



## **State Medicaid Health Information Technology Plan (SMHP)**

October 3, 2013

## DOCUMENT CONTROL

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### Change Record – 2013 SMHP Update

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### Approval Sign-off

Name	Role	Signature	Date
Ramdas Menon	Medicaid/CHIP Health Information Technology Director		
Kay Ghahremani	Medicaid Director		

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## 1. EXECUTIVE SUMMARY

One of HITECH's most important features is its clarity of purpose. Congress apparently sees HIT — computers, software, Internet connection, telemedicine — not as an end in itself but as a *means of improving the quality of health care, the health of populations, and the efficiency of health care systems.*<sup>1</sup>

The Texas Health and Human Services Commission (HHSC) State Medicaid Health Information Technology Plan (SMHP) is the Texas state plan to implement Section 4201 of Health Information Technology for Economic and Clinical Health Act (HITECH) with the American Recovery and Reinvestment Act of 2009 (ARRA). HITECH established a program for eligible Medicare and Medicaid professionals and hospitals to receive incentive payments for the adoption and meaningful use of electronic health records (EHRs) to improve health outcomes, care quality and cost efficiency.

In May 2010, the Texas HHSC engaged Health Management Associates to assist with development of its State Medicaid Health IT Plan (SMHP) and Implementation Advance Planning Document (I-APD) for approval by the Centers for Medicare and Medicaid Services (CMS) so that HHSC can implement this new program in 2011. The SMHP is drafted to respond to each of the questions in the Centers for Medicare and Medicaid Services (CMS) State Medicaid Health Information Technology Plan (SMHP) template, which will hopefully facilitate CMS's review and approval of this plan. The purpose of the SMHP is to provide HHSC and CMS with a common understanding of the activities that HHSC will be engaged in over the next 5 years to implement Section 4201 Medicaid provisions of ARRA.

To help facilitate broader understanding of this process for key stakeholders and providers, HHSC has already engaged in planning Provider Outreach and Education, and has included information about these plans as another section in the SMHP. The team responsible for this section has continuing responsibilities for implementing the provider communication strategy and ensuring ongoing communication is clear, concise and provides complete understanding of the process. Thus, the primary intended audience for the SMHP is CMS and our state partners, and the plan describes the ongoing strategy for provider and other key stakeholder communications

As a result, the Texas Medicaid Health IT Plan includes the following six sections:

- ▶ **As Is Health Information Technology (HIT) Landscape** – describing the current state of HIT activities throughout the state,
- ▶ **To Be Health IT Landscape** – describing HHSC's vision for the meaningful use of HIT to improve HHSC's capabilities as a "Value Purchaser" and provider of health care

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<sup>1</sup> David Blumenthal, M.D., M.P.P., "Stimulating the Adoption of Health Information Technology," NEJM, April 9, 2010

services and improve health care providers capabilities to improve the quality of health care, the health of populations, and the efficiency of health care systems,

- ▶ **EHR Incentive Program** – providing a detailed description of the steps that HHSC will undertake with its contractors and key stakeholders to successfully implement the EHR Incentive Program,
- ▶ **Audit Strategy** – outlining the critical steps for program integrity of the EHR Incentive program,
- ▶ **Outreach and Education** – relating the process for informing, involving and supporting eligible providers and key stakeholders in the program,
- ▶ **Health IT Roadmap** – describing the plans for provider adoption and meaningful use of EHRs.

The plan has been developed in a rapidly changing environment. Seismic shifts in public policy, including the Children’s Health Insurance Program Reauthorization Act (CHIPRA), ARRA and the Patient Protection and Affordability Care Act (ACA) have occurred recently; all of which require health IT to support improvements in health outcomes, care quality and cost efficiency. The State of Texas responded to these policy changes by investing in health IT initiatives, such as state-level health information exchange (HIE) capabilities, health IT regional extension centers (RECs) and health IT workforce training.

This SMHP represents a point in time landscape of health IT, which forms the basis of the health IT roadmap. The plan is regularly updated to provide a pathway for the Health and Human Services (HHS) Enterprise (five agencies with HHSC oversight) to collaborate with its key partners – other public and private entities, health care providers and individuals and their families who receive health care coverage through Texas Medicaid – to improve the quality of health care, the health of populations and the efficiency of health care systems.

The SMHP describes the State’s newly developed policies and processes to implement the Medicaid EHR Incentive program, including a description of how HHSC: identifies eligible providers, makes payments to eligible providers, ensures adequate programmatic oversight of the incentive payments, and educates and encourages providers to adopt certified EHR technology. This SMHP outlines the first steps in a multi-phase approach that develops over time and will, by necessity, include simultaneous planning and implementation activities. The SMHP was most recently updated in an amendment in November 2012 to address changes outlined in the Stage 2 Final Rule (including changes to Stage 1 policies), and was approved by CMS in December 2012. Annual updates will be submitted to describe the progress to date and to request approval for new implementation strategies.

## 1.1 2013 Texas SMHP Update

In this update to the Texas SMHP, revisions have been made to describe progress and changes in Texas health IT initiatives, including the EHR Incentive Program, the Medicaid Clinical Gateway, and the Local Health Information Exchange Grant. The Medicaid e-Prescribing was completed and reported in the previous SMHP update, so it has been removed. The MITA 3.0

State Self-Assessment has been included, which is an update from the MITA 2.0 State Self-Assessment. Health IT projects at the Texas Department of State Health Services (DSHS) have also been updated and new information is provided on the status of ONC-funded health information exchange initiatives. In addition, the plan has been renamed from the Medicaid Health Information Technology Plan (MHP) to State Medicaid Health Information Technology Plan (SMHP).

## **2. BACKGROUND**

### **2.1 Legislation**

On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law, and established the framework for financial incentives to stimulate growth and improve the health of the nation's economy and health care system. ARRA defined specific roles and incentives for the U.S. Department of Health and Human Services (HHS) and its partner – State Medicaid Agencies – in improving the nation's health and health care through the meaningful use of electronic health record (EHR) technologies.<sup>2</sup>

The Texas Legislature created the Texas Health Services Authority (THSA) in 2007 through House Bill 1066. The THSA is a public-private partnership, legally structured as a nonprofit corporation, to promote and coordinate the development of electronic health information exchange (HIE) in Texas.

The Texas Legislature also passed H.B. 1218 in 2009, which sets the stage for Texas Medicaid to align its HIE efforts with national and statewide health IT efforts. A Medicaid HIE Systems Advisory Committee established under H.B. 1218 advises the Texas HHSC on Medicaid activities related to health IT. A key objective of the Committee is to ensure Medicaid/CHIP HIE is "interoperable" with broader statewide health information exchange. In addition to the establishment of the Advisory Committee, H.B. 1218 authorized pilot programs and initiatives to further the advancement of electronic health records (EHRs) in the state.

A more detailed description of the federal laws and rules, the general guidance from CMS and the Texas state laws related to EHR can be found in Appendix A.

### **2.2 Medicaid Health IT Planning Approach**

HHSC initiated the Medicaid EHR Incentive Program to promote the goal of improving health care quality and reducing costs by exchanging health information through the use of certified EHR technologies. Upon approval of its Planning-Advance Planning Document (P-APD) request, Texas Medicaid began the planning process by developing the Medicaid Health IT Plan and the Implementation-Advance Planning Document (I-APD). In January 2012, CMS extended the deadline for HHSC's use of remaining planning money from the IAPD. The P-APD is now closed.

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<sup>2</sup> American Recovery and Reinvestment Act of 2009, accessed on June 17, 2009 at: <http://www.hhs.gov/recovery/overview/index.html>

### **3. THE TEXAS MEDICAID “AS-IS” HEALTH IT LANDSCAPE**

The purpose of the As-Is health IT landscape section is to provide an overview of the current state of projects and activities that support the adoption and meaningful use of EHRs. This section also addresses the existing environment of health IT infrastructure and the level to which it currently supports the private and secure exchange of electronic health information to improve health outcomes and care quality.

#### **3.1 State Organizations Authorized to Facilitate HIE and EHR Adoption**

As the single state agency for the State of Texas designated for purposes of drawing down funding for the Texas Medicaid program and the Children’s Health Insurance Program (CHIP), HHSC has undertaken a number of activities to facilitate HIE and EHR adoption. HHSC established the Office of e-Health Coordination (OeHC) in January 2010. This office works closely with the Texas Health Services Authority, described below.

##### **3.1.1 Texas Medicaid/CHIP Division**

The Medicaid/CHIP Division within HHSC is the lead business operations area for the Texas Medicaid Health IT Plan and Medicaid EHR Incentive program under Title IV of ARRA, for which the agency received \$4.8 million for planning purposes. Another partner that is integral to facilitate HIE and EHR adoption is HHSC IT. HHSC IT, under the direction of the HHSC Deputy Executive Commissioner for Information Technology, supports the business operations areas by providing oversight and collaborating on systems, technology, and architecture solutions to meet their needs.

Medicaid established a Health IT unit to manage health IT initiatives and provide policy advice on HIE and EHR issues that affect Texas Medicaid, including providers and clients. The Health IT unit is responsible for implementing the Medicaid EHR Incentive program and for planning and coordinating health IT services and programs within the Medicaid/CHIP Division.

The Medicaid Health Information Exchange (HIE) Advisory Committee, established in state statute under H.B. 1218, advises HHSC regarding the development and implementation of the Medicaid electronic health information exchange system to improve the quality, safety and efficiency of health care services provided through Medicaid and CHIP.

##### **3.1.2 Office of e-Health Coordination**

The Office of e-Health Coordination (OeHC) was established within the HHSC Office of Health Services (OHS) under the direction of the Deputy Executive Commissioner for Health Services. The OeHC serves as the coordination point for Texas to ensure that health IT initiatives relating to Texas HHS programs are coordinated across the Texas HHS Enterprise.<sup>3</sup>

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<sup>3</sup> HHS CIRCULAR C-032, Health and Human Services Enterprise, Office of e-Health Coordination, January 7, 2010.

OeHC serves as the single point of contact for health information policy and state funding opportunities under Title XIII of ARRA for the Texas HHS Enterprise. The OeHC Director is the State HIT Coordinator, an ex-officio member of the THSA board, and staffs the Texas HHS Health Information Steering Committee. The Steering Committee, chaired by the OHS, includes representatives designated by the commissioners of each Texas HHS agency and major programs within HHSC, including administrative and legal services, to provide strategic direction about projects or policy concerns regarding health information.

### **3.1.3 Texas Health Services Authority (THSA)**

The THSA is a public-private partnership established in 2007 to promote and coordinate the development of electronic HIE in Texas. A 13-member Board of Directors appointed by the Governor of Texas, with the advice and consent of the Texas Senate, governs the THSA. The Department of State Health Services (DSHS) has two ex-officio members of the THSA board.

HHSC submitted the Texas application to the Office of the National Coordinator for Health Information Technology (ONC) for funding of the State HIE Cooperative Agreement Program to support the state in developing its Strategic and Operational Plans in 2010 and statewide HIE capacity. Texas was awarded \$28.8 million in federal funds over four years. HHSC is contracting with the THSA to manage a collaborative stakeholder process and develop the strategic and operational plans as required under the cooperative agreement. The remainder of the grant will be expended in the implementation phase from the fall of 2010 to 2013.

## **3.2 Status of Medicaid HIE and EHR Activities**

### **3.2.1 Medicaid Management Information System**

The Medicaid Management Information System (MMIS) is the primary information technology system serving the Texas Medicaid program. It is operated by a fiscal agent under contract with the HHSC. The MMIS is a composite of multiple subsystems that are grouped into seven (7) functional areas: recipient, provider, reference files, third party liability, claims processing, surveillance and utilization review, and management and administration reporting. The MMIS is the “backbone” of the state’s Medicaid system, which services over 3 million Texans annually— 14 percent of the state’s population or one in seven Texans—and accounts for 26 percent of the state’s budget.<sup>4</sup>

The first five functional areas of the MMIS manages beneficiaries, manages providers, and is the operations management for payment criteria, medical and dental policy, benefit rules edits and audits, claims adjudication, and collection of other third part liability coverage. It also collects encounter data from individual Medicaid managed care organization payment systems for purposes of data capture and reporting. The subsystems contained within the management and administrative reporting (MAR) functionality provides the basis for program management and federal reporting. While essential to the efforts related to Medicaid HIE and EHR activities, the

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<sup>4</sup> Texas Medicaid and CHIP in Perspective, Ninth Edition, January 2013. Access at: <http://www.hhsc.state.tx.us/medicaid/reports/PB9/TOC.shtml>

normalized data within the MMIS is used to compile, report, and prevent fraud, waste and abuse through the surveillance and utilization review functionality. The MMIS also includes the Claims and Encounters Data Warehouse which serves as a storage, archive and a Decision Support System (DSS) platform for all Medicaid claim and encounter data and encounter data for the Children's Health Insurance Program (CHIP). The major components of the existing MMIS system include but are not limited to those described in Appendix B.

The current MMIS contract runs through August 31, 2014, and represents the second of three (3) twelve (12) month extension periods. HHSC is facilitating current work in progress for the existing MMIS, leading towards better compliance with MITA and the HHSC vision for the new MMIS. In December 2011, HHSC entered into a contract for services with a vendor that will assist the state in conducting an assessment and gap analysis of current system functionality and new developments that need to be completed by 2014 to ensure that the state issues an RFP and secures an MMIS that will be MITA 3.0 compliant. On May 17, 2013, the vendor completed the HHSC MITA 3.0 assessment and new "Roadmap." These tools will ensure that any new procurement for the MMIS will be on a path to meet new Federal mandates.

The re-procurement of the MMIS presents a tremendous opportunity to advance the use of health IT to improve health outcomes, care quality and cost efficiency. This will require alignment of technology requirements and services to address these critical business needs. Additionally, HHSC is participating in a 10-state pilot project working directly with CMS to redefine the Medicaid Statistical Information System (MSIS) reporting. CMS initiated this "transformed" MSIS (T-MSIS) pilot project in June 2011 as a result of the CMS Medicaid and CHIP Business Information Solution (MACBIS) initiative started several years ago. Data collection efforts will be expanding the current file formats from the approximately 400 data elements to in excess of 1000 data elements in the new file format. This effort ensures all data elements needed by any business area within CMS are captured. The ultimate impact to Texas will be to eliminate duplicative data submissions from multiple vendors covering Medicaid and CHIP data for claims/encounters, providers, eligibility, TPR, and managed care. It is expected that all states will be required to participate post-pilot project and by 2014.

HHSC also contracts with the current Fiscal Agent for management of Pharmacy Claims and Rebate Administration (PCRA). The contract includes the processing of pharmacy claims, collection of associated data and management of rebates. As part of the current Fiscal Agent contract, the PCRA system will also be replaced when a new MMIS is procured. The current PCRA system includes an interface to a national e-prescribing network which is expected to continue and be enhanced in the new MMIS. This connection allows prescribers with a certified EHR to access medication history for Medicaid clients and Medicaid formulary and pharmacy benefit information during the electronic prescribing process.

### 3.2.2 Coordination of SMHP with MITA Transition Plans

The MITA 3.0 State Self-Assessment (MITA 3.0 SS-A) identified significant barriers for effective provider management in Medicaid, including:

- The provider subsystem utilizes legacy architecture.
- The provider management area uses non-standard applications and data definitions.

- The provider management area uses redundant business processes and systems in multiple agencies. This opportunity is addressed by the Provider Management modernization.
- Communications and messaging are not fully coordinated across HHSC agencies. This opportunity is addressed by the Provider Management modernization and should be reviewed to verify that all functionality is being utilized.
- There is no central repository containing all Medicaid providers.
- There are multiple crosswalks between the National Provider Identifier (NPI) and the Texas Provider Identifier (TPI).
- Communication with current providers is primarily manual and reactive.
- HHSC does not track routine inquiries that can be answered immediately.
- Appeals must be submitted on paper when supporting documentation is required.<sup>5</sup>

The Assessment found that the seven individual business processes related to provider communications are at MITA maturity level Stage 1. Efforts are underway to push Medicaid business processes toward higher levels of MITA maturity based on the MITA Roadmap's five-year timeline.

The Centers for Medicare & Medicaid Services (CMS) published the majority of new MITA 3.0 requirements on March 28, 2012. On July 5, 2013, CMS published an informational bulletin announcing the release of the draft Eligibility and Enrollment Supplement to the Medicaid Information Technology Architecture (MITA) Framework, Version 3.0. This draft represents the remaining requirements.

HHSC conducted an updated "as is" and "to be" gap analysis and the State Self-Assessment using MITA 3.0 guidelines to update the State's Roadmap. These items were submitted to CMS on July 22, 2013 and ensure that new projects, technical developments, and procurements align with the State's technology vision and Federal requirements.

HHSC is coordinating the SMHP with the following strategic projects that align themselves to moving HHSC forward within our current MITA 3.0 Roadmap:

- Provider Management Modernization
- Balancing Incentives Program
- Medicaid Eligibility and Health Information Services (MEHIS) project.
- MMIS enhancements that include ICD-10 implementation and planning for the next generation of the MMIS.

Now that the MITA 3.0 Assessment is completed and the new Roadmap is created, HHSC will continue to evaluate projects to ensure they meet the MITA 3.0 objectives.

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<sup>5</sup> Texas Health and Human Services Commission, "Medicaid Information Technology Architecture (MITA) Version 3.0 State Self-Assessment," May 17, 2013.

### 3.2.3 Medicaid Clinical Gateway

Experience gained during the previous HIE Pilot project is being utilized to design and implement an HIE connector for Medicaid. This interface will provide bidirectional access into the state-layer, HIE services provided by the Texas Health Services Authority (THSA). The Health and Human Services Commission contracts with THSA to administer the federated HIE network established in Texas. Through its connectivity to THSA, Medicaid will receive client clinical data from the Medicaid providers who have connected their EHR systems to one of 12 local HIEs. Medicaid will also provide whatever data is considered helpful for patient treatment to these same providers. As in the HIE Pilot, the first data stream to be implemented will be pharmacy claims. This data has always been in high demand by providers seeking to perform accurate medication reconciliation and prevent adverse reactions to medication.

### 3.2.4 Medicaid Eligibility and Health Information Services

The Medicaid Eligibility and Health Information Services (MEHIS), known publically as “Your Texas Benefits” produces a permanent plastic Medicaid identification card, and provides multiple portals, interactive voice response (IVR) and phone help desks for Medicaid clients, Medicaid providers and HHSC staff. The provider portal automates eligibility verification, and provides an electronic health history for all Medicaid clients. The client portal offers Medicaid program eligibility information, a downloadable image of their Medicaid card, THSteps reminders and the ability to opt out of having their health information shared with providers.

HHSC will extend current MEHIS provider portal capabilities, such as allowing providers to access a claims-based electronic health record (EHR) for Medicaid recipients. The extended capabilities will support laboratory results, extended health history based on claims, encounters, and prescription history

The MEHIS system positions HHSC to provide better access for clients and providers to client health information that will foster improved continuity of care, increased communication between clients and providers, and better health outcomes over time.

### 3.2.5 Enterprise Data Warehouse / Business Intelligence / Enterprise Data Governance

The Enterprise Data Warehouse/Business Intelligence (EDW/BI) project is a mandated project listed in the Texas MITA 3.0 Roadmap. The project’s goal is to enhance staff effectiveness and efficiency through improving the ease of access to comprehensive and reliable client-centric data available across the Texas HHS Enterprise.

For Medicaid, the key outcomes envisioned for this project include:

- Enhanced forecasting, trend analysis, and decision support capabilities across Medicaid programs;
- Improved data definition, transformation, integrity, and quality;

- Ability to develop strategies to improve health outcomes by consolidating disparate data from across agencies and business units; and
- Ability to track and measure health outcomes to better serve citizens of Texas.

HHSC envisions the EDW/BI system as the long term solution to enhance, consolidate and/or link currently compartmentalized analytical systems and data warehouse capabilities across the Texas HHS Enterprise for more comprehensive and useful data to support strategic and operational decision-making. Ultimately the EDW/BI system will replace the enterprise reporting and analytical capabilities that reside in the current MMIS with the Fiscal Agent . HIE-driven analytical capabilities and reporting enhancements that are proposed as part of this SMHP to existing systems will be considered for inclusion in the EDW/BI system as part of its long term vision.

The MITA 2.0 SS-A identified the need for data governance and enterprise data management. Enterprise-level data governance was initially a component of the EDW/BI initiative, but a separate Enterprise Data Governance (EDG) project was established under the direction of CMS. In parallel, the MITA 3.0 SS-A gave greater emphasis for data governance initiatives to establish organizational and process mechanisms across the Texas HHS Enterprise to improve data quality, consistency, accuracy, and usefulness across programs. EDG will develop the master data structures for each Medicaid data domain, establish a Medicaid reference information model (RIM), and make available the metadata for Medicaid source systems. EDW/BI will establish data management artifacts for the Medicaid enterprise, including implementation of the master patient index and master provider index, will provide efficient mechanisms to link information from various data sources with high accuracy, thereby improving data analysis and health care/outcomes management.

As HHSC implements recommendations from the MITA 3.0 Assessment, changes may be identified which would alter and amend the current Roadmap. Since HHSC anticipates that the new EDW/BI system will be an adjunct to the new MMIS, it will be essential that the findings from the MITA 3.0 Assessment be integrated into the procurement of both systems to ensure maximum efficiency and effectiveness for each project.

### **3.2.6 Foster Care Health Passport**

In 2005, the Texas legislature enacted Senate Bill 6, which called for the development of a uniform, comprehensive medical services delivery model for children in foster care through a single managed care entity, including the development of an electronic health information system for the program—the Health Passport. STAR Health, a statewide managed care program for children in foster care, was created through a partnership with HHSC’s Medicaid and CHIP Division and the Department of Family and Protective Services (DFPS). STAR Health serves about 30,000 children statewide.

HHSC was awarded \$4 million in Medicaid Transformation Grant funding, which was used to develop the Foster Care Health Passport. The Health Passport became operational on April 1, 2008. The Passport is a secure claims-based electronic health record (EHR) system that provides online access to a child’s health information for authorized users, such as state staff, providers and medical consenters. The Health Passport was initially populated with two years of

Medicaid and CHIP claims history and pharmacy data. When a child leaves foster care, data from the Health Passport is available, in electronic or printed formats, to a child's legal guardian, managing conservator, parent, or to the individual if at least 18 years of age or an emancipated minor.

### **3.3 Status of Public Health and Bio-surveillance Health IT Activities**

The Department of State Health Services (DSHS) established an office of HIT Policy as a point of contact for health IT initiatives relating to public and bio-surveillance health information. Under the guidance of an executive-level steering committee, DSHS is working to advance an integrated HIT and policy system that improves service delivery, health outcomes, and decision-making that is aligned and supportive of MITA. It is continuing to ensure that business needs drive the development of information resources, that information systems are adaptable and flexible, and that its systems facilitate timely decision-making at the individual and systems level.

DSHS supports and or maintains nearly half of all service delivery applications in the Texas HHS Enterprise. DSHS supports systems, including EHRs, which benefit the following providers and/or consumer groups:

- Substance abuse prevention and treatment providers
- DSHS-operated psychiatric state hospitals
- Community Mental Health Centers
- Public health clinics
- Consumers of health information data:
  - Birth, death, and divorce records
  - Immunizations, cancer, birth defects, trauma, and adult/child lead
  - Hospital discharge
  - Newborn screening.

Additionally, DSHS is responsible for the following disease registries and surveillance systems, which are being aligned with state-level health IT activities:

#### Health Registries

- Trauma Registry
- Birth Defects Registry
- Cancer Registry
- Child and Adult Blood Lead Registry
- Texas Immunization Registry (ImmTrac)

#### Surveillance systems

- Infectious Disease (HIV, STD, TB)
- National Electronic Disease Surveillance System (NEDSS)
- Healthcare Associated Infections

### Health Vital Statistic and Administrative Systems

- Hospital Discharge
- Vital Statistics

### Disease Prevention and Wellness Systems (Case Management Systems)

- Laboratory Newborn Screening (NBS) Enhancements

As part of the planning process for the SMHP, the Texas Medicaid/CHIP Division and DSHS signed an Interagency Contract (IAC) to work together to demonstrate how the existing MITA 2.0 To-Be Roadmap, the Public Health Information Technology Architecture (PHITA), HIE, and EHR activities might be aligned. Historically, public health data collected through DSHS has been shared with Texas Medicaid to support shared program goals.

HHSC is planning for increased data access to and exchange with programs in the Family and Community Health Services and Mental Health and Substance Abuse Services divisions, consistent with applicable laws and regulations. HHSC fully expects that updates will be required once the MITA 3.0 assessment has been completed.

The Texas Immunization Registry made immunization data available to MEHIS in 2011. In 2012, MEHIS made immunization data available to providers through the MEHIS provider portal. Due to confidentiality concerns, the Texas Immunization Registry is currently unable to allow clients to electronically access immunization data, so immunization data is not yet available through the MEHIS client portal. MEHIS and ImmTrac will be collaborating to address the issue.

The Clinical Management for Behavioral Health Services (CMBHS) - Phase Five project, continuing through state FY2014, is an ongoing business improvement initiative that follows DSHS's planned information technology roadmap, further increasing the business capabilities within the DSHS Mental Health and Substance Abuse division, especially advancing the interface between CMBHS and HHSC's Medicaid Management Information System (MMIS).

The following descriptions show the status of projects in DSHS that are being aligned to advance HIE and EHR goals.

#### **3.3.1 Clinical Management for Behavioral Health Services (CMBHS)**

Texas was among the first states to provide substance abuse treatment service contractors with a web-based system, the Behavioral Health Integrated Provider System (BHIPS), to track the delivery of substance abuse services. Texas recognized the importance of advancing the use of technology to improve coordination of health care delivery and has developed the Clinical Management for Behavioral Health Services (CMBHS) system, a follow-on project to BHIPS. CMBHS is a custom, web-based platform that provides a health electronic health record (EHR) for substance abuse treatment services, a data reporting system for mental health care

providers, and a platform for the secure, patient-authorized exchange of behavioral health data. Current users include state-contracted mental health and substance abuse treatment, intervention, and prevention service providers. There are almost 6,700 CMBHS users at more than 720 clinics.

CMBHS currently includes support for contracted behavioral health service providers to document client-related information such as diagnosis, treatment plans and clinical progress notes. It includes standardized assessments for both mental health and substance abuse. Key business processes include client registration; financial eligibility; client enrollment; service authorization; admission; client assessment; client consent; client referral; substance abuse service treatment plan development and review; and discharge-related activities. For substance abuse providers, CMBHS also enables clinicians and staff to record progress notes, generate daily day-rate attendance records, and track of medication orders, and other activities

Substance abuse contractors currently use a web-based user interface (CMBHS Online) while mental health contractors may use either CMBHS Online or submit data using data exchange between locally-managed information systems and CMBHS to report state-required data. CMBHS also provides an interface to which providers may connect their local systems to calculate a recommended level of care using DSHS-hosted business rules, simplifying system maintenance for providers.

CMBHS is being expanded, with funding provided through an APD, to include an interface with the MMIS to process Medicaid mental health and substance abuse treatment claims in three categories: claims for mental health rehabilitation services and mental health case management services for children under 21 that are currently paid to community mental health center providers; claims for the Youth Empowerment Services (YES) program which allows flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances (SED) and their families and was part of Texas' 1915(c) Medicaid Waiver, approved by CMS in April 2009; and Medicaid claims from adult substance abuse treatment benefits included in the Medicaid service expansion included in the 2010-11 (Texas) General Appropriations Act (GAA) (Article IX, Section 17.15, of S.B. 1, 81st Legislature, Regular Session, 2009) and approved to start September 1, 2010.

DSHS expects to continue to advance CMBHS as an integral component of the health IT landscape supporting the integration of primary and behavioral health care in Texas. DSHS has developed a strong working relationship with its contracted providers and has engaged them in discussions regarding activities such as the implementation of ICD-10 in compliance with CMS' October 1, 2014 deadline, inclusion of diagnosis information from the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)*, advancing the integration of primary and behavioral health care, support for improved client consent models, advancement of an expanded continuity of care document (CCD) with support for additional behavioral health information, and advancement of standards for data exchange.

DSHS is engaged with HHSC, the provider community, the THSA, the Substance Abuse and Mental Health Services Administration (SAMHSA), Health Level Seven (HL7), and other partners to advance an infrastructure and foster interoperability between state-managed mental health information and other health care providers.

### 3.3.2 Electronic Medical Record in State Hospital System

The 11 state-operated psychiatric hospitals operated by DSHS and the State Supported Living Centers (SSLCs), operated by the Texas Department of Aging and Disability Services (DADS), use a modified commercial-off-the-shelf (COTS) electronic medical record system called the Client Record System (CRS) to support quality care for patients. CRS provides significant clinical functionality and is augmented by an electronic medication administration system and a pharmacy management system.

DSHS is currently working to secure funding to implement clinical data exchange functionality to support continuity of care between inpatient services provided by the state hospitals and other providers. This functionality supports the state hospital system's vision to partner with consumers, family members, volunteers, service providers, and policy makers to provide quality services responsive to each patient's needs and preferences.

### 3.3.3 State Immunization Registry

ImmTrac is the immunization registry provided by the state of Texas. The web-based registry receives immunization information for children and adults from private and public health care providers across the state, including input from the Vital Statistics Unit, Medicaid, the Texas-Wide Integrated Client Encounter System (TWICES), and health plans. ImmTrac consolidates and stores immunization information electronically in a secure, central system. It allows registered providers to see immunization history for patients, add immunization encounters to patient records, and add consented individuals to the registry. Other types of users (school nurses, childcare centers) are also able to view immunization histories of children. ImmTrac is also used for Emergency Responders and their family members, as well as for tracking immunizations, anti-virals and medications provided in response to or in preparation for a disaster.

The Texas Immunization Registry (ImmTrac) currently supports flat-file format for batch interfaces and queries, including HL7 batch reporting. In 2011 and 2012, DSHS received grant awards to make interoperability enhancements to ImmTrac, which have been completed. The grant awards facilitated system enhancements for interoperability of EHRs and immunization information systems (IIS), which included:

- Identification of large volume reporters (e.g., hospital systems, large multi-site clinics) who use or plan to purchase EHR products;
- Identification of EHR vendors who have a market presence in Texas; and
- Purchase of middleware applications to allow ImmTrac to trade data in HL7 format.

In addition, DSHS contracted with a vendor to assist with:

- Assessment of selected EHR products and reporter systems to determine how they would implement ONC standards;
- Development of standards documentation and an implementation manual for project partners and future EHR/IIS trading partners;
- Selection of partners in setting up communication architecture (messaging system) for ONC-compliant EHR/IIS data interchange; and
- Fulfillment of reporting requirements for the grants.

The program conducted a successful HL7 pilot project with Texas Children’s Hospital (Houston) in July/August 2011. The project has since been extended to other major ImmTrac trading partners and is ongoing.

There are two other local registries – Tarrant County and City of San Antonio. Neither registry has a direct link to ImmTrac. The electronic San Antonio Immunization Registry System (eSAIRS) is currently working with its technology vendor to implement ONC compliant data exchange; once this project has completed, eSAIRS will be able to directly exchange immunization information with ImmTrac. The Texas Immunization Registry at DSHS (ImmTrac) is designated by statute as the immunization registry for the State of Texas.

