings. The KHI-CT is a multidisciplinary team of professionals charged with the implementation of HIT and HIE in Kansas. It includes representatives from Medicaid, the KHA, the KMS, the prescription monitoring program (K-TRACs), the two HIEs in Kansas, KHIN and LACIE, the REC, the HIT Coordinators office and other interested stakeholders. The focus of the group is to coordinate the development of HIT and HIE in Kansas across all constituent groups to maximize functionality and minimize costs. KDHE is heavily involved in its own planning efforts and the REC will offer direct services to many providers across the State. The communication strategy includes three broad focus points:

- Identify the broad range of KHIE and HIO Medicaid providers.
- Create and use a communication plan and materials targeted toward providers at their stage of readiness and work with the REC to reach these users.
- Maintain collaboration in the communication and outreach efforts between the REC and KDHE.

## Section B: State's "To-Be" HIT Landscape

Educational and outreach activities will include onsite stakeholder meetings held across Kansas, newsletters, fact sheets and webinars to connect with the broadest audience possible. All educational and outreach activities are focused on a specific audience, including the following:

- Providers, both adopters and non-adopters of EHR
- Provider gatekeepers and influencers (e.g., office managers, clinical champions)
- Hospital staff (e.g. Chief Financial Officers, Chief Information Officers)

KDHE and the REC will continue to address issues specific to each audience and will guide participants as they determine HIE readiness and move toward meaningful use.

### Leveraging Related Funding Resources (Response to Questions #6 and 9)

The HITECH Act of the ARRA and other healthcare reform initiatives have provided numerous opportunities for providers, hospitals, clinics, health systems and all involved in the delivery of healthcare to benefit from various funding opportunities that either allow for the adoption, implementation or upgrade of EHRs or support quality initiatives where HIT is used in meaningful ways. As KDHE plans for the implementation of the Medicaid EHR Incentive Program, it is also considering how these other resources and funding streams will effectively drive the success of this initiative.

Two specific areas where KDHE will work closely to coordinate funding resources are with 1.) FQHCs who have received funding via HRSA, and 2.) other programs that have been awarded other HIT-related grants, e.g., the State HIE Program. More information regarding HIT related grants awarded to the State is included in Section A.

Kansas is exploring ways to use enhanced 90/10 matching funds from the Medicaid EHR Incentive Program for activities that will help implement proposed SMHP services and equipment. According to recent guidance from CMS, incentive payments may fund more innovative activities related to the EHR Incentive Program, for example:

- System and resource costs associated with:
  - CMS R&A interface

## Section B: State's "To-Be" HIT Landscape

- Development, capture, and audit of provider attestations
  - Collection and verification of meaningful use data from providers' EHRs
  - State interfaces with HIE, Laboratories, Immunization Registries, and Public Health
- Data Warehouse development or enhancement
  - Provider Directory development and maintenance
  - Master Patient Index development and maintenance
  - New Medicaid business processes

Kansas is still considering which innovative activities to fund using enhanced 90/10 match and will describe its funding request in the Implementation Advanced Planning Document (I-APD).

### Addressing the Unique Needs of Special Populations (Response to Question #8)

EHR technology can help to address the unique, complex and special healthcare needs of Medicaid recipients. In addition to addressing racial and ethnic healthcare disparities, EHR technologies have shown decreased administrative burdens and improved quality of care in rural areas.<sup>5</sup>

Special needs populations may have the most to gain from successful EHR adoption and HIE. HIT that adequately captures and exchanges appropriate medical information in real-time is essential for providing effective and appropriate healthcare to populations with unique needs and allows tracking and communication between rural health populations with larger health facilities. For patients with complex healthcare needs, this could include exchanging healthcare information with all providers, social agencies and the patient to coordinate and manage complex conditions. Special need populations may also benefit from participation in a medical home to coordinate their care.

---

<sup>5</sup> United States Government Accountability Office, *Features of Integrated Systems Support Patient Care Strategies and Access to Care, but Systems Face Challenges* (November 2010).

## Section B: State's "To-Be" HIT Landscape

Implementing a medical home model is one of the goals for Kansas HIT. Kansas continues to pursue a Medical Home to address the unique needs of participants of the Medicaid, CHIP, and State Employees Health Plan. Planning for the Medical Home began in 2007 and culminated with the passage of *Senate Bill 81*. In 2009, the Kansas Medical Home Initiative became part of the statewide HIE initiative since information exchange and coordination is a requirement of a successful medical home.

### The Need for Additional Legislation (Response to Question #10)

As addressed in Section A of this document, the Kansas Health Information Technology and Exchange Act was signed into law in May 2011 as part of House Bill 2182. The Kansas Health Information Technology and Exchange Act harmonizes Kansas health information laws with federal HIPAA Privacy and Security Rules in preparation for the exchange of confidential clinical information contained in electronic health records. This should eliminate a significant barrier to the broad use of technological advancements supporting the appropriate and secure collection, use, and exchange of protected health information. The Act will greatly assist the new Kansas Health Information Exchange, Inc., which is charged with overseeing the development of a statewide health information exchange.

Recognizing the importance of a legal environment for HIT and HIE in Kansas, the newly formed KHIE, KDHE and other interested parties will continue to research what, if any additional legislation should be introduced to promote HIE in Kansas.

Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

**Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program**

This section responds to each of the questions listed in the CMS SMHP Template and provides an overview of the activities KDHE will undertake to administer and ensure that eligible professionals and eligible hospitals have met Federal and State statutory and regulatory requirements for the Medicaid EHR Incentive Payment Program.

**Table C.1: Section C Questions from the CMS SMHP Template**

Describe the methods KDHE employs and what activities KDHE will undertake to administer and oversee the Medicaid EHR Incentive Program:
1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?
2. How will the SMA verify whether EPs are hospital-based or not?
3. How will the SMA verify the overall content of provider attestations?
4. How will the SMA communicate to its providers regarding their eligibility, payments, etc?
5. What methodology will the SMA use to calculate patient volume?
6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?
7. How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement?
8. How will the SMA verify <i>adopt, implement or upgrade</i> of certified electronic health record technology by providers?
9. How will the SMA verify <i>meaningful use</i> of certified electronic health record technology for providers' second participation years?
10. 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.
11. How will the SMA verify providers' use of <i>certified electronic health record technology</i> ?
12. 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?
13. * How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?
14. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?

Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

Describe the methods KDHE employs and what activities KDHE will undertake to administer and oversee the Medicaid EHR Incentive Program:
15. What IT systems changes are needed by the SMA to implement the EHR Incentive Program?
16. What is the SMA's IT timeframe for systems modifications?
17. When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (R&A)?
18. 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)?
19. What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc?
20. Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD?
21. What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?
22. 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?
23. 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?
24. What is the SMA's anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)?
25. 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?
26. 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?
27. 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?
28. What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs' 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?
29. 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.?
30. States should explicitly describe what their assumptions are, and where the path and timing of their plans have

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

Describe the methods KDHE employs and what activities KDHE will undertake to administer and oversee the Medicaid EHR Incentive Program:
<p>dependencies based upon:</p> <ul style="list-style-type: none"><li>• The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support)</li><li>• The status/availability of certified EHR technology</li><li>• The role, approved plans and status of the Regional Extension Centers</li><li>• The role, approved plans and status of the HIE cooperative agreements</li><li>• State-specific readiness factors</li></ul>
<p>* May be deferred. ** The first part of this question may be deferred but States do need to include a description of their HIE(s)' geographic reach and current level of participation.</p>

In this section, as with the other sections, KDHE is requesting enhanced 90/10 match for all activities unless otherwise noted. The following steps provide an overview of the activities KDHE will conduct to administer and oversee the Medicaid EHR Incentive Program.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

### Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)

KDHE is responsible for communicating with providers about enrolling in the Medicaid EHR Incentive Program and will:

- Inform providers of the EHR incentive program and the requirements for participation
- Inform providers about how to begin the enrollment process
- Inform providers that:
  - They will be asked for a National Provider Identifier (NPI) when they register
  - An NPI is necessary for the enrollment process and providers should obtain an NPI if they do not have one already (e.g., providers who practice predominantly in a health center)
- Inform hospital providers they are to:
  - Have a CMS Certification Number ending in 0001-0879
  - Have at least 10% Medicaid patient volume (except for Childrens' hospitals"
  - Recommend selecting both Medicare and Medicaid in the R&A system
- Inform providers that, to participate in the incentive program, they must be participating Medicaid providers (KDHE cannot conduct proper oversight, or reclaim overpayments if providers are not enrolled)
- Coordinate with the REC and other resources to provide technical assistance and information related to EHR adoption, implementation, upgrade, and meaningful use of EHRs

KDHE is collaborating with Kansas's REC, part of the Kansas Foundation for Medical Care, to support Medicaid provider outreach and education activities. The REC conducts meetings and provides information to educate providers about the EHR incentive program during which KDHE and the REC discuss the EHR incentive program and how to access the technical support of the REC.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

As an example of coordinated outreach by KDHE with KFMC, during the REC Education Day event held May 3, 2011, KDHE presented information about the Kansas Medicaid EHR Incentive Program outreach.

In addition to collaborating with KFMC, KDHE has also participated in outreach activities to other external and internal organizations. KDHE attended Tribal discussions at the June 24, 2011 Kansas State/Tribal Consultation Meeting in Mayetta, Kansas. At the Tribal Consultation meeting, KDHE provided program information and discussed several topics, including those presented at the REC Education Day. KDHE also presented an overview of the Kansas Medicaid EHR Incentive Program to the KHA on July 12, 2011 and to the Kansas Medicaid HIT Stakeholder group on July 22, 2011.

Through outreach and collaboration activities, KDHE has seen interest and questions from providers about the Medicaid EHR Incentive Program. Some of the questions raised to KDHE are a result of misinformation, conflicting information or a simple lack of information.

To address questions and interest, KDHE believes that a communications plan with consistent messages and multiple vehicles for information distribution will help to raise provider awareness, understanding, participation, and eventually help retain providers in the incentive program so that Medicaid providers become meaningful users of EHRs. Please see Appendix IV for a copy of our Communications Plan.

KDHE will develop several types of provider education and outreach materials and ensure that all educational materials are accurate and communicate a uniform message. In particular, KDHE will provide:

- Materials that explain the Medicaid EHR incentive program
- Educational and technical assistance materials about implementation, upgrade and meaningful use of EHRs in coordination with the REC

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

KDHE's communication and outreach materials will help attract, retain and support EHR Incentive Program participants but the initial focus includes conducting outreach to help eligible participants enroll in the Medicaid EHR Incentive Program.

Examples of outreach materials and communication vehicles include a series of webinars for both providers and hospitals. The webinars cover topics including an overview of the Medicaid EHR Incentive Program, eligibility information, patient volume calculation, program monitoring and program support and resources. The webinar series will allow for live participation and, after KDHE conducts the webinar, KDHE will post the webinar on KDHE's website along with other education and outreach materials and resources.

### Step 2: Providers will enroll in the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (Response to Questions #1, 16, 17 and 30)

Before the provider can apply to participate in the State's Medicaid incentive program, the provider must enroll in the CMS R&A. The goal of the R&A is to ensure that there are no duplicate or improper payments resulting from providers switching among state Medicaid EHR Incentive Programs or between Medicaid and Medicare (applies only to eligible professionals as hospitals can receive both Medicaid and Medicare incentive payments). KDHE is creating the MAPIR system in collaboration with 12 other state Medicaid agencies to interface with the R&A and the core MAPIR system. Multiple states have already tested MAPIR's interface with the R&A but KDHE will need to do additional testing upon the completion of the Kansas specific modifications and implementation. KDHE anticipates that testing Kansas modifications will occur late calendar year 2011. KDHE also anticipates making payments for calendar year 2011 in February or March 2012. This will require a grace period or attestation tail for both eligible hospitals and professionals with a longer attestation period for hospitals. This attestation tail is very important to KDHE's Medicaid EHR Incentive Program because KDHE wants to make sure that Kansas providers can receive incentive payments for both 2011 and 2012.

KDHE's understanding is that the R&A will collect from providers the types of information listed below:

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

- NPI: National Provider Identifier where the source system is NPPES (National Plan and Provider Enumeration System);
- CCN: Provider number (for hospitals);
- Payee TIN type; selection is Tax Information Number (TIN) or Social Security Number (SSN)
- Payee NPI: National Provider Identifier of the entity receiving payment (EPs);
- Payee TIN: TIN that is to be used for payment;
- Personal TIN: Personal TIN or SSN (for EPs);
- Record Number: A unique identifier for each record on the interface file;
- Program Option: Eligible Professional's choice of program to use for incentives; Values include Medicare or Medicaid. For hospitals, a selection of Dually Eligible is also available;
- State: The selected State for Medicaid participation;
- Provider Type: Differentiates types of providers as listed in HITECH legislation;
- Confirmation number: Unique number created by the R&A and used by the State if desired to confirm the provider's identity for registration;
- Providers will indicate whether they wish to assign their incentive payment (and, if so, to whom they wish to assign their incentive payments) in the R&A; and
- Email address of applicant.

The R&A will also interface with other sources of provider information including the Health and Human Services – Office of the Inspector General (HHS-OIG) Exclusions Database, which will help to identify providers who are ineligible due to exclusions or sanctions. After the R&A collects applicable information, the R&A will interface with MAPIR to continue the application process.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

Step 3: The R&A will provide information to KDHE through MAPIR interfaces about providers who have applied for the incentive program (Response to Questions #14, 18, 20 and 29)

The provider applicant will begin the application process by entering information in the R&A. The R&A will then send the provider information to the states in a daily batch file that KDHE will load into MAPIR.

KDHE is developing MAPIR to track and act as a repository for information related to applications, attestations, payments, appeals, reporting, oversight functions and interface with the R&A. KDHE will use the MAPIR system to process most of the stages of the payment enrollment process including:

- Interfaces to the R&A
- Provider applicant verification
- Provider applicant eligibility determination
- Provider applicant attestation
- Provider application payee determination
- Application submittal confirmation/digital signature
- Payment determination (including R&A confirmation)
- Payment generation
- Provider email notifications
- Audits and appeals tracking

KDHE is designing the MAPIR provider interface with the goal of gathering complete information in a manner that reduces burden for the applicant. A MAPIR user guide and detailed help information within MAPIR will provide additional instructions regarding the information that the applicant is to provide or confirm.

KDHE is integrating MAPIR to its existing MMIS Enterprise architecture. KDHE will access MAPIR via the current MMIS provider internet portal. MAPIR will interface with KDHE's MMIS system to validate provider information received from the R&A and will capture and

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

maintain related incentive program information, e.g. registrations, attestations, and payment totals.

Once KDHE approves a provider incentive application for payment, the current MMIS financial system will generate a payment. This will allow KDHE to leverage current financial transactions, including payment via check or EFT, remittance advice notifying the provider of payment, and 1099 processing. Communication via file transfer protocol (FTP) will be required with the R&A.

In addition to the provider interface, MAPIR will have administration interfaces, which KDHE staff will use to review and process provider applications and attestations. MAPIR also provides the opportunity for KDHE users to attach notes to the MAPIR record, attach documents to provider records, track application and decision status, and generate provider correspondence via email.

The initial phase is developing and implementing MAPIR and modifying MMIS to develop the Kansas-specific business and system requirements for the initial provider application processing. Each year additional funding for system modifications will be required for capturing and tracking new meaningful use objectives, for potential changes in R&A interfaces, for upgrades that KDHE and HP may need to perform to improve provider experience as well as obtain additional monitoring, reporting, and outreach capabilities, etc.

Each state in the MAPIR Collaborative will split the total costs of developing the MAPIR core system. The costs for the Kansas share of the core MAPIR development were submitted in a separate I-APD on behalf of the 13 MAPIR states. CMS approved the core MAPIR costs in a letter dated November 15, 2011. KDHE is also seeking 90 percent Federal match for the custom interfaces and system features that HP is developing for KDHE. The costs for this installation and customization of MAPIR in Kansas are divided between a HIT Planning Advanced Planning Document (P-APD) amendment (submitted August 16, 2011) and the EHR Incentive I-APD that KDHE will submit in August 2011.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

MAPIR's "core" and custom system functionalities will facilitate the provider incentive payment and application process, and will interface with the R&A to conduct system edits and ensure that providers meet KDHE requirements. KDHE will notify applicants that do not meet program requirements.

