State Medicaid Health Information Technology Plan (SMHP)

DATE: August 7, 2017
## DOCUMENT CONTROL

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1. EXECUTIVE SUMMARY

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 could implement the program in 2011. The SMHP is drafted to respond to each of the questions in the Centers for Medicare & 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 HHSC will be engaged in 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 8 sections:

1. **As Is Medicaid Health Information Technology (HIT) Landscape** – describing the current state of HIT activities throughout the state

2. **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 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

3. **EHR Incentive Program** – providing a detailed description of the steps HHSC will undertake with its contractors and key stakeholders to successfully implement the EHR Incentive Program

4. **Audit Strategy** – outlining the critical steps for program integrity of the EHR Incentive Program

5. **Outreach and Education** – relating the process for informing, involving and supporting eligible providers (professionals and hospitals) and key stakeholders in the program

6. **Leveraging the Results of EHR**
7. **HIE Implementation** - promoting and expanding Health Information Exchange for the benefit of Medicaid

8. **Health IT Roadmap** – describing the plans for provider adoption and meaningful use of EHRs.

The plan was initially 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 Affordable Care Act (ACA) occurred; all of which required 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 the Medicaid Electronic Health Records (EHR) Incentive Program.

This SMHP represents a point in time landscape of health IT in Texas, 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) system 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 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 (CEHRT).

The SMHP was updated in November 2014 when an SMHP addendum was submitted in response to the Final Rule issued on September 4, 2014. This rule which granted flexibility to eligible providers who are unable to fully implement 2014 Edition certified electronic health record technology for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability. The addendum was approved by CMS in December 2014. Another addendum was approved by CMS on November 17, 2015, for implementation of changes related to the Modifications to Meaningful Use in 2015 Through 2017 Final Rule. Both addenda are incorporated into this SMHP. Annual updates will be submitted to describe the progress to date and to request approval for new implementation strategies.

### 1.1 2017 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, and the Local Health Information Exchange Grant. The 2015 MITA 3.0 State Self-Assessment is referenced; however, the majority of the responses are based on the information collected through the MITA 3.0 State Self-Assessment from 2012. The State has released the 2015 update of the MITA3.0 State Self-Assessment (SSA). 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).
1.2 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.¹

The Texas Legislature created the Texas Health Services Authority (THSA) through House Bill (H.B.) 1066, 80th Legislature, Regular Session, 2007. 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 status and functions of the THSA under legislative authority are now set to expire on September 1, 2021 per Senate Bill (S.B.) 203, 84th Legislature, Regular Session, 2015. The legislation also authorizes the Health and Human Service Commission to designate a private nonprofit organization with relevant knowledge and experience to maintain certain statewide HIE activities. HHSC is developing a plan to meet this requirement.

The Texas Legislature also passed H.B. 1218, 81st Legislature, Regular Session, 2009, which sets the stage for Texas Medicaid to align HIE efforts with national and statewide health IT efforts. A Medicaid HIE Systems Advisory Committee was established under this legislation to advise the Texas HHSC on Medicaid activities related to health IT. In 2015, S.B. 200, 84th Legislature, Regular Session, abolished this committee and HHSC established in its place the e-Health Advisory Committee, tasked with advising the Executive Commissioner and Health and Human Services system agencies on strategic planning, policy, rules, and services related to the use of health information technology, health information exchange systems, telemedicine, telehealth, and home telemonitoring services. A key objective of the Committee is to ensure Medicaid/CHIP HIE is interoperable with broader statewide health information exchange. H.B. 2641, 84th Legislature, Regular Session, 2015, is another recent legislative change from the 84th regular Legislative session related to the definition and exchange of health information, and creating a criminal offense in the state of Texas.² This bill mandates the state’s health and human service agencies adopt nationally recognized standards in their IT systems that interface in sending or receiving protected health information. H.B. 2641, 84th Legislature, regular Session, 2015, also amends a number of mandatory public health reporting statutes to enable DSHS to exchange information for select programs through health information exchanges, at the request and with the authorization of the appropriate entity.

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 By statute, all Health and Human Services programs interpret “health information exchange (HIE)” as it is defined in Section 481.002 (54), Texas Health and Safety Code. See http://www.statutes.legis.state.tx.us/docs/HS/htm/HS.481.htm
1.3 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.
2. 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.

2.1 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.

2.1.1 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, 81st Legislature, Regular Session, 2009, advises HHSC regarding the development and implementation of the Medicaid electronic health information exchange systems to improve the quality, safety and efficiency of health care services provided through Medicaid and CHIP\(^3\). The HIE Advisory Committee was dissolved in 2015 and was replaced by a new e-Health Advisory Committee.

2.1.2 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.

\(^3\) HHS CIRCULAR C-032, Health and Human Services Enterprise, Office of e-Health Coordination, October 27, 2015
The OeHC serves as the coordination point for Texas to ensure health IT initiatives relating to Texas HHS programs are coordinated across the Texas HHS Enterprise.\textsuperscript{4}

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, a member of the THSA board, and staffs the Texas HHS Health Information Executive Steering and Management Committees. The Steering Committee 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.

\textbf{2.1.3 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 on the THSA board. Per THSA bylaws, the Governor shall appoint two non-voting ex officio members representing the Texas Department of State Health Services, and the Governor may appoint other ex officio members as the Governor deems appropriate.

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 contracted with the THSA to manage a collaborative stakeholder process and develop the strategic and operational plans as required under the cooperative agreement. In 2010, HHSC and THSA developed a State HIE Plan that guided the THSA in developing a Texas HIE infrastructure from 2010 until the Cooperative Agreement Program's end in March 2014. THSA published an updated 2014 HIE Plan in June 2014.

\section*{2.2 Status of Medicaid HIE and EHR Activities}

\textbf{2.2.1 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 modules and subsystems grouped into seven (7) functional areas: recipient, provider, reference files, third party liability, claims and encounter processing, surveillance and utilization review, and management and administration reporting. The MMIS is the “backbone” of the state’s Medicaid system, which services over 4.06

\footnote{4 HHS CIRCULAR C-032, Health and Human Services Enterprise, Office of e-Health Coordination, October 27, 2015}
million out of 27.7 million Texans annually. This is one in seven Texans—and accounts for 28.6 percent of the state’s budget.\(^5\)

The first five functional areas of the MMIS manage beneficiaries, manage 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 party liability coverage. It also collects and edits 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 provide the basis for program management and federal reporting. While essential to the efforts related to Medicaid HIE and EHR activities, the 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 MMIS contract was re-procured in 2017 through a Request for Proposals. The new contract takes effect in August 2017. 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.

HHSC contracts for the management of Pharmacy Claims and Rebate Administration (PCRA). The contract includes the processing of pharmacy claims, collection of associated data, and management of rebates. The PCRA system, along with systems for drug prior authorization and utilization review, will be replaced as part of MMIS modernization efforts. The current PCRA system includes an interface to a national e-prescribing network. 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.

2.2.2 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 will be addressed by the Provider Management modernization.
- Communications and messaging are not fully coordinated across HHSC agencies. This will be addressed by the Provider Management modernization and will be reviewed to verify all functionality is being utilized.

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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.⁶

The Assessment found three business processes related to provider communications are at MITA maturity level 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 August 5, 2014, CMS published an informational bulletin announcing the release of an Eligibility and Enrollment Supplement to the Medicaid Information Technology Architecture (MITA) Framework, Version 3.0. This Supplement represents approximately half of 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 in 2016 and ensure that new projects, technical developments, and procurements align with the State’s technology vision and Federal requirements.

HHSC has successfully completed strategic projects since the 2012 State Self-Assessment. These projects include:

- Balancing Incentives Program;
- ICD-10 Implementation;
- Transformed - Medicaid Statistical Information System (T-MSIS) Phases 1 - 3; and,
- CORE Operating Rules (Phases 1 - 3).

HHSC is coordinating the SMHP with the following strategic projects that align themselves to moving HHSC forward within the 2015 MITA 3.0 Roadmap:

- Provider Management Modernization
- Pharmacy System Modernization;
- STAR Kids Implementation; and,
- Electronic Visit Verification

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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### 2.2.3 Medicaid Eligibility and Health Information Services

The Medicaid Eligibility and Health Information Services (MEHIS), known publicly 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 HHS 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. A pilot project introducing providers to the MEHIS portal was rolled out in the Fall of 2014. The portal is currently open to all Medicaid providers and an active recruitment is ongoing. The capabilities include extended health history based on claims, encounters, and prescription history. Currently approximately 7,410 Medicaid providers and provider users are enrolled and using MEHIS.

While not a HITECH-funded initiative, the MEHIS system positions HHS 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.

### 2.2.4 Enterprise Data Governance / Enterprise Data Warehouse

The MITA 2.0 SS-A identified the need for enterprise data governance and the Enterprise Data Governance (EDG) project was established with the approval of CMS. 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. The EDG was planned to 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.

On June 28, 2016, HHSC cancelled the separate contractor solicitation process for the Enterprise Data Warehouse project. The project is suspended until further notice.

### 2.2.5 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. 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.

2.3 Status of Public Health and 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, including syndromic surveillance. 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 with and supportive of MITA. It has adopted a new governance model to improve oversight of resource utilization, continuing efforts to ensure 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 delivery applications in the Texas HHS system. These applications 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
- Health care providers, including participants in CMS’ EHR Incentive Payment Programs
- Emergency and urgent care centers
- Local health departments
- Consumers of health information data:
  - Birth, death, and divorce records
  - Immunizations, cancer, birth defects, trauma, and adult/child lead
  - Hospital discharge, and
  - 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
- Texas Cancer Registry
- Child and Adult Blood Lead Registry
- Texas Immunization Registry (ImmTrac)

**Surveillance systems**

- Infectious Disease (HIV, STD, TB, Zika)
- National Electronic Disease Surveillance System (NEDSS)
- Healthcare Associated Infections
- Statewide Syndromic Surveillance (in development)
- Newborn Screening
- Health Vital Statistic and Administrative Systems
- Hospital Discharge
- Vital Statistics
- Disease Prevention and Wellness Systems
- State laboratory

DSHS continues to support providers in their meaningful use of EHRs, providing exchange capabilities consistent with EHR Incentive Program requirements for a number of programs. HHSC and DSHS continue to collaborate on improving the alignment between public health and Medicaid/CHIP activities, including those related to HIE and EHR utilization. The organizations are working together to develop and implement organizational transformation plans, consistent with the Texas Legislature’s direction, which involves the transfer of a number of programs between organizations. DSHS is supporting Eligible Hospitals, Critical Access Hospitals, and Eligible Providers participating in CMS’ EHR incentive programs. HHSC and DSHS are continuing to work together to exchange data to support shared program goals. DSHS has provided updates to MITA staff as part of the 2014 MITA 3.0 Self-Assessment. 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. Since March 28, 2016 this data has been available to adult Medicaid clients through the MEHIS client portal (www.YourTexasBenefits.com).

The Clinical Management for Behavioral Health Services (CMBHS) - Phase Five project, as part of DSHS’ planned information technology roadmap, further increased the business capabilities within the DSHS Mental Health and Substance Abuse division and for DSHS extensive network of substance use disorder and mental health providers. It advanced the interface between CMBHS and HHSC’s Medicaid Management Information System (MMIS) by allowing providers of Youth Empowerment Services (YES) Waiver Medicaid services to document in CMBHS services delivered and to bill directly to TMHP.

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

**2.3.1 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. The success of BHIPS in improving services and documentation, especially with medium and small service providers, confirmed for Texas the importance of advancing the use of technology to improve coordination of health care delivery. Since deployment in 2010, a custom, web-based application provides an electronic health record (EHR) for substance abuse treatment service providers, 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 providers of mental health and substance abuse treatment, intervention, and prevention services and Medicaid managed care providers of mental health services. There are approximately 5,600 CMBHS users at more than 3000 organizations and clinics locations in Texas.
CMBHS currently includes support for contracted behavioral health service providers to document clinical information such as screenings, diagnosis, treatment plans, and clinical progress notes. It includes standardized assessments for people with mental health and/or substance use disorders, substance abuse service treatment plan development and review, and discharge activities. For substance abuse service providers, CMBHS also enables clinicians and staff to record progress notes, generate daily day-rate attendance records, and tracking of medication orders, and other activities. Key business processes include client registration; financial eligibility; admission; service authorization; client consent; referral; claim documentation; and submission to DSHS for payment.

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 has been expanded to process Medicaid mental health and substance abuse treatment claims for the Youth Empowerment Services (YES) Waiver program which allows flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances (SED) and their families (part of Texas’ 1915(c) Medicaid Waiver, approved by CMS in April 2009). This claims processing functionality was deployed in September 2015.

New projects that are part of DSHS’ planned information technology roadmap are the addition of diagnosis information from the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) to CMBHS, advancement of an expanded continuity of care document (CCD) with support for additional behavioral health information for hospitals and mental health community centers, and advancement of standards for data exchange, all currently underway.

DSHS continues to engage HHSC, the provider community, the Substance Abuse and Mental Health Services Administration (SAMHSA), and other partners to advance an infrastructure that fosters interoperability between state-managed mental health care providers and other health care providers. 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.

### 2.3.2 Electronic Medical Records in State Hospital System

The 11 state-operated psychiatric hospitals operated by DSHS use a modified commercial-off-the-shelf (COTS) electronic medical record system to support quality care for patients. The system provides significant clinical functionality and is augmented by an electronic medication administration system and a pharmacy management system.

DSHS is in the process of updating clinical data exchange to support continuity of care between inpatient services provided by the state hospitals and community-based mental health services 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.
2.3.3 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 have 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 in 2017.
2.3.4 Syndromic Surveillance

In Texas, there is statutory authority but no statutory requirement for the reporting of syndromic surveillance data. As of September 2016, two syndromic surveillance systems operate in Texas: a regional system hosted by Tarrant County Public Health and the former Texas Association of Local Health Officials (TALHO) system currently being maintained by DSHS. Approximately one-third of the data providers in Texas are participating in syndromic surveillance through the Tarrant County system or the TALHO system; however, the two systems do not share data. In addition, a regional system hosted by Houston Health Department is in development.

Syndromic surveillance is transforming in Texas. In collaboration with public health partners across the state, DSHS is in the process of implementing a statewide syndromic surveillance system, Texas Syndromic Surveillance (TxS2). TxS2 will accumulate data through feeds from emergency departments across the state, as well as from the regional systems hosted by Tarrant County Public Health and Houston Health Department. Tarrant County will serve providers in 49 counties located in north Texas in the Dallas-Fort Worth area and Houston Health Department will serve providers in a 16 county area in southeast Texas around Houston. TxS2 will collect data directly from health care providers in the remainder of the state, enabling both regional and statewide analysis.

2.3.5 Health Registries Improvement Initiative

The goals of the Health Registries Improvement Initiative are 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:

- 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 2017.
  - 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.

The TB/HIV/STD registry will be completed in FY 2017.

2.4 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.

The most recent surveys were conducted during the 2014-2015 time frame. Of the 2,415 eligible professionals contacted 458 completed the survey. Thirty percent of respondents had achieved meaningful use (MU), 13 percent had attested to AIU and 16 percent were registered but had not attested to AIU or MU. The majority of responses were from practices with five or less providers. The largest response was from large practices with 50 or more providers. Responses from mid-size practices were low, so conclusions were less reliable due to sample size. Respondents were asked to rate anticipated versus actual difficulty experienced in meeting MU measures. Measures where difficulty was most anticipated and experienced were patient online access, security risk analysis, clinical decision support, clinical summaries, patient reminders, immunization registries, syndromic surveillance and transitions of care. The three main areas where respondents thought program improvement was needed to help EPs overcome barriers to attestation were: process simplification (22%), education and information (22%), and issues such as changing federal rules and lack of standardization (16%).

Responses from the barrier survey were used to develop the new Health IT website to centralize information and simplify navigation and ease of access. Other outreach and advocacy initiatives to respond to impediments identified in the barrier survey include increased stakeholder engagement to advance e-prescribing and ePCS to build familiarity use of EHR technology. To respond to the education and information need identified by the survey, HHSC is exploring possible opportunities to create a free continuing education online library for provider continuing education credit focused on health IT.