In 2013, a project was initiated to replace the current Texas Immunization Registry (ImmTrac). The vendor and software for the replacement immunization registry has been selected. This project will enable the Texas Immunization Registry to implement an HL7 real-time, bi-directional interface. Replacement of the immunization registry is expected to be completed by 2015.

### 3.3.4 Bio-surveillance Reporting

In Texas, there is no statute requiring the reporting or use of syndromic surveillance data. Syndromic surveillance tools (often called Early Event Detection systems in Texas) are in use in many health care facilities across Texas. The DSHS in Austin does not receive syndromic surveillance data centrally.

Currently in Texas syndromic surveillance systems exist within local health agencies or organizations and within regional offices within Texas DSHS using a variety of systems. Therefore, there may be several options within a given geographic area for syndromic surveillance data transmission to fulfill meaningful use criteria.

A limitation of bio-surveillance reporting in Texas is the lack of a legislative mandate requiring health care providers to share health data in the absence of a public health emergency. Consequently, it can be difficult to voluntarily engage providers in health information exchange. Fifty-two emergency departments in various health service regions in Texas use a combination of mail, phone, fax, e-mail, batch or real-time electronic transmission, and the web-based National Electronic Disease Surveillance System (NEDSS) Base System to communicate outbreak information to county health departments, local health care providers, and to larger

databases. Currently, Texas is conducting a feasibility analysis of implementing BioSense 2.0. Health Registries Improvement Initiative.

### 3.3.5 Health Registries Improvement Initiative

The goal of the Health Registries Improvement project is to improve the timeliness, completeness, and validity of health information collected through registries and disease surveillance systems. The assessment phase addressed upgrading sub-standard technology to web-based systems, integration of common functions such as receipt and management of electronic lab reporting across registries, removing duplicative reporting from common sources of data (e.g. hospitals), and improving data linkages to increase efficiencies in data collection. Registries included are those devoted to birth defects, cancer, trauma, lead poisoning, immunizations, and infectious diseases. Key activities of the initiative and their statuses are staged as follows:

- Conducted a technological assessment of select health registries in the Environmental Epidemiology and Disease Registries Section and in other disease surveillance program areas in FY 2010. Assessment Deliverable: *Health Registries Improvement Project Deliverable 2b – Final Summary Report of a Registry Model*, dated September 15, 2010.
- Developed recommendations for integration of health registries in FY 2011, based on finding from Assessment Deliverable: *Health Registries Improvement Project Deliverable 2b – Final Summary Report of a Registry Model*, dated September 15, 2010.
- Initiated recommendations for targeted improvements in technology and data collection based on this assessment in 2011. Registry and disease surveillance systems replacement will be completed by FY 2016.
  - Hospital Acquired Infections, EMS/Trauma, Birth Defects and Child/Adult Blood Lead registry systems were deployed in FY 2012 and FY 2013.
  - The Health Registries Improvement Project which included the Registries Assessment, Birth Defects Registry Model, and the Child and Adult Lead Registry closed in September of 2013.
  - The Patient Adverse Events registry is planned to deploy in FY 2014, and the TB/HIV/STD registry is planned to complete in FY 2016.

### 3.4 Assessing Current Health IT Adoption by Practitioners and Hospitals

As a part of the SMHP process, the HHSC Medicaid/CHIP Division coordinated efforts to survey Texas practitioner and hospital communities on their use of and plans for EHR adoption. This effort was coordinated with OeHC, THSA and the RECs to ensure there was no duplication of effort. Survey questions were designed to help build a shared understanding of the status of EHR adoption, EHR service capabilities, and practitioners' preliminary plans to participate in the Medicare and/or Medicaid EHR Incentive program and health exchange activities. The survey results formed the baseline of EHR adoption and HIE in Texas and will serve as a benchmark for program evaluations.

HHSC began administering the survey in July 2010, with separate hospital and practitioner surveys. While responses to the survey by hospitals were good, the responses from professionals were too low to be statistically valid. Therefore HHSC contracted with the Texas

A&M Public Policy Research Institute to complete the survey with adequate sample size in January 2011. As part of this project Texas A&M analyzed the results from the practitioner survey which were used as our baseline measurement. Results were obtained in May 2011. Below is a summary of the hospital survey that was completed in August 2010 and the practitioner survey that was completed in May 2011. The Office of eHealth Coordination fielded both surveys again in 2012, and began fielding the hospital survey once more in June 2013. The practitioner survey will be coordinated by Medicaid HIT in 2013.

### 3.4.1 Status of Health IT Provider Survey

The practitioner survey was administered using data from the State Professional Licensing Board to develop the sampling universe and was disseminated in both electronic and paper formats to allow practitioners who are not currently connected electronically to participate. Because nurse-midwives comprise less than 1 percent (0.5%) of the practitioner population in Texas, they were not specifically targeted for inclusion in the survey. The results from the 2012 survey are based on a sample of 14,586 practitioners, including Medicaid-eligible providers and non-Medicaid practitioners. The practitioners' survey also queried respondents about broadband access to the Internet.<sup>6</sup> Table 1 quantifies the number of practitioners in Texas for each type of Medicaid-eligible professional.

**Table 1: Provider Populations in Texas**

Eligible Providers	Licenses <sup>7</sup>	% of Total Licenses
Physicians	51,826	68%
Dentists	11,751	16%
Physician Assistants	5,372	7%
Nurse Midwives	268	0%
Nurse Practitioner	6,676	9%
Total	75,893	100%

### 3.4.2 Status of Health IT Hospital Survey

The 2012 hospital survey was administered electronically to all 593 hospitals in Texas and closed in August 2012. A total of 167 hospitals responded to the survey, approximately 28% of the state's facilities. The respondents were mostly general medical/surgical hospitals (82%), but also included acute long-term care (7%), psychiatric (6%), and rehabilitation (3%) hospitals.

Responses from the Health IT Hospital Survey were merged with the most recent Annual Survey of Hospitals, in which all acute care hospitals participate (though some state mental health hospitals and some rural hospitals are exempted) to comply with state laws on hospital reporting. A description of results is in Appendix C.

<sup>6</sup> Draft Survey to Providers, and Draft Survey to Hospitals, provided by OeHC, May 24, 2010.

<sup>7</sup> Data reflects figures from the Texas Medical Board, DSHS Center for Health Statistics, Board of Nursing, and the State Board of Dental Examiners.

The 2013 hospital survey concluded in August 2013 and results from the latest survey will be available this fall.

### 3.4.3 Physician Electronic Health Record Adoption in Texas

In June 2012, initial surveys were sent out via mail to all 14,586 practitioners (7,428 physicians, 5,206 dentists, 1,156 nurse practitioners, and 796 physician assistants). Two weeks later, phone interviews were utilized as a secondary approach to collect data from practitioners. There were a total of 1,891 surveys completed through telephone, mail, and fax, with responses from 923 physicians (49%), 818 dentists (43%), 106 nurse practitioners (6%) and 44 physician assistants (2%).

**Table 2. EMR Status among Texas Physicians**

Status of EMR Use	2012
Fully implemented EHR system in use	38%
Partially implemented EHR system	14%
Plans to implement in the next year	8%
Plans to implement in the next two years	7%
No plans to implement	28%
Unknown	1%

The survey found that 38 percent of respondents reported currently using a fully implemented electronic health record in their practice, while 14 percent have partially implemented an EHR system. Fifteen percent of physicians reported that they plan to implement an EHR either in the next year or within two years, and 28 percent reported no plans to implement an EHR.

Physicians in small practices (2-10 providers) were more likely to report that they currently use an EHR. Thirty-six percent of physicians who currently use or plan to implement an EHR system reported that they use the health information exchange function of the system, and 24 percent report using the public health reporting function.

#### 3.4.3.1 Types of EMR Systems Physicians Use

Physicians were more likely to purchase or license an EHR system than to develop one in-house. A majority of practitioners who are currently using EHRs have no plans to discontinue the use of their systems, however 8 percent have plans to either replace or stop using their system. The most common reasons reported for replacing or uninstalling a system include the software is not user friendly (20%), the need to change software or upgrade (13%), lack of software support (13%), the software does not meet the requirements of the practice (13%), and compatibility problems with other software (10%). Most practitioners were present when the current system was purchased or installed (81%).

Fifty-seven percent of physician respondents to the survey reported being Medicaid providers. Only 44% of physicians reported that they will try to qualify for the EHR incentive payments by

showing meaningful use of EHRs. There were 53 percent of physicians who reported they would not seek incentive payments, and 3 percent said they needed more information.

### 3.4.4 Hospital EHR Adoption in Texas

The Texas Department of State Health Services (DSHS), in collaboration with the American Hospital Association and the Texas Hospital Association, conducts the Annual Survey of Hospitals. All hospitals in Texas are required to complete the survey, which includes questions about EHR adoption, EHR functions, and physician utilization of electronic ordering.<sup>8</sup> The 2007 survey found that less than half (47%) of Texas hospitals have partially adopted (33%) or fully adopted (14%) EHRs. The hospital survey showed the following for hospitals that have fully or partially adopted EHRs:

**Table 3. Examples of Functions of Hospital EHR Systems in Texas**

Hospital EHR function includes:	Percentage of hospitals
Patient-level information	88%
Results management	91%
Order entry management	84%
Decision support	72%

Statistics were also collected on physician use of electronic functions. The data showed that in 82% of Texas hospitals, physicians order medications electronically but in 78% of hospitals, physicians do not order laboratory or other tests electronically.

### 3.5 Health Information Exchange Organizations in Texas

In March 2010, the HHSC received an award from ONC from funding through the State HIE Cooperative Agreement Program. The purpose of this program is to fund state planning and implementation of electronic health information exchange networks to support higher quality, safer, and more efficient healthcare. Texas' allotment through this program is \$28.8 million over four years. In December 2010, the HHSC released a Request for Application for funding under the Local HIE Grant Program and made planning grants to 16 community-based HIEs, entering into contracts with the HIEs to develop Business and Operational (B&O) Plans for the operation of the HIE in the community.

Program awardees, which intend to connect the majority of physicians and hospitals in Texas, conducted a planning process in 2011 and submitted B&O Plans to THSA and HHSC for review and HHSC approval for subsequent implementation funding. In 2012, the local HIEs with approved B&O Plans used the implementation funding to support the overall operations of the HIEs, including personnel, HIE technology selection and deployment, development of

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<sup>8</sup> Texas Health Information Exchange (HIE) Cooperative Agreement Program Proposal prepared for ONC, 2010.

marketing materials, and ongoing sustainability, outreach and provider and patient engagement activities.

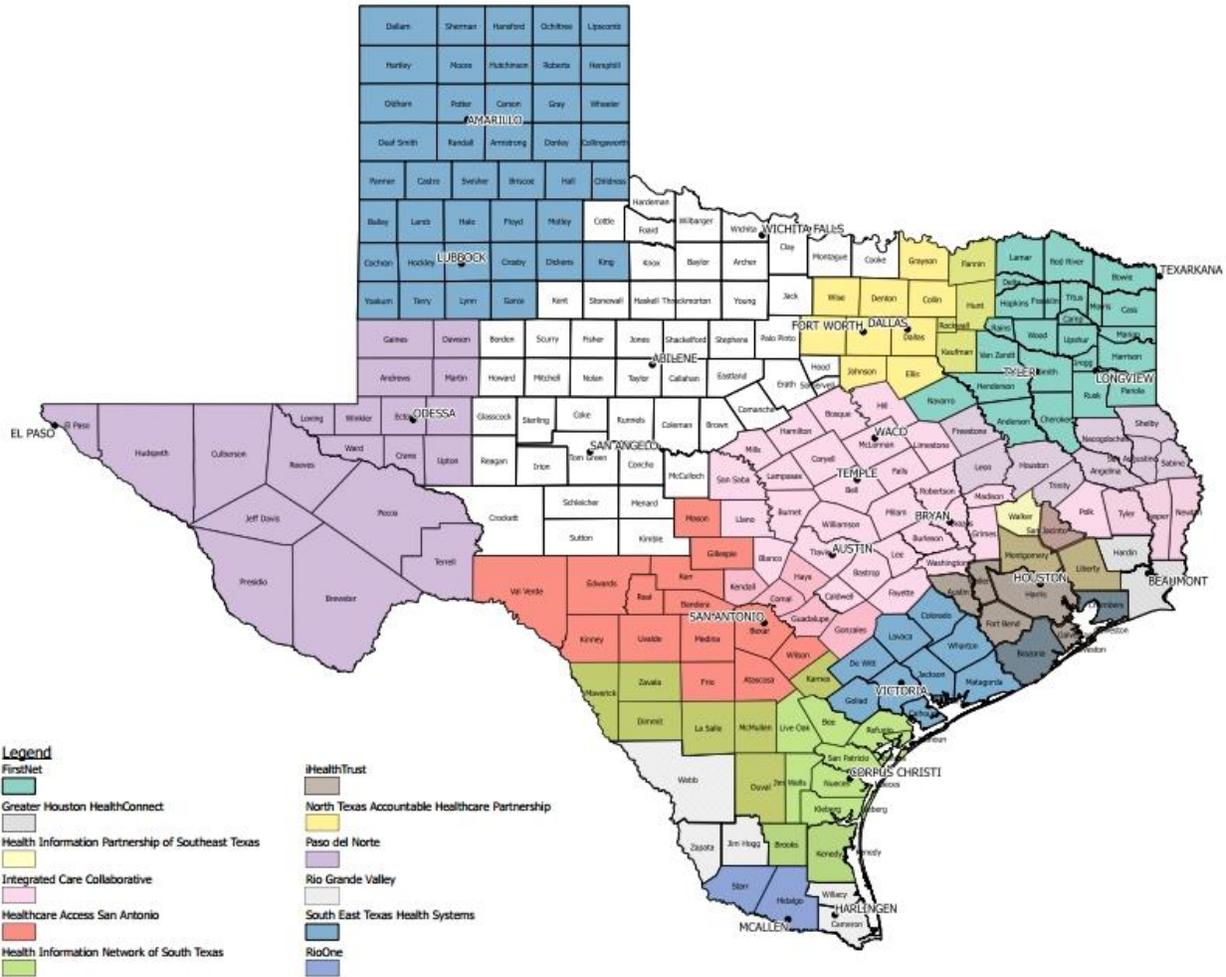
Of the 16 initially funded HIEs, 12 have decided to continue in the program (See Appendix D). At a minimum, these HIEs will support the delivery of lab results and exchange of patient clinical summaries. The HIEs may offer other types of HIE services requested by providers at the community level, such as population health analytic services or patient portals.

The following map shows the geographic coverage of the 12 HIEs participating in the Local HIE Grant Program. As the Texas Statewide HIE Operational Plan evolves, the participation of Texas Medicaid in statewide HIE may be further developed; progress will be detailed in future updates of the Medicaid Health IT Plan.

Figure 1. Geographical Coverage of the Texas HIE Initiatives

# Texas HIE Operations

## Local HIEs and White Space HISPS



Source: State HIE Program (September 2013)

### 3.6 Challenges of Broadband Internet Access

#### 3.6.1 Broadband Internet Access in Texas

In July 2009, the Texas Department of Agriculture (TDA) was charged by the Governor with guiding efforts to make broadband services available across the state and to pursue federal grants in improve access to broadband service in rural communities. In response, TDA established the Texas Broadband Task Force. The task force consists of private-sector

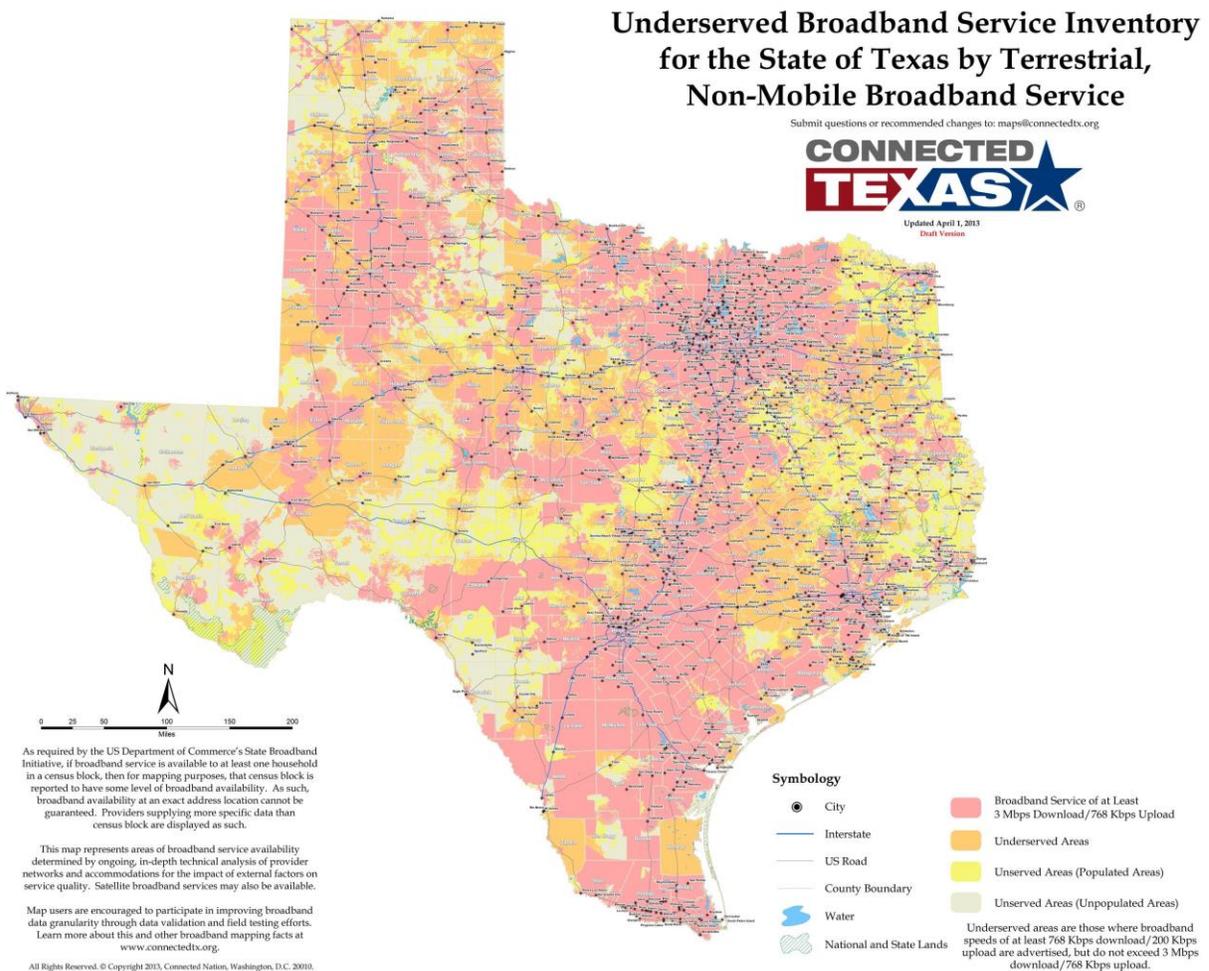
stakeholders and representatives from the Office of the Governor, various state agencies (including HHSC), the Texas Legislature and the Public Utility Commission (PUC).

Using ARRA grant funds, TDA commissioned Connected Texas to work with all broadband providers in Texas to create detailed maps of broadband coverage in order to accurately pinpoint remaining gaps in broadband availability.<sup>9</sup> Connected Texas (<http://www.connectedtx.org>) is a partnership between the Texas Department of Agriculture and the national, nonprofit, Connected Nation. The information gathered by Connected Texas is included in the new, national broadband map mandated by the federal government, which was published in February 2011 and available at [www.broadbandmap.gov](http://www.broadbandmap.gov). The most current picture of broadband availability in Texas is shown in Figure 2.

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<sup>9</sup> Connected Texas, "Connected Nation Receives ARRA Grant for Connected Texas Initiative," Press Release, January 13, 2010.

**Figure 2. Broadband Internet Access in Texas**



**Source: Connected Texas, April 2013.**

### 3.6.2 Federal Communications Grants

Texas organizations have been successful in securing federal broadband grants from the Federal Communications Commission, Department of Commerce, and Department of Agriculture to fund broadband access projects that will benefit health care providers across the state. The list and description of the Texas broadband grant awardees are included in Appendix E. To date, these grants total \$79,442,192 in federal funding.

### 3.7 Health IT Activities Supported by ONC

The HITECH Act has provided several opportunities for Texas-based institutions to receive funding through the ONC to advance health information technology efforts in Texas. To date, the State of Texas and Texas-based institutions have been awarded over \$84 million in HITECH

funding to help develop health information exchanges, promote the adoption of electronic health records, and, through education and training, develop the workforce necessary to implement and sustain health information technology. In addition to the \$28.8 million awarded to HHSC for the State HIE Cooperative Agreement Program described in section 3.1 of the report, other HITECH-funded activities are described below.

### 3.7.1 Health IT Regional Extension Centers

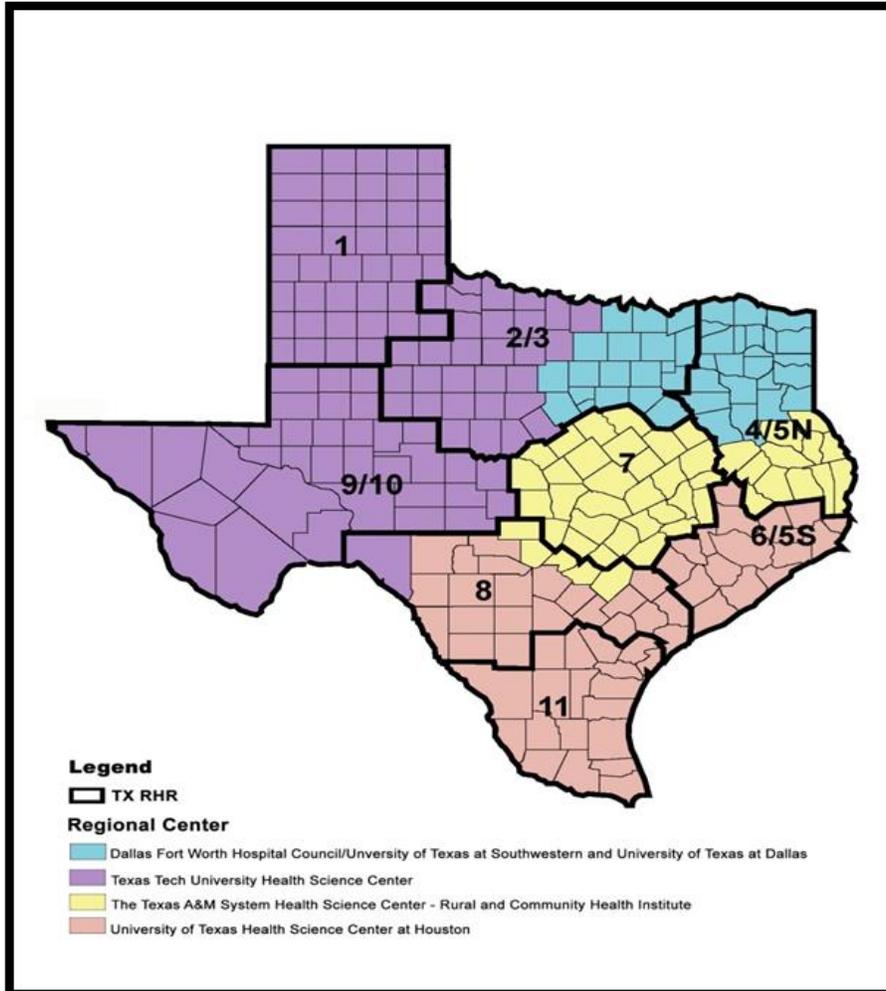
Among the 70 Regional Extension Centers (RECs) funded by the ONC, four were awarded in Texas. Three state universities and one private foundation, with coordinating support from the Texas Medical Association, were awarded nearly \$36 million to start up and provide services to nearly 6,800 primary care providers (PCPs) in private practice, community health centers or rural health centers with 10 or fewer providers, and recently received an additional \$2 million in ONC funding to support adoption of certified EHRs in the outpatient settings of critical access and rural hospitals (CAHs/RHs) in Texas with fewer than 50 beds (Table 4).<sup>10</sup> Each institution is the fiduciary agent for one of the four regions, as illustrated in Figure 3.

**Table 4. Health IT Regional Extension Centers in Texas**

Regional Extension Center	Minimum No. PCPs to be Served	Original Funding
		Rural Hospital Funding
CentrEast Regional Extension Center Texas A&M Health Sciences Center, Rural and Community Health Institute <a href="http://www.centreastrec.org/">http://www.centreastrec.org/</a>	1,000	\$5,279,970
		\$384,000
Gulf Coast Regional Extension Center University of Texas School of Health Information Sciences at Houston <a href="http://www.uthouston.edu/gcrec/index.htm">http://www.uthouston.edu/gcrec/index.htm</a>	2,200	\$15,274,327
		\$612,000
North Texas Regional Extension Center Dallas Fort Worth Hospital Council, Education and Research Foundation (DFWHC-ERF) <a href="http://www.ntrec.org/">http://www.ntrec.org/</a>	1,498	\$8,488,513
		\$108,000
West Texas Regional Extension Center Texas Tech University Health Science Center <a href="http://www.ttuhs.edu/">http://www.ttuhs.edu/</a>	933	\$6,666,296
		\$912,000

<sup>10</sup> See <http://www.healthit.hhs.gov/portal/server.pt?open=512&objID=1495&mode=2>.

Figure 3. Texas Regional Extension Centers



The primary objective of the Texas RECs is to provide technical assistance, guidance and information on best practices concerning EHR adoption and meaningful use. The Texas RECs are targeting their services to small primary care practices in internal medicine, family medicine and pediatrics, as well as critical access and rural hospitals. The RECs are partnering with county medical societies, local universities/medical schools and alumni associations as well as the Texas branch of the American Academy of Family Physicians (AAFP). The overall goal of the RECs is to support potentially late or non-adopters of EHRs. Services to the critical access/rural hospitals will include developing exchange of laboratory results with rural community providers who use hospital-based labs for their office practice.<sup>11</sup>

<sup>11</sup> Personal communications between REC representatives and Medicaid officials, July 9, 2010.

The RECs have collaborated in defining their core services as including<sup>12</sup>:

- Group purchasing function;
- Support for workflow redesign and longer term training, practice management integration and trouble-shooting;
- Support towards achieving meaningful use to receive Medicare and Medicaid EHR incentive payments;
- Education of providers; and
- Workforce enhancement to meet health IT demands.

The RECs do not plan to endorse any vendor, but will be a source for vetting EHR vendors through summary reports (e.g., specifications, ease of use in varied practice settings, integration ease, references). RECs will also review EHR vendor contracts for market reasonableness (e.g., price and terms).

As of March 2013, each of the four Texas RECs has reached 100% of its enrollment target of PCPs and continues to over enroll eligible providers to account for a small amount of attrition. Of the 5,831 PCPs under service agreements with the RECs, a Texas REC average of 85% of PCPs have implemented an electronic health record and a Texas REC average of 32% of PCPs have reached meaningful use (MU).

Going forward, the Texas RECs are determined to implement new strategies and rely on their skilled staff to address the EHR needs of Texas and continue to be a trusted advisor for the support and optimization of HIT, Stage 2 and 3 of meaningful use (MU), and the three-part aim of better care, better health, and cost reduction. These strategies include the following:

- (1) Continue to enroll primary care providers and critical access hospitals eligible for federally subsidized services.
- (2) Provide services to specialists to help drive this group towards MU.
- (3) Participate with the Texas Health and Human Services Commission to provide federal subsidized services to cardiologists, endocrinologists, pulmonologists, and psychiatrists to help drive the providers in these practice areas towards MU.
- (4) Participate with the Texas Health Services Authority (THSA) to promote THSA's White Space Voucher Program and HIE initiatives.

In addition to these strategies, the Texas RECs are reviewing and designing service models to assist healthcare providers meet MU Stage 2 requirements and to provide additional services such as Accountable Care Organizations (ACO) accreditation, Patient-Centered Medical Home recognition, clinical informatics and data warehousing services, ICD-10 transformation, and pay for quality/performance incentive consulting services.

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<sup>12</sup> Presentation by Kristen Jenkins and Tony Gillman, Texas Health IT Summit, April 23, 2010.

### 3.7.2 Strategic Health IT Advanced Research Projects

The University of Texas Health Science Center at Houston was awarded \$15 million in federal funding through the Strategic Health IT Advanced Research Projects (SHARP) program to address key challenges in adoption and meaningful use of health IT.<sup>13</sup>

Research at the National Center for Cognitive Informatics and Decision Making in Healthcare (NCCD) is focused on an area of health informatics that uses information technology to support problem-solving and decision-making to optimize patient outcomes, which is known as patient-centered cognitive support. This project helps the EHR Incentive Program by addressing one of the chief challenges to EHR adoption. Many of today's EHR systems are not as user-friendly as they should be to fully support users' needs. The systems also do not always take into account the decision support capabilities that physicians and other practitioners need to easily access and use health IT information effectively on a daily basis.

NCCD's vision has been to develop a national resource providing strategic leadership in research and applications for patient-centered cognitive support in healthcare. NCCD's mission has been to (1) bring together a collaborative, interdisciplinary team of researchers across the nation with the highest level of expertise in patient-centered cognitive support research from biomedical and health informatics, cognitive science, computer science, clinical sciences, industrial and systems engineering, and health services research; (2) conduct short-term research that addresses the urgent usability, workflow, and cognitive support issues of HIT as well as long-term, breakthrough research that can fundamentally remove the key cognitive barriers to HIT adoption and meaningful use; and (3) translate research findings to the real world through a cooperative program involving researchers, patients, providers, HIT vendors, and other stakeholders to maximize the benefits of HIT for healthcare quality, efficiency, and safety. NCCD has five research projects that directly and fundamentally address the cognitive challenges in HIT identified by ONC, focusing on work-centered design, cognitive foundations for decision making, adaptive decision support, model-based data summarization, and visualization.

### 3.7.3 Health IT Workforce Grants

Texas State University at San Marcos was awarded \$5.4 million through the ONC to directly support the education of about 320 additional students over three years, while establishing additional capacity to meet the ongoing needs of an expanded work force.<sup>14</sup> Other institutional partners include the University of Texas at Austin, School of Natural Sciences, and the University of Texas, School of Health Information Sciences at Houston.

Students are able to choose one of the following six career paths:

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<sup>13</sup> See <http://healthit.hhs.gov/portal/server.pt?open=512&objID=1806&mode=2>.

<sup>14</sup> See <http://www.health.txstate.edu/him/PURE-HIT-Training-Consortium.html>.

- Clinician/public health leader
- Health information management and exchange specialist
- Health information privacy and security specialist
- Research and development scientist
- Programmers and software engineer
- Health IT sub-specialist

### 3.7.4 Community College Consortium for Health IT Education and Training

The Community College Consortium provides assistance to establish or expand health IT education programs. The award was structured to cover all regions of the country through five regional lead awardees. The \$10.9 million award to Pitt Community College in North Carolina covers the Southern region including Texas. Three Texas institutions—Houston Community College, Midland College, and the Dallas County Community College District—are participating in the consortium.

### 3.7.5 Beacon Community Grants

Eight entities from around the State of Texas applied for a Beacon Community Grant from the ONC. No entities in Texas were awarded a Beacon Community Grant.