### Step 4: MAPIR runs edits on info from R&A to determine which providers to contact for the application process (Response to Questions #1, 15, 16 and 29)

Not all applications referred by the R&A will meet KDHE's requirements. KDHE will pend provider applications that do not meet program requirements. KDHE may deny some applicants, and refer some applicants back to the R&A to correct previously submitted information.

For example, providers must be enrolled as Kansas Medicaid providers without disqualifying sanctions or exclusions to qualify for the incentive program. Providers who are not enrolled will need to enroll with Kansas Medicaid prior to using MAPIR. Information on KDHE's website will instruct providers of this enrollment requirement and how to enroll if they are not enrolled as Medicaid providers. Likewise, enrolled providers that do not meet the eligible provider type (e.g., chiropractors) based on information in the MMIS enrollment file will not be able to access MAPIR and MAPIR will direct them to KDHE for assistance.

Upon receiving information from the R&A, MAPIR will perform format and cursory content edits (e.g., Tax ID is numeric and nine digits, CMS Certification Number is six digits, program type is Medicaid, duplicate checking, etc.) in addition to determining whether the provider is on the MMIS Provider file.

If the enrolled provider has a valid Kansas Medicaid Provider logon ID and provider type, MAPIR will perform an automated check based on the NPI number associated with the logon ID or any service locations associated with that logon ID to find a match on an R&A record. If MAPIR finds a match, the provider has been verified and will begin the application process, proceeding to Step 5 of Section C.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

If a provider does not pass the MAPIR edits, then MAPIR will suspend the record and generate correspondence via email to the provider explaining the reason for the application suspension (e.g., provider not enrolled in Medicaid, etc.) and who to contact to discuss corrective action.

Additionally, KDHE will:

- Refer providers back to the R&A for errors on data provided in the R&A (e.g., incorrect Payee TIN);
- Refer non-participating Medicaid providers to the Provider Enrollment unit of the Fiscal Agent for the State of Kansas for assistance with program enrollment;
- Resolve discrepancies between the provider type entered in the R&A and the provider type stored in the MMIS; and
- Suspend and refer applicants sent from the R&A with exclusions for investigation.

KDHE will work with those providers whose applications KDHE has suspended to make every effort to resolve inconsistencies and errors before denying the application.

If the provider passes the MAPIR edits and checks in Step 4, applicants can refer to information on the KDHE's website about how to access the MAPIR application through the Kansas Medical Assistance Programs (KMAP) Provider Portal. Providers who do not pass the edits in Step 4 will not be able to access MAPIR. Introductory educational material and information about how to access MAPIR will also be available on KDHE website, in the Provider Portal, and communication materials.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

### Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)

MAPIR will capture the information submitted during the application and attestation process. MAPIR will apply real-time edits to verify that values entered are valid and that required fields are completed. The MAPIR web-based form will allow providers to save the partially completed application, exit the system and return later to complete the form. If the applicant indicates “No” to any of the attestation questions, KDHE will suspend the application for review. For suspended applications, KDHE then sends email correspondence to the provider applicant indicating that the application is suspended and that the provider can contact KDHE the MAPIR operations team for assistance in order to resume the application process. The following steps outline the information that providers will need to enter to apply and attest.

- Applicant will be asked to confirm information obtained from the R&A including the National Provider Identifier, CMS Certification Number (for hospitals), legal name, business name, address, phone number, Personal Tax Identification Number (TIN), SSN, Payee TIN, R&A confirmation number, and email address.
  - If the information is correct and confirmed, the provider will proceed to the next steps.
  - If KDHE cannot confirm information, KDHE will suspend the application as incomplete and KDHE will direct the applicant to the R&A to fix the information. Once the provider corrects the data in the R&A, the provider will be able to re-enter MAPIR to resume the application process within two days if appropriate.
- MAPIR will collect information regarding the individual completing the application (not necessarily the provider) including name, phone, and email address.
- Applicant will indicate type of individual provider or type of hospital.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

- If an individual provider, the applicant is asked if s/he spends 90 percent of their time or greater as an inpatient or emergency room hospital-based provider. The hover bubble in MAPIR explains the definition of a hospital-based provider.
  - If applicant responds “Yes” s/he will be suspended and eventually denied if applicant does not predominantly practice in an FQHC or Rural Health Center (RHC).
  - If “No” then the applicant is directed to proceed to the next question and can continue to complete the application and attestation information in MAPIR.
- Applicant will confirm s/he is NOT pursuing payment in another state.
- Applicant will confirm there are no sanctions pending against the provider applicant.
- Applicant will confirm compliance with HIPAA laws for electronic data.
- Applicant will confirm s/he has a license to practice, or in the case of hospitals, license to operate in Kansas or other states in which services are rendered.
- Applicant will indicate the EHR software name and Certification Number(s) indicating Federal certification from the list of certified systems that the provider will use to report meaningful use.
- Applicant indicates if s/he practices predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), i.e., 50 percent or more of the time.
  - If the applicant responds “Yes,” then the applicant will complete the patient volume table, which includes locations, numerator (consisting of Medicaid and “needy individuals”) and denominator.
  - If provider applicant does not practice predominantly in an FQHC/RHC or does not meet the 30 percent patient volume requirement based on FQHC/RHC entry, provider will complete a separate patient volume table with locations, numerator (Medicaid only) and denominator. The system checks will calculate patient volumes for all locations (including if a provider

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

practices in an FQHC/RHC or other locations, or both) and suspend applications that do not meet volume requirements.

- Applicant indicates how s/he will calculate their patient volume. Applicants can choose between group practice and individual provider. When entering numerator volume, the applicant must report Medicaid in-state volume (as well as out-of-state Medicaid volume). This allows for validation using Kansas's MMIS claim volume.
  - **Individual Volume:** For an individual applying as an eligible professional (not using group) the calculation will be:
    - Medicaid Patient Encounters (includes Medicaid patient encounters in and out of Kansas) / Total Encounter Volume in and out of Kansas = % Medicaid Patient Volume (must be 30 percent Medicaid patient volume, can be 20 percent for pediatricians)
    - If EP practices predominately in a FQHC/RHC then they will include needy individuals in the total Medicaid encounter volume. Pediatricians must be 30 percent Medicaid patient volume when they practice predominantly in an FQHC/RHC.
  - **Group volume:** For an individual applying as an eligible professional using the Group calculation method, the calculation would be:
    - Medicaid Patient Encounters (includes Medicaid patient encounters in and out of Kansas across the entire group) / Total Encounter Volume in and out of Kansas = % Medicaid Patient Volume (must be 30 percent Medicaid patient volume, can be 20 percent for pediatricians)
    - Eligible professionals will be asked to enter Group NPI (for verification purposes) that comprises the encounter volume they are entering and all members of the group will need to use the same patient volume methodology.
    - If the group is an FQHC/RHC then it will include needy individuals in the total Medicaid encounter volume. Pediatricians must be 30

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

percent Medicaid patient volume when they practice predominantly in an FQHC/RHC.

- KDHE will create a tool to help calculate patient volume and payments. This tool will be available publicly for hospital use. The Medicaid patient volume methodology for Hospitals is shown below:
  - Medicaid Discharges/ Total discharges = % Medicaid Patient Volume (to qualify must be 10 percent; no threshold for Children’s Hospitals)
  - Medicaid patient volume calculations are for 90-day periods and all service locations.
- Applicant must select one of the following phases: Adopt, Implement, or Upgrade; and then respond to questions to verify that the provider has met the selected phase.
- Applicant must confirm payment designation.
- Applicant must review the application. MAPIR will present the entire application to the applicant for final confirmation.
  - At this point, the system will allow changes. If the provider makes changes, then MAPIR will perform edits based on the changes and process the application accordingly.
  - If the application is error free, then a prompt appears for the applicant to FINISH and to indicate that providers can make no further changes. The application and attestation form will require both the applicant and preparer (if different) to digitally sign the form and the preparer will need to disclose relationship with provider.

KDHE will have access through MAPIR to assess completed applications and attestations.

KDHE will also have the availability to clear a submitted application and allow the applicant to re-apply in certain instances.

Step 6: KDHE reviews pended provider application and attestation and determines eligibility or addresses reasons for suspension (Response to Questions #22 and 28)

The MAPIR system will have a series of “hover bubbles” and prompts to help applicants submit a complete and accurate application. The hover bubbles will supply definitions and guidance

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

on the application questions and warnings will flash for incomplete submissions and responses that will terminate the application process.

Once providers have completed the on-line application and attestation, MAPIR will generate an automated list of suspended applicants, based on criteria discussed above, which KDHE will use to complete the eligibility determination process. Applicants can withdraw their applications and attestations through an email to KDHE up to the point when KDHE sends the applicant's information to the R&A for an EHR incentive payment.

In addition to utilizing MAPIR, KDHE will conduct reviews as necessary during the application and registration process and check provider information against MMIS data to confirm true eligibility based on provider type. KDHE's MMIS and internal processes will also facilitate its review of current or pending sanctions for applicants. Therefore, KDHE will be able to use both an internal system, along with MAPIR during its review process.

The MAPIR system will allow KDHE to sort by, or generate reports on, provider type, adoption, implementation, upgrade, or meaningful use, patient volume, and other information fields submitted in MAPIR so that KDHE can prioritize reviews. KDHE will review the application, attestation forms, and any supporting documentation attached to the application for information that has caused the application to suspend. KDHE will follow up with the applicant as necessary. MAPIR will be interactive, so that KDHE staff can update MAPIR with their determinations after reviewing the application and enter notes. KDHE is developing a review process/workflow that identifies staffing and review responsibility by staff member, application items that KDHE staff members will review and verify during the application process and application items that KDHE will review post-application and post-payment. KDHE's process/workflow will also describe the chain of approval and how KDHE will communicate decisions to providers. KDHE will communicate approvals and denials the same way it currently does on other matters. KDHE will follow up with providers when they require clarification, but MAPIR has been designed to reduce the need for this manual intervention, since it will allow KDHE to assure that providers complete all fields with acceptable values before the provider finalizes the application/attestation form.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

### Step 7: If applicable, KDHE denies provider's application (Response to Questions #1 and 22)

KDHE will review the application and attestation form for any information that has caused the application to suspend and follow up with the applicant as necessary. KDHE will notify the applicant regarding the preliminary finding and require a response by the provider within 30 days. The response may require the provider to update additional information with CMS.

If a provider does not respond to the notification or is otherwise determined "not eligible," then KDHE will send a final denial determination communication, along with information about the appeal process. KDHE will also inform CMS of the denial and provide a reason code for each denial.

KDHE's goal is to review applications, additional information, and make a decision about an applicant's eligibility within two weeks of receiving a completed application. However, the process of working with providers on suspended applications may take longer than two weeks if additional information required.

Upon denial by KDHE, providers have the option to appeal a "not eligible" determination. KDHE will handle such appeals the same way it currently addresses provider appeals on other matters. If an appeal is upheld, KDHE will re-review the application with re-application by the provider if necessary. If an appeal is denied, the application process ends but the provider may re-apply.

If the completed application is not denied, the provider will be notified and the process will continue from MAPIR to the R&A.

### Step 8: Provider application clears MAPIR system edits and MAPIR generates approval email with program information to provider (Response to Question #4)

MAPIR will display the entire completed application information entered at the R&A for confirmation by the applicant. The user interface will display information entered by the applicant to date. Information for verification includes applicant information as well as responses provided during the registration and attestation process (e.g., eligibility questions, patient volume information, etc.).

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

The system will provide printing functionality for the summary information along with a “Contact Us” button that allows providers to send an email for inquiries, and information about how to track the status of the application. The system will also generate correspondence to the provider indicating that the application is complete and pending final review, and KDHE will notify the provider of the payment status.

### Step 9 : MAPIR interfaces list of providers who pass edits to R&A for final confirmation (Response to Question #1)

KDHE cannot make payments until the application is error-free and submitted to the R&A system for final duplicate and sanction/exclusion editing. KDHE assumes that when Kansas informs the R&A that a payment is ready to be made, and the system has approved payment, the R&A will “lock” the record so that the provider cannot switch programs or states until after the provider receives the payment from the State that is identified in the system as being ready to make a payment.

### Step 10: KDHE sends approval email to provider with program and payment information (Response to Question #4)

MAPIR will send correspondence to the provider applicant notifying the provider that the application has been approved, and an EHR incentive payment will be issued to the provider or assignee. The correspondence will include information about the estimated timing of the payments, meaningful use requirements in future years, how to apply for future payments, information on oversight mechanisms that will be used, and on the tax implications of the incentive payment.

### Step 11: MMIS issues payment and MAPIR submits payment information to the R&A (Response to Questions #23 - 25)

KDHE anticipates making payments for calendar year 2011 in February or March 2012. This will require a grace period or attestation tail for both eligible hospitals and professionals with a longer attestation period for hospitals. This attestation tail is very important to KDHE’s Medicaid EHR Incentive Program because KDHE wants to make sure that Kansas providers can receive incentive payments for both 2011 and 2012.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

KDHE will use MAPIR to issue a remittance advice and make the incentive payment using a gross adjustment. A unique gross adjustment reason code will be generated and payments will be processed with the weekly Medicaid Financial Cycle. The payment method (paper, electronic funds transfer) will be driven by the information used for claims payment on the provider enrollment file. A remittance advice will provide information on the incentive payment to the provider. Upon completion of the payment cycle, the MMIS will return payment data to MAPIR. MAPIR will generate a payment transaction, including pay information, to the R&A on a monthly payment file. The provider applicant/payee (to whom the payment is assigned) information must be valid in the MMIS in order to make payment.

For EPs, payments are based on the calculations described in CMS regulations. KDHE will make EP payments over six years. For eligible hospitals, KDHE will make payments over three years: 50 percent in the first year, 30 percent in the second year, and 20 percent in the third year. KDHE based hospital payments on the calculations and requirements described in the CMS regulations. See Appendix V for the hospital payment calculator that KDHE developed and CMS reviewed and approved.

Using the MAPIR system, in combination with processes for reviewing applications and resolving issues that have suspended issues, KDHE will be able to make timely provider incentive payments. In the best case scenario (no missing, incomplete or inaccurate information), KDHE anticipates making payments to EPs and hospitals within 30 days of their application completion date.

### Step 12: Post-payment oversight and outreach activities (Response to Questions #3, 6, 7, 8 and 26)

As described in the above steps, the MAPIR system contains numerous checks and edits that will help KDHE to conduct payment oversight at the point of application and attestation. These pre-payment automated checks include sanction, licensure, and provider eligibility.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

Section D describes KDHE's proposed post-payment oversight activities in detail, but, in short, KDHE will focus on three areas: provider eligibility, meaningful use and payment reviews. To complement KDHE's pre- and post-payment oversight activities, KDHE also aims to provide information and materials as outreach communication to facilitate oversight of the EHR incentive program.

KDHE understands the programmatic risks of improper payments and will develop procedures to mitigate these risks. KDHE will identify areas of risk in the eligibility determination and payment processes to enhance reviews that will mitigate the risk of making an improper payment. KDHE will conduct random sampling studies to audit information submitted in attestation forms and from other areas, e.g., meaningful use information, patient volume, FQHC/RHC predominantly practice attestations and assignment of payments.

### Step 13: Ongoing technical assistance for adoption, implementation, upgrade and meaningful use of EHR (Response to Questions #8 and 9)

KDHE understands that incentive payments may motivate providers to begin the adoption process but the incentive payments alone may not be sufficient for successful adoption, implementation and meaningful use. Using its communications plan, KDHE will collaborate with the REC and other resources to educate providers about the incentive program and to provide technical assistance and information on EHR adoption, implementation, upgrade and meaningful use of EHRs.

In addition to reviewing providers who return for additional payments, KDHE will generate reports for the following:

- Providers that apply with the CMS R&A system but have not yet applied through the MAPIR system
- Providers that have not yet applied for the incentive payment program
- Providers that do not apply for year two and beyond incentive payments

MAPIR has the functionality to display providers that have applied through the R&A but not through MAPIR. To identify providers that have not applied for incentive payments, KDHE

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

will compare the MAPIR program applicant information with MMIS information on NPIs for Medicaid providers. KDHE will use MAPIR to identify those providers that do not apply for year two and beyond incentive payments.

Upon generating and compiling the reports and lists of providers in need of additional outreach, KDHE plans to target these types of providers for technical assistance through the REC or other communication vehicles. Encouraging providers to return for future payments and thus become meaningful users is an important goal for KDHE.