2.5 Health Information Exchange Organizations in Texas

HHSC was awarded $28.8 million in federal funds over four years by the Office of the National Coordinator for Health Information Technology (ONC) for funding the State HIE Cooperative Agreement Program to support Texas developing its Strategic and Operational Plans and statewide HIE capacity. HHSC contracted with the Texas Health Services Authority (THSA) to manage a collaborative stakeholder process and develop the strategic and operational plans required under the cooperative agreement. In 2010, HHSC and THSA developed a State HIE Plan that guided the THSA in developing a Texas HIE infrastructure from 2010 until the Cooperative Agreement Program's end in March 2014. THSA published an updated 2014 HIE Plan in June 2014.

Of the 16 initially funded HIEs, six continue from the original program (See Appendix C). At a minimum, the surviving HIEs will support the delivery of lab results and exchange of patient...
clinical summaries. The HIEs offer various types of HIE services requested by providers at the community level, such as population health analytic services and/or patient portals.

2.6 Challenges of Broadband Internet Access

2.6.1 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. 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 was included in the national broadband map mandated by the federal government, which was initially published in February 2011 and available at www.broadbandmap.gov. The status of broadband availability in Texas is monitored by Connected Texas, which updates and publishes statewide broadband maps on their website.

2.6.2 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 D. To date, these grants total $79,442,192 in federal funding.

2.7 Health IT Activities Supported by the Office of the National Coordinator (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 2.5, other HITECH-funded activities are described below.

2.7.1 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 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. Each institution was the fiduciary agent for one of the four regions, as illustrated in Figure 1. As of 2017, the North Texas Regional Extension Center (NTREC) is no longer in operation.

Table 1. Health IT Regional Extension Centers in Texas

<table>
<thead>
<tr>
<th>Regional Extension Center</th>
<th>Minimum No. PCPs to be Served</th>
<th>Original Funding</th>
<th>Rural Hospital Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CentrEast Regional Extension Center</td>
<td>1,000</td>
<td>$5,279,970</td>
<td>$384,000</td>
</tr>
<tr>
<td>Texas A&amp;M Health Sciences Center, Rural and Community Health Institute</td>
<td><img src="http://www.centreastrec.org/" alt="link" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gulf Coast Regional Extension Center</td>
<td>2,200</td>
<td>$15,274,327</td>
<td>$612,000</td>
</tr>
<tr>
<td>University of Texas School of Health Information Sciences at Houston</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>North Texas Regional Extension Center</td>
<td>1,498</td>
<td>$8,488,513</td>
<td>$108,000</td>
</tr>
<tr>
<td>Dallas Fort Worth Hospital Council, Education and Research Foundation (DFWHC-ERF)</td>
<td><img src="http://www.ntrec.org/" alt="link" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Texas Regional Extension Center</td>
<td>933</td>
<td>$6,666,296</td>
<td>$912,000</td>
</tr>
<tr>
<td>Texas Tech University Health Science Center</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 RECs core services include⁸:

- EHR vendor selection;
- 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
- Security risk assessments.

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

As of 2016, the Texas RECs no longer receive funding from Texas Medicaid. Going forward, the Texas RECs will 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, including meaningful use (MU) and the three-part aim of better care, better health, and cost reduction.

2.7.2 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.9

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 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.

2.7.3 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

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9 See https://www.healthit.gov/policy-researchers-implementers/strategic-health-it-advanced-research-projects-sharp
additional capacity to meet the ongoing needs of an expanded work force. 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:

- 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

2.7.4 Community College Consortium for Health IT Education and Training

The Community College Consortium provided 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 covered the Southern region including Texas. Three Texas institutions—Houston Community College, Midland College, and the Dallas County Community College District—participated in the consortium.

2.7.5 Beacon Community Grants

No entities in Texas were awarded a Beacon Community Grant.

2.7.6 Texas Rural “White Space” Strategy

The strategy for rural Texas HIE connectivity (“white space”) is evolving. Under the State HIE Cooperative Agreement Program, the THSA established a marketplace of qualified Health Information Service Providers (HISPs) to provide physicians and hospitals in rural Texas the ability to electronically exchange health information with other clinicians in a way that is simple, secure, cost effective, and compliant with federal and state requirements, including HIPAA and EHR meaningful use.

As the State HIE Cooperative Agreement program came to an end in March 2014, the West Texas HIE White Space Advisory Board re-evaluated how they would like to electronically exchange health-related information within their region, across the state, and the rest of the nation.

To aid in this redevelopment, on July 18, 2014, the THSA issued a Request for Applications (RFA) to expand access to robust HIE services in Texas by establishing a funding opportunity to support planning for extending HIE in West Texas counties not currently served by a local HIE.

The THSA recently announced a partnership with Healthcare Access San Antonio to develop a business and operational plan for the expansion of HIE services under this RFA.
2.8 Coordination of Medicaid Health IT Activities with State HIT Coordinator

The OeHC Director is the designated State HIT Coordinator.10 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.

2.9 Status of Health IT Activities of Special Provider Stakeholders

2.9.1 Federally Qualified Health Centers

There are 70 Federally Qualified Health Care Centers (FQHCs) operating in more than 300 locations throughout Texas. There are also three FQHC “Look-Alikes” that offer services.11 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 funding through 2012. 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 73 in 2016. The Incubator program has granted funding to 60 FQHCs and two FQHC Look-Alikes to become certified or to create a new site or service. Of the 70 FQHCs in Texas, 28 became FQHCs through Incubator Grant funds.

In 2010, TACHC and two FQHCs in Texas (Table 2) 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.12 According to TACHC, at the time approximately one-third of the Texas FQHCs had an EMR, while one-third to one-half were 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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11 Look-Alikes offer FQHC-like services but do not receive all of the benefits of FQHC status.

Table 2. Texas Grantees Awarded HRSA Funding for Health IT

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

2.9.1.1 Leveraging HRSA Health IT Resources

The TACHC Health Center Controlled Networks (HCCN) grant was a grant to advance the adoption and implementation of Health Information Technology (HIT) and to support quality improvement in health centers. The HCCN grant supported the adoption and meaningful use of electronic health records (EHRs) and technology-enabled quality-improvement strategies in federally qualified health centers.

Through coordination with the OeHC, Texas Medicaid received regular updates on the experiences and lessons of EHR adoption from the three entities awarded HRSA health IT funding. As of 2017, eligible professionals at 112 FQHCs have received incentive payments from the Medicaid EHR Incentive Program for the adoption, implementation, or upgrade of a certified EHR. Eligible professionals at 61 FQHCs have received incentive payments for meaningful use of their certified EHR technology.

2.9.2 Department of Veterans’ Affairs – Clinical Facilities

In Texas, there are five Veterans’ Affairs (VA) medical centers, 20 VA outpatient clinics and 36 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.

2.9.3 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 Ysleta Del Sur Pueblo (El Paso). Each of these tribes operates a tribal clinic. The Kickapoo Tribe and the Ysleta Del Sur Pueblo are the only Texas tribes that provide health services and currently bill Medicaid and CHIP. There is a fourth tribe that provides health services and currently bills Medicaid.

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unaffiliated tribal clinic, Urban Inter-Tribal Center (UITC) of Texas, located in Dallas (See Table 3).

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

HHSC attempted to survey the tribes about their EHR adoption status and plans as part of the completion of the Medicaid HIT Plan in 2009. 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>
<thead>
<tr>
<th>Indian Health Services Clinics</th>
<th>City of Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Kina Health Clinic</strong> (Alabama-Coushatta Tribe of Texas)</td>
<td>Livingston</td>
</tr>
<tr>
<td><strong>Kickapoo Health Clinic</strong> (Kickapoo Traditional Tribe of Texas)</td>
<td>Eagle Pass</td>
</tr>
<tr>
<td><strong>Urban Inter-Tribal Center of Texas</strong></td>
<td>Dallas</td>
</tr>
<tr>
<td><strong>Ysleta Del Sur Pueblo Clinic</strong> (Ysleta Del Sur Pueblo)</td>
<td>El Paso</td>
</tr>
</tbody>
</table>

### 2.10 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.
3. THE STATE’S “TO-BE” HEALTH IT 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.

HHSC is one of the largest state agencies in Texas. HHSC is accountable for nearly one-third of the state’s budget for SFY 2015 and for the health care of over 4.06 million Texans through Medicaid. As of SFY 2015, approximately 87% of Medicaid services were administered through managed care organizations. The remaining client population is 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.  

3.1 Health IT Goals and Objectives

3.1.1 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, interoperability, health information exchange, and ultimately, improved health outcomes and efficiencies. 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.”  

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.

3.1.2 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.

14 CFR §495.332

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*.16

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 (Figure 2).

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

#### Figure 2. Medicaid Enterprise and Health Care System Goals

A select group of Texas HHS Enterprise leaders were convened in 2009 to discuss and set the To-Be vision for Texas Medicaid. The group adopted the following vision for Texas:

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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 professionals in the EHR Incentive Program, and
   • Rural physicians, dentists, physician assistants, nurse practitioners and certified nurse midwives who were included as eligible professionals 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.

3.1.3 Achieving the Vision
While health IT can provide significant advantages in data gathering and analysis, meaningful use and quality improvements in health care cannot be accomplished by data gathering alone. Meaningful use requires the actual use of information to change practices in a continuous process of quality improvement.
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 appropriate advisory committee(s), OeHC, the RECs, and professional associations to promote meaningful use and educate on the benefits of EHRs and the electronic exchange of health care information.

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.

3.1.4 Building Consensus on the Vision

Texas Medicaid is applying a multi-pronged approach to inform and engage providers on the various Medicaid HIT initiatives. 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 other HIT initiatives, and solicits feedback and input from members of the following committees:
  - Medicaid e-Health Advisory Committee (formerly Medicaid HIE Advisory Committee)
  - Regional Advisory Committees
  - Managed Care Organization (MCO) Medical Directors Committee
  - HHSC Advisory Council
  - HHSC Stakeholder Forums
  - HHSC Portal Authority
  - HHSC HIT Steering Committee

- **Conferences and Provider Forums** – Medicaid accepts opportunities to speak about the EHR Incentive Program and HIT 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 Healthcare Information and Management Systems Society (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.
Web - A series of web pages on the Texas Medicaid provider website (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. The website includes program guidance, resource documents, news articles, and links to other sites. In addition, HHSC received 90:10 HITECH funding in 2015-2016 to create a stand-alone website dedicated to health IT in Texas.

3.2 Future IT System Architecture

3.2.1 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).” 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, as well as 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), Dental Management Organizations (DMOs), Behavioral Health Organizations (BHOs), and Medical Transportation Organizations (MTOs) for members enrolled in the Medicaid STAR, STAR + PLUS, NorthSTAR, CHIP and STAR Health programs) and processes the encounter data for storage, analytics, and reporting in the existing data warehouse. In compliance with HIPAA, MCOs and other contracted management organizations are required to submit encounter data using Electronic Data Interchange (EDI) standards defined and maintained by the Accredited Standards Committee X12 (ASC X12) or the National Council for Prescription Drug Programs (NCPDP) for certain pharmacy transactions. Specifically, these organizations submit encounters using the following industry standard transactions:

- X12 837P - Professional Health Care Claim Data
- X12 837I - Institutional Health Care Claim Data
- X12 837D - Dental Health Care Claim Data
- NCPDP PA - Post Adjudicated Pharmacy Claim Data

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.

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17 See: http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx.

18 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
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 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.” The goal of any Enterprise Architecture, 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.

3.2.2 Other Critical Projects

HHSC will use opportunities in HITECH to actively work to align its projects and procurements so that they reinforce the HITECH goals to improve patient care and healthcare system efficiency, 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 implemented a new system for the SSLC Electronic Health Record (EHR) enhancement in 2015. 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).

3.3 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.

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19 Ibid.

Texas State Medicaid Health Information Technology Plan (SMHP)
August 7, 2017
ARRA and the ACA 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 in the past was the Medicaid Electronic Health Information Exchange Advisory Committee. This committee had broad representation, including representatives from all HHSC agencies and the OeHC. There were also committee members that represented THSA, regional HIEs, the RECs, health plans, hospitals, dentists, pharmacies and physicians. The role of the advisory committee was to review Medicaid plans and projects and provide guidance, advice, continuity, and direction to Medicaid on Health IT. The HIE Advisory Committee was disbanded in 2015 per state legislation and will be replaced by an e-Health Advisory Committee with similar duties.

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.

### 3.4 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 information about registration and attestation in the program. With CMS approval, HHSC contracted with three RECs to support EHR adoption and meaningful use by specialist physicians in Medicaid. Initially the RECs targeted specialists that treat high cost areas in Medicaid: asthma, diabetes, behavioral health, and heart disease. Subsequently, in 2014 CMS approved the expansion of this effort to all specialists. 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 E. This program ended September 30, 2016.
3.5 **Addressing Populations with Unique Needs**

During the 2009 Texas 81st Legislative Session, the Texas legislature passed Senate Bill 1824, which addresses quality measures and other issues of children with special health care needs (CSHCN)\(^{20}\). 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.” 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.

3.6 **Using Grant Awards for Implementing EHR Incentive Program**

HHSC received $4 million in Medicaid Transformation Grant funds in 2007 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. This interface received results from the larger commercial laboratories from 2011 until November 2012 through HHSC’s MMIS vendor, TMHP. Data transmission was suspended at that time to allow DSHS to create and implement a Master Patient Index to enable filtering of Medicaid-only lab information. DSHS completed the work in 2016, however cost estimates from TMHP to reinstate the interface have been cost prohibitive, so HHSC Medicaid is not currently receiving lab data.

3.7 **Need for New State Legislation**

Texas HHSC does not anticipate the need for new legislative changes in order to continue operating the EHR Incentive Program.

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3.8 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 enable improved health outcomes.

HHSC will also need to continue to work on aligning current and future activities-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.

4. THE EHR INCENTIVE PROGRAM

4.1 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 professionals (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.
- January 3, 2014: Texas launches Meaningful Use Stage 2 attestation for EHs.
- December 11, 2015: Launch of Modified Stage 2 Meaningful Use attestation for EPs and EHs.

As of June 2017, HHSC has disbursed $817 million in incentive funds to 10,400 EPs and 339 EHs participating in the program.

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), which includes the opportunity for providers to select the
payee/recipient of their incentive payment. 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 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.

Providers submit eligibility attestations for Texas Medicaid EHR incentives using an online portal developed by HHSC’s subcontracted vendor, CGI, Inc. The portal is known as Medicaid Incentive 360, or MI360®. To facilitate completion of the process, detailed instructions and online assistance are 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. CGI business services staff also conduct the pre-payment review process to assess the completeness of the provider’s attestation.

Upon successful submission of an attestation, a provider receives an email confirmation that they have reached “payment pending/review” status. Upon final review and approval of their attestation, the provider receives a second email notification that payment has been issued. Payment is made within 45 days after the incentive payment is approved. Texas’s attestation and payment procedures are graphically laid out below in Figure 3. It should be noted that providers who successfully pass the pre-payment review and receive payment may still be subject to post-payment audit and possible recoupment of incentives, as the pre-payment process is a review only of certain attestation elements and is not a formal audit. Recoupment of incentive funds due to discovery of overpayment at any time, and for any reason, may occur through automatic collection against the payee's Medicaid billing account, through full refund, or in some cases through referral to the HHSC Office of Inspector General or State Attorney General’s Office for collection.
4.2 Hospital Eligibility Attestation

After receiving notification of CMS registration, HHSC confirms the hospital is licensed, not sanctioned, and 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 with information to complete the attestation process. Hospitals then complete the attestation 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. For dually eligible EHs, Texas receives notification of successful meaningful use (MU) attestation from CMS and deems the EH to be a meaningful user in Medicaid. The EH must still attest to all other Medicaid EHR Incentive Program requirements, such as patient volume and use of certified EHR technology (CEHRT), in order to receive the MU incentive payment.

Per federal guidelines, EHs have followed 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/review” status by the end of the grace period; otherwise, the current year eligibility is cancelled and the EH is automatically rolled over into the next program year.
On October 16, 2015, CMS published a Final Rule titled, “Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017”. Among other things, this rule changes the EH program year from federal fiscal year to calendar year starting in 2015. The rule also extends the Medicare Program Year 2015 attestation deadline for EHs to February 29, 2016. As a result of this final rule, HHSC allowed an extended grace period for EHs in 2015 to allow sufficient time for dually eligible hospitals to complete their Medicaid attestation after submitting their Medicare meaningful use attestation. In Program Year 2015, HHSC extended the attestation deadline for EHs to April 30, 2016. In subsequent years, EHs in Texas will have the usual 75-day grace period and attestation deadline, based on calendar year.