### 3.7.6 Texas Rural “White Space” Strategy

In May 2011, the THSA issued a Request for Qualifications (RFQ) to identify organizations with the qualifications and experience required to provide electronic capabilities for the transmission of all clinical transactions necessary to enable health care providers to achieve “meaningful use” of electronic health records (EHRs) in the rural regions of the state not served by one of the Local HIE Program participant HIEs. Through the RFQ, the THSA sought to establish a marketplace of qualified health information service providers (HISPs), organizations that support the secure transport of structured or unstructured data (e.g., simple text and PDF, semi-structured text, and highly structured messages and documents) on behalf of the sending or receiving organization or individual, to provide at least “lite” HIE connectivity services to physicians and hospitals located in White Space counties.

As of November 2012, \$750,000 in total funds was available to support the White Space strategy and additional funds are supporting a “boots on the ground” strategy with the West Texas REC. All qualified HISPs participating in the marketplace are eligible to receive a subsidized payment from the THSA based on the number of eligible hospitals and physicians located in the identified White Space counties that each HISP is able to connect. The subsidy, or voucher, is in the amount of \$400 per White Space physician connected and \$5000 for each White Space hospital connected. There are about 160 hospitals and 3000 physicians located in the Texas White Space counties.

The voucher is intended to act as a subsidy, and the HISPs may not charge participating physician or hospitals for any services until the voucher funds have been expended on those

services. However, once those funds have been expended, HISP's may charge physicians and hospitals directly for their services in accordance with each HISP's published pricing available on the THSA website.

The HISP's must adhere to federally required technical standards and operational policies as well as to additional requirements as included in the THSA agreement with the HISP's, including the provision of electronic capabilities for the transmission of all clinical transactions necessary for meaningful use of electronic health records in accordance with recognized federal and state standards. Initially, this includes the transmission of clinical care summaries and lab results.

The THSA issued its RFQ with the expectation that responses would be received from multiple HISP's capable of serving all or a portion of the physicians and hospitals in the White Space counties. Applications received were evaluated for quality, cost, readiness, coverage, and stated willingness to deliver core HIE services, implement required interoperability and privacy and security policies and standards, and participate in program evaluation. "Readiness" means the capability of supporting HIE services today, particularly those required to enable physicians and hospitals to achieve federal Stage 1 meaningful use requirements relating to HIE. Following a rigorous application review and testing process, in August 2011 the THSA approved the preliminary initial selection of six HISP's, and five HISP's received final awards, all of which were required to sign a Uniform HISP Agreement with the THSA in order to be qualified for participation in the White Space program. As of July 2013, the THSA has issued 195 voucher numbers and made voucher payments to HISP's on behalf of 30 hospitals and 76 physicians.

### 3.7.7 HISP Direct Service RFI

Following its 2010 environmental scan to assess initial readiness for HIE implementation in Texas, the THSA sought to augment its previous findings by issuing an additional Request for Information (RFI) in October 2011 to identify organizations that offer or intend to offer Nationwide Health Information Network (NwHIN) Direct protocol-based HIE connectivity services (see sidebar on page 4 for more on the Direct Protocol) to health care providers in Texas that include, at a minimum, the initial federal meaningful use required elements of clinical summary exchange for care coordination and patient engagement and electronic clinical laboratory results delivery.

All organizations that plan to offer Direct-based secure messaging services in Texas, including Texas Local HIE Grant Program participants providing services in their service areas and the six qualified White Space HISP's offering Direct services in the White Space region, were invited to respond by identifying themselves, their Direct-compliant product(s), and related information. The RFI, which was issued to augment the original environment scan and to ensure that responding organization are part of the statewide HIE planning process, included clarification that its purpose was not intended as a "pre-proposal" or to endorse a particular solution,

method, or product. The THSA received responses to the RFI from 17 organizations by the October 28, 2011 deadline.

### **3.8 Coordination of Medicaid Health IT Activities with State HIT Coordinator**

As described in section 3.1.2, the OeHC Director is the designated State HIT Coordinator.<sup>15</sup> As a member of the HHSC staff, the OeHC Director communicates regularly with the Medicaid and CHIP Division, other HHSC departments, as well as the state level HIE Cooperative Agreement award recipient, Texas Health Services Authority (THSA), the RECs, the SHARP grantee, the Health IT workforce grantee, and the three Federally Qualified Health Center entities that received HRSA health IT funding.

### **3.9 Status of Health IT Activities of Special Provider Stakeholders**

#### **3.9.1 Federally Qualified Health Centers**

There are 69 Federally Qualified Health Care Centers (FQHCs) operating in more than 300 locations throughout Texas.<sup>16</sup> There are also two FQHC “Look-Alikes” that offer services.<sup>17</sup> Within DSHS, the Texas Primary Care Office—through a cooperative agreement with HRSA and a partnership with the Texas Association of Community Health Centers (TACHC)— works with health care providers and communities to improve access to care for the underserved, by recruiting and retaining providers to practice in federally-designated shortage areas.

In response to a 2002 federal program to expand FQHCs nationwide, Texas created the FQHC Incubator program in 2003 and appropriated \$5 million per year. This program was designed to offer grants to organizations to help them qualify for FQHC funding or site/service expansions. Since the beginning of the federal initiative, the number of FQHCs in Texas has doubled from 32 in 2002 to 69 in 2012. The Incubator program has granted funding to 60 FQHCs and both FQHC Look-Alikes to become certified or to create a new site or service. Of the 69 FQHCs in Texas, 28 became FQHCs through Incubator Grant funds.

In 2010, TACHC and two FQHCs in Texas (Table 5.) were among 45 FQHC networks nationwide that were awarded nearly \$84 million in grants to help networks of health centers adopt EHRs and other health IT systems.<sup>18</sup> According to TACHC, approximately one-third of the Texas FQHCs have an EMR, while one-third to one-half are looking for new EHR systems. Texas grantees received a total of nearly \$6.9 in HRSA funding under ARRA health IT implementation grants. Barrio Comprehensive Family Health Center, one of the three grantees, also received an earlier round of funding in 2009, and was awarded an EHR Implementation grant in 2008.

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<sup>15</sup> Texas Health Information Exchange (HIE) Cooperative Agreement Program, Proposal prepared for ONC, 2010.

<sup>17</sup> Look-Alikes offer FQHC-like services but do not receive all of the benefits of FQHC status.

<sup>18</sup> HHS News Release, “HHS Awards \$83.9 Million in Recovery Act Funds to Expand Use of Health Information Technology,” June 3, 2010. See: <http://www.hhs.gov/news/press/2010pres/06/20100603a.html>

**Table 5. Texas Grantees Awarded HRSA Funding for Health IT**

HRSA Funding Source	Texas Grantee	City	Award
<b>ARRA - Health Information Technology Implementation Grants (HRSA) (2010)</b>	Texas Association of Community Health Centers	Austin	\$982,587
	Lone Star Circle of Care	Georgetown	\$2,987,610
	Barrio Comprehensive Family Health Care Center, Inc.	San Antonio	\$2,909,072

### 3.9.1.1 Leveraging HRSA Health IT Resources

Through coordination with the OeHC, Texas Medicaid will receive regular updates on the experiences and lessons of EHR adoption from the three FQHCs awarded HRSA health IT funding. Medicaid will include input and feedback from the FQHCs in its development of key messages and outreach strategies to encourage eligible Medicaid providers to adopt certified EHR technology and participate in the EHR Incentive Program. The EHR incentive payments will be leveraged to support the efforts of FQHC providers in Texas to achieve meaningful use of electronic health information.

### 3.9.2 Department of Veterans’ Affairs – Clinical Facilities

In Texas, there are five Veterans’ Affairs (VA) medical centers, 17 VA outpatient clinics and 33 community-based clinics that serve veterans in Texas. The South Texas Veterans Health Care System in Bexar County (San Antonio) contracts with other area hospitals to provide care for qualified patients. These providers are currently working to integrate VA data with other information systems in San Antonio.

### 3.9.3 Tribal Clinics

The Texas tribal population is very small, consisting of three federally-recognized Native American tribes. These tribes are the Alabama-Coushatta Tribe (Livingston), the Kickapoo Traditional Tribe (Eagle Pass), and the Ysletta Del Sur Pueblo (El Paso).<sup>19</sup> Each of these tribes operates a tribal clinic. The Kickapoo Tribe and the Ysletta Del Sur Pueblo are the only Texas tribes that provide health services *and* currently bill Medicaid and CHIP. There is a fourth unaffiliated tribal clinic, Urban Inter-Tribal Center (UITC) of Texas, located in Dallas (See Table 6). It is a FQHC working toward becoming a Medicaid and CHIP provider.<sup>20</sup>

There are no HHS Indian Health Service (IHS) facilities located in Texas. However, the four tribal clinics in Texas receive IHS funding.

<sup>19</sup> Department of the Interior, Bureau of Indian Affairs, Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs, Federal Register, Vol. 74, No. 153, August 11, 2009. Accessed at:

<http://www.ihs.gov/FacilitiesServices/AreaOffices/California/UploadedFiles/Training/FederallyRecognizedTribes2009.pdf>

HHSC attempted to survey the tribes about their EHR adoption status and plans as part of the completion of the Medicaid HIT Plan. One tribal clinic responded. UITC is using the Resource Patient Management System (RPMS) in its clinic and working toward implementing an EHR. Texas Medicaid has a liaison to the tribal clinics who reaches out to the tribes to ensure their awareness of health IT initiatives in Texas and to encourage their participation, whenever possible.

**Table 6. Tribal Clinics in Texas**

Indian Health Services Clinics	City of Location
<b>Chief Kina Health Clinic</b> (Alabama-Coushatta Tribe of Texas)	Livingston
<b>Kickapoo Health Clinic</b> (Kickapoo Traditional Tribe of Texas)	Eagle Pass
<b>Urban Inter-Tribal Center of Texas</b>	Dallas
<b>Ysletta Del Sur Servicie Pueblo</b> (Ysletta Del Sur Pueblo)	El Paso

### 3.10 Summary

Texas has a broad range of activities currently underway to advance the use of HIE and EHRs. Given the size and complexity of a state like Texas, it is reasonable that one of its chief issues moving towards meaningful use is how public and private entities working on adoption of health IT can come together to achieve effective communication, cooperation and the collaboration necessary to achieve positive change in the delivery of health care.

The Medicaid EHR Incentive Program offers a real opportunity to support eligible providers in the adoption and meaningful use of EHRs to improve health outcomes, care quality and cost efficiency. For Texas Medicaid, the challenge is to garner the resources, both human and capital, to support this transformation. Across the Texas HHS Enterprise, it is critical to allow exchange of program-specific proprietary data for analysis in order to measure quality and cost indicators that focus on the value of care provided to Medicaid clients. Statewide, the challenges are not just access to resources to understand and support technology adoption, but also about moving towards a common goal of improving health care and cost effectiveness.

## 4. THE STATE’S “TO-BE” LANDSCAPE

### *Texas Vision for To-Be Landscape – Meaningful Use of Electronic Health Records*

There is increasing emphasis, particularly in the Texas Medicaid program, on improving the quality of services and realizing positive health outcomes. Traditionally, providers have been paid for each procedure performed, without rewards for quality of care or health outcomes for the patient. This approach has resulted in ever-increasing costs. For several years national experts as well as Texas policy leaders, and HHSC leaders and specialists, have been addressing the challenge to develop new approaches that encourage the goals of ensuring quality, outcomes, and cost-effectiveness in the health care delivery system.<sup>21</sup>

HHSC is one of the largest state agencies in Texas. HHSC is accountable for nearly one-third of the state’s budget or \$52.2 billion (all funds) per biennium, and for the health care of over 3 million Texans through Medicaid. As of March 1, 2012, approximately 87% of Medicaid services are administered through managed care organizations. The remaining client population will be served under a fee-for-service arrangement. The Texas State Medicaid Health Information Technology Plan (SMHP) provides an opportunity to analyze and plan for how EHR technology, over time, can be used to enhance quality and health care outcomes, as well as reduce overall health care costs.<sup>22</sup>

#### 4.1 Health IT Goals and Objectives

##### 4.1.1 Context for the EHR Incentive Program Vision

The purpose of this section of the SMHP is to outline the overall vision for Texas Medicaid’s use of HITECH funds to promote the adoption and meaningful use of EHRs among eligible Medicaid providers. The meaningful use of EHRs is essential to support health care reform goals of improved health outcomes, care quality and cost effectiveness. This vision creates a “line of sight” from the baseline of the current health IT landscape of EHR adoption to the future environment of meaningful use in 2014. This vision helps to create the pathway where “investments in technology per se [are] efforts to improve the health of Americans and the performance of their health care system.”<sup>23</sup>

The vision of this program is much larger than hardware and software. The vision seeks to establish the point on the horizon where the program is headed – its strategic direction within the larger context of the health care environment and HITECH.

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<sup>21</sup> Texas HHSC, Strategic Plan 2009-2013, Accessed at [http://www.hhs.state.tx.us/StrategicPlans/HHS09-13/StrategicPlan\\_FY2009\\_2013.pdf](http://www.hhs.state.tx.us/StrategicPlans/HHS09-13/StrategicPlan_FY2009_2013.pdf)

<sup>22</sup> CFR §495.332

<sup>23</sup> Blumenthal, David, M.D., M.P.P. “Launching HITECH,” NEJM, December 30, 2009. Accessed at: <http://healthcarereform.nejm.org/?p=2669&query=home>

#### 4.1.2 Texas EHR Incentive Program Vision

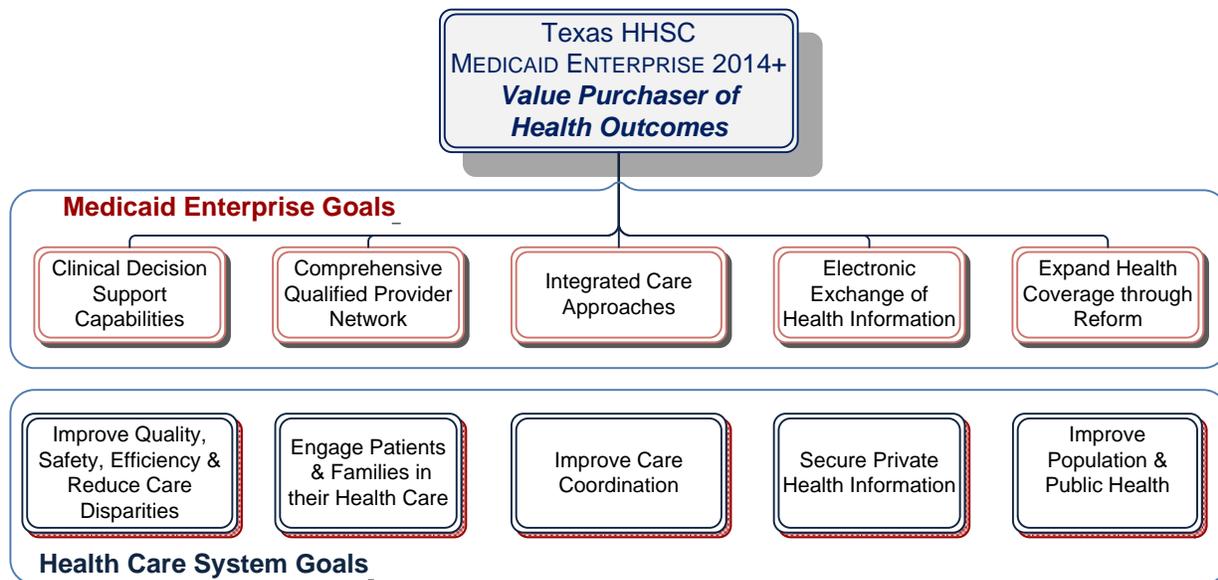
The Texas Medicaid vision is focused on two levels of change that must occur, in concert, to realize the goals and benefits of this HITECH program: the state level and the health care system level. The state-level changes center on Medicaid becoming a **Value Purchaser**. This strategic direction is reinforced by the Texas Health and Human Services (HHS) System Strategic Plan benchmark goals to:

- Restructure Medicaid funding to *optimize investments in health care and reduce the number of uninsured Texans* through private insurance coverage; and
- Enhance the infrastructure necessary to improve the *quality and value of health care* through *better care management and performance improvement incentives*.<sup>24</sup>

To realize this vision for Texas Medicaid and eligible providers, the State requires the commitment, energy and resources of a broad set of stakeholders – health care providers, payers, government entities, legislators, and citizens – who have a shared interest in and will benefit from EHR adoption and meaningful use. Texas Medicaid will provide leadership for this vision through communication and collaboration at the state and local levels.

##### 4.1.2.1 “To-Be” Vision for the Texas Health IT Environment

**Figure 4. Medicaid Enterprise and Health Care System Goals**



<sup>24</sup> Texas Health and Human Services System, Strategic Plan 2011–15, Volume I. Accessed at: [http://www.hhs.state.tx.us/StrategicPlans/SP11-15/Strategic\\_Plan.pdf](http://www.hhs.state.tx.us/StrategicPlans/SP11-15/Strategic_Plan.pdf)

A select group of Texas HHS Enterprise leaders were convened to discuss and set the To-Be vision for Texas Medicaid. The group adopted the following vision for 2014:

**BE A *VALUE PURCHASER* OF QUALITY HEALTH OUTCOMES BY SUPPORTING AND “E-ENABLING” IMPROVEMENTS IN MEDICAID**

1. Utilize clinical decision support and health informatics to analyze Medicaid data from across the HHS Enterprise. Use data to target health quality improvement initiatives, including cost avoidance for Medicaid programs. Strategies will include:
  - Identifying regional variations in health and care needs, and barriers to care coverage, access and the delivery of services;
  - Aligning appropriate care design, care delivery and payment structures to support payment for episodes of care;
  - Addressing the primary drivers of health care costs – utilization, medical price, hospitalization, long term care; and
  - Measuring provider performance, collaborating with providers to ensure consistency in data collection and reporting, making more transparent provider quality performance information, and working with other payers to standardize and benchmark quality measurement of providers.
  - Measuring the effectiveness of HIT implementations and planning further action in order to effect a continuous improvement cycle.
  
2. Establish and maintain a comprehensive and qualified provider network capable of providing quality care based on population needs, unique care conditions, and local service needs by:
  - Identifying and adjusting to changes in utilization patterns and trends;
  - Identifying and addressing care disparities;
  - Evaluating and improving care coordination opportunities;
  - Expanding childhood prevention programs that lead to healthier adults; and
  - Implementing evidence-based best practices in a range of health care settings.

Identifying, assessing and expanding the provider network based on the needs of the current and expanding population covered by Medicaid is important to having a comprehensive and qualified provider network. Without understanding how well the current provider network is addressing the needs of the current Medicaid population or being prepared to address needs of a new population, such as childless adults who will be eligible pursuant to health care reform, Texas Medicaid needs to focus on information that will inform where the network needs to grow or develop to provide high quality care that is safe, effective, efficient, timely, person-centered and equitable.

3. Implement effective and efficient primary and integrated care approaches including:
  - Medical Home models and payment methodologies to support and improve care coordination and health outcomes
  - Integration of physical, behavioral and substance abuse services
  - Broad systems integration through wider use of health information exchange between Medicaid and health care delivery systems
4. Ensure the secure and private exchange of health care information across the HHS Enterprise, consistent with national standards, and including the following providers:
  - Long term care and behavioral health care providers who serve consumers with high cost and high co-morbidity conditions, even though these providers were not directly included as eligible providers in the EHR Incentive Program, and
  - Rural physicians, dentists, physician assistants, nurse practitioners and certified nurse midwives who were included as eligible providers in the final rule, yet face unique challenges being able to participate in health IT efforts under the EHR Incentive Program.
5. Increase health care coverage through health insurance exchanges and expanded Medicaid eligibility criteria to be implemented under federal health care reform, with a focus on:
  - Increasing health care coverage to support continuity of care,
  - High service and care needs due to previous lack of health care coverage
  - Member outreach and education about service availability and establishing a medical home.

**IMPROVE THE HEALTH AND WELL-BEING OF CITIZENS OF TEXAS THROUGH THE WIDESPREAD ADOPTION AND MEANINGFUL USE OF CERTIFIED EHRs**

1. Improve the quality, safety and efficiency of care and reduce health disparities by:
  - Supporting clinical decision support capabilities that better enable providers to make clinical decisions based on patient-centered and population-centered data and analysis;
  - Pursuing value purchasing managed care strategies through Value Purchasing Request for Proposals (RFPs), and assisting health plans to help providers achieve meaningful use of certified EHRs;
  - Promoting evidence-based practices (EBPs), computerized physician order entry (CPOE) and Clinical Decision Support that target high cost patients;
  - Engaging in Medical Home initiatives targeted to people with high cost needs; and
  - Working collaboratively with providers to expand transparency in the delivery of care through provider profiling and public reporting of appropriate performance measures.

2. Engage patients and families in their health care through:
  - Knowledge, by promoting health literacy and education and the use of accessible and understandable information;
  - Data, by using comparative quality information online for health plans, physicians, hospitals, and other providers; and
  - Web-based tools that help patients and their families gain secure access to clinical summaries, pharmacy and medical claims history, and a Personal Health Record, and other resources that will empower patients and families in care decisions and care management.
3. Improve care coordination and integration by:
  - Aligning data exchange standards and national standards (5010, ICD-10);
  - Extracting lessons learned from the e-Prescribing program;
  - Examining opportunities under health care reform (e.g. long term care pilot) to promote improvements in transitions of care and appropriate and timely referral; and
  - Advancing the Patient-Centered Medical Home (PCMH) model by promoting adoption of NCQA standards for PCMH initiatives in Medicaid managed care networks.
4. Ensure privacy and security protection for private health information by:
  - Developing operating policies for all Medicaid-funded health care programs, tracking access to patient data, conducting regular and standardized security analyses and following up with remediation, as needed; and
  - Implementing standards for provider access to private health information (PHI) based on user roles, for all systems that maintain PHI.
5. Improve population and public health outcomes by:
  - Simplifying public health reporting;
  - Improving accountability through transparency as a result of greater collaboration with providers to develop aggregated and standardized quality reporting capabilities;
  - Expanding public awareness and understanding of healthcare-acquired infections through public reporting by facility; and
  - Enhancing emergency preparedness through timely reporting of accurate information on public health risks such as food-borne illnesses, disease outbreaks and environmental hazards;
  - Educating families on the importance and availability of childhood lead screening, and ways to lessen the risks of blood lead poisoning.

#### *4.1.2.2 Being a Value Purchaser: Identifying Effective Measurement Techniques for Medicaid HIT Initiatives*

The Texas Medicaid program has begun to implement HIT initiatives meant to improve patient care, facilitate client access to their health records, and increase efficiency of service delivery. Many more initiatives are expected to be introduced in the future. HHSC is working to identify measurement techniques that provide quantified evidence of the effectiveness of these initiatives while also pointing towards possible improvements.

An obvious example of this need is the obtaining of clinical quality measures data related to health care service delivery to Medicaid clients. Medicaid has begun obtaining quality measure data from the attestations within its EHR Incentive Program. Additionally, our External Quality Review Organization (EQRO) samples data from Medicaid providers and calculates an array of measures. Also, the Medicaid Office of the Medical Director is participating in quality measure development and implementation under grants from CMS and AHRQ. Medicaid intends to go farther than just collecting aggregate measurement data. The Medicaid Clinical Gateway will facilitate the large-scale gathering of fundamental clinical data, such as diagnoses, lab results, diagnostic results, and many more data elements.

Less obvious is the need for quantification of the effects of HIT advancements like the Medicaid e-prescribing functionality that was recently implemented. The advent of instant eligibility checks by prescribers has been theorized to improve patient care and cost effectiveness to the state. Monitoring of these effects is necessary to inform the Medicaid program in how to modify the current functionality to best achieve the desired results as well as provide ideas for future functionality.

Other HIT metrics that Medicaid wishes to develop involve patient and provider interactions with the state MMIS system's patient and provider portals. Medicaid must quantify and analyze usage patterns and generate informative metrics in order to improve our efforts and plan for future functionality. The two examples, of the e-prescribing system and the patient/provider portal, are representative of the many initiatives under way and planned for the future.

#### **4.1.3 Achieving the Vision**

Current efforts to develop the SMHP have focused on reaching consensus on the questions in the CMS Medicaid Health IT Plan template, and planning and initiating the provider outreach and engagement process.

The next phase of the project will focus on engaging the broader community in reviewing, vetting and refining this plan, and initiating action on several essential guiding principles. For success, it will be necessary to improve the alignment of Medicaid program goals across the Texas HHS Enterprise. Texas Medicaid also needs to enhance its accountability for care provided to eligible clients. Making health outcomes and quality of care major priorities is an essential first step. A commitment to work collaboratively with providers and key stakeholders

to bring more transparency to Medicaid—by paying for value rather than services—is also crucial to advancing accountability, and fulfilling the vision of Medicaid as a value purchaser.

While health IT can provide significant advantages in data gathering and analysis, meaningful use and quality improvements in health care cannot be accomplished by another entity; that is, meaningful use cannot be purchased. Meaningful use requires the entity, whether Texas Medicaid, or the eligible professional or hospital, to actually use information to change practices in a continuous process of quality improvement.

Finally, this type of substantial and transformative change will not be successful without key clinicians who serve as champions at the state and local level. Texas Medicaid continues to work with the HIE Advisory Council, OeHC, the RECs, the Office for the Elimination of Health Care Disparities (OEHD) and professional associations to identify physician champions who will assist the Medicaid Program in provider outreach and education. Clinical champions dedicate a substantial portion of their time promoting EHR adoption and demonstrating improved health outcomes through the use of EHR technology. Using champions in the early stage has helped to build a shared commitment for change and a willingness of peers to engage in the incremental process of improved health outcomes.

Achieving a vision of improved health, accountable care and cost effectiveness will not occur overnight and will not be achieved by a few individuals. This effort will only be successful if built on communication, commitment and collaboration. The SMHP provides a tool to initiate this process and will serve as a guide for strategic planning and detailed implementation. It is one step in a longer journey that must involve and entice others into a shared vision.

#### 4.1.4 Building Consensus on the Vision

Texas Medicaid is applying a multi-pronged approach to inform and engage providers on the State Medicaid Health IT Plan. In particular, Medicaid obtains input on the EHR Incentive Program through the following types of activities:

- **Committee Presentations** – Medicaid provides updates on the EHR Incentive Program and SMHP, and solicits feedback and input from members of the following committees:
  - Medicaid HIE Advisory Committee
  - Regional Advisory Committees
  - Public Assistance Health Benefits Review Committee
  - MCO Medical Directors Committee
  - HHSC Advisory Council
  - HHSC Stakeholder Forums
- **Conferences and Provider Forums** – Medicaid accepts opportunities to speak about the EHR Incentive Program at conferences and provider forums across the state, including, but not limited to, provider association conferences, HIT Summits in Texas, MCO meetings, , and local and regional HIMSS events.
- **Provider Associations** –The Medicaid Health IT division communicates and meets with about 20 provider associations, including but not limited to: Texas Medical Association,

Texas Hospital Association, Texas Organization of Rural and Community Hospitals (TORCH), Texas Association of Community Health Centers (TACHC), Texas Pediatric Society, and Texas Osteopathic Medical Association (TOMA).

- Webinars - Medicaid uses web conferencing technology (GoToWebinar) to offer periodic provider forums, open to any interested parties. These include a short presentation on specific topics related to the program, followed by a question and answer period.
- **Webpage** - A series of web pages on an existing website familiar to providers (TMHP.com) has been developed to provide information on Medicaid's health IT initiatives, including the EHR Incentive Program; it will continue to be enhanced over time.<sup>25</sup> The website includes program guidance, resource documents, news articles, and links to other sites.

## 4.2 Future IT System Architecture

### 4.2.1 MMIS and MITA

The current Texas Medicaid Management Information System (MMIS) has been described as a “complex association of business operations, policies, procedures and computer processing, and subsystems performed in partnership with a coalition of vendors known as the Texas Medicaid & Healthcare Partnership (TMHP).”<sup>26</sup> The MMIS is a federally certified MMIS that includes a data warehouse of claims and encounters that provides an ad hoc query and reporting platform and decision support system (DSS) functionality for skilled or power users. This platform is used to analyze various aspects of Medicaid and CHIP service delivery through claims, encounters, eligibility, and provider data. The current MMIS system adjudicates both Medicaid acute and long-term claims in a fee-for-service environment. It takes in encounter data (claims paid under capitated managed care contracts with HHSC and managed care organizations (MCOs)) and processes the encounter data for storage, analytics, and reporting in the existing data warehouse. The encounter data is received from Medicaid and CHIP MCOs in the form of 837 transactions submitted directly to the HHSC fiscal agent.

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The Provider Management Modernization Project is a HHSC project to decouple the provider management services from the TMMIS and addresses new provider screening and enrollment requirements resulting from the Affordable Care Act. The project implements a McKesson COTS solution, centralizes the provider data repository to support provider enrollment, promotes web services where appropriate as the preferred choice for the access and retrieval of provider data, and creates an online provider directory accessible by external and internal

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<sup>25</sup> See: [http://www.tmhp.com/Pages/HealthIT/HIT\\_Home.aspx](http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx).

<sup>26</sup> Texas HHSC RFP for Consultant to Assist in the Procurement for the Design, Development and Implementation of the Replacement Medicaid Management Information System (MMIS), No. 529-10-0074, June 28, 2010

users. The project initially supports Medicaid providers, but will be expanded over time to support providers for other programs across the Texas HHS system.

The Eligibility as a Service is a project that will provide a single source of eligibility information for all programs processed within the Texas Integrated Eligibility Redesign System (TIERS). This solution will contain near real-time eligibility, utilize standardized web services for access, and will be in the format of the TIERS source system. The project will be implemented in phases from standing up a robust infrastructure to support large volumes that Texas expects to experience. Systems will be migrated from legacy interface files in outdated formats in coordinated, cost-efficient steps. This solution is being constructed with the vision in mind to include other State programs enterprise-wide currently not processed through TIERS.

The MITA 3.0 assessment noted that although each of the Texas HHS operating agencies has sound internal processes and systems, the Texas HHS enterprise needs to continue increasing MITA maturity capabilities and that this can be accomplished by focusing on sharing data, aligning common processes, and actively managing the satisfaction level of providers, members, and other entities that interact with the enterprise.

Part of the rationale of MITA is to review an organization as business processes across Medicaid and help identify capabilities and plan to improve the maturity levels of these processes across the Texas HHS Enterprise. This requires executive decision-making and guidance as to what level of *integration* and *standardization* will be developed across Medicaid. .

As the MITA 3.0 Assessment stated, “ Data shared across agencies represents the highest priority opportunity for service development across HHS.”<sup>27</sup> . The goal of any EA, like MITA, is to reduce barriers to effectively working together, reduce processes and information flows since they make more work for providers who serve clients with multiple needs, and eliminate duplicative technology design, development and implementation costs.

A key initiative identified in the MITA 3.0 Assessment and currently in planning to support the long term vision of reducing the compartmentalized nature of Texas Medicaid is the Enterprise Data Warehouse/Business Intelligence project. Recently completed requirements gathering identified Texas Medicaid’s needs for client-centric, clinical views of integrated, episodes of care and drug utilization patterns to paint a picture of a client’s complete life history.