### Step 14: Notification of meaningful use requirements for Year Two and beyond (Response to Questions #10, 11 and 12)

KDHE is not proposing any changes to the proposed meaningful use rule criteria at this time. KDHE will follow CMS' lead for meaningful use requirements. KDHE plans to collaborate with the REC and other resources to the extent possible to educate providers about the meaningful use requirements in year two and to provide technical assistance about meaningful use of EHRs in year two. KDHE also anticipates there will be provider education materials available through the CMS and ONC communications and outreach activities.

KDHE understands that within meaningful use requirements, eligible professionals and hospitals have measures that are dependent on Kansas' HIT infrastructure. KDHE is discussing and will address the ability of Kansas' infrastructure to provide the data necessary for these measures. Included in this discussion is when data will be available. For example, the upload component of the state's immunization registry may be available in an upcoming reporting period. In addition to timeframe, KDHE is also discussing provider access to the information needed to meet meaningful use. For instance, with respect to immunization data, practices going through HIEs will have upload capabilities. As Kansas's infrastructure and the EHR incentive program evolves, and KDHE is able to assess the provider's ability to meet the meaningful use requirements, KDHE's strategies and abilities will also evolve to continue to help providers to achieve meaningful use.

## Section C: Methods and Activities to Administer and Oversee the EHR Incentive Program

### Step 15: Meaningful use payment request or renewal (Response to Questions #9, 12, 13 and 30)

KDHE will allow providers to attest to meaningful use in the first program year and will accept hospitals deemed as meaningful users by CMS. KDHE is also planning to utilize MAPIR eligibility screens, and establish a review process during which it will validate the continued eligibility of each participating providers and that providers meet meaningful use requirements.

The renewal process will incorporate oversight reviews of continuing provider eligibility (e.g., patient volume), check against new information in the R&A, meaningful use criteria, and a review to ensure that provider information such as practice sites has not changed.

Additionally, the MAPIR system has a link to ONC's Certified HIT Product List (CHPL) system which is the most recent list of federally certified EHR systems. KDHE will use the CHPL information during the application process to help ensure that providers continue to acquire and use federally certified systems.

## Section D: The State's Audit Strategy

### Section D: The State's Audit Strategy

This section responds to each of the questions listed in the CMS SMHP Template and provides a description of KDHE's audit, controls and oversight strategy for the Medicaid EHR Incentive Payment Program.

**Table D.1: Section D Questions from the CMS SMHP Template**

What will be the SMA's methods used to avoid making improper payments? (Timing, selection of which audit elements to examine pre- or post-payment, use of proxy payment, sampling, how the SMA will decide to focus audit efforts, etc.)
1. Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.
2. How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?
3. Describe the actions the SMA will take when fraud and abuse is detected.
4. Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.
5. Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?* (i.e. probe sampling; random sampling)
6. **What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc)?
7. Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?
* May be deferred. ** The first part of this question may be deferred but States do need to include a description of their HIE(s)' geographic reach and current level of participation.

## Section D: The State's Audit Strategy

KDHE will follow guidance from CMS in developing and implementing its audit strategy.

CMS has advised that states should:

- Catch the obvious
- Focus on substantial non-compliance
- Employ smart risk-profiling
- Find the balance between cost of oversight and total incentive payment
- Find the balance between high-tech and hands-on approaches (cost and level of effort)
- Maximize existing/third party data sources where appropriate

Many of the controls for KDHE's EHR Incentive audit strategy are based on system edits and checks within the MAPIR system. The MAPIR system will allow providers to apply for the incentive program and make all required attestations. The system edits and checks will generate lists of providers denied for the incentive payment program or pended for further review.

KDHE's oversight efforts will focus on the following areas:

- Provider Eligibility
- Meaningful Use, Adoption, Implementation and Upgrade
- Payment Reviews

The table below provides examples of criteria, for each of the areas that KDHE will review. This section also provides examples of planned oversight efforts.

**Table D.2: Sample Provider Review Criteria by Oversight Area**

Oversight Area	Sample Criteria
1) Provider Eligibility	<ul style="list-style-type: none"><li>• Provider is an enrolled and participating Medicaid provider</li><li>• Provider meets final rule provider definition</li><li>• Provider meets hospital-based provider definition</li><li>• Provider meets Medicaid patient volume thresholds</li></ul>

## Section D: The State’s Audit Strategy

Oversight Area	Sample Criteria
	<ul style="list-style-type: none"> <li>• Provider follows KDHE’s Medicaid patient volume methodology</li> <li>• Providers practicing predominantly in Federally Qualified Health Centers and Rural Health Clinics meet relevant patient volume thresholds and rules</li> <li>• Provider attests s/he is not participating in another state’s Medicaid incentive program or the Medicare incentive program</li> <li>• Provider attests to multiple program eligibility requirements including that there was no coercion when assigning payments, if relevant</li> </ul>
2) Meaningful Use, Adoption, Implementation, and Upgrade	<ul style="list-style-type: none"> <li>• Provider meets requirements for adoption, implementation or upgrade in participation year one</li> <li>• In subsequent years, provider meets the criteria for the appropriate stage of meaningful use</li> <li>• Provider acquires, implements, upgrades to, and meaningfully uses a certified EHR system</li> </ul>
3) Payment Reviews	<ul style="list-style-type: none"> <li>• Provider has not received duplicative payments</li> <li>• Provider returns overpayments in a timely manner</li> </ul>

### Program Oversight (Response to Questions #1 and 7)

KDHE has primary responsibility for program integrity, detecting fraud and abuse in Kansas’s Medicaid Program, including oversight of the Medicaid EHR Incentive Program. Within the organization, KDHE has staff committed to perform audit and monitoring activities related to the EHR incentive payments. KDHE will have at least one staff person dedicated as the primary auditor and oversight lead involved in Kansas’s Medicaid EHR Incentive Program audit strategy. The oversight lead may have support staff or team members to address issues that arise for the Medicaid EHR Incentive Program. The oversight lead and his/her team members will have responsibility to conduct sound audits and act on the findings.

The oversight team’s responsibilities include reviewing both pre- and post- payment elements such as provider eligibility, licensure and sanction information, patient volume, organizational reports (for an FQHC/RHC that is “so-led”), correct payment reassignment when applicable and adopt, implement or upgrade (AIU) documentation. In addition, it will be important to

September 1, 2011

## Section D: The State's Audit Strategy

analyze historical data and develop profiles of health care delivery, reporting those participants or providers whose patterns of care or utilization deviate from established normal patterns of health care delivery. It also includes coordinating with managed care organizations regarding the evaluation of their provider networks, monitoring recipient overuse or abuse and maintaining ongoing working relationships with federal and state enforcement agencies involved in monitoring potential health care fraud and abuse.

The KDHE audit lead will have responsibility for coordinating oversight for all participating providers across KDHE and will rely on information submitted through MAPIR and information housed in MMIS, which KDHE will verify against provider information. The team will review information submitted by providers as they apply in MAPIR.

The audit function serves as another management tool to allow for the evaluation of the delivery and use of medical care, on a case-by-case basis, to safeguard the quality of care, and to guard against fraudulent or misuse of the Kansas Medicaid Incentive Program by providers.

Kansas will use *MITA Reference: PI01 – Identify Candidate Case* as a guide.

KDHE's monitoring and oversight protocol includes reviewing eligibility information and attestations during the application process, while reviewing other areas post-payment. Post-payment review will include a random sampling process. Post-payment activities for year 1 will include an audit of AIU and patient volumes when performing other program integrity audits. KDHE plans to use internal staff to perform monitoring and oversight activities but may use contractors. The majority of audit processes are automated and will utilize other KDHE information systems, including MMIS, as well as MAPIR, to enhance program oversight capabilities. In addition to automated processes, KDHE will use manual processes where necessary pre- or post-payment

Below is a table of audit element examples that will be addressed through pre-payment controls or other methods, and which elements will be addressed post payment.

Section D: The State's Audit Strategy

**Table D.3: Sample Audit Controls, Elements and Examples**

Audit Controls	Audit Elements	Examples
<b>Pre-Payment</b>	<ul style="list-style-type: none"> <li>• Provider Type (category and not hospital-based)</li> <li>• FQHC/RHC</li> <li>• Current or Pending Sanctions</li> <li>• Licensure</li> <li>• HIPAA Compliance</li> <li>• Patient Volume</li> <li>• Provider NPI/CCN</li> <li>• TIN/SSN</li> <li>• R&amp;A Status</li> <li>• Sanctions</li> </ul>	<ul style="list-style-type: none"> <li>• KDHE automated process to verify provider type information in system and check for true eligibility based on provider type</li> <li>• KDHE manual process to review FQHC/RHC organizational information to ensure no other entity/individual claims for the center</li> <li>• KDHE pre-payment automated process to review provider and sanction/exclusion information on a frequent basis</li> <li>• KDHE automated process will crosscheck volume and licensure file, with MMIS</li> <li>• Verification of NPI and for hospitals, CCN</li> <li>• Verification presence</li> <li>• Status as retained on the R&amp;A</li> <li>• Ensure no Federal or State sanctions Verification of NPI and for hospitals, CCN</li> <li>• Verification presence</li> <li>• Status as retained on the R&amp;A</li> <li>• Ensure no Federal or State sanctions</li> </ul>
<b>Post Payment</b>	<ul style="list-style-type: none"> <li>• Current or Pending Sanctions</li> <li>• EHR and Meaningful Use Stage Requirement</li> </ul>	<ul style="list-style-type: none"> <li>• KDHE post-payment manual process to review any provider and sanction information that has changed since the pre-payment review</li> <li>• KDHE is awaiting guidance from CMS on auditing meaningful use attestations</li> </ul>

## Section D: The State's Audit Strategy

MAPIR facilitates application and attestation review and oversight and will be used to store and track records of incentive payments for all participating providers. KDHE will regularly monitor payments to ensure that KDHE does not make overpayments. If KDHE identifies an overpayment, KDHE will use MAPIR to determine the amount of payments made that providers must return upon notification.

### Methods for Avoiding Improper Payments (Response to Questions #1, 4 and 5)

KDHE will implement multiple mechanisms and processes as part of its program oversight. These processes and mechanisms will help avoid making improper payments. KDHE will identify, develop, and hone these mechanisms referenced. KDHE will provide more detail regarding these mechanisms in a future update to this SMHP.

KDHE currently uses existing federal and state data sources as part of its ongoing Medicaid oversight activities. KDHE is in the process of implementing a new MMIS module, MAPIR, for the EHR incentive program to determine provider eligibility and monitor eligibility, meaningful use, and payments.

MAPIR will collect and analyze all information related to provider payment, applications, attestations and oversight functions, and will interface with the R&A. KDHE will use extensive system checks and edits to enhance KDHE's oversight capability by flagging potential errors or issues in MAPIR (e.g., when new R&A data is interfaced with MAPIR data and MAPIR identifies inconsistencies or changes in provider selection of state or from Medicaid to Medicare). KDHE will use MAPIR for automated checks and audits and identify potential concerns real-time (or close to real-time) rather than relying on retrospective review of KDHE's enrollment and payment records. KDHE will review information submitted by providers at multiple points in the application process and against information submitted to the R &A to help reduce the need to recoup funds from providers who are not eligible.

To complement review by CMS, KDHE will conduct additional auditing and oversight. KDHE's oversight process will include validating information at the point of registration,

## Section D: The State's Audit Strategy

validating some attestation data pre-payment, post-payment auditing, and appeals/reviews when applicable.

The steps in the eligibility review and oversight process related to MAPIR include:

- All providers participating in the Medicaid EHR Incentive Program are required to register information at the R &A. As providers submit information, it is checked in the R &A at various points in the application and attestation process.
- The R&A system has automated checks built in during the registration process, which include checking registered providers against the Social Security Administration master death file, the Office of the Inspector General list of sanctioned or excluded providers, and whether the registrant has been paid by Medicare or another state (Medicaid) in the same year. If CMS finds any ineligibility issues for registrants during the process, CMS will not allow the registration to proceed. In addition to suspending the registration process, CMS will inform Kansas through its interface with the R&A.
- Once the provider completes the R&A registration process, the R&A will then send the provider's information available to KDHE through the interface between the R&A and MAPIR. The R&A will send provider registration information to KDHE on a frequent basis. KDHE will use the system checks and edits in MAPIR to identify providers who are potentially eligible to participate in the incentive program. MAPIR will in turn notify those potentially eligible providers via email that they can apply using MAPIR's web-based interface.

Additionally, during the application and attestation process, providers will be required to:

- Verify the information that KDHE has obtained for the applying provider through the R&A
- Attest to being an allowed provider type

## Section D: The State's Audit Strategy

- Answer a series of questions to determine the provider's patient volume requirements using the MAPIR tool
- Attest that they are adopting, implementing, upgrading to or meaningfully using a Federally-certified EHR software system
- Attest that they meet or understand certain Federal rules, e.g., that the assignment of payments is voluntary
- Attest to a number of other items related to their eligibility for the program

KDHE is planning to collect submitted information when necessary (e.g., patient volume documentation from provider, organization chart for FQHC/RHC attesting they are "so-led" by a Physician Assistant, etc.) as part of the application and attestation form. Using the information submitted as part of the online application and attestation process, MAPIR will apply a series of automated edits and checks to determine if the provider meets the basic criteria.

Once the provider has completed the application and attestation, MAPIR will generate an automated list of suspended applicants, which KDHE can review to complete the eligibility determination process. Applicants can withdraw their applications and attestations through an email to KDHE up to the point when KDHE sends the applicant's information to the R&A for an EHR incentive payment. Providers can only make changes after this point through a self-disclosure process since the information will be with the R&A.

KDHE anticipates using a random selection process to review eligible professional and hospital applications based on information provided in the applications prior to making a payment. KDHE may also incorporate edits that suspend certain applications based upon patient volume and other provided information.

The system will allow KDHE to sort by or generate reports, or both, on provider type, adoption, implementation, upgrade, or meaningful use, patient volume and other information fields submitted in MAPIR so that KDHE can prioritize reviews. KDHE will review the application and attestation form for any information that has caused the application to suspend and follow

## Section D: The State's Audit Strategy

up with the applicant as necessary. MAPIR will be interactive, so that KDHE staff can update MAPIR with their determinations after reviewing the application and enter notes. KDHE will follow up with providers when they require clarification, but MAPIR is designed to reduce the need for this manual intervention, since it will allow KDHE to assure that all fields are completed with acceptable values before the provider submits the application/attestation form.

Once KDHE has reviewed the application and any additional information it has gathered, or has obtained information from the provider that was deemed necessary to complete its review determination, KDHE will notify the provider via email correspondence that his/her application has either been approved. KDHE will attempt to work with applicants when information is missing or when an applicant does not appear to be eligible. KDHE will issue a preliminary denial for those who do not appear to be eligible for the Medicaid EHR Incentive Program.

The correspondence to the provider indicating a preliminary finding of not eligible will describe the reason why the provider does not seem eligible and will advise the provider that he/she can respond to KDHE's findings in writing, or by phone, within 30 days. Consideration of any information submitted by the provider to the preliminary findings may result in a determination that KDHE's findings require re-evaluation. KDHE will notify the provider of its final decision following its review of any additional information received.

If a provider does not respond to the preliminary findings correspondence, or if the final finding is that the provider is ineligible, then KDHE will send a final determination correspondence, which will include information about the appeal process. KDHE will also inform CMS of the denial and provide a reason code for each denial.

KDHE's goal is to review applications, any additional information and make a decision about an applicant's eligibility within two weeks of receiving a completed application. However, the process of working with providers on suspended applications may take longer than two weeks if there is something wrong with the application.

## Section D: The State's Audit Strategy

Providers have the option to appeal a "not eligible" determination. KDHE will handle such appeals through the same processes in which KDHE currently addresses provider appeals on other matters. Appeals will be tracked by KDHE's fiscal agent.

Apart from the review process that takes place as part of the MAPIR review, KDHE will review all hospital and provider applications prior to payment. KDHE will use an automated process to check provider eligibility information against what is in their system to verify true eligibility based on provider type. Another review KDHE will conduct includes requesting that a FQHC/RHC "so-led" by a physician assistant submit organizational information (e.g., organizational chart) so KDHE can review who is "so leading" the FQHC or RHC.

As part of its pre-payment review process, KDHE will also review provider information against its internal sanction/exclusion information on a monthly basis using an automated process. KDHE will also incorporate a post-payment sanction review into its process. Along with sanction review, KDHE will have an automated pre-payment process to crosscheck provider information against its MMIS licensure file.