4.2.1 Hospital Volume Attestations

The next step of the hospital process asks the eligible 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.

4.2.2 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, demonstration of access to the system, or other verifiable document. The screen capture in Figure 4 below demonstrates the AIU requirements.
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 or other data sources if appropriate to calculate the growth rate, overall EHR amount, and Medicaid share. An onscreen example is also provided to assist hospitals with their calculations. Hospitals enter up to four years of discharge data from their Medicare cost reports to calculate the growth rate for the incentive payment calculation. If a hospital does not have four years of discharge data at the time of their first year attestation (e.g. a new hospital), the growth rate is calculated based on the available data. However, a hospital must have at least one full, continuous 12-month period of discharges to report for the initial attestation and incentive calculation. HHSC requires hospitals with less than four years of discharge data to upload additional data each year that they attest, and the hospital payment calculation is revised accordingly, until the hospital has received all available incentive payments. Once a hospital has received all available payments, no further adjustment is made to the payment calculation/payment amount unless as a result of an audit, review, discovery of inappropriate payment, or at the request of the hospital (if a cost report has been amended, etc.). The cost report is used to determine other payment calculation factors as well, per CMS instructions. The total hospital incentive amount is then disbursed over three annual payments in a ratio of 50% (Year 1), 40% (Year 2), and 10% (Year 3).
All hospitals are subject to pre-payment review which includes a review of cost report data elements to ensure they match what the EH has entered in their attestation. HHSC reviews the hospital payment calculation by cross-checking the attested numbers on the hospital’s cost report(s) with the CMS-identified cost report lines in order to verify that the information entered by the hospitals matches the cost report. Starting in 2015, EHs also must complete a cost report questionnaire when attesting for a payment. The questionnaire asks hospitals to verify that their attested cost report data reflects federal requirements for incentive payments, including removal or inclusion of certain types of discharges, inpatient bed days, and bad debt from the payment calculation. The pre-payment review does not “look behind” the hospital’s cost report but rather verifies that the attested payment calculation factors match what is reported on the cost report and payment questionnaire. However, hospitals that successfully pass the pre-payment review and receive payment may still be subject to a post-payment audit to ensure that hospitals’ calculations and attestations are compliant with the federal statute and program regulations. The post-payment audit includes procedures to “look behind” the cost report and review additional documents to verify inpatient bed days, Medicaid share, and other payment calculation factors.

The screen captures in Figure 5 and Figure 6 show the summary of the hospital incentive payment calculation:
Figure 5. MI360 Screen Capture: EH Payment Calculation, Part 1

To begin the calculation of your EHR Incentive payment, you will be required to provide details for your participation in the Medicaid Incentive Program. You are required to enter the following to determine your initial incentive amount:
- Annual Growth Rate
- Discharge Amount

Annual Growth Rate

To determine the discharge-related amount for the three subsequent payment years that are included in determining the overall EHR amount, the number of discharges will be based on the average annual growth rate for the hospital over the most recent three years of available data. Discharges must come only from the acute-inpatient portion of the hospital and must exclude discharges from nursery, observation, SNF swing beds, substitute service (e.g., sub-acute wing or skilled nursing wing), psych, and rehab units. The hospital total discharges for the most recent year should be from the most recent continuous 12-month period for which data are available prior to the payment year. Please enter your Annual Growth Rate Below:

<table>
<thead>
<tr>
<th>Year</th>
<th>Discharges</th>
<th>Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>1,100</td>
<td>4.76%</td>
</tr>
<tr>
<td>2013</td>
<td>1,050</td>
<td>1.45%</td>
</tr>
<tr>
<td>2012</td>
<td>1,126</td>
<td>0.98%</td>
</tr>
<tr>
<td>2011</td>
<td>1,025</td>
<td></td>
</tr>
</tbody>
</table>

Average Annual Growth Rate: 2.46%

Check here to confirm the following:
1. Nursery Days, Psychiatric Days, Rehab Days, and/or Skilled Nursing Facility Days have been excluded from the discharge totals.
2. If applicable, Labor and Delivery, NICU, and/or ICU discharges have been included in the discharge totals.

Medicaid Discharge Amount

For the first payment year, the total hospital discharges from the most recent continuous 12-month period for which data are available prior to the payment year are used as the basis for calculating the next three years' discharges, based on the Average Annual Growth Rate determined above. For your yearly allowable discharges (these equal to or above 1,150 and a maximum of 23,600), you will receive an additional $200 for each discharge towards your total amount. For example, if you enter 20,000 as your First Year Discharges, the First Year Allowable Discharges will be set to 18,851 (20,000 - 1,150). If 25,000 is entered, it will be set to 21,149 (23,600 max - 2,451).

<table>
<thead>
<tr>
<th>Year</th>
<th>First Year Discharges</th>
<th>First Year Allowable Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>11,150</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>11,205</td>
<td>18,851</td>
</tr>
<tr>
<td>2016</td>
<td>11,353</td>
<td>21,149</td>
</tr>
<tr>
<td>2017</td>
<td>11,500</td>
<td>23,600</td>
</tr>
</tbody>
</table>

Overall EHR Amount Calculation

<table>
<thead>
<tr>
<th>Year</th>
<th>Base Amount</th>
<th>*Discharge Amount</th>
<th>* Transition Factor</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,000,560</td>
<td>$1,900.00 (0.95 * $2000.00)</td>
<td>1.00</td>
<td>$2,900,000.00</td>
</tr>
<tr>
<td>2</td>
<td>$2,000,000</td>
<td>$2,000.00 (1.00 * $2000.00)</td>
<td>0.95</td>
<td>$2,000,000.00</td>
</tr>
<tr>
<td>3</td>
<td>$2,000,560</td>
<td>$800.00 (+ $300.00)</td>
<td>1.00</td>
<td>$2,300,000.00</td>
</tr>
<tr>
<td>4</td>
<td>$2,000,000</td>
<td>$5,400.00 (2.70 * $2000.00)</td>
<td>0.25</td>
<td>$5,400.00</td>
</tr>
</tbody>
</table>

Overall EHR Amount: $5,002,000.00

For assistance, please call the EHR Help Desk at 1-800-925-9126 option 4 or email us at support@tmhp-mi.com
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 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/review” status. The CGI Business Services Center then conducts a pre-payment review of the hospital’s attested data as described previously. If approved, the hospital is added to the weekly payment cycle and HHSC issues the payment through TMHP.

4.3 Eligible Professional Eligibility Attestation

After receiving notification of CMS registration, HHSC confirms the eligible professional (EP) is licensed, not sanctioned, and not deceased (see Section 3.3.1). The confirmation is routed electronically between the EHR incentive attestation system and TMHP. HHSC then sends an email to inform the EP about the rest of the attestation process. A third party or former employer may not attest for a deceased EP, even if the EP worked at a location with CEHRT or met meaningful use criteria for part of the Program Year.

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

EPs then complete the attestation process in the MI360 portal. In the portal, providers attest to patient 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/review” 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.

On October 16, 2015, CMS published a Final Rule titled, “Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017”. As a result of the late issuance of the Final Rule, HHSC extended the attestation deadline for EPs in PY 2015 to April 30, 2016. This aligned with the extended attestation deadline for EHs as well.

4.3.1 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 general billing purposes, Texas enrolls FQHCs and RHCs in Medicaid with a “facility” designation and the State does not require individual FQHC/RHC providers to enroll in order to provide services to Medicaid clients. However, in order to participate in the EHR Incentive Program, Texas requires individual 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 FQHC/RHC providers for participation in the EHR Incentive Program and cannot be used for billing Medicaid claims. The provider is required to identify the NPI that is currently used for billing (generally the NPI of the FQHC/RHC facility). Under the limited enrollment, the incentive payment must be assigned to the facility’s 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 EPs who are attesting as part of a group practice using the group Medicaid volume calculation to 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 Medicaid enrollment process is lengthy and can take 30 to 90 days to complete. Some providers do not initiate the enrollment process early enough to receive their Medicaid provider credentials in time to meet EHR program deadlines. In the past, Texas has allowed extensions for these providers to allow them to attest. However, this has resulted in significant delays for the State to ‘close out’ each program year. Starting in Program Year (PY) 2015, Texas no longer allows deadline extensions for providers who do not initiate a Texas Medicaid enrollment application by December 31 of the Program Year. For example, if an EP intends to attest to Program Year 2015 but does not initiate a Medicaid enrollment application until January 15, 2016, there is no guarantee the EP’s Medicaid credentials will be issued by the attestation deadline. If the provider’s Medicaid credentials are issued in time for the PY 2015 deadline, he will be allowed to attest. However, if the EP’s credentials are not issued by the attestation deadline, he will not be granted an extension. In another example, if a provider submits an application for Medicaid enrollment prior to December 31, 2015 and has not received his credentials by the PY 2015 deadline, he might be granted an extension to complete the attestation after his Medicaid credentialing is completed.

The following sources are matched for verification prior to Medicaid 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:
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:

- Physician (Doctor of Medicine or Doctor of Osteopathy)
- Nurse Practitioner
- Dentist
- Certified Nurse Midwife
- 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.)
- Optometrist (O.D.)

For purposes of the Texas Medicaid EHR Incentive Program, the provider type “Nurse Practitioner” is limited to a nurse licensed as a Nurse Practitioner by the Texas Board of Nursing. It does not include Clinical Nurse Specialists or other categories of nurses, as the Texas Board of Nursing deems the scope of practice and licensing for these types as separate and distinct from the Nurse Practitioner.

4.3.2 Attesting to Medicaid Patient Volume

The EHR incentive portal provides EPs with the capability to enter Medicaid and total encounter data needed to calculate the 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 pediatric 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.

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21 A Texas State Plan Amendment (SPA) was submitted to CMS on June 28, 2013 to allow Optometrists to qualify for the incentive program. The SPA was approved by CMS on February 11, 2014.
setting. Hospital-based status is determined by a review of the previous 12-month period (calendar year) 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 verification processes.

The first step of the EP attestation process asks EPs to attest to total practice volumes and Medicaid volumes. As allowed by the EHR incentive regulation, Texas gives 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 panel patients. Panel patient counts must be unduplicated from other patient encounters included in the calculation.

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 attesting 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 attesting 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 Medicaid and may include “needy patient encounters” 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. 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.

“Practices predominantly” is defined as having more than 50% of an EP’s 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.

Non-FQHC EPs may use either the individual volume calculation method or group volume calculation. EPs practicing predominantly in an FQHC or RHC may use either the individual volume calculation method or clinic volume calculation. FQHC/RHC providers may use needy patient encounters in determining their individual or clinic volume. All EPs, whether in private practice or working in FQHCs/RHCs will follow an “all in / all out” rule related to the volume calculation, as described by CMS. This means that all providers in a group practice or FQHC/RHC clinic must attest to the same volume methodology – either all must attest using individual volume or all must attest using group/clinic volume.

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.
4.3.2.1 For EPs Attesting to Patient Volume Using the Encounter Methodology

All providers 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, EPs must demonstrate their Medicaid share of encounters over three consecutive calendar months. 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 Medicaid encounters. The consecutive three month volume reporting period is the default option for providers during attestation. 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 SMHP 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 inpatient and outpatient 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 4.3.2.2 below.

Encounters are calculated around count of claims and encounters per performing provider. 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.

In the case of volume reporting for resident physicians, nurse practitioners, and physician assistants who may work under a supervising physician, Texas follows CMS guidance in allowing the supervising physician to count both his own encounters and the encounters of EPs that he supervises. This is allowed for both volume reporting and meaningful use measures (numerator/denominator).22

4.3.2.2 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

22 CMS EHR Incentive Program FAQs #3309 and #2817
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.

4.3.2.3 For EPs Attesting to Patient Volume Using the Group Option (non-FQHC)

Medicaid provides an option for physicians or other EPs practicing in a group to attest to patient volume by group 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 must still complete the individual attestation process but will input the group’s patient volume for their attestation. Texas requires EPs using the group volume calculation to attest that:

(1) The 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. This does not apply to EPs practicing predominantly in an FQHC or RHC who are attesting to their clinic volume;

(3) there is an auditable data source to support the group’s patient volume determination; and

(4) all EPs decide to use one methodology for the same participation year (in other words, groups cannot have some of the EPs using their individual patient volume while others use the group-level data).

4.3.3 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 provide supporting documentation for AIU. All EPs are subject to pre-payment review to verify documentation. Documents are uploaded via the EHR incentive portal to support the provider’s attestation. (Attesting providers are instructed that they should retain evidence of their EHR acquisition in their files in case they are selected for audit.) EPs are required to demonstrate AIU through a document such as a purchase order, contract, software license, or other document that shows a financial relationship between the
software vendor and the EP and/or individual access to the CEHRT. In the case of an EP who attests to adopting free software, such as a free cloud-based CEHRT, the EP must demonstrate that the software was acquired (accessible to the EP) prior to attestation. Because there is no financial relationship between the vendor and the EP for a free CEHRT, the EP must demonstrate acquisition through establishment of an individual, unique login and/or other method of direct provider access to the software prior to attestation. A group practice may not “adopt” a cloud-based EHR, or any licensed CEHRT, through the acquisition of only one log-in credential for the group, as this does not demonstrate AIU at the individual level per CMS requirements. A group practice must acquire sufficient licenses and unique account log-ins to cover “adoption” by all individual users for purchased or free EHR software.

4.4 Appeals During Attestation

Texas Medicaid has established an attestation appeals process for three distinct conditions in accordance with federal regulation. This process is separate and distinct from the post-payment audit appeals process, which is described elsewhere in this SMHP and in the State’s Audit Plan. During attestation, the following types of informal appeals are allowed:

1. Appeals regarding an unfavorable determination of Medicaid volume or other eligibility criteria which prevents approval of the payment.
2. Appeals regarding determination of payment amounts, primarily affecting hospitals or pediatricians.
3. Appeals regarding an unfavorable determination of EHR use—adopt, implement and upgrade and/or meaningful use of EHRs which prevents approval of the payment.

A provider may appeal one of the conditions above during attestation by submitting the appeal request electronically through the MI360 portal. The appeal is reviewed by the program attestation administrator (CGI) and referred to the Medicaid/CHIP Health Informatics Services and Quality (HISQ, formerly Health IT division) within HHSC for an informal desk review and final determination as necessary. This process is detailed graphically below. (A separate appeal process for post-payment audit determinations is described in Section 5 (Audit Strategy)).
4.5 Payment Assignment and Disbursement

Payment is made in the first month following successful attestation and incentive payment approval (not to exceed 45 days from approval). 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 accounts receivable (AR) owed to Texas Medicaid, a portion of the payment may be withheld to satisfy the Medicaid debt, per CMS guidelines. Texas Medicaid does not disburse incentive payments through Medicaid managed care plans. Existing Medicaid audit requirements apply to EHR incentive payments. Audit procedures are detailed in Section 5. Figure 8 below details the payment processing flow for EHR incentive payments.
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.

If an overpayment to an EP or EH is identified, a negative adjustment is applied in the form of an accounts receivable (AR) to the provider’s (payee's) Medicaid account, as shown in the diagram above. The overpayment is recouped against the provider’s (payee's) Medicaid billing stream,
unless an alternative payment plan is agreed upon between the provider and HHSC. In some cases where HHSC is unable to recoup the funds, the case may be sent to the Attorney General’s office for additional recoupment attempts against either the payee or the EP that attested and re-assigned the payment.

Texas uses a three-year payout for hospital 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. Eligible professionals receive up to six incentive payments, following the CMS prescribed payout schedule.

4.5.1 Providers Practicing at More Than One Site

The provider cannot split payment of incentives across multiple entities in a given year; 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. HHSC has no authority in the contractual arrangements between individual providers and their practices. As a result, HHSC is not involved in payment disputes between providers and entities who have received payments on their behalf, and HHSC does not review appeals based on incentive payment disputes.

4.5.2 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.

4.6 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 implemented Stage 2 requirements in January 2014 for EHs 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 CEHRT. After meeting the eligibility requirements, EPs are directed to a series of screens that guide them through attestation for each of the 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 MI360 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 measures, as well as CQMs.

Texas began collection of Stage 1 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 adopted a “learning environment” approach to the implementation of this program, both internally with staff and externally with providers. Texas created web-based computer-based training courses for providers and any interested person to learn about the EHR Incentive Program, including enrollment and attestation requirements, AIU and MU. The training courses have been available since 2012 at www.texasehrincentives.com. With the end of AIU and prohibition of new participants in the EHR Incentive Program after 2016, HHSC will retire the online courses in FFY 2018. Other learning and outreach initiatives are described in Section 6 (Outreach and Education) of this SMHP.