The EDW/BI project expects to support initiatives such as health care reform and HIE by providing timely and accurate information, enabling retrospective and predictive analytics to achieve the strategic visions of improved outcomes, reductions in cost of care, and improvements in quality of care. Implementation planning and procurement strategies for the EDW/BI system will be closely coordinated with MMIS replacement and re-procurement planning decisions. Until the EDW/BI system is in place, however, HHSC and its fiscal agent will continue to employ recently acquired analytical tools and consulting services through OPTUM Insight (formerly Ingenix). The OPTUM Insight Impact Pro tools will be used and available across the Texas HHS Enterprise to:

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<sup>27</sup> Ibid.

- Identify Medicaid members at clinical risk;
- Identify intervention opportunities (cost drivers);
- Assess the value and quality of health care delivery programs;
- Predict future needs based on current consumption patterns; and
- Monitor MCO performance based on established quality parameters.

#### 4.2.2 Other Critical Projects

The purpose of HITECH is not as an end in itself but a “*means of improving the quality of health care, the health of populations, and the efficiency of health care systems.*”<sup>28</sup> HHSC will use opportunities in HITECH to actively work to align its projects and procurements so that they reinforce this purpose, and will seek opportunities to “reuse” information and technical capabilities rather than further compartmentalizing programs and maintaining silos of information and technology systems.

One area of focus is the Texas Department of Aging and Disability Services (DADS), which operates the State Supported Living Center (SSLC) system. DADS is one of five agencies within the Texas HHS system. The SSLC system supports approximately 3,900 developmentally disabled individuals in 13 centers around the state. Approximately 97 percent of the SSLC population is Medicaid-enrolled.

In support of SSLC operations, DADS is developing an implementation strategy for the SSLC Electronic Health Record (EHR) enhancement. This is in accordance with the DADS SMHP vision of including long-term care (LTC) as an equal participant in meaningful use of electronic health record technology and health information exchange (HIE). DADS will request federal financial participation through HHSC for this project.

SSLCs have the goal of achieving meaningful use of electronic records to improve transitions of care and health outcomes for SSLC individuals. The SSLC EHR system requires enhancement in order to fully meet meaningful use. In addition to meaningful use, the SSLC EHR system must also support custom forms to record other encounters with individuals related to the delivery of long term care services. Approximately 70 forms used in the SSLCs continue to be paper based. Staff working in SSLCs currently use a combination of electronic and paper records. Some clinical services are recorded on paper forms and later entered into the electronic system. The lack of real-time availability of clinical service data presents challenges for medical staff providing care for SSLC individuals.

##### 4.2.2.1 Barriers to full implementation and meaningful use of Electronic Health Records in SSLCs:

In addition to the system enhancements necessary to achieve meaningful use, other improvements are necessary in order to fully adopt and optimize the use of electronic health record technology in SSLCs. Increased bandwidth and a high-availability environment are

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<sup>28</sup> David Blumenthal, M.D., M.P.P., “Stimulating the Adoption of Health Information Technology,” NEJM, April 9, 2010.

needed in order to fully support a complete transition to EHR use. The transition will require a change to processes in a way that aligns with EHR use. Staff in SSLCs will need to be fully trained in the use of the technology in order to ensure a successful transformation.

### **Planned Improvements:**

DADS will request FFP in order to:

- Upgrade to ONC-certified software to support meaningful use of EHR, including HIE implementation.
- Assess and improve infrastructure to support the EHR system, provide high-availability, increased bandwidth, and wireless device support.
- Develop a limited number of custom forms currently maintained on paper to facilitate continuity of care improvements for SSLC individuals.
- In order to create a baseline of electronic records, procure contract data entry staff to enter one year of information for existing individuals in the SSLCs (one-time effort).
- Augment IT staff in order to support expanded use of the technology.
- Augment training and change management staff to support learning and transformation management.
- Enhance reporting capabilities.
- Pilot at one SSLC prior to deploying to entire SSLC system.
- Roll out improvements to all SSLCs statewide.

### **4.3 Future HIE Governance Structure**

The chief governance challenges facing the Texas HHS Enterprise are how to coordinate projects and maintain alignment across the enterprise, Medicaid, and statewide and national initiatives related to EHR adoption and interoperability.

As previously referenced, HHSC has 24 IT-related projects identified in the MITA 2.0 To-Be Roadmap that was developed prior to the enactment of ARRA and the ACA. These two initiatives will significantly impact the growth of and demand for IT-enabled projects beyond those that are currently envisioned. To achieve interoperability for meaningful use, the Medicaid/CHIP Division will need to ensure continued collaboration with eligible professionals and hospitals and ongoing coordination activities with the RECs, HIEs, and THSA.

In Texas Medicaid, internal governance will be achieved through a governance body that is chaired by the Medicaid Director and includes the Medicaid Health IT Director, other Medicaid division managers, and key MMIS vendors. This body will be responsible for day-to-day governance and operational oversight on projects that are completely within the Medicaid/CHIP division. However, Medicaid has a presence in other HHSC agencies and Medicaid health IT projects will cross agency boundaries. These cross-agency projects will be governed by the Medicaid health IT governance body and will be coordinated through the Office of e-Health Coordination. The OeHC is organizationally placed in the Office of Health Policy and Clinical Services which oversees all health related programs and services across the

HHSC Enterprise, including Medicaid. As such, the Office of e-Health Coordination is formally recognized within the HHSC Enterprise as the coordination point for all health IT activities that cross organizational boundaries within the HHSC Enterprise (see Sec. 3.9).

Another central point of coordination and governance is the Medicaid Electronic Health Information Exchange Advisory Committee. This committee has broad representation, including representatives from all HHSC agencies and the OeHC. There are also committee members that represent THSA, regional HIEs, the RECs, health plans, hospitals, dentists, pharmacies and physicians. The role of the advisory committee is to review Medicaid plans and projects and provide guidance, advice, continuity, and direction to Medicaid on Health IT.

While there are separate and distinct responsibilities for the successful implementation of the HIE infrastructure and programs, there are many more interdependencies that call for Medicaid to have a key role in the governance and implementation of the HIE infrastructure. The Medicaid Health IT Director and staff have been active participants in THSA's workgroups to develop the statewide HIE plan. Medicaid plans to continue to participate in HIE planning and implementation activities as they unfold. The Medicaid Health IT Director, the CEO for THSA and the HHSC eHealth Coordinator (State HIT Coordinator) have established quarterly coordination calls with stakeholders to keep all parties informed.

#### **4.4 Technical Assistance to Providers for Adoption and Meaningful Use of EHR Technology**

The RECs have agreed to facilitate provider outreach for the EHR Incentive Program, including links to the HHSC website for registration and attestation in the program. With CMS approval, HHSC is contracting with the RECs to support EHR adoption of Medicaid, specialist physicians that treat high cost areas in Medicaid: asthma, diabetes, behavioral health, and heart disease. This technical support is consistent with the criteria and fees per the RECs agreement with the Office of the National Coordinator for Health IT (ONC). Details are described in the SMHP, Appendix G.

#### **4.5 Addressing Populations with Unique Needs**

During the 2009 Texas 81<sup>st</sup> Legislative Session, the Texas legislature passed Senate Bill 1824, which addresses quality measures and other issues of children with special health care needs (CSHCN)<sup>29</sup>. The bill also created a task force to develop a five-year plan to improve the coordination, quality, and efficiency of services for children with special needs. This legislative framework, in conjunction with health IT initiatives and meaningful use measures, provides the cornerstone for collecting evidence-based measures of quality care for CSHCN using the HIE infrastructure developed for Texas Medicaid. Medicaid will continue to pursue further discussions with the Special Needs Task Force regarding how the program will leverage health

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<sup>29</sup> According to the federal Maternal and Child Health Bureau, children with special health care needs are defined as "those who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

IT initiates and the EHR Incentive Program to improve health outcomes for children with special health care needs.

#### **4.6 Using Grant Awards for Implementing EHR Incentive Program**

HHSC received \$4 million in Medicaid Transformation Grant funds to develop and enhance the Foster Care Health Passport and to begin development of the infrastructure for Medicaid HIE, such as a standardized data exchange with the State laboratory for Medicaid lab results, implementing the HIE pilot (discussed earlier), including an HIE opt-out consent process, and enhancements to the MEHIS infrastructure for health information exchange.

Overall, the implementation of the Foster Care Health Passport was considered a success and is currently operating as envisioned. Following the April 2008 implementation of the Passport, HHSC's Medicaid and CHIP Division held several sessions to discuss and obtain feedback on "lessons learned" from staff involved in the development and implementation of the Passport and STAR Health.

Working closely with DSHS, Medicaid staff also used transformation grant funds to develop a standardized HL7 data exchange and web service for sharing laboratory test results. These test results include lab tests associated with THSteps assessments, newborn screening, and other tests performed exclusively by the state lab. While the electronic lab results are currently being shared with the Health Passport, the results will be available to providers through MEHIS by mid-2013.

#### **4.7 Need for New State Legislation**

Texas HHSC does not anticipate the need for new legislative changes in order to implement the EHR Incentive Program. DSHS may need legislation, however, to support expanded data sharing, as utilization limitations exist on certain collected data.

#### **4.8 Medicaid Participation in Funding Health Information Exchange**

The State is exploring ways to create sustainability in HIE initiatives, including requiring participation by as many payers in the state as possible. At such time as such a plan develops, it is anticipated that Texas Medicaid will participate at a level commensurate with the relative proportion of the population covered by Medicaid, as will likely be expected of each payer. The details of such a plan will be submitted as an I-APD-U. At this time, no assumptions are being made about CMS' approval of such a plan.

#### **4.9 Summary**

HHSC is utilizing this planning process to further refine its vision as a value purchaser. HHSC understands and supports the primary purpose of the HITECH EHR Incentive Program—to support the adoption and meaningful use of certified EHRs to improve health outcomes, care quality and cost efficiency. Additionally, HHSC recognizes that Texas Medicaid cannot be fully engaged in this vision without additional changes. Thus, the goals for this program must align with other HHSC activities and provider-level activities to e-enable improved health outcomes.

HHSC will also need to continue to work on aligning current and future activities—the MMIS re-procurement, health IT activities in departments and programs across the Texas HHS Enterprise, and coordination of the state-level HIE strategy and approach—with SMHP goals to create and reinforce the message of change. The result will be improved health outcomes for Texans.

## 5. THE EHR INCENTIVE PROGRAM

### 5.1 Summary

This Executive Summary provides an update on the status and progress of the Texas Medicaid EHR Incentive Program, as well as a brief narrative and more detailed graphical overview of the registration, attestation and payment disbursement process for the EHR Incentive Program.

#### 5.1.1 Texas Medicaid EHR Incentive Program Implementation Progress / Timeline

The Texas Medicaid EHR Incentive Program launched on February 28, 2011. Texas began disbursing incentive payments on May 7, 2011. The following implementation timeline demonstrates the key milestones in the implementation of the EHR incentive program.

- February 28, 2011: Texas Medicaid EHR Incentive Program launches.
- May 7, 2011: Texas initiates EHR incentive payment disbursement.
- December 3, 2011: Enrollment for 2011 Year 1 (AIU) incentive payments to eligible hospitals (EHs) is closed (64 day attestation tail).
- February 29, 2012: Enrollment for 2011 Year 1 (AIU) incentive payments to eligible providers (EPs) closes (60 day attestation tail).
- January 9, 2012: Texas launches Meaningful Use attestation portal for EHs.
- April 1, 2012: Launch of Meaningful Use attestation portal for EPs.

As of September 10, 2013, Texas Medicaid had disbursed \$534,801,288 in incentive payments to EPs and EHs. Payments have been made to 6,436 EPs, totaling \$146,816,333. Payments have been made to 289 EHs, totaling \$387,984,955. One hundred forty three (143) EHs have successfully attested to meaningful use (Year 2 payment) totaling \$124,253,068. One thousand three hundred ninety eight (1,398) EPs have successfully attested to meaningful use in Year 2, totaling \$11,786,678 in payments.

The HHSC Budget and Accounting Divisions have specific guidelines for administering ARRA funds. Separate and unique Department account identification numbers (IDs) are assigned to ARRA projects. These IDs are coded on all ARRA requisitions and EHR Incentive Program payments, as applicable. The IDs are used to separately track and report ARRA funding for the EHR Incentive Program, including 100 percent Federally funded incentive payments and the 90 percent HIT Administrative match.

As described by CMS, the first step in the EHR Incentive Program is registration in the National Level Repository (NLR). HHSC receives notification of the registration via the B6 file from CMS. HHSC then sends a communication by e-mail to NLR-registering providers to contact them about the rest of the attestation and payment disbursement process for Texas Medicaid. The communication specifies that the first step is to check if they are enrolled in Medicaid under the National Provider ID (NPI) that they used to register in the NLR and describe what provider

types are eligible. All information provided parallels information on the HHSC and TMHP websites.

A more detailed narrative description of how Texas Medicaid administers the program follows the Executive summary, organized as follows:

*5.2 Hospital Eligibility Attestations*

*5.3 Eligible Professional Eligibility Attestations*

*5.4 Appeals*

*5.5 Payment Assignment and Disbursement*

*5.6 Capturing Meaningful Use and Outcomes Measures*

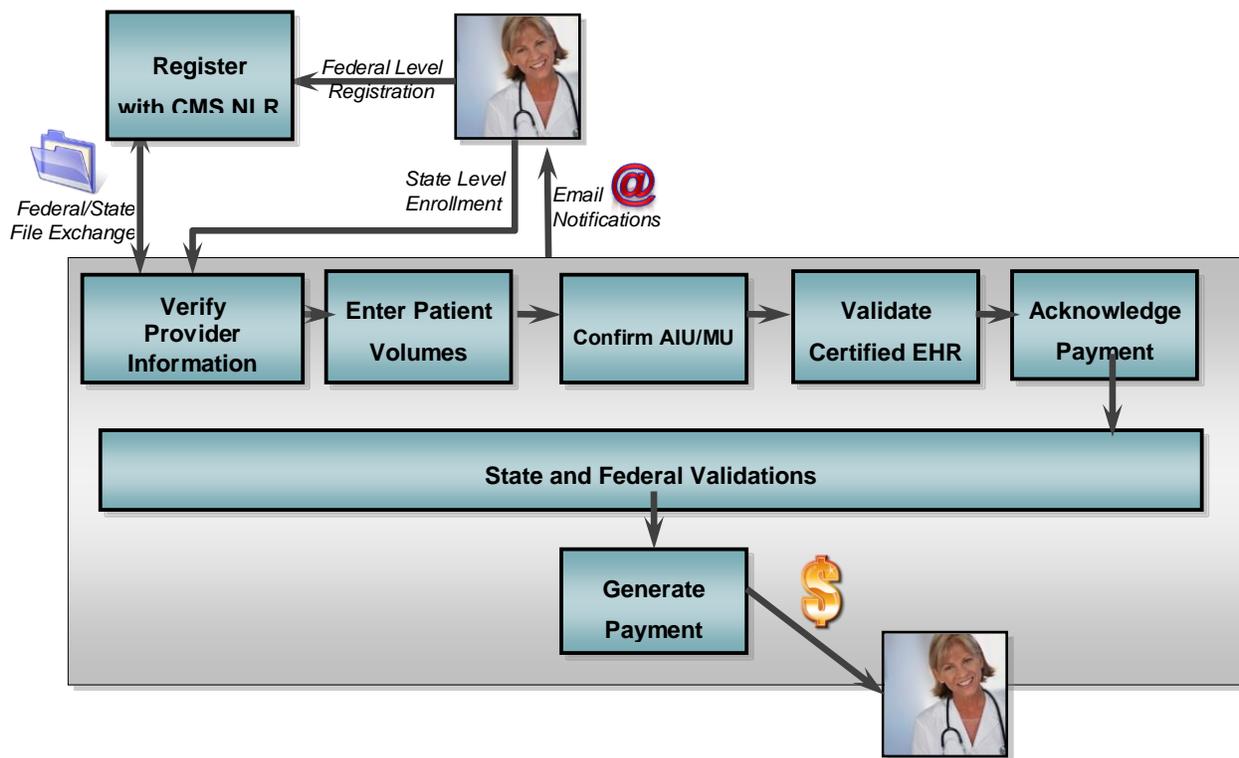
*5.7 Changes to Information Systems and Implementation Vendor Contracts*

Providers submit eligibility attestations for Texas Medicaid EHR incentives using an online portal developed by HHSC's contracted vendor, CGI, Inc. The portal is known as Medicaid Incentive 360, or MI360®. To facilitate completion of the process, detailed instructions and online assistance is provided to help providers calculate patient volume and attest to completed information. At any time during the enrollment process, providers may seek assistance or updates on the status of their eligibility, enrollment, or payment by contacting the EHR Incentive Program's dedicated business services center by phone or email. Program specialists are available Monday through Friday from 7 a.m. to 7 p.m. CST to answer questions and help navigate providers through the attestation process.

As detailed below, completing the online process will fulfill all provider attestations and other requirements to receive incentives. Upon successful submission of an attestation, a provider receives an email confirmation that they have reached "payment pending" status. Upon final review and approval of their attestation, the provider receives a second email notification that payment has been issued. Payment will be made within 45 days after incentive payment is approved. EPs may use the portal to assign the payment to themselves or to their group or clinic. Texas's attestation and payment procedures are graphically laid out below in Figure 5.

HHSC may also follow-up with providers who fail to complete the online enrollment. HHSC will track all providers who register as Texas Medicaid applicants with the NLR. The names of providers who do not complete the online process with HHSC will be retained so that HHSC may reach out to these providers about their participation in the EHR Incentive Program.

**Figure 5. High Level Provider Attestation and Payment Process Workflow**



## 5.2 Hospital Eligibility Attestation

After receiving notification of CMS registration, HHSC confirms that the hospital is licensed and not sanctioned and also confirms the Provider ID as a Medicaid-enrolled hospital provider. This confirmation occurs electronically between the EHR incentive enrollment system (MI360) and the TMHP provider database. HHSC sends an e-mail communication to the hospital to with information to complete the enrollment process. Hospitals then complete the enrollment process in the MI360 portal. In the MI360 portal, hospitals attest to sufficient Medicaid practice volume, financial elements of the incentive formula, AIU of certified EHR technology, and meaningful use for providers who have reached the meaningful use stage.

Per federal guidelines, EHs follow a federal fiscal year schedule for participation in the EHR incentive program. HHSC provides a 75-day “attestation tail period,” or grace period at the end of each federal fiscal year to allow EHs to complete their attestation. EHs must be in “payment pending” status by the end of the grace period; otherwise, the current year eligibility is cancelled and the EP is automatically rolled over into the next program year.

### 5.2.1 Hospital Volume Attestations

The next step of the hospital process asks the acute care hospitals to attest to patient volumes. Hospitals have the option to use a 90-day volume reporting period from the previous fiscal year or from the most recent continuous 12-month period prior to attestation. Portal screens provide hospitals with the capability to enter Medicaid and total encounter data needed to calculate their patient volume percentage. Eligible hospitals are required to have a minimum of 10

percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment, except children’s hospitals, which do not have a Medicaid volume threshold requirement. Medicaid and total discharges are listed on the hospitals’ cost reports. HHSC cross-checks these numbers from the cost reports in order to verify the information entered by the hospitals.

### 5.2.2 Hospital Adopt, Implement and Upgrade Attestation

In the next step of the process, hospitals attest to the adoption, implementation or upgrade (AIU) of a certified EHR system. HHSC validates that the EHR is certified by checking against ONC’s web service for EHR certified products and obtaining a CMS EHR certification number. If a hospital did not provide a CMS EHR certification number, Texas requires eligible hospitals to submit this information from the “Certified HIT Product List” (CHPL) before proceeding through the portal. The hospital is also required to upload AIU documentation such as a purchase order, contract, or other verifiable document. The screen capture below demonstrates the AIU requirements.

The screenshot shows the Medicaid EHR Incentive Program portal for Texas Health Presbyterian Hospital Plano (NPI:1770514077). The current enrollment status is displayed, showing that Step 1 (Registration Verification) and Step 2 (Volume Determination) are completed, while Step 3 (Adopt, Implement, Upgrade) and Step 4 (Payment Determination) are not completed. The main section is titled "Step 3 - Adopt, Implement, Upgrade Certified EHR Software" and includes a red asterisk indicating a required field. It provides definitions for Adoption, Implementation, and Upgrade. Below this, there is a section for "Adopt, Implement, Upgrade Attestation" with radio buttons for "Adopt", "Implement", and "Upgrade". A text field for "CMS EHR Certification ID" contains the value "30000001SWQYEAS". There are checkboxes for "Financially and Legally Binding Supporting Documentation" including Purchase Order, Contract, EHR Software License, and Other. At the bottom, there are buttons for "Previous", "Upload AIU Documents", and "Save & Continue".

### 5.2.3 Hospital EHR Payment Calculation

Attesting hospitals are guided through the EHR payment calculation in the MI360 portal. Hospitals are instructed to enter data directly from the appropriate Medicare cost report and other data sources to calculate the growth factor, overall EHR amount, and Medicaid share. An onscreen example is also provided to assist hospitals with their calculations. All hospitals are subject to pre-payment audit which includes a review of cost report data elements. This, along

with previous automated eligibility verifications, ensures that hospitals' calculations and attestations are compliant with the federal statute and program regulations.

The screen capture below shows the summary of the hospital incentive payment calculation.

The screenshot displays the Medicaid EHR Incentive Program interface. At the top, it shows the Texas Health and Human Services Commission logo and the text "Connect for Quality Care". The page title is "Medicaid EHR Incentive Program" with a "Logout" link. A navigation bar includes "Home", "Enrollment", "Documents", "Appeals", "Status", and "Manage Account". The main content area is for "Texas Health Presbyterian Hospital Plano (NPI-1770514077)".

**Current Enrollment Status**

Hospital: Texas Health Presbyterian Hospital Plano(CCN 450771)	Program Year: 2012	Payment Year: 1
Step 1 - Registration Verification Status: Completed ✓	Step 3 - Adopt, Implement, Upgrade Status: Completed ✓	
Step 2 - Volume Determination Status: Completed ✓	Step 4 - Payment Determination Status: Not Completed ⚠	

**Step 4 - EHR Payment Determination Introduction**

The system will perform the payment calculation of the EHR incentive payment for you. To begin this calculation, you will be required to provide details for your participation in the Medicaid Program. The aggregate EHR incentive amount is based on a four year program model. Your aggregate EHR Incentive Payment will be distributed on the following payment schedule:

- Year 1 - 50%
- Year 2 - 40%
- Year 3 - 10%

**Aggregate EHR Incentive Payment Calculation**

The Base Amount of your EHR Incentive Payment is calculated as the product of two factors:

- Overall EHR Amount:**
  - Sum of:
    - Year 1 - (Base Amount of \$2,000,000.00 - (Number of Discharges [1150 - 23,000] \* \$200.00) \* Transition Factor(1.00))
    - Year 2 - (Base Amount of \$2,000,000.00 - (Number of Discharges [Year 1 Discharge \* Annual Growth Rate] \* \$200.00) \* Transition Factor(.75))
    - Year 3 - (Base Amount of \$2,000,000.00 - (Number of Discharges [Year 2 Discharge \* Annual Growth Rate] \* \$200.00) \* Transition Factor(.50))
    - Year 4 - (Base Amount of \$2,000,000.00 - (Number of Discharges [Year 3 Discharge \* Annual Growth Rate] \* \$200.00) \* Transition Factor(.25))
- Medicaid Share:**
  - Sum of:
    - Estimated number of Medicaid inpatient-bed-days
    - Estimated number of Medicaid managed care inpatient-bed-days
  - Divided by the product of:
    - Estimated total number of inpatient-bed-days during the period
    - Estimated total amount of charges during that period, not including any charges that are attributable to charity care, divided by the estimated total charges during the period
- Aggregate EHR Incentive Amount = Overall EHR Amount \* Medicaid Share**

Buttons for "Previous" and "Save & Continue" are visible. The footer includes the website [www.hhsc.state.tx.us](http://www.hhsc.state.tx.us) and logos for "NS SECURE network solutions" and "DATA PROTECTION".

If the hospital is attesting to AIU, after completing the calculations, the hospital reviews a summary page and a legal statement and then confirms the accuracy of the attestation by submitting an electronic signature. If the hospital is attesting to Meaningful Use (MU) and is a Medicaid-only hospital, data must be manually entered for the MU Core measures, MU Menu measures, and clinical quality measures (CQMs). If the hospital is a dually eligible hospital participating in both the Medicare and Medicaid EHR Incentive Programs, the State receives an electronic transmission of the hospital's Medicare MU attestation data from CMS. Receipt of the Medicare MU data indicates that CMS has deemed the hospital to be a meaningful user. The data is populated in the hospital's Medicaid attestation record for review by the hospital, but manual entry is not required. In all cases, the hospital reviews a summary page and a legal statement and the person completing the attestation confirms the accuracy by entering an electronic signature. Upon confirming and submitting the attestation, the hospital receives an email that the attestation is complete and they are moved to "payment pending" status. The CGI Business Services Center then conducts a pre-payment audit of the hospital's attested data. If approved, the hospital is added to the weekly payment cycle and TMHP issues the payment.

## 5.3 Eligible Professional Eligibility Attestation

After receiving notification of CMS registration, HHSC confirms that the eligible provider (EP) is licensed, not sanctioned, and not deceased (see Section 5.3.1). The confirmation is routed electronically between the EHR incentive enrollment system and TMHP. HHSC then sends an e-mail to inform them about the rest of the enrollment and attestation process.

HHSC verifies the status of the EP's enrollment in Texas Medicaid. Some EPs may need to complete a Medicaid enrollment process or update their existing enrollment in Medicaid in order to receive the incentive payment directly.

EPs then complete the attestation process in the portal. In the portal, providers attest to Medicaid practice volume, AIU of certified EHR technology, and meaningful use for providers who have reached the meaningful use stage.

Per federal guidelines, EPs follow a calendar year schedule for participation in the EHR incentive program. HHSC provides a 75-day "attestation tail period," or grace period, at the end of each calendar year to allow EPs to complete their attestation. EPs must be in "payment pending" status in the MI360 portal by the end of the grace period; otherwise, the current year eligibility is cancelled and EPs are automatically rolled over into the next program year.

### 5.3.1 Medicaid Enrollment

The first element of the online attestation portal is to confirm the Provider ID as a Medicaid-enrolled provider. In some cases, providers may register in the NLR with NPIs that are not known to Medicaid. This is because some performing Medicaid providers (e.g., physicians that practice in FQHCs and RHCs or nurse practitioners that practice under a physician), currently bill for their services using the NPI and Taxpayer Identification Number (TIN) of an associated provider or their clinic and are therefore not recognized Medicaid billing providers in the Texas MMIS. In order to issue an incentive payment, an EP must be enrolled in Medicaid under their personal NPI-TIN, except in the case of EPs who attest as practicing predominantly in a federally qualified health center (FQHC) or rural health clinic (RHC). For billing purposes, Texas currently enrolls FQHCs and RHCs in Medicaid with a "facility" designation and the State does not require individual FQHC/RHC providers to enroll. However, in order to participate in the EHR Incentive Program, Texas requires FQHC/RHC providers to complete, at a minimum, a streamlined limited enrollment process to obtain a Texas Medicaid Identification number (TPI) for use in the Program.

The limited enrollment is only valid for participation in the EHR Incentive Program and cannot be used for billing claims. The provider is required to identify the NPI that is currently used for billing. Under the limited enrollment, the incentive payment must be assigned to the billing NPI-TIN. Alternatively, if the EP wishes to receive the payment directly they must assign the

payment to their personal NPI rather than the NPI they use for billing, and they are required to complete the full Medicaid provider enrollment process as a billing provider.

Texas also requires that EPs who are attesting as part of a group practice using the group Medicaid volume calculation must be formally enrolled as a member of the group practice in the MMIS system. This helps the State identify all of the legitimate group members and facilitates verification of the group volume.

The following sources are matched for verification prior to enrollment:

- The “Do Not Enroll List” – HHSC/TMHP list of providers who are barred from enrolling in Medicaid for various reasons.
- The Open Investigation List – list of providers under open investigation by the Office of the Inspector General (OIG). Providers must be cleared by OIG before being allowed to enroll in Medicaid.
- The Health and Human Services Commission – providers are checked for good standing with HHSC.

To verify a licensure, the provider’s current standing is reviewed with the following entities:

- Texas Medical Board
- Texas State Board of Dental Examiners
- Texas Board of Nursing
- Texas Physician Assistant Board

In addition to verifying Medicaid enrollment, an EP is also verified as an eligible provider type. This verification happens through an automated check in MI360 of the EP’s provider type/specialty code from MMIS. The eligible provider types are:

1. Physician (Doctor of Medicine or Doctor of Osteopathy)
2. Nurse Practitioner
3. Dentist
4. Certified Nurse Midwife
5. Physician Assistant (PA) who practices predominantly in an FQHC or RHC so led by a PA. (PAs are required to submit a signed form attesting to the PA-led status of the clinic where they practice.)

The Texas Medicaid EHR Incentive Program does not include Doctors of Podiatry, Optometry, or Chiropractic as eligible provider types. However, a Texas State Plan Amendment (SPA) was submitted to CMS on June 28, 2013 to allow Doctors of Optometry to qualify for the incentive program. The SPA is currently under review by CMS.

### **5.3.2 Attesting to Medicaid Patient Volume**

The EHR incentive portal provides EPs with the capability to enter Medicaid and total encounter data needed to calculate patient volume percentage using either the encounter,

panel or group option. EPs must meet the 30% Medicaid patient volume threshold, except for pediatricians who may qualify with a minimum of 20% Medicaid patient volume. For purposes of the Texas Medicaid EHR Incentive Program, a pediatrician is defined as a Doctor of Medicine, Doctor of Osteopathy, or Doctor of Dentistry who has completed a residency or is board certified in a pediatric specialty. EPs who attest as pediatricians are required to upload verifying documentation.

EPs must also show sufficient non-hospital practice volume and meaningful use for providers who have reached the meaningful use stage. Hospital-based status is verified electronically between the MI360 enrollment portal and the TMHP provider database. Hospital-based claims and encounters can be determined by place of service codes 21 (Inpatient Hospital) and 23 (Emergency Department or ED setting), therefore an enrolling EP's encounters are analyzed to determine if an enrolling EP appears to have more than 90% of his encounters in a hospital setting. Hospital-based status is determined by a review of the previous 12-month period of the EP's Medicaid encounter data. If the EP has more than 90% of his Medicaid encounters in a hospital setting, supporting documentation – such as non-Medicaid encounters - is requested to support a non-hospital based determination. Otherwise, the EP is determined to be hospital-based and is ineligible for the program. The hospital-based review is carried out for all providers during pre-pay audit.

The first step of the EP attestation process asks EPs to attest to non-hospital practice volumes and Medicaid volumes. As allowed by the EHR incentive regulation, Texas will give EPs the choice of reporting encounter volume or for primary care providers with patient panels, adjusting the patient encounter volumes to include current Medicaid managed care and primary care case management (PCCM) patients. Panel patient counts must be unduplicated from other patient encounters included in the calculation. If an EP wishes to attest using patient volume from multiple locations, they must attest as an individual using either the encounter or panel option.