In addition to reviewing provider information, KDHE will verify patient volume information by requesting reports or other applicable information. KDHE will also crosscheck patient volume attestations against provider information in MMIS.

For providers passing all of the application and attestation steps, MAPIR will generate a preliminary approval. The preliminary approval will trigger MAPIR to send information to the R&A to verify that providers are still eligible for payment (e.g., provider has not, since date of submission of Kansas application, received a payment from another state or that the provider has not had a sanction or exclusion levied against him/her). KDHE will make the incentive payment only after all the provider application passes these steps.

Once KDHE makes the incentive payments, KDHE will provide program oversight as outlined below.

## Section D: The State's Audit Strategy

### *Ongoing Monitoring*

As described above, the MAPIR system contains numerous checks and edits that will help KDHE to conduct payment oversight at the point of application and attestation. These pre-payment automated checks include sanction, licensure, and provider eligibility.

Along with reviewing provider eligibility, KDHE will also focus on meaningful use and incentive payments. KDHE understands the programmatic risks of improper payments and will continue to develop and implement procedures to mitigate these risks. KDHE will identify areas of risk in the eligibility determination and payment processes to enhance reviews that will mitigate the risk of making an improper payment. For example, KDHE will conduct random sampling studies to audit information submitted in attestation forms and from other areas (e.g., meaningful use information, patient volume, FQHC/RHC predominantly practice attestations, assignment of payments, etc.).

In addition to pre- and post-payment control activities (e.g., crosschecks with the R&A), additional KDHE's ongoing monitoring activities include the following:

- Monitor Provider Incentive Payments
  - Provider incentive payments will be stored and tracked in MAPIR. KDHE will regularly review reports from MAPIR that show incentive payment information for each of its assigned providers, e.g., date of last payment and amount of total payments made.
  - Through MAPIR's interface with the R&A, KDHE will also be able to determine if there is new information from the R&A that indicates a payment should not be made, e.g., provider switches to Medicare or switches to another state's Medicaid EHR incentive program.
- Monitor Adoption, Implementation, Upgrade and Meaningful Use.
  - Based on forthcoming CMS guidance, KDHE will monitor EPs on an ongoing basis to verify providers are meeting adoption, implementation, upgrade and meaningful use criteria.

## Section D: The State's Audit Strategy

- MAPIR will collect and store information from providers about how they are meeting meaningful use criteria, including numerator and denominator information. In addition to requesting and collecting reasonable documentation, KDHE will encourage document retention for a period of at least five years in case of an audit (this time period may change based on federal guidance). When an EP has not met the criteria, KDHE will provide technical assistance and may require a corrective action plan to address non-compliance either to rectify the situation or to recoup the incentive funds.
- **Oversee Reviews for Additional Incentive Payments**
  - KDHE will establish a review process during which it will validate the continued eligibility of each of the participating providers. Providers are not required to participate in the program in consecutive years, so the renewal process will start when the provider requests a second or subsequent incentive payment.
  - The review process will be reviewed in MAPIR and will incorporate reviews of the following:
    - Continuing provider eligibility
    - Variance in patient volumes
    - New information in the R&A
    - Meaningful use criteria
    - New provider information (e.g., provider's practice sites closure or move)
    - Continued participation as Medicaid provider
- **Confirm Licensure Status**
  - As mentioned above, KDHE will perform checks of Kansas licensure status to confirm providers are in good standing.

When non-compliance of a provider is determined, e.g., provider does not predominantly practice in an FQHC or RHC but includes needy patients in volume or is not acquiring,

## Section D: The State's Audit Strategy

implementing, upgrading or using a federally certified EHR system, KDHE will determine what actions need to occur. If the non-compliance results in disenrollment, KDHE will take the following steps:

- KDHE will notify the provider through email that KDHE is stopping the payment.
- KDHE will initiate a review to determine whether KDHE should recoup any prior payments.
- KDHE will update MAPIR to indicate the provider is no longer participating and system edits will not permit the provider to re-enroll.
- The record of the termination will be stored in MAPIR.
- MAPIR will notify the R&A and provide a reason code.
- KDHE will provide information to other Medicaid areas of KDHE to ensure all programs have the most recent information for the provider.

### *Use of Other KDHE Information Systems to Enhance Program Oversight Capabilities*

In addition to MAPIR, KDHE will use other sources of data to monitor the program and verify information submitted by providers in the application process and in future years as providers request additional incentive payments. The information below provides additional information for the systems or databases used for program monitoring and oversight.

- Claims Data Systems
  - Data from the MMIS will supplement information gathered through MAPIR. For example, KDHE will check in-state Medicaid patient volume numerators against claims data.
  - Additionally, KDHE will use a systems-based automated process to verify provider type and crosscheck licensure information within their system.
- Health Information Exchanges
  - KDHE will have access to other data through HIEs that will help with ongoing oversight and monitoring of meaningful use. KDHE anticipates using this data in the long-term to monitor future HIE components of

## Section D: The State's Audit Strategy

meaningful use and to help gather the clinical data required under meaningful use.

- Examples of other access to HIE data include immunization registries, public health databases, and the exchange of key clinical information between providers of care and patient authorized entities.
- Sanctions Databases
  - KDHE will review provider information against sanction/exclusion information on a monthly basis. KDHE will conduct the checks pre-payment and, depending on the severity of the sanction, KDHE may terminate a provider during the application process.

### *Post-Payment Audit Strategy*

KDHE understands the programmatic risks of improper payments and will develop processes to ensure accurate payments. For example, KDHE plans to conduct quarterly and annual random sampling studies to audit information submitted in attestation forms and from other areas (e.g. meaningful use information). KDHE may perform reviews and analyses based on some of the following information:

- Adoption, implementation, and upgrade attestations since first year payments are the largest payments
- Attestations on patient volume where Medicaid patients include both in-state and out-of-state patient volume
- Analysis of providers who report a significantly higher patient volume for the 90-day period for attestation compared to historical claims data for the previous year to determine if providers are only seeing Medicaid patients for the 90-day period reported for patient volume
- Providers included in group patient volume calculations
- Providers who have had Medicaid or Medicare sanctions in the past 12 months
- Payments to pediatricians, e.g., KDHE's definition of a pediatrician

## Section D: The State's Audit Strategy

- EPs who attest to predominantly practicing in FQHCs/RHCs and review “needy” patient volume calculations, e.g., uninsured and sliding scale encounters
- Other randomly selected paid applications

KDHE will review cases where erroneous information or duplicative payments are identified. Based on the nature and extent of the infraction, KDHE will determine next steps, including any or both of the following:

- Disqualifying the provider from receiving future payments
- Recouping incentive/adoption funds already paid to a provider and return funds to CMS

### Reducing Provider Burden While Maintaining Oversight (Response to Question #6)

KDHE is working to establish a provider-friendly Medicaid EHR Incentive Program to encourage provider participation and limit the burden on providers. KDHE expects the online application and attestation process to significantly reduce provider burden and facilitate program administration. Examples of methods and processes KDHE will use to reduce provider burden and promote program integrity and efficiency include the following:

- Leverage Existing Data Sources. As discussed earlier, KDHE will leverage existing data sources (e.g. MMIS) so that providers are not required to submit duplicate information to a variety of sources.
- Use MAPIR. As described earlier, MAPIR will both track and act as a repository for information related to payment, applications, attestations, a data source for oversight functions, and interface with the R&A. This system will reduce provider burden and enhance oversight processes; for example, KDHE will gather information from the R&A and, using KDHE's MMIS enterprise system, pre-populate MAPIR with information about providers who apply for the Medicaid EHR Incentive Program, e.g., list of provider sites as determined by claims and encounter data.

## Section D: The State's Audit Strategy

- Coordinate with Kansas' Regional Extension Center. KDHE will work with the REC to make sure KDHE's efforts specific to providers are strategically targeted, coordinated and not duplicative.

### Investigating Fraud and Abuse and Collecting Overpayments (Response to Questions #1 – 3)

#### *Investigating and Acting on Detected Fraud and Abuse*

KDHE believes that current processes for investigating and acting on identified Medicaid fraud and abuse can be appropriately applied to the EHR incentive program. KDHE will implement one of two actions depending on whether it detects fraud or abuse.

Fraud is defined as any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself or some other person. Abuse is any practice that is inconsistent with sound fiscal, business or medical practices, and results in an unnecessary cost to Medicaid. Below are the types of action taken to address fraud and abuse:

- Fraud. Fraud will include intentionally providing false information on the application and attestation form. If KDHE finds a credible suspicion of fraud, findings will be summarized and referred to the Kansas Attorney General's Medicaid Fraud Control Unit (MFCU) for further investigation. MFCU will conduct an investigation. This may include internal discussions with involved parties.
- Abuse. Abuse includes when a provider misstates a part of their application and attestation form. Abuse cases are reviewed and decided upon internally by KDHE after an investigation. This will involve activities such as internal discussions with involved parties, discussions with the provider under review, review of existing data and review of existing documentation.

## Section D: The State's Audit Strategy

If KDHE detects abuse, KDHE will initiate an administrative action such as requiring a Corrective Action Plan (CAP) or recovery of the incentive payment based on the nature of the finding.

When KDHE detects fraud or abuse, KDHE or MFCU will determine if additional actions are required based on each individual case. Examples of additional actions include:

- **Conduct Provider Education or Withhold Payments.** In the case of meeting adoption, implementation, upgrade and meaningful use, KDHE will work with providers to understand and reach meaningful use. This will require significant coordination and collaboration with the Regional Extension Center and other sources of technical assistance and training to providers such as provider associations. KDHE will withhold payments not meeting meaningful use the year after a provider has exercised the option to receive a payment for adoption, implementation, or upgrade.
- **Corrective Action Plans (CAPs).** KDHE may request CAPs for providers who are determined to have violated regulatory compliance, for example, if they have misstated the Medicaid patient volume requirements or adoption activities. KDHE will determine if a provider needs to return a payment and will then monitor the provider's compliance with the CAP and work with them over a designated period based on the individual provider's issue.
- **Recoupment of Funds.** KDHE will recover all overpayments. However, overpayments identified because of a fraud conviction are handled in conjunction with the Medicaid Fraud Control Unit.
- **Disenrollment.** KDHE may determine that the provider should be disenrolled from participation in the EHR provider incentive program, and depending on the case, may also terminate the provider's Medicaid program participation.

## Section D: The State's Audit Strategy

- Prosecution. MFCU may prosecute if there is fraud, which could result in probation or prison, and likely placement on the federal exclusion list.

### *Collecting Overpayments*

MAPIR will be used to store and track records of incentive payments for all participating providers. KDHE will regularly monitor payments to prevent overpayments. Once KDHE identifies an overpayment, the MAPIR system will determine the amount of payments KDHE has made that providers must be return. KDHE will communicate with CMS on repayments. KDHE will generate an accounts receivable to offset payment of future claims to recoup the EHR incentive overpayments. Federal law requires KDHE to return overpayments within 1 year of identification.

Additionally, KDHE has a system in place for tracking recoupment of overpayments from providers. KDHE will expand the system to allow for tracking and reporting specific to EHR provider incentive payments. KDHE will review reports to determine the status of recoupment of overpayments.

If KDHE finds that a provider has committed fraud and abuse and decides that the provider should not participate in the incentive payment program, KDHE will disqualify them from the program, communicate this issue to other areas of KDHE for further review, and send a list of disqualified providers to CMS.

## Section E: The State's HIT Roadmap

### Section E: The State's HIT Roadmap

This section responds to each of the questions listed in the CMS SMHP Template and provides an overview of KDHE's HIT Roadmap as it implements the Medicaid EHR Incentive Program and moves towards achieving its HIT and HIE vision).

**Table E.1: Section E Questions from the CMS SMHP Template**

Please describe the SMA's HIT Roadmap:	
1.	*Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there.
2.	What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type?
3.	Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario.
4.	Discuss annual benchmarks for audit and oversight activities.
	* May be deferred. ** The first part of this question may be deferred but States do need to include a description of their HIE(s)' geographic reach and current level of participation.

## Section E: The State's HIT Roadmap

### Medicaid Agency Five-Year Roadmap (Response to Question #1)

KDHE's Roadmap discusses the journey from the current HIT landscape, "As-Is", to the "To-Be" vision and EHR Incentive payments. The Roadmap highlights strategies for moving beyond HIT adoption and meaningful use to achieving a mass of providers who have adopted EHRs and who are exchanging data via an HIE to improve the quality and coordination of care for Medicaid participants. This journey will likely extend beyond this 5-year projection to the end of the Medicaid EHR Incentive Program in 2021 and beyond.

KDHE's vision and strategy for implementing HIT initiatives, including the Medicaid EHR Incentive Program, is to pursue initiatives that encourage the adoption of certified EHR technology, promote health care quality and advance HIE capacity in Kansas. Figure E.1 below provides project timelines for initiatives currently planned. KDHE will use the Medicaid EHR Incentive Program to develop a system that supports the secure exchange of health information. The system will improve the efficiency and effectiveness of patient-centric health care for all Kansans. The system will ensure the quality and confidentiality of personal health information and will enable healthcare stakeholders to share data to better coordinate patient care.

Section E: The State's HIT Roadmap

Figure E.1: KDHE Strategy Phases

KDHE Projects	SFY 2011				SFY 2012				SFY 2013				SFY 2014				SFY 2015			
	Q1	Q2	Q3	Q4																
<b>Mandates</b>																				
ICD-10 Planning																				
ICD-10 Implementation																				
5010 Upgrade																				
CMS 64 Reporting Changes																				
Drug Rebate Enhancements																				
State Medicaid HIT Plan																				
Provider Enrollment Changes for ACA																				
Pharmacy Pricing Methodology Enhancement (WAC/SMAC)																				
<b>HITECH INCENTIVE PAYMENTS and EHR To-Be Projects</b>																				
MAPIR Core Software Development																				
MAPIR Installation and customization in Kansas																				
Technical Assessment																				
<b>MMIS Reprocurement</b>																				
APD Development and Submission																				
RFP Development and Issuance																				
Bid Evaluation and Contract Award																				
System Takeover and Enhancements																				
<b>K-MED Eligibility System</b>																				
Online Intake Application Development and Implementation																				
Full K-MED Eligibility System including ACA changes - Development, Testing and Implementation																				
New Medicaid Rules and Functionality to Implement ACA including the HIX Solution - Development and Deployment																				
<b>Other</b>																				
Enhanced Prior Authorization Automation																				
Remittance Advice Enhancements																				
Recovery Audit Contractor																				
Provider Enrollment Enhancements																				

*Technical Analysis*

As mentioned in Section B, KDHE has developed a Scope of Work to obtain a detailed technical analysis of Medicaid Systems and the abilities of those systems to support meaningful use of EHRs and integrate Medicaid providers with Kansas' HIE to manage the care Medicaid beneficiaries receive. The technical analysis will provide more information on leveraging current Medicaid systems to further enhance the use of the HIE and EHRs to manage the care of Medicaid beneficiaries. The results of this technical analysis will help to shape KDHE's roadmap as it relates to the following activities included in the technical analysis:

## Section E: The State's HIT Roadmap

- Identifying options for storing and accessing clinical data to support a medical home and coordinate care for Medicaid beneficiaries,
- Identifying systems necessary for true coordination of care for Medicaid beneficiaries,
- Determine how best to utilize the MMIS in relation to HITECH,
- Identify Medicaid options for Master Patient Index and Provider Directory, and
- Determine what is needed from all Kansas RHIOs in order to ensure continuity and coordination of care for Medicaid enrollees

When that technical analysis is complete later this calendar year, KDHE intends to update the SMHP and I-APD as necessary to expand our roadmap information. We will also provide more information on how our HIT activities correlate with MITA goals at that time.

The remainder of the roadmap discussion in this submission focuses primarily on KDHE's goals for administering and overseeing the Medicaid EHR Incentive Program, KDHE's adoption targets and HIT goals for the State.

### *EHR Incentive Payment Issuance, Adoption and Meaningful Use*

As Figure E.2 illustrates, reading from left to right, KDHE expects that KDHE's initial HIT efforts will focus on developing the infrastructure for EHR Incentive Payments. KDHE is concurrently developing a Scope of Work to obtain a detailed technical analysis of Medicaid Systems and the abilities of those systems to support meaningful use of EHRs and integrate with Kansas' HIE to manage the care Medicaid beneficiaries receive. KDHE will administer the Medicaid EHR Incentive Payment Program and work with providers, through resources such as the REC, to move providers from EHR adoption and implementation towards EHR meaningful use. KDHE will use the data submitted by providers to evaluate clinical practices and performance and then supply feedback to providers to help them continue to improve their use of HIT.