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, except for changes related to the 2014 CEHRT Flexibility Final Rule published by CMS on September 4, 2014. These changes were submitted to CMS as an SMHP addendum on December 5, 2014 and were approved on December 8, 2014. The addendum has been incorporated into the SMHP in Section 4.6.1 below, with updates.

Separately, but related to MU modifications, CMS issued a clarification to the reporting period requirement for the meaningful use core measure related to conducting a Security Risk Assessment (SRA). In CMS Frequently Asked Question (FAQ) #10754, CMS clarified that the SRA “may be completed outside of the EHR reporting period timeframe but must take place no earlier than the start of the EHR reporting year and no later than the provider attestation date.” Texas has adopted this guidance for the Stage 1 and Stage 2 attestations in 2014 and beyond.23 The “provider attestation date” within the MI360 portal is determined by the provider’s last submitted attestation. This means that providers who attest, are rejected, and return later to re-submit an attestation for a given Program Year would have an attestation date that corresponds to the most recent submission. Therefore the SRA reporting timeframe would

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23 Prior to 2014, Texas allowed the SRA to be completed any time prior to the EHR reporting period but no later than the last day of the reporting period.
also apply to providers whose attestation date falls outside of the calendar year but still during the allowed grace period (“tail period”) for a given Program Year.

4.6.1 2014 CEHRT Flexibility Rule and Meaningful Use Attestation

The U.S. Department of Health and Human Services (HHS) and CMS published a Final Rule in the Federal Register on September 4, 2014, that allows health care providers more flexibility in the version of Certified Electronic Health Record Technology (CEHRT) that they can use to meet meaningful use in the EHR Incentive Program in 2014. The final rule became effective on October 1, 2014, and grants flexibility to providers participating in the Medicare and Medicaid EHR Incentive Programs in 2014 who are unable to fully implement a 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability. The delay in 2014 Edition CEHRT availability must be attributable to issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor, which resulted in the inability for a provider to fully implement 2014 Edition CEHRT.

Texas implemented the 2014 CEHRT Flexibility Rule (Flex Rule) options on October 1, 2014, via changes in the State's online attestation system, MI360. The changes made to Texas' attestation system follow the guidance given in the Final Rule. Specifically, providers who are unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability will be granted the ability to select the meaningful use Objectives and Clinical Quality Measures (CQMs) based on the CEHRT used for the 2014 program year. The following presents the options available in MI360 to eligible professionals and eligible hospitals based on their software and meaningful use (MU) schedule:

- **2011 CEHRT**
  - If they are scheduled to report Stage 1 or Stage 2 MU, they can attest to:
    - 2013 Stage 1 Objectives and 2013 CQMs
  - Combination of 2011 and 2014 CEHRT
    - If they are scheduled to report Stage 1 MU, they can attest to:
      - 2013 Stage 1 Objectives and 2013 CQMs; or
      - 2014 Stage 1 Objectives and 2014 CQMs
    - If they are scheduled to report Stage 2 MU, they can attest to:
      - 2013 Stage 1 objectives and 2013 CQMs; or
      - 2014 Stage 1 objectives and 2014 CQMs; or
      - Stage 2 objectives and 2014 CQMs

- **2014 CEHRT**
  - If they are scheduled to report Stage 1, they can attest to:
    - 2014 Stage 1 objectives and 2014 CQMs
  - If they are scheduled to report Stage 2 MU, they can attest to:
    - Stage 2 objectives and 2014 CQMs; or
    - 2014 Stage 1 objectives and 2014 CQMs

- Providers will not be given the choice to 'mix and match' measures from different sets and cannot attest to a combination of these editions (e.g., 2014 edition for Core and Menu and 2011 edition for CQMs).
- Providers who choose to attest to an option other than their default must attest that they are unable to fully implement 2014 Edition CEHRT because of issues related to 2014...
Edition CEHRT availability delays. They are required to check a box attesting that they qualify for a flexibility option. They are also required to upload documentation supporting their eligibility for a flexibility option. Documentation may include a vendor letter describing delays in implementation or other appropriate and relevant evidence that the provider was unable to fully implement due to vendor delays.

- If the provider attests to qualifying for a flexibility option due to delays in implementing 2014 CEHRT, the provider is required to enter a free form text reason for their inability to fully implement the 2014 Edition CEHRT.
- After the entry of the reason, they are required to specify the CEHRT version that was used for the 2014 MU reporting period.

Providers are requested to declare their intention of using 2014 Edition CEHRT or take advantage of the 2014 CEHRT Flexibility option. If they choose the fully implemented 2014 Edition CEHRT, they will proceed on the standard path prior to the recent Flex Rule.

Due to the short timeframe for implementation of the Flex Rule, Texas implemented only a few pre-payment review changes for attestations completed using a 2014 CEHRT flexibility option. Providers are required to attest that they qualify for a 2014 flexibility option and could not fully implement 2014 CEHRT due to the delay of 2014 CEHRT as defined by CMS. If a provider selects a 2014 flexibility option, the provider is required to choose from a list of allowable reasons and/or enter free-form text describing the reason that they were unable to fully implement 2014 CEHRT. There are no automated edits on this text. However, HHSC requires additional information during pre-payment review to support this part of a provider's attestation, such as a vendor letter, communications with the vendor regarding system issues and bugs, trouble tickets identifying issues with the software implementation, etc.

The free-form text and required documentation are reviewed manually by program specialists from the program administrator (CGI). If a provider's documentation does not appear to meet the CMS requirements, the case is elevated to HHSC for further review and approval.

In the Flex Rule, CMS provided some clarifications about what might constitute an acceptable reason, as well as what does not qualify for a flexibility option. HHSC will follow the guidance in the Flex Rule to determine what is an acceptable reason, with an emphasis that the delay in 2014 CEHRT availability must be attributable to vendor issues related to software development, certification, implementation, testing or release. For example, per the Flex Rule, the following reasons are acceptable and are listed in the instructional text in the attestation portal:

- A provider is waiting for 2014 CEHRT installation or an upgrade from the vendor.
- The 2014 software itself is presenting problems with functionality or does not yet contain all required components, including the functionality to attest for all MU menu measures.
- A provider could not fully implement 2014 CEHRT for a full reporting period due to vendor issues or delays.
- An inability to train staff, test the updated system or put new workflows in place for a full EHR reporting period because of the delays associated with the installation of 2014 CEHRT.

These examples are not all inclusive. As CMS stated in the Flex Rule, “…we cannot capture every scenario where a provider can use an option for the use of CEHRT…”, hence HHSC will
follow the available guidance and seek further clarification from CMS if an unusual scenario presents itself.

Likewise, the Flex Rule clarifies some reasons that are not acceptable to use a flexibility option. These examples are listed in the instructional text in the attestation portal, and HHSC will adhere to this guidance, which includes, but is not limited to, reasons such as:

- A provider waited too long or refused to purchase/install/update 2014 CEHRT
- A lack of staff or resources, including financial resources, to fully implement 2014 CEHRT.
- A provider cannot meet certain MU measure thresholds or failed to conduct the activities necessary to meet a measure (for reasons unrelated to the inability to fully implement 2014 CEHRT).
- Inability to fully implement 2014 CEHRT due to staff turnover or attrition.

Providers attesting to a 2014 flexibility option undergo all the additional pre-payment review procedures as currently implemented in the system and outlined in the SMHP and the State’s Audit Plan. Any changes to post-payment audit procedures are undetermined at this time and will be described in future updates to the State's Audit Plan.

### 4.6.2 Public Health Meaningful Use Measures

In addition to the specific changes required by the Flex Rule, CMS subsequently issued guidance through Frequently Asked Questions (FAQs), Communities of Practice webinars, and All States Calls regarding the public health meaningful use menu measures. CMS noted that the vendor delays addressed by the Flex Rule might also impact providers’ ability to meet the public health registry reporting requirements of meaningful use. CMS FAQ #2903 addressed the general meaningful use requirements for the public health measures. The FAQ clarified that for Stage 1, a provider who qualifies for an exclusion from both public health menu measures can “meet the menu requirement in one of two ways:

1. Claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set.
2. Report on five menu objectives from outside the public health menu set.”

In a revision to FAQ #2903 on March 10, 2015, CMS indicated that the guidance above applies to Medicare attestations only and implied that the requirements for Medicaid could be determined individually by the States. Therefore, to align with Medicare, Texas has adopted the same options within the Medicaid attestation system for Program Year 2014, with the exception that a provider is required to claim an exclusion to both public health measures in the attestation system before moving forward with option #1 above. This ensures that they are attesting to the fact that they cannot meet either public health menu measure.

In addition, in the March 2, 2015 All States Call, CMS extended the immunization registry reporting timeframe for 2014, stating that in 2014, the immunization registry test for Stage 1 may occur during the calendar year up to the date of attestation, instead of being limited to the 90-day EHR reporting period. In a follow-up email to HHSC on March 5, 2015, CMS clarified that the reporting extension also applies to the syndromic surveillance measure. Therefore, HHSC has adopted this guidance for 2014 attestations. As with the Security Risk Assessment (SRA)
measure, the reporting extension for these public health measures would also apply to providers whose attestation date falls during the allowed grace period (“tail period”) for a given Program Year.

The table below illustrates the various reporting timeframes described above.

**Table 4. Reporting Timeframes/Extensions for Public Health and Security Risk Assessment Measures**

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Measure</th>
<th>Allowable Reporting Timeframe Start</th>
<th>Allowable Reporting Timeframe End</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>Immunization</td>
<td>Start of Current Program Year</td>
<td>Attestation Date</td>
</tr>
<tr>
<td></td>
<td>Syndromic Surveillance</td>
<td>Start of Current Program Year</td>
<td>Attestation Date</td>
</tr>
<tr>
<td></td>
<td>Electronic Lab Reporting</td>
<td>Start of Current Program Year</td>
<td>Attestation Date</td>
</tr>
<tr>
<td>2014</td>
<td>SRA</td>
<td>Start of Current Program Year</td>
<td>Attestation Date</td>
</tr>
<tr>
<td>2015 and 2016</td>
<td>Immunization</td>
<td>Start of Current Program Year (unless already in active engagement from a previous year)</td>
<td>MU Reporting Period End</td>
</tr>
<tr>
<td>2015 and 2016</td>
<td>Syndromic Surveillance</td>
<td>Start of Current Program Year (unless already in active engagement from a previous year)</td>
<td>MU Reporting Period End</td>
</tr>
<tr>
<td>2015 and 2016</td>
<td>Electronic Lab Reporting</td>
<td>Start of Current Program Year (unless already in active engagement from a previous year)</td>
<td>MU Reporting Period End</td>
</tr>
<tr>
<td>2015 and 2016</td>
<td>SRA</td>
<td>Start of Current Program Year</td>
<td>Attestation Date</td>
</tr>
</tbody>
</table>
Table 4. Reporting Timeframes/Extensions for Public Health and Security Risk Assessment Measures (continued)

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Measure</th>
<th>Allowable Reporting Timeframe Start</th>
<th>Allowable Reporting Timeframe End</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 and beyond</td>
<td>Immunization</td>
<td>Start of Current Program (Calendar) Year (unless already in active engagement from a previous year)</td>
<td>End of Calendar Year</td>
</tr>
<tr>
<td>2017 and beyond</td>
<td>Syndromic Surveillance</td>
<td>Start of Current Program (Calendar) Year (unless already in active engagement from a previous year)</td>
<td>End of Calendar Year</td>
</tr>
<tr>
<td>2017 and beyond</td>
<td>Electronic Lab Reporting</td>
<td>Start of Current Program (Calendar) Year (unless already in active engagement from a previous year)</td>
<td>End of Calendar Year</td>
</tr>
<tr>
<td>2017 and beyond</td>
<td>SRA</td>
<td>Start of Current Program (Calendar) Year (unless already in active engagement from a previous year)</td>
<td>End of Calendar Year</td>
</tr>
</tbody>
</table>

4.6.3 Modifications to Meaningful Use in 2015 Through 2017 Final Rule

CMS published a Final Rule, subtitled “Medicare and Medicaid Programs; Electronic Health Record [EHR]Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017”, in the Federal Register on October 16, 2015. This Final Rule, referred to here as the “Modified Stage 2 Final Rule” revises the regulatory requirements for achieving Meaningful Use in the Medicare and Medicaid EHR Incentive Programs for Program Years 2015 through 2017. This Final Rule also establishes the baseline requirements for Stage 3 Meaningful Use that become optional in Program Year 2017 and compulsory for all program participants in Program Year 2018 and beyond. HHSC implemented changes to conform to the Stage 3 MU requirements, with a Stage 3 system 'go live' date of April 1, 2017. This will allow EPs and EHs to optionally attest to Stage 3 in 2017 and will require all providers to attest to Stage 3 in 2018 and beyond.

Changes were implemented in the state's attestation system, known as Medicaid Incentives 360 (MI360), to offer EPs and EHs the option to select Stage 3 attestation in 2017. Once an EP or EH makes their selection, they are directed down the appropriate attestation path in the system to attest to either Stage 2 or Stage 3 MU measures. No new policies are required to allow this option. No new pre-payment review procedures are needed to address this change, as HHSC’s pre-payment review requires submission of an MU dashboard regardless of the provider’s MU stage. Any required changes in post-payment audit procedures will be addressed in a later version of the state's Audit Plan, as HHSC is currently auditing only Program Years 2013 and 2014 at this time.
4.6.3.1 Operational Impact

Through cooperation with HHSC’s Medicaid EHR Incentive Program vendor, CGI, HHSC developed a new release of the Texas State Level Repository (SLR) system to accommodate the Final Rule changes that went into effect on December 15, 2015 related to Stage 2. The Texas SLR changes that were made to the MI360 baseline product accommodate the rules, regulation and subsequent CMS guidance for all components of the Final Rule as related to Stage 2. Specifically, the Texas SLR was modified as follows:

Reporting Period

All Program Year 2015 attestations will require a 90 day meaningful use reporting period regardless of stage or prior attestations. For eligible hospitals and Critical Access Hospitals (CAHs), the continuous 90 day period must occur entirely between October 1, 2014 and December 31, 2015. Eligible professionals are also required to attest using a 90 day meaningful use reporting period for Program Year 2015, within the calendar year 2015, regardless of stage or prior attestations. The Texas SLR requires the attesting provider to explicitly specify the MU reporting start and end, systematically evaluating the values to ensure it is at least a continuous 90 days within the acceptable window. If the provider enters a period that is less than 90 days, or outside of the valid reporting window, the Texas SLR displays an error message and prevents the user from proceeding.

In 2016 and beyond, the Texas SLR will enforce the full calendar year MU reporting period for all provider attestations, with the exception of providers demonstrating meaningful use for the first time. Providers demonstrating meaningful use for the first time in Program Years 2016 and 2017 must attest using meaningful use reporting period of a continuous 90 days within the corresponding calendar year. (Note that Texas implemented these changes in December 2015 per the Modified Stage 2 Final Rule, and these changes remained in effect until the Hospital Outpatient Prospective Payment (OPPS) Rule discussed in Section 4.6.4 went into effect on January 1, 2017.)

Certified EHR Technology (CEHRT) Edition

All Program Year 2015 attestations require the substantiated use of 2014 Edition Certified EHR Technology. The Texas SLR will continue to use the existing ONC verification web-service to ensure that the provider attests with a valid 2014 Edition CEHRT. In Program Years 2016 and 2017, participating providers have the option to use a 2014 Edition CEHRT, 2015 Edition CEHRT, or a combination of the two. The Texas SLR’s CEHRT verification module will be modified to recognize the 2015 Edition CEHRT numbers after the ONC publishes the numbering mechanism that will be used.

Meaningful Use Objectives and Measures

HHSC’s SLR vendor, CGI, supports the operation of the Medicaid EHR Program for five states using the MI360 application. The MI360 application is a highly configurable base system that is used to support all of the five states in the MI360 Consortium. CGI has configured the MI360 system to support the new Meaningful Use Objectives and Measures as defined in the Modified Stage 2 Final Rule to support Program Years 2015 through 2017.
The SLR is configured to support the alternate measure and exclusion attestation options afforded to providers scheduled to demonstrate meaningful use in program years 2015 and 2016. The system maintains the history of all provider attestations and will determine which providers meet the qualifications for the alternate measures. The SLR will only present the alternate measures and exclusions to those qualified providers to prevent the inadvertent selection of exclusions for which they are unqualified. The diagram below depicts the attestation workflow:

The MI360 provider portal is configured to enforce the attestation to the following appropriate meaningful use objectives and measures. The MI360 portal controls the attestation flow based on whether the provider is scheduled for Stage 1 and eligible for the alternate measures. These providers have the option to choose to attest to the Modified Stage 2 measure, the alternate measure, or an exclusion if applicable.