EPs are required to have a minimum of 30 percent Medicaid for all patient encounters over any continuous 90-day period within the most recent calendar year prior to enrolling or in the continuous 12-month period preceding the date of attestation. There are two exceptions:

- Pediatricians qualify if they have at least 20 percent Medicaid patient volume for all patient encounters over any continuous 90-day period within the most recent calendar year prior to enrolling or in the continuous 12-month period preceding the date of attestation.
- EPs practicing predominantly in an FQHC or RHC must have a minimum of 30 percent patient volume attributable to “needy individuals” for all patient encounters over any continuous 90-day period within the most recent calendar year prior to enrolling or in the continuous 12-month period preceding the date of attestation. “Practices predominantly” is defined as having more than 50% of an EPs total encounters in an FQHC or RHC during a six-month period within the previous calendar year or the 12-month period preceding the date of attestation. Needy patient encounters are defined as:

- Medicaid or CHIP encounters.
- Uncompensated care by the provider.
- Encounters from services provided at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

The patient volume calculation for each option is described below. EPs choosing to attest using the patient panel methodology will also use a continuous 90-day reporting period within the most recent calendar year prior to enrolling or in the continuous 12-month period preceding the date of attestation.

#### ***5.3.2.1 For EPs Attesting to Patient Volume Using the Encounter Methodology***

All providers will attest to their number of patient encounters including Medicaid fee-for-service, Medicaid managed care, Medicaid second payer and all other payers. In order to facilitate pre- and post-payment audits, as necessary, we are asking the EPs to demonstrate their Medicaid share of encounters to be three consecutive calendar months. Our solution uses Medicaid claims as an independent verification of attestations, and this check will be significantly facilitated by having calendar month-based attestations. The program develops profiles for providers using a rolling full-month approach where provider profiles are refreshed using a data file with encounter volumes by month, by provider. This facilitates quick and efficient verification of volume attestations. Medicaid will encourage providers to use full-three month attestations whenever possible. However, in accordance with federal rules, providers may also attest using a consecutive 90-day reporting period. Since its inception, the Texas Medicaid EHR Incentive Program has accommodated both a 3-month and 90-day reporting period. Any further references in the Texas MHP to the 3-month volume reporting period are assumed to include the 90-day option as well. It should also be noted that if providers select partial months, volume attestations will need to be validated with provider-specific, date-specific queries which may delay the payment.

Using the encounter methodology, all Medicaid encounters are counted during the three month period for the provider. This includes fee-for-service encounters as well as managed care encounters as the numerator. The denominator is total encounters for the same three month period. If the provider meets the threshold, no further validation is required. If not, primary care providers for Medicaid managed care organizations are offered the option to include panel patients to their patient counts as described in section 5.3.2 below.

Encounters are calculated around count of claims and encounters per performing provider. We anticipate three months of claims lag in populating our claims database for purposes of verifying EP attestations. For that reason, for providers applying in January and February of a given year, we notify them that selecting November or December of the previous year as attestation months may lead to delay in processing their application, as we will likely need to request additional documentation of Medicaid claims for claims submitted within three months of application. We encourage providers to select alternative months in order to facilitate confirmation of their attestation without the need for additional information. In accordance

with the Stage 1 final rule, in 2011 and 2012, a Medicaid encounter was defined as services rendered on any one day to an individual where Medicaid paid for all or part of the services, including premiums, co-payments, or cost-sharing. In accordance with Stage 1 changes outlined in the Stage 2 Final Rule, beginning in 2013 the definition of a Medicaid encounter was revised to include all services rendered on any one day to a Medicaid-enrolled individual, regardless of payer. This allows for the inclusion of zero-pay and denied Medicaid claims in the calculation of Medicaid patient volume. Texas does not have an 1115 waiver that involves non-encounter based provider reimbursement.

#### ***5.3.2.2 For EPs Attesting to Patient Volume Using the Panel Methodology***

Medicaid also provides EPs the option to attest to Medicaid panel assignments plus patient encounters which are unduplicated from panel counts. In other words, encounters are counted over a three month period and then managed care patients are added as long as they are not duplicated. Panel patients can only be counted under the condition that the patient has been seen within the 24 months before the 90-day attestation period.

This information supports application of the Stage 1 final rule's eligibility formula for providers using patient panels to establish eligibility.

#### ***5.3.2.3 For EPs Attesting to Patient Volume Using the Group Option***

Medicaid provides an option for physicians or other EPs practicing in a group or FQHC/RHC to attest to patient volume by group or clinic workload. In the Texas MMIS system, a provider can have more than one Texas Provider Identification Number (TPI). Therefore, in the Texas EHR Incentive Program, a group is defined by TPI in combination with Tax Identification Number (TIN). Individuals and entities (such as multiple sites for the same group practice/clinic) can be grouped under various TPIs if they fall under the same TIN. For a one-site group practice with one TPI and one TIN, all the providers under that TPI and TIN would be included in the group if they choose to attest using the group proxy method. For a practice or clinic with multiple sites, it is up to the practice to designate which of the TPIs will make up the group or groups. As long as the different TPIs fall under the same TIN, they can form a group. Once a group is formed, all members must use the same group volume methodology (i.e. some group providers cannot choose to attest using their individual volume within the clinic).

The group volume option still requires an individual to use the MI360 portal to complete the attestation process for each provider claiming incentives. In other words, providers using this option may impute the group's patient volume for their individual attestation. Texas will require EPs using the group volume calculation to attest that:

- (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP in the group only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- (2) each provider in the group have at least one (1) Medicaid encounter during the calendar year of the reporting period up until the date of attestation;
- (3) there is an auditable data source to support the clinic's patient volume determination; and

(4) so long as the practice and EPs decide to use one methodology for the same participation year (in other words, clinics cannot have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).

### 5.3.3 Adopt, Implement and Upgrade (AIU) Attestation

In the next step of the attestation process, EPs attest to the adoption, implementation or upgrade of a certified EHR system by entering the CMS EHR certification number. HHSC validates that the EHR is certified by checking against ONC’s web service and validating the CMS EHR certification number. EPs are required to attach supporting documentation. All EPs are reviewed during pre-payment audit to verify documentation. Documents may be added via the EHR incentive portal. (Enrolling providers are instructed that they should retain evidence of their EHR acquisition in their files in case they are selected for audit.

**Table 7: Documentation to Show Evidence of Adopted, Implemented or Upgraded**

Type of Use	Evidence— <u>Any</u> of the below
<b>Adopted</b>	<ol style="list-style-type: none"> <li>1. Purchase Order</li> <li>2. Contract</li> <li>3. Software License</li> </ol>
<b>Implemented</b>	<ol style="list-style-type: none"> <li>1. Purchase Order</li> <li>2. Contract</li> <li>3. Software License</li> </ol>
<b>Upgraded</b>	<ol style="list-style-type: none"> <li>1. Purchase Order</li> <li>2. Contract</li> <li>3. Software License</li> </ol>

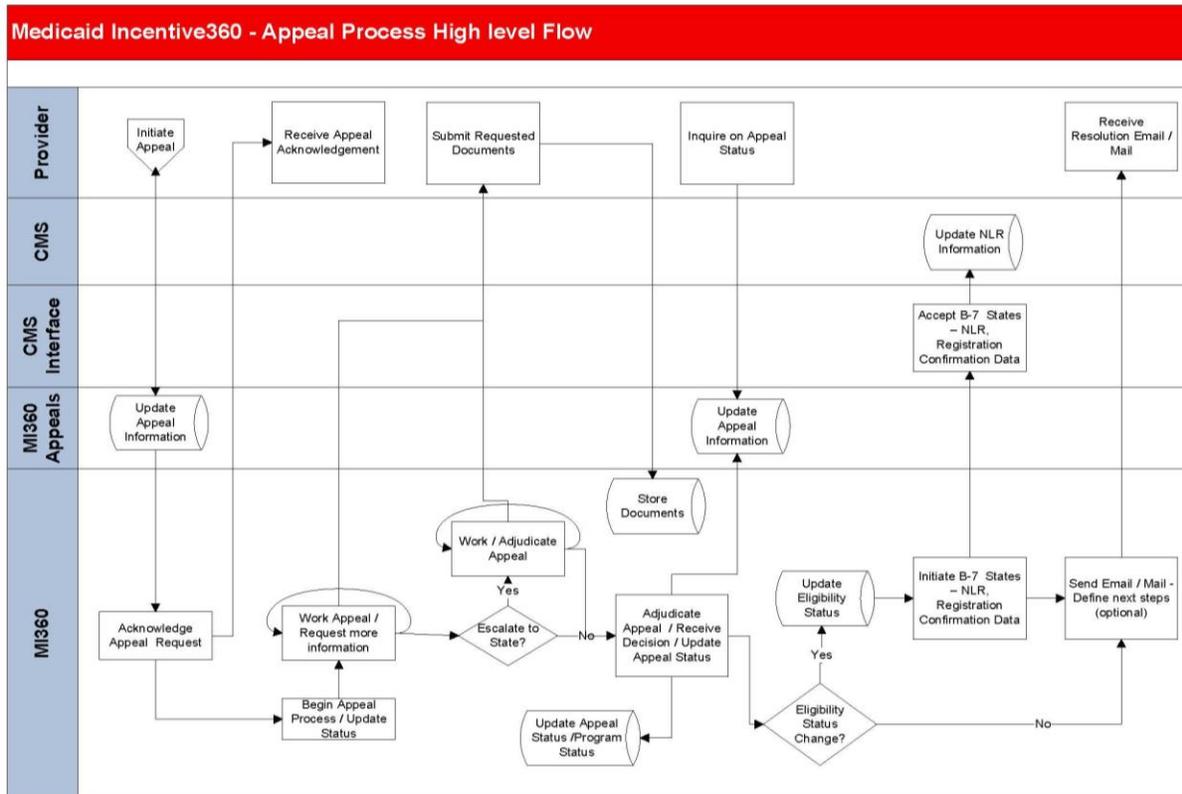
## 5.4 Appeals

Texas Medicaid has established an appeals process for three distinct conditions in accordance with federal regulation:

1. Appeals regarding provider eligibility regarding a determination of Medicaid volume or other eligibility criteria.
2. Appeals regarding payments, with individuals participating who can speak to both hospital and EP data sources.
3. Appeals regarding EHR use—adopt, implement and upgrade (Year 1) and meaningful use (Year 2) of EHRs.

All three appeal types are conducted by the program administrator upon submission of an appeal by the provider through the MI360 portal. If the program administrator rejects the appeal, the final appeal will be referred to the Medicaid/CHIP Health IT division within HHSC.

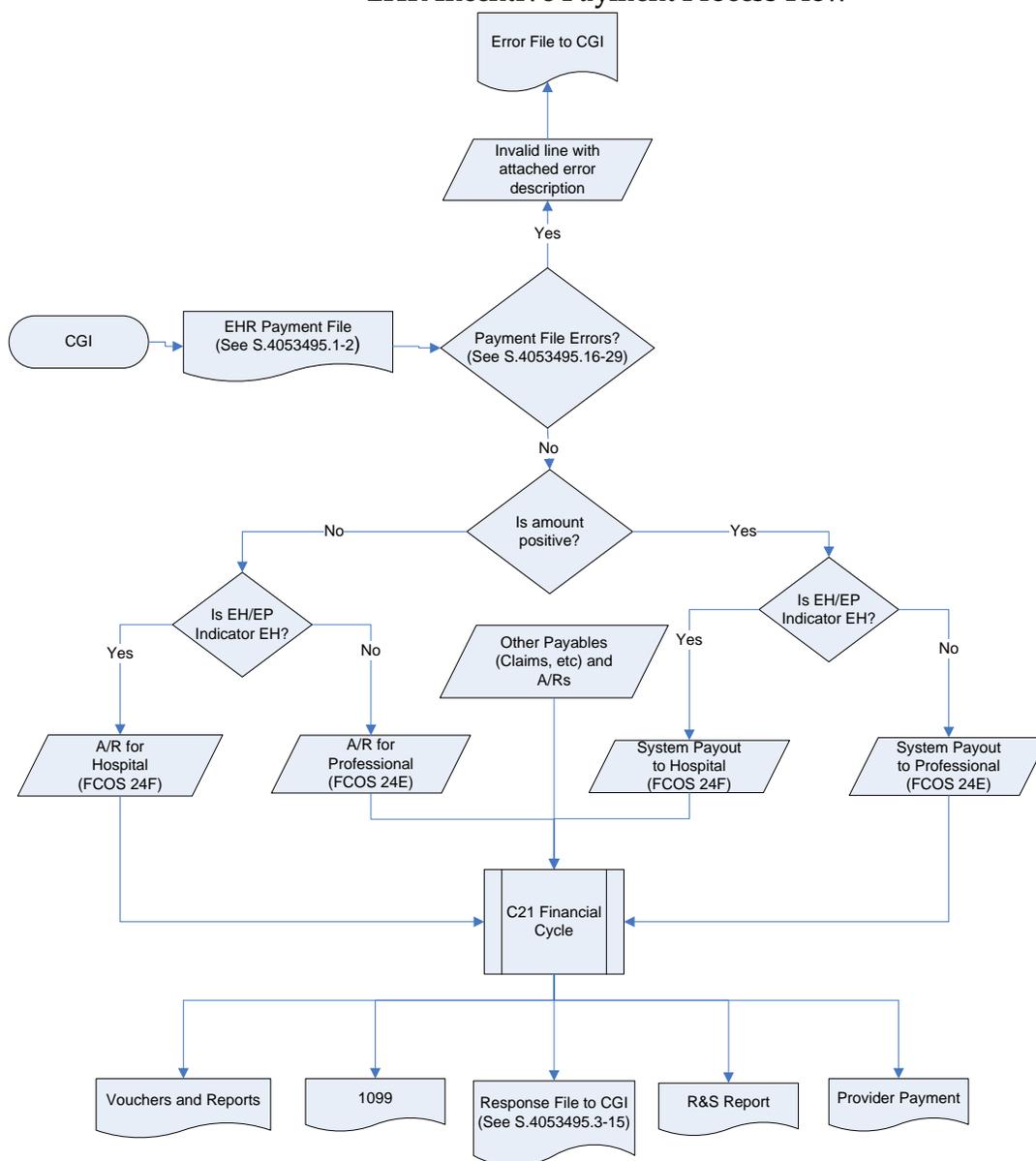
This process is detailed graphically below. (A separate appeal process for post-payment audit determinations is described in Section 6 (Audit Strategy)).



## 5.5 Payment Assignment and Disbursement

Payments are made weekly to each qualifying provider through the payment system in the Texas MMIS which routinely validates the appropriate NPI and Taxpayer Identification Number (TIN) based on the provider’s Medicaid enrollment information. A qualifying provider may only receive one incentive payment per year of program participation. Payments are cycled weekly through a payment notification file from CGI to TMHP which triggers execution of payment directly to the provider or assigned payee. HHSC does not charge fees, administrative costs or other deductions to the provider’s payment. If a provider has an existing account receivable owed to Texas Medicaid, a portion of the payment may be withheld to satisfy the Medicaid debt, per CMS guidelines. Payment is made in the first month following successful attestation and incentive payment approval (not to exceed 45 days from approval). Texas Medicaid does not disburse incentive payments through Medicaid managed care plans. Existing OIG/Medicaid audit requirements apply to EHR incentive payments. Audit procedures are detailed in Section 6. The diagram below details the payment processing flow for EHR incentive payments.

## EHR Incentive Payment Process Flow



In addition to issuing payment to the individual provider or hospital, payment for eligible professionals can be assigned, at the EP’s discretion, to an employer or an affiliated entity such as a practice or clinic with which the EP has a contractual arrangement allowing the employer or entity to bill and receive payment for the EP’s covered professional services designated by the provider.

For eligible hospitals, Medicaid has the flexibility to spread out hospital incentive payments over as few as three or as many as six years. Texas wants to give the hospitals most of their EHR incentive support quickly. Texas therefore uses a three-year payout for the incentives. The hospital payout schedule is 50 percent in the first year, 40 percent in the second year, and 10 percent in the third year.

### 5.5.1 Providers Practicing at More Than One Site

The provider cannot assign split incentives across multiple entities; only one incentive payment will be issued each year for any one provider. An EP who works at multiple sites may combine his/her individual patient volumes to attest as long as those volumes have not been already used as part of a group volume calculation at any of the sites. An EP can attest as an individual and assign the payment to himself or herself; or an EP may instead choose to assign the incentive payment to one of the employers or contracted billing entities. How they allocate the incentive payment with their associates is at their own discretion.

### 5.5.2 Assigning Payments to Entities Promoting EHR Adoption

HHSC does not designate any 'Entities for Promoting EHR Adoption'. Therefore, the option for providers to assign incentive payments to such entities is not available. However, HHSC may decide to designate promoting entities in the future. If so, HHSC will obtain CMS approval before proceeding and the SMHP will be updated accordingly.

## 5.6 Capturing Meaningful Use and Outcomes Measures

In accordance with the EHR incentive regulation Texas began accepting attestation of AIU in 2011 and Stage One meaningful use beginning in 2012. HHSC will implement Stage 2 requirements in January 2014 for EEs and April 2014 for EPs.

After receiving approval from CMS for the State's meaningful use attestation design, the MI360 portal for hospital attestation was put into operation on January 9, 2012. On February 9, 2012, Texas submitted the wireframe design for the EP attestation portal for meaningful use. CMS approved the portal design on March 15, 2012, and Texas launched the EP meaningful use portal in April 2012.

The MI360 attestation portal for meaningful use (MU) is similar to the AIU portal. EPs who attest for meaningful use complete the same series of eligibility questions that are completed for AIU, including attesting to Medicaid volume (group or individual) and type of certified EHR technology (CEHRT). After meeting the eligibility requirements, EPs are directed to a series of screens that guide them through attestation for each of the core and menu MU measures, as well as clinical quality measures (CQMs).

Dually eligible hospitals that complete MU attestation in Medicare prior to Medicaid are deemed as Medicaid meaningful users when HHSC receives the acknowledgement from CMS on the C-5 file exchange. Dually eligible hospitals must still complete the eligibility questions in the MU portal, including attesting to Medicaid volume and type of CEHRT used.

Medicaid-only hospitals complete a full Medicaid MU attestation in the MI360 portal. These hospitals are guided through screens similar to the EP portal that allow them to attest to each of the MU core and menu measures, as well as CQMs.

Texas began collection of CQMs in 2012. Texas may also select a portion of the broader meaningful use measures for electronic reporting for purposes of verifying meaningful use as well as for broader quality improvement purposes. Texas has not yet made the determination

which, if any, of the meaningful use measures will be selected for electronic reporting. However, all meaningful use and CQM attestation data is currently captured in the MI360 system and is available to HHSC for reporting purposes. In addition, HHSC is exploring opportunities available in the ONC's *popHealth* software service as a means to gather and analyze statewide meaningful use data submitted by Texas Medicaid providers..

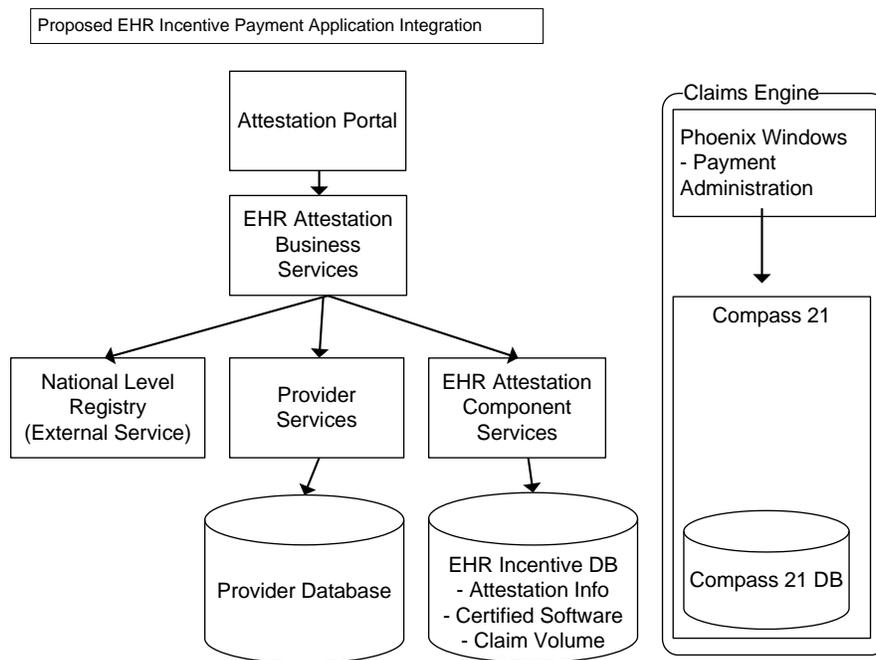
The Medicaid program intends to adopt a “learning environment” approach to the implementation of this program, both internally with staff and externally with providers. In addition to planning for system needs, HHSC needs to consider how to assist its workforce to develop the required analytical capabilities needed for a changing environment, including the need for clinical decision support (CDS) capabilities to support value-based purchasing, policy development and program improvement.

Texas did not propose any state-specific changes in the first stage of meaningful use and does not propose any MU modifications for Stage 2.

### 5.6.1 IT Systems Changes

Systems changes to the TMHP portal presentation, and batch interfaces with external and internal databases, are summarized in the graphic below.

**Figure 6. TMHP System Changes**



### 5.6.2 Schedule of Systems Changes:

### Fall of 2010—Provider Enrollments and CMS Interfaces

1. Modifications to provider subsystems for eligibility determinations. Modifications will include an interface with the National Level Repository. The fall 2010 timeframe is dependent on successful testing of the NLR interface in October 2010.
2. For the EHR incentive portal, Medicaid will provide the capability for EPs and hospitals to provide supporting documentation by uploading to a web portal using specified file types.
3. Call center software modifications will be made to answer provider questions.
4. Reporting/extracting from the claims/encounters data warehouse will require a new extraction format. (Claims are only a data source, so there are no systems changes needed to the claims subsystem itself.)

### First Quarter 2011—Payment Systems and Audit Systems

1. Administrator conducts payment determinations using new elements of the provider portal.
2. Claims system is updated to generate incentive payments.
3. Audit flagging mechanism is built into the provider portal and interface with the audit team.

### Second Half 2011 Changes (for 2012 Go-Live)—Receipt of Quality Measures:

Meaningful use data and clinical quality measures are captured in the MI360 portal via manual entry by the provider.

Systems costs were funded as follows. Modifications for the NLR Interface and eligibility determinations were claimed under the I-APD submitted in October 2010. HHSC uses the HIT I-APD for all changes to MMIS that are related directly to EHR incentive administration. Short-term changes were primarily limited to interfaces. Significant changes to MMIS systems were not required, and to the extent possible, system changes for the administration of the EHR incentive program were decoupled from the MMIS to avoid unintended problems with the current MMIS operations, and aid in the potential transition when the MMIS is re-procured. Any significant changes to the claims system or to other MMIS components, should they become necessary, will be preceded by an amended HIT I-APD.

## **5.7 Existing Contractors' Roles in EHR Incentive Administration**

TMHP, the fiscal agent and contracting organization for MMIS and Medicaid administration, is integrally involved in implementation. This relationship incorporates MMIS functions, exchange of data files such as the provider encounters extract to compare reported Medicaid volume with actual volume, and execution of incentive payments. In addition, one TMHP staff person (Project Specialist) is dedicated to the EHR Incentive Program help desk and assists providers with Medicaid enrollment for the incentive program. Medicaid managed care organizations (MCOs) are not directly involved in implementation, since all MCO providers are also enrolled in Medicaid Fee-For-Service (FFS), and already provide encounter data for purposes of eligibility verification.

## **6. THE STATE'S EHR AUDIT STRATEGY**

### **6.1 Executive Summary**

HHSC will conduct manual and automated checks of provider attestations against auditable data sources such as Medicaid claims on a pre- and post-payment basis. Based on these checks, HHSC issues requests for additional documentation in response to gross discrepancies between HHSC data sources and provider attestations. Other program integrity functions are also conducted. HHSC contracts with an outside audit vendor to conduct post-payment audits for AIU for EPs and EHs, as well as meaningful use audits for EPs and Medicaid-only hospitals. CMS is responsible for auditing dually eligible hospitals, while the State maintains authority to audit the Medicaid-only hospitals.

Detailed post-payment audit methods are described in the State's separately approved EHR Incentive Program Audit Plan.

### **6.2 Auditing Attestations for Discrepancies with Auditable Data Sources**

For most types of eligible professionals and hospitals, Texas has identified auditable data sources that can be checked by HHSC to provide an initial check of Medicaid volume attestation prior to payment. HHSC conducts pre-payment eligibility audits on all eligible hospitals (EHs) and conducts pre-payment eligibility verification of all eligible professionals (EPs). As described below, HHSC verifies a number of eligibility criteria in the pre-payment audits, including eligible provider type, non-hospital based (EPs), and Medicaid volume verification. For example, if a provider attestation is out of line (>1.33 variance factor, or 33% discrepancy) with independently verifiable data such as available Medicaid claims data and cost reports, HHSC sends a request for additional information to support the attestations. Medicaid asks the provider to supply billing or other financial documentation and compares their documentation with Medicaid claims data. If the provider cannot adequately document their Medicaid volume or other eligibility criteria, the provider 'fails' the pre-payment audit and is denied payment.

#### **6.2.1 Hospital Screening Process**

Hospital attestations regarding Medicaid volume submitted during the provider enrollment process are checked against available HHSC data. All EHs are subject to pre-payment audits and checks. Some EHs will also be selected for random or targeted post-payment audits. The main data source for the state to verify hospital attestation regarding Medicaid volumes is hospital Medicaid cost reporting. Hospitals that also receive Disproportionate Share Hospital (DSH) payments are advised to remove unpaid days from their attestation calculation and are required to upload supporting documentation. HHSC also verifies the hospital incentive payment amount calculation and the average length of stay for acute care hospitals (including critical access hospitals).

**Table 8: Hospital Data Sources**

Type of Payer	Auditable Data Source
<b>Medicaid FFS and Medicaid FFS second payer (Duals)</b>	Hospital cost reporting
<b>Medicaid managed care</b>	Medicaid DSH reports for DSH hospitals, Medicaid Encounter Database (I-CHP) for other hospitals
<b>Charity care</b>	Medicaid DSH reports for DSH hospitals.
<b>All other payers</b>	Hospital cost reporting

### 6.2.2 Eligible Professional Screening Process

EP attestations regarding non-hospital volume submitted during the EHR incentive enrollment process are checked against available HHSC data for accuracy. Since all EPs are subject to pre-payment audit, all EPs undergo this volume check. If the EP's attested volume differs from HHSC auditable data sources by more than a factor of 1.33 (in favor of the EP), the EP is contacted by the Business Services Center (BSC). The EP is asked to submit additional documentation to verify Medicaid volumes. In addition to pre-payment screening, some EPs will be selected for post-payment audit (random or targeted). To facilitate reporting of patient volume workload, the Medicaid program developed a tool that creates a provider profile of Medicaid client counts based on historical claims and encounter data. Audit screening identifies possible hospital-based providers and EPs with insufficient Medicaid volume to be eligible. We use provider profiles based on Medicaid claims and encounters as a check of attestations in both areas.

For each eligible provider type, a number of data sources may be used for pre- and post-payment audits of EHR incentive payments:

- **Physicians:** Medicaid claims and Medicaid managed care capitation payments and encounter data.
- **Nurse Practitioners and Certified Nurse Midwives:** Medicaid claims and Medicaid managed care capitation payments and encounter data. Nurse practitioners (NPs) and Certified Nurse Midwives (CNMs) must have their own NPI to qualify. If an NP or CNM does not have a billing history, he or she must provide documentation of supervising physician relationship and cite that physician's Medicaid claims history or provide other documentation to support his/her Medicaid volume. If an individual provider (of any type) is not enrolled in Medicaid for payment under a separate NPI, he or she must enroll in Medicaid and receive a Texas Medicaid Provider Identifier (TPI) number to receive payment.
- **Dentists:** Medicaid claims and Medicaid managed care capitation payments and encounter data.

- **FQHC/RHC-based professionals:** HHSC does not have a record of individual FQHC/RHC provider Medicaid claims because FQHC/RHC providers bill Medicaid claims through their clinic rather than individually. Therefore, at the time of attestation, all self-identified FQHC/RHC-based professionals must provide supporting documentation for their attested Medicaid volumes.
- **Physician Assistants:** At the time of attestation, physician assistants must sign and upload a “Physician Assistant (PA) Attestation Form” to confirm that they work at an FQHC/RHC that is “so-led” by a PA. The form is posted on the Texas Medicaid Provider website<sup>30</sup> and linked to the MI360 attestation portal.

Texas has a number of major cities near the border with other states (e.g., El Paso, Dallas, and Houston) that serve residents from other states. Eligible professionals are instructed to look at Texas Medicaid volume to determine if volume is sufficient. They are also given the opportunity to include out-of-state encounters. However, if they need to include out-of-state Medicaid encounters (numerator) in their patient volume attestation, they are instructed that they also need to include out-of-state encounters in their total (i.e., denominator).

For attestations of non-hospital-based status, if more than 90% of Medicaid claims appear to be inpatient or from an emergency department, the discrepancy triggers HHSC to request additional information from the provider. We use both Place of Service and Procedure Code from Medicaid physician claims to generate the provider profile of all physicians, nurse practitioners (NPs), certified nurse midwives (CNMs) and dentists with NPI numbers in the system. The specific coding that will define hospital-based services, specifically inpatient and emergency department services which require the use of CPT codes to identify those services will be as follows:

- Place of Service code = Facility,
- Procedure Code = CPT for Evaluation & Management Code, In-hospital consultation, or
- CPT for ED-delivered service.

### 6.3 Other Methods to Identify Suspected Fraud and Abuse

Existing Medicaid audit functions are overseen by the Claims Administrator Operations (CAO) unit within HHSC’s Medicaid and CHIP Division. The program administrator, CGI, oversees automated pre-payment verifications for AIU as well as manual pre-payment AIU audits. CGI verifies eligibility criteria, including Medicaid volume, on a pre-payment basis for all EPs and EHS. In certain cases, providers are sent to full audit which requires them to provide additional documentation on all AIU requirements. For post-payment audits, HHSC contracts with an independent auditing firm for auditing services. The costs for this contract are incorporated into the annual I-APD Post-payment audits are conducted based on risk analysis and statistical sampling. Audits focus on information attested to for the EHR Incentive Program, including but not limited to provider type eligibility, patient volume, AIU of a certified electronic health

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<sup>30</sup> [http://www.tmhp.com/Provider\\_Forms/Health%20IT/PA%20Led%20Form\\_Texas\\_FINAL.pdf](http://www.tmhp.com/Provider_Forms/Health%20IT/PA%20Led%20Form_Texas_FINAL.pdf)

record system, and achievement of meaningful use. The audit contractor conducts AIU audits of EPs and EHs, and meaningful use audits of EPs and Medicaid-only hospitals. Volume, scope, methods, and procedures are based on risk assessments and are materially consistent with HHSC audit protocols. The HHSC HIT unit, with support from the HHSC External Audit Division and the HHSC Office of the Inspector General (OIG), will respond to requests for information on the EHR Incentive Program from external audit groups (e.g., CMS program reviews, DHHS Office of Inspector General, etc.). If suspected fraud or abuse is identified, the case will be referred to the OIG for investigation. A separate audit plan was submitted to CMS for review and approval prior to implementing post-payment audits. The audit plan was approved on May 6, 2013 and describes in greater detail HHSC's strategy for verifying proper payment of EHR incentive dollars to eligible providers and hospitals and ensuring recoupment of any improper payments.

### **6.3.1 Tracking Overpayments**

Overpayments to providers are tracked in Accounts Receivable reporting via TMHP's financial system. Overpayments are also processed through the EHR attestation system to document the change in payment amount through the adjustment process. Any identified overpayments will result in a state action request from HHSC to TMHP and handled according to Medicaid's current process for recouping overpayments.