Figure E.2: KDHE Strategy Phases



KDHE anticipates that HIT adoption will result in more effective care and greater efficiencies, which in turn will help KDHE to reduce costs. With these goals in mind, KDHE also recognizes that the roadmap must be flexible to respond to the ever-changing healthcare landscape.

*Encouraging Provider Participation and Adoption*

KDHE continues to refine this roadmap and customize the approach to infrastructure development to mirror the unique needs and challenges facing providers. As discussed in Section A, providers and hospitals are at varying levels of EHR adoption and familiarity with HIT. KDHE will research the functionality of EHR systems and determine how to maximize the use and usefulness of HIE.

KDHE will continue to survey and gather information from providers to determine their progress in EHR adoption following incentive payment awards. Understanding both provider

## Section E: The State's HIT Roadmap

interest as well as their current adoption levels will better position KDHE in refining the HIT Roadmap.

KDHE will also move toward gathering more sophisticated information about the levels of EHR adoption for Kansas providers. One model KDHE is considering to monitor the levels of adoption is the hospital EHR adoption model created by the Health Information Management Systems Society (HIMSS) Analytics group (described in Figure E.3 below). HIMSS devised the Electronic Medical Record (EMR) Adoption Model (EMRAM) to track EMR progress at hospitals and health systems. The EMRAM scores hospitals in the HIMSS Analytics Database on their progress in completing the eight stages to creating a paperless patient record environment. KDHE is reviewing this model with the goal of customizing the various EHR adoption and implementation levels to describe these levels for Medicaid providers.

Figure E.3: U.S. EMR Adoption Model

US EMR Adoption Model <sup>SM</sup>			
Stage	Cumulative Capabilities	2011 Q1	2011 Q2
<b>Stage 7</b>	Complete EMR; CCD transactions to share data; Data warehousing; Data continuity with ED, ambulatory, OP	<b>1.0%</b>	<b>1.1%</b>
<b>Stage 6</b>	Physician documentation (structured templates), full CDSS (variance & compliance), full R-PACS	<b>3.5%</b>	<b>4.0%</b>
<b>Stage 5</b>	Closed loop medication administration	<b>5.9%</b>	<b>6.1%</b>
<b>Stage 4</b>	CPOE, Clinical Decision Support (clinical protocols)	<b>10.7%</b>	<b>12.3%</b>
<b>Stage 3</b>	Nursing/clinical documentation (flow sheets), CDSS (error checking), PACS available outside Radiology	<b>48.4%</b>	<b>46.3%</b>
<b>Stage 2</b>	CDR, Controlled Medical Vocabulary, CDS, may have Document Imaging; HIE capable	<b>14.1%</b>	<b>13.7%</b>
<b>Stage 1</b>	Ancillaries - Lab, Rad, Pharmacy - All Installed	<b>6.7%</b>	<b>6.6%</b>
<b>Stage 0</b>	All Three Ancillaries Not Installed	<b>9.6%</b>	<b>10.0%</b>

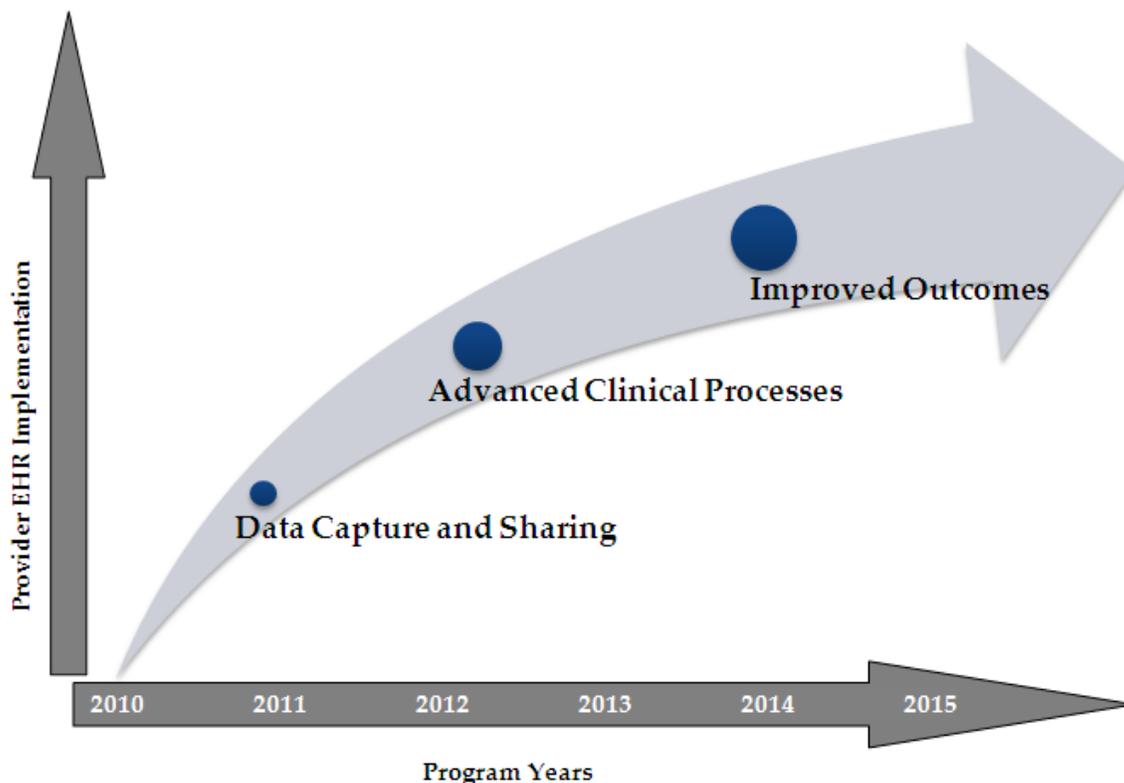
Data from HIMSS Analytics <sup>TM</sup> Database © 2011

N = 5,275    N = 5,310

KDHE will collect information about the level of EHR and HIE adoption, including information about system functionality and progress towards achieving meaningful use. This information will help KDHE to tailor communications and the HIT roadmap.

As shown in figure E.4, KDHE anticipates that as provider EHR adoption rates improve, the abilities to share data between providers will lead to improved outcomes.

Figure E.4: Transforming Care through EHR Adoption Timeline



Critical to this long-term vision is defining provider requirements and expectations for achieving Stage 2 Meaningful Use and beyond. Helping providers maximize the benefits of this program and sustain their involvement is critical to the long-term success of the model. Moving providers who have not adopted EHR to meaningful EHR use will involve changing their perception of sustainability and ability to meet meaningful use criteria. KDHE's strategy will *involve* providers in the incentive program to help them *evolve* in their participation over time. Efforts to clear these hurdles and involve providers in HIT adoption include outreach, collaboration and innovations, as described further below.

- **Outreach.** KDHE has planned provider outreach efforts to maximize Medicaid provider HIT adoption and sustained participation in the incentive program. KDHE is using the data that is collected through multiple provider surveys and through outreach to provider associations and other stakeholders. This information will

## Section E: The State's HIT Roadmap

shape the messages and content of provider communications. Over time, KDHE also plans to use the MAPIR system and the provider statistics captured during the enrollment process to further assess and statistically monitor provider adoption levels and ongoing outreach and technical assistance needs. The MAPIR system will also provide valuable statistics about applications suspended for further review, which will further assist KDHE in targeting outreach efforts.

- **Collaboration.** KDHE will continue to work in collaboration with other HIT and HIE initiatives to maximize the existing resources and to ensure that providers receive an accurate and consistent message regarding the Medicaid EHR Incentive Program. Specifically, Kansas has identified the following needs for collaboration within the provider community and Medicaid.
  - Options for working with Medicaid providers to establish meaningful exchange of health information on behalf of beneficiaries
  - Options for storing and accessing clinical data to support a medical home and coordinate care for Medicaid beneficiaries
  - Systems necessary for true coordination of care for Medicaid beneficiaries
  - Options for Master Patient Index and Provider Directory
  - Option for all Kansas RHIOs to ensure continuity and coordination of care for Medicaid enrollees

KDHE will continue collaboration with KHIE to leverage MMIS, HIE and HIT infrastructure, provider outreach and education where possible. Working together, KDHE and KHIE will maximize the value of Kansas' HIE infrastructure to providers.

## Section E: The State's HIT Roadmap

- **Innovations.** KDHE will also work with providers to identify innovative and effective solutions to EHR and HIT adoption issues. Kansas has determined the following issues requiring innovative techniques.
  - Options for Meaningful Use attestation data collection and analysis
  - Options for Medicaid Member personal health record utilization and chronic condition education and management

KDHE will work closely with provider organizations to analyze innovation successes and determine options for promoting the use of innovations across Kansas.

### *Building Infrastructure to Support Meaningful Use and Exchange*

KDHE identified several objectives in building an infrastructure to support meaningful use and HIE. The following is a high-level description of these activities:

- Develop organizational resources and governance to administer the incentive program and facilitate provider participation, adoption, and meaningful use.
- Modify the MMIS system to support the provider application and incentive payment program via a MAPIR module.
- Work with HIT initiatives to identify means for data exchange to support meaningful use criteria.
- Create a data warehouse to collect meaningful use clinical data and to analyze the data to identify opportunities for quality improvement interventions and support, assist in oversight, etc.

Section E: The State’s HIT Roadmap

KDHE will further develop plans for some of the items above, such as the data warehouse, after the previously addressed technical assessment is complete.

KDHE’s Expectations for Provider EHR Adoption over Time and Annual Benchmarks (Response to Questions #2 and 3)

As noted in Section B, KDHE’s long-term goal is to have 100 percent of eligible Kansas Medicaid providers adopt EHRs. The ultimate goal of the Kansas HIT Initiative is to continue to provide quality services to Medicaid consumers. Table E.1 below describes baselines and defines the overall adoption rate goals for the next five years. These adoption targets do not reflect the ability of these providers to demonstrate meaningful use.

**Table E.1: Percent of Providers Who Have Adopted or Will Adopt EHR Systems**

Year	Physician Adoption Percentage Rate	Hospital Adoption Percentage Rate
Baseline (year)	40 (2011)	78 (2009)
2011	40	78
2012	40	80
2013	50	85
2014	60	85
2015	80	90

Aside from the EHR adoption goals described above, KDHE’s goals for the provider incentive program focus on three critical paths: 1) provider participation, 2) infrastructure development and 3) meaningful use. The goals and strategies described in Table E.2 below will help KDHE assess and describe its progress along these critical paths:

**Table E.2: KDHE’s Goals and Strategies for the EHR Incentive Program**

Goal	Strategy
Increase provider participation in the EHR incentive program	KDHE will employ outreach and education . KDHE also intends to work with the REC to explore options for focused work with Medicaid providers.
Retain majority of enrolled providers in future years, in particular, retain providers between adoption, implementation, upgrade and meaningful use incentive payments	KDHE will employ outreach and education
Provide resources to increase EHR adoption stage rating for all Medicaid providers	KDHE will employ outreach and education and collaborate with the Regional Extension Centers
Track usage of HIE services and increase the percentage of providers exchanging data to support overarching meaningful use and care coordination goals	KDHE will monitor HIE adoption and usage and employ outreach and education
Measure and improve provider satisfaction with the EHR incentive program including satisfaction with the application process and with the assistance provided by KDHE	Develop provider satisfaction surveys, e.g., screens at the end of MAPIR with satisfaction questions
Increase number of providers who meet meaningful use at various stages	Develop interventions to help increase number of providers meeting meaningful use, e.g., collaborate with the REC
Improve provider performance on clinical quality measures and objectives	Develop metrics and tracking mechanisms for meaningful use reporting and develop interventions to improve results of clinical quality measures and objectives

The initial year of the program will serve to define the benchmark, or standard by which we can measure effective HIT improvements. KDHE will then set performance improvement targets in each of the stages defined in the Roadmap.

Annual Benchmarks for Audit and Oversight Activities (Response to Question# 4)

As Sections C and D describe, the MAPIR system will facilitate monitoring and oversight during application, attestation, post payment and during the renewal process. As described in

## Section E: The State's HIT Roadmap

Section D, Program Integrity staff will review both eligible professionals and hospitals but KDHE will review hospitals payments more closely before issuing the payment since the payments are much larger. Some examples of annual benchmarks captured through MAPIR and other oversight activities include:

- Number of on-site and desk reviews conducted by KDHE. EHR incentive payment reviews will be incorporated into other reviews
- 100 percent of overpayments recouped and returned to CMS within 1 year
- Number of Corrective Action Plans and technical assistance referrals made and resolved
- Number of providers who received EHR incentive payment but do not meet adoption, implementation, upgrade, and meaningful use criteria
- Special studies and findings, e.g., patient volume reviews, assignment of payments consensual

Appendix I: Glossary of Terms

**Appendix I: Glossary of Terms and Acronyms**

The below matrix provides a glossary of terms and acronyms that are frequently used in discussions about KDHE’s HIT initiative.

Term	Acronym	Definition
Technology		
CMS Registration and Attestation System	R&A	<p>A system that will be available to states to help avoid duplication of payments to providers participating in the EHR provider incentive program</p> <p>Information the system will store includes provider registration information, meaningful use attestations and incentive payment information</p>
Electronic Health Record	EHR	<p>A subset of information from multiple provider organizations where a patient has had encounters</p> <p>An aggregate electronic record of health-related information for an individual that is created and gathered cumulatively across multiple health care organizations, and is managed and consulted by licensed clinicians and staff involved in the individual’s health and care</p> <p>Connected by a Health Information Exchange (HIE)</p> <p>Can be established only if the EMRs of multiple provider organizations have evolved to a level that can create and support a robust exchange of information</p> <p>Owned by patient</p> <p>Provides interactive patient access and ability for the patient to append information</p>
Electronic Medical Record	EMR	<p>The legal record created in hospitals and ambulatory environments that is the source of data for an electronic health record</p> <p>A record of clinical services for patient encounters in a single provider organization; does not include encounter information from other provider organizations</p> <p>Created, gathered, managed and consulted by licensed clinicians and staff from a single provider</p>

Appendix I: Glossary of Terms

Term	Acronym	Definition
		<p>organization who are involved in the individual's health and care</p> <p>Owned by the provider organization</p> <p>May allow patient access to some results information through a portal, but is not interactive</p>
Health Information Exchange	HIE	<p>The sharing of clinical and administrative data across the boundaries of health care institutions and providers</p> <p>The mobilization of healthcare information electronically across organizations within a region, community or hospital system</p> <p>Provides capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged</p> <p>Goal is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable patient-centered care</p>
Health Information Organization	HIO	<p>A multi-stakeholder organization expected to be responsible for motivating and causing integration and information exchange among stakeholders.</p>
Health Information Technology	HIT	<p>Allows comprehensive management of medical information and its secure exchange between health care consumers and providers</p> <p>Application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data and knowledge for communication and decision-making</p>
Integrated Delivery Network	IDN	<p>An Integrated Delivery Network (IDN) is a network of facilities and providers working together to offer a continuum of care to a specific market or geographic area</p>
Kansas Department of Health and Environment Department of Healthcare Finance	KDHE	<p>The organization within Kansas which administers the Medicaid program, commonly referred to as KDHE</p>

Appendix I: Glossary of Terms

Term	Acronym	Definition
Kansas Health Information Exchange	KHIE	A statewide utility that will connect regional HIE's and integrated health systems
Medical Assistance Provider Incentive Repository	MAPIR	The application is the state-level information system for the electronic health record incentive program. MAPIR will track and act as a repository for information related to payment, applications, attestations, oversight functions, and interface with CMS' National Level Repository.
Medical Management Information System	MMIS	The Medicaid program, enacted in 1965 under Title XIX of the Social Security Act (the Act) is a grant in aid Medical Assistance Program financed through joint Federal and state funding and administered by each state according to an approved state plan. Under this plan, a state reimburses providers of medical assistance to individuals found eligible under Title XIX and various other titles of the Act.
Personal Health Record	PHR	<p>Electronic, cumulative record of health-related information for an individual in a private, secure and confidential manner</p> <p>Drawn from multiple sources</p> <p>Created, gathered, and managed by the individual</p> <p>Integrity of the data and control of access are the responsibility of the individual</p>

## Appendix I: Glossary of Terms

Term	Acronym	Definition
CMS Documentation Requirements for Provider Incentive Program <sup>6,7</sup>		
Implementation Advanced Planning Document	I-APD	A plan of action, and any necessary update documents, that requests FFP and approval to acquire and implement the proposed SMHP services or equipment or both
Planning Advanced Planning Document	P-APD	A plan of action, and any necessary update documents, that requests FFP and approval to accomplish the planning necessary for a State agency to determine the need for and plan the acquisition of HIT equipment or services or both and to acquire information necessary to prepare a HIT implementation advanced planning document (IAPD) or request for proposal to implement the State Medicaid HIT Plan (SMHP)
State Medicaid Agency	SMA	The organization that administers the Medicaid program within a State.
State Medicaid Health Information Technology Plan	SMHP	<p>Document that describes a state's current and future HIT activities in support of the Medicaid EHR incentive program</p> <p>Purpose is to identify the "As-Is" state and "To-Be" (target) state of a state's Medicaid business enterprise and to align business areas and processes in the user community</p> <p>Development of an SMHP provides states an opportunity to analyze and plan for how EHR technology, over time, can be used to enhance quality and health care outcomes and reduce overall health care costs</p>

---

<sup>6</sup> To receive FFP for administering an EHR provider incentive program, a state must develop a HIT PAPD, an SMHP and an HIT IAPD to describe its process to implement and oversee the EHR incentive program. They will help states to construct an HIT roadmap to develop the systems necessary to support providers in their adoption and meaningful use of certified EHR technology.