The table below presents an overview of the Modified Stage 2 meaningful use objectives for EPs with the cross references to the equivalent legacy Stage 1 and Stage 2 objectives. The table presents an indication of whether alternate measures and/or exclusions exist for scheduled Stage 1 providers in Program Year 2015 and/or 2016.
Table 5. Modified Stage 2 EP Objective Summary

<table>
<thead>
<tr>
<th>Modified Stage 2 Objective</th>
<th>2014 Stage 2 Objective</th>
<th>2014 Edition Stage 1 Objective</th>
<th>Alt PY15</th>
<th>Alt PY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1: Protect Electronic Health Information</td>
<td>Core 9: Protect Electronic Health Information</td>
<td>Core 13: Protect Electronic Health Information</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Objective 3: CPOE</td>
<td>Core 1: CPOE</td>
<td>Core 1: CPOE</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Objective 4: Electronic Prescribing</td>
<td>Core 2: e-Prescribing (eRX)</td>
<td>Core 4: e-Prescribing (eRx)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Objective 5: Health Information Exchange</td>
<td>Core 15: Summary of Care</td>
<td>Menu 7: Transition of Care Summary</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Objective 6: Patient Specific Education</td>
<td>Core 13: Patient-Specific Education Resources</td>
<td>Menu 5: Patient-Specific Education Resources</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Objective 7: Medication Reconciliation</td>
<td>Core 14: Medication Reconciliation</td>
<td>Menu 6: Medication Reconciliation</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Objective 9: Secure Messaging</td>
<td>Core 17: Use Secure Electronic Messaging</td>
<td>N/A</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Objective 10: Public Health</td>
<td>Core 16, Menu: 1, 5, 6; Public Health Registries</td>
<td>Menu 8, 9: Public Health Registries</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

The table below presents an overview of the Modified Stage 2 meaningful use objectives for EHs with the cross references to the equivalent legacy Stage 1 and Stage 2 objectives. The table presents an indication of whether alternate measures and/or exclusions exist for scheduled Stage 1 hospitals in Program Year 2015 and/or 2016.
Table 6. Modified Stage 2 EH Objective Summary

<table>
<thead>
<tr>
<th>Modified Stage 2 Objective</th>
<th>2014 Stage 2 Objective</th>
<th>2014 Edition Stage 1 Objective</th>
<th>Alt PY15</th>
<th>Alt PY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1: Protect Electronic Health Information</td>
<td>Core 7: Protect Electronic Health Information</td>
<td>Core 11: Protect Electronic Health Information</td>
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<td>✗</td>
</tr>
<tr>
<td>Objective 2: Clinical Decision Support</td>
<td>Core 5: Clinical Decision Support</td>
<td>Core 2: Implement Drug-Drug Interaction Check Core 9: Clinical Decision Support</td>
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<td>✗</td>
</tr>
<tr>
<td>Objective 3: CPOE</td>
<td>Core 1: CPOE</td>
<td>Core 1: CPOE</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Objective 4: Electronic Prescribing</td>
<td>Menu 5: e-Prescribing (eRX)</td>
<td>N/A</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Objective 5: Health Information Exchange</td>
<td>Core 12: Summary of Care</td>
<td>Menu 7: Transition of Care Summary</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>Objective 6: Patient Specific Education</td>
<td>Core 10: Patient-Specific Education Resources</td>
<td>Menu 5: Patient-Specific Education Resources</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>Objective 7: Medication Reconciliation</td>
<td>Core 11: Medication Reconciliation</td>
<td>Menu 6: Medication Reconciliation</td>
<td>✔</td>
<td>✗</td>
</tr>
<tr>
<td>Objective 9: Secure Messaging (N/A – EHs)</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 10: Public Health</td>
<td>Core 13, 14, 15: Public Health Registry Reporting</td>
<td>Menu 8, 9, 10 : Public Health Registry Reporting</td>
<td>✔</td>
<td>✗</td>
</tr>
</tbody>
</table>

The CQM component of the meaningful use attestation has not been modified. EPs will continue to be required to attest to a minimum of 9 (nine) CQMs across at least three domains. EHs will continue to be required to attest to a minimum of 16 CMQs across at least three domains.

The MI360 provider portal was configured to commence attestations under the Modified Stage 2 Final Rule on December 15, 2015.

Documentation Requirement Changes

HHSC evaluated the regulatory changes defined in the Modified Stage 2 Final Rule and concluded that the existing documentation requirements sufficiently corroborate the provider attestation for the respective measures. The existing supporting documentation requirements will be applied to the equivalent objective under the new numbering system. The table below presents the supplemental documentation requirements (beyond the required CEHRT-generated MU Summary Report) for each objective based on provider type, EP or EH. Please note that we require an MU Summary Report, or screenshot equivalent to corroborate certain measures as applicable.
Table 7. Proposed Modified Stage 2 Objective Documentation Requirements

<table>
<thead>
<tr>
<th>Modified Stage 2 Objective</th>
<th>EP Doc Required?</th>
<th>EH Doc Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1: Protect Electronic Health Information</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Objective 2: Clinical Decision Support</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Objective 3: CPOE</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Objective 4: Electronic Prescribing</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Objective 5: Health Information Exchange</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Objective 6: Patient Specific Education</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Objective 7: Medication Reconciliation</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Objective 8: Patient Electronic Access (VDT)</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Objective 9: Secure Messaging</td>
<td>N</td>
<td>N/A</td>
</tr>
<tr>
<td>Objective 10: Public Health</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Additional documentation may be requested for all MU objectives and measures if needed during pre-payment review and during post-payment audit.

Per the CMS guidance presented in section II.B.1.b.(4).b.(iii), on page 62788 of the Rule, HHSC does not impose any documentation requirement for providers to substantiate their “intent” when exercising the alternate exclusions based on “they did not plan to attest to a menu objective.”

4.6.3.2 SLR Modified Stage 2 Transition Strategy

The MI360 attestation portal remained “open” the entire calendar year 2015, allowing providers to submit AIU and Meaningful Use attestations, while awaiting publication of the Modified Stage 2 Final Rule. HHSC worked closely with CGI to establish a transition plan that allowed the continuation of the AIU attestations without interruption, and transition the meaningful use attestations to the Modified Stage 2 format. HHSC discontinued accepting legacy MU attestations at midnight on November 20, 2015 until the Modified Stage 2 effective date on December 15, 2015. This meaningful use attestation down-time was used to focus all efforts and resources to finalizing the pre-payment reviews of the submitted MU attestations before transition to the Modified Stage 2 structure. Support of AIU attestations was supported continuously without interruption.

The following table represents the schedule of activities for the transition to Modified Stage 2.
Table 8. Modified Stage 2 Transition Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accept Program Year 2015 AIU Attestations</td>
<td>January 1, 2015 – April 30, 2016</td>
</tr>
<tr>
<td>Accept Program Year 2015 90 Day Stage 1 Attestations</td>
<td>March 30, 2015 – November 20, 2015</td>
</tr>
<tr>
<td>Complete 90 Day Stage 1 Attestation Pre-Payment Reviews</td>
<td>November 21, 2015 – December 15, 2015</td>
</tr>
<tr>
<td>Commenced Accepting Modified Stage 2 Attestation</td>
<td>December 15, 2015</td>
</tr>
</tbody>
</table>

Attestation Grace/Tail Period

Due to the timing of the effective date of the Modified Stage 2 Final Rule and the modifications to the attestation system, HHSC received approval from CMS for Program Year 2015 attestation grace/tail periods as follows:

EH Grace/Tail Period: April 30, 2016

CMS also approved extensions to the Program Year 2016 attestation grace/tail periods as follows:

EP Grace/Tail Period: May 15, 2017
EH Grace/Tail Period: May 15, 2017

Attestations for Program Years 2017 and beyond will be subject to HHSC’s current standard grace/tail periods of:

EP Grace/Tail Period: 75 days
EH Grace/Tail Period: 75 days

4.6.3.3 Provider Outreach and Support Related to Modified Stage 2 Final Rule

HHSC is developing and implementing a multi-faceted provider outreach strategy with the goal of ensuring broad awareness of the impact of Modified Stage 2 rules and our approach to facilitate support to maximize the number of righteous attestations. The methods and tools utilized include, but are not limited to the following:

- Mass broadcast emails to all registered providers providing updates and developments as they occur.
- Refreshing the HHSC HIT/EHR Incentive Program website with developments as they occur.
- Schedule and conduct educational webinars for eligible professionals, eligible hospitals and CAHs for live presentation and Q&A sessions.
• Post recordings of webinars for future access

HHSC is collaborating with CGI to jointly develop and implement provider support procedures and tools to support the changes in the Modified Stage 2 Final Rule. The CGI MI360 Business Services team is the primary point of contact for providers requesting support with completing the Medicaid EHR Incentive Program attestations. As such, the CGI Business Services team updated their internal state-specific tip sheets to track the refinements to program parameters, including but not limited to:

• Last day for Program Year 2015 Legacy MU attestation submission
• Start date for Modified Stage 2 attestations
• Tail/Grace Period updates
• Documentation Requirement Updates

The CGI MI360 policy leadership developed training materials and a training plan to impart the intricacies of the regulatory changes. These training materials are also used by the Texas EHR Incentive Program team to supplement internal efforts.

4.6.3.4 Fiscal Services Related to Modified Stage 2 Final Rule

Implementation of the Modified Stage 2 Final Rule structure does not require any modifications or revisions to existing fiscal processes for payments, overpayments, underpayments and recoupments based on the new requirements.

4.6.3.5 Appeals Related to Modified Stage 2 Final Rule

Implementation of the Modified Stage 2 Final Rule structure does not require any modifications or revisions to existing appeal processes.

4.6.3.6 Auditing Changes Related to Modified Stage 2 Final Rule

HHSC is not proposing any changes to the existing pre-payment review requirements.

As mentioned earlier, per the CMS guidance presented in section II.B.1.b.(4).b.(iii), on page 62788, there is no documentation requirement for providers to substantiate their “intent” when exercising the alternate exclusions based on “they did not plan to attest to a menu objective”.

At this time, HHSC is in the process of evaluating the changes that will be made to the post-payment audit process for attestations and payments made to providers attesting to Modified Stage 2. HHSC will continue to monitor subsequent guidance from CMS through email distribution, HITECH All-States calls and FAQs and update the State Audit Strategy accordingly.

4.6.4 EHR Incentive Program Changes Under the Medicare Hospital Outpatient Prospective Payment System Final Rule and MIPS

On November 14, 2016, CMS published a final rule with comment period related to the Medicare hospital outpatient prospective payment system (OPPS) that included modifications
to the EHR Incentive Program. The OPPS rule finalized the following changes that impact the Medicaid EHR Incentive Program for Program Years 2016 and 2017:

- Allows a 90-day EHR reporting period for meaningful use attestations in Program Years 2016 and 2017 for all providers, regardless of their stage of meaningful use.
- Maintains a 365-day reporting period for CQMs for returning meaningful users, regardless of the separate 90-day EHR reporting period for MU measures.
- Changes the policy on measure calculations for actions that occur outside the EHR reporting period, for all measures unless otherwise specified.

Regarding the change in policy on measure calculations, CMS finalized that "...for all meaningful use measures, unless otherwise specified, actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs." In December 2016 CMS further clarified this policy change in Frequently Asked Question (FAQ) #18261, which states that the following objectives and measures fall under this policy in 2017 for Modified Stage 2:

- Protect Patient Health Information: (Security Risk Analysis),
- Health Information Exchange,
- Patient Specific Education,
- Patient Electronic Access (measure 2 - VDT)
- Secure Messaging (EPs only for Modified Stage 2), and
- Public Health Reporting

FAQ #18261 states the following objectives and measures fall under this policy for Stage 3:

- Protect Patient Health Information (Security Risk Analysis),
- Patient Electronic Access to Health Information (measure 2-Patient Specific Educational Resources),
- Coordination of Care Through Patient Engagement (measure 1 – VDT and measure 2-Secure Messaging)
- Health Information Exchange (measure 1 – Send a Summary of Care), and
- Public Health Reporting.

All other MU measures are strictly specified in the CMS specification sheets that actions in the denominator must occur during the EHR reporting period and the numerator must be a subset of the denominator. Therefore, for all measures other than those listed in FAQ #18261, actions counted in the numerator cannot occur outside the attested EHR reporting period and therefore this new policy does not apply. No new pre-payment review procedures are needed to address this change, as our pre-payment review procedure for numerator/denominator measures simply compares a provider's attested data with a system-generated MU dashboard. HHSC will conduct pre-payment review of the Security Risk Analysis and Public Health Reporting in the same manner as currently established, with an allowance for the new reporting timeframe for these measures. Any required changes in post-payment audit procedures will be addressed in a later version of the state's Audit Plan, as HHSC is currently auditing only Program Years 2013 and 2014 at this time.

HHSC implemented all relevant OPPS-related changes in the attestation system on January 1, 2017, which is the effective date of the OPPS final rule.
Medicare Quality Payment Program (QPP)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changed the Medicare provider reimbursement methodology and established the Quality Payment Program (QPP), consisting of the Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). MIPS consolidates three existing quality-reporting programs, including meaningful use. On October 14, 2016, CMS issued a final rule (with comment period), effective January 1, 2017, to implement MIPS. While MIPS incorporates components of meaningful use for Medicare providers and sunsets the Medicare EHR Incentive Program after 2018, the MIPS Rule leaves the Medicaid EHR Incentive Program intact. CMS has confirmed that MIPS does not impact meaningful use as it relates to the Medicaid EHR Incentive Program. Therefore, HHSC does not anticipate any impacts or changes to meaningful use measures or the administration of the Medicaid EHR Incentive Program as a result of MIPS.

The MIPS Rule updated the definition of a meaningful user to include the support of information exchange and the prevention of health information blocking. HHSC is modifying the attestation screens to add a series of "Information Blocking Attestation Statements" to which each provider must attest "yes" or "no". Details of the screen modifications will be available in HHSC's separate screen changes document submission to CMS, which were submitted in January 2017.

The MIPS Rule also established a requirement for each EP to cooperate in good faith with an Office of the National Coordinator (ONC) "direct review" of his or her certified EHR technology (CEHRT) if such a request is received from ONC. "Direct review" means, if requested by ONC, an EP will permit timely access to the CEHRT in order to demonstrate its capabilities as implemented and used by the EP in the field. The purpose of direct review of CEHRT is to verify that certified technologies are functioning properly and meeting certification requirements. The direct review is not an audit of an EP's participation in the EHR Incentive Program and findings of a direct review by ONC will not impact the EP's incentive payments or program eligibility.

The MIPS Rule requires EPs to attest to their acknowledgement of the requirement to cooperate in good faith with ONC direct review of his or her CEHRT. EPs must also attest to having cooperated in good faith with ONC direct review if such a request was received. CMS noted in the MIPS Rule that this second attestation requirement is retrospective, i.e. providers will attest that they did cooperate with a prior direct review of CEHRT if ONC made such a request.

The MIPS Rule also allows EPs to optionally attest to cooperate in good faith with ONC-Authorized Certification Body (ONC-ACB) "surveillance" of his or her CEHRT if such a request is received. "Surveillance" activities may include surveys and/or phone interviews with EPs to determine the extent to which the EP's technology meets the definition of CEHRT. EPs may optionally attest to acknowledgement of the option to cooperate in good faith with ONC-ACB surveillance of his or her CEHRT. EPs may also optionally attest to having cooperated in good faith with ONC-ACB surveillance if such a request was received.

HHSC is modifying the attestation screens to add a series of "ONC Review Attestation Statements" to which each provider must attest "yes" or "no". Details of the screen

Texas State Medicaid Health Information Technology Plan (SMHP)
August 7, 2017
modifications will be available in HHSC's separate screen changes document submission to CMS which was submitted in January 2017.

There are no program or policy changes required to address these MIPS requirement, as direct review and surveillance activities will be carried out independently by ONC. Similarly, HHSC will not audit an EP’s attestation statements related to cooperating with ONC activities.