### **6.3.2 Fraud and Abuse Detection**

When fraud or abuse is detected, a referral will be sent to OIG. In accordance with documented processes, referrals to the OIG result in investigations and reviews of fraud, waste, and abuse in the provision of all health and human services, enforcement of state law relating to the provision of those services, and provision of utilization assessment and review of both clients and providers. The OIG works closely with the Office of the Attorney General to prosecute provider fraud and ensure no barriers exist between the two offices for fraud referrals.

### **6.3.3 Providers with Cross-state Catchments**

For the retrospective audit of EPs, Texas Medicaid will supplement the audits of Medicaid claims and use the provider's electronic claims systems, which will be particularly helpful for providers with multi-state patient bases. HHSC also discussed sharing Medicaid claims, by NPI, with the other states in CMS Region 6, for audit purposes.

### **6.3.4 Verifying Meaningful Use**

EPs and EHs who attest to meaningful use are subject to the same eligibility and CEHRT review as in the AIU pre-payment audit. In June 2013 HHSC began requiring all EPs and Medicaid-only EHs to upload copies of their EHR-generated meaningful use (MU) reports to support their MU attestation. The reports are verified against the provider's manually-entered data and if discrepancies are found, a request for additional information is made. Upload of the reports will also help providers maintain documentation in the event of a post-payment audit. For certain yes/no MU measures, such as enabling drug-drug and drug-allergy checks, a screenshot or other documentation is required to demonstrate that the functionality was turned on at the

time of attestation. For the measure to conduct a security assessment, a copy of the assessment or relevant documentation is required. For the public health data submission measures, the provider must submit a registration number (for immunizations) and/or letter or email from the public health agency verifying their submission. Additional detail on pre-pay MU verification is contained in HHSC's separate Audit Plan.

HHSC conducts two additional MU verification checks during attestation. An EP is asked for additional information if he/she enters a denominator in one or more of the following MU measures that is greater than the reported number of unique patients: Core 1, 8, 9 or Menu 6. These measures use a subset of unique patients for the denominator, so the value should be smaller or equal to total unique patients reported. An EP is asked for additional information if he/she has entered a denominator in one or more of the following MU measures that does not match the reported number of unique patients: Core 3, 5, 6, 7 or Menu 7. These measures use a denominator equal to total unique patients, therefore the denominator values should match.

Post-payment audit of meaningful use is described in the State's separately approved Audit Plan.

### **6.3.5 Sampling as an Audit Strategy**

Texas Medicaid and its selected vendor conduct post-payment audits of provider incentive payments. Audits are conducted based on statistical sampling and risk assessment (random and targeted). Volume, scope, methods, and procedures are materially consistent with existing auditing standards and protocols. Risk-based sampling is based on a variety of criteria or triggers, such as low volume, use of free EHR software, FQHC status, etc., among other triggers that are determined with our audit contractor. Statistical sampling for lower risks also occurs through random sampling. HHSC works with the audit contractor to determine the appropriate sample sizes and methodology, which are described in greater detail in the separate audit plan.

Additionally, CGI Solutions, Inc. has designed and built an audit enhancement to the MI360 Business Services portal that will allow HHSC and the audit contractor to query for random and risk-based sampling of the provider population. This interface provides a tracking system for post-payment audits conducted by the State. It also allows for electronic reporting of audits to CMS in the designated E7 file format.

### **6.3.6 Reducing Provider Burden**

HHSC is taking a number of steps to maximize the use of administrative and clinical data to minimize requests for documentation and audit risk for providers. As new data sources become available, the State will leverage those sources to help reduce a provider's administrative burden.

### **6.3.7 Notification and Appeal of Post-Payment Audit Findings**

HHSC has established a policy for notification of audit and provider appeal of an adverse finding in a post-payment audit, as follows:

- (A) notify the EP or EH of the impending desk or field audit. If the EP or EH is subject to a field audit, the EP or EH must be notified not later than the seventh day before the date the field audit begins, except when the element of surprise is critical to the audit objective;
- (B) limit the period covered by an audit to three years;
- (C) be conducted and reported in accordance with Generally Accepted Governmental Auditing Standards (GAGAS) issued by the Comptroller General of the United States or other appropriate standards;
- (D) conduct an exit interview at the close of a field audit with the EP or EH to review the agency's/auditor's initial findings; in the case of a desk audit, provide an audit results notification to the EP or EH with the agency's/auditor's initial findings;
- (E) at the field audit exit interview or in response to an audit results notification, allow the EP or EH to:
  - a. Respond to the questions by the agency/auditor;
  - b. Comment, if the EP or EH desires, on the initial findings of the agency/auditor, and
  - c. Submit additional supporting documentation, for consideration, that meets the auditing standards required by (C) above, to correct a questioned eligibility criterion, payment amount, or other program requirement, if there is no indication that the error or omission that resulted in the questioned item demonstrates intent to commit fraud;
- (F) permit the EP or EH to produce, for consideration, documentation to address any exception found during an audit not later than the 10<sup>th</sup> day after the date the desk audit or field audit is completed;
- (G) deliver a draft audit report to the EP or EH not later than the 60<sup>th</sup> day after the date the desk audit or field audit is completed to support a proposed adjustment to the EP's or EH's EHR incentive payment;
- (H) permit the EP or EH to submit, for consideration, a written response to the draft audit report appealing the findings in the draft audit report not later than the 30<sup>th</sup> day after the

date the draft audit report is delivered to the EP or EH. The appeal will consist of a desk review by HHSC in conjunction with the auditing division or contractor;

- (I) the auditor may elect whether to issue a revised draft report or to issue a final report; the auditor may revise the draft report as needed to incorporate the management responses and reconsideration of any initial findings; and
- (J) deliver the final audit report not later than the 180<sup>th</sup> day after the date the desk audit or field audit is completed.

The appeal policy is posted on the EHR Incentive Program website at TMHP and included in the audit findings notice sent to providers. A provider who fails a post-payment audit and does not successfully appeal the finding will be subject to recoupment of the incentive payment for the program year under audit. The provider will not be allowed to re-attest to the same program year but may continue to attest in subsequent years of the program.

#### **6.4 HHSC Program Integrity Operations**

Program Integrity is monitored in a number of areas in the Health and Human Services Commission, including at the Health and Human Services Commission's Office of Inspector General (OIG). OIG works to prevent and reduce waste, abuse and fraud within the Texas health and human services system. The OIG works closely with all health and human services agencies and programs, and coordinates with local, state and federal law enforcement agencies to uphold the highest standards of integrity and accountability.

The OIG Audit Section consists of four Audit Units performing engagements consistent with the mission of the OIG. Three of these Audit Units, the Hospital Audit Unit, the Managed Care Organization Audit Unit, and the Contract Audit Unit have a scope of work that broadly encompasses EPs and EHs participating in the EHR Incentive Program. The Hospital Audit Unit audits various aspects of hospitals participating in the Medicaid program. The Managed Care Organization Audit Unit audits managed care entities participating in the Medicaid program. The Contract Audit Unit audits Medicaid service providers other than those covered by the Hospital Audit Unit and the Managed Care Organization Audit Unit. All Audit Units use a risk based approach for conducting their work, and all work is conducted in compliance with Government Auditing Standards and the Principles and Standards for Offices of Inspector General.

## **7. OUTREACH AND EDUCATION**

### **7.1 Plans to Encourage Provider Adoption of Certified EHR Technology**

To successfully achieve its communications vision, Texas Medicaid has implemented and continues to develop new activities to encourage provider adoption of certified EHR technology and other health information technology (IT) initiatives. The steps planned fall into three major categories: education, outreach (provider, client, enterprise staff, and legislature), and coordination.

The Health IT division within Texas Medicaid is responsible for leading the education and outreach efforts to providers and clients regarding the Texas Medicaid EHR Incentive Program, and supporting the education and outreach efforts of other health IT initiatives. HIT Communications staff are involved in developing the messages that are part of Texas Medicaid's education campaign, devising appropriate outreach strategies, obtaining feedback from providers and other stakeholders to improve education and outreach activities, and assisting with coordination of education and outreach across the Texas HHS Enterprise and among external stakeholders.

### **7.2 Key Messages**

#### **7.2.1 Informing Providers about the EHR Incentive Program and other Health IT Initiatives**

Texas Medicaid uses consistent, accurate, and up-to-date information about the EHR Incentive Program rules and eligibility criteria, specifically processes about registration, verification of eligibility, payment, appeals and other processes. The agency also works with other stakeholders to help providers understand the definitions and stages of meaningful use.

Texas Medicaid targets specific messages to particular eligible professionals (EPs) (e.g., physicians, dentists, certified nurse midwives, nurse practitioners, and certain physician assistants) to promote their participation. For example, each stage of meaningful use is and will be defined, and the instructions for attesting are clearly laid out. Materials continue to be developed to ensure this information is communicated accurately.

Additionally, staff will assist in the development of materials and coordinate the outreach for other health IT topics.

#### **7.2.2 Promoting Administrative Benefits of Adopting EHR Technology**

Educational efforts will emphasize the opportunities for providers to reduce administrative burdens through adoption and meaningful use of certified EHRs. The communications plan to encourage adoption of certified EHR technology among Texas Medicaid providers will include linking its clinical management benefits and administrative efficiencies with the rollout of other planned health information systems improvements in Texas Medicaid.

### 7.2.3 Making the Case for Quality Improvement through Health Information Technology

Providers must make an investment in certified EHRs before they can obtain the EHR incentive payment. Among providers who may resist or delay adoption of health IT, it will be important to highlight the evidence on quality improvement, including improved quality of care, better care coordination and more streamlined continuity of care that can result from using EHR technology and exchanging health information. In addition, Texas Medicaid, in coordination with administrators of Texas Health Steps (the EPSDT program) and MCOs, will specifically promote the advantages and benefits of certified EHRs. For example, providers who participate in Texas Health Steps will be able to use certified EHRs to improve their ability to comply with required EPSDT medical assessments, upon which their performance is often evaluated.

### 7.2.4 Educating Texas HHS Enterprise Staff about Health IT Initiatives

For the Medicaid EHR Incentive Program and other Health IT initiatives to be successfully implemented, affected staff within the Texas HHS Enterprise need to have a basic understanding of the programs, their role in supporting the goals of the programs, and how the programs may impact their operations. With an increased focus on quality outcomes, health IT is a critical enabler to reaching these quality goals. Some communications will be directed internally to Texas HHS staff about these topics and how programs can be coordinated.

## 7.3 Outreach and Education

### 7.3.1 Provider Outreach

Texas Medicaid is pursuing several strategies for reaching out to providers about Texas Medicaid Health IT initiatives, including the Medicaid EHR Incentive Program, and why they are being pursued. The key strategies include: presenting at provider stakeholder meetings, provider webinars, leveraging HHSC web-based communications, and leveraging other stakeholder communications.

#### 7.3.1.1 Presentations at Stakeholder Meetings and Conferences

Texas Medicaid makes periodic presentations to the following internal and external stakeholders:

- Provider association conferences – presentations and exhibitor tables
- Provider association meetings – to gather feedback and share information
- Texas Medicaid HIE Advisory Committee
- Regional Advisory Committees (RACs) throughout the state
- Public Assistance Health Benefits Review Committee
- Managed Care Organization (MCO) Quarterly Meetings
- Texas Health Steps Rural Clinic Provider Conference
  - Expert forums for THSteps
  - Regional workshops

- Lunch and Learn sessions within HHSC – Health IT topics
- Division directors affected by the EHR Incentive Program and other Health IT initiatives

### *7.3.1.2 Articles and Other Outreach – External Stakeholders*

Texas Medicaid Health IT reaches out to a multitude of external stakeholders for the purposes of sharing HIT information and initiatives, soliciting feedback and input, and opening dialogue about concerns or barriers. This outreach can take the form of articles, resource documents, news items, program updates and reminders, meetings or conference calls, and more. External stakeholders include, but are not limited to, the following:

- Provider associations (20 or more)
- Texas e-Health Alliance
- Texas Health Services Authority (THSA)
- Local and regional HIMSS meetings and events
- Health Information Exchange (HIE) organizations – directly or through the Texas HIE Coalition
- Regional Extension Centers (RECs)
- GovDelivery notices via email to a Health IT distribution list across the state

### *7.3.1.3 Targeted Communications*

Texas Medicaid collects information on eligible providers who have registered with CMS for the incentive program but who have not yet begun the enrollment and attestation process at the state level, or providers who have attested to early stages of the program but seem to have stopped participation. Texas Medicaid will continue to pursue a strategy of direct outreach to these providers via email and/or other means to encourage them to complete the attestation process.

### *7.3.1.4 Provider Webinars*

Texas Medicaid Health IT staff are featured speakers on periodic REC webinars. Topics to date have included audit, Texas Medicaid registration, EHR Incentive Program rules and attestation, and Meaningful Use stages.

Texas Medicaid will also host periodic webinars to reach out to all providers in the state, including those in rural areas. The agency will use these forums to communicate about health information technology and the Medicaid EHR Incentive Program, and to learn about and address providers' concerns and the barriers they may be experiencing in adopting EHR technology or participating in other health IT initiatives.

### *7.3.1.5 HHSC Web-Based Communications*

The TMHP website, which Texas Medicaid providers are already familiar with, is the primary source of web-based communication for the Medicaid EHR Incentive Program. A dedicated health information technology page has been added to the TMHP website at [http://www.tmhp.com/Pages/HealthIT/HIT\\_Home.aspx](http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx) and this serves as the source of information for the Medicaid EHR Incentive Program, as well as other health IT projects. The

web page contains program rules, resource documents, step-by-step instructions for program participation, news articles, Frequently Asked Questions (FAQs), previous presentations, a hospital payment calculator, and links to online resources for providers. Eligible professionals and hospitals will also log in to the MI360 attestation portal from their account on the TMHP website. TMHP also posts Health IT articles, banner messages, and other documents on the main provider sections of the website, as well as a bi-monthly Texas Medicaid Bulletin

Health IT initiatives and information are also included on the Texas Health and Human Services Commission (HHSC) website. This website is accessed more widely across Texas, whereas the TMHP website is primarily provider-focused.

A new statewide website is under development, which will be used by health IT stakeholders in Texas for the purpose of learning more about health IT topics and how they intersect, current and planned health IT initiatives, and organizations involved in various aspects of planning and implementation – with the goal of providing clarity around these sometimes confusing topics, as well as roles and responsibilities. The site should also provide direction on where people can get more information, or get involved in the statewide efforts. Additionally, this website should serve as a marketing tool for the value of health information technology in improving patient care and coordination, and reducing costs.

#### *7.3.1.6 E-Learning Tool*

Texas Medicaid has developed online computer-based learning tools and training for providers and others to learn more about the Texas Medicaid EHR Incentive Program. The first training includes information for eligible professionals and eligible hospitals on the requirements for meeting Adopt, Implement, Upgrade (AIU) requirements. This e-learning tool launched in April 2012. In addition, a new set of e-learning modules was created on the topic of meaningful use for eligible professionals. Other e-learning tools include HHSC and TMHP-developed training tools aimed at Medicaid providers. These computer-based trainings (CBTs) cover a variety of topics, and include sections on health IT initiatives.

#### *7.3.1.1 Texas Health IT Day*

Texas Medicaid Health IT coordinated and conducted a Texas Health IT Day for Health IT stakeholders, as a pre-conference event to the regional HIMSS conference in May 2013. The purpose of this Health IT Day was to collaborate and innovate on topics such as the health information exchange landscape, legal implications of health IT, and furthering the adoption of these technologies across the state. Format was roundtable discussion, not presentation style. Attendees contributed to the content and ideas being discussed, along with featured guest speakers.

Another Texas Health IT Day is planned in 2014.

#### *7.3.1.2 Provider Surveys*

Provider surveys are conducted to collect statewide information on the prevalence and scope of health information technology adoption by various types of providers and hospitals.

Additionally, a new survey is being conducted in the Fall of 2013 to learn more about the barriers to attesting to A/I/U and Meaningful Use Stage 1.

### **7.3.1.3 Other Stakeholder Communications**

Other stakeholders have or are expected to host meetings and forums about the EHR Incentive Program and other health IT programs. They also provide regularly updated online communications about the programs for their constituents, including Medicaid MCOs, the Regional Extension Centers and their partners (e.g., Texas Medical Association), and various state and county/local associations of eligible professionals.

### **7.3.2 Client Outreach**

Medicaid clients are the primary beneficiaries of the meaningful use of certified EHRs, HIE, and electronic prescribing. Client communication and outreach are necessary to build and sustain client support of EHR use and health information exchange, particularly regarding patient privacy. HHSC will support an educational campaign that will promote wider understanding of the benefits of health information technology among Medicaid clients.

Texas Medicaid and its service partners, including health plans and Texas Health Steps Program, will revise client materials to educate patients about the electronic storage and exchange of medical information as new editions of publications are released. A number of publications have been identified that will include information about health IT in Texas and the impact of electronic health information exchange from a client perspective. These include:

- The 2011 Texas Medicaid client handbook;
- Health plan member materials, including handbooks and enrollment broker letters to client families;
- Communication packets and mailings to Medicaid clients; and
- Advocacy, special interest, and service agency newsletters and websites.

### **7.3.3 Texas HHS Enterprise Outreach**

A series of internal communications through regular channels such as e-mail, internal newsletters, and periodic management meetings across departments and divisions will provide opportunities to communicate along the chain of command in both directions.

### **7.3.4 Legislative Outreach**

Texas Medicaid officials will make periodic presentations and provide updates to state legislators and their staff about the progress of the Medicaid EHR Incentive Program and other Health IT initiatives, and use of related expenditures.

## **7.4 Coordination**

Coordinating education and outreach efforts is critical to the program's success and efficient use of resources. Coordination efforts will be directed within the enterprise and between the enterprise and external stakeholders.

Texas Medicaid has been actively communicating with providers around the state regarding specific health information technology initiatives, particularly the Texas Medicaid Electronic Health Record (EHR) Incentive Program. Hitherto, information has been shared regarding program requirements, participation steps, frequently asked questions, and program updates. Moving forward with this and other statewide health information technology (IT) projects requires a more comprehensive and inclusive communications plan.

Successful health IT is implemented in a way that includes critical partners and allows health information to be available when and where it is needed to care for patients and improve safety, quality, and efficiency. Therefore, the communication and outreach efforts also need to be comprehensive and include all stakeholders, as well as delineate the linkages among initiatives and groups.

Additionally, in order for health IT to be successful and to support Medicaid's quality initiatives, affected staff within the Texas HHS Enterprise need to have an understanding of the opportunities presented by health IT and how they can incorporate it into their operations.

#### 7.4.1 Goals of Communication and Outreach

Health IT is one of the key focus areas to improve patient safety, quality, and cost of care. The goal of the coordinated communications plan is to support those goals and provide information to stakeholders that will result in continued adoption and meaningful use of health information technology.

#### 7.4.2 Key Messages and Scope

Communications and outreach will focus on the following messages: increased clarity around health information technology; provide information needed to participate in health IT initiatives for the benefit of patients; clarify the linkages among health information technology initiatives; promotion of evidence-based approaches; and cast a vision for the future of health IT.

#### 7.4.3 Stakeholders: Developing and Implementing the Plan

With guidance and assistance from the HHSC communications groups, Texas Medicaid and the Office of e-Health Coordination will develop a coordinated communications plan which will incorporate cross-functional activities and key messages among statewide partners: regional extension centers (RECs), local health information exchanges (HIEs), Texas Health Services Authority (THSA), Texas HHS Enterprise, and provider and client associations.

#### 7.4.4 Audience

Communications and outreach will be directed primarily to Texas providers and hospitals, as they are the primary implementers of health IT for the benefit of their patients. Other audiences include patients, legislators, and internal state agency stakeholders.

#### 7.4.5 Primary Communications Methods

In addition to traditional communication media such as articles and websites, Texas Medicaid plans to incorporate the following into a coordinated outreach plan:

- Health IT videos – opportunities and vision
- Statewide survey regarding health IT knowledge gaps and interests
- Success stories from providers
- Tip sheets and flyers
- Frequently Asked Question
- Presentations at conferences and meetings
- Talking points
- Ongoing dialogue and coordination among RECs, THSA, and local HIEs regarding outreach and communications

#### 7.4.6 Departments in the Texas HHS Enterprise and Other State Agencies

Texas Medicaid will be responsible for coordinating with the communications staff for the Texas HHS Enterprise, including the generation and approval of content to inform stakeholders about the EHR Incentive Program and other health IT initiatives. The Office of e-Health Coordination will contribute to content development, and TMHP will advise Texas Medicaid on communications about technical aspects of the program, as appropriate. Texas Medicaid will also coordinate communication and outreach efforts across the Enterprise, including, but not limited to:

- Department of State Health Services (DSHS)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)
- Department of Family and Protective Services (DFPS)
- HHSC Office of Eligibility Services (OES)
- HHSC Office for the Elimination of Health Disparities (OEHD)
- Medicaid managed care health plans (MCOs) and medical directors
- Selected *Frew* Initiative leaders (e.g., IMPROVE website)<sup>31</sup>
- Other state agencies where appropriate (e.g., Texas Department of Rural Affairs)

#### 7.4.7 External Coordination Efforts

Texas Medicaid, in consultation with OeHC and TMHP, will have primary responsibility for coordinating communication among external stakeholders. Key external stakeholders in the EHR Incentive Program include but are not limited to the following:

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<sup>31</sup> IMPROVE is an interactive website sponsored by HHSC and designed to allow front-line providers participating in the Texas Medicaid program the opportunity to identify issues or obstacles they have encountered in the Medicaid program and offer their own solutions.

- Health IT Regional Extension Centers (RECs);
- Texas Health Services Authority (THSA);
- Medical associations and health professions societies (e.g., Texas Medical Association, Texas Hospital Association, Association of Texas Midwives, Texas Nurse Practitioners);
- HHSC Regional Advisory Committees (RACs);
- FQHCs and RHCs; and
- Client advocacy organizations.

## 7.5 Communication Tools for Providers on EHR Incentive Program Procedures

Providers initially submit contact information to CMS via the National Level Repository (NLR) about their intent to participate in the EHR Incentive Program, as described in Section 5. Once CMS has submitted provider information to Texas Medicaid, HHSC communicates to the provider via e-mail to acknowledge registration and notify the provider that he may log into the EHR Incentive Program attestation portal through a single-sign on process via the Texas Medicaid provider website. At the website, the provider verifies an e-mail address and other pertinent information, after which all further communication related to eligibility, payment and other procedures will be electronic.

## 7.6 Texas Medicaid Website Enhancements

Texas Medicaid will facilitate provider enrollment in the EHR Incentive Program by enhancing the website currently maintained by TMHP. The website, [www.TMHP.com](http://www.TMHP.com), serves as a secure portal for providers to enroll in Texas Medicaid, file claims electronically, verify client eligibility, submit prior authorizations, and perform other functions.

Content added to the TMHP website includes:<sup>32</sup>

- Program rules and guidance;
- News articles;
- Resource documents;
- Frequently Asked Questions (FAQs);
- A glossary;
- Presentations and other training materials;
- Tip sheets / instruction sheets;
- Success stories;
- Electronic contact form and contact information via phone or fax; and
- Background information and links to related sites, including the CMS EHR Incentive Program site.

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<sup>32</sup> See: [http://www.tmhp.com/Pages/HealthIT/HIT\\_Home.aspx](http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx).

## **7.7 Sources for Providers to Seek Help about the EHR Incentive Program**

Telephone and email will be primary resources for individual providers to ask specific questions about the EHR Incentive Program.

### **7.7.1 Phone Support**

TMHP has a main call center number for general inquiries, claims, educational opportunities, and other special topics. To provide efficient and effective telephone support to providers, Texas Medicaid regularly works with TMHP to develop Helpline staff training materials and responses to past or likely future questions from providers. In addition, TMHP works with Texas Medicaid to elevate questions to a higher level of response when needed.

### **7.7.2 E-mail Queries**

On the TMHP website described above, providers have the opportunity to submit queries that will be forwarded to staff to triage and respond to or forward appropriately.

Texas Medicaid, TMHP and its subcontractor, CGI, coordinate to respond to and track individual questions or concerns about the program. Periodically, staff analyzes the content of email (and phone) queries to inform updates made to the FAQs available to providers on the TMHP website.

## **7.8 Development of IT Security Education and Training for Meaningful Use**

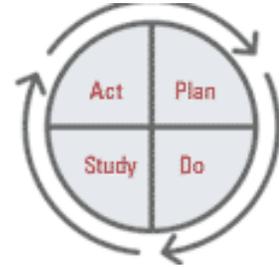
Core measure 15 of the Stage 1 Meaningful Use requirements provides for the protection of data generated by an EHR “through the implementation of appropriate technological capabilities”.

HHSC believes this an important aspect of Meaningful Use and will work to ensure that its clients' Protected Health Information (PHI) is secured by provider organizations. The HHSC HIT Division will contract to study current security standards and best practices in order to determine what "appropriate technological capabilities" will best serve the provider community in Texas. We will work to assist providers in their planning for meaningful use by publishing educational materials and guidance in support of the implementation of proper security policies and procedures by providers utilizing EHR technology.

## 8. THE STATE'S Health IT ROADMAP

### 8.1 "As-Is" – "To-Be" Pathway

Significant work remains to define the specific steps that must occur within Texas Medicaid and across the Texas HHS Enterprise and its success will rest on the collaboration between Health IT, HHSC IT, and Operational business areas to achieve the state's 2014 To-Be vision. HHSC is committed to using the SMHP as an opportunity to define its *Quality Strategy* for the Medicaid Program, as described in Section 4. Through this plan and coordinated implementation steps, Medicaid has set its vision and begun to establish a baseline from which to gauge providers' progress in the adoption and meaningful use of EHR technologies. As these measures are defined, reviewed and refined, HHSC will establish a systematic process to collect, collaborate and make transparent its assessments of progress for Medicaid and the HHS system. HHSC views this as a first step in what will be an ongoing quality improvement process – Plan, Do, Study and Act.



Fulfillment of HHSC's Health IT vision is dependent on transformative changes across the Enterprise, through its departmental levels, and down to the provider level at the point of care. At the departmental level, the Medicaid Program will focus on assisting EPs and eligible hospitals to achieve Stage 1 meaningful use criteria by streamlining the process for provider registration, attestation, verification and clinical quality measurement and reporting in the EHR Incentive Program.

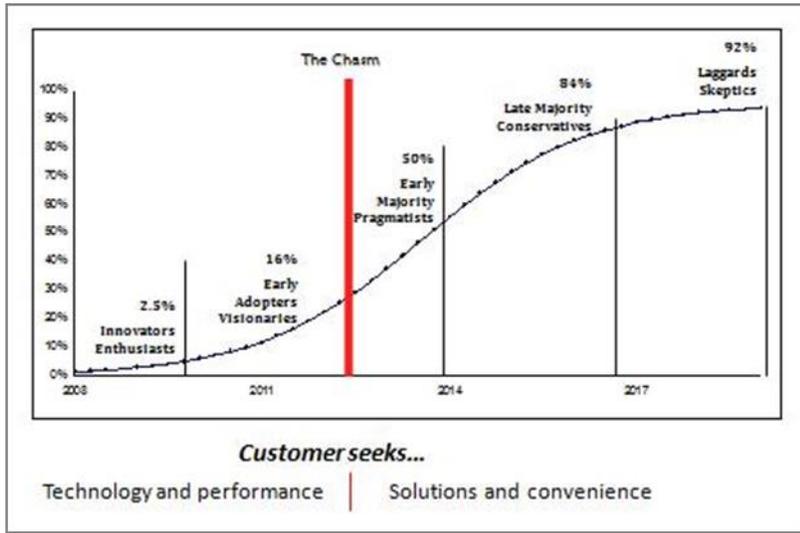
HHSC is also working aggressively at the Enterprise level to improve coordination and collaboration, and to eliminate duplicative quality reporting requirements for providers with an eye toward achieving the state's long-term goal of value-based purchasing. For example, HHSC recently established a Quality Payment advisory committee of HHSC officials and external experts, and created a new unit on quality and performance measurement. The unit will conduct an inventory of state-based and nationally endorsed performance measures that the Medicaid/CHIP Program currently collects from providers. These include measures used by the Physician Quality Reporting Initiative (PQRI), CHIPRA measures, and measures endorsed by the National Quality Forum. Results will be used to propose measures to eliminate and to add and align with the core set of measures required for clinical quality reporting related to meaningful use.

In addition, HHSC will leverage its resources to promote providers' adoption of the Plan, Do, Study, Act method of quality improvement as part of a sustainable strategy for improving health system performance, including the incorporation of measures of the meaningful use of EHRs.

## 8.2 Provider EHR Technology Adoption Expectations

The MU Workgroup developed across-the-board projections of growth in EHR adoption. The workgroup found it difficult to develop a meaningful projection without better data.

**Figure 7. Technology Adoption Curve**



Since the provider survey and modeling data from the fiscal agent are not yet complete, the workgroup's initial recommendations were reviewed by select members of the Core Project Team and the Medicaid Directors. Based on their recommendation, members agreed to model the project based on Moore's Technology Adoption Curve,<sup>33</sup> which posits that there is a chasm between the early adopters of technology (enthusiasts and visionaries) and the early majority

(pragmatists) due to differing expectations of what the technology is to deliver. Early adopters seek to use technology to enhance performance, while later adopters are driven by a need for convenience in their solution. As a result, this "chasm" suggests the need for different communication, collaboration and support strategies between the early and later adopters. While HHSC recognizes there are early EHR adopters, it anticipates that the incentive program will accelerate the adoption rate. To that end, HHSC has begun conversations and planning efforts with THSA as well as the RECs to further develop the analysis and measurement of provider adoption patterns.

Based on an early analysis of data and an understanding of the Technology Adoption Curve, HHSC has identified the following projections for eligible hospital (EH) and eligible professional (EP) adoption rates, as summarized in Table 9.

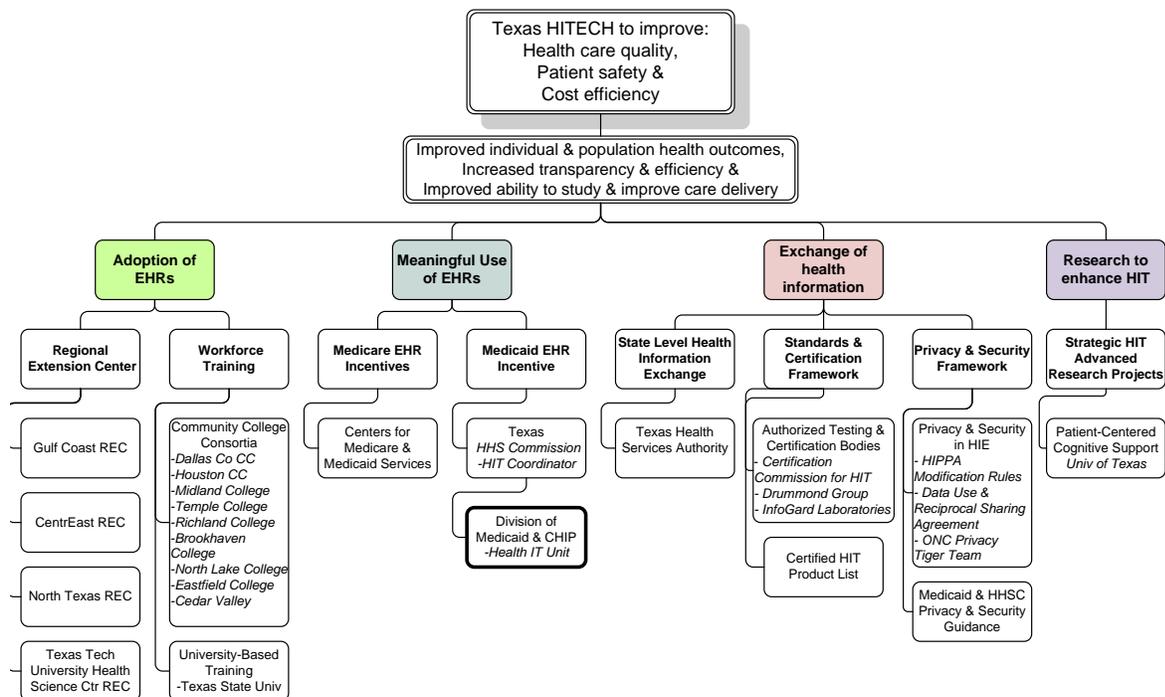
<sup>33</sup> Geoffrey A. Moore, *Crossing the Chasm, Marketing and Selling High-Tech Products to Mainstream Customer* (revised edition), HarperCollins Publishers, New York, 1999.