<sup>7</sup> The APD process allows states to update their APD when they anticipate changes in scope, cost, schedule, etc. States may add tasks to the contract, which they identified after the HIT PAPD was written and as they worked on tasks included in the original submission. This is a complex initiative that will most likely result in an "as needed" and "annual" update to the original scope of work.

Appendix I: Glossary of Terms

Term	Acronym	Definition
Other		
American Recovery and Reinvestment Act	ARRA	Commonly referred to as the Stimulus or The Recovery Act, is an economic stimulus package enacted by the 111th United States Congress in February 2009
Children’s Health Insurance Program Reauthorization Act	CHIPRA	Provides grant funding for demonstration programs
Health Information Technology for Economic and Clinical Health Act	HITECH	Act that provides for funding opportunities to advance health information technology
Medicaid Information Technology Architecture	MITA	<p>Both a framework and an initiative:</p> <p>National framework to support improved systems development and health care management for the Medicaid enterprise</p> <p>Initiative to establish national guidelines for technologies and processes that enable improved program administration for the Medicaid enterprise, and which includes an architecture framework, models, processes and planning guidelines for enabling State Medicaid enterprises to meet common objectives with the framework while supporting unique local needs</p>
Nationwide Health Information Network	NHIN	The nationwide health information network is a set of standards, services and policies that enable secure health information exchange over the Internet. The network will provide a foundation for the exchange of health information across diverse entities, within communities and across the country, helping to achieve the goals of the HITECH Act.
National Health Interview Survey	NHIS	The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian non-institutionalized population of the United States and is one of the major data collection programs of the National Center for Health Statistics (NCHS), which is part of the Centers for Disease Control and Prevention (CDC).

Appendix I: Glossary of Terms

Term	Acronym	Definition
Office of National Coordinator	ONC	Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.
Regional Extension Centers	REC	<p>Entities that have received grants funds to offer technical assistance, guidance, and information to support and accelerate health care providers' efforts to become meaningful users of EHRs</p> <p>Designed to ensure primary care clinicians who need help are provided with an array of on-the-ground support to meaningfully use EHRs</p> <p>Entities will provide training and support services to assist doctors and other providers in the adoption and meaningful use of EHR systems</p> <p>Part of the Health Information Technology Extension Program authorized through the HITECH Act</p>
State Health Insurance Assistance Program	SHIP	The State Health Insurance Assistance Program, or SHIP, is a state-based program that offers local one-on-one counseling and assistance to people with Medicare and their families. Through CMS funded grants directed to states, SHIPs provide free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities.

Appendix II: SMHP Crosswalk

Appendix II: SMHP Response Crosswalk

SMHP Question	Corresponding Answer
Section A	
<p>1. What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State’s providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of provider? Does the SMA have data on EHR adoption by types of provider (e.g. children’s hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)?</p>	<p>Current EHR and HIT Adoption (Response to Question #1)</p>
<p>2. To what extent does broadband internet access pose a challenge to HIT/E in the State’s rural areas? Did the State receive any broadband grants?</p>	<p>Access to Broadband Internet (Response to Question #2)</p>
<p>3. Does the State have Federally-Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe.</p>	<p>Federally Qualified Health centers (FQHCs) and Health Resource Services Administration (HRSA) Funding (Response to Question #3)</p>
<p>4. Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.</p>	<p>Veterans Administration (VA) or Indian Health Services (Response to Question #4)</p>
<p>5. What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?</p>	<p>Stakeholder Engagement in Existing HIT/HIE Activities (Response to Question #5)</p>
<p>6. Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc) of these activities?</p>	<p>Current HIE Organizations and Activities in Kansas (Response to Questions # 6, 7 and 9)</p>
<p>7. Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? How extensive is their geographic reach and scope of participation?</p>	<p>Current HIE Organizations and Activities in Kansas (Response to Questions # 6, 7 and 9)</p>

Appendix II: SMHP Crosswalk

<p>8. Please describe the role of the MMIS in the SMA's current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how.</p>	<p>Role of MMIS in Current HIT/E Environment (Response to Question #8)</p>
<p>9. What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use?</p>	<p>Current HIE Organizations and Activities in Kansas (Response to Questions # 6, 7 and 9)</p>
<p>10. Explain the SMA's relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program.</p>	<p>Relationship with State Government HIT Coordinator (Response to Question #10)</p>
<p>11. What other activities does the SMA currently have underway that will likely the direction of the EHR Incentive Program over the next five years?</p>	<p>Current Department Activities Likely to Influence EHR Incentive Program (Response to Question #11)</p>
<p>12. Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe.</p>	<p>Recent Relevant Changes to State Laws and Regulations (Response to Question #12)</p>
<p>13. Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe.</p>	<p>HIT/E Activities Crossing State Lines (Response to Question #13)</p>
<p>14. What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)?</p>	<p>Current Interoperability Status of State Immunization Registry and Public Health Surveillance Reporting (Response to Question #14)</p>
<p>15. If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.</p>	<p>Transformation Grant or CHIPRA HIT Grant (Response to Question #15)</p>
<p>Section B</p>	
<p>1. Looking forward to the next five years, what specific HIT/E goals and objectives does the</p>	<p>KDHE's Goals (Response to Questions #1 and</p>

## Appendix II: SMHP Crosswalk

<p>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.</p>	<p>#4)</p>
<p>2. *What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locator Service?</p>	<p>MMIS System Architecture and EHR Incentive Program System (Response to Questions #2, 3, and 4)</p>
<p>3. How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?</p>	<p>MMIS System Architecture and EHR Incentive Program System (Response to Questions #2, 3, and 4)</p>
<p>4. Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA's HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.</p>	<p>KDHE's Goals (Response to Questions #1 and #4)  MMIS System Architecture and EHR Incentive Program System (Response to Questions #2, 3, and 4)</p>
<p>5. What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?</p>	<p>Role in Encouraging HIT Adoption and Ongoing Provider Outreach and Education (Response to Questions #5 and 7)</p>
<p>6. ** If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption?</p>	<p>Leveraging Related Funding Resources (Response to Questions #6 and 9)</p>
<p>7. ** How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?</p>	<p>Role in Encouraging HIT Adoption and Ongoing Provider Outreach and Education (Response to Questions #5 and 7)</p>
<p>8. ** How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?</p>	<p>Addressing the Unique Needs of Special Populations (Response to Question #8)</p>
<p>9. If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder</p>	<p>Leveraging Related Funding Resources (Response to Questions #6 and 9)</p>

Appendix II: SMHP Crosswalk

relationships, governance structures, legal/consent policies and agreements, etc.?	
10. Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.	The Need for Additional Legislation (Response to Question #10)
Section C	
1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?	<p>Step 2: Providers will enroll in the CMS Medicare &amp; Medicaid EHR Incentive Program Registration and Attestation System (Response to Questions #1, 16, 17 and 30)</p> <p>Step 4: MAPIR runs edits on info from R&amp;A to determine which providers to contact for the application process (Response to Questions #1, 15, 16 and 29)</p> <p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p> <p>Step 7: If applicable, KDHE denies provider’s application (Response to Questions #1 and 22)</p>
2. How will the SMA verify whether EPs are hospital-based or not?	Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)

Appendix II: SMHP Crosswalk

<p>3. How will the SMA verify the overall content of provider attestations?</p>	<p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p> <p>Step 12: Post-payment oversight and outreach activities (Response to Questions #3, 6 , 7, 8 and 26)</p>
<p>4. How will the SMA communicate to its providers regarding their eligibility, payments, etc?</p>	<p>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</p> <p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p> <p>Step 10: KDHE sends approval email to provider with program and payment information (Response to Question #4)</p>
<p>5. What methodology will the SMA use to calculate patient volume?</p>	<p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p>
<p>6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?</p>	<p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26,</p>

Appendix II: SMHP Crosswalk

	<p>28 and 30)</p> <p>Step 12: Post-payment oversight and outreach activities (Response to Questions #3, 6 , 7, 8 and 26)</p>
<p>7. How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement?</p>	<p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p> <p>Step 12: Post-payment oversight and outreach activities (Response to Questions #3, 6 , 7, 8 and 26)</p>
<p>8. How will the SMA verify <i>adopt, implement or upgrade</i> of certified electronic health record technology by providers?</p>	<p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p> <p>Step 12: Post-payment oversight and outreach activities (Response to Questions #3, 6 , 7, 8 and 26)</p>
<p>9. How will the SMA verify <i>meaningful use</i> of certified electronic health record technology for providers' second participation years?</p>	<p>Step 13: Ongoing technical assistance for adoption, implementation, upgrade and meaningful use of EHR (Response to Questions #8 and 9)</p> <p>Step 15: Meaningful use payment request or renewal (Response to Questions #9, 12, 13 and 30)</p>

Appendix II: SMHP Crosswalk

<p>10. 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.</p>	<p>Step 14: Notification of meaningful use requirements for Year Two and beyond (Response to Questions #10, 11 and 12)</p>
<p>11. How will the SMA verify providers' use of <i>certified electronic health record technology</i>?</p>	<p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p> <p>Step 14: Notification of meaningful use requirements for Year Two and beyond (Response to Questions #10, 11 and 12)</p>
<p>12. 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?</p>	<p>Step 14: Notification of meaningful use requirements for Year Two and beyond (Response to Questions #10, 11 and 12)</p> <p>Step 15: Meaningful use payment request or renewal (Response to Questions #9, 12, 13 and 30)</p>
<p>13. * How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?</p>	<p>Step 15: Meaningful use payment request or renewal (Response to Questions #9, 12, 13 and 30)</p>
<p>14. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?</p>	<p>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</p> <p>Step 3: The R&amp;A will provide information to KDHE through MAPIR interfaces about providers who have applied for the incentive</p>

Appendix II: SMHP Crosswalk

	<p>program (Response to Questions #14, 18, 20 and 29)</p> <p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p>
15. What IT systems changes are needed by the SMA to implement the EHR Incentive Program?	Step 4: MAPIR runs edits on info from R&A to determine which providers to contact for the application process (Response to Questions #1, 15, 16 and 29)
16. What is the SMA's IT timeframe for systems modifications?	<p>Step 2: Providers will enroll in the CMS Medicare &amp; Medicaid EHR Incentive Program Registration and Attestation System (Response to Questions #1, 16, 17 and 30)</p> <p>Step 4: MAPIR runs edits on info from R&amp;A to determine which providers to contact for the application process (Response to Questions #1, 15, 16 and 29)</p>
17. When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (R&A)?	Step 2: Providers will enroll in the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (Response to Questions #1, 16, 17 and 30)
18. 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)?	Step 3: The R&A will provide information to KDHE through MAPIR interfaces about providers who have applied for the incentive program (Response to Questions #14, 18, 20 and 29)

Appendix II: SMHP Crosswalk

<p>19. What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc?</p>	<p>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</p>
<p>20. Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD?</p>	<p>Step 3: The R&amp;A will provide information to KDHE through MAPIR interfaces about providers who have applied for the incentive program (Response to Questions #14, 18, 20 and 29)</p>
<p>21. What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?</p>	<p>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</p>
<p>22. 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?</p>	<p>Step 6: KDHE reviews pended provider application and attestation and determines eligibility or addresses reasons for suspension (Response to Questions #22 and 28)</p> <p>Step 7: If applicable, KDHE denies provider's application (Response to Questions #1 and 22)</p>
<p>23. 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?</p>	<p>Step 11: MMIS issues payment and MAPIR submits payment information to the R&amp;A (Response to Questions #23 - 25)</p>
<p>24. What is the SMA's anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)?</p>	<p>Step 11: MMIS issues payment and MAPIR submits payment information to the R&amp;A</p>

Appendix II: SMHP Crosswalk

	(Response to Questions #23 - 25)
25. 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?	<p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p> <p>Step 11: MMIS issues payment and MAPIR submits payment information to the R&amp;A (Response to Questions #24 and 25)</p>
26. 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?	<p>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</p> <p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p>
27. 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?	<p>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</p>
28. What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs’ 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?	<p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26, 28 and 30)</p> <p>Step 6: KDHE reviews pended provider</p>

Appendix II: SMHP Crosswalk

	<p>application and attestation and determines eligibility or addresses reasons for suspension (Response to Questions #22 and 28)</p>
<p>29. 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.?</p>	<p>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</p> <p>Step 3: The R&amp;A will provide information to KDHE through MAPIR interfaces about providers who have applied for the incentive program (Response to Questions #14, 18, 20 and 29)</p> <p>Step 4: MAPIR runs edits on info from R&amp;A to determine which providers to contact for the application process (Response to Questions #1, 15, 16 and 29)</p>
<p>30. States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:</p> <ul style="list-style-type: none"> <li>• The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support)</li> <li>• The status/availability of certified EHR technology</li> <li>• The role, approved plans and status of the Regional Extension Centers</li> <li>• The role, approved plans and status of the HIE cooperative agreements</li> </ul>	<p>Step 1: KDHE conducts education and outreach strategy for providers and stakeholders (Response to Questions #4, 14, 19, 21, 26, 27, 29 and 30)</p> <p>Step 2: Providers will enroll in the CMS Medicare &amp; Medicaid EHR Incentive Program Registration and Attestation System (Response to Questions #1, 16, 17 and 30)</p> <p>Step 5: Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system edits (Response to Questions #1 – 8, 11, 14, 25, 26,</p>

Appendix II: SMHP Crosswalk

<ul style="list-style-type: none"> <li>• State-specific readiness factors</li> </ul>	<p>28 and 30)</p> <p>Step 15: Meaningful use payment request or renewal (Response to Questions #9, 12, 13 and 30)</p>
<p>Section D</p>	
<p>1. Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.</p>	<p>Program Oversight (Response to Questions #1 and 7)</p> <p>Methods for Avoiding Improper Payments (Response to Questions #1, 4 and 5)</p> <p>Investigating Fraud and Abuse and Collecting Overpayments (Response to Questions #1 – 3)</p>
<p>2. How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?</p>	<p>Investigating Fraud and Abuse and Collecting Overpayments (Response to Questions #1 – 3)</p>
<p>3. Describe the actions the SMA will take when fraud and abuse is detected.</p>	<p>Investigating Fraud and Abuse and Collecting Overpayments (Response to Questions #1 – 3)</p>
<p>4. Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.</p>	<p>Methods for Avoiding Improper Payments (Response to Questions #1, 4 and 5)</p>
<p>5. Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?* (i.e. probe sampling; random sampling)</p>	<p>Methods for Avoiding Improper Payments (Response to Questions #1, 4 and 5)</p>

## Appendix II: SMHP Crosswalk

<p>6. <b>**</b>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)?</p>	<p>Reducing Provider Burden While Maintaining Oversight (Response to Question #6)</p>
<p>7. Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?</p>	<p>Program Oversight (Response to Questions #1 and 7)</p>
<p>Section E</p>	
<p>1. *Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there.</p>	<p>Medicaid Agency Five-Year Roadmap (Response to Question #1)</p>
<p>2. What are the SMA's expectations regarding provider EHR technology adoption over time? Annual benchmarks by provider type?</p>	<p>KDHE's Expectations for Provider EHR Adoption over Time and Annual Benchmarks (Response to Questions #2 and 3)</p>
<p>3. Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario.</p>	<p>KDHE's Expectations for Provider EHR Adoption over Time and Annual Benchmarks (Response to Questions #2 and 3)</p>
<p>4. Discuss annual benchmarks for audit and oversight activities.</p>	<p>Annual Benchmarks for Audit and Oversight Activities (Response to Question# 4)</p>

**Appendix III: Physician Survey Results**

For the SMHP, Kansas has relied heavily on the Docking Institute analysis of data compiled from the Kansas Health Policy Authority (KHPA, now KDHE) Physician Survey conducted from January 7 to February 15, 2011, and merged with data provided from KHPA, now KDHE. Presented in this Appendix are key findings that have informed the policymaking in the SMHP.