4.6.5 IT Systems Changes for Implementation of the EHR Incentive Program

Systems changes to the TMHP portal presentation, and batch interfaces with external and internal databases, are summarized in Figure 9.

Figure 9. TMHP System Changes for EHR Program Implementation

4.6.6 Schedule of Systems Changes:

This section describes the historical changes made in 2010 and 2011 as part of the EHR Incentive Program implementation in Texas.

Fall of 2010—Provider Enrollments and CMS Interfaces

1. Modifications to provider subsystems for eligibility determinations. Modifications included an interface with the National Level Repository.
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 were 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 conducted payment determinations using new elements of the provider portal.
2. Claims system was updated to generate incentive payments.
3. Pre-pay review flagging mechanism was built into the provider portal and interface with the pre-payment review 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.

4.7 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 (Provider Relations 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.
5. THE STATE’S EHR AUDIT STRATEGY

5.1 Overview

HHSC conducts 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 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 historically has been responsible for auditing dually eligible hospitals, while the State maintains authority to audit the Medicaid-only hospitals.

The EHR program subcontractor, CGI, oversees automated and manual pre-payment verifications for AIU and MU. CGI program specialists verify eligibility criteria, including Medicaid volume and adoption of CEHRT, on a pre-payment basis for all EPs and EHs. These reviews are not considered to be formal “audits” and providers who undergo pre-payment review are not exempt from selection for a formal post-payment audit. In addition, successful completion of a pre-payment review and issuance of an incentive payment to the provider does not guarantee that a post-payment audit will be favorable for the EP or EH. The post-payment audit is a formal process to verify that program and eligibility requirements were fully met, and a more stringent verification process is completed per formal auditing standards.

For post-payment audits, HHSC contracts with an independent auditing firm. 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 all program requirements and information attested to for the EHR Incentive Program, including but not limited to provider type eligibility, patient volume, AIU of a certified electronic health 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. (Texas has given CMS the authority and responsibility to audit dually eligible hospitals.) Volume, scope, methods, and procedures are based on risk assessments and are materially consistent with HHSC audit protocols. Audit notices are sent to providers with a questionnaire and instructions to submit the necessary documentation for review. Once a provider has been notified of an audit, he or she loses the right to “voluntarily” return the incentive payment and may not re-attest for that payment or program year.

If a provider fails a post-payment audit, the provider may appeal to HHSC through an established appeals process. If a provider chooses not to appeal, or pursues an appeal that does not result in a favorable outcome, the incentive payment is recouped and the provider may not re-attest for that program year or payment unless an exception is granted at HHSC’s discretion. Recoupment of incentive payments based on adverse audit findings are processed through the existing accounts receivable process at TMHP and are recouped against the Medicaid billing account of the designated payee that received the incentive funds. Once the accounts receivable is established, the provider may also submit a check to TMHP to fulfill all or a portion of the accounts receivable. If HHSC is unable to recoup from the payee, some cases may be referred to the Attorney General’s office for additional recoupment actions against the payee or the EP who attested and re-assigned the payment.
Detailed audit methods are described in the State’s separately approved EHR Incentive Program Audit Plan.

### 5.2 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 used to provide an initial check of Medicaid volume attestation prior to payment. HHSC conducts pre-payment eligibility reviews on all eligible hospitals and eligible professionals. As described below, HHSC verifies a number of eligibility criteria in the pre-payment review, including eligible provider type, non-hospital based status for EPs, adoption of CEHRT and Medicaid volume verification. For example, if a provider Medicaid volume attestation is out of line (>1.33 variance factor) with independently verifiable data such as available Medicaid claims data, HHSC sends a request for additional information to support the attestation. HHSC 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 review and is denied payment for that program year. The provider may attest for the payment in a subsequent year.

#### 5.2.1 Hospital Screening Process

Hospital Medicaid volume data submitted during the attestation process are checked against available HHSC data. All EHs are subject to pre-payment verification and checks. (Some EHs will be selected for random or targeted post-payment audits.) The main data source for the state to verify hospital attestation regarding Medicaid incentive payment calculations is hospital Medicaid cost reporting. HHSC follows CMS guidance to verify specific cost report lines related to the hospital payment calculation against the hospital’s attested data. Beginning in 2015, all hospitals attesting for a payment are required to complete a cost report questionnaire to verify that the cost report data aligns with federal program requirements for the incentive calculation. HHSC also verifies the average length of stay for acute care hospitals (including critical access hospitals), adoption of CEHRT, and reviews attested inputs for the hospital payment calculation.

#### 5.2.2 Eligible Professional Screening Process

All EPs undergo an automated volume check that compares the attested Medicaid volume to HHSC MMIS claims and encounter data. If the EP’s attested volume differs from HHSC auditable data sources by more than a factor of 1.33, the EP is contacted by the Business Services Center (BSC). The EP is asked to submit additional documentation to verify Medicaid volumes. Eligibility screening also identifies possible hospital-based providers and EPs with insufficient Medicaid volume to be eligible. Provider profiles based on Medicaid claims and encounters are used as a check of attestations in both areas.

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

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24 CMS FAQ #3471
Physicians: Medicaid claims and Medicaid managed care capitation payments and encounter data, if appropriate.

Nurse Practitioners and Certified Nurse Midwives: Medicaid claims and Medicaid managed care capitation payments and encounter data, if appropriate. 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 demonstrate the supervising physician relationship via 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, if appropriate.

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: In addition to patient volume documentation, 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 website25 and linked to the MI360 attestation portal.

Optometrists: Medicaid claims and Medicaid managed care capitation payments and encounter data, if appropriate.

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 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. Place of Service (POS) Code from Medicaid physician claims is used 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 are POS 21 and POS 23.

In addition to the volume screening, HHSC reviews other eligibility criteria during pre-payment screening, such as adoption of CEHRT, eligible provider type, and meaningful use measures.

25 http://www.tmhp.com/Provider_Forms/Health%20IT/PA%20Led%20Form_Texas_FINAL.pdf
Some EPs will also be selected for random or targeted post-payment audits. Detailed information on the post-payment audit methodologies are found in HHSC’s separate CMS-approved Audit Plan.

5.3 Other Methods to Identify Suspected Fraud and Abuse

The HHSC Health Informatics Services and Quality Department (HISQ, formerly 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 and describes in greater detail HHSC’s strategy for verifying proper payment of EHR incentive dollars to eligible professionals and hospitals and ensuring recoupment of any improper payments.

5.3.1 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 are handled according to Medicaid’s current process for recouping overpayments. In most cases, this involves the establishment of an Accounts Receivable on the payee Medicaid account, which is triggered by a negative adjustment reported on the weekly EHR Incentive Program electronic payment file from CGI to TMHP. A provider also has the option of submitting a check to repay the balance in full. In the past, HHSC reported recoupment of incentive overpayments to CMS as collections on the CMS-64 financial report. After clarification from CMS in May 2015, HHSC began reporting overpayment recoupments from EPs and EHs as negative expenditures on Federal Category of Service lines 24E and 24F, respectively, and HHSC made correcting entries for the recoupments that have historically been reported as collections.

5.3.2 Fraud and Abuse Detection

When fraud or abuse is detected, a referral will be sent to HHSC OIG. In accordance with documented processes, referrals to the OIG may 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.

5.3.3 Providers with Cross-state Catchments

For the post-payment audit of EPs, HHSC will supplement the available MMIS claims and encounters data with data from the provider’s electronic claims system, which is particularly helpful for providers with multi-state patient bases. HHSC also asks other states to share Medicaid claims data for audit purposes when a provider is attesting to out-of-state encounters.

5.3.4 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 review process. 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 also helps 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 details on pre-pay MU verification are contained in HHSC’s separate Audit Plan.

HHSC conducts additional MU verification checks during attestation. An EP is asked for additional information if he/she enters a denominator for certain MU measures that is greater than the reported number of unique patients. Some 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 for certain MU measures that does not match the reported number of unique patients. Some 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.

5.3.5 CMS Batch File MU Reporting for Medicare Payment Adjustments

CMS imposes Medicare payment penalties on those providers who have not achieved MU in either the Medicare or Medicaid EHR Incentive Programs. Therefore, providers who receive Medicaid meaningful use payments are reported to CMS as meaningful users for purposes of avoiding Medicare payment penalties. CMS established a batch reporting file for submission by states on a minimum quarterly basis. This file verifies providers who have successfully achieved MU in the Medicaid EHR Incentive Program. Texas identifies meaningful users based on the date of their initial attestation submission in the MI360 portal. If a provider is later determined to not be a meaningful user (for example during a pre-payment review or post-payment audit), the provider would be removed from the next quarterly submission of the meaningful use batch file.

5.3.6 Sampling as an Audit Strategy

HHSC’s selected vendor conducts 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 risk categories that are determined with the 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 State’s separate Audit Plan.

5.3.7 Reducing Provider Burden

HHSC uses data available to the State for provider audit purposes. MMIS data is used to verify Medicaid volume so that most providers do not have to supply additional volume data during pre-payment review. Pre-payment documentation requirements, especially related to meaningful use, minimize provider burden during post-payment audit. A document management function in MI360 guides providers through the required document upload and saves all documentation in
the attestation portal. In the event of a future post-payment audit, the auditors will have direct access to the provider’s documentation in the portal, thus reducing the burden on providers to find or recreate some of the data needed.

5.3.8 “Soft Recoupment”

The HHSC post-payment audit process includes the opportunity for an EP or EH to modify certain information during the audit in order to meet program requirements as long as the changes still fall within federal guidelines. For example, providers may change their attested volume reporting period to another qualified period if their attested volume reporting period would result in a failed audit. Providers may have the opportunity to change their meaningful use reporting period if doing so would result in a passed audit rather than a failure. HHSC’s audit contractor verifies any new data submitted during the audit process through the established audit procedures. If a provider can pass the audit based on revised data, no further action is taken by the auditor, HHSC or the provider. CMS refers to this as a “soft recoupment,” although in these cases in Texas, no financial recoupment actually occurs. Rather, the auditors note in their findings if they considered revised data or revised reporting periods in making the final audit determination.

5.3.9 Notification of Audit and Appeal of Post-Payment Audit Findings

HHSC follows rules established in the Texas Administrative Code for notification of audit, recoupment, and provider appeal of an adverse finding, as follows.26

- 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;
- Limit the period covered by an audit to three years;
- 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;
- 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;
- At the field audit exit interview or in response to an audit results notification, allow the EP or EH to:
  - Respond to the questions by the agency/auditor;
  - Comment, if the EP or EH desires, on the initial findings of the agency/auditor, and

26 Texas Administrative Code (TAC), Title 1, Part 15, Chapter 354, Subchapter B, Rule §354.1450 and TAC, Title 1, Part 15, Chapter 356, Subchapter B, Rule §356.202
• 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;

• Permit the EP or EH to produce, for consideration, documentation to address any exception found during an audit not later than the 10th day after the date the desk audit or field audit is completed;

• Deliver a draft audit report to the EP or EH not later than the 60th 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;

• 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 30th 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;

• 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

• Deliver the final audit report not later than the 180th day after the date the desk audit or field audit is completed.

The appeal policy is posted on the EHR Incentive Program website and included in the audit findings notice sent to providers. A provider who fails a post-payment audit will be subject to recoupment of the incentive payment via the established TMHP accounts receivable process for the program year under audit. The provider may appeal the audit finding per the procedures listed above. If the provider’s appeal is successful, the provider may be asked to re-attest for the same payment. Otherwise, no other action is taken. If the provider’s appeal is unsuccessful, the provider’s payment is recouped. 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.

5.4 HHSC Program Integrity Operations

Audit and program integrity functions generally fall under the Health Informatics Services and Quality (HISQ) Department which oversees the EHR Incentive Program. More broadly, HHSC’s Office of Inspector General (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, including the EHR Incentive Program, 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, although they do not directly audit incentive program payments to EHs.
6. OUTREACH AND EDUCATION

6.1 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 four major categories: education, outreach (provider, client, enterprise staff, and legislature), advocacy, and stakeholder coordination.

The Health IT division within Texas Medicaid is responsible for leading the education, outreach and advocacy efforts to providers and clients regarding the Texas Medicaid EHR Incentive Program, and supporting the education and outreach efforts of other health IT initiatives. Health IT Communications staff are involved in developing the messages that are part of Texas Medicaid’s outreach campaign, devising appropriate 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.

6.2 Key Messages

6.2.1 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, optometrists, 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. For example:

Texas implemented the 2014 CEHRT Flexibility Rule options in the State’s attestation portal on October 1, 2014. This was accompanied by a multi-pronged effort to notify providers of the Final Rule and the attestation options available to them. HHSC’s outreach efforts included:

- A notice posted on the Texas Medicaid provider website
- Email notices sent to providers through the attestation portal
- Email notices sent to providers through the Texas Gov Delivery notification system
- Notifications to stakeholder and provider groups, as well as the four Texas Regional Extension Centers (RECs)
- Inclusion of information on the Flexibility Rule in EHR Incentive Program webinars, including presentation at the Texas Health Information Exchange Advisory Committee public hearing in October 2014.
HHSC uses similar outreach methods when CMS makes other federal rule changes, and did so when CMS published the Modified Stage 2 and Stage 3 Final Rule in 2015 and the Merit-Based Incentive Payment System (MIPS) Final Rule in 2016. HHSC also works directly with providers, associations, and the RECs to answer questions and provide up to date information on the EHR Incentive Program as it becomes available.

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

**6.2.2 Making the Case for Quality Improvement, Coordination of Care, Medication reconciliation and e-Prescribing 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 is important to identify barriers and then apply appropriate outreach responses. In addition, Texas Medicaid Health IT, in coordination with administrators of Texas Health Steps (the EPSDT program), Health Quality, MCOs and other HHS program areas, will develop strategies and projects to advance meaningful use of EHR and HIE such as Computer-Based Training (CBT) and CME certified modules, tutorials and other training. Providers who participate in Texas Health Steps will be able to use certified EHR Technology (CEHRT) to improve their ability to comply with required EPSDT medical assessments, upon which their performance is often evaluated.

In 2015 Health IT Communications started a state-wide stakeholder initiative to increase electronic prescribing of controlled substances (ePCS). This initiative included monthly stakeholder calls consisting of provider organizations, pharmacy organizations and vendors. Stakeholders contributed ads in organizational periodicals, and handed out 20,000 HHSC supplied brochures at events and during provider visits. Vendors and others hosted webinars on ePCS that were promoted by Health IT and other stakeholders. Health IT has mailed out 50,000 ePCS brochures, advertised in the Texas Medical Association magazine and made presentations at MCO and pharmacy leadership meetings as well as the Texas Behavioral Health Institute conference. Health IT Communications is working closely with Health IT analytics staff to use claims-based data to identify providers likely to start using ePCS or increase use. The Health IT Communications strategy is to increase provider familiarity and use of Health IT tools such as e-prescribing to continue advancing such technology into common use to improve coordination and quality of care.

Discussions are underway to integrate health IT language into Texas Health Steps CME training. Information on Health IT is planned for the Texas Medicaid Provider Procedures Manual and the Texas Medicaid: Uniform Managed Care Manual. Quarterly Back to Basics and Beyond Basics provider workshops and manuals have growing content on EHR, HIE and e-prescribing. A public awareness campaign will address reducing barriers hindering EHR and HIE use.

**6.2.3 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 needs 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. Presentations to other program areas, articles in HHSC In Touch magazine and other means will be used to inform the HHS enterprise and identify
opportunities for coordination. 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.

6.3 Outreach and Education

6.3.1 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:

- Leveraging provider relations
- Making beneficial resources available online
- Presenting at stakeholder meetings
- Creating Webinars to inform and influence provider decisions
- Leveraging TMHP and HHSC web-based communications to keep health IT and the Medicaid EHR Incentive Program visible
- Webcasting advisory committee meetings as a forum to increase state-wide provider engagement
- Working with local and state HIEs as well as Regional Extension Centers, Regional Advisory Councils and organizations such as Health Information Management Systems Society (HIMSS), Texas Medical Association and other respected industry stakeholders

Provider outreach efforts are intended to increase the rate and progress of Medicaid EHR Incentive attestation and increase provider and hospital connectivity and data exchange through HIEs such as developing admit, discharge, transfer (ADT) event notices, and increasing the use of e-prescribing, e-prescribing of controlled substances (EPCS), electronically accessing lab reports, use of EHR for medication reconciliation to reduce adverse drug reactions (ADR) and other quality improvements tied to MU measures. Recognizing health IT achievements that improve quality and care coordination will increase the value of achieving meaningful use and motivate increased adoption and use. Collaborating with MCOs, Texas Health Steps and other program areas will also be used to reach providers in clinical settings, as well as leveraging other stakeholder communications such as through the Texas Medicaid Provider Procedures Manual (TMPPM) and the Texas Medicaid Uniform Managed Care Manual (UMCM) and aiding provider understanding through materials presented at quarterly TMHP Back to Basics and Beyond Basics provider workshops.