**Table 8. Projected Adoption by Eligible Provider Type**

Provider Type	2011 Estimated Baseline	2012	2013	2014
EH - Acute Care	10%	20%	40%	70%
EH – Children’s Hospital	20%	40%	60%	85%
EP – Physician	5%	10%	25%	45%
EP – Pediatrician				
EP – CNMs				
EP – Nurse Practitioners				
EP – PAs when practicing at an FQHC/RHC	3%	10%	20%	35%
EP – Dentists	3%	6%	8%	15%

Texas HHSC intends to continue to build on the good work of providers and HHSC and to leverage the wide ranging resources, which Texas actively sought and successfully gained through the HITECH Act. These HITECH resources in Texas provide support for the meaningful use of EHRs as illustrated in the graphic below (Figure 8).

**Figure 8. Texas HITECH Resources**



David Blumenthal, M.D., M.P.P., Launching HITECH, New England Journal of Medicine 362:5 .....  
 February 4, 2010. Accessed at: <http://www.nejm.org/doi/pdf/10.1056/NEJMp0912825?source=hcrc> .....  
 Framework adapted from HITECH Act Framework for Meaningful Use of EHRs. ....

In addition to these resources supporting improvement in health care quality, patient safety and cost efficiency, Texas HHSC communicated with the Office for the Elimination of Health Disparities (OEHD) to explore activities to increase the involvement of minority communities in improving health care using EHR technologies as an essential tool in this process.

OEHD proposed a number of activities that were referred to in the October 28, 2010, Implementation Advance Planning Document to help address this “digital divide” and enhance the effectiveness of the EHR Incentive program to improve quality of care and enhance trust between members of the minority community and their health care providers. HHSC submitted an IAPD-U on June 17, 2011, to request reallocation of a portion of training and outreach dollars to cover the costs of system enhancements to the EHR Incentive Program enrollment portal. Therefore, these specific OEHD outreach activities were not pursued. However all client communications are developed to address diverse client backgrounds and ethnicities. Understanding that there exists a “digital divide,” as well as health care disparities, HHSC reviews all client messages with a communications group that edits documents to bridge those divides. This communications group has specific guidelines for outgoing communications that level the playing field, ensuring that messages are appropriate for all clients. Additionally, HHSC is careful to not use new terminology or acronyms unfamiliar to clients. Instead, we use lay terminology (for example, “sharing your health information with other medical professionals”, instead of “health information exchange”).

Table 9 below describes the EHR adoption progress measures for the incentive program. In 2011, HHSC surpassed its goals of 3%-5% adoption by EPs and 10%-20% for EHs through the incentive program. Most recent data indicates a 2011 EP adoption rate of 6.4% and an EH adoption rate of over 30%. Table 10 provides a plan of detailed set of steps and activities to support the improvement of health outcomes, care quality and cost efficiency in Texas through the adoption and meaningful use of EHR technologies (Table 10).

**Table 9. Plan for Adoption and Meaningful Use of EHRs among Eligible Providers**

Plan to Benchmark and Measure Progress of EHR Adoption and Meaningful Use, 2010 - 2014				
2010	2011	2012	2013	2014
Perform provider surveys and develop baseline projections to be included in the SMHP	<p>Expected baseline of eligible providers at the innovator adoption level is 2.5%. However, the market may have already surpassed the innovator stage and moved to the early adopter stage which is marked by a growth of 13.5%.</p> <p>Medicaid is targeting 10%-20% adoption among hospitals and 3%-5% for eligible professionals.</p> <p>Providers incentives for adopt, implement and upgrade only by attestation. Few providers will be meaningful users.</p> <p>Understanding of the incentive program, EHR technology and meaningful use grows across the state.</p>	<p>Expected adoption growth among early adopters continues. Adoption by the early majority begins which represents a growth of up to 34%— if HHSC and RECs are successful in addressing “the chasm” between early adopters and the early majority.</p> <p>The target will be 20%-40% among hospitals and 6%-10% among eligible professionals.</p> <p>Adopters from 2011 will begin achieving meaningful use.</p> <p>AIU and/or meaningful use will likely be most pronounced in urban and suburban areas throughout the state.</p>	<p>The Early Majority, adoption continues in 2013.</p> <p>Medicaid is targeting 40%-60% adoption among hospitals and 8%-25% adoption among eligible professionals.</p> <p>Meaningful use among adopters will continue to increase.</p> <p>Key issues will be: available resources to assist providers, ready access to technology infrastructure (certified EHRs, broadband and local champions and success stories)</p> <p>Explore inclusion of a requirement in MCO contracts for e-Transmission of laboratory results.</p>	<p>The Late Majority (up to 34%) will begin investigating the adoption of EHRs.</p> <p>Medicaid targets 70%-85% adoption among hospitals and 15%-45% adoption among eligible professionals.</p> <p>Meaningful use growth across urban and rural communities statewide.</p>

### 8.3 Annual Benchmarks

**Table 10. Annual Benchmarks for Meaningful Use**

Measure	2011	2012	2013	2014
<b>1. To be a <i>Value Purchaser</i> of quality health outcomes by supporting and “e-enabling” these Medicaid enterprise improvements</b>				
<b>1.1. Utilize clinical decision support and health informatics to analyze Medicaid data from across the state enterprise. Use data to target health quality improvement initiatives including cost avoidance for Medicaid.</b>	<ul style="list-style-type: none"> <li>Identify high cost/high risk patients, stratify population needs, and ensure use of evidence based practices through core measures.</li> <li>Establish desired outcomes, targets and critical measures.</li> <li>Align reporting quality measures across payer type and/or programs.</li> <li>Determine how EHR Reporting requirements can contribute to Healthcare Reform objectives.</li> </ul>	<ul style="list-style-type: none"> <li>Begin collecting core clinical measures and/or alternate core measures from EPs &amp; EHs. Identify top performers or provider champions.</li> <li>Medicaid HMO Quality Challenge Pool (HMO capitation payments are at risk for missed targets. These funds can be redistributed to other HMOs that demonstrate additional value-added for meeting objectives). Current priority: Decrease ED and hospital utilization.</li> </ul>	<ul style="list-style-type: none"> <li>Explore the development of physician report cards which ranks how providers are meeting MU criteria and Evidence-based Guidelines (EBGs) compared to peers.</li> <li>Begin collecting Stage 2 Meaningful Use Criteria.</li> <li>Begin collecting additional children’s quality measures.</li> </ul>	<ul style="list-style-type: none"> <li>Explore the use of incentives to providers dedicated to MU criteria and following clinical guidelines.</li> </ul>

<p><b>1.2. Comprehensive and qualified provider network capable of providing quality care based on population needs, unique care conditions, and locus of service needs</b></p>	<ul style="list-style-type: none"> <li>• Increase universal availability of health summary information (lab/test results, prior health visits, medications, other ancillary health services, etc.)</li> <li>• Utilizing MEHIS to make data available to providers and recipients. –Increase electronic communication among providers (obtain base-line from the HIE).</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Align measures across programs - FFS, Managed Care Organizations, and children’s measures (Foster Care and others)</li> <li>• Begin collecting core clinical measures and/or alternate core measures from EPs &amp; EHs. Identify top performers or provider champions.</li> <li>• Easily reportable and accessible Immunization data.</li> </ul>	<ul style="list-style-type: none"> <li>• Begin collecting Stage 2 Meaningful Use Criteria</li> <li>• Begin collecting additional children’s quality measures</li> <li>•</li> <li>• Explore the development of physician report cards which ranks how providers are meeting MU criteria and Evidence-based Guidelines (EBGs) compared to peers</li> </ul>	<ul style="list-style-type: none"> <li>• Provide useful feedback to providers</li> </ul>
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<p><b>1.3. Implement effective and efficient primary and integrated care approaches</b></p>	<ul style="list-style-type: none"> <li>• PCPs coordinate care with specialists, allied health care (e.g., physical, occupational and speech therapy), behavioral health and dental as needed.</li> <li>• Care Coordination and integrated health care will be performed by the TX Medicaid Health Management Program for high-cost/high-risk clients served under traditional Medicaid. The program will integrate EHR incentive core clinical measures. MCO case managers are responsible for care coordination for clients served in managed care.</li> <li>• Define preventive care approaches for 2012</li> <li>• Pilot THSteps – EPSDT – visit forms</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Explore open source data solutions for the THSteps visit form - directly reportable as an add-on to certified EHRs.</li> <li>• Implement Preventive Care approaches.</li> <li>• Explore expansion of MEHIS data and functionality.</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>	
<p><b>1.4. Ensure the secure and private</b></p>	<ul style="list-style-type: none"> <li>• Plan how to make health information data</li> </ul>	<ul style="list-style-type: none"> <li>• Explore opportunities for</li> </ul>		<ul style="list-style-type: none"> <li>• Electronic Data Warehouse will</li> </ul>

<p><b>exchange of health care information across the Medicaid enterprise consistent with national standards, and including specialty focus providers</b></p>	<p>available, meet with providers to review, check and confirm data format is meaningful and then make data available</p> <ul style="list-style-type: none"> <li>• Cross walk codes to make information available in user-friendly format (e.g. Rx Norm)</li> <li>• Begin design phase of a single point of entry into HHSC data systems and view the client life – Encounter Data Warehouse.</li> </ul>	<p>MEHIS to integrate client data throughout the enterprise.</p> <ul style="list-style-type: none"> <li>•</li> <li>• Explore the development of clinical decision support capabilities.</li> </ul>		<p>integrate all points of client care and store within warehouse for Medicaid.</p>
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<p><b>1.5. Expand health care coverage to newly eligible Medicaid population under national health insurance reform</b></p>	<p>HHSC identifies resource needs for data storage of personal health information to accommodate the estimated 1.3 million newly eligible Medicaid clients and 750,000 currently eligible but not enrolled Medicaid and CHIP clients, beginning January 1, 2014.</p>	<p>HHSC develops a detailed work plan for infrastructure changes that will need to occur to accommodate transmission of personal health information for the 1.3 million newly eligible Medicaid clients and 750,000 currently eligible but not enrolled Medicaid and CHIP clients.</p>	<p>HHSC secures resources for increased personal health information storage for the expanded population and develops and tests systems modifications and interfaces.</p>	<p>HHSC begins new Medicaid and CHIP eligibility determination processes and Medicaid expansion, effective January 1, 2014.</p>
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<p><b>2. To improve the health and well-being of citizens of the state of Texas through the widespread adoption and meaningful use of certified EHRs</b></p>				
	<p><b>2011</b></p>	<p><b>2012</b></p>	<p><b>2013</b></p>	<p><b>2014</b></p>
<p><b>2.1. Improving alignment of Medicaid program goals across the enterprise</b></p>	<ul style="list-style-type: none"> <li>Ongoing collaboration and data sharing with DSHS, DFPS and DADS program executives to determine how Medicaid goals can integrate.</li> </ul>	<p>Ongoing collaboration strategy</p>		
<p><b>2.2. Making Medicaid programs more accountable for the care provided to</b></p>	<ul style="list-style-type: none"> <li>Set targets for desired outcomes</li> <li>Develop a design of a quality report card for</li> </ul>			

<p><b>eligible clients</b></p>	<p>health plans.</p> <ul style="list-style-type: none"> <li>Evaluate annually for continuity of care, care coordination and improved clinical health outcomes. Possible tools may include client surveys, analytics tools, etc.</li> </ul>			
<p><b>2.3. Utilizing health IT to obtain improved data to analyze and measure quality factors</b></p>	<p>Establish a Medicaid Quality Outcomes workgroup that will perform health care analytics, and decision support to identify areas for quality improvement.</p> <p>The HHSC Quality group has just formed recently and is still developing their work plan and goals and objectives. HHSC intends to develop a Quality coordination infrastructure to support the collection and analysis of all clinical quality data received from health plans or providers. Texas HHSC will align quality measures across programs including CHIPRA and to</p>	<p>Analyze</p> <ul style="list-style-type: none"> <li>provider adoption rates of EHR</li> <li>policy issues</li> <li>legislative requests.</li> </ul> <p>Examples:  (1) THSteps – use reported data to target quality improvement initiatives.  (2) Meaningful use of clinical measures.</p>	<p>Expansion of meaningful use and clinical quality data from EHRs.</p>	

	<p>alleviate redundant or duplicative reporting by managed care entities and providers. All data, including the meaningful use data, will be reviewed and analyzed to assess status of health and care quality for Medicaid clients and providers across the Medicaid/CHIP program and guide the development of initiatives to improve quality.</p>			
<p><b>2.4. Providing visibility and transparency into Medicaid quality</b></p>	<ul style="list-style-type: none"> <li>• Collaboratively work with provider community to develop measures.</li> <li>• Reporting of quality metrics for Medicaid via a dashboard.</li> </ul>	<ul style="list-style-type: none"> <li>• Aligning and reporting metrics for HMOs with Texas Dept. of Insurance.</li> </ul>		

## APPENDIX A – Legislative Background

### National

On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law, and established the framework for financial incentives to stimulate growth and improve the health of the nation’s economy and health care system. ARRA defined specific roles and incentives for the U.S. Department of Health and Human Services (HHS) and its partners – State Medicaid agencies (SMA) – in improving the nation’s health and care through the meaningful use of electronic health record (EHR) technologies.<sup>34</sup> Two Titles in ARRA, Title XIII, Division A, Health Information Technology, and Title IV Division B, Medicare and Medicaid Health Information Technology, comprise the “*Health Information Technology for Economic and Clinical Health*” (HITECH) Act, which provides unprecedented opportunities for states to plan, design, and meaningfully use EHRs and health information exchange (HIE) to improve health, care quality and cost efficiency.

Title XIII, Health Information Technology, establishes the Office of the National Coordinator of Health Information Technology (ONC) and provides nearly \$2 billion in grant funds for the Office to administer in supporting the adoption of EHR’s, the electronic exchange of health information, and research to enhance the use of HIT.

Title VI, Medicaid and Medicaid Health Information Technology establishes the EHR Incentive Payment Program that is administered through the Centers for Medicare and Medicaid Services (CMS), and the Medicaid program is administered in cooperation with the state Medicaid agency. This program is responsible for an estimated \$27 billion in direct funds, and a projected \$36 to \$46 billion in total funds and costs savings nationwide.

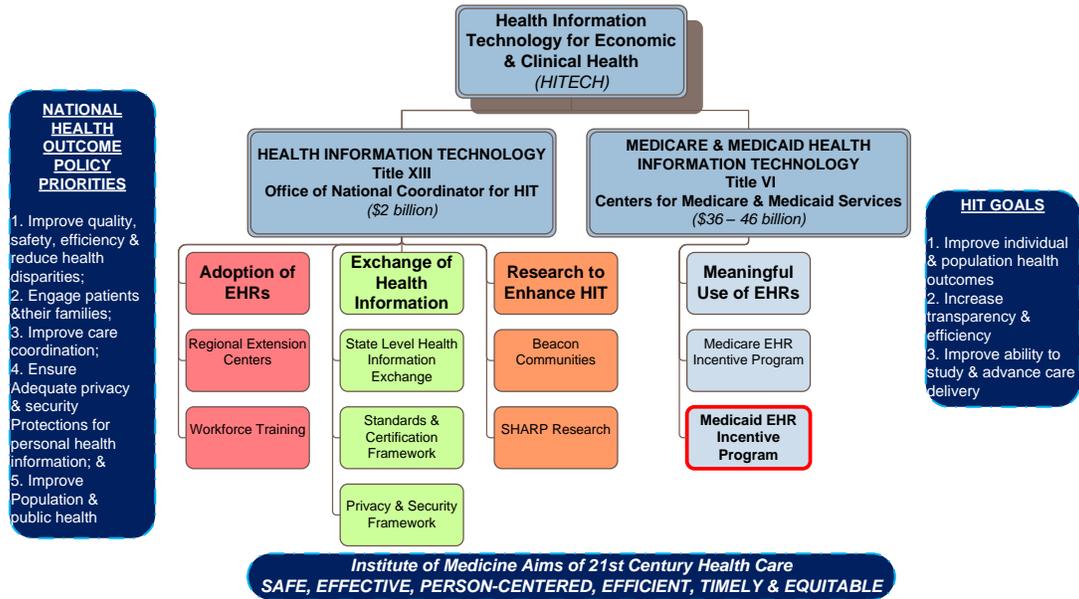
These transformative programs are driven by the goals of HITECH to:

1. Improve individual and population health,
2. Increase transparency and efficiency, and
3. Improve the ability to study and advance care delivery.

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<sup>34</sup> American Recovery and Reinvestment Act of 2009, accessed on June 17, 2009 at: <http://www.hhs.gov/recovery/overview/index.html>

Figure 9. HITECH Organization



The vision of the CMS, which administers this EHR Incentive Program with State Medicaid agencies, is “The right care, for every person every time.” CMS has developed an overarching Quality Strategy for Medicaid and Children’s Health Insurance Program (CHIP) that is aligned with the Institute of Medicine’s “Aims of a 21<sup>st</sup> Century Health Care System” to ensure care “safe, effective, efficient, person-centered, timely and equitable.” The pillars of the Quality Strategy are to:

Focus on Patient Centeredness	Implement Evidenced-Based Care and Quality Measurement	Support Value-Based Payment Systems	Leverage Health IT – turn Data into Information	Continue to Build Effective Partnerships	Disseminate Information and Provide Technical Assistance	Facilitate Equity in the Delivery of Care
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The Center for Medicaid and State Operations within the Centers for Medicare and Medicaid Services (CMS) issued two State Medicaid Director’s letters, one on September 1, 2009, and one on July 23, 2010, to provide additional guidance and interpretation of the rules. As states develop their SMHPs and I-APDs to implement the EHR Incentive Payment program, CMS addresses their questions and provides further guidance through bi-weekly All-States’ Calls and through FAQs on their website. As the program develops at the national level, these tools have been critical in further directing states.

## State

### House Bill 1218 – passed in 2009

#### HIE Pilot Program

H.B. 1218 authorized HHSC to establish a health information exchange pilot program to determine the feasibility, costs and benefits of Medicaid and CHIP exchanging secure electronic health information with local and regional HIEs comprising hospitals, clinics, physicians' offices and other health care providers. The pilot program consisted of bidirectional exchange of filled prescription histories between HHSC and a local HIE. The purpose of the pilot program was to explore the feasibility of exchanging clinical data and begin identifying legal, policy, and other procedural barriers to implementing HIE initiatives.

#### Medicaid Electronic Health Information Exchange System

H.B. 1218 authorized HHSC to develop an electronic health information exchange system to improve the quality, safety and efficiency of health care services provided under the CHIP and Medicaid programs. The legislation requires that the system be developed in accordance with the Medicaid Information Technology Architecture (MITA) initiative of CMS's Center for Medicaid and State Operations and conform to other standards required under federal law. The System is being implemented in three stages:

- Stage 1 directs HHSC to implement a health information exchange system that offers an electronic health record for all Medicaid recipients. In addition, Stage 1 requires HHSC to coordinate e-prescribing tools used by health care providers and health care facilities under the Medicaid and CHIP programs and develop a claims-based electronic health record in Medicaid.
- Stage 2 would expand the EHR to include CHIP program clients; add state laboratory results, including the results of newborn screenings and tests conducted under the Texas Health Steps (EPSDT) program; improve data gathering capabilities; and use evidence-based technology tools to create client profiles.
- Stage 3 involves developing evidence-based benchmarking tools that can be used by health care providers to evaluate their own performances on health care outcomes and overall quality of care as compared to aggregated performance data regarding peers; and expanding the system to include data exchange with state agencies, additional health care providers, laboratories, diagnostic facilities, hospitals, and medical offices.

#### HIE Systems Advisory Committee

The HIE Systems Advisory Committee established under H.B. 1218 advises HHSC on Medicaid activities related to health information technology. A key objective of the Committee is to ensure Medicaid/CHIP HIE is "interoperable" with broader statewide health information exchange being planned through the THSA.<sup>35</sup> The advisory committee is responsible for advising HHSC on issues regarding development and implementation of the electronic health

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<sup>35</sup> See: <http://www.senate.state.tx.us/75r/senate/commit/c610/h2010/0415-JosephSchneider.pdf>

information exchange system, including: data to be included; presentation of data; useful measures for quality of services and patient health outcomes; federal and state laws regarding privacy of private patient information; incentives for increasing adoption and usage; and data exchange with regional health information exchanges.

#### Health Information Technology Standards

H.B. 1218 requires that any health information technology used by HHSC or any entity acting on behalf of HHSC, in the Medicaid program or CHIP conform to standards required under federal law.

## APPENDIX B – Texas MMIS Overview and MITA Assessment

### Components of existing Texas MMIS system:

- Data Entry
- Acute and Long Term Care Claims processing and adjudication
- Claim Check
- Financial
- Health Insurance Premium Payments System (HIPPS) and Insurance Premium Payment System (PPS)
- Long Term Care Client Assessment, Review and Evaluation (CARE) Form Processing
- Third Party Liability
- Provider
- Client/Recipient
- Medicare Buy-In
- Automatic Voice Response System
- Online Provider Lookup
- Provider Portal and Bulletin Board System
- Prescription Drug Point of Sale System
- Pharmacy Claims Payment
- Electronic Data Interchange (EDI) Processing System
- Customer Service Request (CSR) System
- Retrospective Drug Utilization Review (DUR)
- Reports online
- Web Portal
- Case Tracking
- Claims and Encounters Data Warehouse
- Ad hoc query and reporting platform
- Management and Administrative Reporting Subsystem (MARS)
- Surveillance and Utilization Review System (SURS)
- Medicaid Statistical Information System
- Program Integrity
- System Maintenance and Modification
- System Operations, Disaster Recovery, and Integrated Test Facility

Additionally, the system has multiple interfaces and ancillary applications that support internal and external users, state agencies and other vendors. The business functions performed by the Fiscal Agent include, but are not limited to the following:

- Primary Care Case Management
- Provider Services
- Client Services
- Decision Support Services
- Medical Policy
- Prior Authorization
- Surveillance/Utilization Review
- Third Party Resources
- Claims Processing
- Long Term Care Client Assessment, Review and Evaluation (CARE) Form Processing
- Long Term Care Programs
- Children with Special Health Care Needs (CSHCN)
- Family Planning
- County Indigent Health Care Program
- Medically Needy Program
- Financial Management
- Management and Administrative Reporting
- Reference Data Maintenance
- Eligibility Verification

## Other Critical Medicaid Projects

In July 2010, HHSC release a Request for Quote to hire a vendor to assist HHSC Medicaid/CHIP Division in fully implementing *value-based purchasing* in Medicaid/CHIP managed care products and services. The goals of this initiative are to improve the quality of care provided to Medicaid/CHIP enrollees while reducing total program cost. HHSC seeks to:

1. Evaluate the implementation of value-based purchasing in Medicaid/CHIP managed care products and services, including an evaluation of existing Texas Medicaid/CHIP programs to determine opportunities to more fully implement value-based purchasing in current managed care operations;
2. Analyze availability of existing data as well as the quality and format of program data from various sources for use with this project;
3. Develop a roadmap to further align operations and management of Medicaid/CHIP Health Management Organization's (HMO) into alignment with value-based purchasing;
4. Provide recommendations based on evidence-based practices and principles; and
5. Assess program resource requirements necessary to achieve value-based purchasing objectives and expectations of managed care program growth over time.

In August 2010, HHSC released an RFQ for a vendor to assist with the development, analysis and implementation of cost containment strategies in anticipation of legislative interest and imposition of state agency budget reductions. Subsequently, HHSC chose to pursue cost containment strategies through a dedicated unit created in 2011 within Texas Medicaid.

In August 2010, HHSC released an RFQ for a vendor to assist the Medicaid/CHIP Division develop, document and implement of *quality-based reimbursement and payment methodologies* for specified Medicaid/CHIP programs. HHSC is working to develop quality-based payment proposals to submit to CMS for pilots and projects newly available under the health care reform, and provide financial incentives to providers in fee for service, primary care case management and in HMOs, to provide quality services to enrollees and the state, and to continually increase quality.

In 2011, the Texas Legislature passed Senate Bill 7, which created the Quality-Based Payment Advisory Committee to make recommendations to HHSC and Texas Medicaid in the development of quality-based reimbursement and payment methodologies. HHSC did not pursue the August 2010 RFQ and no contract was awarded.

HHSC will conduct research for the HHSC staff and the Quality-based Payment Advisory Committee on quality-based payment initiatives, including but not limited to: quality of care standards, evidence-based protocols and measurable goals for the pilots. The project assesses current payment methodologies, recommend quality-based rate processes for Medicaid/CHIP, develop proposals, such as waivers, state plan amendments, and/or proposals on quality based

payment initiatives, including but not limited to: Bundled payments for episodes of care that include hospitalizations, Global capitated payments to safety net hospital systems, and Pediatric medical providers organized as accountable care organizations (ACOs) to share in cost-savings Health homes, including for enrollees with chronic conditions (Patient Protection and Affordable Care Act Section 2703).

## MITA

The Gap Analysis conducted under the MITO 3.0 Assessment reiterated many of these themes across each of the MITA Business Process Areas:

- **Member Management** – The Member Management business area suffers from many obstacles seen in other business areas. These include compartmentalized processes, redundant systems, lack of data standardization, and overstretched staff. Some of the remedies identified include simplifying current IT security processes, standardizing data across programs and structuring IT resources so that programs can maintain current functionality and have the ability to incorporate applicable enhancements.
- **Provider Management** – Texas is making strides in offering automated, self-service channels for providers, but significant barriers still exist to achieving higher MITA Maturity Levels. Continuing requirements for original signatures and notarized forms prevents complete automation of some processes in this business area. Also, complex medical policies and business rules leads to tedious documentation requirements and claims denials. This can result in a high volume of appeals and claims reprocessing. Possible improvements can be made by taking advantage of existing conditions such as federal funding, collaboration and consolidation of resources, elimination of silos, and leveraging other systems and data stores for provider information. Nonetheless, much more can be accomplished if these barriers can be overcome.
- **Contractor Management** – Centralization of activities remains the chief obstacle to maturation of the Contractor Management Business Processes. As silos continue to exist across the Texas HHS Enterprise, redundancies can be found in many business areas for many activities. In addition, these processes are affected by variability in the consistency and timeliness of both internal and external communications. Developing and implementing standards and automated processes will help propel the Texas HHS Enterprise toward higher levels of process maturity.
- **Plan Management** - There are robust processes within each operating agency that could be aligned and used enterprise-wide; however, there is little automation and formal process structures for the majority of processes within this business area. Other challenges include manual business process steps, non-standardized documentation, inaccessible information and the resulting inefficiencies for staff workload. Opportunities for capability improvements including using data analysis tools, automated workflow capabilities, electric document management, and user configurable business rules. Standardization of data definitions across the Texas Medicaid Enterprise

would reduce the need to verify information, support direct system-to-system exchange of information, and allow more process steps to be automated. Additional opportunities include continuing to increase the use of electronic mechanisms in the exchange of information and expanding the use of performance measures.

- **Performance Management** - Enterprise activities in this area are well documented and supported by effective automation. The data used in performance management is primarily electronic and recent expansions of fraud and abuse detection have placed further structure and metrics on these processes. Performance management business processes however face internal challenges due to staff turnover and the increasing need for significant technology, business process, and business organization improvements. Current solutions include automating the desk review process for business areas, implementing provider compliance systems and enhancing data standards and sharing across agencies.
- **Operations Management** – The strength of the operations management’s business processes starts with knowledgeable staff and robust system support in C21, CMS, and other operational support systems. Additionally, Texas has adopted a strategy of movement towards managed care that allows vendor staff to meet the operational needs of Texas Medicaid. The majority of operations management business processes are siloed processes, which create challenges. Furthermore, like most states, Texas has faced ongoing funding constraints that have resulted in limited staffing resources to meet program needs. Texas will need to focus on program optimization, business process improvements, and reductions in redundancies to meet program needs on ever shrinking budgets. Opportunities for improvement include implementing National Provider Identification numbers as the ID for provider records; reducing duplicative efforts between agencies; and making use of data standards as they are being developed and adopted by CMS.
- **Eligibility and Enrollment Management** – The processes within eligibility and enrollment management have seen significant attention in Texas. With the recent MEHIS project and the upcoming provider portal enhancements, this business area is a clear priority for the State. Each of the operating agencies has processes in place to meet the needs of eligibility and enrollment for members and providers. This business area is challenged by the fragmented systems and processes of each agency across the enterprise. Additionally, when providers interact with the Texas Medicaid Enterprise, they must often use different application forms, communication protocols, and processes depending on the program, agency, or MCO. The State has opportunities to increase effectiveness, accuracy, and access for the Eligibility and Enrollment Management business area. These opportunities include improved training for State Eligibility workers; a single point of entry for clients and providers to complete enrollment applications online in real time; and simplify and update forms, processes and outdated systems.

- **Business Relationship Management** – The manual nature of many Texas HHS enterprise processes and the lack of consistent standards for data sharing with outside entities results in slow and manual processing as well as potential interruption of numerous processes. Opportunities to address these gaps include implementing a web-based business relationship management tool to facilitate interoperability with outside entities and clarifying data sharing agreements between agencies.
- **Financial Management** – The Texas Medicaid Enterprise has a wide and varied set of business processes and units that manage the extensive financial information used across all programs. The systems and business units supporting financial management tend to be fragmented across the various agencies; each unit uses its own robust systems and processes. The enterprise would benefit from promoting standard best practices across all units. There are a number of capabilities already in use by some units within the Texas Medicaid Enterprise that, if expanded, could have a large impact on improving maturity levels for many program management business processes such as data analysis tools, automated workflow capabilities, electric document management, and user configurable business rules. Standardization of data definitions across the Texas Medicaid Enterprise would reduce the need to verify information, support direct system-to-system exchange of information, and allow more process steps to be automated. Additional opportunities include continuing to increase the use of electronic mechanisms in the exchange of information and expanding the use of performance measures.
- **Care Management** – This business area is conducted through various processes and systems throughout the enterprise, without consistent integration, data standards, or data exchange interfaces. The recently implemented CMBHS system for DSHS does address some of these issues and eliminates several manual and paper-driven processes. However, this system only affects the behavioral health and substance abuse related programs. Upon implementation, and where feasible, Texas HHS Enterprise could leverage technology and lessons learned from the CMBHS project to other program areas.