**Table Appendix II.1: Summary of findings from Docking Institute**

Topic	Findings
<b>EHR stimulus funding</b>	<ul style="list-style-type: none"> <li>• 61% of respondents plan to seek Medicare stimulus funding, while approximately 5% plan to seek Medicaid funding.</li> <li>• Approximately 2% of respondents do not plan to apply for stimulus funding, while almost 32% are not sure if they will apply for stimulus funding.</li> <li>• Of the 34% who are not definitely planning to apply for stimulus funding, fully 28% state that the reason for not seeking stimulus funding or incentives through Medicare or Medicaid was that they “Need further information about these opportunities.” The second most popular response, chosen by 9%, was “Unsure of what Electronic Health Record system to purchase.” Another 8% of the respondents “do not serve Medicare or Medicaid patients.”</li> </ul>
<b>Technology readiness</b>	<ul style="list-style-type: none"> <li>• Fiber optic cable (19.2%), T-1 (17.7%), cable (14.6%) and DSL (13.0%) provide internet access to substantial numbers of respondents.</li> <li>• Fully 73% of respondents prefer contact via email.</li> <li>• Only one respondent (0.1%) does not submit primary insurance claims electronically. However, 357 (21%) do not submit secondary insurance claims electronically, and 773 (45.6%) do not submit insurance claims through a website provided by the payer.</li> <li>• Nearly 36% do not verify insurance eligibility electronically, and 25% do not use a payer website to verify insurance eligibility electronically.</li> <li>• Transaction including remittance advice, claims status requests, claims attachment and electronic fund transfers are conducted electronically from 42% of the time (remittance advice) to 25% of the time (claims attachments)</li> </ul>
<b>EHR adoption and meaningful use</b>	<ul style="list-style-type: none"> <li>• Fully 48% of respondents currently use an EHR system in their practice.</li> <li>• C/S MPM (25.3%) and eClinicalWorks (20.0%) account for 45% of all EHR systems among respondents.</li> <li>• The number of EHR implementations peaked in 2009, with 112 systems installed in that year. This fell off to 80 installations during 2010.</li> <li>• Over 12% (209) of respondents answered that the EHR system in use is not connected to any ancillary departments or outside facilities.</li> <li>• Of those who do access ancillary services and outside facilities, the most</li> </ul>

### Appendix III: Physician Survey Results

Topic	Findings
	<p>frequently accessed services are radiology (28% web respondents), laboratory (19.6%) and pathology (15.7% web respondents).</p> <ul style="list-style-type: none"> <li>Nearly 80% of practices have electronic medication history information available. If available, 81% claim to use it either “all of the time” or “most of the time.”</li> </ul>
<b>EHR Planning</b>	<ul style="list-style-type: none"> <li>Approximately 42% of those without EHR do not plan to invest in an EHR system within the next 2 years.</li> <li>Nearly 66% of respondents currently without EHR have seriously considered purchasing a system.</li> <li>Of those not planning to invest in an EHR system, 72% cite cost (“too expensive”) as the reason not to invest.</li> <li>Fully 51% are satisfied with the current paper-based system.</li> </ul>
<b>On-site Laboratory</b>	<ul style="list-style-type: none"> <li>Nearly 31% of respondents have an onsite laboratory.</li> <li>More than half (57%) of the labs have the capability to receive orders electronically.</li> <li>Half (50%) have the capability to send results electronically.</li> <li>Only 12% provide results to external entities.</li> </ul>
<b>Patient Portal</b>	<ul style="list-style-type: none"> <li>Of all potential respondents, only 6.5% use a patient portal for secure access to clinical records.</li> <li>Almost 6% use a patient portal for secure electronic communications with provider.</li> <li>Only 3% use a patient portal for scheduling and payment.</li> </ul>
<b>Practice Management</b>	<ul style="list-style-type: none"> <li>Just over half (55%) of the practices currently use a Practice Management System (PMS).</li> </ul>
<b>HIE Availability and Use</b>	<ul style="list-style-type: none"> <li>At the current time, only 4% of respondents participate in Health Information Exchange (HIE).</li> <li>Funding is the biggest barrier to participating in Health Information Exchange (HIE), cited by nearly 23% of respondents, followed by limited resources, cited by 18%.</li> <li>Nearly 14% of respondents face no barriers to participating in HIE.</li> </ul>
<b>Data Interface Problems</b>	<ul style="list-style-type: none"> <li>Nearly 43% of all participants in the surveys experience problems interfacing data with external healthcare systems.</li> </ul>
<b>KHPA (now KDHE) Assistance</b>	<ul style="list-style-type: none"> <li>Large numbers of participants do wish to have additional information from KHPA regarding EHR educational opportunities (24%), EHR Medicare incentives (34%), EHR Medicaid incentives (26%) and HIE development (38%).</li> </ul>

### Appendix III: Physician Survey Results

Topic	Findings
	<ul style="list-style-type: none"><li>• Regarding EHR installation and use, approximately one fourth (26%) of all respondents would like to be contacted about interfacing the Kansas HIE, and 11% would like to be contacted about workflow redesign.</li></ul>

**Appendix IV: Communications Plan**

**Kansas Department of Health and Environment  
Division of Health Care Finance  
Medicaid Electronic Health Record Incentive Program  
Communications Plan**

**Introduction**

The Kansas Department of Health and Environment, Division of Health Care Finance (KDHE/DHCF, hereafter referred to as KDHE) is the designated State agency that administers the Kansas Medicaid program. Kansas has elected to participate in the Medicaid Electronic Health Record (EHR) Incentive Program funded through Centers for Medicare and Medicaid Services (CMS) and KDHE is leading the development of the State Medicaid Health Information Technology Plan (SMHP), and the implementation of all Medicaid Health Information Technology (HIT) initiatives.

KDHE developed this Communications Plan to provide information about KDHE's communications objective and planned strategy, materials, messages, and collaboration toward promoting and supporting the Medicaid EHR Incentive Program. As a complement to the SMHP, this document gives a more-detailed description of the communication and outreach KDHE is performing to encourage and support participation in the Medicaid EHR Incentive Program.

### **Objective of the Communication Plan**

The objective of Kansas's Communications Plan (the Plan) is to describe the strategy, messages, and tools KDHE uses to achieve its goal of raising practitioner awareness and participation in the Medicaid EHR Incentive Program. Through education and outreach, KDHE plans to enable these practitioners to become meaningful users of certified EHR technologies. The Plan will provide an insight into KDHE's communications activities and approach, including:

- Informing providers about:
  - The EHR incentive program
  - The requirement that providers must be participating Medicaid providers to participate in the incentive program
  - How to begin the enrollment process
- Coordinating with the Regional Extension Center (REC) and other resources to provide technical assistance and information related to the benefits of EHR adoption, implementation, upgrade and meaningful use of EHRs
- Participating in meetings or events with stakeholders to disseminate information, and gather feedback, about KDHE's HIT goals and initiatives, including the Medicaid EHR Incentive Program

### **Strategy for Achieving KDHE Communications Goals**

KDHE's strategy for encouraging and supporting provider adoption of certified EHR technology includes the following:

- Identify and analyze EHR audiences
- Develop and incorporate education and outreach materials regarding EHR technology
- Deliver strategic messages using multiple communication channels

The communications strategy will leverage existing, as well as develop new, relationships, communication vehicles, and messages. In order to effectively provide outreach and education, KDHE utilized existing stakeholder and provider analysis and interaction done at the statewide HIE level, including groups and associations with which KDHE has been engaged for some time, to identify EHR audiences. Based on the audiences, KDHE developed appropriate and helpful materials and messages regarding EHR technology. KDHE disseminates the messages and materials through a variety of communication vehicles toward raising practitioner awareness and participation in the Medicaid EHR Incentive Program.

### **Audiences**

Kansas recognizes providers may or may not be current adopters of EHR technology. Providers will benefit from being able to access health records and KDHE ensures the delivery of consistent and audience-specific messages toward achieving awareness and participation in the EHR incentive program.

Through current interaction and input from providers, associations, and organizations, KDHE analyzed providers and determined to target the following audiences:

- Eligible Professionals (EPs), both adopters and non-adopters of EHR
- Eligible Hospitals, both adopters and non-adopters of EHR

## Appendix IV: Communications Plan

In addition to Eligible Professionals and Hospitals, KDHE understands the importance of also reaching out to individuals from organizations, associations, and medical provider offices who affect participation with EHR. Therefore, in addition to targeting EPs and Eligible Hospitals, KDHE also provides Medicaid EHR Incentive Program information and outreach to associations, organizations, and groups that can benefit from EHR technology. Additional information regarding KDHE's work with groups is found in later sections of this document. KDHE believes outreach to individuals in these groups and the above audiences facilitate an atmosphere and culture of EHR adoption, utilization, and support.

### **Communication Vehicles**

Kansas will use various communication vehicles to engage the key audiences highlighted above, such as the following:

- Fact Sheets
- Frequently Asked Questions (FAQs)
- Presentations/Slides
- Outreach guide/manual
- Website content
- Webinars

The table below highlights, by audience, the various communication vehicles and their description and communication channel.

**Table 1.a: Communication Vehicles by Audience Type**

Target Audience	Vehicle Name	Vehicle Description	Vehicle Communication Channel
EPs / Hospitals	FAQs	Frequently asked questions and responses about Kansas's Medicaid EHR Incentive Program	Website, Distribution Lists, Events
EPs / Hospitals	Fact Sheet: The Basics	Provides basic introductory information about Kansas's Medicaid EHR Incentive Program	Website
EPs / Hospitals	Fact Sheet: Enrollment	Information about enrollment in Kansas's Medicaid EHR Incentive Program	Website
EPs / Hospitals	Fact Sheet: Volume Requirements	Quick reference for volume threshold requirements for Kansas's Medicaid EHR Incentive Program	Website
EPs / Hospitals	Fact Sheet: Payments	Information about Medicaid EHR Incentive Program payments	Website
EPs / Hospitals	Issue Brief: Meaningful Use	Defines meaningful use as per Final Rule, <i>42 CFR Parts 412, 413, 422, and 495</i> (published July 28, 2010)	Website
EPs / Hospitals	Medicaid Bulletin(s)	Provides information about the EHR incentive program and how providers may enroll	Website, Bulletins
EPs / Hospitals	Webinar 1: Overview of the EHR Incentive Program	Overview of the EHR Incentive Program and application process, e.g., eligibility, Federal rules, payment, etc.	Website, Webinars
Hospitals	Webinar 2: Hospital Program Overview	Overview of the Medicaid EHR Incentive Program and application process, e.g., eligibility, Federal rules, payment, etc., specific to Hospitals. Includes non-EP information such as hospital payment calculation	Website, Webinars
EPs	Webinar 3: Patient Volume Calculation	Presentation about calculating patient volume	Website, Webinars
EPs / Hospitals	Webinar 3: Monitoring and Oversight	Presentation about attestations, monitoring and documentation	Website, Webinars

Appendix IV: Communications Plan

Target Audience	Vehicle Name	Vehicle Description	Vehicle Communication Channel
EPs / Hospitals	Outreach Guide/ Manual	Manual providing general information and describing the value of health information technology and exchanges and the benefits of EHR	Website
State staff, EPs, Hospitals, Consumers	State Medicaid HIT Plan	State Medicaid Health Information Technology Plan for Kansas’s vision implementing provisions in Section 4201 of ARRA	Website and Meetings

These communication vehicles will help Kansas achieve audience awareness, participation and compliance with the Medicaid EHR Incentive Program. KDHE will update communication vehicles as needed, in order to provide time-relevant information and to incorporate audience and stakeholder input. Each vehicle will use communication channels, such as webinars and the KDHE website, to provide information to Eligible Professionals and Hospitals.

## Appendix IV: Communications Plan

### Webinars

KDHE is hosting a series of webinars to provide information on various topics regarding the Medicaid EHR Incentive Program. KDHE announces the webinar weeks before the scheduled date through an invitation flyer that is distributed to Eligible Professionals and Hospitals, as well as applicable groups. Individuals may view the webinar presentation live on the date it is scheduled. Webinars are easy to access online and KDHE will invite participants to dial in to a toll-free phone number for the audio portion of the session. When the webinar is finished, KDHE posts the webinar presentation on its website so individuals not able to participate live in the webinar will have access to the presentation.

The images below demonstrate examples of two presentation slides from Webinar #1 (Overview of the EHR Incentive Program):

Figure 1.a: Webinar#1 Presentation Slide Example – EHR Incentive Program Visions and Goals

# EHR Incentive Program Vision and Goals

**Vision:** To improve the quality and coordination of care by connecting providers to patient information at the point of care through the meaningful use of EHRs



**Goals:** Increased quality, awareness, coordination, and system redesign through enhanced data collection

---

The Division of Health Care Finance shall develop and maintain a coordinated health policy agenda that combines the effective purchasing and administration of health care with promotion oriented public health strategies.



9

Figure 1.b: Webinar#1 Presentation Slide Example – EHR Benefits (Non-Adopters of EHR)

## Electronic Health Record – Key Benefits

- Improve and Increase of Care Coordination and Public Health
- Quality of Care
- Time and Billing Efficiency
- Evolving Standard of Care
- Information Security and Patient Safety
- Engage Families and Beneficiaries
- Improve Public Health Tracking and Reporting
- Facilitates Meaningful Use Achievement
- Stimulus Funding



---

The Division of Health Care Finance shall develop and maintain a coordinated health policy agenda that combines the effective purchasing and administration of health care with promotion oriented public health strategies.

10

## Appendix IV: Communications Plan

### Website

The KDHE website (<http://www.kdheks.gov/hcf/hite/default.htm>) is a critical piece of Kansas's Medicaid EHR Incentive Program outreach and education strategy. KDHE's goal is for its website to be an effective mode of communication and support. Kansas's website will provide online and public access to various education and outreach materials highlighted in Table 1.a above, including webinar presentations, fact sheets, FAQs, an outreach guide, and the SMHP.

In addition to FAQs, Fact Sheets, webinar presentation materials discussed above, and other materials, KDHE's website will also have direct links to resources such as CMS and Kansas-related HIE and EHR information. The website will include information about the program, how to enroll, useful links, and other useful information.

The following screen shots illustrate currently published information on Kansas's website.

Figure 1.c: KDHE Website – HIT/HIE Information

**Kansas**  
Department of Health and Environment

**The Kansas Department of Health and Environment**  
Sam Brownback, Governor - Robert Moser, MD, Secretary  
Curtis State Office Building, 1000 SW Jackson, Topeka, Kansas 66612

[KDHE Home](#) [Health](#) [Health Care Finance](#) [Environment](#) [Laboratories](#) [A to Z Index](#)

[Division of Health Care Finance Home](#)  
[About Us](#)  
[Consumer Health Information](#)  
[News and Reports](#)  
[Medicaid and HealthWave](#)  
[State Employee Health Plan](#)  
[HealthQuest](#)  
[Health Policy](#)  
[Health Information Technology/Exchange](#)  
[Health Care Finance Program Improvement](#)  
[Data Consortium](#)  
[Data Reports and Requests](#)  
[Meetings and Events](#)  
[Office of Inspector General](#)  
[Policies and Procedures](#)  
[Site Map](#)  
[Contact Us](#)

[KDHE Home - DHCF - Health Information and Technology Exchange](#)

### Health Information Technology and Health Information Exchange (HIT/HIE)

Health Information Technology and Exchange are two of the cornerstones of efforts in Kansas to improve the coordination and delivery of health care services. They are also central to federal efforts under the [Affordable Care Act](#) to improve the quality and effectiveness of health care services.