6.3.1.1 Presentations at Stakeholder Meetings and Conferences
Texas Medicaid makes periodic presentations to the following internal and external stakeholders:

- Texas Medicaid HIE Advisory Committee
- Regional Extension Center Webcasts
- Quality-Based Payment Advisory Committee
- Texas Association of Community Health Centers
• Health Information Management System Society
• A&M Regional Learning Center
• Children's Policy Council
• Texas Association of State Systems for Computing and Communications
• Regional Advisory Committees (RACs) throughout the state
• Managed Care Organization (MCO) Quarterly Meetings

6.3.1.2 Articles and Other Outreach – External Stakeholders

Texas Medicaid Health IT reaches out to 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 surveys, 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
• EHR Incentive Program participants via email
• Other HHS Agencies

6.3.1.3 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, REC direct contact, surveys, events, health plans, websites, webcasts, Texas Health Steps, health IT organizations, and/or other means to encourage them to complete the attestation process.

6.3.1.4 Provider Webinars

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

Texas Medicaid may 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.
6.3.1.5 HHSC Web-Based Communications

The TMHP website, which Texas Medicaid providers are already familiar with, has been the primary source of web-based communication for the Medicaid EHR Incentive Program. A dedicated health information technology page was added to the TMHP website at:

http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx

This website has served as a 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 (http://healthit.hhsc.texas.gov) was launched in 2015 for Health IT stakeholders in Texas to learn about the Texas Medicaid EHR Incentive Program, Health Information Exchange (HIE) and other important Health IT topics. The Health IT website is used to raise awareness and advocate for the importance of using information technology in healthcare and demonstrate how Health IT, EHR technology, HIE and other related aspects intersect. The Health IT website informs on current and planned Health IT initiatives and provides direction on where people can get more information, or get involved in statewide efforts such as the electronic prescribing of controlled substances (ePCS) outreach campaign. Additionally, the Health IT website advocates the value of health information technology in improving patient care and coordination, and reducing costs.

6.3.1.6 E-Learning Tool

Texas Medicaid 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. An additional set of e-learning modules was created on the topic of meaningful use for eligible professionals. In consideration of the end of AIU in 2016 and changes to meaningful use that have occurred since 2012, HHSC will retire the EHR Incentive Program computer-based trainings in September 2017.

6.3.1.7 Texas Health IT Day

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

The fourth Texas Health IT Day occurred in May 2016. Future Health IT Days are not being planned at this time.

### 6.3.1.8 Provider and Hospital Surveys

Provider and hospital surveys are conducted to collect statewide information on the prevalence and scope of health information technology adoption by various types of providers and hospitals. This includes the surveys to identify barriers to attesting to A/I/U and Meaningful Use Stage 1.

### 6.3.1.9 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.

### 6.3.2 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 for clients with complex health conditions and their families. This includes understanding how EHR and HIE effect patient privacy. A study was conducted to determine the best way to reach and inform clients regarding the benefits of using EHR and HIE to manage, coordinate and transition care. Texas Medicaid and its service partners, including health plans and Texas Health Steps Program, are revising 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 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.

### 6.3.3 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.

### 6.3.4 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.
6.4 Coordination

Successful health IT is implemented in a way that allows health information to be available when and where it is needed to care for patients and improve safety, quality, and efficiency. Communication and outreach efforts 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.

6.4.1 Goals of Communication and Outreach

Health IT is one of the key focus areas to improve patient safety, quality, coordination and cost of care. Communications and outreach will focus on the following goals:

- Understanding and addressing barriers to adoption of health information technologies
- Recognizing and elevating the value of meaningful users in the health care community and the public
- Raising awareness of the importance of healthcare transformation with providers and clients
- Communicating a value proposition to specific identifiable provider and client segments who will experience the most immediate gains, such as coordination of care and quality improvement incentives
- Targeting areas for increased utilization such as e-prescribing and health information exchange

6.4.2 Stakeholders

With guidance and assistance from the HHSC communications groups, Texas Medicaid and the Office of e-Health Coordination create and disseminate 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.

6.4.3 Audience

Communications and outreach are directed primarily to Texas providers and hospitals, as they are the primary implementers of health IT, as well as to clients who benefit. Other audiences include legislators, influential organizations, and key internal state agency stakeholders such as the MCOs, Texas Health Steps, and the Children with Special Health Care Needs program.

6.4.4 Communication Methods

In addition to traditional communication media such as articles and websites, Texas Medicaid utilizes and is planning additional communications methods and strategies, including:

- Assessment of Barriers to Medicaid EHR Incentive Program attestation.
- Texas case studies that demonstrate lessons learned on new Health IT website
- Training and tools to aid providers to more quickly adapt to use of EHR and HIE
- Meaningful Use Provider Directory on Health IT website
- Tip sheets and flyers
- Frequently Asked Questions
- Presentations at conferences and meetings
- Talking points
- Ongoing dialogue and coordination among RECs, THSA, and local HIEs regarding outreach and communications

**6.4.5 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 Family and Protective Services (DFPS)
- HHSC Access and Eligibility Services (AES) Department
- HHSC Center for the Elimination of Disproportionality and Disparities (CEDD)
- Office of Minority Health and Health Equity (OMHHE)
- Medicaid managed care health plans (MCOs) and medical directors
- Other state agencies where appropriate (e.g., Texas Department of Rural Affairs)

**6.4.6 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:

- Health IT Regional Extension Centers (RECs);
- Texas Health Services Authority (THSA);
- Local/regional Health Information Exchanges
- 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.

**6.5 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.

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

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

6.6.1 **Phone Support**

TMHP has a main call center number for general inquiries, claims, educational opportunities, and other special topics. In addition, the EHR Incentive Program has a direct phone number to the Program’s Business Services Center (BSC). The BSC functions as the primary phone support/help desk for EHR Incentive Program. The BSC is staffed by trained program specialists from TMHP’s subcontractor, CGI. In addition, TMHP and the BSC work with Texas Medicaid to elevate questions to a higher level of response when needed.

6.6.2 **E-mail Queries**

Providers have the opportunity to submit questions and/or concerns about the EHR Incentive Program by email to dedicated email addresses at TMHP, HHSC, and the BSC. 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. LEVERAGING RESULTS OF THE EHR INCENTIVE PROGRAM

This section highlights some of the data-driven initiatives emerging out of the EHR Incentive program and how they will be benefit the Medicaid enterprise.

7.1 Health Information Technology Analytics Program

The Health Informatics Services and Quality (HISQ) unit at HHSC has created an analytics program to aid in fulfilling the goals and vision expressed in this SMHP.

7.2 EHR Incentive Program Operational Analytics and Business Intelligence

Operational analytics provide for both tactical and strategic business intelligence intended to aid the operation of the EHR Incentive Program. Data is extracted from the State Level Repository (SLR) and placed into the HISQ unit's analytics platform. This, and other data sources, provide managers of the EHR Incentive Program with valuable data upon which to make decisions. This business intelligence also supports the incentive program audit strategy.

7.2.1 EHR Incentive Program Effects and Insights

Analytics work in this category includes such endeavors as joining Medicaid prescription claims and health department immunization registry data to the EHR Incentive Program data. From such an amalgamation of data, one can study the differences between participating EHR program Medicaid providers and non-participating Medicaid providers. For example, efforts have included examining and comparing trends such as reporting rates in the immunization registry between participating and non-participating providers, and e-prescribing rates between the two.

7.2.2 Demonstrating the Merging of Clinical and Administrative Data

As a result of efforts to promote the use of EHRs, large amounts of structured, coded health data are being created. Health Information Exchange (HIE) activities will make this data available to Medicaid. The HISQ unit will design and implement initial procedures on how this new data can be merged with existing administrative data. Use of this merged data for the incentive program’s goals will act as an example for other Medicaid programs.

7.2.3 Analytics and Data-mart Platform

A data and analytics platform has been implemented expressly for the analytics initiatives described in this SMHP.

7.2.3.1 Software and Services for Analysis and Data Transformation

A variety of software solutions have been procured to aid in analytics pursuits. Contractor services may be procured for assistance in implementing and maintaining these software resources.

7.2.3.2 Data Sources

The HISQ unit's analytics program involves the use of techniques that merge multiple data sources. Sometimes these data sources will be procured on a fee basis. In other instances, it may be necessary to expend funds to integrate with a data source. Additionally, it may be
necessary to expend funds in order to groom and transform a data source for use in the system. Examples of data sources already integrated into the team’s analytics efforts include:

- Administrative claims data garnered from MCOs and Fee-for-Service program.
- Quality measure data from the Meaningful Use Clinical Quality Measure reporting
- State Medical Board license data
- Medication history lookup logs from Texas Medicaid’s Surescripts interface
- Morphine Milligram Equivalency tables and drug formulary to aid in analyzing e-prescribing patterns
- NPPES NPI Registry data

### 7.2.4 Analytics Learning and Collaboration

The staff involved with the analytics program will expend funds for attending industry events that provide learning relevant to the analytics program. Additionally, learning resources such as on-demand media and on-site training may be procured for the benefit of the team, covering general topics, specific software and specialized techniques. Funding may be expended to facilitate collaborative efforts to share and utilize data with other Medicaid and HHS programs.

### 7.3 Assisting with HIE-enabled Payment Reform Strategies

The HISQ unit will offer assistance to other Medicaid programs that endeavor to incorporate data garnered from HIEs into their business processes. For example, the acquisition of structured and coded data will assist Medicaid programs in conceptualizing and moving towards population health management.

HISQ has recently authored and proposed HIE-related performance measures for use by the state’s Delivery System Reform Incentive Program (DSRIP). This and further measures will aid in moving Medicaid providers toward robust adoption of the Health IT and HIE resources that can benefit Medicaid and its clients.

### 7.4 Empowering Coordination of Care through the Use of HIE

Coordination of care is one of the changes to the health care delivery system with the most potential to further the triple aim of increasing population health, improving patient experiences and controlling cost. Many forms of care coordination are emerging and most depend upon, or are significantly enhanced by, health information exchange. The HISQ unit works with the Medicaid enterprise to identify where HIT and HIE elements can be applied for benefit. As Texas' state-wide HIE infrastructure is implemented and matures, new opportunities will present themselves. The HIT unit submitted an HIE-related Implementation Advanced Planning Document (IAPD) as part of this effort. As of July 24, 2017 this IAPD is under review by CMS and awaiting approval.

Near-term efforts in this area will include the implementation of a system to create and distribute alerts about Medicaid patients entering hospital emergency departments. Several use cases have been demonstrated by other states for these Admissions, Discharge and Transfer (ADT) alerts. Primarily, the alerts allow a care coordinator at a health plan and/or the patient's medical home to intervene in a patient's care in a timely manner. In an additional use case, specific care team members such as behavioral health professionals can be alerted so that
beneficial interventions can occur at the point of care that improve patient outcomes and reduce costs to the health plan.

7.5 **Building HIE Infrastructure**

Continuing the build-out of the infrastructure necessary to support the state's HIE strategy, HHSC will procure funding to implement additional HIE components.

7.5.1 **State-Level Services Layer**

The original HIE funding provided by the Office of the National Coordinator of Health Information Technology (ONC) has laid a foundation for HIE in Texas. Medicaid will work with local HIEs and HIETexas to find ways to assist in building and maintaining the infrastructure necessary to power HIE between Medicaid providers and delivery of client clinical data to Medicaid.

7.5.2 **Medicaid Access to HIE Data**

The Medicaid enterprise has a great deal to gain from the incorporation of clinical data into its business processes. The incorporation of clinical data is a first step towards population management of health. HHSC will pave the way for the reception of clinical data via the emerging, state-wide HIE infrastructure. This will include the legal and regulatory work necessary for Medicaid to join HIETexas, our state-level HIE services platform.

7.6 **Provider Connectivity to HIEs**

HHSC will utilize HITECH funding to promote provider connectivity to the state HIE network. This is known as "last mile" connectivity, i.e., the connection between a practice or hospital's EHR and an entry point to the state network. Once these connections are widespread, the HIE infrastructure currently being built will begin providing the benefits of HIE to Medicaid and other stakeholders. HHSC will begin by assisting EHR Incentive Program providers, as they are high-volume Medicaid providers and have shown the ability to utilize EHRs.

7.7 **HIE-enabled Quality and Performance Improvement Programs**

Recognizing a disconnect between quality measure design and emerging data sources, the HIT team will work with existing programs within Medicaid to incorporate the use of data emerging from EHRs and HIEs. Quality measurement programs that do not currently utilize clinical data will be encouraged to redesign measures or augment measures with electronic options that leverage emerging HITECH resources. New measurement mechanisms may be created that reward provider participation in quality programs that feature electronic exchange of clinical data or usage of HIE-enabled care coordination strategies.
8. THE STATE’S HEALTH IT ROADMAP

8.1 “As-Is” – “To-Be” Pathway
Fulfillment of HHSC’s Health IT vision is dependent on transformative changes across the System, through its departmental levels, and down to the provider level at the point of care. At the departmental level, the Medicaid Program focuses on assisting EPs and eligible hospitals to achieve adoption and meaningful use of CEHRT through the EHR Incentive Program.

HHSC is also working at the System 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 established a Quality Payment advisory committee of HHSC officials and external experts, and created a unit on quality and performance measurement.

8.2 Provider EHR Technology Adoption Expectations
In developing its first SMHP in 2010, the HHSC 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.

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, 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.

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Based on an early analysis of data and an understanding of the Technology Adoption Curve (Figure 5), in 2010 HHSC identified the following projections for eligible hospital (EH) and eligible professional (EP) adoption rates, as summarized in Table 9. Table 10 and Table 11 are historical tables describing the progress of the EHR Incentive Program in the early years of implementation, from 2011-2014.