Texas HHS will align its strategic systems planning with MITA and the seven conditions and standards over the next five (5) years. This planning includes increasing the use of Service Oriented Architecture (SOA) and a modularization of the business processes for a component-driven approach to designing enterprise systems business functionality. Texas HHS has already started the process of moving to modularity through initiatives, such as EaaS and provider management modernization.

Under MITA, with its emphasis on SOA, the opportunity exists to reduce the risk of implementing an all-inclusive MMIS by breaking it up into its component parts<sup>36</sup>. This modular

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<sup>36</sup> SOA separates functions into distinct units, or services, which developers make accessible over a network that users can combine and reuse in the production of applications. These services can then

requirement has now been outlined by CMS in its April 2011 Medicaid IT Supplement. The projects included in the MITA 3.0 Roadmap have been developed to meet the requirements of the seven conditions and standards.

**Figure 10. Texas HHSC Current MITA 3.0 Roadmap**

ID	Task Name	Start	Finish	2013				2014				2015				2016				2017				2018			
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1	MITA Transformation Project	12/3/2012	12/1/2015	[Gantt bar from Q4 2012 to Q4 2015]																							
2	The MMIS Modernization Project	6/3/2014	3/30/2017	[Gantt bar from Q2 2014 to Q4 2017]																							
3	Provider Management Modernization	6/3/2013	12/31/2014	[Gantt bar from Q2 2013 to Q4 2014]																							
4	Enterprise Data Warehouse (EDW)	6/4/2012	10/31/2018	[Gantt bar from Q2 2012 to Q4 2018]																							
5	Medicaid Enterprise Data Governance (MEDG) Planning	10/3/2011	5/30/2014	[Gantt bar from Q4 2011 to Q2 2014]																							
6	Eligibility as a Service (EaaS)	7/1/2013	2/31/2014	[Gantt bar from Q3 2013 to Q1 2014]																							
7	Enhanced Eligibility System Modernization	12/3/2012	12/1/2017	[Gantt bar from Q4 2012 to Q4 2017]																							
8	Balanced Incentive Program (BIP)	2/1/2013	12/31/2015	[Gantt bar from Q1 2013 to Q4 2015]																							
9	IMPACT Modernization Project	12/3/2012	12/1/2015	[Gantt bar from Q4 2012 to Q4 2015]																							
10	ICD-10 Planning and Implementation	12/3/2012	6/29/2016	[Gantt bar from Q4 2012 to Q2 2016]																							
11	PHSU and Title V MCH FFS Cons. Sys. Implementation	12/3/2012	2/2/2015	[Gantt bar from Q4 2012 to Q1 2015]																							
12	CMBHS Phase V – Mental Health Services and Certification	12/3/2012	11/3/2014	[Gantt bar from Q4 2012 to Q3 2014]																							
13	Health Registries Improvement Project (HRIP)	12/3/2012	4/1/2016	[Gantt bar from Q4 2012 to Q1 2016]																							
14	Registry Plus	12/3/2012	7/2/2015	[Gantt bar from Q4 2012 to Q2 2015]																							
15	Registry Plus Stage 2 EHR Meaningful Use	12/3/2012	3/30/2016	[Gantt bar from Q4 2012 to Q1 2016]																							
16	ImmTrac Replacement Phase II	12/3/2012	9/3/2015	[Gantt bar from Q4 2012 to Q3 2015]																							
17	Texas Electronic Registrar (TER) Replacement	6/3/2013	3/29/2016	[Gantt bar from Q2 2013 to Q1 2016]																							
18	Clinical Data Exchange for Behavioral Health	6/3/2013	2/27/2015	[Gantt bar from Q2 2013 to Q1 2015]																							
19	Project NEO	6/3/2013	11/27/2015	[Gantt bar from Q2 2013 to Q3 2015]																							
20	Single Service Authorization System (SSAS) – Phase 1	12/3/2012	12/2/2015	[Gantt bar from Q4 2012 to Q4 2015]																							
21	Single Service Authorization System (SSAS) – Phase 2	6/3/2013	7/1/2015	[Gantt bar from Q2 2013 to Q1 2015]																							
22	Cost Avoidance Project	12/3/2012	5/1/2014	[Gantt bar from Q4 2012 to Q2 2014]																							
23	DADS/HHSC PASRR Project	12/3/2012	6/2/2014	[Gantt bar from Q4 2012 to Q2 2014]																							

Fundamental to the success of many of these projects is the replacement of the MMIS with a component-based, rules-driven system comprised of a service oriented architecture (SOA). In addition, HHSC anticipates the new MMIS to be agile, adaptable, interoperable and fully capable of integrating, normalizing and analyzing cost and quality data to support performance management across the enterprise and health care system.

communicate with each other by passing data from one service, or business process, to another, or by coordinating an activity between two or more services.

## APPENDIX C – Hospital Survey Results

The 2012 Health Information Technology Survey for Hospitals was developed to measure EHR adoption in the state’s hospitals, determine the utilization levels of specific EHR functions, estimate HIE participation, and gauge interest in the Medicare and Medicaid incentive programs. The survey was made available electronically from May 2012 to September 2012 to all hospitals that participated in the DSHS/AHA/THA Annual Hospital Survey.

The results of the hospital survey show that 49 percent of hospitals have fully implemented EHRs in all units and 31 percent have partially implemented or begun implementation. Another 16 percent of hospitals are planning EHR implementations in the next one to two years. Only 4 percent of hospitals have no plans to implement an EHR.

**Table 11. Hospital Survey Results**

Level of EHR Adoption	Percent	Frequency
EHR is implemented in all units	49	81
EHR is implemented in at least one unit	18	30
Implementation begun	13	22
Implementation planned in the next year	8	13
Implementation planned in next two years	8	13
No implementation planned	4	7

Of the hospitals that have implemented or begun implementation, the most popular functions are patient demographic characteristics, laboratory reports, and radiologic reports. The functions that are least likely to be implemented are drug dose support, clinical guidelines, and consultation requests.

**Table 12. Hospital EHR Functions**

EHR Functions	Implemented in all units	Implemented in at least one unit	Implementation begun or planned	No implementation planned
Demographic characteristics of patients	87.97%	5.26%	5.26%	0.00%
Physicians’ notes	35.34%	24.81%	33.83%	4.51%
Nursing assessments	73.68%	15.79%	8.27%	0.75%
Problem lists	63.16%	17.29%	16.54%	1.50%

Medication lists	72.93%	12.78%	12.78%	0.00%
Discharge summaries	63.91%	15.79%	17.29%	1.50%
Advanced directives	60.15%	14.29%	20.30%	3.76%
Laboratory reports	80.45%	7.52%	8.27%	2.26%
Radiologic reports	79.70%	6.77%	9.77%	2.26%
Radiologic images	72.93	6.77	12.78	6.02
Diagnostic-test results	78.20	7.52	10.53	2.26
Diagnostic-test images	68.42	6.02	17.29	6.77
Consultant reports	66.92	6.77	20.30	4.51
Laboratory tests	78.20	9.02	9.02	2.26
Radiologic tests	75.19	9.02	10.53	3.76
Medications	72.93	14.29	10.53	0.75
Consultation requests	54.89	12.03	22.56	9.02
Nursing orders	72.93	11.28	11.28	3.01
Clinical guidelines	53.38	17.29	19.55	8.27
Clinical reminders	53.38	14.29	24.81	6.02
Drug-allergy alerts	74.44	14.29	9.77	0.00
Drug-drug interaction alerts	70.68	16.54	10.53	0.75
Drug-laboratory interaction alerts	56.39	14.29	21.80	6.02
Drug-dose support	52.63	18.05	20.30	7.52

The facilities that plan to implement in the next year or two show a similar preference for these EHR functions.

When asked about HIE participation, 30.12 percent of responding hospitals reported that their facility currently participates in HIE. These hospitals most often use HIE to exchange electronic clinical laboratory ordering and results delivery, eligibility and claims transactions, and quality reporting.

**Table 13. Hospital HIE Functions**

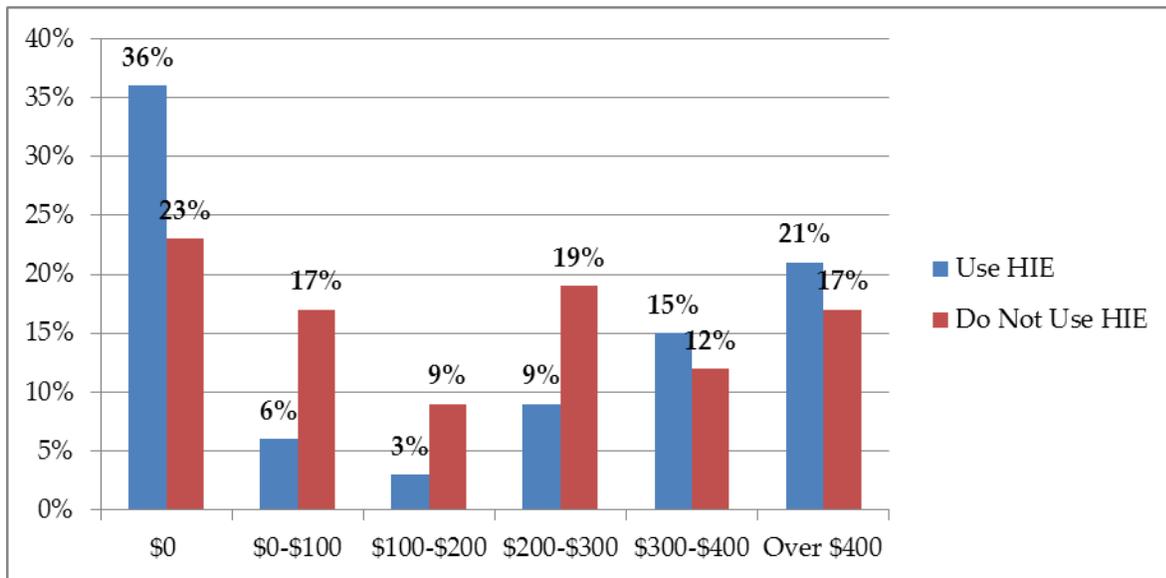
HIE Functions	Percent
Electronic eligibility and claims transactions	58%
Electronic prescribing and refill requests	44%
Electronic clinical laboratory ordering and results delivery	56%
Electronic public health reporting	42%
Quality reporting capabilities	34%
Prescription fill status and or medication fill history	34%
Clinical summary exchange for care coordination and patient engagement	60%

Of hospitals that do not currently participate in HIE, most would see value in electronic clinical summary exchange for care coordination and patient engagement (87%), clinical laboratory ordering and results delivery (85%), and quality reporting (86%).

Among hospitals that do not pay to participate in HIE, 21 percent report they would be willing to pay more than \$400 a month for their HIE services, 15 percent would pay \$300-\$400, 9 percent would pay \$200-\$300, 3 percent would pay \$100-\$200, and 6 percent would pay \$0-\$100.

The majority of hospitals (74%) who do not currently receive HIE services indicated that they would be willing to pay a monthly fee to receive these services.

**Figure 13. Amount Hospitals are Willing to Pay for HIE Services**



## APPENDIX D – Local HIE Grant Program Participants

### FIRSTNET EXCHANGE

FirstNet Exchange, headquartered in Tyler, Texas, was formed in 1996 by the East Texas Medical Center (ETMC) Regional Healthcare System as a regional HIE with a mission to “optimize quality care, services, and cost management by streamlining the exchange of healthcare information.” It started by connecting ETMC hospitals and physicians, but grew quickly over the years to provide a data exchange for numerous East Texas providers. Today, FirstNet’s stakeholders include 15 hospitals and over 600 physicians, and its exchange spans 21 counties with data on over one million patients.



### GREATER HOUSTON HEALTHCONNECT

Founded through the collaboration of the Center for Houston’s Future and the Harris County Healthcare Alliance, Greater Houston Healthconnect was launched in 2010. The organization was inspired by the vision of Houston area business and community leaders to work hand-in-hand with local healthcare providers to achieve a decisive gain in community health. Greater Houston Healthconnect was developed with the support of numerous organizations and interested individuals, including the area’s major healthcare systems and medical schools, along with the Harris County Medical Society.



Two regional HIEs, Galveston County HIE and the HIE of South East Texas have merged with Healthconnect, expanding the service area to 20 counties serving 6.8million people, 14,000 physicians and more than 130 hospitals. Healthconnect has begun connecting major hospital systems in its service area through the regional community health portal. In addition, the HIE offers Direct Messaging and a referral platform. By Q2 2013, lab results and medication fill data will also be available to participating providers.

### HEALTH INFORMATION NETWORK OF SOUTH TEXAS

The Health Information Network of South Texas (HINSTX) is a not for profit organization comprised of public, private and non-profit organizations whose population center is Corpus Christi and includes eleven rural Coastal Bend counties that is committed to providing the health information technology infrastructure to expand access to quality healthcare, enable patient engagement and improve health outcomes for all people in the region. HINSTX will accomplish this through the establishment of a health information exchange (HIE) that is continually adapting, transparent and accountable, community-based, and self-sustaining and demonstrates quantifiable social, clinical, and economic benefits for patients and providers. HINSTX is building on past health IT initiatives in South Texas and leveraging existing resources to create a foundation for a health information exchange that will assist providers and patients across the



entire continuum of care - including the essential connectivity with state and federally-based HIE initiatives and networks, such as the Texas Health Services Authority (THSA) and the National Health Information Network (NwHIN).

#### HEALTH INFORMATION PARTNERSHIP OF SOUTHEAST TEXAS

Health Information Partnership of Southeast Texas (HIPSET) covers Montgomery, San Jacinto, Liberty, and Walker counties with a total population over 630,000. HIPSET was formed to promote the health of citizens in these counties through facilitating the creation and operation of an HIE with the objectives to increase access to care, quality of care, and efficiency in providing care, including for Medicaid, self-pay and the uninsured population.



The goal, objectives, and benchmarks for HIPSET include providing aggregated data to identify disease populations for individuals for management, especially asthma, congestive heart failure, diabetes, and hypertension. The program will also look to identify system abuse and overuse in an attempt to direct individuals' care to more appropriate solutions. Finally, we wish to assist physicians in treating patients, reducing unnecessary and duplicative testing and procedures and empower patients to better manage their healthcare strategies. HIPSET plans to develop a community-based resource to facilitate disease management programs, systems abuse mitigating strategies, and create surge capacity by reducing Emergency Department visits. Recognizing the referral patterns that exist with Harris County, HIPSET intends to facilitate the exchange of data across the region in collaboration with the other regional HIEs operating in Southeast Texas.

#### HEALTHCARE ACCESS SAN ANTONIO

Healthcare Access San Antonio (HASA) is a non-profit community collaborative, including premier hospital systems, community health providers, and the San Antonio Metropolitan Health Department. HASA's mission—to enhance access to care for community residents—is realized by facilitating the exchange of patient information across providers in a safe and secure environment. In working in close partnership with its stakeholders, HASA intends to provide HIE to the benefit of residents and providers in 22 counties in the Central and Southwest Texas area.



As a safety net for the uninsured, HASA has provided a platform for patient information exchange since 2008. As a community collaborative, HASA provides these services in complement to what providers have implemented for internal use. Additionally, a portal for providers with limited or no electronic medical record capabilities will be made available. HASA's objectives for 2011-2013 include connecting providers in rural and urban Central and Southwest Texas and expand this connectivity to all patient types. As a community collaborative, HASA intends to provide value to multiple community stakeholders including providers, physicians, consumers, companies, and payers. Through collaboration with other

community providers, HASA intends to assist in providing patient-centered, high quality and cost efficient care for its service area.

### IHEALTH TRUST

iHealth Trust is a Houston community owned and directed nonprofit organization whose purpose is to improve healthcare quality and contain rising costs in the Greater Houston area by engaging patients, their healthcare providers, and other authorized entities in the exchange of health information, with assured privacy and anytime-anywhere access, resulting in all stakeholders having complete healthcare information and decision support.



The vision of iHealth Trust is to enhance healthcare quality and effectiveness for all patients, the healthcare sector should be supported by an infrastructure made up of interoperable, electronic health records composed of standardized, structured data elements that are exchanged among authorized healthcare organizations and providers across secure regional and statewide networks.

The mission of iHealth Trust is to improve the quality, safety, and efficiency of the community's healthcare sector by enabling the delivery of high quality, cost-effective healthcare for all patients by utilizing electronically collected information, serving as a trusted third party fiduciary for the depositor of that information.

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### INTEGRATED CARE COLLABORATION

The Integrated Care Collaboration (ICC) is a nonprofit alliance of healthcare organizations in Central Texas dedicated to the collection, analysis, and sharing of health information. The ICC has been nationally recognized for its efforts in HIE and community-wide care transformation to improve quality, increase access, and lower costs across unaffiliated providers throughout the spectrum of healthcare delivery. The ICC upgraded its HIE platform to support technology-enabled, patient-centric care delivery and the ability to measure Accountable Care Organizations established outcomes. With federal and state emphasis on HIT, Meaningful Use requirements, and ACOs, providers are now looking to ICare as the regional HIE solution for Central Texas. The ICC's target patient population is all individuals regardless of insurance status, race, sex, or age.



The ICC offers both query based and Direct-protocol based HIE solutions. ICare 2.0 is the ICC's second-generation query based HIE solution and has been live and in-use by providers and hospitals since September, 2011. With the development of ICare 2.0, a Data Warehousing and Analytics solution has been coupled with the data to facilitate performance-based outcome analysis, validate patient information and assess the community health research.

The ICC's Texas Direct secure messaging system, based on the ONC's Direct protocol, facilitates the electronic exchange of referrals, test results, reports, and other clinical data over a secure network. Texas Direct allows providers on an EHR, as well as though without an EHR, to quickly and easily exchange patient information without the burden of fax, phone, or traditional mail services.

#### NORTH TEXAS ACCOUNTABLE HEALTHCARE PARTNERSHIP

The North Texas Accountable Healthcare Partnership (NTAHP) is a non-profit, multi-stakeholder organization designed to implement a health information exchange (HIE) in North Texas. NTAHP's mission is to promote and reward local healthcare clinical performance for the citizens of North Texas, that is coordinated, transparent, and value based. The NTAHP HIE's service area covers 11,700 physicians, 137 hospitals and over 6.6 million patients in Dallas, Tarrant, and 11 other counties around the Dallas-Fort Worth Metroplex.



At its core, NTAHP seeks to be the primary driver and champion of healthcare value for the region it serves. It is the intent of the NTAHP HIE to facilitate health information exchange services for all interested providers in the defined 13-county region. This includes all licensed hospitals, physicians and mid-level providers. The NTAHP HIE capabilities center around a query-based solution that provides clinicians a longitudinal patient health record, which includes rapid, secure access to: patient demographics, allergies, lab results, radiology reports, medications, problems and procedures, and transcribed documents. In addition to the query based solution, NTHAP HIE also has Direct Secure Messaging embedded within the HIE platform, based on the ONC's protocols. To allow for proactive care coordination, NTAHP HIE uses alerts and notifications for its clinical users based on triggering events to allow providers to know that their patients have had activity within the HIE and allow for the continuity of care to be timely and efficient.

After the establishment of the core HIE platform, NTAHP envisions two distinct categories of services, (a) services offered and administered by NTAHP at the direction of our community stakeholders and (b) use of the NTAHP HIE capabilities by stakeholders to drive their core business operations or "NTAHP HIE Enabled Services". Thanks to the collaborative efforts of NTAHP's stakeholders, including leading area providers, payers, and businesses, the NTAHP HIE will play a central role in this region's efforts to lower costs, improve health outcomes, and improve the overall health of citizens of North Texas.

#### PASO DEL NORTE HIE

The Paso del Norte (PdN) HIE is a nonprofit corporation formed to benefit and promote the health of the residents of El Paso County, Texas and surrounding communities. The mission of the PdN HIE is to improve the quality, safety, and efficiency of healthcare services in the Paso del Norte region, through privacy protected exchange of health information.



Members of the PdN HIE act together as a collaborative of physicians, hospitals, health departments, clinics, mental health authorities, other providers, and consumers through secure exchange of privacy-protected health information and the sharing of best practices for the improvement of care.

The PdN HIE received a planning grant and is in the process of finalizing the organizations' goals and objectives. In preliminary conversations, stakeholders have identified the following priorities:

- Prevent unnecessary test duplication
- Enhanced patient safety
- Improve quality of medical treatment
- Enable greater care coordination
- Enable disease surveillance

#### RIO GRANDE VALLEY HIE

Rio Grande Valley HIE (RGV HIE) intends to provide services to extreme South Texas and is comprised of a multi-disciplined, multi-stakeholder, multi-county representative board designed to provide guidance and oversight to the exchange of critical information. Working in close partnership with its stakeholders, the RGV HIE intends to provide HIE to the benefits of residents and providers by expanding access to quality healthcare and improving health outcomes for all people in the service region. From Brownsville to Laredo, patients will have the ability to provide medical information to those who need it most, just when they need it.



The goal of RGV HIE is to facilitate access to, and retrieval of, clinical information to provide safer, more timely, efficient, and effective patient-centered care. By having access to all patient data, healthcare providers can reduce time and expense associated with duplicate tests and effort spent locating missing patient information such as referrals, consults, radiology, and lab result orders.

It provides the capability to electronically access clinical information across disparate healthcare information systems while maintaining the meaning of the information being exchanged. HIE is part of an evolving strategy on the national, state, regional, and local levels. These strategies may include telemedicine, social networking, patient-centered medical homes, and accountable care organizations.

#### RIO ONE HEALTH NETWORK

Rio One Health Network is a Texas non-profit corporation specifically established to participate in the planning and subsequent development of a HIE organization in Hidalgo and Starr Counties in compliance with state and federal standards. The goal of this organization is to create an active exchange of healthcare information between all participating entities and physicians for the benefit of patients in this



region that meets all security and privacy requirements for patient information. Further, this network plan is intended to promote cooperative cost reduction measures for these local providers, pharmacies, and laboratories.

Rio One Health Network understands the challenge of sustainability and maintaining a positive dialogue with the medical community on the benefits of a fully developed and compliant HIE in this region and intends to consistently promote the goal through professional meetings and community education. This will ensure that providers, patient, and support services are all engaged in a patient centric HIE designed to reduce costs, protect patient privacy, and promote the essential need to conserve limited healthcare resources through a systematic exchange of reliable health information.

#### SOUTHEAST TEXAS HEALTH SYSTEM (SETHS)

Southeast Texas Health System (SETHS) is a non-profit corporation equally owned by nine hospitals whose purpose is to collaborate to create economies of scale and scope in the delivery of healthcare. The members share common goals of operating a cost-effective, quality healthcare delivery system to provide a continuum of healthcare services and products that offer greater efficiency, economy, quality, and availability of such services than the individual providers can offer alone.



SOPHIE, the SETHS-Operated Provider HIE, is designed to serve as the rural HIE solution. It is integrating hospitals, providers, pharmacies and labs both locally and regionally for the purpose of meeting HIE requirements in a manner that preserves the local control and independence of all participants. SOPHIE is a cost effective Open Source HIE solution designed to consume data in any format, remove the implementation pain points away from the HIO, and ultimately enable providers to meet Meaningful Use.

The technology partners developed SOPHIE with the following guiding principles in mind:

- Implement a patient-centric approach
- Focus on the needs of rural and/or small hospitals, providers, pharmacies and labs
- Support national standards for maximum interoperability
- Collect data from HIE participants in whatever form it is provided
- Provide multiple mechanisms for accessing HIE data
- Utilize Open Source technologies to avoid vendor lock-in

## APPENDIX E – Texas Broadband Grant Awardees

Table 14. Texas Broadband Grant Awardees

Texas Broadband Grant Awardees		
Name	Description	Grant Award
The Texas Healthcare Information Network for Collaboration (THINC)	THINC received \$16 million in 2007 funding from the Federal Communications Commission to support a Rural Health Care Mechanism Pilot program in Texas. This funding represented 85 percent of first year development costs, with the other 15 percent funded through membership and user fees. The state’s largest provider of rural healthcare services, CHRISTUS Health System, is the fiscal agent for and statewide coordinator for the consortium.	\$16,000,000
TierOne Converged Networks, Inc. TX	This approximately \$19 million award, will allow TierOne Converged Networks, Inc. to offer broadband service speeds of up to 6.5 megabytes per second in 11 north Texas counties.	\$19,244,200
DOC - Peoples Telephone Cooperative TX	This approximately \$28.8 million award will allow the People Telephone Cooperative (PTC) to offer affordable middle-mile broadband service in eastern Texas. The project plans to directly connect as many as 190 community institutions to broadband.	\$28,825,356
DOC - Texas A&M University TX	This approximately \$6.6 million award, with nearly \$3 million in matching contributions, will allow Texas A&M University System to offer affordable middle-mile broadband service in areas of Texas. The project plans to connect almost 50 community anchor institutions, including more than 12 institutions of higher education serving more than 110,000 students and 27,000 faculty and staff.	\$6,550,775
DOC - City of Brownsville TX	This approximately \$865,000 award, matched by more than \$370,000 in matching contributions, will allow the City of Brownsville, Texas to foster economic growth by increasing public computer access and awareness of the benefits of broadband.	\$865,920
DOC - Library & Archives Commission, State TX	This approximately \$8 million award, with nearly \$3.7 million in matching contributions, will allow the Texas State Library & Archives Commission to deploy the Technology, Expertise, Access and Learning for all Texans (TEAL) project which will provide greater broadband computer access at faster speeds by upgrading 125 public computer centers and establishing approximately 30 new centers equipped with 2,200 new workstations.	\$7,955,941

## APPENDIX F – Regional Extension Center Technical Support

The Texas Health and Human Services Commission (HHSC) received \$5 million from the Center for Medicare and Medicaid Services (CMS) at 90:10 federal financial participation to promote certified electronic health record technology (CEHRT) use in the physician specialist Medicaid community. HHSC is contracting with the four Regional Extension Centers in Texas to leverage their knowledge in this arena to recruit 1,000 cardiologists, endocrinologists, pulmonologists, and psychiatrists who treat the top four chronic conditions with the greatest impact to client health and Medicaid costs: diabetes, heart disease, asthma, and mental illness. Specialists will be recruited in a population-based manner to implement certified EHR technology in a way that will:

- Enable these physician specialists to provide insight into the quality of care for a specific Medicaid population;
- Create a foundation for better coordination of care between provider and specialist;
- Integrate patient health information to support patient-centered clinical decisions.

Texas Medicaid expects that each REC will provide services to the Medicaid provider groups specified above, consistent with ONC specifications for the priority primary care practitioner. ONC's purpose and goals for the RECs is to provide education, outreach, and technical assistance to providers in their geographic service areas select, successfully implement, and meaningfully use certified EHR technology to improve the quality and value of health care. Consistent with these goals, RECs help providers achieve compliance with the Medicare and Medicaid EHR Incentive Program. The specific scope of service the RECs will be expected to provide for Texas Medicaid is:

1. **Education and Outreach to Providers** – The RECs will provide for dissemination of knowledge about the effective strategies and practices to select, implement, and meaningfully use certified EHR technology to improve quality and value of healthcare. At a minimum, this support should consist of materials designed to be widely and rapidly disseminated, both for provider self-study and for use by other RECs. Other education and outreach activities can include, but are not limited to:

- support of regional communities of practice for providers and those who support their health IT implementation;
- health IT training events for clinical professionals and their support staff; and
- instruction and assistance on using health IT to enhance the patient-provider relationship and encourage patient self-management.

Training events, programs, and communities of practice may be co-sponsored with other local resources, such as (but not necessarily limited to) state and local health services oversight agencies, professional organizations, provider organizations, and consumer organizations.

2. **Vendor Selection** - This includes assistance in assessing the health IT needs of providers, and selecting and negotiating contracts with vendors or resellers (of EHR systems, hardware and network infrastructure, and IT services). RECs should assist providers in holding vendors accountable for adhering to service level agreements. RECs are expected to offer unbiased advice on the systems and services best suited to enable the providers to become meaningful users of EHRs. RECs will avoid entering into business arrangements creating an actual or apparent conflict of interest with the REC's obligation to act solely in the best interests of advancing meaningful use of certified health IT by the providers it serves.
3. **Project Oversight**- RECs will provide project oversight support, including individualized and on-site coaching, consultation, troubleshooting, and other activities required to assure that the supported provider is able to assess and enhance organizational readiness for health IT, assess and remediate gaps in IT infrastructure, configure the software to meet practice needs and enable meaningful use, ensure adequate software training for all staff, and track and adhere to implementation timelines.
4. **Practice and Workflow Redesign** - RECs will provide support for practice and workflow redesign necessary to achieve meaningful use of EHRs. This support will require working with the providers, and their EHR vendor(s), to implement and troubleshoot the use of the EHR system for the consistent documentation of essential clinical information in structured format, instituting electronic administrative transactions, electronic prescribing, electronic laboratory ordering and resulting, sharing key clinical data across practice settings, providing patient access to their health information, public health reporting, and policies and practices that protect the privacy and security of personal health information. RECs must be capable of mapping and redesigning work processes, updating roles and responsibilities for clinicians and support staff, and leading continuous quality improvement activities involving rapid cycle feedback.
5. **Functional Interoperability and Health Information Exchange** – RECs will assist providers in connecting to available health information exchange infrastructure(s), including local health information exchange organizations and state-based shared utilities or directory services in compliance with applicable statutory and regulatory requirements, patient preferences, and the state plans for health information exchange. RECs will focus on meeting the functional interoperability needs of practices, including, but not limited to the electronic exchange of administrative transactions, laboratory orders and results, medication prescriptions, quality and public health reports, patient summaries, and the information required to ensure continuity across the spectrum of care.
6. **Privacy and Security Best Practices** – RECs will support providers in implementing best practices with respect to the privacy and security of personal health information, including: implementation and maintenance of physical and network security, user-based access

controls, disaster recovery, encryption and storage of backup media, human resources training and policies; and identification of state laws and regulatory requirements that impact privacy and security policies for electronic interoperable health information exchange.

7. **Progress Towards Meaningful Use** – The RECs’ personnel shall participate in program training and be able to provide their clients effective assistance in attaining meaningful use. Participation in this training will also assure that the educational and informational offerings to providers in the centers’ geographic areas are accurate and aligned with, but not duplicative of, the education and outreach on the provider incentives that will be furnished to providers nationwide by CMS. RECs shall review the utilization of the EHRs within their participating practices, and provide appropriate feedback and support to improve low utilization of features essential for meaningful use (e.g., electronic prescribing). Where structural, technical, or policy barriers hinder progress, the RECs will work with the HITRC and local stakeholders to report to ONC the existence and nature of these barriers. RECs will also help priority primary-care providers to understand, and implement technology and process changes needed to attain MU requirements and demonstrate this achievement.

#### Fees

Texas Medicaid will pay fees consistent with ONC provisions.

The ultimate measure of a REC’s effectiveness will be whether it has assisted providers in becoming meaningful users of certified EHR technology. Payments to the RECs will be equally divided with achievement of the three milestones. Program outcomes will be assessed consistent with ONC quantitative performance measures and milestones:

- Milestone 1: signed contracts
- Milestone 2: certified EHR implementation
- Milestone 3: Achievement of meaningful use