**HEALTH INFORMATION TECHNOLOGY** refers to electronic systems that make it possible for health care providers to better manage patient care through secure use and sharing of health information. Health IT includes the use of electronic health records (EHRs) instead of paper medical records to maintain people's health information.

**HEALTH INFORMATION EXCHANGE** refers to the electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.

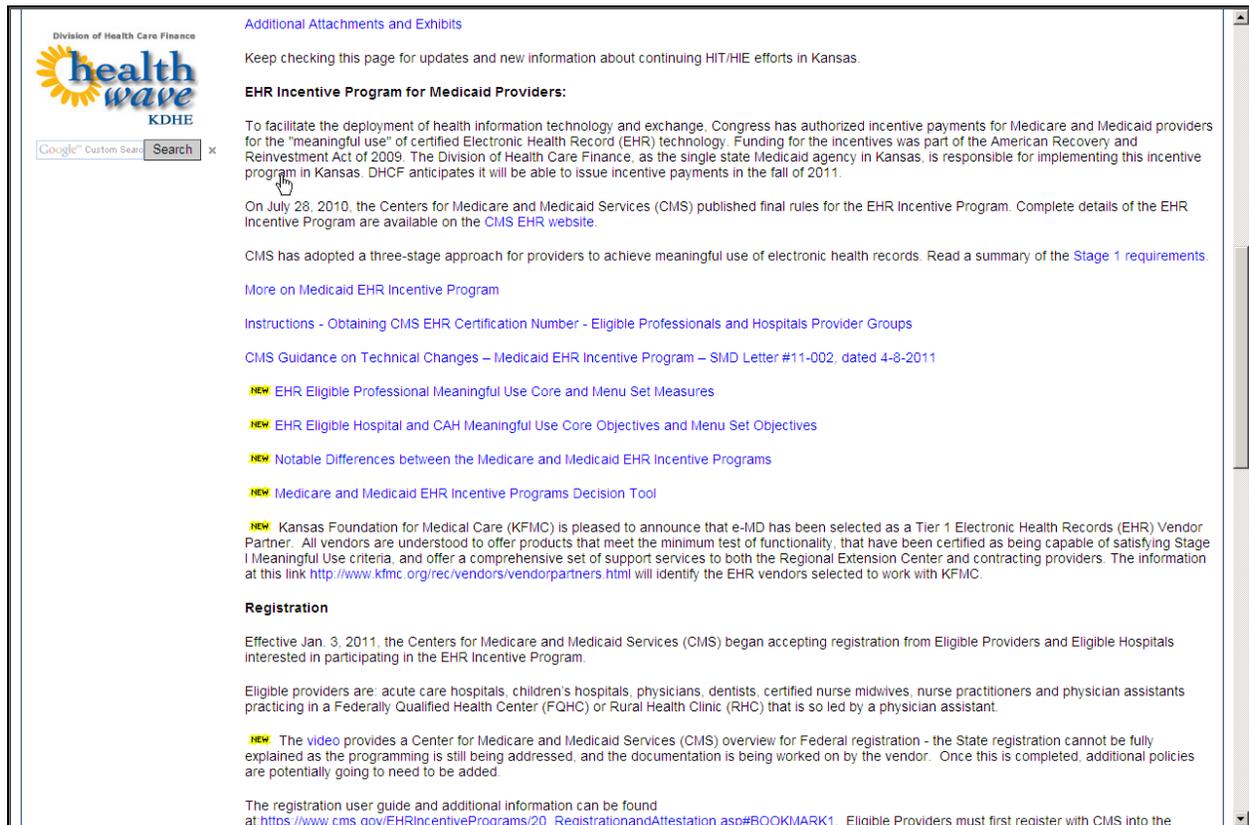
The [Kansas Department of Health and Environment](#) (KDHE) is the lead agency in charge of coordinating state efforts to secure federal HIT/HIE funding for Kansas. To facilitate that process, DHCF will participate with KDHE in working with stakeholder groups and other interested parties to help set priorities and develop specific proposals for the implementation of HIT and HIE in Kansas, and to ensure they are implemented in the Kansas Medicaid and HealthWave programs.

DHCF is also working to secure federal incentive funding for Medicaid providers to assist them in acquiring and implementing HIT and HIE. Additional information is available in this overview of the [State Medicaid HIT Plan \(SMHP\)](#).

In 2010, the State of Kansas issued a Request for Proposal (RFP) to obtain competitive responses from vendors to develop a State Medicaid HIT Plan. This RFP closed December 1, 2010. See links below to view the RFP, Amendment 1, Amendment 2 and additional attachments and exhibits related to this RFP.

[RFP](#)  
[Amendment 1](#)  
[Amendment 2](#)

Figure 1.d: KDHE Website – EHR Incentive Program Information



Along with general information displayed above, and upon completion of the custom MAPIR interface for Kansas, KDHE will also provide links to examples of its MAPIR interface.

### Communication and Outreach Messages

KDHE will disseminate information through consistent and effective messages and communication. Communication regarding the Medicaid EHR Incentive Program will cover the following areas:

- General Overview
- Eligibility

## Appendix IV: Communications Plan

- Enrollment
- Value and Benefits
- Incentives
- Meaningful Use

KDHE’s messages will highlight and discuss the key benefits of EHR technology. The table below provides a detailed breakdown of the key benefit messages developed for Kansas’s outreach and communication.

**Table 1.b: Key Benefit Messages**

Key Benefit	Message
<b>Quality Outcomes</b>	<ul style="list-style-type: none"> <li>• Patient/population health data from EHRs can be shared across providers and health institutions to support public health and contribute to the effectiveness, access, cost and quality of care</li> <li>• EHRs provide access to more information about an individual to help health care providers diagnose health problems earlier and reduce medical errors</li> <li>• EHRs support better follow-up information for patients (e.g., after a visit, follow-up instructions and information for the patient can be available; and reminders for follow-up care can be sent automatically to the patient)</li> <li>• EHRs allow fewer errors for claims, billing and information delivery</li> </ul>
<b>Increased and Improved Care Coordination</b>	<ul style="list-style-type: none"> <li>• Providers can use electronic information from other clinical providers to make informed health care decisions at point of care</li> <li>• EHRs allow information transfer and communication goals among providers that allow more effective and less fragmented care</li> <li>• EHRs improve patient and provider convenience by allowing prescriptions to be ordered and ready before the patient leaves the provider’s office</li> <li>• EHRs allow the automatic delivery of information that needs to be shared with public health agencies for quality measurement</li> </ul>

Appendix IV: Communications Plan

Key Benefit	Message
<b>Administrative Efficiency – Save Time and Optimize Billing</b>	<ul style="list-style-type: none"> <li>• EHRs reduce the amount of and time spent on paperwork, including the storing of paper records and mailings to other providers, patients and insurers</li> <li>• EHRs allow immediate filing of insurance claims from the provider’s office</li> <li>• EHRs help optimize billing, allowing for fewer billing errors, as EHRs can “auto-populate” services being rendered</li> <li>• EHRs reduce the duplication of testing, as well as the time and resources associated with it</li> <li>• EHRs allow access to more information and this helps health care providers deliver more efficient and safer care, which may lead to improved outcomes – thereby decreasing overall cost of care</li> <li>• EHRs reduce malpractice costs since EHRs help notify providers of potential errors in treatment</li> </ul>
<b>Incentive Payments</b>	<ul style="list-style-type: none"> <li>• EHR technology adoption allows for incentive payments (if eligibility and applicable requirements are met) to help pay costs associated with the purchase and installation of certified EHR systems</li> <li>• EHR technology adoption reduces the total amount a provider pays for an EHR system</li> </ul>
<b>Patient Safety</b>	<ul style="list-style-type: none"> <li>• EHRs improve patient safety by bringing all of a patient’s medical information together and identifying potential safety issues – providing “decision support” to assist clinicians</li> <li>• EHRs may have the capability to automatically check for problems when a new medication is prescribed and alert the clinician to potential conflicts</li> </ul>
<b>Security of Health Information</b>	<ul style="list-style-type: none"> <li>• EHRs improve privacy and security and, with proper training and effective policies, EHRs can be more secure than paper</li> <li>• EHRs allow the secure storing and transmitting of a patient’s medical information electronically</li> </ul>

**Collaboration**

KDHE will collaborate with the various groups and associations, such as the Kansas Hospital Association and the Regional Extension Center (REC) to the extent possible to educate providers about the incentive program and to provide technical assistance and information about EHR adoption, implementation, upgrade and meaningful use of EHRs. An example of KDHE's collaboration is with Kansas's Regional Extension Center, the Kansas Foundation for Medical Care, Inc. (KFMC). KFMC holds and is involved in meetings with participants ranging from physicians, health and medical centers and health-related associations and organizations such as the Kansas Health Information Network (KHIN). KDHE leverages the existing relationship between the REC and organizations to present and provide information to individuals that may be eligible for the Medicaid EHR Incentive Program.

**KDHE Outreach and Presentations at Meetings and Events**

In addition to the webinar series KDHE presents, KDHE also sends representatives to meetings and events which they have identified, or been notified through collaboration with groups or organizations, as an outreach opportunity.

Sample Meeting and Events

Below is a sample of meetings or events at which KDHE provides targeted outreach.

**Table 1.c: Sample of Participation and Outreach Meetings and Events**

Meeting or Event	Date	Location
REC Education Day*	May 3, 2011	Topeka, KS
Provider Workshop*	May 13, 2011	Topeka, KS
Kansas State/Tribal Consultation Meeting	June 24, 2011	Mayetta, KS
Kansas Hospital Association Meeting	July 12, 2011	Topeka, KS
Kansas Medicaid Health Information Technology (HIT) Stakeholder Workgroup Meeting	July 22, 2011	Topeka, KS
United Health Care Town Hall Meetings (4 meetings)*	1 <sup>st</sup> Week of August, 2011	Various Locations
Kansas Hospital Association Meaningful Use Summit	September 14-15, 2011	Topeka, KS

\* Indicates a meeting or event that KFMC notified KDHE as a presentation or outreach opportunity

One example from the table above is the coordinated outreach by KDHE with KFMC at the May 3, 2011 REC Education Day. At this event, KDHE presented information as part of their Kansas

## Appendix IV: Communications Plan

Medicaid Electronic Health Record Incentive Program outreach.

### Sample Presentation Topics

KDHE's presentation at the REC Education Day provided information on HIT/HIE, the Medicaid EHR Incentive Program, the SMHP and IAPD, and available resources for interested and eligible providers. KDHE's presentation "Kansas Medicaid Health Information Technology Initiative" consisted of the following topics:

- HIT and HIE
- Medicaid Electronic Health Record Initiative Program
- Medicaid EHR Incentive Program Basics
  - Eligibility
  - Patient Volume
  - Payments – EP and Hospital
- SMHP and I-APD
- Timeline for Medicaid EHR Incentive Program and Payments
- Resources
  - Assistance for Rural Providers
  - KDHE
  - CMS

### Other Outreach Opportunities

In addition to collaborating with KFMC on REC Education Day, KDHE participates in other outreach activities to other external and internal organizations. KDHE attended Tribal discussions at the June 24, 2011 Kansas State/Tribal Consultation Meeting in Mayetta, Kansas. At the Tribal Consultation meeting, KDHE provided program information and discussed several topics, including those highlighted above for the REC Education Day. KDHE also presented an overview of the Kansas Medicaid EHR incentive payment program to the Kansas Hospital Association (KHA) on July 12, 2011 and to the Kansas Medicaid Health Information Technology (HIT) Stakeholder Workgroup on July 22, 2011.

KHA is a voluntary non-profit organization existing to provide leadership and services to member hospitals. KHA is the lead organization in a group of companies and affiliates that provide a wide array of services to the hospitals of Kansas and the Midwest region. KDHE initiated the Kansas Medicaid HIT Stakeholder Workgroup to ensure collaboration and input to fully leverage the opportunities presented by the federal legislation. The group is comprised of over 30 participants/organizations, including health care plans, health care associations, public agencies, and the REC.

Based on the collaboration and outreach events and activities discussed, KDHE has seen interest from providers in the EHR incentive program. Outreach and collaboration also allows KDHE to field questions with consistent messages. Some of the questions raised to KDHE are a result of misinformation, conflicting information, or a simple lack of information. To address questions and interest, KDHE believes its communications approach with consistent messages and multiple venues for information distribution will help to raise provider awareness, understanding, participation, and eventually help to retain providers in the incentive program and have them become meaningful users. KDHE understands the importance of providing targeted messages through various materials and resources. To complement the live outreach detailed above, KDHE also provides information and support through its website.

## Appendix IV: Communications Plan

### **Summary**

KDHE recognizes that one of the keys to a successful Medicaid EHR Incentive Program is an effective communications strategy and approach. KDHE's Communications Plan provides the strategy, messages, vehicles, and other components to conduct education and outreach for providers and stakeholders. By implementing its plan, KDHE will provide the outreach, education, materials, and tools necessary to support program success and achieve its goal of raising practitioner awareness and participation in the Medicaid EHR Incentive Program.



## Appendix V: Hospital Payment Calculator

Year 4                      4,766    -1,149 \*\$200                      \$723,386                      eligible dischg                      4,766    py \* annual growth rate                      4,766

Total 4 year discharge related amount                      Sum                      **\$2,719,295**    calculated total discharge payment trended by growth factor for 4 years

Step 3: Compute the initial amount for 4 years	Year 1	Year 2	Year 3	Year 4
Years 1 - 4 base amount of \$2,000,000 per year	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Years 1-4 discharge related amount (step 2) (flow from above)                      flows	\$637,170	\$665,005	\$693,734	\$723,386
Aggregate EHR amount for 4 years	<b>\$2,637,170</b>	<b>\$2,665,005</b>	<b>\$2,693,734</b>	<b>\$2,723,386</b>
<i>*Medicare Share Set at 1</i>				
Step 4: Apply Transition Factor--part of formula	1.00	0.75	0.50	0.25
Calculated Overall EHR Amount	<b>\$2,637,170</b>	<b>\$1,998,754</b>	<b>\$1,346,867</b>	<b>\$680,846</b>
Step 5: Compute the overall EHR amount for 4 years	sum <b>\$6,663,637</b>			

**Step 6: Computation of Medicaid Share from the Medicare cost report**                      (Medicaid carve-out)

(estimated Medicaid inpatient-bed-days + estimated Medicaid HMO inpatient-bed-days) /  
 (est. Medicaid IP-bed-days x ((est. total charges - est. charity care charges) / est. total charges))

w/s S-3 part I, col. 5, line 12	Total Acute Care Medicaid FFS and HMO Days	input	<b>2,701</b>	count days if Medicaid paid something on claim. Exclude Nu 2,701
w/s C part I, col. 8, line 101 w/s S-10, line 30	Total Hospital Charges Other uncompensated care charges Total Hospital Charges - charity chgs divided by Total Hospital Charges	input input	<b>\$48,569,742</b> <b>(\$890,456)</b> \$47,679,286 <hr/> \$48,569,742	
w/s S-3 part I, col. 6, line 12	Non-charity percentage Total Hospital Days Total Hospital Nursery Days Total Adjusted Hospital days (excluding Nursery) Non-charity total Hospital Days (total days * non-charity %)	input	98.17% <b>22,508</b> <b>(1,200)</b> <b>21,308</b>	20,917
	(Total Medicaid and HMO Medicaid days) divide non-charity hospital days		<b>12.91%</b>	Medicaid to total days ratio

Step 7: Computation of Medicaid aggregate EHR incentive amount	
Aggregate EHR amount for 4 years	\$6,663,637
(Total Medicaid and HMO Medicaid days) divided by non-charity hospital days	12.91%

## Appendix V: Hospital Payment Calculator

Medicaid Aggregate EHR Incentive Amount	Medicaid share only	\$860,457
This is the total amount the facility is eligible to receive		

**Step 8: Apply Distribution Schedule**

Total Payment Amount is \$860,457

Once the aggregate amount is determined it is paid out over a specified number of years (3 for example):

Year	Payment %	Payment Year	
Base Year	50%	\$430,229	year/period of payment 2011
Year 2	30%	\$258,137	year/period of payment 2012
Year 3	20%	\$172,091	year/period of payment 2013
<b>Total</b>	<b>100%</b>	<b>\$860,457</b>	