**Table 9 . Projected Adoption by Eligible Provider Type**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>2011 Estimated Baseline</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>EH - Acute Care</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
<td>70%</td>
</tr>
<tr>
<td>EH – Children’s Hospital</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>85%</td>
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<tr>
<td>EP – Physician</td>
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<tr>
<td>EP – Pediatric</td>
<td>5%</td>
<td>10%</td>
<td>25%</td>
<td>45%</td>
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<tr>
<td>EP – CNMs</td>
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<tr>
<td>EP – Nurse Practitioners</td>
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<tr>
<td>EP – PAs when practicing at an FQHC/RHC</td>
<td>3%</td>
<td>10%</td>
<td>20%</td>
<td>35%</td>
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<tr>
<td>EP – Dentists</td>
<td>3%</td>
<td>6%</td>
<td>8%</td>
<td>15%</td>
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</table>
Table 10. 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 | 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%. Medicaid is targeting 10%-20% adoption among hospitals and 3%-5% for eligible professionals. Providers incentives for adopt, implement and upgrade only by attestation. Few providers will be meaningful users. Understanding of the incentive program, EHR technology and meaningful use grows across the state. | Expected adoption growth among early adopters continues. Adoption by the early majority begins which represents a growth of up to 34%—if HHSC and REC's are successful in addressing “the chasm” between early adopters and the early majority. The target will be 20%-40% among hospitals and 6%-10% among eligible professionals. Adopters from 2011 will begin achieving meaningful use. AIU and/or meaningful use will likely be most pronounced in urban and suburban areas throughout the state. | The Early Majority, adoption continues in 2013. Medicaid is targeting 40%-60% adoption among hospitals and 8%-25% adoption among eligible professionals. Meaningful use among adopters will continue to increase. Key issues will be: available resources to assist providers, ready access to technology infrastructure (certified EHRs, broadband and local champions and success stories) Explore inclusion of a requirement in MCO contracts for e-Transmission of laboratory results. | The Late Majority (up to 34%) will begin investigating the adoption of EHRs. Medicaid targets 70%-85% adoption among hospitals and 15%-45% adoption among eligible professionals. Meaningful use growth across urban and rural communities statewide. |
8.3 Historic Annual Benchmarks

Table 11. Annual Benchmarks for Meaningful Use

<table>
<thead>
<tr>
<th>Measure</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
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<tr>
<td>1. To be a <em>Value Purchaser</em> of quality health outcomes by supporting and “e-enabling” these Medicaid enterprise improvements</td>
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<tr>
<td>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.</td>
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<td>• Identify high cost/high risk patients, stratify population needs, and ensure use of evidence based practices through core measures.</td>
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<tr>
<td>• Establish desired outcomes, targets and critical measures.</td>
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<td>• Align reporting quality measures across payer type and/or programs.</td>
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<td>• Determine how EHR Reporting requirements can contribute to Healthcare Reform objectives.</td>
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<tr>
<td>• Begin collecting core clinical measures and/or alternate core measures from EPs &amp; EHs. Identify top performers or provider champions.</td>
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<tr>
<td>• 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.</td>
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<tr>
<td>• Explore the development of physician report cards which ranks how providers are meeting MU criteria and Evidence-based Guidelines (EBGs) compared to peers.</td>
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<tr>
<td>• Begin collecting Stage 2 Meaningful Use Criteria.</td>
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<tr>
<td>• Begin collecting additional children’s quality measures.</td>
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<tr>
<td>• Explore the use of incentives to providers dedicated to MU criteria and following clinical guidelines.</td>
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<tr>
<td>Measure</td>
<td>2011</td>
<td>2012</td>
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<td>------------------------------------------------------------------------</td>
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<tr>
<td>1.2. Comprehensive and qualified provider network capable of providing quality care based on population needs, unique care conditions, and locus of service needs</td>
<td>• Increase universal availability of health summary information (lab/test results, prior health visits, medications, other ancillary health services, etc.)&lt;br&gt;• Utilizing MEHIS to make data available to providers and recipients. –Increase electronic communication among providers (obtain base-line from the HIE).</td>
<td>• Align measures across programs - FFS, Managed Care Organizations, and children’s measures (Foster Care and others)&lt;br&gt;• Begin collecting core clinical measures and/or alternate core measures from EPs &amp; EHs. Identify top performers or provider champions.&lt;br&gt;• Easily reportable and accessible Immunization data.</td>
<td>• Begin collecting Stage 2 Meaningful Use Criteria&lt;br&gt;Begin collecting additional children’s quality measures&lt;br&gt;• Explore the development of physician report cards which rank how providers are meeting MU criteria and Evidence Based Guidelines (EBG) compared to peers&lt;br&gt;• Begin collecting Stage 2 Meaningful Use Criteria.</td>
<td>• Provide useful feedback to providers</td>
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<tr>
<td>Measure</td>
<td>2011</td>
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| **1.3. Implement effective and efficient primary and integrated care approaches** | • PCPs coordinate care with specialists, allied health care (e.g., physical, occupational and speech therapy), behavioral health and dental as needed.  
• 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.  
• Define preventive care approaches for 2012  
• Pilot THSteps – EPSDT – visit forms | • Explore open source data solutions for the THSteps visit form - directly reportable as an add-on to certified EHRs.  
• Implement Preventive Care approaches.  
• Explore expansion of MEHIS data and functionality. | | |
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<th>Measure</th>
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| **1.4. Ensure the secure and private exchange of health care information across the Medicaid enterprise consistent with national standards, and including, specialty focus providers** | • Plan how to make health information data available, meet with providers to review, check and confirm data format is meaningful and then make data available  
  • Cross walk codes to make information available in user-friendly format (e.g. Rx Norm)  
  • Begin design phase of a single point of entry into HHSC data systems and view the client life – Encounter Data Warehouse. | • Explore opportunities for MEHIS to integrate client data throughout the enterprise.  
  • Explore the development of clinical decision support capabilities. | • Electronic Data Warehouse will integrate all points of client care and store within warehouse for Medicaid. |
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<tr>
<td>1.5. Expand health care coverage to newly eligible Medicaid population under national health insurance reform</td>
<td>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.</td>
<td>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.</td>
<td>HHSC secures resources for increased personal health information storage for the expanded population and develops and tests systems modifications and interfaces.</td>
<td>HHSC begins new Medicaid and CHIP eligibility determination processes and Medicaid expansion, effective January 1, 2014.</td>
</tr>
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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

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<tr>
<td>2.1. Improving alignment of Medicaid program goals across the enterprise</td>
<td>• Ongoing collaboration and data sharing with DSHS, DFPS and DADS program executives to determine how Medicaid goals can integrate.</td>
<td></td>
<td>Ongoing collaboration strategy</td>
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<td>2.2. Making Medicaid programs more accountable for the care provided to eligible clients</td>
<td>• Set targets for desired outcomes • Develop a design of a quality report card for health plans. • Evaluate annually for continuity of care, care coordination and improved clinical health outcomes. Possible tools may include client surveys, analytics tools, etc.</td>
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<td>Measure</td>
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<td><strong>2.3. Utilizing health IT to obtain improved data to analyze and measure quality factors</strong></td>
<td>Establish a Medicaid Quality Outcomes workgroup that will perform health care analytics, and decision support to identify areas for quality improvement. 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 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</td>
<td>Analyze • provider adoption rates of EHR • policy issues • legislative requests. Examples: (1) THSteps – use reported data to target quality improvement initiatives. (2) Meaningful use of clinical measures.</td>
<td>Expansion of meaningful use and clinical quality data from EHRs.</td>
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<td>Medicaid/CHIP program and guide the development of initiatives to improve quality.</td>
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| **2.4. Providing visibility and transparency into Medicaid quality** | • Collaboratively work with provider community to develop measures.  
  • Reporting of quality metrics for Medicaid via a dashboard. | • Aligning and reporting metrics for HMOs with Texas Dept. of Insurance. |
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”).

8.4 Progress of EHR Incentive Program

More recent analysis of adoption progress, conducted in 2015, shows good progress when compared to projections. Specifically, Texas HHSC has used existing EHR Incentive Program and Medicaid Management Information System (MMIS) data to estimate progress of Texas Medicaid providers in joining the Program. The method used to derive this estimate has been designed to provide an extremely conservative, minimum percentage of all eligible Medicaid providers that have entered the Program by completing AIU. This method involves creating a window of Medicaid claims volume that corresponds to the range of claims volume typically seen from successful EHR Incentive Program providers. By applying this claims range as a filter to our full MMIS claims database, we have been able to identify what part of our full provider population may have enough volume to qualify for our program. This is then compared to the number of providers, meeting the same criteria that are already in our program. This provides us with an estimate of the percentage of eligible Medicaid providers that have already joined our program. Sections 8.2.1 through 8.2.3 describe the methodology used to determine that, by 2015, at least 52% of potentially eligible professionals had adopted CEHRT and were participating in the EHR Incentive Program.

8.4.1 Analysis of Provider Population

There are certain provider types and data issues in the incentive program and MMIS data that cause problems when attempting to build an eligibility model and estimate progress based upon that model. Thus, the population of incentive program and non-incentive program providers used to create our progress estimation was restricted to a few taxonomy types, such as family practice. This was accomplished by joining taxonomy data from the National Plan & Provider Enumeration System (NPPES). These taxonomy restrictions were applied equally to both the incentive program provider population and the full MMIS provider population. It is expected that
any resulting program participation estimates for these taxonomies should be indicative of the participation levels of other taxonomies.

Additionally, the population of providers has been restricted to full-time providers within the chosen taxonomies. It would not be possible to compare incentive program providers with the rest of the provider population in our MMIS without an assumption of full-time practice.

8.4.2 Analysis of Expected Medicaid Volume

The American Academy of Family Physicians Practice Profile Study28 found that in June 2008, a full-time family practice physician had 74.9 office visits, 3.9 hospital visits, 1.9 nursing home visits, and 0.4 home visits per week. This totals 81.1 encounters per week. Thus, over a 46 week work year, a full-time family practice physician would be expected to have 3,721 encounters.

A full-time physician, having 3,721 encounters a year, would need a minimum of 1,116 (3,721 * 0.30) Medicaid encounters a year to achieve a 30% Medicaid volume. Upper and lower bounds were created to provide a window of claims volume that described a provider that was likely to meet volume criteria for program eligibility. This window would be used to predict whether a provider not already in the program might be eligible. The volume attestations of incentive program providers were normalized from their 90-day volume reports to a full year to match the window size and the calculations of provider volume from the MMIS data.

8.4.3 Estimated Program Participation

Of the 764 providers in our incentive program that met our population criteria, 54% (N=409) fell within our volume eligibility prediction window.

Of the 7,890 other Texas Medicaid providers that met our population criteria, 10% (N=788) fell within our volume eligibility prediction window.

These results indicate that at least 52% of potentially eligible professionals were already participating in the incentive program at the time of analysis.

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 6).

28 http://www.aafp.org/about/the-aafp/family-medicine-facts/table-6.html
Figure 11. Texas HITECH Resources

Texas HITECH to improve:
- Health care quality
- Patient safety
- Cost efficiency

- Improved individual & population health outcomes
- Increased transparency & efficiency
- Improved ability to study & improve care delivery

Adoption of EHRs
- Regional Extension Center
  - Gulf Coast REC
  - CentEast REC
  - North Texas REC
  - Texas Tech University Health Science Ctr REC

Workforce Training
- University-Based Training - Texas State Univ

Meaningful Use of EHRs
- Medicare EHR Incentives
  - Centers for Medicare & Medicaid Services
- Medicaid EHR Incentive
  - Texas HHS Commission - HIT Coordinator

State Level Health Information Exchange
- Division of Medicaid & CHIP Health IT Unit

Standards & Certification Framework
- Certified HIT Product List
- Authorized Testing & Certification Bodies
  - Certification Commission for HIT
  - Drummond Group
  - InfoGard Laboratories

Privacy & Security Framework
- Patient-Centered Cognitive Support
  - Univ of Texas

Strategic HIT Advanced Research Projects
- Medicaid EHR Incentive
- Texas HHS Commission - HIT Coordinator
- Texas Health Services Authority
- Authorized Testing & Certification Bodies
  - Certification Commission for HIT
  - Drummond Group
  - InfoGard Laboratories

Framework adapted from HITECH Act Framework for Meaningful Use of EHRs

Texas State Medicaid Health Information Technology Plan (SMHP)
August 7, 2017
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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. 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.

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 21st 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 |

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.
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 /e-Health Advisory Committee
The HIE Systems Advisory Committee established under H.B. 1218 advised 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.30 The advisory committee is responsible for

advising HHSC on issues regarding development and implementation of the electronic health
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. In 2016 the advisory committee was
renamed as the eHealth Advisory Committee.

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.

House Bill 2641
H.B. 2641 in the 84th regular Legislative session, relates to the exchange of health information.
This bill mandates that the state’s health and human service agencies adopt nationally recognized
standards in their IT systems that interface in sending or receiving protected health information
going forward. H.B. 2641 also amends a number of mandatory public health reporting statutes to
enable DSHS and appropriate entities to exchange data through health information exchanges.
Additionally, the language in HB 2641 protects providers that submit information to an HIE
from litigation if the HIE or another provider accessing the information uses it in a way that
violates state or federal privacy and security laws relating to the disclosure of protected health
information. Lastly, H.B. 2641 directs the Texas Health and Human Services Commission
(HHSC) to develop a method, if determined feasible and cost effective, for reimbursing
Medicaid providers who review and transmission of electronic health information through HIEs.
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
MITA

The Gap Analysis conducted under the 2015 MITA 3.0 State Self-Assessment reiterated many of these themes across each of the MITA Business Process Areas:

- **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. Although the agency is exploring possibilities for using electronic signatures on some provider forms, 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 implementing and expanding the use of electronic signatures, improving provider portals to improve communications and encourage self-service, simplifying and consolidating the credentialing process, and leveraging other systems and data stores for provider information.

- **Contractor Management** – A lack of automated tools for MCO contract oversight and timeliness requirements in state laws, regulations and policies prevent the agency from achieving higher levels of maturity. Web portals are planned for vendor inquiries for contract documents which will assist some contractor management processes in improving MITA maturity.

- **Plan Management** - Obstacles preventing improved MITA maturity in Plan Management include the timeliness of managing reference information. The time period is established by state law, and a lack of reference code information at a federal level also prevents further MITA maturity. Many processes in plan management are manual which also results in low MITA maturity scores. The timeliness in the Rate Setting process has a low MITA maturity score since the requirements for timeliness are legislatively driven and therefore cannot be changed by the agency.

- **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 expansions of fraud and abuse detection have placed further structure and metrics on these processes. However, processes involving large numbers of stakeholders cannot feasibly be performed in the timeframe specified by MITA to achieve a higher maturity level. In addition, MITA assumes that automation is helpful, possible and desirable for all processes, but improvements in MITA maturity for some processes in Performance Management have not been deemed cost effective.

- **Operations Management** – The strength of the operations management’s business processes starts with knowledgeable staff and robust system support in C21, the long-term services and supports Claims Management System and other operational support systems. Additionally, Texas has moved the majority of Medicaid clients to managed care which allows vendor staff to meet the operational needs of Texas Medicaid. Opportunities for improvement include implementing National Provider Identification numbers as the ID for provider records and making use of data standards as they are developed and adopted by CMS.
• **Eligibility and Enrollment Management** – The processes within eligibility and enrollment management have seen significant attention in Texas. This business area is a clear priority for the State. The Texas HHS Enterprise has processes in place to meet the needs of eligibility and enrollment for members and providers. Factors which lower MITA maturity include the process for providers to 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. The agency is actively pursuing opportunities for improving MITA maturity in this area.

• **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. In some business processes, the time required to complete the process is by necessity much longer than allowed under higher MITA maturity levels (e.g., vendor contracting). In addition, the agency does not have plans to survey vendors and contractors regarding specific MITA questions (e.g., linguistically and culturally appropriate communications); such surveys would be necessary for higher MITA maturity levels. Opportunities to improve MITA maturity include implementing web-based business relationship management systems which include improved workflow for internal operations.

• **Financial Management** – Texas Medicaid 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. Improvements are planned for Third Party Liability recoveries and the management of capitation payments.

• **Care Management** – This business area is conducted through various processes and systems throughout the enterprise, without consistent integration, data standards, or data exchange interfaces. DSHS’ CMBHS system addresses some of these issues and eliminates several manual and paper-driven processes for behavioral health and substance abuse related programs. In addition, improvements are planned for business processes including the establishment of cases and managing registries.

Texas HHS continues to align its strategic systems planning with MITA and the twelve conditions and standards. 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 MMIS initiatives.
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. The CMS requirement for modular systems has been specified in the December 4, 2015 final rule and the March 31, 2016 sub-regulatory guidance. Texas HHS is currently working with CMS to transition to these new requirements in the process of modernizing our MMIS business processes and associated systems. This will ultimately result in higher MITA maturity levels across many business processes in the agency.

Figure 13. Texas HHSC Current MITA 3.0 Roadmap

Fundamental to the success of many of these projects is the replacement of the MMIS with a component-based, rules-driven system comprised of service oriented architecture modules. 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 overall state health benefits programs.

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 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 – Local HIE Grant Program Participants as of 2016

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 24 counties serving over 7 million people. 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.

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 provides HIE to the benefit of residents and providers in 22 counties in the Central and Southwest Texas area and had expanded to also cover a 13 county area in North Texas.

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. 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.

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.

PHIX (FORMERLY PASO DEL NORTE HIE)

PHIX (formerly 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 PHIX 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 PHIX 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.

PHIX 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.
## APPENDIX D -- Texas Broadband Grant Awardees

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Grant Award</th>
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<tbody>
<tr>
<td>The Texas Healthcare Information Network for Collaboration (THINC)</td>
<td>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.</td>
<td>$16,000,000</td>
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<tr>
<td>TierOne Converged Networks, Inc. TX</td>
<td>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.</td>
<td>$19,244,200</td>
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<td>DOC - Peoples Telephone Cooperative TX</td>
<td>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.</td>
<td>$28,825,356</td>
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<td>DOC - Texas A&amp;M University TX</td>
<td>This approximately $6.6 million award, with nearly $3 million in matching contributions, will allow Texas A&amp;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.</td>
<td>$6,550,775</td>
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<td>DOC - City of Brownsville TX</td>
<td>This approximately $865,000 award, matched 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.</td>
<td>$865,920</td>
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<td>DOC - Library &amp; Archives Commission, State TX</td>
<td>This approximately $8 million award, with nearly $3.7 million in matching contributions, will allow the Texas State Library &amp; 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.</td>
<td>$7,955,941</td>
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